



YOUR GROUP INSURANCE PLAN BENEFITS

HILTON WATERFRONT BEACH RESORT

CLASS 0002

AD&D, OPTIONAL LIFE, DENTAL, LIFE, 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.

The Guardian Life Insurance Company of America

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

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

New Mexico Residents
Consumer Complaint Notice

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

<http://www.osi.stat.nm.us/ConsumerAssistance/index.aspx>

CCN-2019-NM

B999.0042

You May not be covered by all options in this Certificate.

This Certificate contains all the benefits and options that are available under the Policy. You are insured only for those benefits and options that you are eligible and enrolled for, and for which the required premium has been paid.

CERTIFICATE OF COVERAGE

The Guardian

*10 Hudson Yards
New York, New York 10001*

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

Group Policy No.	Certificate No.	Effective Date
Issued To		

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

The Guardian Life Insurance Company of America



Michael Prestileo, Senior Vice President

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COMPLAINT NOTICE

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

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

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

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

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

Option E

Dental Services Not Covered By This Plan **IMPORTANT:** If you opt to receive dental services that are not covered services under this plan, a participating dental provider may charge you his or her usual and customary rate for those services. Prior to providing a patient with dental services that are not a covered benefit, the dentist should provide to the patient a treatment plan that includes each anticipated service to be provided and the estimated cost of each service. If you would like more information about dental coverage options, you may call member services at 1-888-618-2016 or your insurance broker. To fully understand your coverage, you may wish to carefully review this evidence of coverage document.

CGP-3-CADISC

B120.0074

GENERAL PROVISIONS

As used in this booklet:

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

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

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

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

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

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

CGP-3-R-GENPRO-90

B160.0002

Limitation of Authority

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

CGP-3-R-LOA-90

B160.0004

Incontestability

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

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

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

CGP-3-R-INCY-96

B160.0061

Examination and Autopsy

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

CGP-3-R-EA-90

B160.0006

Accident and Health Claims Provisions

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

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

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

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

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

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

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

Accident and Health Claims Provisions (Cont.)

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

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

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

CGP-3-R-AHC-90

B160.0005

Coordination Between Continuation Sections

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

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

CGP-3-R-COC-87

B240.0044

An Important Notice About Continuation Rights

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

CGP-3-R-NCC-87

B240.0064

YOUR CONTINUATION RIGHTS

Federal Continuation Rights

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

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

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

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

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

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

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

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

Federal Continuation Rights (Cont.)

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

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

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

CGP-3-R-COBRA-96-1

B235.0631

All Options

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

All Options

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.

Federal Continuation Rights (Cont.)

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

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

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

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

CGP-3-R-COBRA-96-3

B235.0178

All Options

Your Employer's Responsibilities

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

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

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

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

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

Your Employer's Liability

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

Election of Continuation

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

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

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

Federal Continuation Rights (Cont.)

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

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

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

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

CGP-3-R-COBRA-96-4

B235.0198

Uniformed Services Continuation Rights

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

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

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

CGP-3-R-COBRA-96-4

B235.0195

ELIGIBILITY FOR LIFE COVERAGES

B264.0002

Employee Coverage

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

Other Conditions You must:

- (a) be legally working in the United States.
- (b) be regularly working at least the number of hours in the normal work week set by your *employer* (but not less than 30 hours per week), at:
 - (i) your *employer's* place of business;
 - (ii) some place where your *employer's* business requires you to travel; or
 - (iii) any other place you and your *employer* have agreed upon for performance of occupational duties.

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

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

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

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

CGP-3-EC-90-1.0

B264.0892

All Options

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

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

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

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

CGP-3-EC-90-2.0

B264.3210

All Options

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

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

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

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

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

CGP-3-EC-90-3.0

B264.0697

All Options

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

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

Continuation of Coverage Life 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

All Options

GROUP TERM LIFE INSURANCE SCHEDULE

CGP-3-R-SCH-90

B265.0002

All Options

Employee Basic Term Life Insurance

CGP-3-R-SCH-90

B265.0003

All Options

Your Basic Term Life Insurance Amount	Insurance Amount	\$20,000.00
	CGP-3-R-SCH-90	B265.0011

All Options

Reduction of Basic 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 basic life insurance amount is reduced, when he or she reaches age 70, by 50% of the amount which otherwise applies to his or her classification and/or option. But in no case will such reduced amount be less than \$1,000.00. The preceding reduction also applies to an employee's initial insurance amount if his or her insurance starts after he or she reaches age 70.
	CGP-3-R-SCH-90
	B265.0483

LIFE INSURANCE

B270.0070

All Options

Your Group Term Life Insurance

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

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

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

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

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

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

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

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

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

CGP-3-R-LB-90

B270.0113

Portability Privilege

Applicability	This provision applies only to this plan's employee Basic group term life insurance. It does not apply to supplemental life insurance, if any is included in this plan. And it does not apply to Accidental Death and Dismemberment Insurance.
Important Restriction	You must provide proof of insurability satisfactory to us.
Portability Of Basic Group Term Life Insurance	You may elect to continue all or part of your employee Basic group term life insurance, by choosing a portable certificate of coverage, subject to the following terms. You may port your coverage if coverage under this plan ends because you: (a) have terminated employment; or (b) stop being a member of an eligible class of employees. You may not port your coverage, if you: (a) have reached your 70th birthday on the day coverage under this plan ends; or (b) are eligible for this plan's Basic Group Term Life Insurance Extended Life Benefit. You may not port your coverage if coverage under this plan ends due to: (a) failure to pay any required premium; or (b) the end of this group plan. You may port: (a) the full amount(s) of your Basic term life insurance as of the day your coverage under this plan ends, or (b) 50% of such amount, if such amount under this plan is at least \$50,000.00.
The Portable Certificate Of Coverage	You can port to a portable certificate of coverage. The certificate provides group term insurance. It does not provide any: (a) accidental death and dismemberment benefits; (b) income replacement benefits; or (c) extended life benefits or waiver of premium privileges. The benefits provided by the portable certificate of coverage may not be the same as the benefits of this group plan. The premium for the portable certificate of coverage will be based on: (a) your rate class under this plan; and (b) your age bracket as shown in the Basic Life Portability Coverage Premium Notice.
How To Port	To get a portable certificate of coverage, you must: (a) apply to us in writing; and (b) pay the required premium. You have 31 days from the date your coverage under this plan ends to do this. We require proof of insurability satisfactory to us.
Defined Term	As used in this provision, the term "port" means to choose a portable certificate of coverage which provides group term life insurance.

CGP-3-R-LP-00

B270.0390

Information About Conversion and Portability

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

CGP-3-R-LPN-95

B270.0326

THE FOLLOWING PROVISION APPLIES TO YOUR BASIC TERM LIFE INSURANCE:

B275.0076

Converting This Group Term Life Insurance

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

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

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

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

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

Converting This Group Term Life Insurance (Cont.)

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

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

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

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

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

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

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

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

Converting This Group Term Life Insurance (Cont.)

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

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

CGP-3-R-LCONV-99-CA

B275.0217

All Options

Your Extended Life Benefit With Waiver Of Premium

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

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

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

- (a) not able to perform any work for wages or profit; and
- (b) you are receiving regular doctor's care appropriate to the cause of disability.

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

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

- (a) become totally disabled before you reach age 60 and while insured by the group plan; and
- (b) remain totally disabled for 09 continuous months.

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

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

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

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

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

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

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

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

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

- (a) 09 continuous months from the date active full-time service ends due to total disability; or
- (b) the date we approve you for this benefit.

CGP-3-R-LW-TD-99-1

B275.0513

All Options

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

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

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

- Proof Of Death** We'll pay as soon as we receive
- (a) written proof of your death, that is acceptable to us; and
 - (b) medical proof that you were continuously disabled until your death. This must be sent within one year of your death.

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

B275.0059

Option E

ELIGIBILITY FOR DENTAL COVERAGE

B489.0002

Option E

Employee Coverage

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

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

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

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

CGP-3-EC-90-1.0

B489.0122

Option E

Dental Plan Election Procedures Since Managed DentalGuard is offered to you as an alternative to this dental coverage, you may change your election, and enroll in Managed DentalGuard as follows.

If you drop your coverage under this *plan*, at any time other than during an open enrollment period, you may not enroll in Managed DentalGuard until the open enrollment period which starts at least 12 months after the date coverage is dropped.

If you remain covered under this plan, you may change your election, and enroll in Managed DentalGuard during an open enrollment period. Your coverage under this *plan* ends on the date coverage under Managed DentalGuard begins.

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

If you change your election, your covered dependents will automatically be switched to Managed DentalGuard at the same time as you.

CGP-3-EC-90-1.0

B489.0137

Option E

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

Option E

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

Option E

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

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

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

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

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

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

Coverage During a Temporary Leave

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

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

CGP-3-EC-90-3.0

B489.0628

Option E

Dependent Coverage

B200.0271

Option E

Eligible Dependents For Dependent Dental Benefits

Your *eligible dependents* are: (a) your legal spouse; (b) your dependent children who are under age 26.

CGP-3-DEP-90-2.0

B489.0460

Option E

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

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

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

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

CGP-3-DEP-90-3.1

B489.0499

Option E

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

Option E

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

Option E

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 later of the first of the month which coincides with or next follows the date you sign the enrollment form; and 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

B489.0055

Option E

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

Option E

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

CGP-3-DEP-90-8.0

B489.0232

Option E

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

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

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

Dependent Coverage (Cont.)

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

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

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

CGP-3-DEP-90-9.0

B489.0465

CERTIFICATE AMENDMENT

Effective September 1, 2007, this rider amends the dependent coverage provisions as follows:

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

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

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

As used here:

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

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

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

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

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

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

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

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

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

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

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

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

Certificate Amendment (Cont.)

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

The Guardian Life Insurance Company of America

A handwritten signature in black ink, appearing to read "M. Prestileo", with a stylized flourish at the end.

Michael Prestileo, Senior Vice President

CGP-3-A-DMST-CA-05

B489.0223

Option E

DENTAL HIGHLIGHTS

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

- **PPO 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

- **Non-PPO 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

B497.0070

Option E

- **Payment Rates for Services Furnished by a Preferred Provider:**

For Group I Services	100%
For Group II Services	90%
For Group III Services	60%
For Group IV Services	50%

- **Payment Rates for Services Not Furnished by a Preferred Provider:**

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

CGP-3-DENT-HL-90

B497.0089

Option E

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

For Group I, II and III Services	Up to \$1,500.00
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- **Non-PPO Benefit Year Payment Limit for Non-Orthodontic Services**

For Group I, II and III Services	Up to \$1,000.00
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- **Lifetime Payment Limit for Orthodontic Treatment**

For Group IV Services	Up to \$1,000.00
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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

B497.1434

Option E

DentalGuard Preferred Plus Benefits for services provided by a preferred provider in the plus program ("DentalGuard Preferred Plus Providers") will be reimbursed based on the non-preferred provider (Non-PPO) payment rates, deductibles, benefit year and lifetime payment limits, frequency and age limitations, coverages and exclusions.

CGP-3-DENT-HL-90

B497.2458

Option E

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

CGP-3-DENT-HLTS

B497.2411

Option E

DENTAL EXPENSE INSURANCE

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

CGP-3-DG2000

B498.0007

Option E

DentalGuard Preferred - This Plan's Dental Preferred Provider Organization

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

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

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

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

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

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

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

CGP-3-DGY2K-PPO

B498.0151

Covered Charges

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

If a *covered person* uses the services of a *non-preferred provider*, covered charges are reasonable and customary charges for the dental services listed in this *plan's* List of Covered Dental Services.

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

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

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. A covered charge for *orthodontic treatment* is incurred on the date the *active orthodontic appliance* is first placed. All other covered charges are incurred on the date the services are furnished. If a service is started while a *covered person* is insured, we'll only pay benefits for services which are completed within 31 days of the date his or her coverage under this *plan* ends.

CGP-3-DGY2K-CC

B498.0066

Option E

Alternate Treatment

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

Proof Of Claim

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

CGP-3-DGY2K-AT

B498.1141

Option E

Pre-Treatment Review

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

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

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

Pre-Treatment Review (Cont.)

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

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

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

CGP-3-DGY2K-PTR

B498.0003

Option E

Benefits From Other Sources

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

CGP-3-DGY2K-OS

B498.0005

Option E

The Benefit Provision - Qualifying For Benefits

CGP-3-DGY2K-BEN

B498.0072

Option E

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

- All Group II Services.

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

- All Group III Services.

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

- All Group IV Services.

The Benefit Provision - Qualifying For Benefits (Cont.)

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

B498.0231

Option E

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

Covered charges used to satisfy a *covered person's* Non-PPO deductible are also credited toward his or her PPO deductible. And covered charges used to satisfy a *covered person's* PPO deductible are also credited toward his or her Non-PPO deductible.

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

B498.0177

Option E

All covered charges must be incurred while insured. And we limit what we pay each benefit year to \$1,500.00 for the services of a *preferred provider*, and \$1,000.00 for the services of a *non-preferred provider*.

Benefits applied to a *covered person's* Non-PPO *benefit year payment limit* are also applied to his or her PPO *benefit year payment limit*. And benefits applied to a covered person's PPO *benefit year payment limit* are also applied to his or her Non-PPO *benefit year payment limit*.

CGP-3-DGY2K-BP

B498.0191

Option E

The Benefit Provision - Qualifying For Benefits

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

Option E

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

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

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

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

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

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

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

- *Rollover Threshold* \$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:

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

- 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, 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*.

CGP-3-DG-ROLL-04-2

B498.9137

Option E

How We Pay Benefits For Group IV Orthodontic Services

This *plan* provides benefits for Group IV orthodontic services.

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

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

We make the initial payment when the *active orthodontic appliance* is first placed. We make further payments at the end of each subsequent three month period, upon receipt of verification of ongoing treatment. But, treatment must continue and the *covered person* must remain covered by this *plan*. We limit what we pay for orthodontic services to the lifetime payment of \$1,000.00. What we pay is based on all of the terms of this *plan*.

The Benefit Provision - Qualifying For Benefits (Cont.)

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

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

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

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

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

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

CGP-3-DGY2K-OR

B498.0057

Option E

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

Option E

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

- Benefits for Group I Services performed by
a *preferred provider* 100%
- Benefits for Group I Services performed by
a *non-preferred provider* 100%
- Benefits for Group II Services performed by
a *preferred provider* 90%
- Benefits for Group II Services performed by
a *non-preferred provider* 80%
- Benefits for Group III Services performed by
a *preferred provider* 60%
- Benefits for Group III Services performed by
a *non-preferred provider* 50%
- Benefits for Group IV Services performed by
a *preferred provider* 50%
- Benefits for Group IV Services performed by
a *non-preferred provider* 50%

CGP-3-DGY2K-PR B498.0080

Option E

After This Insurance Ends

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

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

CGP-3-DGY2K-END B498.0233

Option E

Special Limitations

CGP-3-DGY2K-LMT B498.0138

Option E

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

Option E

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

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

CGP-3-DGY2K-PP

B498.0129

Option E

Exclusions

We will not pay for:

- Any service or supply which is not specifically listed in this *plan's* List of Covered Dental Services.
- Any procedure performed in conjunction with, as part of, or related to a procedure which is not covered by this *plan*.
- Educational services. This includes, but is not limited to: oral hygiene instruction; plaque control; tobacco counseling; or diet instruction.
- Precision attachments and the replacement of part of a precision attachment; magnetic retention; or overdenture attachments.

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

Exclusions (Cont.)

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

CGP-3-DGY2K-EXCH-01

B498.2173

Option E

List of Covered Dental Services

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

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

CGP-3-DNTL-90-13

B490.0048

Option E

Group I - Preventive Dental Services (Non-Orthodontic)

Prophylaxis And Fluorides

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

- Adult prophylaxis covered age 12 and older.

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

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

Office Visits, Evaluations And Examination

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

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

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

CGP-3-DNTL-90-14

B498.4803

Option E

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.

CGP-3-DNTL-90-14

B498.0164

Option E

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

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

CGP-3-DNTL-90-14

B498.2042

Option E

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.

CGP-3-DNTL-90-14

B498.0166

Option E

Group II - Basic Dental Services (Non-Orthodontic)

Diagnostic Services Allowance includes examination and diagnosis.

Group II - Basic Dental Services (Cont.)

(Non-Orthodontic)

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.

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

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

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

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

Silicate cement, per restoration
Composite resin

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

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

CGP-3-DNTL-90-15

B498.2765

Option E

Crown And Prosthodontic Restorative Services

Also see the "Major Restorative Services" section.

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

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

- Inlay or onlay
- Crown
- Bridge

Adding teeth to partial dentures to replace extracted natural teeth

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

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

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

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

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

CGP-3-DNTL-90-15

B498.1122

Option E

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

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

Endodontic Therapy

Root canal therapy on anterior and bicuspid teeth

Root canal retreatment on anterior and bicuspid teeth, 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-DNTL-90-15.0

B498.2044

Option E

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

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

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

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

CGP-3-DNTL-90-15.0

B498.0202

Option E

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

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

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

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

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

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

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

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

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

Periodontal surgery related

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

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

CGP-3-DNTL-90-15.0

B498.0203

Option E

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

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

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

Other diagnostic radiographs:

- Intraoral periapical or occlusal films - single films

CGP-3-DNTL-90-15.0

B498.2043

Option E

Non-Surgical Extractions	Allowance includes the treatment plan, local anesthetic and post-treatment care. Uncomplicated extraction, one or more teeth Root removal non-surgical extraction of exposed roots
Surgical Extractions	Allowance includes the treatment plan, local anesthetic and post-surgical care. Services listed in this category and related services, may be covered by your medical plan. Surgical removal of erupted teeth, involving tissue flap and bone removal Surgical removal of residual tooth roots Surgical removal of impacted teeth
Other Oral Surgical Procedures	Allowance includes diagnostic and treatment radiographs, the treatment plan, local anesthetic and post-surgical care. Services listed in this category and related services, may be covered by your medical plan. Alveoloplasty, per quadrant Removal of exostosis, per site Incision and drainage of abscess Frenulectomy, Frenectomy, Frenotomy Biopsy and examination of tooth related oral tissue Surgical exposure of impacted or unerupted tooth to aid eruption Excision of tooth related tumors, cysts and neoplasms Excision or destruction of tooth related lesion(s) Excision of hyperplastic tissue Excision of pericoronal gingiva, per tooth Oroantral fistula closure Sialolithotomy Sialodochoplasty Closure of salivary fistula Excision of salivary gland Maxillary sinusotomy for removal of tooth fragment or foreign body Vestibuloplasty

CGP-3-DNTL-90-15.0

B498.1124

Option E

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 <i>plan</i> .
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Injectable antibiotics needed solely for treatment of a dental condition.

CGP-3-DNTL-90-15

B498.0206

Group III - Major Dental Services
(Non-Orthodontic)

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

Single Crowns

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

Inlays

- Onlays, including inlay
- Labial veneers

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

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

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

Crown or core buildup, including pins

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

Abutment supported crown

Implant supported crown

Abutment supported retainer for fixed partial denture

Implant supported retainer for fixed partial denture

Implant/abutment supported removable denture for completely edentulous arch

Implant/abutment supported removable denture for partially edentulous arch

Implant/abutment supported fixed denture for completely edentulous arch

Implant/abutment supported fixed denture for partially edentulous arch

Dental implant supported connecting bar

Prefabricated abutment

Custom abutment

Group III - Major Dental Services (Cont.)

(Non-Orthodontic)

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

Surgical placement of implant body, endosteal implant

Surgical placement, eposteal implant

Surgical placement, transosteal implant

Other Implant services

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

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

Repair implant supported prosthesis

Repair implant abutment

Implant removal

CGP-3-DNTL-90-16

B498.1148

Option E

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

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

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

Bridge Pontics

Resin with metal

Porcelain

Porcelain with metal

Full cast metal

3/4 cast metal crowns

3/4 porcelain crowns

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

Complete or Immediate dentures, upper or lower

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

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

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

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

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

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

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

Simple stress breakers, per unit

CGP-3-DNTL-90-16

B498.1146

Option E

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

Endodontic Therapy

Root canal therapy on molar teeth

Root canal retreatment on molar teeth, limited to once per tooth, per lifetime

CGP-3-DNTL-90-16

B498.2045

Group IV - Orthodontic Services

Orthodontic Services Any covered Group I, II or III service in connection with *orthodontic treatment*.

Transseptal fiberotomy

Surgical exposure of impacted or unerupted teeth in connection with *orthodontic treatment* - Allowance includes treatment and final radiographs, local anesthetics and post-surgical care.

Treatment *plan* and records, including initial, interim and final records.

Limited *orthodontic treatment*, Interceptive *orthodontic treatment* or Comprehensive *orthodontic treatment*, including fabrication and insertion of any and all fixed *appliances* and periodic visits.

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

CGP-3-DNTL-90-8

B498.0071

ELIGIBILITY FOR VISION CARE EXPENSE COVERAGE

B505.0152

Employee Vision Care Expense Coverage

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 August 1st to August 31st 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.

CGP-3-EC-90-1.0

B505.0060

When Your Coverage Starts Your coverage under this *plan* is scheduled to start on your effective date. 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, your effective date 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

B505.1681

All Options

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

Your coverage ends on the date you die.

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

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

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

CGP-3-EC-90-3.0

B505.0083

All Options

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

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

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

CGP-3-EC-90-3.0

B505.1449

All Options

Dependent Vision Care Expense Coverage

CGP-3-DEP-90-1.0

B505.0099

All Options

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

B505.0782

All Options

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 physical custody for the purpose of adoption. We treat such a child this way whether or not a final adoption order is ever issued. We cover your adopted child from the moment of his or her placement if you are already covered for dependent child coverage when the child is placed for adoption. If you do not have dependent coverage when the child is placed for adoption, we cover the child for the first 31 days from the moment of his or her placement. To continue the child's coverage past the 31 days, you must enroll the child and agree to make any required premium payments within 31 days of the date of placement. If you fail to do this, the child's coverage will end at the end of the 31 days, and the child cannot be enrolled for this coverage until the plan's next open enrollment period.

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-90-3.1

B505.0537

All Options

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

All Options

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

If you do this on or before your *eligibility 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 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

B505.0130

All Options

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

CGP-3-DEP-90-7.0

B505.0132

All Options

Newborn Children We cover your newborn child from the moment of birth if you are already covered for dependent child coverage when the child is born. If you do not have dependent coverage when the child is born, we cover the child for the first 31 days from the moment of his or her birth. To continue the child's coverage past the 31 days, you must enroll the child and agree to make any required premium payments within 31 days of the date the child is born. If you fail to do this, the child's coverage will end at the end of the 31 days, and the child cannot be enrolled for this coverage until the plan's next open enrollment period.

CGP-3-DEP-90-8.0

B505.0538

All Options

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.)

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

B505.0746

CERTIFICATE AMENDMENT

Effective September 1, 2007, this rider amends the dependent coverage provisions as follows:

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

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

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

As used here:

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

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

- are 18 years of age or older;
- are unmarried, constitute each other's sole domestic partner, and have not had another domestic partner in the last 12 months;
- share the same permanent address for at least 12 consecutive months and intend to do so indefinitely;
- share joint financial responsibility for basic living expenses including food, shelter and medical expenses;
- are not related by blood to a degree that would prohibit marriage in the employee's state of residence; and

- are financially interdependent which must be demonstrated by at least four of the following:
 - a. ownership of a joint bank account;
 - b. ownership of a joint credit account;
 - c. evidence of a joint mortgage or lease;
 - d. evidence of joint obligation on a loan;
 - e. joint ownership of a residence;
 - f. evidence of common household expenses such as utilities or telephone
 - g. execution of wills naming each other as executor and/or beneficiary;
 - h. granting each other durable powers of attorney;
 - i. granting each other health care powers of attorney;
 - j. designation of each other as beneficiary under a retirement benefit account; or
 - k. evidence of other joint financial responsibility.

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

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

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

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

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

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

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

Certificate Amendment (Cont.)

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

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

The Guardian Life Insurance Company of America

A handwritten signature in black ink, appearing to read "Mr. Prestileo", is positioned above the printed name.

Michael Prestileo, Senior Vice President

CGP-3-A-DMST-CA-05

B505.0540

VISION CARE HIGHLIGHTS

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.

PPO Copayments	Examinations	\$10.00
	Standard Frames and/or Standard Lenses	\$25.00
	Necessary Contact Lenses	\$25.00
Non-PPO Cash Deductibles	Examinations	\$10.00
	Standard Frames and/or Standard Lenses	\$25.00
	Necessary Contact Lenses	\$25.00
Payment Rates	For Covered Charges	100%

VISION CARE EXPENSE INSURANCE

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

CGP-3-VSN-96-VIS

B505.0007

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

Vision Service Plan This *plan* is designed to provide high quality vision care while controlling the cost of such care. To do this, the *plan* encourages a *covered person* to seek vision care from doctors and vision care facilities that belong to Vision Service Plan (VSP), a vision care *preferred provider* organization (PPO).

This vision care PPO is made up of *preferred providers* in a *covered person's* geographic area. A vision care *preferred provider* is a vision care practitioner or a vision care facility that: (a) is a current provider of VSP; and (b) has a participatory agreement in force with VSP.

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

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

What we pay is based on all the terms of this *plan*. The *covered person* should read this material with care, and have it available when seeking vision care. Read this *plan* carefully for specific benefit levels, *copayments*, *deductibles*, payment rates and payment limits.

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

Choice Of Preferred Providers When a person becomes enrolled in this *plan*, he or she will receive a list of VSP *preferred providers* in his or her area. A *covered person* may receive vision services from any VSP *preferred provider*.

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

Vision Service Plan

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

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

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

CGP-3-VSN-96-PPOA

B505.0009

All Options

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

No benefits will be paid for Necessary Contact Lenses if prior approval is not received from VSP.

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

CGP-3-VSN-96-PTR2

B505.0014

All Options

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

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

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

Vision Service Plan

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

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

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

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

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

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

CGP-3-VSN-96-APP

B505.0015

All Options

How This Plan Works

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

Services or Supplies From a Preferred Provider

If a *covered person* uses the services of a *preferred provider*, the *preferred provider* must receive approval from VSP prior to providing the *covered person* with any service or supply. See the "Pre-Authorization of Preferred Provider Services" section of this *plan* for specific requirements.

Services or Supplies From a Preferred Provider (Cont.)

Copayments The *covered person* must pay a *copayment* when he or she receives services from a *preferred provider*. We pay benefits for the covered charges a *covered person* incurs in excess of the *copayment*. This *plan's copayments* are as follows:

For each vision examination from a *preferred provider* \$10.00

For each pair of *standard frames* and/or
standard lenses from a *preferred provider* \$25.00

For Necessary Contact Lenses from a *preferred provider* \$25.00

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

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

For covered charges 100%

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

The discounts are:

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

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

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

CGP-3-VSN-96-BEN1

B505.0933

All Options

Services or Supplies From a Non-Preferred Provider

If a *covered person* uses the services of a *non-preferred provider*, the *covered person* must submit the itemized bill to VSP for claims payment. All claims must be sent to VSP within 180 days of the date services are completed or supplies are received. The benefits we pay are subject to all of the terms of this *plan*.

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

Cash Deductible For Services Of A Non-Preferred Provider There are separate cash *deductibles* for each covered service provided by a *non-preferred provider*. These cash *deductibles* are shown below. The *covered person* must have covered charges in excess of the cash *deductible* before we pay him or her any benefits for the service or supply.

For each vision examination provided by a *non-preferred provider* . . . \$10.00

For each pair of *standard frames* and/or
standard lenses from a non-preferred provider \$25.00

For each pair of Necessary Contact Lenses from
a *non-preferred provider* \$25.00

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

Payment Rates Once a *covered person* has met any applicable *deductible*, we pay benefits for covered charges under this *plan* as follows. What we pay is subject to all of the terms of this *plan*.

For covered charges 100%

CGP-3-VSN-96-BEN2

B505.0021

All Options

Covered Charges

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

Covered Services and Supplies

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

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

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

- prescribing and ordering of proper lenses;

Covered Services and Supplies (Cont.)

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

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

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

CGP-3-VSN-96-LIST1

B505.0935

All Options

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

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

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

CGP-3-VSN-05-SL

B505.0453

All Options

We do not cover charges for more than one set of *standard lenses* in any 12 month period.

CGP-3-VSN-05-SL

B505.0455

All Options

Standard Frames We cover charges for standard frames.

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

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

We don't cover charges for more than one set of standard frames in any 24 month period.

If the covered person chooses elective contact lenses, we do not cover standard frames for 24 months from the date the elective contacts are purchased.

CGP-3-VSN-05-SF

B505.1261

All Options

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

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

We don't cover charges for more than one pair of Necessary Contact Lenses in any 12 month period.

If a *covered person* receives Necessary Contact Lenses from a *preferred provider*, we pay 100% of covered charges. If he or she receives Necessary Contact Lenses from a *non-preferred provider*, we limit what we pay to \$210.00 in any 12 month period.

CGP-3-VSN-96-LIST7

B505.0028

All Options

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

If we cover charges for elective contact lenses, we will not cover charges for standard lenses for 12 months and standard frames for at least 24 months.

We limit what we pay for elective contact lenses to \$130.00 once every 12 months.

CGP-3-VSN-05-ECL

B505.0427

All Options

Special Limitations

If This VSP Plan Replaces Another VSP Plan

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

CGP-3-VSN-96-SL1

B505.0031

All Options

Exclusions

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

CGP-3-VSN-96-EXC1

B505.0034

All Options

- We will not pay for plano lenses (lenses with less than a .38 diopter power).
- We will not pay for two sets of glasses in lieu of bifocals.
- We will not pay for replacement of lenses and frames furnished under this plan which are lost or broken, except at normal intervals when services are otherwise available.
- We will not pay for blended lenses.
- We will not pay for oversized lenses.
- We will not pay for the laminating of the lens or lenses.
- We will not pay for a frame that costs more than the plan allowance.
- We will not pay for UV (ultraviolet protected lenses).
- We will not pay for cosmetic lenses or any cosmetic process, unless specifically shown as covered in the "Covered Services and Supplies" section.

Exclusions (Cont.)

- We will not pay for progressive multifocal lenses.
- We will not pay for the coating of the lens or lenses.
- We will not pay for photochromic lenses and tinted lenses, except for pink #1 and pink #2.

CGP-3-VSN-05-EXC

B505.0428

All Options

Charges not covered due to this provision are not considered covered vision services and cannot be used to satisfy this *plan's copayments or deductibles*, if any.

CGP-3-VSN-96-EXC17

B505.0037

CERTIFICATE AMENDMENT

(To be attached to certificates issued to you)

The certificate is amended as follows:

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

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

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

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

**Continuation Of
Coverage During A
Labor Dispute**

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

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

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

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

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

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

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

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

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

- (a) the end of the six month continuation period;
- (b) the day on which the number of employees covered under this section is less than 75% of those insured under the group plan on the day work stopped;
- (c) the day the work stoppage ends;
- (d) when the employee enters full-time employment with another employer;
- (e) at the end of the period for which the last premium payment is made, if the employee stops paying premium;
- (f) the date the employee stops being eligible as defined in this plan, for reasons other than not meeting "actively at work" or "full-time" requirements; and
- (g) with respect to a dependent, the date such dependent stops being an eligible dependent as defined in the group plan.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

The Guardian Life Insurance Company of America

A handwritten signature in black ink, appearing to read "M. Prestileo", with a stylized flourish at the end.

Michael Prestileo, Senior Vice President

B531.0684

CERTIFICATE AMENDATORY RIDER

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

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

Timely Access to Care

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

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

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

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

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

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

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

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

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

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

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

Continuity Of Care

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

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

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

Reference to the term "spouse" within the contract, means the person to whom you are legally married, or your registered domestic partner, civil union partner or equivalent as recognized and allowed by federal law, or state law in your state of residence or the state in which the marriage or your registered domestic partner, civil union partner or equivalent was recorded.

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

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

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

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

Continuing Coverage Past the Child Age Limit

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

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

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

The Guardian Life Insurance Company of America



Michael Prestileo, Senior Vice President

B531.0825

CERTIFICATE AMENDMENT

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



Michael Prestileo, Senior Vice President

COORDINATION OF BENEFITS

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.

Definitions

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

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

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

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

Plan This term means any of the following that provides benefits or services for health care or treatment: (1) group, blanket or franchise insurance coverage; (2) service plan contracts, group practice, individual practice and other prepayment coverage; (3) any coverage under labor-management trustee plans, union welfare plans, employer organization plans, or employee benefit organization plans; and (4) governmental benefits, except Medicare, as permitted by law.

This term does not include: (a) individual or family insurance; (b) individual or family subscriber contracts; (c) school-type blanket accident and sickness insurance; (d) blanket accident insurance that is excess to other coverage; (e) medical benefit payments in traditional automobile contracts; or (f) 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.

CGP-3-R-COB-05

B555.0293

Option E

Order Of Benefit Determination

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

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

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

When all plans have coordination of benefits provisions, the rules to determine the order of payment are listed below. The first of the rules that applies is the rule to use.

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

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:

- (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.

Order Of Benefit Determination (Cont.)

- (3) In the absence of a court decree, if the parents are not married, or are separated (whether or not they ever have been married), or are divorced, the order of benefit determination is: (a) the plan of the custodial parent; (b) the plan of the spouse of the custodial parent; (c) the plan of the noncustodial parent; and (d) the plan of the spouse of the noncustodial parent.

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

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

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

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

CGP-3-R-COB-05

B555.0295

Option E

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 the applicable benefit limit of this plan.

Right To Receive And Release Needed Information

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

Facility Of Payment

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

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

Right Of Recovery

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

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

CGP-3-R-COB-05

B555.0296

Option E

CERTIFICATE AMENDMENT

Notwithstanding any provision in the Plan to the contrary, it is hereby agreed that the Group Plan is amended September 1, 2007 so that,

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

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

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

The Guardian Life Insurance Company of America



Michael Prestileo, Senior Vice President

All Options

GLOSSARY

This Glossary defines the italicized terms appearing in your booklet.

CGP-3-GLOSS-90

B900.0118

All Options

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

CGP-3-VSN-96-DEF1

B750.0457

Option E

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

CGP-3-GLOSS-90

B750.0663

Option E

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

CGP-3-GLOSS-90

B750.0664

Option E

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

CGP-3-GLOSS-90

B750.0665

All Options

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

CGP-3-VSN-96-DEF3

B750.0458

Option E

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

CGP-3-GLOSS-90

B750.0666

All Options

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

CGP-3-VSN-96-DEF3

B750.0459

All Options

Coated Lenses means substance added to a finished lens on one or both surfaces.
CGP-3-VSN-96-DEF3 B750.0460

All Options

Copayment with respect to Vision Care Insurance, means a charge, expressed as a fixed dollar amount, required to be paid by or on behalf of a *covered person* to a *preferred provider* at the time covered vision services are received.
CGP-3-VSN-96-DEF3 B750.0461

Option E

Covered Dental Specialty means any group of procedures which falls under one of the following categories, whether performed by a specialist *dentist* or a general *dentist*: restorative/prosthetic services; endodontic services, periodontic services, oral surgery and pedodontics.
CGP-3-GLOSS-90 B750.0667

Option E

Covered Family means an employee and those of his or her dependents who are covered by this *plan*.
CGP-3-GLOSS-90 B750.0668

Option E

Covered Person means an employee or any of his or her covered dependents.
CGP-3-GLOSS-90 B750.0669

All Options

Covered Person with respect to Vision Care Insurance, means an *employee* or eligible dependent who meets this *plan's* eligibility criteria and who is covered under this *plan*.
CGP-3-VSN-96-DEF3 B750.0462

All Options

Customary with respect to Vision Care Insurance, means, when referring to a covered charge, that the charge for the covered vision condition isn't more than the *usual* charge made by most other doctors with similar training and experience in the same geographic area.
CGP-3-VSN-96-DEF3 B750.0484

All Options

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

CGP-3-VSN-96-DEF3

B750.0483

Option E

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

CGP-3-GLOSS-90

B750.0670

Option E

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

CGP-3-GLOSS-90

B750.0671

All Options

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

CGP-3-GLOSS-90

B900.0003

All Options

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

CGP-3-GLOSS-90

B750.0015

Option E

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

CGP-3-GLOSS-90

B750.0672

All Options

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

CGP-3-GLOSS-90

B750.0006

All Options

Employer means HILTON WATERFRONT BEACH RESORT .

CGP-3-GLOSS-90

B900.0051

All Options

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

CGP-3-GLOSS-90

B900.0004

All Options

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

CGP-3-GLOSS-90

B750.0229

All Options

Incurred, Or Incurred Date with respect to Vision Care Insurance, means the placing of an order for lenses, frames or contact lenses, or the date on which such an order was placed.

CGP-3-VSN-96-DEF3

B750.0466

All Options

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

CGP-3-GLOSS-90

B900.0006

Option E

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

CGP-3-GLOSS-90

B750.0673

All Options

Keratoconus means a development or dystrophic deformity of the cornea in which it becomes coneshaped due to a thinning and stretching of the tissue in its central area.

CGP-3-VSN-96-DEF11

B750.0467

All Options

Lenticular Lenses mean high-powered lenses with the desired prescription power found only in the central portion. The outer carrier portion has a front surface with a changing radius of curvature.

CGP-3-VSN-96-DEF11

B750.0485

All Options

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

CGP-3-GLOSS-90

B900.0008

Option E

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

CGP-3-GLOSS-90

B750.0674

All Options

Non-Preferred Provider with respect to Vision Care Insurance, means any optometrist, optician, ophthalmologist, or other licensed and qualified vision care provider who has not contracted with the *plan* to provide vision care services and/or vision care materials to *covered persons* of the *plan*.

CGP-3-VSN-96-DEF14

B750.0487

Option E

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

CGP-3-GLOSS-90

B750.0675

All Options

Orthoptics means the teaching and training process for the improvement of visual perception and coordination of two eyes for efficient and comfortable binocular vision.

CGP-3-VSN-96-DEF16

B750.0472

All Options

Oversize lenses mean larger than a *standard lens* blank, to accommodate prescriptions.

CGP-3-VSN-96-DEF17

B750.0489

Option E

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

CGP-3-GLOSS-90

B750.0676

Option E

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

CGP-3-GLOSS-90

B750.0677

All Options

Photochromic Lenses mean lenses which change color with the intensity of sunlight.

CGP-3-VSN-96-DEF17

B750.0490

Option E

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

CGP-3-GLOSS-90

B750.0679

Option E

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

CGP-3-GLOSS-90

B750.0678

Option F

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

CGP-3-GLOSS-90

B900.0039

All Options

Plan Benefits with respect to Vision Care Insurance, mean the vision care services and vision care materials which a *covered person* is entitled to receive by virtue of coverage under this *plan*.

CGP-3-VSN-96-DEF17

B750.0492

All Options

Plano Lenses mean lenses which have no refractive power (lenses with less than a +/- .38 diopter power).

CGP-3-VSN-96-DEF17

B750.0491

Option E

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

CGP-3-GLOSS-90

B750.0680

All Options

Preferred Provider with respect to Vision Care Insurance, means an optometrist, ophthalmologist or optician or other licensed and qualified vision care provider who has contracted with the *plan* to provide vision care services and/or vision care materials on behalf of *covered persons* of the *plan*.

CGP-3-VSN-96-DEF14

B750.0488

Option E

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

CGP-3-GLOSS-90

B750.0681

Option E

Proof Of Claim 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

All Options

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

CGP-3-GLOSS-90

B900.0010

All Options

Standard Frames mean frames valued up to the limit published by VSP which is given to *preferred providers*.

CGP-3-VSN-96-DEF17

B750.0478

All Options

Standard Lenses mean regular glass or plastic lenses. See the "Special Limitations" section for what we limit or exclude.

CGP-3-VSN-96-DEF17

B750.0479

All Options

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

CGP-3-VSN-96-DEF17

B750.0480

All Options

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

CGP-3-VSN-96-DEF17

B750.0481

All Options

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

CGP-3-VSN-96-DEF17

B750.0482

Option E

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

CGP-3-GLOSS-90

B750.0683

All Options

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

STATEMENT OF ERISA RIGHTS

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

Receive Information About Your Plan and Benefits

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

Continue Group Health Plan Coverage

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

Prudent Actions By Plan Fiduciaries

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

Enforcement Of Your Rights

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

Statement of Erisa Rights (Cont.)

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

Assistance with Questions

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

Qualified Medical Child Support Order

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

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

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

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

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

B800.0094

All Options

The Guardian's Responsibilities

B800.0048

Option E

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

All Options

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

B800.0055

All Options

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

B800.0049

Group Health Benefits Claims Procedure

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

Guardian is the Claims 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.)

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

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

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

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

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

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

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

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

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

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

Group Health Benefits Claims Procedure (Cont.)

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

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

Adverse Benefit Determination

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

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

Appeal of Adverse Benefit Determinations

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

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

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

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

Group Health Benefits Claims Procedure (Cont.)

- a review that takes into account all comments, documents, records and other information submitted by the claimant relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination.

In reviewing an appeal, Guardian will:

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

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

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

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

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

Alternative Dispute Options

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

B800.0076

Termination of This Group Plan

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

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

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

B800.0007

STATEMENT OF ERISA RIGHTS

The Guardian Life Insurance Company of America

10 Hudson Yards
New York, New York 10001
(212) 598-8000

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

ERISA provides that all plan participants shall be entitled to:

Receive Information about Your Plan and Benefits

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

Prudent Actions by Plan Fiduciaries

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

Enforcement of Your Rights

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

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

Assistance with Questions

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

Life Insurance Claims Procedure

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

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

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

Definitions

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

Timing for Initial Benefit Determination of Life Insurance Claims

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

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

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

**Adverse Benefit
Determination of
Life Insurance
Claims**

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

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

B752.0173

All Options

**Appeals of Adverse
Determinations of
Life Insurance
Claims**

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

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

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

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

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

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

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

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

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

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

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

Adverse Benefit Determination

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

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

B752.0067

All Options

Appeals of Adverse Determinations for Waiver of Premium

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

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

In reviewing an appeal, Guardian will:

- Provide for a review conducted by a named fiduciary who is neither the person who made the initial adverse determination nor that person's subordinate;

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

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

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

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

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

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

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

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

B752.0068

You May not be covered by all options in this Certificate.

This Certificate contains all the benefits and options that are available under the Policy. You are insured only for those benefits and options that you are eligible and enrolled for, and for which the required premium has been paid.

CERTIFICATE OF COVERAGE

Guardian

10 Hudson Yards
New York, New York 10001

We, *Guardian*, certify that the *employee* named below is entitled to the insurance benefits provided by *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 *Guardian*.

The Guardian Life Insurance Company of America



Michael Prestileo, Senior Vice President

B815.0004

COMPLAINT NOTICE

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

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

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

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

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

B815.0314

TABLE OF CONTENTS

The forms listed below are attached to and made part of this certificate. The listed forms describe the coverages which the *Planholder* has elected.

All terms in italics are defined terms with special meanings. Definitions are shown in the Glossary or are defined where they are used.

B815.0006

**Vision Care
Expense Insurance**

Eligibility for Vision Care Expense Coverage	CGP-CA-VSP-10
Employee Coverage	
Dependent Coverage	
Vision Care Benefits	

B815.0007

GENERAL PROVISIONS

As used in this certificate:

"Accident and health" means any vision insurance provided by this *plan*.

"Covered person" means *you* or any of *your* dependents insured by this *plan*, except in the "Repayment" section where "covered person" has a special meaning. See that section for details.

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

"Employer" and "Planholder" mean the employer who purchased this *plan*.

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

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

"You," "your," and "certificateholder" mean an *employee* covered by this *plan*.

B815.0010

Limitation of Authority

No person, except by a writing signed by the President, a Vice President or a Secretary of *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 *Guardian*; (c) bind *us* by any statement or promise relating to any insurance contract issued or to be issued; or (d) accept any information or representation which is not in a signed application.

Incontestability

(a) After two years from the insured's date of coverage under this plan, no misstatements, except fraudulent misstatements, made by the insured in the application for such coverage shall be used to void the policy or to deny a claim for loss incurred or disability (as defined in the policy) commencing after the expiration of the two-year period.

(b) No claim for loss incurred or disability (as defined on the policy) commencing after two years from the insured's date of coverage under this plan shall be reduced or denied on the ground that a disease or physical condition not excluded from coverage by name or specific description effective on the date of loss had existed prior to the insured's effective date of coverage under this *plan*.

B815.0014

Vision Claims Provisions

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

Notice Written notice of an injury or sickness for which a claim is being made must be given to *us* 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, the dependent's name should also be noted.

We will not void or reduce a claim if notice is not given within the required time. But, notice must be given to *us* as soon as reasonably possible.

Claim Forms We will provide forms for filing proof of loss within 15 days of receipt of notice. But if we do not provide the forms on time, we will accept a written description and adequate documentation of the injury or sickness that is the basis of the claim as proof of loss. The nature and extent of the loss for which the claim is being made must be detailed.

Proof of Loss Written proof of loss must be furnished to *us* at *our* designated office.

This proof must be furnished within 90 days of the loss.

We will not void or reduce a claim if proof is not given within the required time. But, proof must be given as soon as reasonably possible and, except in the absence of legal capacity, no later than one year from the time proof is otherwise required.

Claims Communications We will reply, not later than the 30th day after receipt, to all pertinent communications about a pending claim from a claimant that reasonably indicates a response is expected.

Payment of Benefits We completely discharge our liability for any amounts paid as follows:

We will pay vision benefits as soon as we receive written proof of loss.

Unless otherwise required by law or regulation, we pay all vision benefits to *you* if *you* are living. If *you* or any other payee is not living, we have the right to pay all vision benefits, to one of the following: (a) *your* estate; (b) *your* spouse; (c) *your* parents; (d) *your* children; (e) *your* brothers and sisters; or (f) any unpaid provider of health care services.

When proof of loss is filed, *you* or any other payee 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. But, we can not require that a particular provider provide such care. And, *you* or any other payee may not assign *your* right to take legal action under this *plan* to such provider.

Vision Claims Provisions (Cont.)

- 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 the death, where allowed by law. We will pay for all such examinations and autopsies.
- Legal Actions** No legal action against this *plan* will be brought until 60 days from the date proof of loss has been given as stated above. And, no legal action will be brought against this *plan* after 3 years from the date written proof of loss is required to be given.
- Workers' Compensation** The vision benefits provided by this *plan* are not in place of, and do not affect requirements for coverage by Workers' Compensation.

B815.0015

All Options

Repayment

We will not pay any benefits under this *plan*, to or on behalf of a *covered person*, who has received payment in whole from a *third party*, or its insurer for past or future vision charges, resulting from the negligence, intentional act, or no-fault tort liability of a *third party*.

If a *covered person* or his or her beneficiary makes a claim to *us* for vision charges, under this *plan* prior to receiving payment from a *third party* or its insurer, the *covered person* or his or her beneficiary must agree, in writing, to repay *us* from any amount of money they receive from the *third party*, or its insurer. This agreement will not apply to any damages awarded by a court for pain and suffering.

The repayment will be equal to the amount of benefits paid by *us*. However, the *covered person* or his or her beneficiary may deduct the *reasonable pro-rata expenses incurred* in effecting the *third party* payment from the repayment to *us*.

The repayment agreement will be binding upon the *covered person* or his or her beneficiary whether: (a) the payment received from the *third party*, or its insurer, is the result of a legal judgement, an arbitration award, a compromise settlement, or any other arrangement; or (b) the *third party*, or its insurer, has admitted liability for the payment; or (c) the vision charges, are itemized in the *third party* payment.

As used in this provision:

"Covered person" means *you* or your dependent, including the legal representative of a minor or incompetent, insured by this *plan*.

Repayment (Cont.)

"Reasonable pro-rata expenses" are those costs, such as lawyers fees and court costs, *incurred* to effect a third party payment, expressed as a percentage of such payment.

"Third party" means anyone other than *Guardian*, the *employer* or the *covered person*.

B815.0017

YOUR CONTINUATION RIGHTS

Coordination Between Continuation Sections

A *covered person* may be eligible to continue his or her group health benefits under this *plan's* "Federal Continuation Rights" section and under other continuation sections of this *plan* at the same time. If he or she chooses to continue his or her group health benefits under more than one section, the continuations:

- (a) start at the same time;
- (b) run concurrently; and
- (c) end independently, on their own terms.

A *covered person* covered under more than one of this *plan's* continuation sections:

- (a) will not be entitled to duplicate benefits; and
- (b) will not be subject to the premium requirements of more than one section at the same time.

B815.0018

An Important Notice About Continuation Rights

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

B815.0019

Federal Continuation Rights

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

This provision applies only to any vision coverage which is part of this *plan*. In this provision, this coverage is referred to as "group health benefits."

Federal Continuation Rights (Cont.)

This provision 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 provision.

Under this provision, "qualified continuee" means any person who, on the day before any event which would qualify him or her for continuation under this provision, 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 provision is not a qualified continuee.

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 the "When Continuation Ends" section.

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, 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 before the earlier of: (a) the end of the 18 month continuation period; or (b) 60 days after the date the qualified continuee is determined to be disabled. If, during this extra 11 month continuation period, the qualified continuee is determined to be no longer disabled under the Social Security Act, he or she must notify *your employer* within 30 days of such determination, and continuation will end, as explained in "When Continuation Ends."

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

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.

B815.0272

All Options

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 the "When Continuation Ends" section.

B815.0024

All Options

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 the "When Continuation Ends" section.

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 the "When Continuation Ends" section.

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; or (b) the loss of dependent eligibility, as defined in this *plan*, of an insured dependent child.

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

B815.0025

All Options

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

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

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

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

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

Federal Continuation Rights (Cont.)

When Continuation Ends	A qualified continuee's continued group health benefits end on the first of the following: (1) with respect to continuation upon <i>your</i> 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 <i>your</i> death, <i>your</i> 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) with respect to a dependent whose continuation is extended due to <i>your</i> entitlement to Medicare while the dependent is on continuation, the end of the 36 month period which starts on the date the group health benefits would otherwise end; (5) the date the <i>employer</i> ceases to provide any group health <i>plan</i> to any <i>employee</i>; (6) the end of the period for which the last premium payment is made; (7) 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 (8) the date, after the date of election, he or she becomes entitled to Medicare.
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B815.0026

All Options

GLOSSARY

This Glossary defines the italicized terms appearing in *your* certificate.

General Definitions

Active Work, Actively-At-Work Or Actively Working means *you* are able to perform and are performing all the regular duties of *your* work for *your employer* and working *your* regular number of hours at: (a) one of *your employer's* usual places of business; (b) some place where *your employer's* business requires *you* to travel; or (c) any other place *you* and *your employer* have agreed on for *your* work

B815.0030

All Options

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

B815.0031

All Options

Enrollment Period for dependent coverage is the 31 day period which starts on the date that *you* first become eligible for dependent coverage.

B815.0032

All Options

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

B815.0033

All Options

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

B815.0035

All Options

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

B815.0036

All Options

Definitions Applicable to Vision Care Expense Coverage

B815.0039

All Options

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

B815.0040

All Options

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

B815.0041

All Options

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

B815.0042

All Options

Coated Lenses mean finished lenses that have a substance added on one or both surfaces.

B815.0043

All Options

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

B815.0044

All Options

Incurred, Or Incurred Date means the placing of an order for lenses, frames or contact lenses, or the date on which such an order was placed.

B815.0045

All Options

Keratoconus means a development or dystrophic deformity of the cornea in which it becomes coneshaped due to a thinning and stretching of the tissue in its central area.

B815.0046

All Options

Lenticular Lenses mean high-powered lenses with the desired prescription power found only in the central portion. The outer carrier portion has a front surface with a changing radius of curvature.

B815.0047

All Options

Low Vision means a partial loss of vision. It is a loss of acuity or sharpness or a loss of side vision.

B815.0048

All Options

Necessary Contact Lenses are contact lenses needed:

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

B815.0049

All Options

Non-Preferred Provider means any licensed and qualified provider acting within the scope of his or her license who has not contracted with this *plan's* PPO to provide services and/or materials to a *covered person*.

B815.0050

All Options

Orthoptics means the teaching and training process for the improvement of visual perception and coordination of two eyes for efficient and comfortable binocular vision.

B815.0051

All Options

Oversize Lenses mean larger than a *standard lens* blank, to accommodate prescriptions.

B815.0052

All Options

Photochromic Lenses mean lenses which change color with the intensity of sunlight.

B815.0053

All Options

Plan Benefits mean the vision care services and vision care materials which a *covered person* is entitled to receive by virtue of coverage under this *plan*.

B815.0054

All Options

Plano Lenses mean lenses which have no refractive power (lenses with less than a .38 diopter power).

B815.0055

All Options

Preferred Provider means any licensed and qualified provider acting within the scope of his or her license who has contracted with the *plan's* PPO to provide services and/or materials to a *covered person*.

B815.0056

All Options

Standard Frames mean frames valued up to the limit published by VSP which is given to *preferred providers*.

B815.0057

All Options

Standard Lenses mean regular glass or plastic lenses.

B815.0058

All Options

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

B815.0059

All Options

Visually Necessary means that your provider has determined the service or supply to be essential for the restoration or maintenance of a *covered person's* visual acuity and health.

B815.0060

All Options

The Guardian Life Insurance Company of America

VISION CARE EXPENSE INSURANCE

ELIGIBILITY FOR VISION CARE EXPENSE COVERAGE

B815.0062

All Options

Employee Coverage

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

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

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

Once *you* enroll in this *plan*, *you* can not drop *your* vision coverage until this *plan's* next vision open enrollment period. And if *you* drop *your* vision coverage, *you* can not 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 the vision coverage under this *plan* within 30 days of the date that any of these events occur.

B815.0067

All Options

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 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 work.*

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

B815.0091

All Options

When Your Coverage Ends *Your coverage ends on the last day of the month in which you cease active work for any reason. Such reasons include disability, retirement, layoff, leave of absence and the end of employment.*

Your coverage ends on the date you die.

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

If you are required to pay 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 vision care benefits for a limited time.

B815.0093

All Options

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

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

B815.0264

All Options

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

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

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

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

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

- **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.

B815.0099

All Options

Dependent Coverage

B815.0100

All Options

Eligible Dependents For Dependent Vision Care Benefits

Your *eligible dependents* are: (a) *your* spouse; and (b) *your* dependent children who are under age 26.

For the purpose of this Plan, the term spouse shall include *your* domestic partner which means an adult who has chosen to share his or her life with *you* in an intimate and committed relationship of mutual caring as defined under Section 297 of the California Family Code.

B815.0102

All Options

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

We treat a child as legally adopted from the time the child is placed in *your* custody for the purpose of adoption. We treat such a child this way whether or not a final adoption order is ever issued. We cover *your* adopted child from the moment of his or her placement if *you* are already covered for dependent child coverage when the child is placed for adoption. If *you* do not have dependent coverage when the child is placed for adoption, we cover the child for the first 31 days from the moment of his or her placement. To continue the child's coverage past the 31 days, *you* must enroll the child and agree to make any required premium payments within 31 days of the date of placement. If *you* fail to do this, the child's coverage will end at the end of the 31 days, and the child cannot be enrolled for this coverage until the plan's next open enrollment period.

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.

B815.0104

All Options

Handicapped Children *You* may have a child with a mental or physical handicap, or developmental disability, who is chiefly dependent upon *you* for support and maintenance. 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, subject to the conditions shown below.

- His or her condition started before he or she reached this coverage's age limit.
- He or she became Covered for dependent vision benefits before he or she reached the age limit, and remained continuously covered until he or she reached the age limit.
- He or she is unmarried and remains: (i) incapable of self-sustaining employment; and (ii) dependent upon *you* for most of his or her support and maintenance.
- *You* send us written proof of the child's disability and dependence within 31 days from the date he or she reaches the age limit. After the two year period following the child's attainment of the age limit, we can ask for periodic proof that the child's condition continues, but we cannot ask for this proof more than once a year.

The child's coverage ends when *yours* does.

B815.0106

All Options

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

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

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

If *you* do this after the *enrollment period* ends, *you* can not 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 not 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 not be dropped until the next vision open enrollment period. And once coverage is dropped for a dependent, the dependent can not be enrolled again until the next vision open enrollment period.

B815.0107

All Options

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

B815.0109

All Options

Newborn Children *We* cover *your* newborn child from the moment of his or her birth if *you* are already covered for dependent child coverage when the child is born. If *you* do not have dependent coverage when the child is born, *we* cover the child for the first 31 days from the moment of his or her birth. To continue the child's coverage past the 31 days, *you* must enroll the child and agree to make any required premium payments within 31 days of the date the child is born. If *you* fail to do this, the child's coverage will end at the end of the 31 days, and the child cannot be enrolled for this coverage until the plan's next open enrollment period.

B815.0110

All Options

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

If a surviving dependent elects to continue his or her dependent benefits under this *plan's* "Federal Continuation Rights" provision, or under any other continuation provision of this *plan*, 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 provision.

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 or she stops being an eligible dependent. This happens to a child on the last day of the month in which the child attains this *plan's* age limit, or, for your handicapped child who has reached the age limit, when he or she marries, or 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.

B815.0322

VISION CARE HIGHLIGHTS

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.

PPO Copayments	Examinations	\$10.00
	<i>Standard Frames and/or Standard Lenses</i>	\$25.00
	Necessary Contact Lenses	\$25.00
Non-PPO Cash Deductibles	Examinations	\$10.00
	<i>Standard Frames and/or Standard Lenses</i>	\$25.00
	Necessary Contact Lenses	\$25.00
Payment Rates	For Covered Services and Supplies	100%

B815.0118

VISION CARE BENEFITS

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

B815.0122

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

Vision Service Plan This *plan* is designed to provide high quality vision care while controlling the cost of such care. To do this, the *plan* encourages a *covered person* to seek vision care from doctors and vision care facilities that belong to Vision Service Plan (VSP), a vision care *preferred provider* organization (PPO).

This vision care PPO is made up of *preferred providers* in a *covered person's* geographic area. A vision care *preferred provider* is a vision care practitioner or a vision care facility that: (a) is a current provider of VSP; and (b) has a participatory agreement in force with VSP.

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

When an *you* and *your* dependents enroll in this *plan*, they will get an enrollment packet which will tell them how to obtain benefits and information about current vision care *preferred providers*.

What we pay is based on all the terms of this *plan*. The *covered person* should read this material with care, and have it available when seeking vision care. Read this *plan* carefully for specific benefit levels, *copayments*, *deductibles*, payment rates and payment limits.

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

Choice of Preferred Providers When a person becomes enrolled in this *plan*, he or she will receive a list of VSP *preferred providers* in his or her area. A *covered person* may receive vision services from any VSP *preferred provider*.

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

Vision Service Plan

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

Continuity Of Care - Terminated Provider: A covered person may request for the continuation of covered services to be rendered by a terminated Preferred Provider when he or she is undergoing treatment from a terminated provider for an acute condition or serious chronic, performance of surgery or other procedure authorized by VSP as part of a documented course of treatment that is to occur within 90 days of the contract termination date. This provision does not apply to Preferred Providers who voluntarily leave VSP. The request must be made in writing and sent to:

Vision Service Plan, Inc.
3333 Quality Drive
Rancho Cordova, California 95670

Or contact VSP's Member Services Department at (800) 622-7444 during normal business hours. The terminating Preferred Provider must accept the contracted rate for that covered person's treatment and agree not to seek payment from the covered person for any amounts for which the covered person would not be responsible if the provider were still on the network. The approval of the request to continue covered person's treatment will be at the VSP's discretion. VSP is not required to provide benefits that are not otherwise covered under the terms and conditions of the plan. In the event the terminating provider or covered person wishes to appeal an adverse decision, VSP will review the request and make the final determination.

This provision will not apply to any provider terminated for reasons relating to a disciplinary cause or reason, or fraud or other criminal activity.

Continuity Of Care - Arrangements With A Terminated Provider: VSP requires the terminated provider to agree in writing to be subject to the same contractual terms and conditions that are imposed upon currently contracted providers, including, but not limited to, credentialing, hospital privileging, utilization review, peer review, and quality assurance requirements. VSP is not required to continue the services a provider is providing to a covered person if the provider does not agree to comply or does not comply with these contractual terms and conditions.

Unless VSP and the provider agree otherwise, the services rendered pursuant to this policy shall be compensated at rates and methods of payment similar to those used by VSP for currently contracted providers providing similar services who are not capitated and who are practicing in the same or a similar geographic area as the terminated provider. VSP is not required to continue the services a provider is providing to a covered person if the provider does not accept the payment rates provided for in this paragraph.

The amount of, and the requirement for payment of copayments during the period of completion of covered services with a terminated provider are the same as would be paid by the covered person if receiving care from a provider currently contracted with VSP.

Vision Service Plan

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

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

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

B815.0124

All Options

Pre-Treatment Review for Necessary Contact Lenses Subject to prior approval by VSP consultants, we will pay benefits for necessary contact lenses provided to a *covered person*. A *covered person's* doctor must request approval for necessary contact lenses from VSP.

No benefits will be paid for necessary contact lenses if prior approval is not received from VSP.

What we pay for necessary contact lenses is subject to all of the terms of this *plan*.

B815.0127

All Options

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

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

Vision Service Plan

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

Any dispute or question arising between VSP and any *covered person* involving the application, interpretation or performance under this *plan* shall be settled, if possible, by amicable and informal negotiations, allowing such opportunity as may be appropriate under the circumstances for fact finding and mediation.

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

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

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

Vision Service Plan, Inc.
3333 Quality Drive
Rancho Cordova, California 95670
(800) 622-7444

B815.0128

How This Plan Works

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

Services or Supplies From a Preferred Provider

If a *covered person* uses the services of a *preferred provider*, the *preferred provider* must receive approval from VSP prior to providing the *covered person* with any service or supply. See the "Pre-Authorization of Preferred Provider Services" section of this *plan* for specific requirements.

Copayments The *covered person* must pay a *copayment* when he or she receives services from a *preferred provider*. We pay benefits for the covered charges a *covered person* incurs in excess of the *copayment*. This *plan's* *copayments* are as follows:

- For each vision examination from a *preferred provider* \$10.00
- For each pair of *standard frames* and/or
standard lenses from a *preferred provider* \$25.00
- For necessary contact lenses from a *preferred provider* \$25.00

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

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

- For covered services and supplies 100%

B815.0141

Services or Supplies From a Non-Preferred Provider

If a *covered person* uses the services of a *non-preferred provider*, the *covered person* must submit the itemized bill to VSP for claims payment. All claims must be sent to VSP within 90 days of the date services are completed or supplies are received. The benefits we pay are subject to all of the terms of this *plan*.

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

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

For each vision examination provided by a *non-preferred provider* . . . \$10.00

For each pair of *standard frames* and/or
standard lenses from a non-preferred provider \$25.00

For each pair of necessary contact lenses from
a *non-preferred provider* \$25.00

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

Payment Rates Once a *covered person* has met any applicable *deductible*, we pay benefits for covered charges under this *plan* as follows. What we pay is subject to all of the terms of this *plan*.

For covered services and supplies 100%

B815.0142

All Options

Covered Charges

Covered charges are the charges for the services and supplies described below. We pay benefits only for covered charges incurred by a *covered person* while he or she is insured by this *plan*. Charges in excess of any payment limits shown in this *plan* are not covered charges. If more than one type of service can be used to treat a condition, we have the right to base benefits on the least expensive service or supply.

Covered Services and Supplies

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

All covered vision services must be furnished by or under the direct supervision of an optometrist, ophthalmologist or other licensed or qualified vision care provider.

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

Covered Services and Supplies (Cont.)

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

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

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

B815.0131

All Options

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

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

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

B815.0151

All Options

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

B815.0171

All Options

Standard Frames We cover charges for standard frames.

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

Covered Services and Supplies (Cont.)

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

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

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

B815.0197

All Options

Necessary Contact Lenses We cover charges for Necessary Contact Lenses and charges for related professional services only upon prior approval by VSP. See "Pre-Treatment Review for Necessary Contact Lenses" for Details.

We limit what we pay for Necessary Contact Lenses to \$210.00 in any calendar year period.

B815.0205

All Options

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

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

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

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

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

B815.0214

All Options

Special Limitations

If this VSP Plan Replaces Another VSP Plan

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

B815.0227

All Options

Exclusions

We won't pay for:

- Orthoptics or vision training and any associated supplemental testing.
- Medical or surgical treatment of the eyes.
- Any eye examination or corrective eyewear required by an employer as a condition of employment.

B815.0231

All Options

We won't pay for:

- A frame that costs more than the plan allowance.
- *Plano lenses*.
- Two sets of glasses in lieu of bifocals.
- Replacement of lenses and frames furnished under this *plan* which are lost or broken, except at normal intervals when services are otherwise available.
- Expenses associated with securing materials such as lenses and frames.
- Refitting of contact lenses after the initial 90 day fitting period.
- Routine maintenance of contact lenses such as polishing or cleaning.
- Corneal Refractive Therapy (CRT) or Orthokeratology (procedure using contact lenses to change the shape of the cornea in order to reduce myopia).

B815.0232

All Options

- We won't pay for photochromic lenses and tinted lenses, except for pink #1 and pink #2.

B815.0233

All Options

- We won't pay for UV (ultraviolet) protected lenses.

B815.0234

All Options

- We won't pay for the scratch resistant coating of the lens or lenses.

B815.0235

All Options

- We won't pay for blended lenses.

B815.0236

All Options

- We won't pay for high index lenses.

B815.0237

All Options

- We won't pay for mirror/ski coating of the lens or lenses.

B815.0238

All Options

- We won't pay for oversized lenses.

B815.0239

All Options

- We won't pay for laminating of the lens or lenses.

B815.0240

All Options

- We won't pay for edge treatment.

B815.0241

All Options

- We won't pay for progressive lenses.
- We won't pay for progressive multifocal lenses.

B815.0242

All Options

- We won't pay for anti-reflective coating of the lens or lenses.

B815.0243

All Options

- We won't pay for polycarbonate lenses.

B815.0244

All Options

Charges not covered due to this provision are not considered covered vision services and cannot be used to satisfy this *plan's copayments or deductibles*, if any.

B815.0245

SAMPLE BENEFIT CALCULATOR

We pay benefits for covered charges shown in the Covered Services and Supplies section of this *plan*. We only pay for covered charges incurred by a *covered person* while he or she is insured. Charges in excess of any payment limits shown in the *plan* are not covered charges.

A *covered person* may receive covered services or supplies from a VSP *preferred provider*. He or she may also receive covered services from any other vision care provider. But, this *plan* usually pays more in benefits for covered services furnished by a *preferred provider*. The example below shows how benefits may differ.

The benefits shown below are for illustration only. Read this plan carefully to determine actual covered services, copayments, deductibles, payment rates or payment levels.

Example of In and Out-of-Network Benefits For Split Copayment, Full-Service Plan

Preferred Provider - Split Copayment Plan

Cost of Exam:	Paid by VSP
Copayment Applied to Exam:	\$10.00
Cost of Standard Lenses:	Paid by VSP
Cost of Standard Frames:	Paid by VSP
Copayment Applied to Lenses:	\$20.00
Copayment Applied to Frames:	\$20.00

Insured's Total Costs: \$50.00

Non-Preferred Provider - Split Copayment Plan

Cost of Exam:	\$65.00
Deductible Applied to Exam:	\$10.00
Remainder:	<u>\$55.00</u>
Exam Allowance:	\$35.00
Insured Pays Additional:	\$20.00

Cost of Lenses:	\$55.00
Deductible Applied to Lenses:	\$20.00
Remainder:	<u>\$35.00</u>
Lens Allowance:	\$25.00
Insured Pays Additional:	\$10.00
Cost of Frames:	\$80.00
Deductible Applied to Frames:	\$20.00
Remainder:	<u>\$60.00</u>

Frame Allowance:	\$35.00
Insured Pays Additional:	\$25.00
Insured's Total Costs:	\$105.00

B815.0247

STATEMENT OF ERISA RIGHTS

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

Receive Information About Your Plan and Benefits

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

Continue Group Health Plan Coverage

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

Prudent Actions By Plan Fiduciaries

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

Enforcement Of Your Rights

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

Statement of Erisa Rights (Cont.)

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

Assistance with Questions

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

Qualified Medical Child Support Order

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

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

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

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

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

B815.0250

All Options

The Guardian's Responsibilities

B815.0252

All Options

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

B815.0253

All Options

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

B815.0255

Group Health Benefits Claims Procedure

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

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

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

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

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

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

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

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

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

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

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

Group Health Benefits Claims Procedure (Cont.)

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

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

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

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

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

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

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

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

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

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

Group Health Benefits Claims Procedure (Cont.)

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

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

Adverse Benefit Determination

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

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

Appeal of Adverse Benefit Determinations

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

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

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

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

Group Health Benefits Claims Procedure (Cont.)

- 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

B815.0256

Termination of This Group Plan

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

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

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

B815.0257

All Options

NOTICE OF PRIVACY PRACTICES

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

PLEASE REVIEW IT CAREFULLY.

Effective: 5/01/2016

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

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

What is Protected Health Information (PHI):

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

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

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

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

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

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

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

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

The Guardian Life Insurance Company of America, 10 Hudson Yards, New York, NY

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

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

B998.0051

All Options

Guardian is required to use or disclose your PHI :

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

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

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

Other Uses and Disclosures .

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

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

The Guardian Life Insurance Company of America, 10 Hudson Yards, New York, NY

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

B998.0052

All Options

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

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

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

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

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

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

The Guardian Life Insurance Company of America, 10 Hudson Yards, New York, NY

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

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

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

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

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

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

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

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

B998.0053

All Options

The Guardian Life Insurance Company of America, 10 Hudson Yards, New York, NY

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

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

How to Contact Us:

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

Attention:

Guardian Corporate Privacy Officer
National Operations

Address:

The Guardian Life Insurance Company of America
Group Quality Assurance - Northeast
P.O. Box 981573
El Paso, TX 79998-1573

B998.0055

You May not be covered by all options in this Certificate.

This Certificate contains all the benefits and options that are available under the Policy. You are insured only for those benefits and options that you are eligible and enrolled for, and for which the required premium has been paid.

CERTIFICATE OF COVERAGE

The Guardian Life Insurance Company of America

10 Hudson Yards
New York, New York 10001
(212) 598-8000

The Group Term Life Insurance described in this Certificate is attached to the group Policy effective September 1, 2007. This Certificate replaces any Certificate previously issued under this Policy or under any other plan providing similar or identical benefits issued to the Policyholder by Guardian.

GROUP TERM LIFE INSURANCE

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

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

FOR INSURED PERSONS AGE 65 OR OLDER WHO PAY SOME OR ALL OF THE COST OF THIS INSURANCE: YOU HAVE A 30 DAY EXAMINATION PERIOD AFTER THE RECEIPT OF THIS CERTIFICATE DURING WHICH YOU MAY CANCEL THE COVERAGE AND RETURN THIS CERTIFICATE BY MAIL OR OTHER DELIVERY METHOD. SUCH RETURN WILL VOID THE CERTIFICATE FROM THE BEGINNING, AND THE PARTIES WILL BE IN THE SAME POSITION AS IF A CERTIFICATE HAD NOT BEEN ISSUED. ALL PREMIUMS PAID WILL BE FULLY REFUNDED IN A TIMELY MANNER NOT LATER THAN 30 DAYS AFTER THE COMPANY RECEIVES THE RETURNED CERTIFICATE.

Policyholder: HILTON WATERFRONT BEACH RESORT
Group Policy Number: 00429264

The Guardian Life Insurance Company of America



Harris Oliner, Senior Vice President,
Corporate Secretary



Michael Prestileo,
Senior Vice President

B401.1934

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COMPLAINT NOTICE

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

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

If You feel Your complaints have not been resolved after contacting the Guardian You may contact the California Department of Insurance at the following address and phone number:

Department of Insurance
300 South Spring Street
Los Angeles, California 90013
Consumer Hotline: 1-800-927-HELP (4357)
TDD: 1-800-482-4TDD (4883)
Website: www.insurance.ca.gov/01-consumers/

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GENERAL PROVISIONS

The Contract and Limitation Of Authority

The entire contract between the Policyholder and Us consists of:

- The Policy;
- The Schedule of Premium Rates;
- This Certificate(s) which describe(s) the insurance for which Covered Persons are insured;
- Any attached riders, schedule of benefits or amendments; (5) and the application.

In the event of a conflict, the Policy shall reign.

We can amend the Policy at any time, without the consent of the insured Employees or any other person having a beneficial interest in it:

- Upon written request made by the Policyholder and agreed to by Us; or
- On any date Our obligation under the Policy with respect to the Policyholder, or under this Certificate with respect to You, is changed because of statutory or other regulatory requirements.

Upon request, You may obtain a copy of the Policy from Us.

If We amend this Certificate, except upon request made by You, We must give You written notice of such change. Any amendments to this Certificate will be without prejudice to any claim arising prior to the date of the change.

No person, except by a writing signed by the President, a Vice President or a Secretary of Guardian, has the authority to act for Us to:

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

Applicable Benefits

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

- They were previously selected in an enrollment form or other required form; and
- We have received any required premium.

If Proof of Insurability is required, You will not be covered unless You satisfy the Proof of Insurability requirements stated in the Certificate and Schedule of Benefits.

Incontestability

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

No statement in any application, made by You, or any dependent, will be used to contest the validity of Your insurance or to deny a claim for a loss incurred, or for a disability which starts, after such insurance has been in force for two years during Your lifetime.

If this Certificate replaces a plan Your Employer had with another insurer, We may rescind this Certificate based on misrepresentations or omissions made by Your Employer or You in a signed application for up to two years from the Effective Date of the Policy.

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

Physical 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 the Certificate as often as We feel is reasonably necessary. We also have the right to have an autopsy performed in the case of death where allowed by law. We will pay for all such examinations and autopsies.

Overpayment Recovery

If We overpay benefits, all such benefits must be repaid in full. We have the right to reduce the benefit or reduce any other benefits payable under this Certificate, toward recovery of any overpayment.

B401.1937

ELIGIBILITY FOR GROUP TERM LIFE COVERAGE - EMPLOYEE COVERAGE

Conditions Of Eligibility

Subject to the conditions of eligibility set forth below, and to all of the other conditions of this Certificate, You are eligible for Group Term Life coverage if You are:

- In an eligible class of Employees;
- An active Full time Employee;
- Legally working in the United States and/or Canada or working outside of the United States for a United States based Employer in a country or region approved by Us; and
- Working at least the minimum number of hours of an Employee in Your eligible class at:
 - The Employer's place of business;
 - Some place where the Employer's business requires You to travel; or
 - Any other place You and the Employer have agreed upon for the performance of your occupational duties.

You are **not** eligible for Group Term Life coverage if You are:

- A temporary or seasonal Employee.

Enrollment Requirement If You must pay all or part of the cost of Your coverage, We will not cover You until You enroll and agree to make the required payments.

Proof Of Insurability Part or all of Your insurance amounts may be subject to proof that You are insurable. The Schedule of Benefits explains if and when We require Proof of Insurability. You will not be covered for any amount that requires such Proof of Insurability until You provide such proof to Us and We approve it in writing.

The Waiting Period If You are in an eligible class, You are eligible for Group Term Life insurance under this Certificate after You complete the service waiting period, if any, established by the Employer.

Multiple Employment If You work for both the Employer and a covered associated company, or for more than one covered associated company, We will treat You as if only one firm employs You. You will not have multiple life insurance coverage under this Certificate. But, if this Certificate uses the amount of Your Insured Earnings to set the rates, determine class, figure insurance amounts, or for any other reason, such Insured Earnings will be figured as the sum of Your Insured Earnings from all covered Employers.

B400.3124

All Options

When Coverage Starts

For coverage to start, You must be fully capable of performing the major duties of Your regular occupation for the Employer and working the minimum required number of hours of an Employee in Your eligible class at 12:01 A.M. Standard Time for Your place of residence on Your scheduled Eligibility Date. And, for coverage to start, You must satisfy all of the Conditions of Eligibility described above, and the conditions shown below which apply to You. If You are not fully capable of performing the major duties of Your regular occupation on Your scheduled Eligibility Date, We will postpone the start of Your coverage until You are so capable and working the minimum required number of hours of an Employee in Your eligible class for one full day, with the capacity to do so for one full week.

Whether You must pay all or part of the cost of Your coverage, You must elect to enroll and agree to make the required payments before Your coverage starts. If You do this on or before Your Eligibility Date, Your coverage is scheduled to start on Your Eligibility Date. If You do this within 31 days after Your Eligibility Date, Your coverage is scheduled to start on the date You sign Your enrollment form. If You elect to enroll and agree to make the required payments more than 31 days after Your Eligibility Date, Your coverage will not start until You send Us Proof Of Insurability. Once We approve such Proof Of Insurability, Your coverage will start on the date we approve such coverage.

B400.3130

All Options

Exception to When Coverage Starts

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

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

and if:

- You are fully capable of performing the major duties of Your regular occupation for Your Employer for the minimum number of hours of an Employee in Your eligible class at 12:01 AM Standard Time for Your place of residence on the scheduled Eligibility Date; and

- You were performing the major duties of Your regular occupation and working the minimum number of hours of an Employee in Your eligible class on Your last regularly scheduled work day;

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

Any part of Your coverage which is subject to Proof Of Insurability will not start unless You send such proof to Us, and We approve it in writing. Once We have approved it, that part of Your coverage is scheduled to start on Your approved Eligibility Date.

B400.3131

All Options

Delayed Eligibility Date For Employee Voluntary Term Life Insurance

If due to sickness or injury, You are not Actively at Work and working the minimum required number of hours of an Employee in Your eligible class, on the date Your Voluntary Term Life coverage is scheduled to start, We will postpone coverage for an otherwise covered loss for any condition that prevents you from meeting the Actively at Work requirement. We will postpone such coverage until You:

- Complete one full day of Active Work, working the minimum number of hours of an Employee in Your eligible class, with the capacity to do so for one full week; and,
- Do not miss a day of work due to the same condition.

Coverage for an otherwise covered loss due to all other conditions will start on the date You:

- Return to Active Work working the minimum number of hours of an Employee in Your eligible class and;
- Are performing the regular duties of your occupation.

B400.3132

All Options

When Coverage Ends

Your coverage will end on the first of the following dates:

- The date Your Active Work ends for any reason, except as noted below under Coverage During Leave of Absence. Such reasons include:
 - Disability;
 - Death;
 - Retirement;
 - Layoff;

- Leave of absence;
 - The end of employment; and
 - Expiration of the employment contract.
- The date You stop being an eligible Employee under this Certificate.
 - The date You are no longer working in the United States and/or Canada, or no longer working outside the United States for a United States based Employer in a country or region approved by Us. Any incidental business or personal travel outside of the United States and/or Canada, or outside of a country or region approved by Us, is covered. Such travel will be considered incidental if it is for a period not to exceed 30 consecutive days.
 - The date the group Certificate ends, or is discontinued for a class of Employees to which You belong.
 - The last day of the period for which required payments are made for You.

You may have the right to continue certain group benefits for a limited time after Your coverage would otherwise end. And, You may have the right to replace certain group benefits with converted policies. The Employer will notify you of any conversion options available.

B400.3135

CONTINUATION OF COVERAGE

Coverage During Disability

If Your Active Work ends because You are Totally Disabled, You and Your Employer may agree to continue Your insurance for the amount of voluntary term life insurance for which You are insured on Your last day of Active Work, subject to continued payment of all required premiums, until the earlier of:

- The date you are no longer Totally Disabled, as defined by this Certificate;
- 12 months; from the date Your Total Disability began;
- The date you are approved for any Waiver of Premium Benefit for which you are eligible; or
- The date of Your 99th birthday.

We may require written Proof of Loss that You remain Totally Disabled and are receiving regular Doctor's care to maintain this benefit. This Proof of Loss must be given to Us within 30 days of the date We request it. Your eligibility for benefits will be governed by all the terms of this Certificate.

Coverage During Temporary Layoff

If Your Active Work ends because You are temporarily laid off, You and Your Employer may agree to continue Your insurance, subject to continued payment of all required premium, until the earlier of:

- The end of the temporary layoff; or
- The end of the month in which You are laid off plus 1 months.
- The end of the time period covered under a severance agreement not to exceed 1 months.

If You die or become Disabled under this Certificate while Your coverage is being continued during a temporary layoff, Your eligibility for benefits will be governed by all the terms of this Certificate.

Coverage During Temporary Leave of Absence

If Your Active Work ends because You go on a leave of absence that has been approved by Your Employer, You and Your Employer may agree to continue Your insurance, subject to continued payment of all required premiums, until the earlier of:

- The end of the Employer approved leave of absence; or

- The end of the month in which Your leave begins plus 1 months.

If You become Disabled under this Certificate while Your coverage is being continued during a leave of absence, Your eligibility for benefits will be governed by all the terms of this Certificate.

B400.3137

All Options

**ELIGIBILITY FOR GROUP TERM LIFE COVERAGE
DEPENDENT COVERAGE**

B400.3143

All Options

**Eligible Dependents For Dependent Voluntary
Term Life Insurance**

Your eligible dependents are Your:

- Spouse who is under age 70; and
- dependent children from birth until they reach age 26.

B400.3190

All Options

Adopted Children And Step-Children

Your dependent children include Your legally adopted children and Your step-children. However, to qualify as a dependent, each person must be chiefly dependent upon on You for support and maintenance. 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.

B401.1940

All Options

Dependents Not Eligible

We exclude:

- A dependent who is on Active Duty in any armed force.

B400.3201

All Options

**Continuing Coverage For Dependent Children
Past the Limiting Age**

If You have a child or children who:

- Is/are incapable of self-sustaining employment by reason of an intellectual disability or physical handicap; and

- Is/are chiefly dependent upon You for support and maintenance,

Then, the child or children may remain eligible for dependent benefits past the age limit provided all the conditions shown below are satisfied.

Each such child:

- Must have an intellectual disability or physical handicap that began before he or she reached the dependent age limit;
- Became covered by this Certificate, or the prior carrier's group life policy that it replaced, before he or she reached the dependent age limit, and remained continuously covered until he or she reached the age limit;
- Remains:
 - Incapable of self-sustaining employment; and
 - Primarily dependent upon You for most of his or her support and maintenance; and

You must send Us written proof, and we must approve such proof, of the child's disability or handicap and dependence within 31 days from the date he or she reaches the dependent age limit. After the two year period following the child's attainment of the age limit, We can ask for periodic proof that the child's condition continues, but We cannot ask for this proof more than once a year.

Irrespective of this provision, any coverage provided under this section ends when Your coverage ends.

B401.1941

All Options

Proof Of Insurability

Part or all of Your dependent insurance amounts may be subject to proof that they are insurable. The Schedule of Benefits explains if and when We require Proof of Insurability. Your dependents will not be covered for any amount that requires Proof of Insurability until You provide that proof to Us and We approve that proof in writing.

B400.3203

All Options

When Dependent Coverage Starts

In order for Your dependent coverage to start, You must already be covered for Employee coverage, or enroll for Employee and dependent coverage at the same time.

Subject to the Exception shown below and to all of the other terms of this Certificate, the date Your dependent coverage starts depends on when You elect to enroll Your Initial Dependents and agree to make any required payments.

Initial Dependents If You enroll Your Initial Dependents on or before Your Eligibility Date, the dependents' coverage begins on the later of Your Eligibility Date and the date You become covered for Employee coverage.

If You enroll Your Initial Dependents within the Enrollment Period, their coverage begins on the later of Your Eligibility Date and the date You become covered for Employee coverage.

If You do not enroll Your Initial Dependents when they are first eligible, and enroll those Initial Dependents after the Enrollment Period ends, You must supply Proof Of Insurability and coverage will not start until We approve that proof in writing.

If an Initial Dependent becomes eligible after this Certificate's Effective Date, his or her coverage will start on the date We approve him or her for coverage.

If Dependent Proof of Insurability is required Subject to the Exception shown below, if Proof Of Insurability is required for dependent benefits, You must send Us the proof We require, and We must approve that proof in writing. Those benefits will then begin on the approved Eligibility Date.

If You must pay part of the cost of dependent coverage, We will not cover You for such coverage until You enroll each of Your dependents, agree to make the required payments, submit Proof Of Insurability and We approve that proof in writing.

Newly Acquired Dependents If You do not pay any part of the cost of dependent coverage, a Newly Acquired Dependent is covered from the date he or she first becomes eligible.

If You must pay part of the cost of dependent coverage, and are already enrolled for dependent child coverage for Your Initial Dependent children, any Newly Acquired Dependent children will be covered as of the date he or she is first eligible.

However, if You were previously eligible to enroll for dependent child coverage and waived coverage or failed to enroll, We will not cover any of Your dependent children until You submit Proof of Insurability and we approve that proof in writing and you make any additional required payments.

B400.3204

All Options

Exception We will postpone the Eligibility Date of a dependent's, other than a newborn child's, coverage if, on that date, he or she is confined to a hospital or other health care facility or home confined.

In that case, We will postpone the Eligibility Date of his or her coverage until the day after the date of his or her discharge from such facility or his or her home confinement ends.

If a dependent was covered under a prior plan at transfer, this language will not apply to the amount of coverage that was in force with the prior plan.

B401.1943

All Options

When Dependent Coverage Ends

Dependent coverage ends for all of Your dependents when:

- Your Employee coverage ends;
- You stop being a member of a class of Employees eligible for such coverage;
- This Certificate ends; or
- Dependent coverage is discontinued from this Certificate for all Employees or for Your 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 or she stops being an eligible dependent. For dependent children the coverage ends at 12:01 A.M. Standard Time for Your place of residence on the date the child attains this Certificate's age limit, or when a step-child is no longer dependent on You for at least 50% of their support and maintenance, or for Your disabled child who has reached the age limit, when he or she is no longer eligible under the Continuing Coverage for Dependent Children Past the Limiting Age provision.

Coverage ends for a Spouse when a marriage is lawfully terminated, and with respect to Voluntary life coverage, it happens at 12:01 A.M. on the date the Spouse reaches age 70.

Read this Certificate 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.

B400.3210

All Options

EMPLOYEE TERM LIFE INSURANCE

B400.3211

All Options

Voluntary Term Life Insurance

Subject to the limitations and exclusions shown below, if You die while covered for this Group Term Life insurance, We will pay Your beneficiary the amount shown in the Schedule Of Benefits for the plan of voluntary term life insurance You have elected. The voluntary term life insurance amount may be subject to reductions. These reductions are also shown in the Schedule Of Benefits. Your voluntary term life insurance amount, a part of it, 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 Of Benefits.

B401.2790

All Options

The Choices You may elect to be covered for any of the plans of employee voluntary term life insurance offered by the Employer. These plans are shown in the Schedule Of Benefits. But, You can only be covered under one plan at a time. You must notify the Employer of Your election and pay the required premium.

B400.3214

All Options

You may switch to another plan of voluntary term life insurance during the voluntary life enrollment period shown in the Schedule Of Benefits. Subject to any of this Certificate's Proof Of Insurability requirements, You will be covered under the new plan as of the transfer date shown in the Schedule Of Benefits. You must notify the Employer of any desired switch.

B400.3216

All Options

Suicide Exclusion We pay no voluntary term life insurance benefits if Your death is due to suicide, and if such death occurs within 2 years from Your voluntary term life insurance effective date under this Certificate. And, We pay no increased voluntary term life insurance benefit amount if Your death is due to suicide, and if such death occurs within 2 years from the effective date of the increase.

If this Certificate replaces another voluntary Group Term Life insurance plan Your Employer had with another insurer, You will be given credit for the amount of time covered under the prior plan's Suicide Exclusion if:

- You were covered under the prior plan when it ended;
- You Enrolled for voluntary Group Term Life insurance under this Certificate on or before this Certificate's effective date; and
- You are Actively At Work on the effective date of this Certificate.

If You satisfy these conditions We will credit any time covered under the prior term life plan toward meeting this Certificate's 2 year Suicide Exclusion requirement.

However, We limit Your voluntary term life insurance benefit under this Certificate if it is more than the benefit for which You were insured under the prior term life plan. In this case, We limit the benefit to the amount You would have been entitled to under the prior term life plan.

The Beneficiary You decide who receives this benefit when You die. You may designate a beneficiary by doing so in writing on a form and filing the form with the Employer.

You can change Your beneficiary at any time by providing written notice; unless You have assigned this insurance. But, the change will not take effect until We or the Employer records the change.

We will not be liable for any amounts paid before receiving notice of a beneficiary change.

If You named more than one person as a primary beneficiary, but You do not specify what shares each such primary beneficiary is entitled to receive, We will divide the benefits equally among all such named primary beneficiaries who survive You. If someone You named as a primary beneficiary dies before You, that person's share will be divided equally by the primary beneficiaries still alive; unless You have specified otherwise.

If You have named a contingent beneficiary or contingent beneficiaries, We will pay Your contingent beneficiary or contingent beneficiaries, if no primary beneficiary survives You. If there is more than one contingent beneficiary who is eligible for benefits, We will divide the benefits equally among all such named contingent beneficiaries who survive You; unless You have specified otherwise.

If there is no primary or contingent beneficiary or beneficiaries eligible for benefits when You die, We will pay this benefit as follows:

- To Your Spouse;
- If Your Spouse does not survive You, then to Your children who survive You in equal shares;
- If no Spouse or children survive You, then to Your parents who survive You in equal shares;
- If no Spouse, children, or parents survive You, then to Your brothers and sisters in equal shares;
- If none of the above parties survive You, then to Your executors or administrators of Your estate.

Assigning This 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:

- Your Spouse;
- One of Your parents or grandparents;
- One of Your children or grandchildren;
- One of Your brothers or sisters; or
- The trustee(s) of a trust set up for the benefit of one or more of these relatives.

We will recognize an assignee as the owner of the rights assigned only if:

- The assignment is in writing and signed by You; and
- A signed or certified copy of the written assignment has been received and approved by Us in writing.

We are not responsible for any legal, tax, or other effects of any assignment, or for any benefits We pay under this Certificate before We receive and approve any assignment. Assigning this life insurance may limit Your ability to exercise certain rider benefits.

We suggest You speak to Your lawyer before You make any assignment.

Payment Of Funeral Expenses We have the option of paying up to \$500 of this benefit to any person who incurred expenses for Your funeral.

Repatriation Benefit We will pay an extra sum for covered loss of life which occurs at least 75 miles from Your home. In that case, We reimburse up to \$5,000 to any person who incurred expenses to prepare and transport Your body to a mortuary chosen by You or an authorized agent. The total repatriation benefit payable under Your life and AD&D contracts will not exceed \$5,000.

B401.1945

CONVERTING THIS EMPLOYEE VOLUNTARY TERM LIFE INSURANCE

**If Employment Or
Eligibility Ends**

Your group life insurance ends on the date:

- Your active Full-Time employment ends; or
- You stop being a member of an eligible class.

If Your group life insurance ends, Your Employer is responsible for providing You Notice of Your Right to Convert.

If You are not Totally Disabled, You can apply to convert Your Employee group voluntary life insurance to a permanent life insurance policy.

You can apply to convert up to the full amount of voluntary life insurance for which You were insured under this Certificate on the date Your insurance ended, less any group life insurance for which You become eligible in the 31 days after Your insurance under this Certificate ends.

**If This Certificate
Ends Or Group Life
Insurance Is
Discontinued**

Your group life insurance also ends:

- If this Certificate ends; or
- Life insurance is discontinued from this Certificate for all Employees or for Your class.

If Your group life insurance ends for either of these reasons, You may apply to convert Your Employee group voluntary life insurance to a Converted Policy.

You can apply to convert to a permanent life insurance policy, if

- You are not Totally Disabled; and
- You have been insured by a Guardian group life insurance plan or a group plan it replaces for at least five consecutive years.

However, the amount of life insurance that You can convert in either scenario is limited to the lesser of:

- \$2,000, or
- The amount of Your voluntary life insurance under this Certificate, less any group life insurance for which You become eligible in the 31 days after Your insurance under this Certificate ends.

**If You Are Totally
Disabled**

Your group life insurance ends on the date:

- Your active Full-Time employment ends;
- You stop being a member of an eligible class;
- This Certificate ends; or

- Life insurance is discontinued from this Certificate for all Employees or for Your class;

and

- You are Totally Disabled; and
- You are eligible for Waiver of Premium Benefits pursuant to the Waiver of Premium Benefit Rider, but You have not yet been approved for the Waiver of Premium of Benefit,

You can apply to convert Your group term life insurance to:

- A permanent life insurance policy; or
- Interim term life insurance coverage.

You can apply to convert up to the full amount of voluntary life insurance for which You are insured under this Certificate on the date Your insurance ends, less any group life insurance for which You become eligible in the 31 days after Your insurance under this Certificate ends.

However, if You have coverage under this Certificate's Exception to When Employee Coverage Starts, You may not convert if You are eligible or could become eligible under the prior plan's waiver of premium provision.

If You have converted and are later approved for this Certificate's Waiver of Premium Benefit, the Converted Policy will be cancelled as of the date You are approved for the Waiver of Premium Benefit. In this instance, Your coverage under this Certificate will continue subject to its terms, provided You remain eligible for the Waiver of Premium Benefit.

Interim Term Life Insurance

You may choose to apply to convert to interim term life insurance coverage if:

- You are Totally Disabled; and
- You may be eligible for Waiver of Premium Benefits based upon Your age, but You have not yet been approved for the Waiver of Premium Benefit.

If interim term life insurance coverage is issued to You, it can remain in force for up to one year from the date the interim term life insurance coverage goes into force and effect.

If You are approved for this Certificate's voluntary Waiver of Premium Benefit during this year, the interim term life insurance coverage will be cancelled as of the date that You are approved for the Waiver of Premium Benefit. In this instance, Your coverage under this Certificate will continue subject to its terms, provided You remain eligible for the Waiver of Premium Benefit. If You have not been approved for this Certificate's voluntary Waiver of Premium Benefit, the interim term life insurance coverage will end exactly one year from the first day said coverage goes into force and effect, and Your life insurance will be converted to a permanent life insurance policy. Premiums for the permanent life insurance policy will be based on Your age as of the date You convert from the interim term life insurance coverage.

If You are Totally Disabled, but You are not eligible for the Waiver of Premium Benefit based on Your age, You can apply to convert to a permanent life insurance policy.

How and When to Convert To obtain a Converted Policy, We must receive a written application fully completed by You, and all required premiums within the Conversion Period. Your Employer is responsible for providing You with Notice of Your Right to Convert within 15 days of the date Your group life insurance ends. We will not ask for proof that You are insurable. In order to obtain a Converted Policy, You must satisfy all conditions required to convert within the Conversion Period.

Coverage will begin under the Converted Policy when We receive:

- A written application fully completed by You; and
- All required premiums during the Conversion Period.

Death During The Conversion Period We will pay a death benefit equal to the amount of life insurance that could have been converted if:

- You die within the Conversion Period; and
- But for Your death, You would have been entitled to purchase a Converted Policy; and
- We receive Proof of Loss.

Any benefit payable under the group Certificate will be paid to the beneficiary You designate under the group Certificate. However, if the Converted Policy has already taken effect, any benefit payable under the Converted Policy will be paid to the beneficiary You designated for the individual life insurance on the application for conversion. Under no circumstances will a benefit be paid under both the group Certificate and the Converted Policy.

B400.3232

All Options

Portability And Conversion If You choose to convert, this Certificate's portability privilege will not be available. In the event that a person would be eligible to both convert and to port, only one of these privileges may be chosen. Coverage under both a Conversion Policy and a portable certificate of coverage at the same time is not permitted. You should read the entire Certificate, as well as any related materials carefully before making a choice.

B400.3234

DEPENDENT TERM LIFE INSURANCE

B400.3235

Voluntary Term Life Insurance

A Subject to the limitations and exclusions shown below, If Your dependent dies while insured for this benefit, We will pay You the amount shown in the Schedule Of Benefits. If You are not living when Your dependent dies, We will pay this benefit as follows:

If the dependent was Your Spouse, We will pay this benefit to the Spouse's estate. If there is no established estate, We will pay this benefit in equal shares to the first eligible party or parties in the following order:

- To Your Spouse's children in equal shares;
- If no children survive him or her, then to his or her parents in equal shares;
- If no children, or parents survive him or her, then to then to his or her brothers and sisters in equal shares;
- If none of the above parties survive Your Spouse, then to the executors or administrators of Your estate.

If the dependent was Your child, we will pay this benefit in equal shares to the first eligible party or parties in the following order:

- Your child's custodial parent(s);
- If no custodial parent survives him or her, then to Your parents;
- If no custodial parent or Your parents survive him or her, then to Your child's estate;
- If none of the above parties survive him or her and no estate exists, then to the executors or administrators of Your estate;
- If none of the above parties survive him or her, and no estates exist, then to Your child's siblings.

We have the option of paying up to \$500 of this benefit to any person who incurred expenses for your dependent's funeral.

B401.2793

All Options

The Choices: You may elect coverage of any of the plans of dependent Spouse voluntary term life insurance and any of the plans of dependent child voluntary term life insurance offered by the Employer. These plans are shown in the Schedule Of Benefits. But, You can only be covered for one Spouse plan and one child plan at a time. You must notify the Employer of Your election and pay the required premium.

You may switch to another Spouse and child plan during the dependent voluntary life enrollment period shown in the Schedule Of Benefits. Subject to any of this Certificate's Proof Of Insurability requirements, You will be covered for the new plan as of the transfer date shown in the Schedule of Benefits. You must notify the Employer of any desired switch.

B400.3242

All Options

Suicide Exclusion We pay no voluntary term life insurance benefits if Your dependent's death is due to suicide, if such death occurs within 2 years from his or her voluntary term life insurance effective date under this Certificate. And, We pay no increased voluntary term life insurance benefit amount if Your dependent's death is due to suicide, if such death occurs within 2 years from the effective date of the increase.

If this Certificate replaces another voluntary term life insurance plan Your Employer had with another insurer, your dependent may be given credit for the amount of time covered. If your dependent was:

- Covered under the prior plan when it ended;
- Enrolled for insurance under this Certificate on or before this Certificate's effective date; and
- You were actively working on the effective date of this Certificate;

We credit any time covered under the prior plan toward meeting this Certificate's 2 year Suicide Exclusion requirement.

However, We limit Your dependent voluntary term life insurance benefit under this Certificate if it is more than the benefit for which Your dependents were insured under the prior plan. In this case, We limit the benefit to the amount Your dependents would have been entitled to under the prior plan.

B400.3246

CONVERTING THIS DEPENDENT TERM LIFE INSURANCE

**If A Dependent's
Life Insurance Ends**

Dependent term life insurance ends for all of Your dependents when Your group life insurance eligibility ends. Your group life insurance eligibility ends if:

- Your active Full-Time employment ends;
- You stop being a member of an eligible class; or
- Your group life insurance is continued under the Waiver of Premium Benefit provision; or
- 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 Dependent Life Insurance ends for any of the above reasons any dependent who was insured under this Certificate may apply to convert all or part of the amount for which he or she was insured on the day before insurance ended. Your Employer is responsible for notifying You or Your dependents of any conversion options available.

Your dependent may apply to convert up to the full amount of voluntary life insurance for which he or she was insured under this Certificate on the date his or her insurance ended to a permanent life insurance policy.

**If This Certificate
Ends Or Group Life
Insurance Is
Discontinued**

Dependent term life insurance also ends for all of Your dependents:

- If this Certificate ends; or
- Dependent life insurance is discontinued from this Certificate for all Employees or for Your class.

If Dependent term life insurance ends for either of these reasons, and any of Your dependents have been insured by a Guardian Group plan, or a group plan it replaces, for at least five consecutive years, each such dependent may apply to convert to a permanent life insurance policy.

However the amount that he or she can convert in either scenario is limited to the lesser of:

- \$2,000; or
- The amount of Your dependent's life insurance under this Certificate, less any group life insurance for which Your dependent becomes eligible in the 31 days after dependent life insurance under this Certificate ends.

**If A Dependent
Stops Being Eligible**

A dependent's term life insurance ends when he or she stops being an eligible dependent. A Spouse is no longer an eligible dependent when:

- A marriage is lawfully terminated; or

- He or she reaches age 70.

A child is no longer an eligible dependent when he or she reaches the limiting age.

If a dependent stops being eligible, he or she may convert all or part of the amount for which he or she was insured on the day before insurance ended to a permanent life insurance policy.

B401.1965

All Options

How And When to Convert To obtain a Converted Policy, We must receive a written application fully completed by You or Your dependent, and all required premiums within the Conversion Period. Your Employer is responsible for providing You and Your dependents with written Notice of Your Right to Convert within 15 days of the date Your group life insurance ends. You will have 31 days after Your dependent group voluntary life insurance ends to convert. We will not ask for proof that he or she is insurable. If the dependent is a minor or incompetent, the person who cares for and supports the dependent may apply for him or her.

Death During The Conversion Period We will pay a death benefit equal to the amount of dependent life insurance that could have been converted if:

- Your dependent dies within the Conversion Period; and
- But for his or her death, Your dependent would have been entitled to purchase a Converted Policy; and
- We receive Proof of Loss.

Any benefit payable under the group Certificate will be paid to you. However, if the Converted Policy has already taken effect, any benefit payable under the Converted Policy will be paid to the beneficiary You or Your dependent designated for the individual life insurance on the application for conversion. Under no circumstances will a benefit be paid under both the group Certificate and the Converted Policy.

B400.3501

CLAIM PROVISIONS

Your right to make a claim for Group Term Life insurance benefits provided by this Certificate is governed as follows:

Administration We have the responsibility to fairly, thoroughly, objectively and timely investigate, evaluate and determine Your eligibility for benefits under this Plan.

We will:

- Obtain only such information that is necessary to evaluate a claim for benefits. This information will be obtained as set forth herein with respect to notice and proofs of loss.
- Consider and interpret the terms of this Plan and all information obtained by Us and submitted that relates to a claim for benefits and make a determination based on that information and in accordance with the terms of this Plan and applicable California state law.
- If a claim is approved, review the determination as often as is reasonably necessary to determine continued eligibility for benefits.
- If a claim is denied, provide the claimant within a reasonable period of time a written notification of an adverse determination. Such notification will include the specific reason(s) for the adverse determination.

All such determinations are conclusive and binding, except that they may be modified or reversed by a court or regulatory agency with appropriate jurisdiction.

Notice of Claim Written notice of intent to file a claim under this Certificate must be sent to Us within 20 days of the date of the loss. This Notice should include the name of the insured and the Policy number. If the claim is being made for any other Covered Person, his or her name should also be shown. For details, You can call Us at 1-800-525-4542.

Claim Forms We will furnish forms for filing proof of death within 15 days of receipt of Notice. If we do not furnish the forms on time, We will accept a written Notice and adequate proof of death that is the basis of the claim as Proof of Loss.

Proof of Loss You must send written Proof of Loss to Our designated office within 90 days of the loss.

Late Notice and Proof of Loss We will not void or reduce Your claim if we do not receive Notice and Proof of Loss within the required time. In that case, Notice and Proof of Loss must be sent as soon as reasonably possible.

Proof of loss and other claim data should be submitted to:

The Guardian Life Insurance Company of America
Group Life Claims Department

P.O. Box 981573
El Paso, TX 79998-1573

Payment Of Benefits Subject to all the terms of this Certificate, We will pay this insurance as soon as We receive written Proof of Loss. This should be sent to Us as soon as possible. We will pay this benefit in a lump sum.

Interest will be paid on the proceeds if not paid within 30 days of the death of the Insured. Interest will be computed daily at the rate of interest currently payable on individual life policy dividends left on deposit. Such amount shall be added to the life insurance benefit amount.

Legal Actions No legal action against Guardian related to this Certificate may be brought until 60 days from the date Proof of Loss has been given as shown above. No legal action may be brought against Guardian related to claims for benefits under this Certificate after three years from the date of the final benefit determination.

B401.2794

All Options

DEFINITIONS

This section defines certain terms appearing in this Certificate.

B400.3503

All Options

Active Work or Actively At Work These terms mean You are able to perform, and are performing, all of the regular duties of Your work for the Employer, on a Full-Time basis at:

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

B400.3504

All Options

Certificate This term means this Certificate of Coverage, including any riders and enrollment forms that may be attached to this Certificate.

B400.3506

All Options

Conversion Period This term means the consecutive 31 day period beginning on the date Your Employee and dependent group voluntary life insurance ends.

B400.3510

All Options

Converted Policy This term means a policy which provides individual life insurance, on an interim term or permanent basis, resulting from the option to convert provided in the Policy. The Converted Policy will not provide any:

- Benefits for accidental death;
- Waiver of Premium Benefits; or
- Other supplemental benefits.

The benefits provided by the Converted Policy may not be the same as the benefits provided by this Certificate.

The premium for the Converted Policy will be based on

- Your risk and rate class under this Certificate; and
- Your age on the date the Converted Policy goes into effect.

B400.3513

All Options

Covered Person This term means the Employee and dependents who are insured by this Certificate.

B400.3514

All Options

Disabled This term means the Covered Person is:

- Not able to perform any work for wage or profit; and
- Receiving Regular and Appropriate Care for the cause of Disability.

B400.3516

All Options

Doctor Any medical practitioner We are required by law to recognize. He or she must:

- Be properly licensed or certified by the laws of the state where he or she practices; and
- Provide services that are within the lawful scope of his or her practice.

B400.3517

All Options

Domestic Partner This term means Your domestic partner who is registered with the California Secretary of State.

B401.1950

All Options

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

B400.3518

All Options

Eligibility Date This term means the earliest date a Covered Person is eligible for coverage under this Certificate, and he or she has satisfied all requirements for coverage to begin, as required by this Certificate.

- For Employee coverage, this term means the earliest date You are eligible for coverage under this Certificate.
- For an Employee in Active Work who has completed any waiting period required by the Employer as of the Effective Date of this Certificate, the Eligibility Date means the Effective Date of this Certificate.

- For an Employee in Active Work as of the Effective Date of this Certificate who has not completed any waiting period required by the Employer, the Eligibility Date will be the date following the completion of the required waiting period.
- For an Employee hired on or after the Effective Date of this Certificate, the Eligibility Date will be the later of the Employee's date of hire or the first date after the end of any waiting period required by the Employer.

If this plan requires Employees to elect coverage under this Certificate, the Eligibility Date will be the later of:

- The Employee's date of hire;
- The first date after any waiting period required by the Employer; or
- The approval by Us in writing of any coverage for which You were required to provide Proof of Insurability.

For dependent coverage, this term means the earliest date on which:

- You have Initial Dependents; and
- Are eligible for dependent coverage.

B400.3519

All Options

Employee This term means a person who works for the Employer at the Employer's place of business and whose income is reported to the United States Internal Revenue Service, and/or a state, for tax purposes. Partners and proprietors will also be treated as employees if the Conditions of Eligibility requirements are met.

B400.3521

All Options

Employer This term means HILTON WATERFRONT BEACH RESORT .

B400.3522

All Options

Enrollment Period This term means the 31 day period which starts on the date the Covered Person first becomes eligible for coverage.

B400.3523

All Options

Full-Time This term means You are not a part time Employee as defined by Your Employer and the average number of hours You worked for the 6 months prior to the last full day worked was at least 30 hours per week at:

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

B400.3525

All Options

Initial Dependents This term means those eligible dependents You have at the time You first become eligible for Employee coverage. If at this time You do not have any eligible dependents, but You later acquire them, the first eligible dependents You acquire are Your Initial Dependents.

B400.3526

All Options

Newly Acquired Dependent This term means an eligible dependent You acquire after You already have coverage in force for Initial Dependents.

B400.3538

All Options

Notice of Right to Convert This term means the written notice presented to You by the Employer, delivered to Your last known address.

B400.3539

All Options

Policy or Plan This term means the Group Term Life insurance coverage described in the Policy and this Certificate.

B400.3541

All Options

Proof Of Insurability This term means the completion of an evidence of insurability requirement as defined in the Schedule of Benefits.

B400.3542

All Options

Proof of Loss This term means the documents that We use to substantiate a claim. Examples of documents used for Proof of Loss include:

- An original certified finalized death certificate;

- The beneficiary designation in effect at the time of death;
- Enrollment information documenting that the insured was properly enrolled for the amount of coverage claimed;
- A fully completed claim form; and
- Any additional information deemed necessary during the course of Our claim investigation. This may include, but is not limited to, an autopsy report, investigative reports, toxicology reports and medical records.

B401.1951

All Options

Reasonable Accommodation This term means any modification or adjustment that the Employer willingly provides to:

- A job;
- An employment practice;
- A work process; or
- The work place.

The modification or adjustment must make it possible for a Disabled person to:

- Reach the same level of performance as a similarly situated non-disabled person; or
- Enjoy equal benefits and privileges of employment as are available to a similarly situated non-disabled person.

The modification or adjustment must not place an undue hardship on the Employer.

B400.3545

All Options

Regular and Appropriate Care This term means, with respect to Your disabling condition(s) and any other condition(s) which, if left untreated, would adversely affect Your disabling condition, You:

- Visit a Doctor as frequently as recommended by a Doctor to effectively manage these conditions; and
- Are receiving appropriate treatment designed to achieve maximum medical improvement in these conditions.

Appropriate treatment is that treatment a patient would make a reasonable decision to accept after duly considering the opinions of medical professionals, and such treatment must be provided by a Doctor or Doctors whose specialty is appropriate for Your:

- Disability; and
- Any other conditions which left untreated would adversely affect Your disabling condition.

Regular and Appropriate Care does not require treatment for a disabling condition where no additional medical treatment will likely cure or improve that condition, and You have achieved maximum medical improvement.

B401.1952

All Options

Spouse This term means Your lawful spouse, which shall include the marriage between opposite or same-sex partners legally performed in other jurisdictions. This term shall also include Your Domestic Partner.

B401.1953

All Options

Total Disability and Totally Disabled This term means that, due to sickness or injury, the Covered Person is:

- Not able during the first 24 months of claimed Total Disability to perform all the material duties of his or her occupation with Reasonable Accommodation, and after 24 months he or she is not able to perform any occupation for which he or she is reasonably fitted by education, training or experience.

B401.1954

All Options

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

B400.3550

All Options

You or Your These terms mean the insured Employee.

B400.3551

All Options

GROUP TERM LIFE SCHEDULE OF BENEFITS

B400.4199

All Options

Employee Voluntary Term Life Insurance Schedule

B400.4492

All Options

Initial Election You may choose to be insured under one of the plans of Voluntary Term Life Insurance shown below. You may only be insured under one plan at a time. You must notify the Employer of Your election and pay the required premium.

B400.4496

All Options

Changing Election You may switch to another plan of Voluntary Term Life Insurance during the Voluntary life enrollment period. Each year, the Voluntary life enrollment period starts on August 1st and ends on August 31st. You must notify the Employer of any desired switch. We may require Proof Of Insurability before You become insured under the new plan of benefits. See below For details. If We do not require Proof, You will become insured under the new plan of benefits as of the September 1st which coincides with or next follows the end of the Voluntary life enrollment period.

B400.4495

All Options

Voluntary Term Life Insurance Amount *Plan A*

The insurance amount is \$25,000.00

B400.4497

All Options

Voluntary Term Life Insurance Amount *Plan B*

The insurance amount is \$50,000.00

B400.4497

All Options

Voluntary Term Life Insurance Amount *Plan C*

The insurance amount is \$75,000.00
B400.4497

All Options

Voluntary Term Life Insurance Amount *Plan D*

The insurance amount is \$100,000.00
B400.4497

All Options

Voluntary Term Life Insurance Amount *Plan E*

The insurance amount is \$125,000.00
B400.4497

All Options

Voluntary Term Life Insurance Amount *Plan F*

The insurance amount is \$150,000.00
B400.4497

All Options

Voluntary Term Life Insurance Amount *Plan G*

The insurance amount is \$175,000.00
B400.4497

All Options

Voluntary Term Life Insurance Amount *Plan H*

The insurance amount is \$200,000.00
B400.4497

All Options

Voluntary Term Life Insurance Amount *Plan I*

The insurance amount is \$250,000.00
B400.4497

All Options

Voluntary Term Life Insurance Amount *Plan J*

The insurance amount is \$300,000.00

B400.4497

All Options

Annual Election After You first enroll for Employee Voluntary Term Life Insurance, You may choose to increase Your amount of Voluntary Term Life Insurance by an amount not to exceed an increase of \$50,000 as shown above. This option is available once annually during the Voluntary life enrollment period described above. Proof Of Insurability will not be required unless the insurance amount exceeds the amount of Voluntary Term Life Insurance for which Proof Of Insurability is required as shown below.

If Proof Of Insurability is required and has been submitted and approved by Us, Proof of Insurability for additional increases will be required on the second anniversary of the date we approve such coverage.

If Proof Of Insurability is required and has been declined, You will not be eligible for additional annual increases without submitting Proof Of Insurability for them, and then if such increases are approved by Us in writing.

B400.4698

All Options

Family Status Change You may request a change to your Voluntary Term Life Insurance coverage if you have experienced a Family Status Change.

A Family Status Change includes one or more of the following:

- Marriage or divorce;
- Death of a Spouse or child;
- Birth or adoption of a child;
- Your Spouse's termination of employment or a change in Your Spouse's employment that results in the loss of group coverage.

The term "marriage" may also refer to civil unions and domestic partnerships, as recognized by the jurisdiction in which You reside.

If a change in Family Status occurs, You may request an increase to Your Voluntary Term Life Insurance amount or the addition of Employee voluntary term life for which You were not previously insured. You may also request an increase or the addition of dependent Spouse or dependent child Voluntary Term Life Insurance for your living eligible dependents. You must provide proof of the Family Status Change and request the change to Your Voluntary Term Life Insurance in writing within 31 days after the date of the Family Status Change as described below.

Proof Of Insurability is not required for the change to Voluntary Term Life Insurance due to Family Status Change as long as the change to Your Voluntary Term Life Insurance does not exceed the Proof of Insurability requirements as shown in the Schedule of Benefits. Refer to When Coverage Begins and When Dependent Coverage Begins in the Eligibility section of Your Certificate for information regarding when this coverage is effective.

B400.3558

All Options

Reduction of Voluntary Life Insurance Amount Based on Age

If You are less than age 65 when Your insurance under this Policy starts, Your insurance amount is reduced at 12:01 A. M. Standard Time for your place of residence on the date You reach age 65, by 35% of the amount which otherwise applies to Your classification. But in no case will such reduced amount be less than \$1,000.00. The reduced amount is in place of the amount which otherwise applies to Your classification. This reduction also applies to Your initial insurance amount if Your insurance starts after You reach age 65, but before You reach age 70.

If You are less than age 70 when Your insurance under this Policy starts, Your insurance amount is reduced at 12:01 A. M. Standard Time for your place of residence on the date You reach age 70, by 50% of the amount which otherwise applies to Your classification. But in no case will such reduced amount be less than \$1,000.00. The reduced amount is in place of the amount which otherwise applies to Your classification. This reduction also applies to Your initial insurance amount if Your insurance starts after You reach age 70.

B400.4734

All Options

Proof Of Insurability Requirements

Depending on the coverage selected, or as otherwise required in this Certificate, You may be required to supply proof that the person applying for coverage is insurable for the amount and type of coverage selected. This requirement is called Proof of Insurability. For purposes of this section, any person applying for coverage requiring Proof of Insurability is referred to as "Applicant."

To determine if the coverage requires an applicant to submit Proof of Insurability, please see below.

Any applicant required to submit Proof of Insurability is required to complete and submit to Us an Enrollment/Change form. We may also require the completion of additional forms so that We may determine whether the Applicant is insurable, according to Our underwriting standards for the amount and type of coverage applied for. To determine if the Applicant is insurable, We may also need to obtain and review the Applicants:

- Health and medical history;
- Prescription history;
- Records relating to treatment, diagnostic testing, hospitalization; and
- Records pertaining to an Applicants driving and motor vehicle history.

No coverage requiring Proof of Insurability will become effective unless and until it is approved by Us in writing. Our receipt of any premiums associated with coverage requiring Proof of Insurability does not waive or modify any condition that must be satisfied for coverage to begin, including but not limited to the requirement that the applicant submit Proof of Insurability. In the event that any premiums are overpaid, Our only obligation is to return the amount of overpaid premiums.

The Policyholder, or its designee, must give Us complete and accurate information so that we may determine:

- Who is insured;
- The type and amount of coverage for which someone is insured; and

Any other information required so that Guardian may meet its obligations under the Policy.

Proof Of Insurability Requirements

Proof of Insurability requirements apply to Voluntary Term Life Insurance. Such requirements may apply to the full insurance amount, or just part of it, as outlined below. When Proof of Insurability requirements apply, it means You must submit to Us Proof that You are insurable, and We must approve the Proof of Insurability in writing before the insurance, or the specified amount of insurance becomes effective.

We require Proof of Insurability as follows:

B400.4903

All Options

We require Proof of Insurability before We will insure You if You enroll for Voluntary Term Life Insurance after the time allowed for enrolling as specified in this Policy.

B400.4906-R

All Options

We require Proof of Insurability before You switch from Your current plan of Voluntary Term Life Insurance to a plan which provides greater benefits.

B400.4909-R

All Options

We require Proof for any amount of Optional Term Life Insurance, which, when combined with the amount for which the employee is insured under his or her GIAC Group Flexible Adjustable Life Insurance Certificate, exceeds \$200,000.00.

B400.4912-R

All Options

We require Proof for any amount of Optional Term Life Insurance, which, when combined with the amount for which the employee is insured under his or her GIAC Group Flexible Premium Adjustable Life Insurance Certificate, exceeds \$10,000.00, if the employee's scheduled Optional Term Life effective date is after he or she reaches age 65.

B400.4915-R

All Options

We require Proof for all amounts of Voluntary Term Life Insurance, If Your scheduled Voluntary term life effective date is after You reach Age 70.

B400.4917-R

All Options

Dependent Voluntary Term Life Insurance Schedule

B400.5473

All Options

Initial Election You may choose the plan of dependent Spouse Voluntary Term Life Insurance and the plan of dependent child Voluntary life insurance shown below. You must notify the Employer of Your election and pay the required premium.

B400.5476

All Options

Voluntary *Plan A*
Dependent Spouse
Term Life Insurance An amount equal to 50% of Your voluntary term life insurance amount, to a
Amount maximum of \$150,000.00.

B400.5553

All Options

Voluntary Dependent Child Insurance Amount	Plan A Child's Age At Death	Insurance Amount
	From birth but less than 14 days	\$500.00
	At least 14 days but less than 26 years	10% of Your Voluntary Term Life amount, to a maximum of \$10,000.00
		B400.6727

All Options

In no event may the insurance amount of a dependent Spouse exceed 50% of Your insurance amount.

B400.6652

All Options

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

B400.6653

All Options

Reduction of Dependent Voluntary Life Insurance Amount Based on Age	An employee's dependent benefits are reduced in the same manner as his or her employee benefits. The dependent reductions are based on the employee's age.	B400.5474
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All Options

Proof Of Insurability Requirements	Depending on the coverage selected, or as otherwise required in this Certificate, Your Spouse and Dependent Children may be required to supply proof that the person applying for coverage is insurable for the amount and type of coverage selected. This requirement is called Proof of Insurability. For purposes of this section, any person apply for coverage requiring Proof of Insurability is referred to as "Applicant." To determine if the Applicant is required to submit Proof of Insurability for the type and amount of coverage sought, please see below. Any applicant required to submit Proof of Insurability is required to complete and submit to Us an Enrollment/Change form. We may also require the completion of additional forms so that we may determine whether the Applicant is insurable according to our underwriting standards for the amount and type of coverage applied for. To determine if the Applicant is insurable, We may also need to obtain and review the Applicant's: ● Health and medical history; ● Prescription history; ● Records relating to treatment, diagnostic testing, hospitalization; and
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- Records pertaining to the Applicant's driving and motor vehicle history.

No coverage requiring Proof of Insurability will become effective unless and until it is approved by Us in writing. Our receipt of any premiums associated with coverage requiring Proof of Insurability does not waive or modify any requirement that must be satisfied for coverage to begin, including but not limited to the requirement that the Applicant provide Proof of Insurability. In the event that any premiums are overpaid, Our only obligation is to return the amount of overpaid premiums.

The Policyholder, or its designee, must give Us complete and accurate information so that We may determine:

- Who is insured;
- The type and amount of coverage for which someone is insured; and
- Any other information required so that Guardian may meet its obligations under the Policy.

We require Proof of Insurability as follows:

B400.6014

All Options

We require Proof Of Insurability that a dependent is insurable if You:

- Enroll a dependent, submit the dependent's signed health statement, and agree to make the required payments after the end of the Enrollment Period;
- 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
- 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.

B400.6018

All Options

A dependent is not covered by any part of this Policy that requires such proof until You give Us this proof and We approve it in writing.

If Your dependent coverage ends for any reason, including failure to make the required payments, Your dependents will not be covered by this Policy again until You give Us new proof that they are insurable and We approve that proof in writing.

B400.6019

All Options

We require Proof of Insurability before We will insure any dependent Spouse who is enrolled for dependent Spouse Voluntary Term Life Insurance after the time allowed for enrolling as specified in this Policy.

B400.6048-R

All Options

We require Proof of Insurability for any increase in the amount of dependent Voluntary Term Life Insurance with respect to a dependent Spouse.

B400.6049-R

All Options

We require Proof for any amount of Dependent Optional Term Life Insurance, with respect to a dependent spouse, which, when combined with the amount for which the spouse is insured under the Spouse Term Life Rider to the employee's GIAC Group Flexible Premium Adjustable Life Insurance Certificate, exceeds \$25,000.00.

B400.6051-R

All Options

We require Proof for any amount of dependent optional term life insurance, with respect to a dependent spouse, which, when combined with the amount for which the spouse is insured under the Spouse Term Life Rider to the employee's GIAC Group Flexible Premium Adjustable Life Insurance Certificate, exceeds \$5,000., if the dependent spouse's scheduled optional term life effective date is after he or she reaches age 65.

B400.6050-R

All Options

We require Proof of Insurability before We will insure any dependent child who is enrolled for dependent child Voluntary Term Life Insurance after the time allowed for enrolling as specified in this Policy.

B400.6060-R

All Options

We require Proof of Insurability for any increase in the amount of dependent Voluntary Term Life Insurance with respect to a dependent child.

B400.6061-R

All Options

We require Proof for any amount of Dependent Optional Term Life Insurance, with respect to a d dependent child, which, when combined with the amount for which the child is insured under the Child Term Life Rider to the employee's GIAC Group Flexible Premium Adjustable Life Insurance Certificate, exceeds \$10,000.00.

B400.6062-R

All Options

Changes to Insurance

B400.6066

All Options

Changes In Insurance Amounts If You are not Actively At Work on a Full-Time basis, any change in Your amount of coverage will not become effective prior to the date You return to Active Work on a Full-Time basis.

B400.6069

All Options

Changes In Insurance Classification If Your classification changes, insurance will not be changed to the new amount until the first day on which You are:

- Actively At Work on a Full-Time basis; and
- Make a contribution, if required, for the new classification.

If a contribution is required for the new classification for which a larger amount of insurance is provided, You must make the required contribution for the new amount within 31 days of the change. If You do not make the required contribution within 31 days of the change or within 31 days of becoming Actively At Work on a Full-Time basis, if You are not Actively At Work on a Full-Time basis, when Your classification changes, no increase will be allowed due to such change or any later change. In that case, in order to become insured for the larger amount, You must:

- Make the required contribution for the new amount; and
- Furnish Proof Of Insurability to Us, which We approve in writing.

If the insurance amount was previously reduced because of age or retirement, it will be retained at the reduced amount.

B400.6072

SUPPLEMENTAL RIDER - Accelerated Life Benefit

This Rider is effective as of the effective date of the Employee's Certificate. If this Rider is added to an inforce Certificate, the Rider becomes effective on its issue date. This Rider amends the Certificate by the addition of the following:

Note: This benefit is not available for retirees.

Employee Accelerated Voluntary Life Benefit

IMPORTANT NOTICE: USE OF THIS BENEFIT MAY HAVE TAX IMPLICATIONS. IT MAY ALSO AFFECT GOVERNMENT BENEFITS OR CLAIMS OF CREDITORS. YOU SHOULD CONSULT YOUR TAX OR FINANCIAL ADVISOR BEFORE YOU APPLY FOR THIS BENEFIT.

THE AMOUNT OF YOUR GROUP TERM LIFE INSURANCE IS PERMANENTLY REDUCED BY THE GROSS AMOUNT OF THE ACCELERATED LIFE BENEFIT.

Accelerated Life Benefit You may be eligible for an Accelerated Life Benefit if you meet the following conditions:

- You have a Terminal Condition;
- You supply the required written proof of Your Terminal Condition (see "Notice of Claim");
- You apply for this benefit in writing while living and before You attain age 60. If You are unable to request this benefit yourself, Your legal representative may request it on Your behalf.

This benefit is a payment of part of Your Group Term Life Insurance made to You before death. You may use this benefit in any way You choose, subject to the restrictions stated below.

If You qualify for the Accelerated Life Benefit, We will subtract the Gross Amount paid to You as an Accelerated Life Benefit from the amount of Your Group Term Life Insurance under the Certificate. The remaining amount of Group Term Life Insurance is permanently reduced by the Gross Amount of this benefit.

You may only receive one Employee Accelerated Life Benefit during Your lifetime. This benefit does not have to be repaid, even if You:

- Live longer than 12 months from the date We receive Your request for this benefit; or
- Recover from the Terminal Condition.

However, the amount of this benefit will not be restored to Your remaining Group Term Life Insurance. And, You may not receive another Accelerated Life Benefit under any circumstances and even if You:

- Have a relapse; or

- You are subsequently diagnosed as having another Terminal Condition.

Benefit Amount For The Accelerated Life Benefit 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 subject to the following minimum and maximum amounts.

The minimum benefit amount is the lesser of: (1) \$10,000.00; or (2) 50% of Your amount of Group Term Life Insurance.

The maximum benefit amount is the lesser of: (1) \$250,000.00; or (2) 50% of Your amount of Group Term Life Insurance.

Discount The amount of the Accelerated Life Benefit which is available to You is discounted to the present value in 12 months from the date this benefit is paid. The discount is based on the maximum adjustable policy loan interest rate permitted in the state in which the group policy is delivered.

A detailed statement of the method of computing the amount of the Accelerated Life Benefit is available from Us on request.

Payment Of The Accelerated Life Benefit If We approve Your request for this benefit, We pay the amount You have elected, less the present value discount. We pay this benefit to You in one lump sum. This payment is subject to all of the other terms of the Certificate.

Notice of Claim You must send Us a request which includes written proof from a Doctor who is operating within the scope of his or her license that You have a Terminal Condition. We must approve such proof in writing before this benefit is paid.

Physical Examinations

We may have You examined by a Doctor of Our choice to determine whether the Terminal Condition exists. We will pay the cost of such exam.

If We approve Your request to receive this benefit, We will provide You with a statement along with Your benefit payment which shows:

- The amount of the Accelerated Life Benefit You requested;
- The amount of the present value discount;
- The amount of Your Accelerated Life Benefit check; and
- The remaining amount of Your Voluntary Life Insurance coverage.

Even if You have been approved for a waiver of premium benefit under this Certificate, You may still apply for an Accelerated Life Benefit. But, if 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 Your Accelerated Life Benefit.

If You Have Assigned Your Group Term Life Insurance If You have already assigned Your Group Term Life Insurance, or any portion thereof, You cannot apply for an Accelerated Life Benefit.

If You Are Legally Incompetent If You are not legally competent, Your lawful guardian, conservator, legal representative, or any person or fiduciary with the lawful authority to act on Your behalf or handle Your affairs may apply for the Accelerated Life Benefit on Your behalf.

Your Remaining Group Term Life Insurance The remaining amount of Your Group Term Life Insurance after You receive an Accelerated Life Benefit payment is subject to any increases or reductions that would otherwise apply to Your insurance. Applicable reductions are applied to the amount of Group Term Life Insurance for which You were insured on the day before the date You applied for the Accelerated Life Benefit.

If Your Life Benefit is scheduled to reduce within 12 months of the date You apply for the Accelerated Life Benefit, any applicable reduction will also be applied to Your Accelerated Benefit amount.

The premium cost of Your remaining insurance is based on the amount of Group Term Life Insurance for which You were insured on the day before the date You applied for the Accelerated Life Benefit.

The total amount of Group Term Life Insurance Your beneficiary would otherwise receive on Your death is reduced by the Gross Amount of the Accelerated Life Benefit.

If You die after applying, and were eligible, for the Accelerated Life Benefit, but before We send You the benefit, Your beneficiary will receive the full amount of Group Term Life Insurance for which You were insured on the day before the date You applied for the Accelerated Life Benefit.

Restrictions We will not pay an Accelerated Life Benefit if:

- Your coverage under the Certificate ends for any reason after You apply for the Accelerated Life Benefit, but before We pay such benefit;
- You are required by law to use the proceeds of the Group Term Life Insurance from the Certificate to meet the claims of creditors, whether or not You are in bankruptcy;
- You are required by court order to pay all or part of the proceeds of the Group Term Life Insurance from the Certificate to another person; or
- You are required by a government agency to use the payment to apply for, receive or maintain a governmental benefit or entitlement.

Definitions This section defines certain terms appearing in this Rider. Additional terms, not listed here, are defined in the Certificate.

- **Doctor:** Any medical practitioner We are required by law to recognize. He or she must:
 - Be properly licensed or certified by the laws of the state where he or she practices; and
 - Provide services that are within the lawful scope of his or her practice.
- **Gross Amount:** This term means the amount of the Accelerated Life Benefit elected by You before subtraction of the discount.

- **Group Term Life Insurance:** This term means the amount of Employee Voluntary Group Term Life Insurance for which You are insured under the Certificate. The term does not include any:
 - Accidental death benefits; or
 - Scheduled increase in the amount of Employee Voluntary group term life insurance that is due within the 12 month period after the date You apply for the Accelerated Life Benefit.
- **Terminal Condition:** This term means a medical condition that is reasonably expected to result in death within 12 months from the date You apply for the Accelerated Life Benefit.

The Guardian Life Insurance Company of America

A handwritten signature in black ink, appearing to read "M Prestileo", written in a cursive style.

Michael Prestileo, Senior Vice President

B401.1995

SUPPLEMENTAL RIDER - Seatbelt and Airbag Benefit

This Rider is effective as of the effective date of the Employee's Certificate. If this Rider is added to an inforce Certificate, the Rider becomes effective on its issue date. This Rider amends the Certificate by the addition of the following:

Terms not specifically defined within this Rider are defined in the Certificate.

**Employee Voluntary Term Life Insurance and
Dependent Voluntary Term Life Insurance
Seatbelt and Airbag Benefit**

This rider applies to Your Voluntary term life insurance and dependent Voluntary term life insurance.

Seatbelt And Airbag Benefits If You die as a direct result of an automobile accident while properly wearing a seatbelt, We will increase Your term life benefit amount by \$10,000. 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 will increase Your term life benefit amount by an additional \$5,000, for a total increase of \$15,000.

Notice of Claim: You must send Us a request which includes written proof that You were properly wearing a seatbelt. A law enforcement official investigating the accident must certify that the seatbelt was properly fastened and that the automobile in which the deceased was traveling was equipped with airbags. A copy of such certification must be submitted to Us with the claim for benefits. We must approve such proof in writing before this benefit is paid.

Proof of Loss: You must send written Proof of Loss to Our designated office within 90 days of the loss.

If We cannot determine that You were wearing a seatbelt at the time of the Accident, We will increase Your term life benefit amount by \$1,000.

If We determine that a seatbelt was not worn at the time of the automobile accident directly resulting in Your death, or if the required official report is not provided, no Seatbelt or Airbag benefit will be paid.

The total amount payable for the Seatbelt and Airbag Benefit under Your Voluntary term life insurance and Basic Accidental Death and Dismemberment insurance may not exceed \$30,000.

Late Notice and Proof of Loss: We will not void or reduce Your claim if we do not receive Notice and Proof of Loss within the required time. In that case, Notice and Proof of Loss must be sent as soon as reasonably possible.

Proof of loss and other claim data should be submitted to:

The Guardian Life Insurance Company of America

Group Life Claims Department
P.O. Box 981573

Exclusions This Policy does not pay a Seatbelt or Airbag Benefit for loss of life caused by, or related to an accident occurring:

- While You are legally intoxicated; or
- While You are voluntarily using a controlled substance, unless:
 - It was prescribed for You by a doctor; and
 - It was used as prescribed.

A controlled substance is anything called a controlled substance in Title II of the Comprehensive Drug Abuse Prevention and Control Act of 1970, as amended from time to time.

- While You were intentionally or voluntarily inhaling or ingesting a gas, chemical, solvent, poison or other substances not intended for internal consumption; or
- During Your commission of, or attempt to commit a felony as defined per the laws in the jurisdiction in which the felony was committed or attempted, or as defined under federal law if the offense charged was a federal offense.

Dependent Seatbelt and Airbag Benefit

Seatbelt And Airbag Benefits If Your dependent dies as a direct result of an automobile accident while properly wearing a seatbelt, We will increase his or her Voluntary term life benefit amount by \$5,000. And, if Your 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 will increase his or her Voluntary term life benefit amount by an additional \$2,500, for a total increase of \$7,500.

You are responsible for providing proof that Your dependent was properly wearing a seatbelt. A law enforcement official investigating the Accident must certify that the seatbelt was properly fastened and that the automobile in which the deceased was traveling was equipped with airbags. A copy of such certification must be submitted to Us with the claim for benefits.

If We cannot determine that Your dependent was wearing a seatbelt at the time of the automobile accident directly resulting in his or her death, We will increase Your dependent term life benefit amount by \$1,000.

If We determine that a seatbelt was not worn at the time of the automobile accident directly resulting in Your dependent's death, or if the required official report is not provided, no Seatbelt or Airbag Benefit will be paid.

Exclusions This Policy does not pay a Seatbelt or Airbag Benefit for loss of life caused by, or related to an accident occurring:

- While Your dependent is legally intoxicated; or
- While Your dependent is voluntarily using a controlled substance, unless:
 - It was prescribed for the dependent by a doctor; and
 - It was used as prescribed.

A controlled substance is anything called a controlled substance in Title II of the Comprehensive Drug Abuse Prevention and Control Act of 1970, as amended from time to time.

- While Your dependent intentionally or voluntarily inhales or ingests a gas, chemical, solvent, poison or other substances not intended for internal consumption; or
- During Your dependent's commission of, or attempt to commit a felony as defined per the laws in the jurisdiction in which the felony was committed or attempted, or as defined under federal law if the offense charged was a federal offense.

The Guardian Life Insurance Company of America

A handwritten signature in black ink, appearing to read "Mr. Prestileo", with a stylized flourish at the end.

Michael Prestileo, Senior Vice President

B401.2060

SUPPLEMENTAL RIDER - Waiver of Premium Benefit

This Rider is effective as of the effective date of the Employee's Certificate. If this Rider is added to an inforce Certificate, the Rider becomes effective on its issue date. This Rider amends the Certificate by the addition of the following:

**Employee Voluntary Term Life Insurance
Waiver Of Premium Benefit**

Important Notice This rider applies to Your Voluntary term life insurance. It does not apply to any of Your dependent life insurance under the Certificate. To continue dependent life insurance, You must convert Your dependent coverage. See "Converting This Dependent Term Life Insurance" for details.

If You Are Disabled If You are Totally Disabled, and meet the requirements in "How And When To Apply," We will extend Your Voluntary life insurance without payment of premiums from You or the Employer in an amount equal to the amount of Voluntary life insurance for which You are insured on Your last day of Active Work.

How And When To Apply To apply for this benefit, You must submit, while living, written medical proof of Your Total Disability satisfactory to Us within one year of the start of that disability. Any claim filed after one year from the start of Total Disability will be denied, unless We receive written proof that:

- You lacked the legal capacity to file the claim; or
- It was not reasonably possible for You to file the claim within the required period of time.

To be approved for this benefit, You must:

- Become Totally Disabled before You reach age 60 and while insured by the Certificate; and
- Remain Totally Disabled for at least 9 months in a row.

You should apply for this benefit immediately at the start of Your Total Disability.

Continued Proof For Waiver of Premium Benefit We may require written proof that You remain Totally Disabled and receive regular Doctor's care to maintain this benefit. This proof must be given to Us within 30 days of the date We request it.

We can also require that You take part in a medical assessment by a medical professional of Our choice as often as We feel is reasonably necessary during the first 2 years We have waived Your life insurance premiums pursuant to the Rider. After 2 years, We cannot have You examined more than once a year.

Until You Have Been Approved For This Benefit If Your life insurance under the Certificate ends after You have become Totally Disabled and applied for Waiver of Premium Benefits, but before We have approved You for this benefit, You may:

- Continue to pay your group premium payments, including any part which would have been paid by the Employer, until You are approved or declined for this benefit; or
- Apply to convert to an individual permanent or term life insurance policy.

Please read "Converting This Employee Voluntary Term Life Insurance" for details on how to convert.

Converting Your life insurance does not stop You from claiming Your rights under this section. But, if You apply to convert and obtain a policy, and We later approve You for this benefit, We will cancel the converted policy on the date We approve You for this Benefit. See "Converting This Employee Voluntary Term Life Insurance" for details on how We do this. Once You are approved for this benefit, Your insurance under the Certificate will be reinstated at no further cost to You or the Employer.

If You are declined for the Waiver of Premium benefit, You will have the option to apply to convert to an individual permanent or term life insurance policy. If You do not convert within 31 days of the date You are declined for the Waiver of Premium benefit, and You have not returned to Active Work, Your coverage will end.

If the Certificate terminates before You are approved

If this group Certificate terminates and You are Totally Disabled and eligible, but not yet approved, for this Waiver of Premium benefit, You must apply to convert to an individual permanent or term policy, and remain insured under such policy until You are approved by Us for the Waiver of Premium benefit.

When This Waiver Begins

Once approved by Us, Your Waiver of Premium benefit will be effective on the date following the day You have been Totally Disabled for 9 months in a row.

When This Waiver Ends

Your Waiver of Premium benefit will end on the earliest of:

- The date You are no longer Totally Disabled;
- The date We ask You to be examined by Our Doctor, and You refuse;
- The date You do not give Us the proof of Total Disability We require;
- the date you have been out of the United States and/or Canada or a country or region approved by Us for more than 2 months in a 12 month period;
- The date You are no longer receiving regular Doctor's care appropriate to the cause of Your claimed Total Disability;
- The day before the date You reach age 65.

If Your Waiver of Premium Benefit ends and You do not return to Active Work, You will have the option to convert the Employee Voluntary life insurance that was in effect on the date the Waiver of Premium Benefit ends.

Please read "Converting This Employee Voluntary Term Life Insurance" for details on how to convert.

**If You Die While
Covered By This
Waiver of Premium
Benefit**

If You die while covered for this benefit, We will pay Your beneficiary the amount of Voluntary life insurance for which You were insured as of Your last day of Active Full-Time Work. This payment is subject to all the terms of the Certificate and all reductions which would have applied had You remained an Active at Work Employee.

**If You Die Prior to
Approval for This
Waiver of Premium
Benefit**

If You die prior to being approved for the Waiver of Premium Benefit and within 12 months of the onset date of Total Disability 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 provided You:

- Were Totally Disabled, as defined by this Rider, through the date of death,
- Became Totally Disabled prior to age 60; and
- Became Totally Disabled while insured; and
- We received the required premiums for this coverage.

Proof Of Death

We will pay the term life insurance benefit as soon as We receive:

- Written proof of Your death; and
- Medical proof that You were continuously Totally Disabled until Your death.

This proof must be sent to Us within one year of Your date of death.

B400.3854

All Options

Definitions

This section defines certain terms appearing in this Rider. Additional terms, not listed here, are defined in the Certificate.

Reasonable Accommodation: This term means any modification or adjustment that the Employer willingly provides to:

- A job;
- An employment practice;
- A work process; or
- The work place.

The modification or adjustment must make it possible for a Disabled person to:

- Reach the same level of performance as a similarly situated non-disabled person; or
- Enjoy equal benefits and privileges of employment as are available to a similarly situated non-disabled person.

The modification or adjustment must not place an undue hardship on the Employer.

Regular and Appropriate Care: This term means, with respect to Your disabling condition(s) and any other condition(s) which, if left untreated, would adversely affect Your disabling condition, You:

- Visit a Doctor as frequently as recommended by a Doctor to effectively manage these conditions; and
- Are receiving appropriate treatment designed to achieve maximum medical improvement in these conditions.

Appropriate treatment is that treatment a patient would make a reasonable decision to accept after duly considering the options of medical professionals, and such treatment must be provided by a Doctor or Doctors whose specialty is appropriate for You:

- Disability; and
- Any other conditions which left untreated would adversely affect Your disabling condition.

Regular and Appropriate Care does not require treatment for a disabling condition where no additional medical treatment will likely cure or improve that condition and You have achieved maximum medical improvement.

"Total Disability" and "Totally Disabled": This term means that, due to sickness or injury, You are:

- Not able during the first 24 months of Your claimed Total Disability to perform all the major duties of Your occupation with Reasonable Accommodation, and after 24 months You are not able to perform any occupation for which You are reasonably fitted by education, training or experience.

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

The Guardian Life Insurance Company of America



Michael Prestileo, Senior Vice President

B401.2005

SUPPLEMENTAL RIDER - Portability Privilege

This Rider is effective as of the effective date of the Employee's Certificate. If this Rider is added to an inforce Certificate, the Rider becomes effective on its issue date. This Rider amends the Certificate by the addition of the following:

PORTABILITY PRIVILEGE

This rider applies only to Your Employee and dependent Voluntary term life insurance.

**Portability
Conditions**

Portability is subject to all of the conditions described below.

- You may Port if Your coverage under the Certificate if coverage ends because:
 - You are no longer employed by the Employer; or
 - You are no longer a member of an eligible class of Employees
- You may **not** Port unless You have been covered by the Certificate, or the plan it replaced, for Employee Voluntary term life insurance for at least three months in a row prior to the date Your coverage under the Certificate ends.
- You may **not** Port if You have reached age 70 on the date coverage under the Certificate ends.
- You may **not** Port if You are eligible for the Certificate's Waiver of Premium Benefit.
- You may **not** Port if coverage under the Certificate ends due to:
 - Failure to pay any required premium; or
 - Termination of the Certificate

Portability Options

You may Port the full amount of Your Voluntary term life insurance in force as of the date Your coverage under the Certificate ends. If You do not wish to Port the full amount, You may choose to Port 50% of such amount, if such amount under the Certificate is at least \$50,000 and does not exceed \$1,000,000.

You may Port the full amount of Your dependent's Voluntary term life insurance in force as of the date Your coverage under the Certificate ends. If You do not wish to Port the full amount, You may choose to Port 50% of such amount if:

- Your dependent Spouse amount under the Certificate is at least \$10,000; and
- Your dependent child amount under the Certificate is at least \$2,000.

You may Port:

- Your insurance only;
- Your insurance and insurance of Your covered Spouse; or
- Your insurance and the insurance of all of Your covered dependents.

If You Port the full amount of Your insurance and You choose to Port Your dependent's insurance, You must Port the full amount of Your dependent's insurance. If You Port 50% of Your insurance and You choose to Port Your dependent's insurance, You must Port 50% of Your dependent's insurance.

A dependent must be insured as of the date Your coverage under the Certificate ends in order to be eligible for Portability.

If You die while insured for dependent Voluntary term life insurance, Your Spouse may Port Your dependent Voluntary term life insurance as described above. Your Spouse and dependent children must be insured under the Certificate on the date of Your death. But, this option is not available if:

- There is no surviving Spouse; or
- Your surviving Spouse has reached age 70 on the date of Your death.

The Portable Certificate Of Coverage

If You Port, You will obtain a new Certificate of coverage, which will be issued under the Portable group policy and will describe the benefits provided. The Portable group policy has been established specifically for, and limited to, providing portability coverage for Employees and their dependents whose coverage ends under an Employer's plan. The benefits provided by the Portable certificate of coverage may not be the same as the benefits provided by the Certificate provided by your Employer. The group term life insurance provided by the Portable Certificate of coverage will not provide any of the following benefits or types of coverage:

- Accidental death or dismemberment;
- Income replacement;
- Or Waiver of Premium benefits.

The premium for the Portable certificate of coverage will be based on:

- the covered person's rate class under the Ported Policy; and
- Your or Your surviving Spouse's age bracket as shown in the Life Portability Coverage Premium Notice.

The Portable Certificate of Coverage ends at age 70.

How To Port You or Your surviving Spouse must:

- Apply to Us in writing; and
- Pay the required premium.

You or Your surviving Spouse must do this within 31 days from the date Your coverage under the Certificate ends. In order to port Your Voluntary term life insurance, We will not ask for proof that You or Your surviving Spouse is insurable.

Portability And Conversion If You or Your surviving Spouse choose to Port, the Certificate's conversion privilege will not be available. In the event that a person would be eligible to both convert and to Port, only one of these privileges may be chosen. Coverage under both a converted policy and a Portable certificate of coverage at the same time is not permitted. You or Your surviving Spouse should read the entire Certificate, as well as any related materials carefully before making a choice.

Definitions

This section defines certain terms appearing in this Rider. Additional terms, not listed here, are defined in the Certificate.

- **Port or "To Port":**these terms mean to choose a Portable certificate of coverage which provides group term life insurance.

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

The Guardian Life Insurance Company of America



Michael Prestileo, Senior Vice President

B400.3884

AMENDATORY RIDER

This Rider amends the Certificate and Policy as follows and is effective on the later of the Policy Date or the date requested by the Policyholder.

The definition of **Spouse** and **Domestic Partner** is replaced with the following:

Spouse: The person to whom You are legally married or Your **Domestic Partner** or civil union partner.

Domestic Partner: The same-sex or different-sex person with whom You have registered Your relationship with any state or local governmental domestic partner registry

Or

the same-sex or different-sex person with whom you have not registered your relationship if you satisfy the following requirements:

- You live and share financial assets and obligations with this person.
- This person is at least 18 years of age, is able to provide legal consent, and is not a blood relative.
- Neither you nor this person are in a marriage or domestic partnership with anyone else or legally separated from anyone else.
- You submit acceptable documentation that you meet the above criteria. An affidavit attesting to these facts may be required.

Except as specifically noted above for relationships that are not registered, **Domestic Partners** are not subject to any proof of relationship or waiting period requirements that are not also imposed upon marriages. A **Domestic Partner** registry certificate will be accepted as fully equivalent to a marriage certificate. Similarly, a dissolution of domestic partnership notice will be accepted as fully equivalent to a divorce decree.

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

The Guardian Life Insurance Company of America



Michael Prestileo, Senior Vice President

B601.0243

STATEMENT OF ERISA RIGHTS

The Guardian Life Insurance Company of America

10 Hudson Yards
New York, New York 10001
(212) 598-8000

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

ERISA provides that all plan participants shall be entitled to:

Receive Information about Your Plan and Benefits

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

Prudent Actions by Plan Fiduciaries

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

Enforcement of Your Rights

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

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

Assistance with Questions

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

Life Insurance Claims Procedure

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

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

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

Definitions

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

Timing for Initial Benefit Determination of Life Insurance Claims

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

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

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

**Adverse Benefit
Determination of
Life Insurance
Claims**

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

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

B997.0239

All Options

**Appeals of Adverse
Determinations of
Life Insurance
Claims**

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

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

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

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

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

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

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

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

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

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

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

Adverse Benefit Determination

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

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

B997.0240

All Options

Appeals of Adverse Determinations for Waiver of Premium

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

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

In reviewing an appeal, Guardian will:

- Provide for a review conducted by a named fiduciary who is neither the person who made the initial adverse determination nor that person's subordinate;

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

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

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

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

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

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

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

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

B997.0241

CERTIFICATE OF COVERAGE

The Guardian Life Insurance Company of America

10 Hudson Yards
New York, New York 10001
(212) 598-8000

The Group Accidental Death and Dismemberment Coverage described in this Certificate is attached to the group Policy effective September 1, 2007. This Certificate replaces any Certificate previously issued under this Policy or under any other plan providing similar or identical benefits issued to the Policyholder by Guardian.

GROUP ACCIDENTAL DEATH AND DISMEMBERMENT COVERAGE

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

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

FOR INSURED PERSONS AGE 65 OR OLDER WHO PAY SOME OF ALL OF THE COST OF THIS INSURANCE: YOU HAVE A 30 DAY EXAMINATION PERIOD AFTER THE RECEIPT OF THIS CERTIFICATE DURING WHICH YOU MAY CANCEL THE COVERAGE AND RETURN THIS CERTIFICATE BY MAIL OR OTHER DELIVERY METHOD. SUCH RETURN WILL VOID THE CERTIFICATE FROM THE BEGINNING, AND THE PARTIES WILL BE IN THE SAME POSITION AS IF A CERTIFICATE HAD NOT BEEN ISSUED. ALL PREMIUMS PAID WILL BE FULLY REFUNDED IN A TIMELY MANNER NOT LATER THAN 30 DAYS AFTER THE COMPANY RECEIVES THE RETURNED CERTIFICATE.

Policyholder: HILTON WATERFRONT BEACH RESORT
Group Policy Number: 00429264

The Guardian Life Insurance Company of America



Harris Oliner, Senior Vice President,
Corporate Secretary



Michael Prestileo,
Senior Vice President

B401.2172

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COMPLAINT NOTICE

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

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

If You feel Your complaints have not been resolved after contacting the Guardian You may contact the California Department of Insurance at the following address and phone number:

Department of Insurance
300 South Spring Street
Los Angeles, California 90013
Consumer Hotline: 1-800-927-HELP (4357)
TDD: 1-800-482-4TDD (4883)
Website: www.insurance.ca.gov/01-consumers/

B401.2173

GENERAL PROVISIONS

The Contract and Limitation Of Authority

The entire contract between the Policyholder and Us consists of:

- The Policy;
- The Schedule of Premium Rates;
- This Certificate(s) which describe(s) the insurance for which Covered Persons are insured;
- Any attached riders, schedule of benefits or amendments; and Your application.

In the event of a conflict, the Policy shall reign.

We can amend the Policy at any time, without the consent of the insured Employees or any other person having a beneficial interest in it:

- Upon written request made by the Policyholder and agreed to by Us; or
- On any date Our obligation under the Policy with respect to the Policyholder, or under this Certificate with respect to You, is changed do to the requirements of state or federal law or regulation.

Upon request, You may obtain a copy of the Policy from Us.

If We amend this Certificate, except upon request made by You, We must give You written notice of such change.

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

No person, except by a writing signed by the President, a Vice President or a Secretary of Guardian, has the authority to act for Us to:

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

Applicable Benefits

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

- They were previously selected in an enrollment form or other required form; and
- We have received any required premium.

Incontestability

Any statement made by You, in the absence of fraud, will be deemed a representation and not a warranty. No statement will be used to avoid insurance, reduce benefits or defend a claim unless it is material to the risk accepted or the hazard assumed by Us, has been signed by You, and a copy of the statement has been given to You or to Your Beneficiary. We shall not contest this coverage after it has been in force during Your lifetime for three years from the Effective Date of the Policy.

Physical 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 the Certificate as often as We feel necessary. We also have the right to have an autopsy performed in the case of death where allowed by law. We will pay for all such examinations and autopsies.

Overpayment Recovery

If We overpay benefits, all such benefits must be repaid in full. We have the right to reduce the benefit, or reduce any other benefits payable under this Certificate, toward recovery of any overpayment.

B401.2175

ELIGIBILITY FOR ACCIDENTAL DEATH AND DISMEMBERMENT COVERAGE EMPLOYEE COVERAGE

Conditions Of Eligibility

Subject to the conditions of eligibility set forth below, and to all of the other conditions of this Certificate, You are eligible for Accidental Death and Dismemberment coverage if You are

- In an eligible class of Employees;
 - Are an active Full time Employee;
 - Legally working in the United States and/or Canada or working outside of the United States for a United States based Employer in a country or region approved by Us;
- and
- Working at least the minimum number of hours of an Employee in Your eligible class at:
 - The Employer's place of business;
 - Some place where the Employer's business requires You to travel; or
 - Any other place You and the Employer have agreed upon for the performance of your occupational duties.

You are **not** eligible for Accidental Death and Dismemberment coverage if You are

- A temporary or seasonal Employee.

The Waiting Period If You are in an eligible class, You are eligible for Accidental Death and Dismemberment coverage under this Certificate after You complete the service waiting period, if any, established by the Employer and as stated in the Schedule of Benefits.

Multiple Employment If You work for both the Employer and a covered associated company, or for more than one covered associated company, We will treat You as if only one firm employs You. You will not have multiple Accidental Death and Dismemberment Coverage under this Certificate. But, if this Certificate uses the amount of Your Insured Earnings to set the rates, determine class, figure insurance amounts, or for any other reason, such Insured Earnings will be figured as the sum of Your Insured Earnings from all covered Employers.

B400.6098

When Coverage Starts

For coverage to start, You must be fully capable of performing the major duties of Your regular occupation for the Employer and working the minimum required number of hours of an Employee in Your eligible class at 12:01 A.M. Standard Time for Your place of residence on Your scheduled Eligibility Date. And, for coverage to start, You must satisfy all of the Conditions of Eligibility described above, and the conditions shown below which apply to You. If You are not fully capable of performing the major duties of Your regular occupation on Your scheduled Eligibility Date, We will postpone the start of Your coverage until You are so capable and working the minimum required number of hours of an Employee in Your eligible class for one full day, with the capacity to do so for one full week.

Your coverage is scheduled to start on Your Eligibility Date.

B400.6105

All Options

Exception to When Coverage Starts

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

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

and if:

- You are fully capable of performing the major duties of Your regular occupation for Your Employer for the minimum number of hours of an Employee in Your eligible class at 12:01 AM Standard Time for Your place of residence on the scheduled Eligibility Date ; and
- You were performing the major duties of Your regular occupation and working the minimum number of hours of an Employee in Your eligible class on Your last regularly scheduled work day;

Your coverage will start on the scheduled Eligibility Date. However, in no event will any coverage or part of coverage for which You must elect and pay all or part of the cost, start if You are on an approved leave, layoff or absence and such coverage or part of coverage was not previously in force for You under a prior plan which this Certificate replaced.

B400.6106

When Coverage Ends

Your coverage will end on the first of the following dates:

- The date Your Active Work ends for any reason, except as noted below under Coverage During Leave of Absence. Such reasons include:
 - Disability;
 - Death;
 - Retirement;
 - Layoff;
 - Leave of absence;
 - The end of employment; and
 - Expiration of the employment contract.
- The date You stop being an eligible Employee under this Certificate.
- The date You are no longer working in the United States and/or Canada, or no longer working outside the United States for a United States based Employer in a country or region approved by Us. Any incidental business or personal travel outside of the United States and/or Canada, or outside of a country or region approved by Us, is covered. Such travel will be considered incidental if it is for a period not to exceed 30 consecutive days.
- The date the group Certificate ends, or is discontinued for a class of Employees to which You belong.
- The last day of the period for which required payments are made for You.

You may have the right to continue certain group benefits for a limited time after Your coverage would otherwise end. Contact Your Employer regarding any continuation options available.

B400.6110

CONTINUATION OF COVERAGE

Coverage During Disability

If Your Active Work ends because You are Totally Disabled, You and Your Employer may agree to continue Your insurance, subject to continued payment of all required premiums, until the earlier of:

- The date you are no longer Totally Disabled, as defined by this Certificate;
- 12 months; from the date Your Total Disability began;
- The date you are approved for any Waiver of Premium Benefit for which you are eligible; or
- The date of Your 99th birthday.

We may require written Proof of Loss that You remain Totally Disabled and receiving regular Doctor's care to maintain this benefit. This Proof of Loss must be given to Us within 30 days of the date we request it.

Your eligibility for benefits will be governed by all the terms of this Certificate.

Coverage During Temporary Layoff

If Your Active Work ends because You are temporarily laid off, You and Your Employer may agree to continue Your insurance, subject to continued payment of all required premium, until the earlier of:

- The end of the temporary layoff; or
- The end of the month in which You are laid off plus 1 months following the date the temporary layoff begins.
- The end of the time period covered under a severance agreement not to exceed 1 months.

If You die or become Disabled under this Certificate while Your coverage is being continued during a temporary layoff, Your eligibility for benefits will be governed by all the terms of this Certificate.

Coverage During Temporary Leave of Absence

If Your Active Work ends because You go on a leave of absence that has been approved by Your Employer, You and Your Employer may agree to continue Your insurance, subject to continued payment of all required premiums, until the earlier of:

- The end of the Employer approved leave of absence; or

- The end of the month in which Your leave begins plus 1 months following the date the approved leave of absence begins.

If You become disabled under this Certificate while Your coverage is being continued during a leave of absence, Your eligibility for benefits will be governed by all the terms of this Certificate.

B400.6111

**EMPLOYEE ACCIDENTAL DEATH AND DISMEMBERMENT
(AD&D) INSURANCE**

B400.6134

Basic Accidental Death and Dismemberment Insurance

B400.6135

We will pay the benefits described below if You suffer an irreversible loss due to an Accident and the Accident occurs while You are insured by this Certificate. The loss also must:

- Be a result of the Accident; and
- Occur within 365 days of the date of the Accident.

Payment Of Benefits We will pay this insurance as soon as We receive written Proof of Loss as shown in the Claims Provisions section of this Certificate.

Payment Of Benefits For Covered Loss of life, We pay the beneficiary of Your Accidental Death and Dismemberment Insurance under the Employer's Policy with Us.

For all other Covered Losses, We pay You if You are living. If You are not living, We pay the beneficiary of Your Term Life coverage under the Employer's Plan with Us.

Subject to all the terms of this Certificate, We pay all benefits in a lump sum as soon as We receive written proof of Covered Loss and proof of claim. This should be sent to Us as soon as possible.

The Beneficiary You decide who receives this benefit when You die. You may designate a beneficiary by doing so in writing on a form and filing the form with the Employer.

You can change Your beneficiary at any time by providing written notice. But, the change will not take effect until We or the Employer records the change.

We will not be liable for any amounts paid before receiving notice of a beneficiary change.

In no event may a beneficiary be changed by a Power of Attorney.

If You named more than one person as a primary beneficiary, but You do not specify what shares each such primary beneficiary is entitled to receive, We will divide the benefits equally among all such named primary beneficiaries who survive You. If someone You named as a primary beneficiary dies before You, that person's share will be divided equally by the primary beneficiaries still alive; unless You have specified otherwise.

If You have named a contingent beneficiary or contingent beneficiaries, We will pay Your contingent beneficiary or contingent beneficiaries, if no primary beneficiary survives You. If there is more than one contingent beneficiary who is eligible for benefits, We will divide the benefits equally among all such named contingent beneficiaries who survive You; unless You have specified otherwise.

If there is no primary or contingent beneficiary or beneficiaries eligible for benefits when You die, We will pay this benefit as follows:

- To Your Spouse;
- If Your Spouse does not survive You, then to Your children who survive You in equal shares;
- If no Spouse or children survive You, then to Your parents who survive You in equal shares;
- If no Spouse, children, or parents survive You, then to then to Your brothers and sisters in equal shares;
- If none of the above parties survive You, then to Your executors or administrators of Your estate.

Payment Of Funeral Expenses We have the option of paying up to \$500 of this benefit to any person who incurred expenses for Your funeral.

B401.2183

All Options

Covered Losses Benefits will be paid only for losses listed in the Table of Covered Losses shown below. Your insurance amount is shown in the Accidental Death and Dismemberment Schedule Of Benefits.

B400.6147

All Options

ACCIDENTAL DEATH AND DISMEMBERMENT

Table Of Covered Losses

Covered Loss	Benefit
Loss of life	100% of Your AD&D insurance amount.
Disappearance	100% of Your AD&D insurance amount.
Loss of a hand	50% of Your AD&D insurance amount. No benefit will be paid if benefits have been paid for "loss of one arm".

Loss of a foot	50% of Your AD&D insurance amount. No benefit will be paid if benefits have been paid for "loss of one leg".
Loss of sight in one eye	50% of Your AD&D insurance amount.
Loss of thumb and index finger of same hand	25% of Your AD&D insurance amount. No benefit will be paid if benefits have been paid for "Loss of a hand" or "loss of one arm".
Loss of four fingers of same hand	25% of Your AD&D insurance amount. No benefit will be paid if benefits have been paid for "Loss of a hand" or "loss of one arm".
Loss of all toes of same foot	25% of Your AD&D insurance amount. No benefit will be paid if benefits have been paid for "Loss of a foot" or "loss of one leg".
Loss of the great toe (hallux)	15% of Your AD&D insurance amount. No benefit will be paid if benefits have been paid for "Loss of a foot" or "loss of one leg".

B400.6143

All Options

As used here:

- "Loss of a hand" means the hand is completely severed at or above the wrist.
- "Loss of a foot" means the foot is completely severed at or above the ankle.
- "Loss of sight" means total and permanent loss of sight.
- "Loss of thumb and index finger of same hand" or "Loss of four fingers of same hand" means complete severance at the metacarpophalangeal joints of the same hand.
- "Loss of all toes of same foot" means complete severance at the metatarsalphalangeal joint.
- "Loss of the great toe (hallux)" means complete severance at the metatarsalphalangeal joint.

B400.6149

All Options

Multiple Losses For more than one Covered Loss due to the same Accident, We will pay up to 100% of Your Accidental Death and Dismemberment Insurance amount. We will not pay more than 100% of Your Accidental Death and Dismemberment Insurance amount for all losses due to the same Accident, except as shown under the Common Carrier Benefit, Seatbelt And Airbag Benefits and Repatriation Benefit.

B400.6151

All Options

Repatriation Benefit We pay an extra sum for Covered Loss of life due to an Accident which occurs at least 75 miles from Your home. In that case, We pay up to \$5,000 for costs to prepare and transport Your body to a mortuary chosen by You or an authorized agent. In the event that a Repatriation Benefit is paid under Your Group Term Life Insurance Certificate, no additional benefit will be paid under this Accidental Death and Dismemberment Certificate.

B400.6155

All Options

Exposure If You suffer a Covered Loss shown in the Table of Covered Losses due to an Accidental bodily injury caused by being unavoidably exposed to the elements, We will pay the amount which otherwise applies to the loss. If Covered Loss benefits are deemed payable under Exposure, the Covered Loss benefit is only paid once, not in addition to the Exposure payments.

B400.6156

All Options

Disappearance You will have a presumed Covered Loss due to an Accident if:

- You are riding in a public conveyance that is involved in an Accident;
- As a result of the Accident, the public conveyance is wrecked, sinks, is stranded or disappears;
- Your body is not found within 365 days of the day the Accident; and
- The Accident occurs while You are covered by this Certificate.

If Covered Loss benefits are deemed payable under Disappearance, the Covered Loss benefit is only paid once, not in addition to the Disappearance payments.

B400.6157

CLAIM PROVISIONS

Administration: We have the responsibility to fairly, thoroughly, objectively and timely investigate, evaluate and determine Your eligibility for benefits under this Plan.

We will:

- Obtain only such information that is necessary to evaluate a claim for benefits. This information will be obtained as set forth herein with respect to notice and proofs of loss.
- Consider and interpret the terms of this Plan and all information obtained by Us and submitted that relates to a claim for benefits and make a determination based on that information and in accordance with the terms of this Plan and applicable California state law.
- If a claim is approved, review the determination as often as is reasonably necessary to determine continued eligibility for benefits.
- If a claim is denied, provide the claimant within a reasonable period of time a written notification of an adverse determination. Such notification will include the specific reason(s) for the adverse determination.

Notice of Claim: Written notice of intent to file a claim under this Certificate must be sent to Us within 20 days of the date of the loss, or as soon thereafter as is reasonably possible. This Notice should include the name of the insured and the Policy number. If the claim is being made for any other Covered Person, his or her name should also be shown. For details, You can call Us at 1-800-525-4542.

Claim Forms: We will furnish forms for filing proof of death within 15 days of receipt of Notice. If we do not furnish the forms on time, We will accept a written Notice and adequate proof of death that is the basis of the claim as Proof of Loss.

Proof of Loss: You must send written Proof of Loss to Our designated office within 90 days of the loss. Failure to furnish such proof within the time required shall not invalidate nor reduce any claim if it was not reasonably possible to give proof within such time, provided such proof is furnished as soon as reasonably possible and in no event, except in the absence of Your legal capacity, later than one year from the time proof is otherwise required.

Proof of Loss and other claim data should be submitted to:

The Guardian Life Insurance Company of America

Group Life Claims Department

P.O. Box 981573

El Paso, TX 79998-1573

Time of Payment of Claim: We will pay the Group Accidental Death & Dismemberment Insurance Benefit immediately upon receipt of written Proof of Loss.

Legal Actions: No legal action against Guardian related to this Certificate may be brought until 60 days from the date Proof of Loss has been given as shown above. No legal action may be brought against Guardian related to claims for benefits under this Certificate after three years from the date of the final benefit determination.

B401.2193

All Options

DEFINITIONS

This section defines certain terms appearing in Your Certificate.

B400.7183

All Options

Accident This term means an unexpected event or occurrence, which results in bodily injury or death while a Covered Person is insured by this Certificate. The term Accident does not include a Sickness.

B401.2194

All Options

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

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

B400.7186

All Options

Certificate This term means this Certificate of Coverage, including any riders and enrollment forms that may be attached to this Certificate.

B400.7188

All Options

Covered Loss This term means loss due to an Accident while a Covered Person is insured by this Certificate and as outlined in the Table of Covered Losses.

B400.7189

All Options

Covered Person This term means the Employee insured by this Certificate.

B400.7191

All Options

Domestic Partner This term means Your domestic partner who is registered with the California Secretary of State.

B401.2196

All Options

Effective Date The date the Certificate goes into force and effect as stated on the cover page of the Certificate of Coverage, or any change to the Certificate as requested by the Policyholder and approved by Us and in force and effect as stated on the cover page of the Certificate of Coverage.

B400.7192

All Options

Eligibility Date This term means the earliest date a Covered Person is eligible for coverage under this Certificate, and he or she has satisfied all requirements for coverage to begin, as required by this Certificate.

- For Employee coverage, this term means the earliest date You are eligible for coverage under this Certificate.
- For an Employee in Active Work who had completed any waiting period required by the Employer as of the Effective Date of this Certificate, the Eligibility Date means the Effective Date of this Certificate.
- For an Employee in Active Work as of the Effective Date of this Certificate who has not completed any waiting period required by the Employer, the Eligibility Date will be the first date following the completion of the required waiting period.
- For an Employee hired on or after the Effective Date of this Certificate, the Eligibility Date will be the later of the Employee's date of hire, or the first date following the completion of any waiting period required by the Employer.

If this plan requires Employees to elect coverage under this Certificate, the Eligibility date will be the later of:

- The Employee's date of hire;
- The first date following the completion of any waiting period required by the Employer; or
- The approval by Us in writing of any coverage for which You were required to provide Proof of Insurability.

B400.7194

All Options

Employee This term means a person who works for the Employer at the Employer's place of business and whose income is reported to the United States Internal Revenue Service, and/or a state, for tax purposes. Partners and proprietors will also be treated as Employees if the eligibility requirements are met.

B400.7195

All Options

Employer This term means HILTON WATERFRONT BEACH RESORT .

B400.7196

All Options

Enrollment Period This term means the 31 day period which starts on the date You first become eligible for coverage.

B400.7197

All Options

Full-Time This term means You are not a part time Employee as defined by Your Employer and the average number of hours You worked for the six months prior to the last full day worked was at least 30 hours per week at:

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

B401.3005

All Options

Legally Intoxicated "Intoxicated" means that the Covered Person's blood alcohol content meets or exceeds the percentage or amount of blood alcohol content that creates a legal presumption of intoxication under the laws of the state or territory in which the loss occurred for operating a motor vehicle under the influence, regardless of whether the Covered Person was operating a motor vehicle at the time the loss occurred.

B400.7219

All Options

Month or Months or Monthly These terms mean a consecutive 30 day period.

B400.7220

All Options

Policy or Plan This term means the Group Accidental Death and Dismemberment Coverage described in the Policy and in this Certificate.

B400.7223

All Options

Proof Of Insurability This terms means the completion of an evidence of insurability form, which shows that a person is insurable.

B400.6388

All Options

Proof of Loss This term means the documents that We use to substantiate an accidental death and dismemberment claim. Examples of documents used for Proof of Loss include:

- An original certified finalized death certificate;
- The beneficiary designation in effect at the time of death;
- Enrollment information documenting that the insured was properly enrolled for the amount of coverage claimed;
- A fully completed claim form; and
- Any additional information deemed necessary during the course of Our claim investigation. This may include, but is not limited to, an autopsy report, investigative reports, toxicology reports and medical records.

B401.2197

All Options

Spouse This term means Your lawful spouse, which shall include the marriage between opposite or same-sex partners legally performed in other jurisdictions. This term shall also include Your Domestic Partner.

B401.2198

All Options

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

B400.7229

All Options

You or Your These terms mean the insured Employee.

B400.7230

EXCLUSIONS

Conditions that are not considered Covered Losses and that are not covered under the terms of this Certificate.

- Willful self-injury, suicide, or attempted suicide while sane or insane;
- Sickness, disease, mental infirmity, or result of any medical or surgical treatment;
- Infection, except pyogenic infections which result from a bodily injury or bacterial infections which result from the unintentional ingestion of contaminated substances;
- The intentional or voluntary inhalation or ingestion of gas, chemical, solvent, poison or other substances not intended for internal consumption;
- An injury the Covered Person suffers while taking part in a riot or other civil disorder; or in the commission of or attempt to commit a felony, as defined per the laws in the jurisdiction in which the felony was committed or attempted, or as defined under federal law if the offense charged was a federal offense;
- Injury suffered while travelling on any type of aircraft if the Covered Person is an instructor or crew member; or has any duties at all on that aircraft;
- Injury suffered in declared or undeclared war or act of war or armed aggression;
- Injury suffered while the Covered Person is a member of any armed force;
- Injury suffered while the Covered Person is Legally Intoxicated; or
- Injury suffered while the Covered Person is voluntarily using a controlled substance, unless:
 - It was prescribed for the Covered Person by a doctor; and
 - It was used as prescribed.

A controlled substance is anything called a controlled substance in Title II of the Comprehensive Drug Abuse Prevention and Control Act of 1970, as amended from time to time.

B401.2787

All Options

**GROUP ACCIDENTAL DEATH AND DISMEMBERMENT
SCHEDULE OF BENEFITS**

B400.7846

All Options

**Employee Basic Accidental Death And Dismemberment (AD&D)
Insurance Schedule**

B400.7859

All Options

Basic AD&D Insurance Amount	The Insurance Amount is \$20,000.00
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B400.7860

All Options

Reduction of Basic AD&D Insurance Amount Based on Age	If You are less than age 65 when Your insurance under this Policy starts, Your insurance amount will be reduced at 12:01 A.M. Standard Time for Your place of residence on the date You reach age 65, by 35% of the amount which otherwise applies to Your classification. But in no case will such reduced amount be less than \$1,000.00. This reduction also applies to Your initial insurance amount if Your insurance starts after You reach age 65, but before You reach age 70.
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If You are less than age 70 when Your insurance under this Policy starts, Your insurance amount will be reduced at 12:01 A.M. Standard Time for Your place of residence on the date You reach age 70, by 50% of the amount which otherwise applies to Your classification. But in no case will such reduced amount be less than \$1,000.00. This reduction also applies to Your initial insurance amount if Your insurance starts after You reach age 70.

The reduced amount is in place of the amount which otherwise applies to Your classification.

B400.7899

All Options

Proof of Insurability	Depending on the coverage selected, or as otherwise required in this Certificate, You, Your Spouse and/or Dependents may be required to supply proof that the person applying for coverage is insurable for the amount and type of coverage selected. This requirement is called Proof of Insurability. For purposes of this section, any person applying for coverage requiring Proof of Insurability is referred to as "Applicant."
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To determine if the Applicant is required to submit Proof of Insurability for the type and amount of coverage sought, please see below.

Any applicant required to submit Proof of Insurability is required to complete and submit to Us an Enrollment/Change form. We may also require the completion of additional forms so that We may determine whether the Applicant is insurable, according to Our underwriting standards for the amount and type of coverage applied for. To determine if the Applicant is insurable, We may also need to obtain and review the Applicant's health and medical history; prescription history; records relating to treatment, diagnostic testing, hospitalization and the like; and records pertaining to Applicant's driving and motor vehicle history.

No coverage requiring Proof of Insurability will become effective unless and until it is approved by Us in writing. Our receipt of any premiums associated with coverage requiring Proof of Insurability does not waive or modify any requirement that must be satisfied for coverage to begin, including but not limited to the requirement that the Applicant submit Proof of Insurability. In the event that any premiums are overpaid, Our only obligation is to return the amount of overpaid premiums.

The Policyholder, or its designee, must give Us complete and accurate information so that we may determine:

- Who is insured;
- The type and amount of coverage for which someone is insured; and
- Any other information required so that Guardian may meet its obligations under the Policy.

Proof Of Insurability Requirements

Proof Of Insurability requirements apply to Basic Accidental Death and Dismemberment Insurance. Such requirements may apply to the full insurance amount, or just part of it, as outlined below. When Proof Of Insurability requirements apply, it means You must submit to Us Proof that You are insurable, and We must approve the Proof in writing before the insurance, or the specified part becomes effective.

We require Proof of Insurability as follows:

If You:

- Do not meet this Policy's enrollment requirement within 30 days after You first become eligible; or
- Enroll after You previously had coverage which ended because You failed to make a required payment,

We will require that You provide Proof Of Insurability. And, You will not be covered until We approve that proof in writing.

If Your Active Full-Time Work ends before You meet any Proof Of Insurability requirements that apply You will still have to meet those requirements if You are later re-employed by the Employer or an associated company.

B400.8032

All Options

Changes to Insurance

B400.9564

All Options

Changes In Insurance Amounts If You are not Actively At Work on a Full-Time basis, any change in Your amount of coverage will not become effective prior to the date You return to Active Work on a Full-Time basis.

B400.9567

All Options

Changes In Insurance Classification If Your classification changes, insurance will not be changed to the new amount until the first day on which You are:

- Actively At Work on a Full-Time basis; and
- Make a contribution, if required, for the new classification.

If a contribution is required for the new classification for which a larger amount of insurance is provided, You must make the required contribution for the new amount within 31 days of the change. If You do not make the required contribution within 31 days of the change or within 31 days of becoming Actively At Work on a Full-Time basis, if You are not Actively At Work on a Full-Time basis, when Your classification changes, no increase will be allowed due to such change or any later change. In that case, in order to become insured for the larger amount, You must:

- Make the required contribution for the new amount; and
- Furnish Proof Of Insurability to Us, which We approve in writing.

If the insurance amount was previously reduced because of age or retirement, it will be retained at the reduced amount.

B400.9570

CERTIFICATE RIDER - Seatbelt and Airbag Benefit

This Rider is effective as of the effective date of the Employee's Certificate. If this Rider is added to an inforce Certificate, the Rider becomes effective on its issue date. This Rider amends the Certificate by the addition of the following:

Terms not specifically defined within this Rider are defined in the Certificate.

**Employee Basic Accidental Death
and Dismemberment Insurance
Seatbelt and Airbag Benefit**

This rider applies to Your Basic Accidental Death and Dismemberment Insurance.

**Seatbelt And Airbag
Benefits**

If You die as a result of an automobile Accident while properly wearing a seatbelt, We will increase Your Accidental Death and Dismemberment Benefit amount by \$10,000. And, if You die as a result of an automobile Accident while both properly wearing a seatbelt, and sitting in a seat equipped with an airbag, We will increase Your Accidental Death and Dismemberment Benefit amount by an additional \$5,000, for a total increase of \$15,000.

Notice of Claim: You must send Us a request which includes written proof that You were properly wearing a seatbelt. A law enforcement official investigating the accident must certify that the seatbelt was properly fastened and that the automobile in which the deceased was traveling was equipped with airbags. A copy of such certification must be submitted to Us with the claim for benefits. We must approve such proof in writing before this benefit is paid.

Proof of Loss: You must send written Proof of Loss to Our designated office within 90 days of the loss.

If We cannot determine that You were wearing a seatbelt at the time of the Accident, We will increase Your Accidental Death and Dismemberment Benefit amount by \$1,000.

If We determine that a seatbelt was not worn at the time of the automobile Accident resulting in Your death, or if the required official report is not provided, no Seatbelt or Airbag Benefit will be paid.

The total amount payable for the Seatbelt and Airbag Benefit under Your Basic Accidental Death and Dismemberment Insurance and Basic and Voluntary Group Term Life Insurance and may not exceed \$30,000.

**Late Notice and
Proof of Loss:** We will not void or reduce Your claim if we do not receive Notice and Proof of Loss within the required time. In that case, Notice and Proof of Loss must be sent as soon as reasonably possible.

Proof of loss and other claim data should be submitted to:

The Guardian Life Insurance Company of America
Group Life Claims Department
P.O. Box 981573
El Paso, TX 79998-1573

Exclusions This Certificate Rider does not pay a Seatbelt or Airbag Benefit for loss of life caused by, or related to an Accident occurring:

- While You are Legally Intoxicated;
- While You are voluntarily using a controlled substance, unless:
 - It was prescribed for You by a Doctor; and
 - It was used as prescribed.

A controlled substance is anything called a controlled substance in Title II of the Comprehensive Drug Abuse Prevention and Control Act of 1970, as amended from time to time.

- While You were intentionally or voluntarily inhaling or ingesting a gas, chemical, solvent, poison or other substances not intended for internal consumption; or
- During Your commission of, or attempt to commit a felony as defined per the laws in the jurisdiction in which the felony was committed or attempted, or as defined under federal law if the offense charged was a federal offense.

The Guardian Life Insurance Company of America



Michael Prestileo, Senior Vice President

B401.2222

CERTIFICATE RIDER

This Rider is effective on the Policy Date. This Rider amends the Certificate by the replacement of the Incontestability provision to the following:

Time Limit On Certain Defenses

After the Policy has been in force for a period of two years, no statements of the Policyholder contained in the application, and no statement relating to insurability made by any Employee eligible for coverage under the Policy shall be used to deny a claim or in contesting the validity of the insurance with respect to which such statement was made after the insurance has been in force prior to the contest for a period of two years during the lifetime of the person with respect to whom any such statement was made.

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

Guardian Life Insurance Company of America



Michael Prestileo, Senior Vice President

B439.0017

AMENDATORY RIDER

This Rider amends the Certificate and Policy as follows and is effective on the later of the Policy Date or the date requested by the Policyholder.

The definition of **Spouse** and **Domestic Partner** is replaced with the following:

Spouse: The person to whom You are legally married or Your **Domestic Partner** or civil union partner.

Domestic Partner: The same-sex or different-sex person with whom You have registered Your relationship with any state or local governmental domestic partner registry

Or

the same-sex or different-sex person with whom you have not registered your relationship if you satisfy the following requirements:

- You live and share financial assets and obligations with this person.
- This person is at least 18 years of age, is able to provide legal consent, and is not a blood relative.
- Neither you nor this person are in a marriage or domestic partnership with anyone else or legally separated from anyone else.
- You submit acceptable documentation that you meet the above criteria. An affidavit attesting to these facts may be required.

Except as specifically noted above for relationships that are not registered, **Domestic Partners** are not subject to any proof of relationship or waiting period requirements that are not also imposed upon marriages. A **Domestic Partner** registry certificate will be accepted as fully equivalent to a marriage certificate. Similarly, a dissolution of domestic partnership notice will be accepted as fully equivalent to a divorce decree.

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

The Guardian Life Insurance Company of America



Michael Prestileo, Senior Vice President

B601.0243

STATEMENT OF ERISA RIGHTS

The Guardian Life Insurance Company of America

10 Hudson Yards
New York, New York 10001
(212) 598-8000

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

ERISA provides that all plan participants shall be entitled to:

Receive Information about Your Plan and Benefits

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

Prudent Actions by Plan Fiduciaries

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

Enforcement of Your Rights

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

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

**Assistance with
Questions**

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

**Accidental Death
and
Dismemberment
Insurance Claims
Procedure**

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

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

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

Definitions

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

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

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

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

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

**Adverse Benefit
Determination of
Accidental Death
and
Dismemberment
Insurance Claims**

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

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

B997.0242

All Options

Appeals of Adverse Determinations of Accidental Death and Dismemberment Insurance Claims

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

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

In reviewing an appeal, Guardian will:

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

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

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

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

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

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

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

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

Guardian will make a determination of whether the claimant meets the plan's standard for total disability not later than 45 days from the date of receipt of a claim. This period may be extended by up to 30 days if Guardian determines that an extension is necessary due to matters beyond the control of the plan, and so notifies the claimant before the end of the initial 45-day period. Such notification will include the reason for the extension and a date by which the determination will be made. If prior to the end of the 30-day period Guardian determines that an additional extension is necessary due to matters beyond the control of the plan, and so notifies the claimant, the time period for making a benefit determination may be extended for up to an additional period of up to 30 days. Such notification will include the special circumstances requiring the extension and a date by which the final determination will be made.

A notification of an extension to the time period in which a benefit determination will be made will include an explanation of the standards upon which entitlement to a benefit is based, any unresolved issues that prevent a decision on the claim, and the additional information needed to resolve those issues.

If Guardian extends the time period for making a benefit determination due to a claimant's failure to submit the information necessary to decide the claim, the claimant will be given at least 45 days to provide the requested information. The extension period will begin on the date on which the claimant responds to the request for additional information.

Adverse Benefit Determination If a claim for an extension of benefits is denied, Guardian will provide a notice that will set forth:

- The specific reason(s) for the adverse determination;
- References to the specific provisions in the Policy, Certificate, plan or other documents, on which the determination is based;
- A description of any additional material or information needed to perfect the claim, and an explanation of why such material or information is necessary;
- A description of the plan's claim review procedures which a claimant may follow to have a claim for benefits reviewed and the time limits applicable to such procedures;

- A statement disclosing any internal rule, guideline, protocol or similar criterion relied on in making the adverse benefit determination (or a statement that such information will be provided free of charge upon request); or a statement that no internal rule, guideline, protocol or similar criterion was relied upon in making the adverse benefit determination;
- If applicable, an explanation of the basis of disagreement with or not following the views presented by you, of health care professionals who treated you and vocational professionals who evaluated you;
- If applicable, an explanation of the basis for disagreeing with or not following the views of any medical or vocational expert whose advice was obtained on our behalf in connection with the adverse benefit determination, without regard to whether the advice was relied upon in making the determination;
- If applicable, an explanation of the basis for disagreeing with or not following a disability determination made by the Social Security Administration that you present to us;
- A description of the plan's review procedures and the time limits applicable to such procedures, including a statement of the claimant's right to bring a civil action under ERISA Section 502(a) following an adverse benefit determination; and
- In the case of adverse benefit determination based on medical necessity or experimental treatment, notice will either include an explanation of the scientific or clinical basis for the determination, or a statement that such explanation will be provided free of charge upon request.

B997.0243

All Options

Appeals of Adverse Determinations for Waiver of Premium

If a claim for Waiver of Premium is denied, the claimant will have up to 180 days to make an appeal. Guardian will conduct a full and fair review of an appeal which includes providing to claimants the following:

- The opportunity to submit written comments, documents, records and other information relating to the claim;
- The opportunity, upon request and free of charge, for reasonable access to, and copies of, all documents, records and other information relevant to the claim; and
- A review that takes into account all comments, documents, records and other information submitted by the claimant relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination.

In reviewing an appeal, Guardian will:

- Provide for a review conducted by a named fiduciary who is neither the person who made the initial adverse determination nor that person's subordinate;

- In deciding an appeal based upon a medical judgment, consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment;
- Identify medical or vocational experts whose advice was obtained in connection with an adverse benefit determination; and
- Ensure that a health care professional engaged for consultation regarding an appeal based upon a medical judgment shall be neither the person who was consulted in connection with the adverse benefit determination, nor that person's subordinate.

Guardian will notify the claimant of its decision not later than 45 days after receipt of the request for review of the adverse determination. This period may be extended by an additional period of up to 45 days if Guardian determines that special circumstances require an extension of the time period for processing and so notifies the claimant before the end of the initial 45-day period.

A notification with respect to an extension will indicate the special circumstances requiring an extension of the time period for review, and the date by which the final determination will be made.

In the event Guardian denies the appeal of an adverse benefit determination, it will:

- Provide the specific reason or reasons why the appeal was denied;
- Refer to the specific provisions in the Policy, Certificate, plan, or other documents on which the benefit determination is based;
- Provide a statement that the claimant is entitled to receive, upon request and free of charge, reasonably access to, and copies of all documents, records, and other information relevant to the claimant's claim for benefits;
- Provide a statement disclosing any internal rule, guideline, protocol or similar criterion relied on in making the adverse benefit determination (or a statement that such information will be provided free of charge upon request); or a statement that no internal rule, guideline, protocol or similar criterion was relied upon in making the adverse benefit determination;
- If applicable, provide an explanation of the basis of disagreement with or not following the views presented by you, of health care professionals who treated you, and vocational professionals who evaluated you;
- If applicable, provide an explanation of the basis for disagreeing with or not following the views of any medical or vocational expert whose advice was obtained on our behalf in connection with the adverse benefit determination, without regard to whether the advice was relied upon in making the determination;
- If applicable, provide an explanation of the basis for disagreeing with or not following a disability determination made by the Social Security Administration that you present to us;

- Provide a statement describing the claimant's right to bring a civil suit under Section 502(a) of the Employee Retirement Income Security Act of 1974 which shall also describe any applicable contractual limitations period that applies the claimant's right to bring such an action, including the calendar date on which the contractual limitations period expires for the claim, and;
- In the event the adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, provide either an explanation of the scientific or clinical judgment for the determination, applying the terms of the plan to the claimant's medical circumstances, or a statement that such explanation will be provided free of charge upon request.

**Alternative Dispute
Options**

The claimant and the plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact the local U.S. Department of Labor Office and the State insurance regulatory agency.

In addition to any legal rights you may have under section 502(a), if you believe that we have violated ERISA's procedural requirements, you may request that we review any claimed violation(s) and we will respond to you within ten days.

B997.0244

You May not be covered by all options in this Certificate.

This Certificate contains all the benefits and options that are available under the Policy. You are insured only for those benefits and options that you are eligible and enrolled for, and for which the required premium has been paid.

COMBINED EVIDENCE OF COVERAGE AND DISCLOSURE FORM

Managed Dental Care of California
21820 Burbank Boulevard, Suite 200
Woodland Hills, CA 91367
1-800-273-3330

This combined evidence of coverage and disclosure form constitutes only a summary of the health plan. The health plan contract must be consulted to determine the exact terms and conditions of coverage.

The Group Dental Coverage described in this Evidence of Coverage is attached to the group policy "Policy" effective September 1, 2007. This Evidence of Coverage replaces any Evidence of Coverage previously issued under this Policy or under any other policy providing similar or identical benefits issued to the Policyholder by Us.

Managed Dental Care (MDC) of California is a California corporation, licensed as a Knox-Keene Health Care Service Plan under applicable California law, whose primary purpose is to operate a dental care service plan.

MANAGED DENTAL CARE PLAN

GROUP CONTRACT FOR PREPAID DENTAL SERVICES

PLEASE READ THIS ENTIRE EVIDENCE OF COVERAGE CAREFULLY. IT DESCRIBES THE BENEFITS AVAILABLE UNDER THE GROUP POLICY. IT IS YOUR RESPONSIBILITY TO UNDERSTAND WHAT IT COVERS, LIMITS, AND EXCLUDES.

We certify that the Employee to whom this Evidence of Coverage is issued is eligible for the coverage, and in the amount, described herein. In order to be eligible for coverage, the Employee must: (a) satisfy all of the Policy's eligibility and Effective Date requirements; (b) be listed in Our and/or the Policyholder's records as a validly covered Employee under the Policy; and (c) all required premium payments must have been made by or on behalf of the Employee.

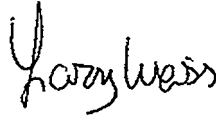
The Employee is not covered by any part of the Policy for which he or she has waived coverage. Such a waiver of coverage is shown in Our and/or the Policyholder's records.

Policyholder: HILTON WATERFRONT BEACH RESORT
Group Policy Number: 00429264
Effective Date: September 1, 2007

Managed Dental Care of California

A handwritten signature in black ink, appearing to read "Jill Purcell". The signature is fluid and cursive, with the first name "Jill" being more prominent.

Jill M. Purcell, President

A handwritten signature in black ink, appearing to read "Larry Weiss". The signature is cursive, with the first name "Larry" being more prominent.

Larry Weiss, Assistant Vice President
and Controller

B425.1021

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Option F

GENERAL PROVISIONS

Applicable Benefits

This Evidence of Coverage may include multiple benefit options and types of benefits. You will only be covered for benefits if:

- They were previously selected in an acceptable manner and mode, such as an enrollment form or other required form; and
- We have received any required premium.

B425.0637

Option F

Public Policy Committee

MDC maintains a Public Policy Committee composed of at least three Members, one Contracted Dentist and one member of MDC's Board of Directors. Members may call MDC for more information about the Committee. MDC communicates material changes affecting public policy to Members in periodic newsletters.

B425.0638

Option F

Confidentiality

A STATEMENT DESCRIBING OUR POLICIES AND PROCEDURES FOR PRESERVING THE CONFIDENTIALITY OF MEDICAL RECORDS IS AVAILABLE AND WILL BE FURNISHED TO YOU UPON REQUEST.

You may contact Our customer services department by telephone at 1-800-273- 3330, or by mail to P.O. Box 2474, Spokane, WA 99210-2474 to request a copy of the Policy's confidentiality statement. The confidentiality statement describes how MDC maintains the confidentiality of dental information obtained by and in the possession of MDC.

B425.1022

Option F

Limitation of Authority

Only Our President, a Vice President or a Secretary has the authority to act for Us in a written and signed statement to:

- Determine whether any contract, Policy or Evidence of Coverage is to be issued;
- Waive or alter any contract, Policy or Evidence of Coverage, or any of Our requirements;
- Bind Us by any statement or promise relating to the Policy issued or to be issued; or
- Accept any information or representation which is not in a signed application.

Agents and brokers do not have the authority to change the contract or Policy or waive any of its provisions.

B425.0640

Option F

Incontestability

All statements made on Your enrollment form shall be considered representations and not warranties. The statements are considered to be truthful and are made to the best of Your knowledge and belief. No statement contained in Your enrollment form will void Your coverage or reduce Your benefits after Your coverage has been in force for two years. Within the first two years of issuance of coverage under this Policy, We may rescind Your coverage based on any fraudulent statement or intentional misrepresentation of material fact made on Your signed enrollment application.

The statements and information contained in the Your enrollment form are represented by You to be true and correct and incorporated into the Policy. You also recognize that MDC has issued the Policy in reliance on those statements and information. The Policy replaces and cancels all other contracts, if any, issued to You by Us.

In the event Your coverage is rescinded, We will refund premiums paid for the periods such coverage is void. The premium paid by You will be sent to Your last known address on file with the Employer or Us.

B425.1024

Option F

Language Assistance

As an MDC Member, You have a right to free language assistance services, including interpretation and translation services. MDC collects and maintains Your language preferences, race, and ethnicity so that We can communicate more effectively with Our Members. If You require spoken or written language assistance or would like to inform MDC of Your preferred language, please contact Us at 1-800-273-3330. TDD/TTY for the hearing impaired is available through 1-800-947-6644.

B425.1026

Option F

CONDITIONS OF ELIGIBILITY FOR GROUP DENTAL COVERAGE

B425.0011

Option F

Enrollment Procedures

You may enroll for dental coverage by:

- Completing and signing the appropriate enrollment form and any additional material required by Your Policyholder.
- Returning the enrollment material to your Policyholder. Your Policyholder will forward these materials to Us.

The enrollment materials require You to select a Primary Care Dentist ("PCD") for each Member. After Your enrollment material has been received by Us, We will determine if a Member's selected PCD is available under Your Policy. If the PCD is available under the Policy, the selected Dentist will be assigned to the Member as his or her PCD. If a Member's selection is not available, an alternate Dentist will be assigned as the PCD. A Member need only contact his or her assigned PCD's office to obtain services.

We will issue You and Your dependents, either directly or through Your Policyholder's representative, an ID card. The ID card will show the Member's name and the name and telephone number of his or her assigned PCD.

B425.1038

Option F

Open Enrollment Period

If You do not enroll Yourself or Your eligible dependents for dental coverage under this Policy within 30 days of: a) the date of becoming eligible or b) the date of a Qualifying Event, You must wait until the next open enrollment period to enroll. The open enrollment period is a 30 day period which occurs once every 12 months after this Policy's Effective Date, or at time intervals mutually agreed upon by Your Policyholder and Us.

Enrollment is for a minimum of 12 consecutive months while You are eligible. Voluntary termination from this Policy will only be permitted during the open enrollment period.

If after initial enrollment You, or one of Your dependents disenroll from the Policy before the open enrollment period, the Member may not re-enroll until the next open enrollment period which occurs after the Member has been without coverage for one full year.

B425.1027

Option F

Employee Eligibility

You are eligible for dental coverage if You are:

- In an eligible class of Employees;
- An active Full-Time Employee; and
- Working at least the minimum required number of hours in Your eligible class at:
 - The Employer's place of business;
 - Some place where the Employer's business requires You to travel; or
 - Any other place You and the Employer have agreed upon for the performance of the major duties of Your job.

You are **not** eligible for dental coverage if You are:

- A temporary or seasonal Employee; or
- The Employee for whom, pursuant to a collective bargaining agreement, the Employer makes any payments to any kind of health and welfare benefit plan other than under this Evidence of Coverage.

B425.0656

Option F

Dependent Eligibility

Your eligible dependents are Your:

- Spouse; and
- Dependent child, including:
 - A newborn child, natural child, stepchild or a child placed with You for adoption or foster care who is under age 26; and
 - A child who is incapable of self-sustaining employment by reason of a physically or mentally disabling injury, illness, or condition; and is chiefly dependent upon the Employee for support and maintenance, may remain eligible for dependent benefits past the age limit, subject to the following:

- We will send notice to You at least 90 days prior to the limiting age and You must send Us written proof that the child is dependent upon You for support and maintenance as is incapable of self-sustaining employment by reason of a physically or mentally disabling injury, illness, or condition. You have 60 days from the date the child reaches the age limit to do this. We will continue coverage until a determination about the child's eligibility is made. We can ask for periodic proof that the child's condition continues, but We cannot ask for this proof more than once a year after the two-year period following the child's attainment of the limiting age.

Eligible dependent does not include anyone who is insured under this Policy as the Employee.

B425.1047

Option F

When Coverage Starts

Your Employer will inform You of Your Effective Date under the dental Policy. Your coverage begins on the date:

- You and Your eligible dependents are eligible for the dental Policy as stated in the Conditions Of Eligibility for Group Dental Coverage section; and
- You and Your eligible dependents have enrolled in the dental Policy; and
- Required premiums have been paid.

If you do not enroll by Your Effective Date, Your coverage will begin on:

- The first day of the month following the date enrollment materials are received by Us; or
- The first day of the month after the end of any waiting period Your Policyholder may require; or
- The date you are eligible for the Policy based on the Policyholder's eligibility rules as approved by Us.

B425.0392

Option F

Exception to When Coverage Starts

Sometimes a scheduled Eligibility Date is not a regularly scheduled work day. If the scheduled Eligibility Date falls on:

- A holiday;
- A vacation day;

- A non-scheduled work day;
- A day during an approved leave of absence not due to sickness or injury of 90 days or less; or
- A day during a period of absence that is less than 7 days in duration;

And if:

- You were fully capable of performing Active Work for the Employer for the minimum number of hours of the Employee in Your eligible class at 12:01 AM Standard Time for Your place of residence on the scheduled Eligibility Date; and
- You were Actively at Work and working the minimum number of hours of the Employee in Your eligible class on Your last regularly scheduled work day;

Your coverage will start on the scheduled Eligibility Date. However, any coverage or part of coverage for which You must elect and pay all or part of the cost will not start if You are on an approved leave and such coverage or part of coverage was not previously in force for You under a prior plan which this Evidence of Coverage replaced.

B425.0674

Option F

Termination of Coverage

In the event of cancellation by either Us (except in the case of fraud or deception in the use of services or facilities of MDC or knowingly permitting such fraud or deception by another) or You, We shall within 30 days return to You any pro rata portion of fees paid by You which corresponds to any unexpired period for which payment has been received, together with amounts due on claims, if any, less any amounts due.

Termination by You

You may cancel your coverage at any time during the grace period outlined below or by giving Us 31 days advance written notice. This notice must be sent to Our office. The Policyholder will owe Us all unpaid premiums for the period that coverage is in force.

Termination by MDC

We shall have the right to cancel Your coverage upon providing written notice to the Policyholder, who is required to promptly send such notice to You, in the following circumstances:

- Termination by MDC for Non-payment of Premium. We may cancel or decline to renew Your coverage for cause if the Policyholder fails to pay all premiums in accordance with the following terms and conditions:

- A grace period of 30 days, starting after the last date of paid coverage, will be allowed for outstanding premium payments. You will receive a written notice stating the start and end dates of the grace period from the Policyholder.
- If the Policyholder, or another party acting on the Policyholders behalf, makes the necessary premium payment and that payment is received on or before the last day of the grace period, We shall ensure that coverage is not cancelled or not renewed on account of non-payment of such premiums.
- If any premium with respect to the Members covered by the Policy is not paid before the end of the grace period, coverage ends with respect to all Members covered by the Policy immediately following the end of the grace period. You will receive a written notice of end of coverage no later than five (5) business days following the last day of paid coverage from the Policyholder.
- If the Policyholder give Us advance written notice of an earlier termination date during the grace period, Your coverage will end as of such earlier date.
- If Your coverage ends during or at the end of the grace period, the Policyholder will still owe Us premium for all the time the Policy was in force during the grace period.
- Termination by MDC for Intentional Misrepresentation of Material Fact by You. We may cancel or decline to renew Your coverage if We demonstrate an intentional misrepresentation of a material fact by You or the Policyholder in obtaining Your coverage. You will receive 30 days' advance written notice of cancellation from the Policyholder.
- Termination by MDC for Violation of Material Provision Relating to Employer Contributions or Group Participation Rates. We may cancel or decline to renew Your coverage if the Policyholder violates a material provision of the Policy relating to employer contributions or group participation rates. You will receive 30 days' advance written notice of cancellation from the Policyholder.

- Termination by MDC Due to Cessation of Services in the State or Withdrawal of Policy from the Market. Subject to providing 180 days' advance written notice to the Director of the Department of Managed Health Care and You via the Policyholder, We may discontinue or terminate Your coverage if the cancellation or nonrenewal is due to MDC ceasing to provide or arrange for the provision of health benefits for new plan contracts in the individual or group market in this State pursuant to Health and Safety Code section 1365(a)(5). Subject to providing 90 days' advance written notice to the Director of the Department of Managed Health Care and You via the Policyholder, We may discontinue or terminate Your coverage if the MDC withdraws the health benefit plan from the market pursuant to Health and Safety Code section 1365(a)(6).

If You believe that Your coverage has been or will be improperly canceled, rescinded, or not renewed, You may file request a review by the Department of Managed Health Care, within 180 days of receipt of the notice of cancellation, pursuant to Section 1368 of the Health and Safety Code. Such request for review may be submitted directly to the Department of Managed Health Care by mail to the attention of the Help Center, Department of Managed Health Care, 980 Ninth Street, Suite 500, Sacramento, CA 95814-2725; by phone at 1-888-466-2219/TDD 1-877-688-9891; by fax at 1-916-255- 5241; or online at www.healthhelp.ca.gov. Such review shall be in accordance with Sections 1368 and 1365(b) of the Health and Safety Code.

B425.1029

Option F

When Your Dependent Coverage Ends

Your dependent Coverage will end on the first of the following events:

- When Your Coverage ends.
- When You stop being an eligible Employee under this Evidence of Coverage.
- The date the group Evidence of Coverage ends, or dependent Coverage is discontinued for a class of Employees to which You belong.
- The last day of the period for which required payments are made for Your dependent.
- On the last day of the month in which Your child attains the age limit, except as described in the Dependent Eligibility section.
- For Your Spouse, on the last day of the month in which Your marriage ends in legal divorce or annulment.

B425.0692

Option F

CONTINUATION OF COVERAGE

You may have the right to continue certain group benefits for a limited time after Your coverage would otherwise end. Read this Evidence of coverage carefully for details and discuss with Your Employer or administrator.

B425.0696

Option F

Continuation Rights

You may be eligible to continue Your group dental coverage under more than one Continuation Rights section at the same time. If You choose to continue Your group dental coverage under more than one section, the continuations: (1) start at the same time; (2) run concurrently; and (3) end independently, on their own terms.

If continuing coverage under more than one continuation section: (1) You will not be entitled to duplicate benefits; and (2) You will not be subject to the premium requirements of more than one section at the same time.

B425.0071

Option F

Uniformed Services Continuation Rights

USERRA (Uniformed Services Employment and Reemployment Rights Act) is a federal law that provides reemployment rights for veterans and members of the National Guard and Reserve following military service. It also prohibits employer discrimination against any person on the basis of that person's past military service, current military obligations or intent to join one of the uniformed services.

If Your group dental coverage under this Policy would otherwise end because You enter into active military service, You may elect to continue such coverage for Yourself and Your eligible dependents in accordance with the provisions of USERRA.

You may contact Your Employer for additional information.

B425.0078

Cal-COBRA Continuation Rights

Important Notice: This notice contains important information about the right to continue group dental coverage. In addition to the continuation rights described below, other health coverage alternatives may be available through states' Health Insurance Marketplaces. Please read the information contained in this notice very carefully.

This section applies to the dental benefits of this Policy. In this section, these benefits are referred to as "group dental benefits."

Under this section, a "qualified beneficiary" means any person who, on the day before any event which would qualify him or her for continuation under this section, is covered for dental benefits under this Policy as: (a) an active, covered Employee; (b) the spouse of an active, covered Subscriber; or (c) the dependent Child of an active covered Employee. A child born to, or adopted by, the covered Employee during a continuation period is also a qualified beneficiary if the child is enrolled in the Policy as a dependent within 30 days of the child's birth or placement for adoption. Any other person who becomes covered under this Policy during a continuation period provided by this section is not a qualified beneficiary.

A qualified beneficiary will be eligible for continuation coverage without demonstrating evidence of insurability upon certain "qualifying events." "Qualifying events" are defined as: (a) the death of the covered Employee; (b) the termination or reduction of work hours of the covered Employees employment, if he or she was not terminated for gross misconduct; (c) the divorce or legal separation of the covered Employee from the covered Employees spouse; (d) the loss of dependent status by a dependent enrolled in the group Policy; and (e) the covered Employees eligibility for coverage under Medicare.

Conversion: Continuing the group health benefits does not stop a qualified beneficiary from converting some of these benefits when continuation ends. But, conversion will be based on any applicable conversion privilege provisions of this Policy in force at the time the continuation ends.

If Your Group Health Benefits End: If Your group dental benefits end due to Your termination of employment or reduction of work hours, You may elect to continue such benefits for up to 18 months, if You were not terminated due to gross misconduct. The continuation: (a) may cover You or any other qualified beneficiary; and (b) is subject to "When Continuation Ends."

Extra Continuation for Disabled Qualified Beneficiaries: If a qualified beneficiary is determined to be disabled under Title II or Title XVI of the Social Security Act on or during the first 60 days after the date his or her group health benefits would otherwise end due to the Employees termination of employment or reduction of work hours, he or she may elect to extend his or her 18 month continuation period explained above for up to an extra 11 months.

To elect the extra 11 months of continuation, the qualified beneficiary must give Your Employer written proof of Social Security's determination of his or her disability before the earlier of: (a) the end of the 18 month continuation period; or (b) 60 days after the date the qualified beneficiary is determined to be disabled. If, during this extra 11 month continuation period, the qualified beneficiary is determined to be no longer disabled under the Social Security Act, he or she must notify You within 30 days of such determination, and continuation will end, as explained in "When Continuation Ends."

This extra 11 month continuation is subject to "When Continuation Ends."

An additional 50% of the total premium charge also may be required from the qualified beneficiary by the insurer during this extra 11 month continuation period.

If You Die While Insured: If You die while insured, any qualified beneficiary whose group health benefits would otherwise end may elect to continue such benefits. The continuation can last for up to 36 months subject to "When Continuation Ends."

If Your Marriage Ends: If Your marriage ends due to legal divorce or legal separation, any qualified beneficiary whose group dental benefits would otherwise end may elect to continue such benefits. The continuation can last for up to 36 months, subject to "When Continuation Ends."

If A Dependent Loses Eligibility: If a dependent child's group dental benefits end due to his or her loss of dependent eligibility as defined in this Plan, other than Your coverage ending, he or she may elect to continue such benefits. However, such dependent child must be a qualified beneficiary. The continuation can last for up to 36 months, subject to "When Continuation Ends."

Concurrent Continuations: If a dependent elects to continue his or her group dental benefits due to Your termination of employment or reduction of work hours, the dependent may elect to extend his or her 18 month continuation period up to 36 months, if during the 18 month continuation period, either: (i) the dependent becomes eligible for 36 months of group dental benefits due to any of the reasons stated above; or (ii) You become entitled to Medicare.

The 36 month continuation period starts on the date the 18 month continuation period started, and the two continuation periods will be deemed to have run concurrently.

Special Medicare Rule: If You become entitled to Medicare before a termination of employment or reduction of work hours, a special rule applies for Your dependents. The continuation period, after Your later termination of employment or reduction of work hours, will be the longer of: (a) 18 months from Your termination of employment or reduction of work hours; or (b) 36 months from the date of Your earlier entitlement to Medicare. If Medicare entitlement occurs more than 18 months before termination of employment or reduction of work hours, this special Medicare rule does not apply.

B425.0699

Option F

The Qualified Beneficiary's Responsibilities: A person eligible for continuation under this section must notify Your Employer, in writing, of: (a) Your legal divorce or legal separation from Your spouse; or (b) the loss of dependent eligibility, as defined in this Policy, of a dependent.

Such notice must be given to Your Employer within 60 days of either of these events. Employee must request the continuation in writing and deliver the written request, by first-class mail, or other reliable means of delivery, including personal delivery, express mail, or private courier company, to the health care service plan, or to the Employer if the Policy has contracted with the Employer for administrative service, within the 60-day period following the later of (1) the date that the Employees coverage under the group benefit plan terminated or will terminate by reason of a qualifying event, or (2) the date the Employee was sent notice of that ability to continue coverage under the group benefit plan. A qualified beneficiary electing continuation shall pay to the Policy, in accordance with the terms and conditions of the Policy Contract, which shall set forth in the notice to the qualified beneficiary, the amount of the required premium payment.

Your Employer's Responsibilities: Your Employer must notify the qualified beneficiary, in writing, of: (a) his or her right to continue this Policy's group dental benefits; (b) the monthly premium he or she must pay to continue such benefits; and (c) the times and manner in which such monthly payments must be made.

Your Employer must provide the qualified beneficiary with written notice of the necessary benefit information, premium information, enrollment forms and instructions within 14 days of: (a) the date a qualified beneficiary's group dental benefits would otherwise end due to Your death or Your termination of employment or reduction of work hours; or (b) the date a qualified beneficiary notifies Your Employer, in writing, of Your legal divorce or legal separation from Your spouse, or the loss of dependent eligibility of a dependent child.

The Employer's Liability: Your Employer will be liable for the qualified beneficiary's continued group health benefits to the same extent as, and in place of, MDC, if: (a) Your Employer fails to remit a qualified beneficiary's timely premium payment to MDC on time, thereby causing the qualified beneficiary's continued group dental benefits to end; or (b) Your Employer fails to notify the qualified beneficiary of his or her continuation rights, as described above.

Election of Continuation: To continue his or her group dental benefits, the qualified beneficiary must give Your Employer written notice that he or she elects to continue. This must be done within 60 days of the date a qualified beneficiary receives notice of his or her continuation rights from Your Employer as described above. And the qualified beneficiary must pay his or her first month's premium within 45 days by first-class mail, certified mail, or other reliable means of delivery, including personal delivery, express mail, or private courier company, to the Policy, or to the Employer if the Employer has contracted with the Policy to perform the administrative services. The first premium payment must equal an amount sufficient to pay any required premiums and all premiums due, and failure to submit the correct premium amount within the 45-day period will disqualify the qualified beneficiary from receiving continuation coverage pursuant to this article.

The subsequent premiums must be paid to Your Employer, by the qualified beneficiary, in advance, at the times and in the manner specified by Your Employer. No further notice of when premiums are due will be given.

The monthly premium will be the total rate which would have been charged for the group dental benefits had the qualified continuee stayed enrolled in the group Policy on a regular basis. It includes any amount that Your Employer would have paid. Except as explained in "Extra Continuation for Disabled Qualified Beneficiary," Your Employer may require an additional charge of 2% of the total premium charge. If the qualified beneficiary fails to give Your Employer notice of his or her intent to continue, or fails to pay any required premiums in a timely manner, he or she waives his or her continuation rights.

Grace in Payment of Premiums: A qualified beneficiary's premium payment is timely if, with respect to the first payment after the qualified beneficiary elects to continue, such payment is made no later than 45 days after such election. In all other cases, such premium payment is timely if it is made within 31 days of the specified due date.

When Continuation Ends: A qualified beneficiary's continued group dental benefits end on the first of the following to occur:

- a) with respect to continuation upon Your termination of employment or reduction of work hours, the end of the 18 month period which starts on the date of the qualifying event;
- b) with respect to a disabled qualified beneficiary who has elected an additional 11 months of continuation, the earlier of: (1) the end of the 29 month period which starts on the date of the qualifying event; or (2) the first day of the month which coincides with or next follows the date which is 30 days after the date on which a final determination is made that a disabled qualified beneficiary is no longer disabled under Title II or Title XVI of the Social Security Act;
- c) with respect to continuation upon Your death, Your legal divorce or legal separation, or the end of a dependent's eligibility, the end of the 36 month period which starts on the date of the qualifying event;
- d) with respect to a dependent whose continuation is extended due to the Employees entitlement to Medicare, while the dependent is on continuation, the end of the 36 month period which starts on the date of the qualifying event;
- e) the date Your Employer ceases to provide any group dental plan to any Employee;
- f) the end of the period for which the last premium is made;
- g) the date he or she becomes covered under any other group dental plan which does not contain any pre-existing condition exclusion or limitation affecting him or her;
- h) the date he or she becomes entitled to Medicare.

B425.0700

Small Employer Group

Applies to Members who are covered under a Policy between Us and a California small employer group with two (2) through nineteen (19) eligible employees.

You are eligible if You are a permanent employee who is actively engaged on a full-time basis in the conduct of the business of the small employer with a normal workweek of at least 30 hours, at the small employer regular places of business, and have met any statutorily authorized applicable waiting period requirements. It also includes any eligible employee who obtains coverage through a guaranteed association. This does not include employees who work on a part-time, temporary, or substitute basis.

Permanent employees who work at least 20 hours but not more than 29 hours are deemed to be eligible employees if all four of the following apply:

(1) they otherwise meet the definition of an eligible employees except for the number of hours worked; (2) the employer offers the employee health coverage under a health benefit plan; (3) all similarly situated individuals are offered coverage under the health benefit plan; and (4) the employee must have worked at least 20 hours per normal workweek for at least 50% of the weeks in the previous calendar quarter.

In order to receive CAL-COBRA benefits for yourself and/or Dependent(s), You or Dependent(s) must provide written notice to Us within sixty (60) days of the qualifying events, except if coverage terminates due to a reduction of employee work hours or termination of your employment. If Your coverage and/or coverage for Dependents will terminate due to a reduction of Your work hours or termination of Your employment, Your employer must notify Us within 30 days of the qualifying event. Notice will be sent to the last known address.

If you or Dependent(s) do not notify MDC within sixty (60) days of the qualifying event(s), You and Dependents(s) will not receive Cal-COBRA benefits. Dependents may also be disqualified from receiving Cal-COBRA benefits if your employer does not provide Us with notification as required by law and summarized in the Policy.

Within fourteen (14) days of receiving notification of a qualifying event, We will mail Cal-COBRA information package to the last known address of the Dependent. The package will contain premium information, enrollment forms and the disclosures necessary to formally elect Cal-COBRA continuation benefits and will be sent to the Dependents last known address.

If you and/or Dependent(s) are eligible for extended continuation coverage for twenty-nine (29) months as a result of a disability, You and/or Dependent(s) must notify Us within thirty (30) days of a determination that the Member is no longer disabled.

B425.0701

Option F

Family Medical Leave Of Absence (FMLA)

There are certain leaves of absence that may qualify for continuation of coverage under the Family and Medical Leave Act of 1993 (FMLA), or other similar laws. Please contact Your Employer for information regarding such legally mandated leave of absence laws.

B425.0081

Option F

Dependent Survivorship Benefit

If You die while covered, We will continue dependent coverage for those of Your dependents who were covered when You died. We will do this for six months at no cost, provided: 1) this Employer's dental coverage remains in force; 2) the dependents remain eligible dependents; and 3) in the case of a Spouse, the Spouse does not remarry.

If a surviving dependent elects to continue his or her dependent benefits under another continuation provision, if any, this free continuation period will be provided as the first six months of such continuation.

B425.0083

Option F

DENTAL BENEFITS

This Policy will cover many of the dental expenses incurred by You and those of Your dependents who are covered under this Policy. We interpret how the Policy is to be administered. What We cover and the terms of coverage are explained below.

B425.0084

Option F

How to Contact Us

Our customer service associates can assist You with benefit coverage questions, resolving problems, selecting or changing a Dentist. A customer service associate can be reached toll free Monday through Friday at 1-888-273-3330 from 8:00 am to 8:00 pm, Pacific Standard Time. An automated service is also provided after hours for eligibility verification.

B425.1030

Option F

Managed Dental Care

This Policy is designed to provide quality dental care while controlling the cost of such care. To do this, the Policy requires Members to seek dental care from Contracted Dentists that belong to the Network.

The Network is made up of Contracted Dentists in the Policy's approved Service Area. A Contracted Dentist is a Dentist that has a participation agreement in force with Us.

When a Member enrolls in this Policy, he or she will get information about current Contracted General Dentists. Each Member must be assigned to a Primary Care Dentist ("PCD"). The PCD will coordinate all of the Member's dental care covered by this Policy. After enrollment, a Member will receive an ID card. A Member must present this ID card or supply the Group Number and Member ID number when he or she goes to their PCD.

All dental services covered by this Policy must be coordinated by the PCD to whom the Member is assigned. What We cover is based on all the terms of this Policy. Please refer to the Schedule of Benefits for Group Dental Coverage information including Covered Dental Procedures and Patient Charges, Benefit Limitations and Exclusions.

B425.1039

Option F

Principal Benefits and Coverages

A complete list of Patient Charges, Limitations and Exclusions are included in the Schedule of Benefits section of this Evidence of Coverage. This is an essential part of this document. Many services are provided at no charge to you, while some procedures have a Patient Charge. Services specifically excluded from this coverage are listed in the section titled Exclusions in the Schedule of Benefits. Please read this section carefully. Dental services performed by a Non-Contracted Dentist are not covered, except under certain emergency situations as explained under the section titled Emergency Dental Services.

PLEASE READ THE FOLLOWING INFORMATION SO YOU WILL KNOW FROM WHOM OR WHAT GROUP OF DENTIST DENTAL CARE MAY BE OBTAINED.

B425.0703

Option F

Choice of Dentists

A Member may choose any available Contracted General Dentist as his or her PCD. A request to change a PCD must be made to Us. Any such change will be effective the first day of the month following approval however, We may require up to 30 days to process and approve such request. All fees and Patient Charges due to the Member's current PCD must be paid in full prior to such transfer.

B425.0088

Option F

Changes in Dentist Participation

We may have to reassign a Member to a different Contracted Dentist if:

- The Member's Dentist is no longer a Contracted Dentist in the Network; or
- We take an administrative action which impacts the Dentist's participation in the Network.

If this becomes necessary, the Member will have the opportunity to request another Contracted Dentist.

If a Member has a dental service in progress at the time of the reassignment, We will, at Our option and subject to applicable law, either:

- Arrange for completion of the services by the original Dentist; or
- Make reasonable and appropriate arrangements for another Contracted Dentist to complete the service.

B425.0089

Option F

Refusal of Recommended Treatment

A Member may decide to refuse a course of treatment recommended by his or her PCD or Contracted Specialist. The Member can request and receive a second opinion by contacting a customer service associate. If the Member still refuses the recommended course of treatment, the PCD or Contracted Specialist may have no further responsibility to provide services for the condition involved and the Member may be required to select another PCD or Contracted Specialist.

B425.0090

Option F

Specialty Referrals

A Member's PCD is responsible for providing all covered services. But, certain services may be eligible for referral to a Contracted Specialist. We will pay for covered services for specialty care, less any applicable Patient Charges, when such specialty services are provided in accordance with the specialty referral policy guidelines described below.

In order for specialty services to be covered by this Policy, the referral policy guidelines stated below must be followed:

- A Member's PCD must coordinate all dental care. Any Member who elects specialty care without prior referral by his or her PCD will be responsible for all charges incurred.
- When the PCD determines that the care of a Contracted Specialist is required, the PCD must complete the specialty referral request form. At this point, the following options are available:
 - (a) The PCD may decide to preauthorize the specialty care he or she feels is necessary. The PCD will forward all necessary documentation to Us. We will review the documentation and provide a written response with a benefit determination. The Member will be instructed to contact the Contracted Specialist to schedule an appointment.

(b) The PCD may determine that the direct referral to the Contracted Specialist fits the referral policy guidelines. If so, the PCD will complete the specialty referral request form and provide this form to the Member and the Contracted Specialist. We will retrospectively review the direct referral upon receipt of the Contracted Specialist's claim, once the Contracted Specialist's procedures or services have been completed.

If the PCD's request for specialty referral is denied (an Adverse Determination), the PCD and the Member will receive a written notice along with information on how to appeal the denial to an independent review organization. Refer to the Grievance Process section for additional information.

If the service in question is a covered service and no exclusions or limitations apply to that service, the PCD may be asked to perform the service directly, or to provide additional information.

A specialty referral is not a guarantee of covered services. The Policy's benefits, conditions, limitations and exclusions will determine coverage in all cases. If a referral is made for a service that is not a covered service under the Policy, the Member will be responsible for the entire amount of the specialist's charge for that service.

A Member who receives authorized specialty services must pay all applicable Patient Charges associated with the services provided.

When specialty dental care is referred by the PCD, a Member will be referred to a Contracted Specialist for treatment. The Network includes Contracted Specialists in: (a) oral surgery; (b) periodontics; (c) endodontics; (d) orthodontics; and (e) pediatric dentistry, located in the Policy's approved Service Area. If there is no Contracted Specialist in the Policy's approved Service Area, We will refer the Member to a Non-Contracted specialist Dentist of Our choice.

B425.0091

Option F

Facilities

MDC PCD's available under the Policy Contract are listed in the Network General Dentist booklet. MDC's PCD offices are open during normal business hours and some offices are open limited Saturday hours. Please remember, if You cannot keep Your scheduled appointment, You must notify Your PCD at least 24 hours in advance or You will be responsible for the broken appointment fee listed in the Covered Dental Services and Patient Charges section of this booklet. Broken appointment fees will be waived in exigent circumstances (e.g., emergency hospitalization of Member).

You may contact MDC's Member Services Department at 1-800-273-3330 to request the Network General Dentist booklet.

B425.1040

Option F

Emergency Dental Services

The Network also provides for Emergency Dental Services 24 hours a day, 7 days a week, to all Members. A Member should contact his or her PCD, who will arrange for such care.

A Member may require Emergency Dental Services when he or she is unable to obtain services from his or her PCD. The Member should contact his or her PCD for a referral to another Dentist or contact Us for an authorization to obtain services from another Dentist. If Emergency Dental Services are performed by a Contracted General Dentist, We will reimburse the Member for the cost of covered Emergency Dental Services, less the applicable Patient Charge(s). If Emergency Dental Services are performed by a Non-Contracted specialist Dentist, the Member will be responsible for the Dentist's usual fee.

Members must submit, to Us, the following information within 60 days or as soon as reasonably possible:

- A copy of the Dentist statement for the emergency services.
- Evidence of payment.
- A brief explanation of the emergency.

When Emergency Dental Services are provided by a Dentist other than the Member's assigned PCD, and without referral by the PCD or authorization by Us, coverage is limited to the benefit for a palliative treatment (code D9110).

B425.0092

Option F

Out-of-Area Emergency Dental Services

If You are out of the area, and Emergency Dental Services are required, You should seek palliative treatment from a Dentist. You must file a claim within 180 days of service. You must present a detailed statement from the treating Dentist, which lists the services provided. MDC will reimburse you within 30 days for any covered Emergency Dental Services, less applicable Patient Charges, up to \$50 per incident. This paperwork should be submitted to the address listed on page 1.

Timely Access to Care

Covered dental services must be provided in a timely manner appropriate with the nature of Your condition consistent with good professional dental practice.

Managed Dental Care's network has adequate capacity and availability of Contracted Dentists to offer appointments for covered dental services in accordance with the following Timely Access to Care requirements:

- Urgent appointments to be offered within 72 hours of the time of request for an appointment when consistent with the nature of Your condition and as required by professionally recognized standards of dental practice.
- Non-urgent appointments (initial/routine) to be offered within 36 business days of the request for an appointment.
- Preventive dental care appointments to be offered within 40 business days of the request for an appointment.

The Timely Access to Care appointment wait time standards may not apply if You are requesting a specific date and time. The applicable waiting time for a particular appointment may also be longer if the referring or treating Dentist, acting within the scope of the Dentist's practice and consistent with professionally recognized standards of dental practice, has determined and noted in the relevant record that a longer waiting time will not have a detrimental impact on Your health.

When it is necessary for Your Dentist or You to reschedule an appointment, the appointment will be promptly rescheduled by Your Dentist in a manner that is:

- Appropriate for Your dental care needs;
- Ensures continuity of care consistent with good professional dental practices; and
- Meets California's standards regarding the accessibility of dental services in a timely manner.

Language and interpreter services are available for You at no cost. Interpreter services, if requested, must be coordinated with scheduled appointments in a manner that ensures interpreter services are provided at the time of the appointment, consistent with California standards, without imposing a delay in scheduling.

Contracted Dentists are required to have an answering service or a telephone answering machine during non-business hours. Their message must provide instructions regarding how You may obtain urgent or emergency care, including how to contact another Dentist who has agreed to be on-call to triage or screen by phone, or, if needed, deliver urgent or emergency care. If the Contracted Dentist does not answer and You have an emergency, You may call 911 or go to the nearest hospital. Emergency/urgent services may be received by any Dentist.

Telephone triage or screening services are to be provided in a timely manner appropriate for Your condition. During normal business hours, the waiting time for You to speak by telephone with a knowledgeable and competent customer service representative regarding Your questions and concerns will not exceed 10 minutes.

If You have any questions or want to request an interpreter, please call Managed Dental Care's Customer Response Unit at 1-800-273-3330.

B425.1031

Option F

Continuity of Care - Terminated Dentist

The Member may request for the continuation of covered services to be rendered by a terminated Contracted Dentist when the Member is undergoing treatment from a terminated Dentist for an acute condition or serious chronic condition, performance of surgery or other procedure authorized by MDC as part of a documented course of treatment that is to occur within 180 days of the contract termination date for current Members or 180 days from the effective date for newly covered Members. This includes completion of covered services for newborn children between birth and age 36 months for 12 months from the termination date of the Contracted Dentist's Agreement or 12 months from the effective date of coverage for newly covered Members.

This provision does not apply to Contracted Dentists who voluntarily leave the plan. The Member must make the request in writing and send to:

Managed Dental Care of California
Quality Management Department
605 E. Holland Avenue, Suite 300
Spokane, WA 99218

Or contact MDC's customer services department at 1-800-273-3330 during normal business hours. The terminating Dentist must accept the contracted rate for that Member's treatment and agree not to seek payment from the Member for any amounts for which the Member would not be responsible if the Dentist were still in the network. The approval of the request to continue Member's treatment will be at the discretion of the Dental Director. MDC is not required to provide benefits that are not otherwise covered under the terms and conditions of the group contract. In the event the terminating Dentist or Member wishes to appeal an adverse decision, the Peer Review Committee will review the request and make the final determination.

This provision will not apply to any terminated Dentist for reasons relating to a disciplinary cause or reason, as defined in paragraph (6) of subdivision (a) of Section 805 of the Business and Professional Code, or fraud or other criminal activity.

B425.1032

Option F

Continuity of Care - Non-Contracted Dentist

The Member, including a newly covered Member, may request for the continuation of covered services to be rendered by the Non-Contracted Dentist when the Member is undergoing treatment from the Non-Contracted Dentist for an acute condition, serious chronic condition, performance of surgery, or other procedure authorized by MDC as part of a documented course of treatment that is to occur within 180 days. This includes completion of covered services for newborn children between birth and age 36 months for 12 months from the termination date of the Non-Contracted Dentist's Agreement or 12 months from the Effective Date of coverage for newly covered Members. The Member must make the request in writing and send to:

Managed Dental Care of California
Quality Management Department
605 E. Holland Avenue, Suite 300
Spokane, WA 99218

Or contact MDC's customer services department at 1-800-273-3330 during normal business hours. MDC may obtain copies of the Member's dental records from the Member's Dentist in order to evaluate the request. The Dental Director (or his/her designee) will determine if the Member is eligible for continuation of care under this Policy and the California Knox-Keene Act.

The Dental Director's decision shall be consistent with professionally recognized standards of practice. The Dental Director shall consider:

1. Whether one of the circumstances described above exists;
2. Whether the requested services are covered by Policy; and
3. The potential clinical effect that a change of Dentist would have on the Member's treatment.

B425.1033

Option F

Extended Dental Benefits

If a Member's coverage ends, We extend dental expense benefits for him or her under this Policy. We extend benefits for covered services other than orthodontic services only if the procedures are started before the Member's coverage ends and are completed within 90 days after the date his or her coverage ends.

- Inlays, onlays, crowns and bridges are started on the date the tooth or teeth are initially prepared.
- Dentures are started on the date the impressions are taken.
- Root canals are started on the date the pulp chamber is opened.

Coverage for orthodontic services ends upon the termination of the Member's coverage under this Policy.

The extension of benefits ends 90 days after the Member's coverage ends or the date he or she becomes covered under another plan which provides coverage for similar dental procedures, whichever occurs first. But, if the plan which succeeds this Policy excludes the above services through the use of an elimination period, then the extension of benefits will end 90 days after the Member's coverage ends.

We don't grant an extension if the Member voluntarily terminates his or her coverage. And what We pay is based on all the terms of this Policy.

B425.0093

COORDINATION OF BENEFITS (COB)

A Member may have dental coverage through multiple plans. When that occurs, one plan is determined to be primary while the other is deemed to be secondary.

Rules to make the primary/secondary determination are:

- The plan without a coordination provision is always primary.
- If a medical plan provides coverage for the dental service, that plan is primary. This excludes Affordable Care Act (ACA) compliant plans.
- If both plans have a COB provision, the plan providing coverage to an Employee is primary.
- A plan that provides coverage for an active Employee will be primary over a retiree plan.
- If a child is covered under both parents' plans:
 - When the parents are living together, the plan of the parent whose birthday is earlier in the year is primary.
 - When the parents are separated and not living together:
 - Any applicable court order will apply.
 - With 50/50 custody situations, the plan of the parent whose birthday is earlier in the year is primary.
 - With no court order benefits will be coordinated in the following order; (1) natural parent with custody; (2) step parent with custody; (3) natural parent without custody; and (4) step parent without custody.
- When none of these rules apply, the plan that has provided coverage the longest is primary.

When We are primary, benefits are determined as if no other plan exists.

B425.0096

Option F

Coordination with a Pre-Paid Dental Plan

A Member may also be covered under another pre-paid dental plan where they pay a fixed payment amount for each covered service. When the PCD participates under both pre-paid plans, the Member will never be responsible for more than the Patient Charge.

For Contracted Specialists' services, when this Policy is secondary, any payment made by the primary carrier is credited against the Patient Charge. In many cases the Member will have no out-of-pocket expenses.

B425.0097

Option F

Coordination with a PPO Dental Plan

When a Member is covered by this Policy and a fee-for-service plan, the following rules will apply:

- For PCD services: If this Policy is the primary plan, the PCD submits a claim to the secondary plan for the Patient Charge amount. Any payment made by the secondary carrier must be deducted from the Member's Patient Charge.
- For PCD services: If this Policy is the secondary plan, the PCD submits a claim to the primary plan for his or her usual or contracted fee. The primary plan's payment is then credited against the Patient Charge, reducing the Member's out-of-pocket expense.
- For Contracted Specialist services: If this Policy is the primary plan, benefits are paid as usual.
- For Contracted Specialist services: If this Policy is the secondary plan, any payment made by the primary carrier is credited against the Patient Charge, reducing the Member's out-of-pocket expense.

B425.0098

Our Right to Certain Information

In order to coordinate benefits, We need certain information. A Member must supply Us with as much information as he or she can. If he or she can't give Us all the information needed, We have the right to request this information from any source. If another carrier needs information to apply its coordination provision, We have the right to give that carrier such information. If We give or get information, We can't be held liable for such action except as required by law.

When payments that should have been made by this Policy have been made by another plan, We have the right to repay that plan. If We do so, We are no longer liable for that amount. If We pay out more than We should have, We have the right to recover the excess payment.

B425.0099

GRIEVANCE PROCESS

Member grievances are to be submitted to MDC's Quality of Care Liaison ("QCL") who processes the grievances. The QCL can be contacted at 1-800-273-3330 or by mail to P.O. Box 2474, Spokane, WA 99210-2472. The QCL hours are from 8:00 a.m. to 5:00 p.m. Pacific Time. Grievances may also be submitted on Our website at www.manageddentalcare.net.

The grievance process is designed to address Member concerns quickly and satisfactorily. It is generally recognized that grievances may be classified into two categories:

- Administrative Services: financial, accounting, procedural matters, coverage information such as effective dates, explanations of policy and Evidence of Coverage, claims, benefits and coverage, or benefit terms and definitions.
- Health Services: quality of care, access, availability, standards of care, appeal of denied second opinion requests, appeals of Specialty Referral decisions, professional and ethical considerations.

A grievance means any dissatisfaction expressed by a Member, orally or in writing, regarding MDC's operation, including but not limited, to Policy administration, denial of access to a specialty referral as services are covered at the general Dentist office, a determination that a procedure is not covered under the contract, an appeal of a denied second opinion request, the denial, reduction, or termination of a service, the way a service is provided, or disenrollment decisions. A grievance related to the denial of specialty care services for the lack of medical necessity will be handled by the grievance process. Where MDC cannot distinguish between an inquiry and a grievance, it shall be considered a grievance.

A grievance and a complaint are one and the same.

Coverage dispute means that a Member is not provided a covered service as a Policy benefit.

In order to be responsive to Member problems and concerns about coverage provided by MDC, the following grievance procedures have been established:

1. Questions or concerns may be directed to MDC either by telephone or by mail by the Member or Member's Designee ("Member"). When Member inquiries are received by telephone, the customer services representative documents the call and works with the Member to resolve the issue. If the issue is as an inquiry or complaint and is not a coverage dispute, a disputed dental care service involving medical necessity or experimental or investigational treatment, and that is resolved by the next business day following receipt, it may be handled by the customer services department. All other issues that are grievances will be documented on a grievance form by the customer services representative on behalf of the Member and the grievance form will be forwarded to the Quality of Care Liaison or Designee (QCL). The Member may be sent a grievance form to complete, if requested.

When a Member who files a grievance or wants to file a grievance has a language barrier, cultural need or disability that requires special assistance, the Member Services Department will work with the QCL and provide accommodation, according to MDC guidelines.

2. Assistance in filing grievances shall be provided at each dental office as well as by MDC. Each dental office has a grievance form and a description of the grievance process readily available and will provide the form promptly upon request. The dental office will submit the grievance form to MDC at the Member's request.
3. Members may file a grievance up to 180 calendar days following any incident or action that is the subject of the dissatisfaction. In the case of a grievance alleging that the Member's coverage has been or will be improperly cancelled, rescinded, or not renewed, the 180 days begins on the date indicated on the Notice of Cancellation, Rescission, or Nonrenewal.
4. No later than five (5) calendar days after receipt of the grievance, or three (3) calendar days for grievances received via the MDC website, an acknowledgment letter is sent to the Member indicating the date the grievance was received, the name and telephone number of the QCL that a review is taking place and the grievance will be responded to within 30 days from the date of MDC's receipt of the grievance in a resolution letter.
5. Under the supervision of the QCL, supporting documentation is collected on the issue. The dental office may be requested to provide additional information, such as copies of all relevant dental records and radiographs, and statements of the Dentist or office personnel. MDC may arrange a second opinion, if appropriate.

6. Upon receipt of complete documentation, a resolution is determined based upon objective evaluation. A resolution letter will be sent to the Member within 30 calendar days from the date of MDC's receipt of the grievance. Quality of care issues or potential quality of care issues are resolved under the supervision of the Dental Director or designee (Dental Director). Issues of a complex nature and/or quality of care issues, at the discretion of the Dental Director, may be presented to the Grievance Committee or Peer Review Committee for review and resolution.

The Dental Director reviews all quality of care or potential quality of care grievances at least biweekly and reviews and approves all letters of resolution that are sent to Members. The Dental Director will indicate his/her review of available documentation by initialing a copy of the resolution letter.

The resolution letter to the Member will detail in a clear, concise manner the reasons for MDC's response. For grievances involving the delay, denial or modification of dental care services, the response letter shall describe the criteria used and the clinical reasons for its decision, including all criteria and clinical reasons related to medical necessity. If MDC, or one of its clinical reviewers, issues a determination delaying, denying or modifying dental care services based in whole or in part on a finding that the proposed dental care services are not a covered benefit under the Policy that applies to the Member, the letter shall clearly specify the provisions in the Policy that exclude that coverage. In the event that an MDC grievance involves the delay, modification or denial of a covered service due to medical necessity, the resolution letter will include an IMR application and a Department of Managed Health Care addressed envelope.

B425.1034

Option F

7. Within thirty (30) calendar days following receipt of a resolution letter, a Member, or Member's Designee, may also request voluntary mediation with MDC prior to exercising the right to submit a grievance to the Department of Managed Health Care. Additional time may be requested due to a Member's extraordinary circumstance. The use of mediation services shall not preclude the right to submit a grievance to the Department of Managed Health Care. In order to initiate mediation, the Member or the Member's Designee and MDC shall voluntarily agree to mediation. Expenses for mediation shall be borne equally by both sides. The Department of Managed Health Care shall have no administrative or enforcement responsibilities in connection with the voluntary mediation process authorized by this paragraph.

Following the use of the voluntary mediation process, the Member and MDC each have the right to use the legal system or arbitration for any claim involving the professional treatment performed by a Dentist.

8. A grievance may be submitted to the Department of Managed Health Care for review and resolution prior to any arbitration.

9. 9.Members shall not be required to complete the grievance process, or participate in the process for at least thirty (30) calendar days before submitting a complaint to the Department of Managed Health Care in any case determined by the Department of Managed Health Care to be a case involving an imminent and serious threat to the health of the patient, including but not limited to severe pain, the potential loss of life, limb or major bodily function; for any case involving cancellation, rescission, or nonrenewal of coverage; or in any other case where the Department of Managed Health Care determines that an earlier review is warranted.
10. MDC shall keep all copies of grievances, and the responses to grievances, for a period of five years.
11. MDC's Secretary, who is an officer of the plan, or designee, has primary responsibility for MDC's grievance system.
12. A written record of office specific and aggregate tabulated grievances will be maintained for each grievance received by MDC and that record will be reviewed quarterly by the Dental Director, the Quality Assurance Committee, the Public Policy Committee and the Board of Directors.
13. MDC asserts that there is no discrimination against a Member (including cancellation of the contract) solely on the grounds that the Member filed a complaint.

The Department of Managed Health Care may contact MDC's Quality Management Staff regarding urgent grievances every business day from 8:00 am to 5:00 pm by calling 1-800-273-3330. For urgent grievances received from the Department of Managed Health Care during business hours, MDC will respond within 30 minutes. For urgent grievances after business hours, The Department of Managed Health Care should contact MDC's staff in the following order:

14. Dental Director/Plan Officer Responsible for Grievances at 1-310-908-1917, Quality of Care Liaison at 1-818-437-4177, and President at 1-207-210-8727. For urgent grievance calls received after hours, the above listed personnel will respond to the Department of Managed Health Care within one (1) hour after initial contact. Within one (1) business day of receipt of the Department of Managed Health Care's notice of acceptance of a proper complaint related to the cancellation, rescission, or nonrenewal of a Member's coverage, MDC shall respond and provide the Department of Managed Health Care with a copy of all information MDC used to make its termination of coverage determination and all other relevant information necessary for the Department of Managed Health Care's review.

Grievances Requiring Expedited Review

MDC will review grievances on an expedited basis when the grievances involve an imminent and serious threat to the health of the Member, including, but not limited to, severe pain, potential loss of life, limb, or major bodily function. They may also include, but are not limited to, procedures administered in a hospital, Dentist's office, dental clinic, or other comparable facility, to evaluate and stabilize dental conditions of a recent onset and severity accompanied by excessive bleeding, severe pain, acute infection, fever, swelling or to prevent the imminent loss of teeth that would lead a prudent layperson possessing an average knowledge of dentistry to believe that immediate care is needed and which are covered under the Policy.

MDC shall also conduct expedited review of grievances concerning the cancellation, rescission, or nonrenewal of coverage.

When MDC has notice of a grievance requiring expedited review, the grievance process requires MDC to immediately inform Members in writing of their right to notify the Department of Managed Health Care of the grievance. MDC also will provide Members and the Department of Managed Health Care with a written statement on the disposition or pending status of the grievance no later than three days from receipt of the grievance. MDC shall consider the Member's medical condition when determining the response time for an expedited grievance.

If the Member files a grievance before the effective date of a cancellation, rescission, or nonrenewal, for reasons other than nonpayment of premiums, MDC shall continue to provide coverage to the Member pursuant to the terms of the Member's Policy while the grievance is pending with MDC and/or the Department of Managed Health Care.

The following grievance disclosure will be on all Member correspondence:

Disclosure:

With respect to certain actions that impact You and Your coverage, Managed Dental Care or Your Employer will provide You with notice:

- When premium has not been paid and Your coverage is in force due solely to the Policy's Grace Period;
- When this Policy or Your coverage under this Policy is rescinded due to certain contractual provisions; or
- When this Policy is terminated for any other reason as may be allowed by the Policy.

The California Department of Managed Health Care is responsible for regulating health care service plans. If you have a grievance against your health plan, you should first telephone your health plan at **1-800-273-3330** and use your health plan's grievance process before contacting the department. Utilizing this grievance procedure does not prohibit any potential legal rights or remedies that may be available to you. If you need help with a grievance involving an emergency, a grievance that has not been satisfactorily resolved by your health plan, or a grievance that has remained unresolved for more than 30 days, you may call the department for assistance. You may also be eligible for an Independent Medical Review (IMR). If you are eligible for IMR, the IMR process will provide an impartial review of medical decisions made by a health plan related to the medical necessity of a proposed service or treatment, coverage decisions for treatments that are experimental or investigational in nature and payment disputes for emergency or urgent medical services. The department also has a toll-free telephone number **(1-888-466-2219)** and a TDD line **(1-877-688-9891)** for the hearing and speech impaired. The department's internet website **www.dmhca.ca.gov** has complaint forms, IMR application forms, and instructions online.

You may also access grievance forms at Managed Dental Care's website at **www.manageddentalcare.net**. Click on the "GRIEVANCE FORM" Portal box or may be obtained by contacting MDC's Customer Care Team at (800) 273- 3330 .

Note: Free language assistance services are available for You and Your dependents to assist with Your dental needs. Please contact Managed Dental Care's Member Services Department at 1-800-273-3330, Your assigned network general dentist or Your network specialist (for Managed Dental Care's approved specialty care) if English is not Your or Your dependents preferred spoken or written language.

Nota: Los servicios gratuitos de ayuda con el idioma están disponibles para usted y sus dependientes para ayudarle con sus necesidades dentales. Si el inglés no es el idioma preferido de usted o sus dependientes, por favor comuníquese a nuestro Departamento de Servicios para Miembros al 1-800-273- 3330, su dentista general de red asignada o su especialista de red (para una atención especializada de Managed Dental Care).

B425.1036

Option F

Covered Services

MDC covers diagnostic, preventive, restorative, endodontic, periodontic, removable prosthodontics, fixed prosthodontics, oral surgery, orthodontics and adjunctive general as well as specialist and Emergency Dental Services. Covered services will be provided as necessary for a Member's dental health consistent with professionally recognized standards of practice, subject to the limitations and exclusions described in connection with each category of covered services.

Covered services include:

DIAGNOSTIC

- Clinical Oral Evaluations
- Radiographs (X-rays)
- Tests and Examinations

* A complete list of covered diagnostic services is listed in the Schedule of Benefits.

PREVENTIVE

- Prophylaxis (cleaning)
- Topical Fluoride
- Space Maintainers

* A complete list of covered preventive services is listed in the Schedule of Benefits.

RESTORATIVE

- Amalgam (silver fillings)
- Resin Based Composite (white fillings)
- Inlays
- Onlays
- Crowns
- Other Restorative Services

* A complete list of covered restorative services is listed in the Schedule of Benefits.

ENDODONTICS

- Pulp Capping
- Pulpotomy
- Endodontic Therapy (root canals)
- Endodontic Retreatment
- Apicoectomy/Periradicular Services

* A complete list of covered endodontic services is listed in the Schedule of Benefits.

PERIODONTICS

- Surgical Services
- Non-Surgical Services

* A complete list of covered periodontic services is listed in the Schedule of Benefits.

PROSTHODONTICS (Removable)

- Complete Dentures
- Partial Dentures
- Adjustments to Dentures
- Repairs
- Rebase
- Reline

* A complete list of covered prosthodontics (removable) services is listed in the Schedule of Benefits.

IMPLANT SERVICES

- Abutment Supported
- Implant/Abutment Supported Removable Dentures
- Implant/Abutment Supported Fixed Dentures
- Abutment Supported Retainers

* A complete list of covered implant services is listed in the Schedule of Benefits

PROSTHODONTICS (Fixed)

- Fixed Partial Denture Pontics
- Fixed Partial Denture Retainers - Crowns

* A complete list of covered prosthodontics (fixed) services is listed in the Schedule of Benefits.

Note: Treatment which requires the services of a Prosthodontist are not covered.

ORAL SURGERY

- Surgical Extractions
- Other Surgical Procedures
- Alveoloplasty
- Surgical Excision of Intra-Osseous Lesions
- Surgical Incision

* A complete list of covered oral surgery services is listed in the Schedule of Benefits.

ORTHODONTICS

- Orthodontic Treatment

* A complete list of covered orthodontic services is listed in the Schedule of Benefits.

ADJUNCTIVE GENERAL SERVICES

- Palliative Treatment
- Professional Consultations
- Professional Visits

* A complete list of covered adjunctive general services is listed in the Schedule of Benefits.

A list of the services covered by this Policy, including Patient Charges is provided in the section Schedule of Benefits.

Exclusions and limitations will apply to some of the services. Refer to the Benefit Limitations, Additional Conditions and Exclusions sections of the Schedule of Benefits.

B425.1037

Option F

DEFINITIONS

This section defines certain terms appearing in Your Evidence of Coverage.

B425.0712

Option F

Act: This term means the Knox-Keene Health Care Service Plan of 1975 (California Health and Safety Code Sections 1340 et seq).

B425.0713

Option F

Active Work or Actively At Work or Actively Working: These terms mean You are able to perform, and are performing, all of the regular duties of Your work for the Employer, at:

- One of the Employer's usual places of business;
- Some place where the Employer's business requires You to travel; or
- Any other place You and the Employer have agreed on for Your work.

B425.0102

Option F

Alternative Procedure: This term means a procedure other than that recommended by the Member's Primary Care Dentist, but which in the opinion of the Primary Care Dentist also represents an acceptable treatment approach for the Member's dental condition.

B425.0103

Option F

Code: This term means the California Health and Safety Code.

B425.0714

Option F

Combined Evidence of Coverage and Disclosure Form: This term means this booklet issued to You, which summarizes the essential terms of this Policy.

B425.0724

Option F

Contracted Dentist: This term means a licensed Dentist or a dental care facility that is under contract with Us to participate in Our dental Network.

B425.0105

Option F

Contracted General Dentist: This term means a licensed dentist under contract with Us who is listed in Our directory of Contracted Dentists as a general practice dentist and who may be selected as a Primary Care Dentist by a Member.

B425.0106

Option F

Contracted Specialist: This term means a licensed Dentist under contract with Us as an endodontist, oral surgeon, orthodontist, pediatric dentist or periodontist.

B425.0107

Option F

Dentist and Dentists: This term means any dental or medical practitioner We are required by law to recognize who: (1) is properly licensed or certified under the laws of the state where he or she practices; and (2) provides services which are within the scope of his or her license or Evidence of Coverage and covered by this Policy.

B425.0715

Option F

Effective Date: This term means the date the Policy goes into force and effect as stated on the cover page of the Evidence of Coverage of Coverage, or any change to the Policy as requested by the Employer and approved by Us and in force and effect as stated on cover page of the Evidence of Coverage of Coverage.

B425.0717

Option F

Eligibility Date: This term means the earliest date You are eligible for coverage under this Evidence of Coverage as directed by the Employer, and you have satisfied all requirements for coverage to begin, as required by this Evidence of Coverage.

B425.0719

Option F

Emergency Dental Service: This term means services which are reasonably necessary to relieve the sudden onset of severe pain, fever, swelling, serious bleeding or severe discomfort or to prevent the imminent loss of teeth.

B425.0113

Option F

Evidence of Coverage: This term means this certificate of coverage, including the Schedule of Benefits and any riders and enrollment forms that may be attached to this Evidence of Coverage.

B425.0720

Option F

Full-time: This term means:

You are not a Part-time Employee as defined by Your Employer and You work at least the minimum required number of hours for the Employee in Your eligible class (but not less than 30 hours per week) at:

- Your Employer's place of business; or
- Some place where the Employer's business requires You to travel; or
- Any other place You and Your Employer have agreed upon for the performance of Your job.

B425.0116

Option F

Member: This term means You, if You are covered by this Policy, and any of Your covered dependents.

B425.0118

Option F

Network: This term means The Managed Dental Care network.

B425.0120

Option F

Non-Contracted Dentist: This term means a licensed Dentist or dental care facility that is not under contract with Us to provide dental services to Employees in Our benefit Policy.

B425.0122

Option F

Patient Charge: This term means the amount the Member is responsible for. Patient Charge amounts are listed under the Covered Dental Procedures and Patient Charges section of the Schedule of Benefits.

B425.0123

Option F

Policy: This term means the Group Dental Coverage described in the Policy and this Evidence of Coverage.

B425.0721

Option F

Policyholder: This term means an Employer that is offering benefits to a Member under this Policy.

B425.0125

Option F

Primary Care Dentist (PCD): This term means a Contracted General Dentist selected by a Member who is responsible for providing or arranging for a Member's dental services.

B425.0126

Option F

Prior Carrier's Group Dental Policy: This term means the Employer's Policy of group dental coverage which was in force immediately prior to this Policy. For a Policy to be considered a Prior Policy, the Policy with Us must start immediately after the prior coverage ends.

B425.0128

Option F

Qualifying Event: This term means a specific occurrence that changes a Member's eligibility status such as Your Spouse's loss of employment; Your Spouse's loss of eligibility under his or her dental Policy; divorce; death of Your Spouse; termination of another dental Policy; or any other event as required by state or federal law or in accordance with Your Employer's rules.

B425.0130

Option F

Service Area: This term means the geographic area in which We have arranged to provide for dental services for Members.

B425.0131

Option F

Spouse: This term means the person to whom You are legally married, or Your domestic partner, civil union partner or equivalent as recognized and allowed by federal law, state law or local law in Your state of residence or the state in which the marriage or Your domestic partner, civil union partner or equivalent was recorded.

B425.1050

Option F

We, Us, Our and MDC: These terms mean Managed Dental Care of California.

You or Your or Yourself: These terms mean the covered Employee.

B425.0723

STATEMENT OF ERISA RIGHTS

The Guardian Life Insurance Company of America

*10 Hudson Yards
New York, New York 10001
(212) 598-8000*

Your group Dental benefits may be covered by the Employee Retirement Income Security Act of 1974 (ERISA). If so, you are entitled to certain rights and protections under ERISA.

ERISA provides that all plan participants shall be entitled to:

**Receive Information
About Your Plan
and Benefits**

- (a) Examine, without charge, at the plan administrator's office and at other specified locations, such as worksites and union halls, all documents governing the plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the plan with the U. S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.
- (b) Obtain, upon written request to the plan administrator, copies of documents governing the operation of the plan, including insurance contracts, collective bargaining agreements and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The administrator may make a reasonable charge for the copies.
- (c) Receive a summary of the plan's annual financial report. The plan administrator is required by law to furnish each participant with a copy of this summary annual report.

**Prudent Actions By
Plan Fiduciaries**

In addition to creating rights for plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate the plan, called "fiduciaries" of the plan, have a duty to do so prudently and in the interest of plan participants and beneficiaries. No one, including your employer, your union, or any other person may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

**Enforcement Of
Your Rights**

If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules (see Claims Procedures below).

Statement of Erisa Rights (Cont.)

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report from the plan and do not receive them within 30 days, you may file suit in a state or Federal court. In such a case, the court may require the plan administrator to provide the materials and pay you up to \$110.00 a day until you receive the material, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a federal court. If it should happen that plan fiduciaries misuse the plan's money or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds that your claim is frivolous.

Assistance with Questions

If you have questions about the plan, you should contact the plan administrator. If you have questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the plan administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor listed in your telephone directory or the Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

Qualified Medical Child Support Order and Qualified Domestic Relations Order

Federal law requires that group health plans provide medical care coverage of a dependent child pursuant to a qualified medical child support order (QMCSO). A dependent child also includes a child for whom You must provide Dental Insurance due to a QMCSO as defined in the ERISA Section 609(a) United States Employee Retirement Income Security Act of 1974, as amended.

You and your beneficiaries can obtain, without charge, from the plan administrator, a copy of any procedures governing Qualified Domestic Relations Orders (QDRO) and QMCSO. You may also obtain this information on the U.S. Department of Labor's website or You may contact them in your telephone directory.

A dependent enrolled due to a QMCSO will not be considered a late enrollee in the plan.

If you have questions about this section, see your plan administrator.

Statement of Erisa Rights (Cont.)

Dental Benefits
Claims Procedure Claim forms and instructions for filing claims may be obtained from The Guardian Life Insurance Company of America (hereinafter referenced as Guardian).

Guardian is the Claims Fiduciary with discretionary authority to interpret and construe the terms of the Policy, the Certificate, the Schedule of Benefits, and any riders, or other documents or forms that may be attached to the Certificate or the Policy, and any other plan documents. Guardian has discretionary authority to determine eligibility for benefits and coverage under those documents. Guardian has the right to secure independent professional healthcare advice and to require such other evidence as needed to decide your claim.

In addition to the basic claim procedure explained in your certificate, Guardian will also observe the procedures listed below. These procedures are the minimum requirements for benefit claims procedures of employee benefit plans covered by Title 1 of ERISA.

B425.0167

Option F

Definitions "Adverse Benefit Determination" means any denial, reduction or termination of a benefit or failure to provide or make payment (in whole or in part) for a benefit.

Timing For Initial Benefit Determination The Benefit Determination period begins when a claim is received. Guardian will make a Benefit Determination and notify a claimant within a reasonable period of time, but not later than the maximum time period shown below. A written or electronic notification of any adverse Benefit Determination must be provided.

Guardian will provide a Benefit Determination not later than 45 days from the date of receipt of a claim. This period may be extended by up to 30 days if Guardian determines that an extension is necessary due to matters beyond the control of the plan, and so notifies the claimant before the end of the initial 45-day period. Such notification will include the reason for the extension and a date by which the determination will be made. If prior to the end of the 30-day period Guardian determines that an additional extension is necessary due to matters beyond the control of the plan, and so notifies the claimant, the time period for making a Benefit Determination may be extended for up to an additional period of up to 30 days. Such notification will include the special circumstances requiring the extension and a date by which the final determination will be made.

A notification of an extension to the time period in which a Benefit Determination will be made will include an explanation of the standards upon which entitlement to a benefit is based, any unresolved issues that prevent a decision of the claim, and the additional information needed to resolve those issues.

If Guardian extends the time period for making a Benefit Determination due to a claimant's failure to submit information necessary to decide the claim, the claimant will be given at least 45 days to provide the requested information. The extension period will begin on the date on which the claimant responds to the request for additional information.

Adverse Benefit Determination

If a claim is denied, Guardian will provide a notice that will set forth:

- The specific reason(s) for the Adverse Benefit Determination;
- References to the specific provisions in the Policy, Certificate, plan or other documents, on which the determination is based;
- A description of any additional material or information necessary to reconsider the claim and an explanation of why such material or information is necessary;
- A description of the plan's claim review procedures which a claimant may follow to have a claim for benefits reviewed and the time limits applicable to such procedures;
- Identification and description of any specific internal rule, guideline or protocol that was relied upon in making an Adverse Benefit Determination, or a statement that a copy of such information will be provided to the claimant free of charge upon request;
- A description of the plan's review procedures and the time limits applicable to such procedures, including a statement of the claimant's right to bring a civil action under ERISA Section 502(a) following an Adverse Benefit Determination on appeal, and;
- In the case of an Adverse Benefit Determination based on medical necessity or experimental treatment, either an explanation of the scientific or clinical basis for the determination, or a statement that such explanation will be provided free of charge upon request.

Appeal of Adverse Benefit Determinations

If a claim is wholly or partially denied, the claimant will have up to 180 days to make an appeal. Guardian will conduct a full and fair review of an appeal which includes providing to claimant(s) the following:

- The opportunity to submit written comments, documents, records and other information relating to the claim;
- The opportunity, upon request and free of charge, for reasonable access to, and copies of, all documents, records and other information relating to the claim; and
- A review that takes into account all comments, documents, records and other information submitted by the claimant relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination.

In reviewing an appeal, Guardian will:

- Provide for a review conducted by a named fiduciary who is neither the person who made the initial Adverse Benefit Determination nor that person's subordinate;

- In deciding an appeal based upon a dental or medical judgment, consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment;
- Identify dental or medical experts whose advice was obtained in connection with an Adverse Benefit Determination; and
- Ensure that a health care professional engaged for consultation regarding an appeal based upon a professional judgment shall be neither the person who was consulted in connection with the Adverse Benefit Determination, nor that person's subordinate.

Guardian will notify the claimant of its decision not later than 45 days after receipt of the request for review of the Adverse Benefit Determination. This period may be extended by an additional period of up to 45 days if Guardian determines that special circumstances require an extension of the time period for processing and so notifies the claimant before the end of the initial 45-day period.

A notification with respect to an extension will indicate the special circumstances requiring an extension of the time period for review, and the date by which the final determination will be made.

In the event Guardian denies the appeal of an Adverse Benefit Determination, it will:

- Provide the specific reason or reasons why the appeal was denied;
- Refer to the specific provisions in the Policy, Certificate, plan, or other documents on which the benefit determination is based;
- Provide a statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claimant's claim for benefits;
- If applicable, provide the internal rule, guideline, protocol, or other similar criterion relied upon in making the Adverse Benefit Determination, either the specific rule, guideline, protocol, or other similar criterion; or a statement that such rule, guideline, protocol, or other similar criterion was relied upon in making the Adverse Benefit Determination and that a copy of the rule, guideline, protocol, or other similar criterion will be provided free of charge to the claimant upon request.

Alternative Dispute Options The claimant and the plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact the local U.S Department of Labor Office and the State insurance regulatory agency.

B425.0168

Option F

Managed Dental Care of California
605 E. Holland Avenue, Suite 300
Spokane, WA 99218
1-800-273-3330

GROUP DENTAL COVERAGE

SCHEDULE OF BENEFITS

The Schedule of Benefits provides dental benefit information. This schedule lists the procedures covered by this Policy, as well as the Patient Charges, Benefit Limitations, Additional Conditions and the Exclusions. Please read the entire Certificate of Coverage, along with this Schedule of Benefits, to fully understand all the terms, conditions, limitations and exclusions that apply.

B425.1051

Option F

COVERED DENTAL PROCEDURES AND PATIENT CHARGES - N500

The procedures covered by the Policy are named in this list. If a procedure is not on this list, it is not covered. All procedures must be provided by the assigned Primary Care Dentist (PCD) or by referral to a Contracted Specialist.

A Member must pay the listed Patient Charge. The benefits We provide are subject to all of the terms of the Policy, including the Benefit Limitations, Additional Conditions and Exclusions.

A Member may be charged a Patient Charge for a missed appointment or a cancelled appointment if the dental office is not given at least 24 hours' notice of cancellation.

The Patient Charges listed are only valid for covered procedures that are: (1) started and completed under the Policy, and (2) rendered by Contracted Dentists.

B425.1052

Option F

COVERED DENTAL PROCEDURES AND PATIENT CHARGES - PLAN N500

CDT CODE Current Dental Terminology (CDT) © American Dental Association (ADA)

CDT CODE	COVERED DENTAL PROCEDURES	PATIENT CHARGE
D0100-D0999 DIAGNOSTICS		
D0999	Office visit during regular hours, General Dentist only	\$5
D0120	Periodic oral evaluation - established patient	\$0
D0140	Limited oral evaluation - problem focused	\$0
D0145	Oral evaluation for a patient under three years of age and counseling with primary caregiver	\$0
D0150	Comprehensive oral evaluation - new or established patient	\$0
D0160	Detailed and extensive oral evaluation - problem focused by report	\$0
D0170	Re-evaluation - limited, problem focused (established patient; not post-operative visit)	\$0
D0171	Re-evaluation - post-operative office visit	\$0
D0180	Comprehensive periodontal evaluation - new or established patient	\$0
D0190	Screening of a patient	\$0
D0191	Assessment of a patient	\$0
D0210	Intraoral - complete series of radiographic images	\$0
D0220	Intraoral - periapical first radiographic image	\$0
D0230	Intraoral - periapical each additional radiographic image	\$0
D0240	Intraoral - occlusal radiographic image	\$0
D0250	Extra-oral - 2D projection radiographic image created using a stationary radiation source, and detector	\$0
D0270	Bitewing - single radiographic image	\$0
D0272	Bitewings - two radiographic images	\$0
D0273	Bitewings - three radiographic images	\$0
D0274	Bitewings - four radiographic images	\$0
D0277	Vertical bitewings - 7 to 8 radiographic images	\$0
D0330	Panoramic radiographic image	\$0
D0340	2D cephalometric radiographic image - acquisition, measurement and analysis	\$0
D0350	2D oral/facial photographic image obtained intra-orally or extra-orally	\$0
D0364	Cone beam CT capture and interpretation with limited field of view - less than one whole jaw	Not Covered
D0365	Cone beam CT capture and interpretation with field of view of one full dental arch - mandible	Not Covered
D0366	Cone beam CT capture and interpretation with field of view of one full dental arch - maxilla, with or without cranium	Not Covered
D0367	Cone beam CT capture and interpretation with field of view of both jaws; with or without cranium	Not Covered

COVERED DENTAL PROCEDURES AND PATIENT CHARGES - PLAN N500 (Cont.)

D0415	Collection of microorganisms for culture and sensitivity	\$0
D0425	Caries susceptibility tests	\$0
D0431	Adjunctive pre-diagnostic test that aids in detection of mucosal abnormalities including premalignant and malignant lesions, not to include cytology or biopsy procedures	\$35
D0460	Pulp vitality tests	\$0
D0470	Diagnostic casts	\$0
D0472	Accession of tissue, gross examination, preparation and transmission of written report	\$0
D0473	Accession of tissue, gross and microscopic examination, preparation and transmission of written report	\$0
D0474	Accession of tissue, gross and microscopic examination, including assessment of surgical margins for presence of disease, preparation and transmission of written report	\$0
D0480	Accession of exfoliative cytologic smears, microscopic examination preparation and transmission of written report	\$0
D0486	Laboratory accession of transepithelial cytologic sample, microscopic examination preparation and transmission of written report	\$0
D0502	Other oral pathology procedures, by report	\$0
D1000-D1999 PREVENTIVE		
D1110	Prophylaxis - adult, for the first two procedures in any 12 month period	\$0
D1120	Prophylaxis - child, for the first two procedures in any 12 month period	\$0
D1999	Prophylaxis - adult or child, for each additional procedure in the same 12 month period (maximum of 2 additional in the same 12 month period)	\$35
M1110	Prophylaxis - One additional prophylaxis in any 12 month period will be covered at no charge for Members who: (a) are pregnant and in their 2nd or 3rd trimester; (b) have clinically demonstrable xerostomia (dry mouth) due to chemotherapy or radiation therapy for the treatment of cancer; or (c) are on dialysis.	\$0
D1206	Topical application of fluoride varnish, for the first two procedures in any 12 month period	\$0
D1208	Topical application of fluoride - excluding varnish, for the first two procedures in any 12 month period	\$0
D2999	Topical fluoride each additional procedure in same 12 month period . . .	\$20
D1310	Nutritional counseling for control of dental disease	\$0
D1320	Tobacco counseling for the control and prevention of oral disease	\$0
D1330	Oral hygiene instructions	\$0
D1351	Sealant - per tooth - molars	\$5
D9999	Sealant - per tooth - non-molars	\$35
D1352	Preventive resin restoration in a moderate to high caries risk patient - permanent tooth	\$5
D1353	Sealant repair - per tooth	\$0
D1510	Space maintainer - fixed - unilateral	\$35
D1515	Space maintainer - fixed - bilateral	\$65
D1520	Space maintainer - removable - unilateral	\$35
D1525	Space maintainer - removable - bilateral	\$65
D1550	Re-cement or re-bond space maintainer	\$6

COVERED DENTAL PROCEDURES AND PATIENT CHARGES - PLAN N500 (Cont.)

D1555 Removal of fixed space maintainer \$20

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D2000-D2999 RESTORATIVE

D2140 Amalgam - one surface, primary or permanent \$0
D2150 Amalgam - two surfaces, primary or permanent \$0
D2160 Amalgam - three surfaces, primary or permanent \$0
D2161 Amalgam - four or more surfaces, primary or permanent \$0
D2330 Resin-based composite - one surface, anterior \$5
D2331 Resin-based composite - two surfaces, anterior \$15
D2332 Resin-based composite - three surfaces, anterior \$20
D2335 Resin-based composite - four or more surfaces or involving incisal
angle, (anterior) \$30
D2390 Resin-based composite crown, anterior \$40
D2391 Resin-based composite - one surface, posterior \$15
D2392 Resin-based composite - two surfaces, posterior \$25
D2393 Resin-based composite - three surfaces, posterior \$30
D2394 Resin-based composite - four or more surfaces, posterior \$40
D2510 Inlay - metallic - one surface** \$110
D2520 Inlay - metallic - two surfaces ** \$150
D2530 Inlay - metallic - three or more surfaces** \$150
D2542 Onlay - metallic - two surfaces ** \$150
D2543 Onlay - metallic - three surfaces** \$160
D2544 Onlay - metallic - four or more surfaces** \$180
D2610 Inlay - porcelain/ceramic - one surface \$110
D2620 Inlay - porcelain/ceramic - two surfaces \$150
D2630 Inlay - porcelain/ceramic - three or more surfaces \$160
D2642 Onlay - porcelain/ceramic - two surfaces \$150
D2643 Onlay - porcelain/ceramic - three surfaces \$160
D2644 Onlay - porcelain/ceramic - four or more surfaces \$170
D2650 Inlay - resin-based composite - one surface \$150
D2651 Inlay - resin-based composite - two surfaces \$195
D2652 Inlay - resin-based composite - three or more surfaces \$220
D2662 Onlay - resin-based composite - two surfaces \$195
D2663 Onlay - resin-based composite - three surfaces \$220
D2664 Onlay - resin-based composite - four or more surfaces \$250
D2710 Crown - resin-based composite (indirect) \$150
D2712 Crown - 3/4 resin-based composite (indirect) \$150
D2720 Crown - resin with high noble metal** \$175
D2721 Crown - resin with predominantly base noble \$175
D2722 Crown - resin with noble metal \$175
D2740 Crown - porcelain/ceramic substrate \$225
D2750 Crown - porcelain fused to high noble metal** \$190
D2751 Crown - porcelain fused to predominantly base metal \$190
D2752 Crown - porcelain fused to noble metal \$190
D2780 Crown - 3/4 cast high noble metal** \$180
D2781 Crown - 3/4 cast predominantly base metal \$180
D2782 Crown - 3/4 cast noble metal \$180
D2783 Crown - 3/4 porcelain/ceramic \$180
D2790 Crown - full cast high noble metal** \$190
D2791 Crown - full cast predominantly base metal \$190

COVERED DENTAL PROCEDURES AND PATIENT CHARGES - PLAN N500 (Cont.)

D2792	Crown - full cast noble metal	\$190
D2794	Crown - titanium	\$190
D2910	Re-cement or re-bond inlay, onlay, veneer or partial coverage restoration	\$10
D2915	Re-cement or re-bond indirectly fabricated or prefabricated post and core	\$10
D2920	Re-cement or re-bond crown	\$10
D2929	Prefabricated porcelain/ceramic crown - primary tooth	\$40
D2930	Prefabricated stainless steel crown - primary tooth	\$15
D2931	Prefabricated stainless steel crown - permanent tooth	\$15
D2932	Prefabricated resin crown	\$40
D2933	Prefabricated stainless steel crown with resin window	\$40
D2934	Prefabricated esthetic coated stainless steel crown - primary tooth	\$45
D2940	Protective restoration	\$5
D2941	Interim therapeutic restoration - primary dentition	\$5
D2949	Restorative foundation for an indirect restoration	\$0
D2950	Core buildup, including any pins when required	\$40
D2951	Pin retention - per tooth, in addition to restoration	\$7
D2952	Post and core in addition to crown, indirectly fabricated	\$55
D2953	Each additional indirectly fabricated post - same tooth	\$20
D2954	Prefabricated post and core in addition to crown	\$40
D2955	Post removal	\$35
D2957	Each additional prefabricated post - same tooth	\$10
D2960	Labial veneer (resin laminate) - chairside	\$100
D2961	Labial veneer (resin laminate) - laboratory	\$195
D2962	Labial veneer (porcelain laminate) - laboratory	\$125
D2971	Additional procedures to construct new crown under existing partial denture framework	\$125
D2980	Crown repair necessitated by restorative material failure	\$35
D2981	Inlay repair necessitated by restorative material failure	\$70
D2982	Onlay repair necessitated by restorative material failure	\$75
D2983	Veneer repair necessitated by restorative material failure	\$70
D2990	Resin infiltration of incipient smooth surface lesions	\$15

D3000-D3999 ENDODONTICS

D3110	Pulp cap - direct (excluding final restoration)	\$5
D3120	Pulp cap - indirect (excluding final restoration)	\$5
D3220	Therapeutic pulpotomy (excluding final restoration) - removal of pulp coronal to the dentinocemental junction and application of medicament	\$20
D3221	Pulpal debridement, primary and permanent teeth	\$20
D3222	Partial pulpotomy for apexogenesis - permanent tooth with incomplete root development	\$20
D3230	Pulpal therapy (resorbable filling) - anterior, primary tooth (excluding final restoration)	\$22
D3240	Pulpal therapy (resorbable filling) - posterior, primary tooth (excluding final restoration)	\$25
D3310	Endodontic therapy, anterior tooth (excluding final restoration)	\$75
D3320	Endodontic therapy, bicuspid tooth (excluding final restoration)	\$85
D3330	Endodontic therapy, molar (excluding final restoration)	\$150

COVERED DENTAL PROCEDURES AND PATIENT CHARGES - PLAN N500 (Cont.)

D3331	Treatment of root canal obstruction; non-surgical access	\$45
D3332	Incomplete endodontic therapy; inoperable, unrestorable or fractured tooth	\$75
D3333	Internal root repair or perforation defects	\$45
D3346	Retreatment of previous root canal therapy - anterior	\$110
D3347	Retreatment of previous root canal therapy - bicuspid	\$125
D3348	Retreatment of previous root canal therapy - molar	\$185
D3351	Apexification/recalcification - initial visit (apical closure/calcific repair of perforations, root restoration, etc.)	\$25
D3352	Apexification/recalcification - interim medication replacement	\$18
D3353	Apexification/recalcification - final visit (includes completed root canal therapy - apical closure/calcific repair of perforations, root restoration, etc.)	\$55
D3410	Apicoectomy - anterior	\$105
D3421	Apicoectomy - bicuspid (first root)	\$115
D3425	Apicoectomy - molar (first root)	\$110
D3426	Apicoectomy - (each additional root)	\$45
D3427	Periapical surgery without apicoectomy	\$100
D3430	Retrograde filling - per root	\$15
D3450	Root amputation - per root	\$60
D3920	Hemisection (including any root removal), not including root canal therapy	\$54
D3950	Canal preparation and fitting of preformed dowel or post	\$20

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D4000-D4999 PERIODONTICS

D4210	Gingivectomy or gingivoplasty - four or more contiguous teeth or tooth bounded spaces per quadrant	\$70
D4211	Gingivectomy or gingivoplasty - one to three contiguous teeth or tooth bounded spaces per quadrant	\$25
D4212	Gingivectomy or gingivoplasty to allow access for restorative procedure, per tooth	\$18
D4240	Gingival flap procedure, including root planing - four or more contiguous teeth or tooth bounded spaces per quadrant	\$130
D4241	Gingival flap procedure, including root planing - one to three contiguous teeth or tooth bounded spaces per quadrant	\$85
D4245	Apically positioned flap	\$100
D4249	Clinical crown lengthening - hard tissue	\$110
D4260	Osseous surgery (including elevation of a full thickness flap and closure) - four or more contiguous teeth or tooth bounded spaces per quadrant	\$195
D4261	Osseous surgery (including elevation of a full thickness flap and closure) - one to three contiguous teeth or tooth bounded spaces per quadrant	\$120
D4263	Bone replacement graft - first site in quadrant	\$98
D4264	Bone replacement graft - each additional site in quadrant	\$59
D4266	Guided tissue regeneration - resorbable barrier, per site	\$88
D4267	Guided tissue regeneration - non-resorbable barrier, per site (includes membrane removal)	\$88
D4268	Surgical revision procedure, per tooth	\$0
D4270	Pedicle soft tissue graft procedure	\$125

COVERED DENTAL PROCEDURES AND PATIENT CHARGES - PLAN N500 (Cont.)

D4273	Autogenous connective tissue graft procedure (including donor and recipient surgical sites) first tooth, implant or edentulous tooth position.	\$169
D4274	Distal or proximal wedge procedure (when not performed in conjunction with surgical procedures in the same anatomical area)	\$45
D4275	Non-autogenous connective tissue graft (including recipient site and donor material) first tooth, implant, or edentulous tooth position in graft	\$168
D4276	Combined connective tissue and double pedicle graft, per tooth	\$175
D4277	Free soft tissue graft procedure (including recipient and donor surgical sites) first tooth, implant, or edentulous tooth position in graft	\$155
D4278	Free soft tissue graft procedure (including recipient and donor surgical sites) each additional contiguous tooth, implant or edentulous tooth position in same graft site	\$90
D4283	Autogenous connective tissue graft procedure (including donor and recipient surgical sites) - each additional contiguous tooth, implant or edentulous tooth position in the same graft site	\$98
D4285	Non-autogenous connective tissue graft procedure (including recipient surgical site and donor material) - each additional contiguous tooth, implant or edentulous tooth position in the same graft site	\$110
D4341	Periodontal scaling and root planing - four or more teeth per quadrant	\$35
D4342	Periodontal scaling and root planing - one to three teeth per quadrant	\$25
D4355	Full mouth debridement to enable comprehensive evaluation and diagnosis	\$18
D4381	Localized delivery of antimicrobial agents via a controlled release vehicle into diseased crevicular tissue, per tooth	\$25
D4910	Periodontal maintenance	\$20
D4920	Unscheduled dressing change (by someone other than treating dentist or their staff)	\$20
D4921	Gingival irrigation - per quadrant	\$35
D4999	Periodontal maintenance, for each additional procedure in same 12 month period (maximum of 2 additional in the same 12 month period)	\$60

D5000-D5899 PROSTHODONTICS - REMOVABLE

D5110	Complete denture - maxillary	\$190
D5120	Complete denture - mandibular	\$190
D5130	Immediate denture - maxillary	\$190
D5140	Immediate denture - mandibular	\$190
D5211	Maxillary partial denture - resin base (including any conventional clasps, rests and teeth)	\$155
D5212	Mandibular partial denture - resin base (including any conventional clasps, rests and teeth)	\$155
D5213	Maxillary partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth	\$220
D5214	Mandibular partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth	\$220

COVERED DENTAL PROCEDURES AND PATIENT CHARGES - PLAN N500 (Cont.)

D5221	Immediate maxillary partial denture - resin base (including any conventional clasps, rests and teeth)	\$163
D5222	Immediate mandibular partial denture - resin base (including any conventional clasps, rests and teeth)	\$163
D5223	Immediate maxillary partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	\$231
D5224	Immediate mandibular partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	\$231
D5225	Maxillary partial denture - flexible base (including any clasps, rests and teeth)	\$295
D5226	Mandibular partial denture - flexible base (including any clasps, rests and teeth)	\$295
D5281	Removable unilateral partial denture - one piece cast metal (including clasps and teeth)	\$88
D5410	Adjust complete denture - maxillary	\$10
D5411	Adjust complete denture - mandibular	\$10
D5421	Adjust partial denture - maxillary	\$10
D5422	Adjust partial denture - mandibular	\$10
D5510	Repair broken complete denture base	\$10
D5520	Replace missing or broken teeth - complete denture (each tooth)	\$10
D5610	Repair resin denture base	\$10
D5620	Repair cast framework	\$85
D5630	Repair or replace broken clasp - per tooth	\$15
D5640	Replace broken teeth - per tooth	\$10
D5650	Add tooth to existing partial denture	\$15
D5660	Add clasp to existing partial denture - per tooth	\$15
D5670	Replace all teeth and acrylic on cast metal framework (maxillary)	\$55
D5671	Replace all teeth and acrylic on cast metal framework (mandibular)	\$55
D5710	Rebase complete maxillary denture	\$45
D5711	Rebase complete mandibular denture	\$45
D5720	Rebase maxillary partial denture	\$45
D5721	Rebase mandibular partial denture	\$45
D5730	Reline complete maxillary denture (chairside)	\$20
D5731	Reline complete mandibular denture (chairside)	\$20
D5740	Reline maxillary partial denture (chairside)	\$20
D5741	Reline mandibular partial denture (chairside)	\$20
D5750	Reline complete maxillary denture (laboratory)	\$35
D5751	Reline complete mandibular denture (laboratory)	\$35
D5760	Reline maxillary partial denture (laboratory)	\$35
D5761	Reline mandibular partial denture (laboratory)	\$35
D5810	Interim complete denture (maxillary)	\$165
D5811	Interim complete denture (mandibular)	\$165
D5820	Interim partial denture (maxillary)	\$95
D5821	Interim partial denture (mandibular)	\$95
D5850	Tissue conditioning, maxillary	\$10
D5851	Tissue conditioning, mandibular	\$10

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COVERED DENTAL PROCEDURES AND PATIENT CHARGES - PLAN N500 (Cont.)

D6000-D6199 IMPLANT SERVICES

D6010	Surgical placement of implant body: endosteal implant	Not Covered
D6011	Second stage implant surgery	Not Covered
D6055	Connecting bar - implant supported or abutment supported . . .	Not Covered
D6056	Prefabricated abutment - includes modification and placement	Not Covered
D6057	Custom fabricated abutment - includes placement	Not Covered
D6058	Abutment supported porcelain/ceramic crown	Not Covered
D6059	Abutment supported porcelain fused to metal crown (high noble metal)**	Not Covered
D6060	Abutment supported porcelain fused to metal crown (predominantly base metal)	Not Covered
D6061	Abutment supported porcelain fused to metal crown (noble metal)	Not Covered
D6062	Abutment supported cast metal crown (high noble metal)**	Not Covered
D6063	Abutment supported cast metal crown (predominantly base metal)	Not Covered
D6064	Abutment supported cast metal crown (noble metal)	Not Covered
D6065	Implant supported porcelain/ceramic crown	Not Covered
D6066	Implant supported porcelain fused to metal crown (titanium, titanium alloy, high noble metal)**	Not Covered
D6067	Implant supported metal crown (titanium, titanium alloy, high noble metal)**	Not Covered
D6068	Abutment supported retainer for porcelain/ceramic FPD	Not Covered
D6069	Abutment supported retainer for porcelain fused to metal FPD (high noble metal)**	Not Covered
D6070	Abutment supported retainer for porcelain fused to metal FPD (predominantly base metal)	Not Covered
D6071	Abutment supported retainer for porcelain fused to metal FPD (noble metal)	Not Covered
D6072	Abutment supported retainer for cast metal FPD (high noble metal)**	Not Covered
D6073	Abutment supported retainer for cast metal FPD (predominantly base metal)	Not Covered
D6074	Abutment supported retainer for cast metal FPD (noble metal)	Not Covered
D6075	Implant supported retainer for ceramic FPD	Not Covered
D6076	Implant supported retainer for porcelain fused to metal FPD (titanium, titanium alloy, or high noble metal)**	Not Covered
D6077	Implant supported retainer for cast FPD (titanium, titanium alloy, or high noble metal)**	Not Covered
D6092	Re-cement or re-bond implant/abutment supported crown	Not Covered
D6093	Re-cement or re-bond implant/abutment supported fixed partial denture	Not Covered
D6094	Abutment supported crown (titanium)	Not Covered
D6101	Debridement of a peri-implant defect or defects surrounding a single implant, and surface cleaning of the exposed implant, surfaces, including flap entry and closure	Not Covered

COVERED DENTAL PROCEDURES AND PATIENT CHARGES - PLAN N500 (Cont.)

D6102	Debridement and osseous contouring of a peri-implant defect or defects surrounding a single implant and includes surface cleaning of the exposed implant surfaces, including flap entry and closure	Not Covered
D6103	Bone graft for repair of peri-implant defect - does not include flap entry and closure	Not Covered
D6104	Bone graft at time of implant placement	Not Covered
D6110	Implant/abutment supported removable denture for edentulous arch - maxillary	Not Covered
D6111	Implant/abutment supported removable denture for edentulous arch - mandibular	Not Covered
D6112	Implant/abutment supported removable denture for partially edentulous arch - maxillary	Not Covered
D6113	Implant/abutment supported removable denture for partially edentulous arch - mandibular	Not Covered
D6114	Implant/abutment supported fixed denture for edentulous arch - maxillary	Not Covered
D6115	Implant/abutment supported fixed denture for edentulous arch - mandibular	Not Covered
D6116	Implant/abutment supported fixed denture for partially edentulous arch - maxillary	Not Covered
D6117	Implant/abutment supported fixed denture for partially edentulous arch - mandibular	Not Covered
D6190	Radiographic/surgical implant index, by report	Not Covered
D6194	Abutment supported retainer crown for FPD (titanium)	Not Covered

B425.0176

D6200-D6999 PROSTHODONTICS - FIXED

D6205	Pontic - indirect resin based composite	\$60
D6210	Pontic - cast high noble metal**	\$195
D6211	Pontic - cast predominantly base metal	\$195
D6212	Pontic - cast noble metal	\$195
D6214	Pontic - titanium	\$195
D6240	Pontic - porcelain fused to high noble metal**	\$195
D6241	Pontic - porcelain fused to predominantly base metal	\$195
D6242	Pontic - porcelain fused to noble metal	\$195
D6245	Pontic - porcelain/ceramic	\$215
D6250	Pontic - resin with high noble metal**	\$175
D6251	Pontic - resin with predominantly base metal	\$175
D6252	Pontic - resin with noble metal	\$175
D6545	Retainer - cast metal for resin bonded fixed prosthesis	\$195
D6548	Retainer - porcelain/ceramic for resin bonded fixed prosthesis	\$215
D6600	Retainer inlay - porcelain/ceramic, two surfaces	\$150
D6601	Retainer inlay - porcelain/ceramic, three or more surfaces	\$160
D6602	Retainer inlay - cast high noble metal, two surfaces**	\$150
D6603	Retainer inlay - cast high noble metal, three or more surfaces**	\$160
D6604	Retainer inlay - cast predominantly base metal, two surfaces	\$150

COVERED DENTAL PROCEDURES AND PATIENT CHARGES - PLAN N500 (Cont.)

D6605	Retainer inlay - cast predominantly base metal, three or more surfaces	\$160
D6606	Retainer inlay - cast noble metal, two surfaces	\$150
D6607	Retainer inlay - cast noble metal, three or more surfaces	\$160
D6608	Retainer onlay - porcelain/ceramic, two surfaces	\$160
D6609	Retainer onlay - porcelain/ceramic, three or more surfaces	\$175
D6610	Retainer onlay - cast high noble metal, two surfaces**	\$160
D6611	Retainer onlay - cast high noble metal, three or more surfaces **	\$175
D6612	Retainer onlay - cast predominantly base metal, two surfaces	\$160
D6613	Retainer onlay - cast predominantly base metal, three or more surfaces	\$175
D6614	Retainer onlay - cast noble metal, two surfaces	\$160
D6615	Retainer onlay - cast noble metal, three or more surfaces	\$175
D6624	Retainer inlay - titanium	\$150
D6634	Retainer onlay - titanium	\$160
D6710	Retainer crown - indirect resin based composite	\$145
D6720	Retainer crown - resin with high noble metal **	\$175
D6721	Retainer crown - resin with predominantly base metal	\$175
D6722	Retainer crown - resin with noble metal	\$175
D6740	Retainer crown - porcelain/ceramic	\$225
D6750	Retainer crown - porcelain fused to high noble metal **	\$190
D6751	Retainer crown - porcelain fused to predominantly base metal	\$190
D6752	Retainer crown - porcelain fused to noble metal	\$190
D6780	Retainer crown - 3/4 cast high noble metal **	\$180
D6781	Retainer crown - 3/4 cast predominantly base metal	\$180
D6782	Retainer crown - 3/4 cast noble metal	\$180
D6783	Retainer crown - 3/4 porcelain/ceramic	\$180
D6790	Retainer crown - full cast high noble metal **	\$190
D6791	Retainer crown - full cast predominantly base metal	\$190
D6792	Retainer crown - full cast noble metal	\$190
D6794	Retainer crown - titanium	\$190
D6930	Re-cement or re-bond fixed partial denture	\$10
D6940	Stress breaker	\$45
D6980	Fixed partial denture repair necessitated by restorative material failure	\$45
D6999	Multiple crown and fixed partial denture retainers (bridge) treatment plan - per unit, six or more	\$125
D7000-D7999 ORAL AND MAXILLOFACIAL SURGERY		
D7111	Extraction - coronal remnants - deciduous tooth	\$5
D7140	Extraction - erupted tooth or exposed root (elevation and/or forceps removal)	\$10
D7210	Surgical removal of erupted tooth requiring removal of bone and/or sectioning of tooth, and including elevation of mucoperiosteal flap if indicated	\$30
D7220	Removal of impacted tooth - soft tissue	\$50
D7230	Removal of impacted tooth - partially bony	\$60
D7240	Removal of impacted tooth - completely bony	\$80
D7241	Removal of impacted tooth - completely bony, with unusual surgical complications	\$90

COVERED DENTAL PROCEDURES AND PATIENT CHARGES - PLAN N500 (Cont.)

D7250	Surgical removal of residual tooth roots (cutting procedure)	\$35
D7251	Coronectomy - intentional partial tooth removal	\$60
D7260	Oroantral fistula closure	\$90
D7261	Primary closure of a sinus perforation	\$250
D7270	Tooth re-implantation and/or stabilization of accidentally evulsed or displaced tooth	\$130
D7280	Surgical access of an unerupted tooth	\$90
D7282	Mobilization of erupted or malpositioned tooth to aid eruption	\$90
D7283	Placement of device to facilitate eruption of impacted tooth	\$30
D7285	Incisional biopsy of oral tissue - hard (bone, tooth)	\$55
D7286	Incisional biopsy of oral tissue - soft	\$45
D7287	Exfoliative cytological sample collection	\$45
D7288	Brush biopsy - transepithelial sample collection	\$65
D7291	Transseptal fiberotomy/supra crestal fiberotomy, by report	\$25
D7310	Alveoloplasty, in conjunction with extractions - four or more teeth or tooth spaces, per quadrant	\$45
D7311	Alveoloplasty, in conjunction with extractions - one to three teeth or tooth spaces, per quadrant	\$30
D7320	Alveoloplasty, not in conjunction with extractions - four or more teeth or tooth spaces, per quadrant	\$45
D7321	Alveoloplasty, not in conjunction with extractions - one to three teeth or tooth spaces, per quadrant	\$35
D7450	Removal of benign odontogenic cyst or tumor - lesion diameter up to 1.25 cm	\$50
D7451	Removal of benign odontogenic cyst or tumor - lesion diameter greater than 1.25 cm	\$110
D7471	Removal of lateral exostosis (maxilla or mandible)	\$75
D7472	Removal of torus palatinus	\$75
D7473	Removal of torus mandibularis	\$75
D7485	Surgical reduction of osseous tuberosity	\$75
D7510	Incision and drainage of abscess - intraoral soft tissue	\$30
D7511	Incision and drainage of abscess - intraoral soft tissue - complicated (includes drainage of multiple fascial spaces)	\$35
D7520	Incision and drainage of abscess - extraoral soft tissue	\$40
D7521	Incision and drainage of abscess - extraoral soft tissue - complicated (includes drainage of multiple fascial spaces)	\$45
D7953	Bone replacement graft for ridge preservation - per site	\$88
D7960	Frenulectomy - also known as frenectomy or frenotomy - separate procedure not incidental to another procedure	\$65
D7963	Frenuloplasty	\$110
D7970	Excision of hyperplastic tissue - per arch	\$33
D7971	Excision of pericoronal gingiva	\$25
D7972	Surgical reduction of fibrous tuberosity	\$45

B425.0198

D8000-D8999 ORTHODONTICS

D8010	Limited orthodontic treatment of the primary dentition	\$700
D8020	Limited orthodontic treatment of the transitional dentition	\$700
D8030	Limited orthodontic treatment of the adolescent dentition	\$700
D8040	Limited orthodontic treatment of the adult dentition	\$700
D8050	Interceptive orthodontic treatment of the primary dentition	\$900

COVERED DENTAL PROCEDURES AND PATIENT CHARGES - PLAN N500 (Cont.)

D8060	Interceptive orthodontic treatment of the transitional dentition	\$900
D8070	Comprehensive orthodontic treatment of the transitional dentition . . .	\$1,895
D8080	Comprehensive orthodontic treatment of the adolescent dentition	\$1,895
D8090	Comprehensive orthodontic treatment of the adult dentition	\$2,195
D8660	Pre-orthodontic treatment examination to monitor growth and development (includes treatment plan, records, evaluation and consultation)	\$250
D8670	Periodic orthodontic treatment visit	\$0
D8680	Orthodontic retention (removal of appliances, construction and placement of retainer(s))	\$400
D8681	Removable orthodontic retainer adjustment	\$0

B425.0178

D9000-D9999 ADJUNCTIVE GENERAL SERVICES

D9110	Palliative (emergency) treatment of dental pain - minor procedure	\$10
D9120	Fixed partial denture sectioning	\$12
D9210	Local anesthesia not in conjunction with operative or surgical procedures	\$0
D9211	Regional block anesthesia	\$0
D9212	Trigeminal division block anesthesia	\$0
D9215	Local anesthesia in conjunction with operative or surgical procedures	\$0
D9219	Evaluation for deep sedation or general anesthesia	\$55
D9223	Deep sedation/general anesthesia - each 15 minute increment	\$98
D9230	Inhalation of nitrous oxide/analgesia, anxiolysis	\$25
D9243	Intravenous moderate (conscious) sedation/analgesia - each 15 minute increment	\$40
D9248	Non-intravenous conscious sedation	\$75
D9310	Consultation - diagnostic service provided by dentist or physician other than requesting dentist or physician	\$30
D9430	Office visit for observation (during regularly scheduled hours) - no other services performed	\$0
D9440	Office visit - after regularly scheduled hours	\$50
D9450	Case presentation, detailed and extensive treatment planning	\$0
D9610	Therapeutic parenteral drug, single administration	\$10
D9612	Therapeutic parenteral drugs, two or more administrations, different medications	\$15
D9630	Other drugs and/or medicaments, by report	\$15
D9910	Application of desensitizing medicament	\$15
D9940	Occlusal guard, by report	\$45
D9942	Repair and/or reline occlusal guard	\$7
D9951	Occlusal adjustment - limited	\$10
D9952	Occlusal adjustment - complete	\$85
D9971	Odontoplasty, 1-2 teeth; includes removal of enamel projections	\$14
D9972	External bleaching - per arch - performed in office	\$165
D9975	External bleaching for home application, per arch; includes materials and fabrication of custom trays	\$99

COVERED DENTAL PROCEDURES AND PATIENT CHARGES - PLAN N500 (Cont.)

D9986	Missed appointment	\$25
D9987	Cancelled appointment	\$25

** The Policy provides for the use of noble metal for crowns, fixed partial dentures (bridges), inlays and onlays. When high noble metal (including gold) is used, the Member will be responsible for the listed Patient Charge for the crowns, fixed partial dentures (bridges), inlays and onlays, plus an additional charge for the actual cost of the high noble metal.

B425.0199

Option F

PLAN N500

B425.0139

Option F

BENEFIT LIMITATIONS

This section lists the dental benefits and procedures Members are allowed to obtain through the Policy when the procedures are necessary for their dental health, consistent with professionally recognized standards of practice, subject to the Benefit Limitations, Additional Conditions and Exclusions listed below.

NOTICE: Any benefit that includes an age restricted limitation will be subject to an exception based on medical necessity.

B425.1017

Option F

- General**
- Emergency Dental Services when more than fifty (50) miles from the PCD office: Limited to a \$50.00 reimbursement per incident.
 - Emergency Dental Services when provided by a Dentist other than the Member's assigned PCD, and without referral by the PCD or authorization by Us: Limited to the benefit for palliative treatment (D9110) only.

B425.0142

Option F

- Diagnostic**
- One intraoral complete series of radiographic images and one panoramic radiographic image: Limited to 1 each in 36 months.
 - Bitewing radiographic images: Limited to 2 sets in 12 months.
 - 2D oral/facial photographic image: Limited to 1 in 12 months.
 - Caries susceptibility tests: Limited to 1 in 24 months.
 - Adjunctive pre-diagnostic test that aids in the detection of mucosal abnormalities including premalignant and malignant lesions, not to include cytology or biopsy procedures: Limited to 1 in 24 months for persons age 40 or older.
 - Accession of tissue is covered only when performed in conjunction with a tooth-related biopsy, when performed by a Contracted Dentist.

B425.0146

Option F

- Preventive** ● Prophylaxis (D1110 or D1120) or periodontal maintenance (D4910): Limited to 2 in 12 months. One of the covered periodontal maintenance may be performed by a periodontist Contracted Specialist if done within 3 to 6 months following completion of approved periodontal scaling and root planing or osseous surgery by a periodontist Contracted Specialist. Members are eligible to receive 2 additional prophylaxes or periodontal maintenance in the same 12 months at the Patient Charge of D1999 (for prophylaxes) or D4999 (for periodontal maintenance).

One additional prophylaxis will be covered at no charge for Members in any 12 month period who: (a) are pregnant in their 2nd or 3rd trimester; or (b) have clinically demonstrable xerostomia (dry mouth) due to chemotherapy or radiation therapy for the treatment of cancer; or (c) are on dialysis. Verification of the condition must be provided by the Member with a doctor's note to the PCD.

- Fluoride treatment: Limited to 2 in 12 months. Members are eligible to receive 2 additional fluoride treatments in the same 12 months at the Patient Charge of D2999.
- Sealants or preventive resin restoration: Limited to permanent teeth that are free from occlusal restorations, up to age 16, once per tooth in 36 months.
- Sealant Repair: Limited to 1 per tooth in 12 months.

B425.0147

Option F

- Crowns & Fixed Partial Dentures (Bridges)** ● Crowns, fixed partial dentures (bridges), inlays, onlays & veneers: Covered when recommended by the PCD. The replacement of a crown, fixed partial denture (bridge), inlay, onlay or veneer is limited to once in 5 years based on the original placement date while covered under the Policy.
- Multiple crown and fixed partial denture (bridge) unit treatment plan: When a Member's treatment plan includes 6 or more covered units of crown and/or fixed partial denture (bridge) to restore teeth or replace missing teeth, the Member will be responsible for the Patient Charge for each unit of crown or fixed partial denture (bridge), plus an additional charge per unit (D6999), as shown in the Covered Dental Procedures and Patient Charges section.

- Porcelain crowns and/or porcelain fused to metal crowns: Covered on all permanent adult teeth when recommended by the PCD.
- The Policy provides for the use of noble metal for crowns, fixed partial dentures (bridges), inlays and onlays. When high noble metal (including gold) is used, the Member will be responsible for the listed Patient Charge for the crowns, fixed partial dentures (bridges), inlays and onlays, plus an additional charge for the actual cost of the high noble metal.
- In the event a covered indirect restoration (inlays, onlays, crowns and fixed partial dentures - bridges) is recommended and the Member elects to have a porcelain/ceramic substrate indirect restoration made using a CAD/CAM machine in one appointment, in lieu of a laboratory processed porcelain/ceramic substrate indirect restoration (more than one appointment), the Member will be responsible for a fee of \$500 in addition to the listed Patient Charge for such porcelain/ceramic substrate indirect restoration. Please note that the one-appointment porcelain/ceramic substrate indirect restoration may not be available at all Contracted General Dentist locations.

B425.0148

Option F

- Endodontics**
- Root amputation, per root: Limited to once per tooth.
 - Hemisection: Limited to once per tooth.

B425.0149

Option F

- Periodontics**
- Gingival flap procedure or osseous surgery: Limited to 1 procedure per quadrant in 36 months.
 - Tissue grafts: Limited to 1 procedure per tooth/site in 36 months.
 - Periodontal scaling and root planing: Limited to once per quadrant in 12 months.
 - Bone replacement grafts: Limited to once per site in 10 years when the tooth is present.
 - Guided tissue regeneration: Limited to once per site in 10 years when the tooth is present.

B425.0151

Option F

- Prosthodontics**
- Reline and rebase of a complete or partial denture: Limited to once per denture in 12 months.
 - The benefit for dentures includes all post-delivery care including adjustments for 6 months after insertion. The benefit for immediate dentures includes follow-up care for 6 months but does not include rebasing or relining procedures or a complete new denture.
 - Replacement of dentures: Covered when recommended by the PCD and only if the existing denture cannot be made satisfactory by reline, rebase or repair. The replacement of a denture is limited to once in 5 years based on the original placement date while covered under the Policy.
 - Immediate dentures are not subject to the 5-year replacement limitation.

B425.0152

Option F

- Oral and Maxillofacial Surgery**
- Routine post-operative office visits and care: Included in the surgical procedure.

B425.0154

Option F

- Orthodontics**
- The Policy covers orthodontic procedures as listed under Covered Dental Procedures and Patient Charges. Coverage is limited to one course of comprehensive treatment per Member. Treatment must be preauthorized and be performed by an orthodontist Contracted Specialist.
 - The listed Patient Charge for each phase of orthodontic treatment (limited, interceptive or comprehensive) covers up to 24 months of active treatment. If treatment is necessary beyond 24 months, the Member will be responsible for each additional month of treatment, based upon the orthodontist Contracted Specialist's contract.
 - Orthodontic procedures are not covered if comprehensive treatment begins before the Member is eligible for benefits under the Policy except as described under the Treatment in Progress - Takeover Benefit for Orthodontic Treatment Provision.
 - If a Member's coverage terminates after the fixed banding appliances are inserted, the Member is responsible for any additional charges incurred for the remaining orthodontic treatment. The orthodontist Contracted Specialist may prorate his or her usual fee over the remaining months of treatment. The Member is responsible for all payments to the orthodontist Contracted Specialist for procedures after the termination date.
 - Retention procedures are covered at the Patient Charge shown in the Covered Dental Procedures and Patient Charges section. They are covered only if following a course of comprehensive orthodontic treatment started and completed under the Policy.

- If a Member transfers to another orthodontist Contracted Specialist after authorized comprehensive orthodontic treatment has started under the Policy, the Member will be responsible for any additional costs associated with the change in orthodontist Contracted Specialist and subsequent treatment.
- The benefit for the treatment plan and records includes initial records and any interim and final records. The benefit for comprehensive orthodontic treatment covers the fixed banding appliances and related visits only. Additional fixed or removable appliances will be the Member's responsibility.
- The benefit for orthodontic retention is limited to 12 months and covers any and all necessary fixed and removable appliances and related visits. Retention procedures are covered only following a course of comprehensive orthodontic treatment covered under the Policy.
- The Policy does not cover any incremental charges for non-standard orthodontic appliances or those made with clear, ceramic, white or other optional material or lingual brackets. Any additional costs for the use of optional materials will be the Member's responsibility.
- If a Member has orthodontic treatment associated with orthognathic surgery (a non-covered procedure involving the surgical moving of teeth), the Policy provides the standard orthodontic benefit. The Member will be responsible for additional charges related to the orthognathic surgery and the complexity of the orthodontic treatment. The additional charge will be based on the orthodontist Contracted Specialist's usual fee.

B425.0407

Option F

Adjunctive General Services

- Deep sedation/general anesthesia, IV sedation, nitrous oxide, non-intravenous conscious sedation: Limited to procedures provided by an oral surgeon Contracted Specialist. Not all oral surgeon Contracted Specialists offer these procedures. The Member is responsible for identifying and receiving procedures from an oral surgeon Contracted Specialist who is willing to provide deep sedation/general anesthesia, IV sedation, nitrous oxide or non-intravenous conscious sedation. The Member's Patient Charge is shown in the Covered Dental Procedures and Patient Charges section.
- Occlusal guard: Limited to 1 in 5 years. Covered only if performed by the PCD.
- Repair and/or reline of occlusal guard: Limited to 1 in 24 months if performed more than 24 months after initial fabrication and delivery.
- Occlusal adjustment - limited: Limited to a total of 2 visits, per lifetime.

B425.0156

Option F

ADDITIONAL CONDITIONS

B425.0157

Option F

Alternative Procedure Policy There may be a number of accepted methods of treating a specific dental condition. In all cases where there is more than one course of treatment (procedure) available, a full disclosure of all the treatment options must be given to the Member before treatment is initiated. This PCD-presented document should include a written treatment plan, as well as the cost of each treatment option, in order to minimize the potential for confusion over what the Member should pay, and to fully document the informed consent of the treatment recommended.

When a Member selects an Alternative Procedure over the procedure recommended by the PCD, the Member must pay the difference between the PCD's usual charges for the recommended procedure and the Alternative Procedure chosen by the Member. The Member will also have to pay the applicable Patient Charge for the recommended procedure.

If any of the Alternative Procedures that are selected by the Member are not covered under the Policy, the Member must pay the PCD's usual fee for the Alternative Procedure.

If any treatment is specifically not recommended by the PCD (i.e., the PCD determines it is not an appropriate procedure for the condition being treated), the PCD is not obliged to provide that treatment even if it is a covered procedure under the Policy.

Members can request and receive a second opinion by contacting Our Member Services department in the event they have questions regarding the recommendations of the PCD or Contracted Specialist.

B425.0158

Option F

Exceptions to Alternative Procedure Policy When the Member selects a posterior composite restoration as an Alternative Procedure to a recommended amalgam restoration, the Alternative Procedure policy does not apply.

When the Member selects an extraction, the Alternative Procedure policy does not apply.

When the PCD recommends a crown, the Alternative Procedure policy does not apply regardless of the type of crown placed. The type of crown includes, but is not limited to: (a) a full metal crown; (b) a porcelain fused to metal crown; or (c) a porcelain crown. The Member must pay the applicable Patient Charge for the crown actually placed.

B425.0159

Option F

Second Opinion Consultation A Member may wish to consult another Dentist for a second opinion regarding procedures recommended or performed by the Member's PCD or Contracted Specialist through a referral. To have a second opinion consultation covered by Us, the Member must call or write Our Member Services department for prior authorization. We only cover a second opinion consultation when the recommended procedures are covered under the Policy.

A Member Services associate will help identify a Contracted Specialist to perform the second opinion consultation. The second opinion consultation will include the applicable Patient Charge for code D9310.

The Plan's benefit for a second opinion consultation is limited to \$50.00. If a Contracted Specialist is the consulting Dentist, the Member is responsible for the applicable Patient Charge for code D9310. If a Non-Contracted Dentist is the consulting Dentist, the Member must pay the applicable Patient Charge for code D9310 and any portion of the Dentist's fee over \$50.00.

The Member Services associate will arrange for any available records or radiographs and the necessary second opinion form to be sent to the consulting Dentist.

B425.0727

Option F

Third Opinion Consultation Third opinions are not covered unless requested by Us. If a third opinion is requested by the Member, the Member is responsible for the payment. Exceptions will be considered on an individual basis, and must be approved, in writing, by Us.

B425.0161

Option F

Treatment in Progress-Takeover Benefit for Orthodontic Treatment Provision This provision provides a Member who qualifies, as explained below, a benefit to continue comprehensive orthodontic treatment that was started under another Dental HMO plan with the current/original treating orthodontist, after the Policy becomes effective. A Member may be eligible for this provision if all of these conditions are met:

- The Member was covered by another dental HMO plan just prior to the Effective Date of the Policy and had started comprehensive orthodontic treatment (D8070, D8080 or D8090) with the current/original treating orthodontist under the prior Dental Policy. This benefit applies to Members who are eligible for coverage on the Effective Date of the Policy and enroll for such coverage within 30 days. It does not apply to persons who become newly eligible for coverage after the Effective Date of the Policy.
- The Member has such orthodontic treatment in progress at the time the Policy becomes effective.

- The Member continues such orthodontic treatment with the current/original treating orthodontist.
- A "Treatment in Progress - Takeover Benefit for Orthodontic Treatment" form, completed in its entirety by the treating orthodontist, is submitted to Us within 6 months of the Effective Date of the Policy.

The benefit amount will be calculated based on the prior dental HMO carrier's pro-rated remaining benefit balance; up to a maximum benefit of \$1,200 per Member. The Member is responsible for the Dentist's original comprehensive treatment fee and Patient Charges under the original contract and financial agreement made between the Member and the Dentist. The Member is responsible for any increase in fee as a result of the takeover process. Additionally, the Plan will only cover up to a total of 24 months of comprehensive orthodontic treatment.

B425.0728

Option F

EXCLUSIONS

- We will not pay benefits for:**
- Treatment needed due to an on-the-job or job-related injury or a condition for which benefits are payable by Worker's Compensation, occupational disease law or similar laws, whether or not the Member claims his or her rights to such benefits.
 - Any treatment of congenital and/or developmental malformations. This exclusion will not apply to an otherwise covered procedure involving (a) congenitally missing or (b) supernumerary teeth.
 - Removal of tumors, cysts, neoplasms or foreign bodies that are not of tooth origin.
 - Any oral surgery requiring the setting of a fracture or dislocation.
 - Dispensing of drugs not normally supplied in a dental office for treatment of dental diseases.
 - Any treatments or appliances requested, recommended or performed: (a) which in the opinion of the Contracted Specialist or Contracted General Dentist are not necessary for maintaining or improving the Member's dental health, or (b) which are solely for cosmetic purposes, except for bleaching.
 - Any procedure or treatment method which does not meet professionally recognized standards of dental practice or is considered by the American Dental Association (ADA) to be experimental in nature.
 - Replacement of lost, missing, or stolen appliances or prosthesis, or the fabrication of a spare appliance or prosthesis.
 - Replacement or repair of prosthetic appliances damaged due to the neglect of the Member.
 - Any Member request for specialist procedures or treatment which can be routinely provided by the PCD, or by a specialist without a direct referral from the PCD or a pre-authorization by Us.
 - Treatment provided by any public program, or paid for or sponsored by any government body, unless We are legally required to provide benefits for such treatment.
 - Any restoration, procedure, appliance or prosthetic device used solely to: (1) alter vertical dimension; (2) restore or maintain occlusion; (3) treat a condition necessitated by attrition or abrasion; (4) splint or stabilize teeth for periodontal reasons; or (5) improve cosmetic appearance, except for bleaching.
 - Any procedure, appliance, device or modality intended to treat disturbances of the temporomandibular joint (TMJ).
 - Dental procedures, other than covered Emergency Dental Services, which were performed by any Dentist other than the Member's selected and assigned PCD, unless previous written authorization was provided by Us.

- 2D cephalometric radiographic images except when performed as part of an orthodontic treatment plan and records for a covered course of orthodontic treatment.
- Treatment which requires the procedures of a prosthodontist.
- Treatment or Procedures which requires the services of a pediatric dentist Contracted Specialist, after the Member's 9th (ninth) birthday.
- Consultations for non-covered procedures.
- Any procedure or treatment not specifically listed in the Covered Dental Procedures and Patient Charges section.
- Any covered procedure, regardless of specialty, that was started, but not completed, prior to the Member's eligibility to receive benefits under the Policy except as described under Treatment in Progress - Takeover Benefit for Orthodontic Treatment Provision.
- Extractions performed solely to facilitate orthodontic treatment.
- Extractions of impacted teeth with no radiographic evidence of pathology. The removal of impacted teeth is not covered if performed for prophylactic reasons.
- Orthognathic surgery (moving of teeth by surgical means) and associated incremental charges.
- Clinical crown lengthening performed in the presence of periodontal disease on the same tooth.
- Procedures performed to facilitate non-covered procedures, including, but not limited to, root canal therapy to facilitate overdentures.
- Procedures, appliances or devices to guide minor tooth movement, except as covered under limited, interceptive or comprehensive orthodontic treatment or correct or control harmful habits.
- Any procedure or appliance requested, recommended or performed for a tooth or teeth with a guarded, questionable or poor prognosis.
- Retreatment of orthodontic cases, or changes in orthodontic treatment necessitated by any kind of accident.
- Replacement or repair of orthodontic appliances lost or damaged.
- Accident injury. An accident injury is defined as damage to the hard and/or soft tissue of the oral cavity resulting from forces external to the mouth. Damages to the hard and soft tissues of the oral cavity from normal masticatory (chewing) functions will be covered at the amount as shown in the Covered Dental Procedures and Patient Charges section.

B425.0731

COMBINED EVIDENCE OF COVERAGE AMENDMENT

This Rider amends the Combined Evidence of Coverage as follows and is effective on 07/01/2017.

Timely Access to Care

Covered dental services must be provided in a timely manner appropriate with the nature of Your condition consistent with good professional dental practice.

Managed Dental Care's network has adequate capacity and availability of Contracted Dentists to offer appointments for covered dental services in accordance with the following Timely Access to Care requirements:

- Urgent appointments to be offered within 72 hours of the time of request for an appointment when consistent with the nature of Your condition and as required by professionally recognized standards of dental practice.
- Non-urgent appointments (initial/routine) to be offered within 36 business days of the request for an appointment.
- Preventive dental care appointments to be offered within 40 business days of the request for an appointment.

The Timely Access to Care appointment wait time standards may not apply if You are requesting a specific date and time. The applicable waiting time for a particular appointment may also be longer if the referring or treating Dentist, acting within the scope of the Dentist's practice and consistent with professionally recognized standards of dental practice, has determined and noted in the relevant record that a longer waiting time will not have a detrimental impact on Your health.

When it is necessary for Your Dentist or You to reschedule an appointment, the appointment will be promptly rescheduled by Your Dentist in a manner that is:

- Appropriate for Your dental care needs;
- Ensures continuity of care consistent with good professional dental practices; and
- Meets California's standards regarding the accessibility of dental services in a timely manner.

Language and interpreter services are available for You at no cost. Interpreter services, if requested, must be coordinated with scheduled appointments in a manner that ensures interpreter services are provided at the time of the appointment, consistent with California standards, without imposing a delay in scheduling.

Contracted Dentists are required to have an answering service or a telephone answering machine during non-business hours. Their message must provide instructions regarding how You may obtain urgent or emergency care, including how to contact another Dentist who has agreed to be on-call to triage or screen by phone, or, if needed, deliver urgent or emergency care. If the Contracted Dentist does not answer and You have an emergency, You may call 911 or go to the nearest hospital. Emergency/urgent services may be received by any Dentist.

Telephone triage or screening services are to be provided in a timely manner appropriate for Your condition. During normal business hours, the waiting time for You to speak by telephone with a knowledgeable and competent customer service representative regarding Your questions and concerns will not exceed 10 minutes.

If You have any questions or want to request an interpreter, please call Managed Dental Care's Customer Response Unit at 1-800-273-3330.

This Rider is part of the Evidence of Coverage. Except as stated in this Rider, nothing contained in this Rider changes or affects any other terms of the Evidence of Coverage.

Managed Dental Care of California



Larry Weiss, Assistant Vice President
and Controller



Jill M. Purcell, President

B425.0840

Option F

EVIDENCE OF COVERAGE AMENDATORY RIDER

This Rider amends the Evidence of Coverage as follows and is effective on 01/20/2022.

The Emergency Dental Services provision is replaced with the following:

Emergency Dental Services

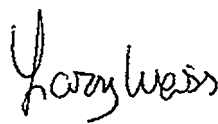
The MDC Network also provides for Emergency Dental Services 24 hours a day, 7 days a week, to all Members. You should contact Your selected PCD, who will arrange for such care. If You are not able to reach Your PCD in an emergency during normal business hours, You must call MDC's Member Services Department for instructions. If You are not able to reach Your PCD in an emergency after normal business hours, You may seek Emergency Dental Services from any Dentist. MDC will reimburse You for the cost of the Emergency Dental Services, less any Patient Charge which may apply. You should present a statement from the treating Dentist. You must file a claim within 180 days of service. This should be submitted to the address listed on page 1.

This Rider is part of the Evidence of Coverage. Except as stated in this Rider, nothing contained in this Rider changes or affects any other terms of the Evidence of Coverage.

Managed Dental Care of California



Jill M. Purcell, President



Larry Weiss, Assistant Vice President
and Controller

B425.1210

Option F

MATRIX

THIS MATRIX IS INTENDED TO BE USED TO HELP YOU COMPARE COVERAGE BENEFITS AND IS A SUMMARY ONLY. THE EVIDENCE OF COVERAGE AND PLAN CONTRACT SHOULD BE CONSULTED FOR A DETAILED DESCRIPTION OF COVERAGE BENEFITS AND LIMITATIONS.

PLAN N500G	Deductibles	Lifetime Maximums	Professional Services			
			Diagnostic	Preventive	Restorative	Endodontic
	None					
Services			Oral Evaluations; X-Rays: Intraoral Bitewings Panorex; Miscellaneous: Primary Care Diagnostic Services	Prophylaxis (Cleaning); Flouride; Sealants; Space Maintainers	Amalgam & Resin: Restorations (Fillings); Crowns And Pontics; Inlay And Onlay Miscellaneous: Restorative Services	Pulp Cap; Pulpotomy; Root Canals; Retreatments; Apicoectomy; Retrograde Filling
Patient Charge Range			Oral Evaluations; Radiographic Images (X-Rays) Intraoral Panorex - \$0; Miscellaneous Primary Care Diagnostic Services - \$0	Prophylaxis - \$0 - \$35; Flouride - \$0 - \$20; Sealants - \$5 - \$35; Space Maintainers - \$35 - \$65	Amalgam - \$0; Resin - \$5 - \$40; Crowns - \$150 - \$225; Inlays & Onlays - \$110 - \$250; Labial Veneer - \$100 - \$195; Miscellaneous Restorative Services - \$0 - \$75	Pulp Cap -\$5; Pulpotomy - \$20; Root Canals - \$75 - \$150; Retreatments - \$110 - \$185; Apicoectomy - First Root - \$105 - \$115; Apicoectomy - Each Additional Root - \$45; Retrograde Filling - Per Root - \$15; Canal Preparation - \$20

THIS MATRIX IS INTENDED TO BE USED TO HELP YOU COMPARE COVERAGE BENEFITS AND IS A SUMMARY ONLY. THE EVIDENCE OF COVERAGE AND PLAN CONTRACT SHOULD BE CONSULTED FOR A DETAILED DESCRIPTION OF COVERAGE BENEFITS AND LIMITATIONS. (CONTINUED)

N500G	Deductibles	Lifetime Maximums	Professional Services (Continued)			
			Diagnostic	Preventive	Restorative	Endodontic
Limitations		One Course Of Comprehensive Orthodontic Treatment Per Member	Full Mouth X-Rays - 1 Set Per 3 Year Period; Bite Wing X-Rays - 2 Sets In Any 12 Month Period; Panoramic - One In Any 3 Year Period Adjunctive Pre-Diagnostic Test In Detection Of Abnormalities One In Any 2-Year Period After 40th Birthday	Routine Cleaning (Prophylaxis) or Periodontal Maintenance Procedure - Total Of 4 Services In Any 12-Month Period Fluoride Treatment Sealants - Limited To Permanent Teeth, Up To 16th Birthday, One Per Tooth In Any 3-Year Period	Crown Replacement - Once Per 5 Years; Actual Cost Of Gold/High Noble Metal Is Member's Responsibility	

GC-DHMO-MATRIX-16-CA

B425.0766

Option F

THIS MATRIX IS INTENDED TO BE USED TO HELP YOU COMPARE COVERAGE BENEFITS AND IS A SUMMARY ONLY. THE EVIDENCE OF COVERAGE AND PLAN CONTRACT SHOULD BE CONSULTED FOR A DETAILED DESCRIPTION OF COVERAGE BENEFITS AND LIMITATIONS. (CONTINUED)

N500G	Professional Services					
	Periodontic	Prosthodontics	Implants	Oral Surgery	Orthodontic	Adjunctive General Services
Services	Gingivectomy/ Gingivoplasty; Gingival Flap Procedure; Osseous Surgery; Scaling & Root Planing; Soft Tissue Graft; Miscellaneous Periodontal Services	Complete Dentures; Partial Dentures; Relines; Repairs; Denture Adjustments	Abutment Supported Crowns; Implant Supported Dentures, Abutment Supported Retainers; Bone Graft, Re-Cement/ Rebond Implant	Extractions; Biopsy; Alveoplasty; Incision And Drainage; Frenectomy/ Frenulectomy; Removal Of Cyst/Tumor	Comprehensive Treatment; Retention; Pre-Orthodontic Treatment; Treatment Plan And Records	Office Visit; Palliative Treatment; Local Anesthesia
Patient Charge Range	Gingivectomy/ Gingivoplasty - \$18 - \$70**; Gingival Flap Procedure - \$85 - \$130; Osseous Surgery - \$120 - \$195**; Scaling & Root Planing - \$25 - \$35; Soft Tissue Graft - \$90 - \$155; **Per - Quadrant	Prosthodontics Removable Complete Denture - \$190; Partial Denture - \$88 - \$295; Reline - \$20 - \$35; Repair - \$10 - \$85; Denture Adjustment - \$10 Prosthodontics Fixed Pontic - \$60 - \$215 Inlay and Onlay - \$150 - \$175 Crown - \$145 - \$225	Abutment Supported Crowns - Not Covered; Covered Implant Supported Dentures - Not Covered; Abutment Supported Retainers - Not Covered; Bone Graft - Not Covered; Re-Cement/ Rebond Implant - Not Covered;	Simple Extractions - Removal Of Complete Bony Impactions - \$80 - \$90; Biopsy, Oral Tissue - \$45 - \$55 Alveoloplasty - \$30 - \$45; Incision - And Drainage - \$30 - \$45; Frenectomy/ Frenulectomy - \$65 - \$110 Removal of Cyst/Tumor - \$50 - \$115;	Under age 19 - \$1,895; Age 19 and Above - \$2,195; Retention - \$400; Treatment Plan And Records - \$250	Office Visit - \$0; After Hours Office Visit - \$50; Palliative Treatment - \$10; Local Anesthesia - \$0;

GC-DHMO-MATRIX-16-CA

B425.0767

Option F

THIS MATRIX IS INTENDED TO BE USED TO HELP YOU COMPARE COVERAGE BENEFITS AND IS A SUMMARY ONLY. THE EVIDENCE OF COVERAGE AND PLAN CONTRACT SHOULD BE CONSULTED FOR A DETAILED DESCRIPTION OF COVERAGE BENEFITS AND LIMITATIONS. (CONTINUED)

N500G	Professional Services					
	Periodontic	Prosthodontics	Implants	Oral Surgery	Orthodontic	Adjunctive General Services
Limitations	Gingival Flap/ Osseous Surgery - One Service Per Quadrant Or Area In Any 3 Year Period; Soft Tissue Graft - One Service Per Area In Any 3 Year Period; Scaling And Root Planing - One Per Quadrant In Any 12 Month Period	Actual Cost Of Gold/High Noble Metal Is Member's Responsibility; Reline Of Denture - One Per Denture In Any 12 Month Period; Rebase Of Denture - One Per Denture In Any 12 Month Period	Implants - Limited To 2 Per 12 Months. Replacement Of An Implant/ Abutment Is Not covered Within 10 Years Of The Original Placement Date	Impacted Teeth - Radiographic Evidence Of A Pathology; Limited To Non-Orthodontic Extractions; Biopsy - Tooth Related Only; Removal Of Cyst/Tumor - Tooth Related Only	One Course of Comprehensive Treatment Per Member; 24 Months Of Active Treatment; Limited To Fixed Banding Appliances Only; Limited To Initial Comprehensive Treatment Only	

THIS IS A REVISED UNIFORM MATIRX WHICH SUPERSEDES ANY OTHER UNIFORM MATRIX INCLUDED IN THE EVIDENCE OF COVERAGE/DISCLOSURE FORM.

REGULATIONS REQUIRE THE PLAN TO PROVIDE A UNIFORM HEALTH PLAN BENEFITS AND COVERAGE MATRIX.

GC-DHMO-MATRIX-16-CA

B425.0768

Option F

THIS MATRIX IS INTENDED TO BE USED TO HELP YOU COMPARE COVERAGE BENEFITS AND IS A SUMMARY ONLY. THE EVIDENCE OF COVERAGE AND PLAN CONTRACT SHOULD BE CONSULTED FOR A DETAILED DESCRIPTION OF COVERAGE BENEFITS AND LIMITATIONS. (CONTINUED)

N500G	Outpatient Services	Hospitalization Service	Emergency Health Coverage		Ambulance Services	Prescription Drug Services
			In-Area Emergency Dental Service	Out-Of-Area Emergency Dental Service		
	Not Covered*	Not Covered*	MDC Network Provides For Emergency Dental Services 24 Hours Per Day, 7 Days Per Week	Emergency Dental Service When More Than 50 Miles From Primary Care Dentist's Office: Limited to \$50 Reimbursement Per Incident	Not Covered*	Not Covered*
N500G	Durable Medical Equipment	Mental Health Services	Chemical Dependency Services	Home Health Services	Other	
	Not Covered*	Not Covered*	Not Covered*	Not Covered*	Not Covered*	

***SERVICES LISTED AS "NOT COVERED" ARE GENERALLY INAPPLICABLE TO DENTAL COVERAGE.**

THIS IS A REVISED UNIFORM MATRIX WHICH SUPERSEDES ANY OTHER UNIFORM MATRIX INCLUDED IN THE EVIDENCE OF COVERAGE/DISCLOSURE FORM.

REGULATIONS REQUIRE THE PLAN TO PROVIDE A UNIFORM HEALTH PLAN BENEFITS AND COVERAGE MATRIX.

GC-DHMO-MATRIX-16-CA

B425.0769

YOUR BENEFITS INFORMATION - ANYTIME, ANYWHERE

www.guardianlife.com

You can access helpful, secure information about your Guardian benefits online 24 hours a day, 7 days a week.

Anytime, anywhere you have internet access, you'll be able to:

- Review your benefits
- Look up coverage amounts
- Check the status of your claim
- Print forms and plan materials
- And so much more!

To register, go to **www.guardianlife.com**

B101.0002



**The Guardian Life Insurance
Company of America**
10 Hudson Yards
New York, New York 10001

The GUARDIAN Life Insurance Company of America
A Mutual Life Insurance Company
10 Hudson Yards, New York, New York 10001

Incorporated 1860 By The Laws of The State of New York

Amendment to Group Policy No. G- 00429264-

(To be attached to and made a part of the Policy)

The Policyholder and the Insurance Company hereby agree that Group Policy No. G- 00429264- is hereby amended effective October 1, 2019 as follows:

Your Employer Rider is hereby declared null and void and replaced with the revised corresponding Employer Rider attached hereto.

The Guardian Life Insurance Company of America

A Mutual Company - Incorporated 1860 by the State of New York
10 Hudson Yards, New York, New York 10001

POLICYHOLDER: HILTON WATERFRONT BEACH RESORT

GROUP POLICY NUMBER

G-00429264

DELIVERED IN

California

POLICY DATE

September 1, 2007

POLICY ANNIVERSARIES: September 1st of each year, beginning in 2008

THE GUARDIAN LIFE INSURANCE COMPANY OF AMERICA (herein called the Insurance Company) in consideration of the Application for this Policy and of the payment of premiums as stated herein, **AGREES** to pay benefits in accordance with and subject to the terms of this Policy.

Premiums are payable by the Policyholder as hereinafter provided. The first premium is due on the Policy Date, and subsequent premiums are, during the continuance of this Policy, due on the 1st of each month

This Policy is delivered in the jurisdiction specified above and is governed by the laws thereof.

The provisions set forth on the following pages are part of this Policy.

This Policy takes effect on the Policy Date specified above.

IN WITNESS WHEREOF, THE GUARDIAN LIFE INSURANCE COMPANY OF AMERICA has caused this Policy to be executed as of September 30, 2019 which is its date of issue.



Michael Prestileo, Senior Vice President

**GROUP INSURANCE POLICY
PROVIDING
BENEFITS AS DESCRIBED HEREIN**

Dividends Apportioned Annually

GP-1

P100.9000-R

COMPLAINT NOTICE

This notice is to advise you that should any complaints arise regarding this insurance you may contact the Guardian at the following address or phone number:

**The Guardian Sales Office
801 Parkview Drive North, Suite 100
El Segundo, CA 90245
Telephone: (310) 765- 2200
(800) 225-3399
Fax: (310) 765-2040**

If you feel your complaints have not been resolved after contacting the Guardian you may contact the California Department of Insurance at the following address or phone number:

**Department of Insurance
300 South Spring St.
Los Angeles, CA 90013
Consumer Hotline: 1-800-927-4357
Website: www.insurance.ca.gov/01-consumers/**

GP-1-CADISC-91

P120.0072-R

SCHEDULE OF INSURANCE AND PREMIUM RATES

This plan's classifications, and the option packages of benefits which are available to covered persons who are members of each classification, are shown below.

Class Description

- Class 0001** GENERAL MANAGERS, CONTROLLERS, DIRECTORS, ASST. DIRECTORS, EXECUTIVE CHEF, EXECUTIVE HOUSEKEEPER, EXECUTIVE STEWARD, MANAGERS, ASST MANAGERS, PASTRY CHEF, BANQUET CHEF, SOUS CHEF, ASST EXECUTIVE HOUSEKEEPER, ASST CONTROLLER AND ACTIVITIES DIRECTOR
- Class 0002** ALL OTHER ELIGIBLE EMPLOYEES***
- Class 0003** ROBERT MAYER EMPLOYEES (CFO, CHAIRMAN, VICE CHAIRMAN, PRESIDENT, VICE PRESIDENT, CONTROLLER, EXECUTIVE ASSISTANT AND ACCOUNTING CLERK)

GP-1-SI

P130.1566-R

Option Packages Available

Employees may choose from the benefit packages available to members of their class. The option packages are summarized in "Summary of Option Packages" below.

GP-1-SI

P130.1710-R

Members of Class 0001 may choose from benefit option packages A and B.

GP-1-SI

P130.1568-R

Members of Class 0002 may choose from benefit option packages E and F.

GP-1-SI

P130.1568-R

Summary of Option Packages

The following are summaries of the benefit option packages available. For a complete explanation of the benefits provided by this plan, including all limitations and exclusions, please read the entire plan.

GP-1-SI

P130.1585-R

Group Flexible Premium Adjustable Life Insurance, provided by The Guardian Insurance & Annuity Company, Inc. (GIAC). See the GIAC portion of this document for details.

GP-1-SI

P130.3658-R

- Option A** Employee and Dependent Dental with benefits for preventive services paid at a rate of 100%, basic services paid at a rate of 90%, major services paid at a rate of 60% and orthodontic services paid at a rate of 50%. A benefit year deductible of \$50.00 applies to the non- orthodontic services. A lower level of benefits is paid if the covered person does not use the services of a preferred provider.

GP-1-SI

P130.1830-R

Summary of Option Packages (Cont.)

Employee and Dependent Vision Care Expense Insurance with various copayments for services and supplies from PPO providers, and various deductibles for services and supplies from Non-PPO providers.

GP-1-SI P130.3656-R

Employee and Dependent Vision Care Expense Insurance with various copayments for services and supplies from PPO providers, and various deductibles for services and supplies from Non-PPO providers.

GP-1-SI P130.3656-R

Option E Employee Basic Term Life Insurance in the amount of \$20,000.00.

GP-1-SI P130.1586-R

Employee and Dependent Dental with benefits for preventive services paid at a rate of 100%, basic services paid at a rate of 90%, major services paid at a rate of 60% and orthodontic services paid at a rate of 50%. A benefit year deductible of \$50.00 applies to the non- orthodontic services. A lower level of benefits is paid if the covered person does not use the services of a preferred provider.

GP-1-SI P130.1830-R

Employee and Dependent Vision Care Expense Insurance with various copayments for services and supplies from PPO providers, and various deductibles for services and supplies from Non-PPO providers.

GP-1-SI P130.3656-R

Option F Employee Basic Term Life Insurance in the amount of \$20,000.00.

GP-1-SI P130.1586-R

Employee and Dependent Vision Care Expense Insurance with various copayments for services and supplies from PPO providers, and various deductibles for services and supplies from Non-PPO providers.

GP-1-SI P130.3656-R

Options E and F

Schedule of Benefits

Employee Basic Term Life Insurance

GP-1-SI P130.1995-R

Options E and F

Basic Term Life Insurance Amount	The Insurance Amount is	\$20,000.00
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GP-1-SI P130.2003-R

Schedule of Benefits
Employee Basic Term Life (Cont.)

Options E and F

**Reduction of Basic
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 basic life insurance amount is reduced, when he or she reaches age 70, by 50% of the amount which otherwise applies to his or her classification and/or option. But in no case will such reduced amount be less than \$1,000.00.

The preceding reduction also applies to an employee's initial insurance amount if his or her insurance starts after he or she reaches age 70.

GP-1-SI

P130.1971-R

Options A and E

Schedule of Benefits
Employee and Dependent Dental Expense

GP-1-SI

P130.9303-R

Options A and E

Cash Deductible

PPO Benefit Year Cash Deductible for Non-Orthodontic Services:

Group 1 Services	None
Group 2 and 3 Services	\$50.00

for each covered person

Non-PPO Benefit Year Cash Deductible for Non-Orthodontic Services:

Group 1 Services	None
Group 2 and 3 Services	\$50.00

for each covered person

GP-1-SI

P130.1446-R

Options A and E

Payment Rates

Payment Rate for Services Furnished By A Preferred Provider:

Group 1 Services	100%
Group 2 Services	90%
Group 3 Services	60%
Group 4 Services	50%

Payment Rate for Services **Not** Furnished By A Preferred Provider:

Group 1 Services	100%
Group 2 Services	80%
Group 3 Services	50%
Group 4 Services	50%

GP-1-SI

P130.1380-R

Schedule of Benefits

Employee and Dependent Dental Expense (Cont.)

Options A and E

Payment Limits	PPO Benefit Year Payment Limit for Non-Orthodontic Services - up to	\$1,500.00
	Non-PPO Benefit Year Payment Limit for Non-Orthodontic Services - up to	\$1,000.00
	Orthodontic Lifetime Maximum for PPO and Non-PPO 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.

A "benefit year" is a 12 month period which starts on January 1st and ends on December 31st of each year.

GP-1-SI

P130.6431-R

Options A and E

DentalGuard Preferred Plus	Benefits for services provided by a preferred provider in the plus program ("DentalGuard Preferred Plus Providers") will be reimbursed based on the non-preferred provider (Non-PPO) payment rates, deductibles, benefit year and lifetime payment limits, frequency and age limitations, coverages and exclusions.
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GP-1-SI

P130.9093-R

Options A and E

Group Enrollment Period	A group enrollment period is held each year. The group enrollment period is a time period agreed to by the employer and us. During this period, eligible employees may elect to enroll in dental insurance under this plan. Coverage starts on the first day of the month that next follow the date of enrollment. The employee and his or her eligible dependents are not subject to late entrant penalties if they enroll during the group enrollment period.
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GP-1-SI

P130.8677-R

Options A, B, E and F

Schedule of Benefits

Employee and Dependent Vision Expense

GP-1-SI

P130.3506-R

Options A, B, E and F

PPO Copayments	Examinations	\$10.00
	Standard Frames and/or Standard Lenses	\$25.00
	Contact Lenses	\$25.00

Options A, B, E and F

Non-PPO Cash Deductibles	Examinations	\$10.00
	Standard Frames and/or Standard Lenses	\$25.00
	Contact Lenses	\$25.00

Schedule of Benefits

Employee and Dependent Vision Expense (Cont.)

Options A, B, E and F

If a member receives elective contact lenses from a preferred provider that is not part of the formulary, we waive the plan's materials copay. We also waive the copay for elective contact lenses received from a non-preferred provider.

Options A, B, E and F

Payment Rates	For Covered Charges	100%
	GP-1-SI	P130.3516-R

Options A, B, E and F

Schedule of Benefits

Effective Dates for Changes to Insurance

GP-1-SI

P130.3343-R

Options A, B, E and F

Changes in Insurance Amounts

Any increase or decrease in the amount of insurance on any individual shall become effective on the effective date of a change in the Employee's classification, except that any increase in the amount of insurance on an Employee or a Qualified Dependent eligible for benefits under an established benefit period shall become effective:

- in the case of an Employee not actively at work, on the day on which he returns to active work on a full-time basis (or the day on which his benefit period terminates, whichever is later) or
- in the case of an Eligible Dependent confined to a hospital, on the day on which the dependent is discharged from the hospital (or the day on which his benefit period terminates, whichever is later).

In no event shall the insurance of an Eligible Dependent of an Employee who is not actively at work on a full-time basis be increased or decreased prior to the date such Employee returns to active work on a full-time basis.

GP-1-SI

P130.9324-R

Options A, B, E and F

Changes in Insurance Classification

If an insured Employee's classification changes, the Employee's insurance shall be adjusted automatically to conform to the new classification on the first day on which he is actively at work on full-time and makes a contribution, if required, applicable to the new classification; provided that if thirty-one days elapse after a change to a classification for which a larger amount of insurance is provided, and the Employee fails to make a contribution, if required, applicable to the new classification by the first day thereafter on which he is actively at work on full-time, no increase shall be allowed as a result of such change or any subsequent change unless the Employee furnishes evidence of insurability satisfactory to the Insurance Company. However, any Employee whose benefits were previously reduced because of an age limitation will be retained at the reduced benefits.

GP-1-SI

P130.9326-R

Schedule of Premium Rates

The monthly premium rates, in U.S. dollars, for the insurance provided under this plan are listed below.

GP-1-SI

P130.9260-R

Options E and F

Premium Rates

Employee Basic Term Life Insurance

GP-1-SI

P130.2823-R

Options E and F Class 0002

The following set of rates represents the rate per \$1,000.00 of coverage.

Rate per Employee

\$ 0.13

GP-1-SI

P130.2838-R

Options A and E

Premium Rates

Dental Expense Insurance

GP-1-SI

P130.2834-R

Options A and E Classes 0001 and 0002

Rate per Employee	per Employee and One Insured Dependent	per Employee and Two Insured Dependents	per Employee and Three or More Insured Dependents
\$ 50.89	\$ 94.51	\$ 161.58	\$ 161.58

GP-1-SI

P130.1539-R

Options A, B, E and F

Premium Rates

Vision Care Expense Insurance

GP-1-SI

P130.3517-R

Options A, B, E and F Classes 0001 and 0002

Rate per Employee	per Employee and One Insured Dependent	per Employee and Two Insured Dependents	per Employee and Three or More Insured Dependents
\$ 8.43	\$ 12.78	\$ 22.48	\$ 22.48

GP-1-SI

P130.3518-R

We have the right to change any premium rate(s) set forth above at the times and in the manner established by the provision of the group plan entitled "Premiums".

GP-1-SI

P130.9298-R

Options A, B, E and F

GENERAL PROVISIONS

Definitions

As used in this policy:

"Guardian," "Insurance Company," "our," "us" and "we" mean The Guardian Life Insurance Company of America.

"Plan" means this group insurance policy.

"Covered person" means an employee or dependent insured by this policy.

GP-1-R-GENPRO-90

P140.0136-R

Option I

GENERAL PROVISIONS

Definitions

As used in this policy:

"Guardian," "Insurance Company," "our," "us" and "we" mean The Guardian Life Insurance Company of America.

"Plan" means this group insurance policy.

"Covered person" means an employee insured by this policy.

GP-1-R-GENPRO-90

P140.0138-R

All Options

Incontestability

This Policy shall be incontestable after two years from its policy date, except for non-payment of premiums.

No statement in any application, except a fraudulent statement, made by a person insured under this policy shall be used in contesting the validity of his insurance or in denying a claim for a loss incurred, or for a disability which starts, after such insurance has been in force for two years during his lifetime.

If this policy replaces the group policy of another insurer, we may rescind this policy based on misrepresentations made in the policyholder's signed application for up to two years from this policy's policy date.

GP-1-R-INCY-96

P140.0238-R

All Options

Associated Companies

An associated company is a corporation or other business entity affiliated with the policyholder through common ownership of stock or assets.

If the policyholder asks us in writing to include an associated company under this policy, and we give our written approval, we'll treat employees of that company like the policyholder's employees. Our written approval will include the starting date of the company's coverage under this policy. But each eligible employee of that company must still meet all of the terms and conditions of this policy before he'll be insured.

The policyholder must notify us in writing when a company stops being associated with him. On the date a company stops being an associated company, this policy will end for all of that company's employees, except those employed by the policyholder or another covered associated company as eligible employees, on such date.

GP-1-R-AC-90

P140.0151-R

All Options

Premiums

Premiums due under this policy must be paid by the policyholder at an office of the Guardian or to a representative that we have authorized. The premiums must be paid as specified on the first page of this policy, unless by agreement between the policyholder and the Guardian, the interval of payment is changed. In that event, adjustment will be made to provide for payment annually, semi- annually, quarterly or monthly.

The premium due under this policy on each policy due date will be the sum of the premium charges for the insurance coverages provided under this policy. The premium charges are based upon the rates set forth in this policy's "Schedule of Insurance and Premium Rates" section.

However, we may change such rates: (a) on the first day of any policy month; (b) on any date the extent or terms of coverage for a policyholder are changed by amendment of this policy; (c) on any date our obligation under this policy with respect to a policyholder is changed because of statutory or other regulatory requirements; or (d) if this policy supplements, or coordinates with benefits provided by any other insurer, non-profit hospital or medical service plan, or health maintenance organization, on any date our obligation under this policy is changed because of a change in such other benefits.

We must give the policyholder 31 days written notice of the rate change. Such change will apply to any premium due on and after the effective date of the change stated in such notice.

Adjustment of Premiums Payable Other Than Monthly or Quarterly

Under the above provision, if a premium rate is changed after an annual or semi-annual premium became payable with respect to coverage on and after the date of such change, the premium will be adjusted by a proportionate increase or decrease for the unexpired period for which the premium became payable. If the adjustment results in a decrease, the amount of the decrease will be paid to the policyholder by us. If the adjustment results in an increase, the amount of the increase will be considered a premium due on the date of the rate change. This policy's grace period provisions will apply to any such premium due.

Grace in Payment of Premiums - Termination of Policy

A grace period of 31 days, without interest charge, will be allowed the policyholder for each premium payment except the first. If any premium is not paid before the end of the grace period, this policy automatically ends at the end of the grace period. However, if the policyholder gives us advance written notice of an earlier termination date during the grace period, this policy will end as of such earlier date.

If this policy ends during or at the end of the grace period, the policyholder will still owe us premium for all the time this policy was in force during the grace period.

This policy ends immediately on any date when an insurance coverage under this policy ends and, as a result, no benefits remain in effect under this policy.

GP-1-R-PREM-90

P140.0529-R

All Options

Term of Policy - Renewal Privilege

This policy is issued for a term of one (1) year from the policy date shown on the first page of this policy. All policy years and policy months will be calculated from the policy date. All periods of insurance hereunder will begin and end at 12:01 A.M. Standard Time at the policyholder's place of business.

If this policy provides coverage on a non-contributory basis, 100% of the employees eligible for insurance must be enrolled for coverage. If dependent coverage is provided on a non-contributory basis, all eligible dependents must be enrolled.

The policyholder may renew this policy for a further term of one (1) year, on the first and each subsequent policy anniversary. All renewals are subject to the payment of premiums then due, computed as provided in this policy's "Premiums" section.

However, we have the right to decline to renew this policy, or any coverage hereunder on any policy anniversary or premium due date, if, on that date: (a) less than 10 employees are insured under this policy; or (b) with respect to a non-contributory policy, less than 100% of those employees eligible are insured under this policy; or (c) with respect to a contributory policy, less than 75% of those employees eligible are insured under this policy.

P140.0626-R

- with respect to contributory Vision Care Expense insurance, less than 75% of those employees who are eligible for insurance under this plan are insured; or

If this policy provides dependents coverage, we may decline to renew such coverage on any policy anniversary or premium due date, if: (a) with respect to a non-contributory policy, less than 100% of all eligible dependents are enrolled for coverage under this policy; or (b) with respect to a contributory policy, less than 75% of those employees eligible for dependents coverage are insured as such.

The policyholder may cancel this policy at any time by giving us 31 days advance written notice. This notice must be sent to our Home Office. And the employer will owe us all unpaid premiums for the period this plan is in force.

The Contract

The entire contract between the Guardian and the policyholder consists of this policy, and the policyholder's application, a copy of which is attached hereto or endorsed hereon.

We can amend this policy at any time, without the consent of the insured employees or any other person having a beneficial interest therein, as follows:

We can amend this policy: (a) upon written request made by the policyholder and agreed to by the Guardian; (b) on any date our obligation under this policy with respect to a policyholder is changed because of statutory or other regulatory requirements; or (c) if this policy supplements, or coordinates with benefits provided by any other insurer, non-profit hospital or medical service plan, or health maintenance organization, on any date our obligation under this policy is changed because of a change in such other benefits.

If we amend the policy, except upon request made by the policyholder, we must give the policyholder written notice of such amendment.

Any amendments to this policy will be without prejudice to any claim arising prior to the date of the change.

No person, except by a writing signed by the President, a Vice President or a Secretary of The Guardian, has the authority to act for us to: (a) determine whether any contract, policy or certificate of insurance is to be issued; (b) waive or alter any provisions of any insurance contract or policy, or any requirements of The Guardian; or (c) bind us by any statement or promise relating to the insurance contract issued or to be issued; or (d) accept any information or representation which is not in a signed application.

All personal pronouns in the masculine gender used in this policy, will be deemed to include the feminine also, unless the context clearly indicates the contrary.

GP-1-R-TERM-90

P140.0627-R

All Options

Clerical Error - Misstatements

Neither clerical error by the policyholder, a participating employer or the Guardian in keeping any records pertaining to insurance under this policy, nor delays in making entries thereon, will invalidate insurance otherwise validly in force or continue insurance otherwise validly terminated. However, upon discovery of such error or delay, an equitable adjustment of premiums will be made.

Premium adjustments involving return of unearned premium to the policyholder will be limited to the period of 90 days preceding the date of our receipt of satisfactory evidence that such adjustments should be made.

If the age of an employee, or any other relevant facts, are found to have been misstated, and the premiums are thereby affected, an equitable adjustment of premiums will be made. If such misstatement involves whether or not an insurance risk would have been accepted by us, or the amount of insurance, the true facts will be used in determining whether insurance is in force under the terms of this policy, and in what amount.

Statements

No statement will void the insurance under this policy, or be used in defense of a claim hereunder unless: (a) in the case of the policyholder, it is contained in the application signed by him; or (b) in the case of a covered person, it is contained in a written instrument signed by him.

All statements will be deemed representations and not warranties.

GP-1-R-CE-90

P140.0309-R

Options A, B, E and F

Assignment

An employee's right to assign any interest under this policy is governed as follows:

- With respect to any death benefits (including any basic term life, supplemental term life, optional term life or accidental death and dismemberment coverages provided by this policy), the employee may, subject to the following conditions, assign all rights or interest in such insurance which he now has, or may later acquire.

The assignment of an employee's group term life insurance is irrevocable and absolute in form, for no value. The employee retains no further interest in such insurance.

The assignment may be made only to one of the following: The employee's spouse, child, grandchild, parent, grandparent, brother or sister. It may also be made to the trustee of a trust established for the benefit of one or more of these people.

We will not be charged with notice of any assignment of any interest under this policy until the original assignment has been accepted and filed with us at our Home Office. And we assume no responsibility as to the validity or effect of any such assignment.

- With respect to accident and health insurance, both the employee's certificate and his right to insurance benefits under this policy are not assignable. However, the employee may direct us, in writing, to pay hospital, surgical, major medical, or dental benefits to the recognized provider who provided the covered service for which benefits became payable. We may honor such request at our option. But, the employee may not assign his right to take legal action under this policy to such provider. And we assume no responsibility as to the validity or effect of any such direction.

Assignment By Policyholder

Assignment or transfer of the interest of the policyholder will not bind us without our written consent thereto.

GP-1-R-ASSIGN-90

P140.0164-R

Option I

Assignment

An employee's right to assign any interest under this policy is governed as follows:

- Any death benefits (including any basic term life, supplemental term life, optional term life or accidental death and dismemberment coverages) provided by this policy, may not be assigned.
- With respect to accident and health insurance, both the employee's certificate and his right to insurance benefits under this policy are not assignable. However, the employee may direct us, in writing, to pay hospital, surgical, major medical, or dental benefits to the recognized provider who provided the covered service for which benefits became payable. We may honor such request at our option. But, the employee may not assign his right to take legal action under this policy to such provider. And we assume no responsibility as to the validity or effect of any such direction.

Assignment By Policyholder

Assignment or transfer of the interest of the policyholder will not bind us without our written consent thereto.

GP-1-R-ASSIGN-90

P140.0165-R

All Options

Dividends

The portion, if any, of the divisible surplus of the Guardian allocable to this policy at each policy anniversary will be determined annually by the Board of Directors of the Guardian and will be credited to this policy as a dividend on such anniversary, provided this policy is continued in force by the payment of all premiums to such anniversary.

Any dividend under this policy will be paid to the policyholder in cash, or at the option of the policyholder it may be applied to the reduction of the premiums then due.

In the event that the employees are contributing toward the cost of the coverage under any group policy issued to the policyholder and the aggregate dividends under this policy and any other group policy or policies issued to the policyholder are in excess of the policyholder's share of the aggregate cost, such excess will be applied by the policyholder for the sole benefit of the employees.

Payment of any dividend to the policyholder will completely discharge our liability with respect to the dividend so paid.

GP-1-R-DIV-90

P140.0168-R

All Options

Employee's Certificate

We will issue to the policyholder, for delivery to each employee insured under this policy, a certificate of coverage. The certificate will state the essential features of the insurance to which the employee is entitled and to whom the benefits are payable. But the certificate does not constitute a part of this policy and will in no way modify any of the terms and conditions set forth in this policy.

In the event this policy is amended, and such amendment affects the material contained in the certificate of coverage, a rider or revised certificate reflecting such amendment will be issued to the policyholder for delivery to affected employees.

Claims of Creditors

Except when prohibited by the laws of the jurisdiction in which this policy was issued, the insurance and other benefits under this policy will be exempt from execution, garnishment, attachment, or other legal or equitable process, for the debts or liabilities of the covered persons or their beneficiaries.

Records - Information To Be Furnished.

The policyholder must keep a record of the insured employees containing, for each employee, the essential particulars of the insurance which apply to the employee. The policyholder must periodically forward to us, on our forms, such information concerning the employees in the classes eligible for insurance under this policy as may reasonably be considered to have a bearing on the administration of the insurance under this policy and on the determination of the premium rates. For benefits which are based on an employee's salary, changes in an employee's salary must promptly be reported to us. The policyholder's payroll and other such records which have a bearing on the insurance must be furnished to us at our request at any reasonable time.

GP-1-R-CERT-90

P140.0167-R

Options E, F and I

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 policy 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.

GP-1-R-EA-90

P140.0166-R

Options A, B, E and F

Accident And Health Claims Provisions

An employee's right to make a claim for any accident and health benefits provided by this plan is governed as follows:

Notice: The employee must send us written notice of an injury or sickness for which a claim is being made within 20 days of the date the injury occurs or the sickness starts. This notice should include his name and plan number. If the claim is being made for one of the employee's covered dependents, the dependent's name should also be noted.

Proof of Loss: We'll furnish the employee with forms for filing proof of loss within 15 days of receipt of notice. But if we don't furnish the forms on time, we'll accept a written description and adequate documentation of the injury or sickness that is the basis of the claim as proof of loss. The employee must detail the nature and extent of the loss for which the claim is being made. He must send us written proof within 90 days of the loss.

If this plan provides weekly loss-of-time insurance, the employee must send us written proof of loss within 90 days of the end of each period for which we're liable. If this plan provides long term disability income insurance, he must send us written proof of loss within 90 days of the date we request. For any other loss, he must send us written proof within 90 days of the loss.

Late Notice or Proof: We won't void or reduce a claim if the employee can't send us notice or proof of loss within the required time. But he must send us notice and proof as soon as reasonably possible.

Payment of Benefits: We'll pay benefits for loss of income once every 30 days for as long as we're liable, provided the employee submits periodic written proof of loss as stated above. We'll pay all other accident and health benefits to which the employee's entitled as soon as we receive written proof of loss.

We pay all accident and health benefits to the employee, if he is living. If he's not living, we have the right to pay all accident and health benefits, except dismemberment benefits, to one of the following: (a) his estate; (b) his spouse; (c) his parents; (d) his children; (e) his brothers and sisters; or (f) any unpaid provider of health care services. See "Employee Accidental Death and Dismemberment Benefits" for how dismemberment benefits are paid.

When the employee files proof of loss, he may direct us, in writing, to pay health care benefits to the recognized provider of health care who provided the covered service for which benefits became payable. We may honor such direction at our option. But we can't tell the employee that a particular provider must provide such care. And the employee may not assign his right to take legal action under this plan to such provider.

Limitation of Actions: The employee can't bring a legal action against this plan until 60 days from the date he files proof of loss. And he can't bring legal action against this plan after three years from the date he files proof of loss.

Workers' Compensation: The accident and health benefits provided by this plan are not in place of and do not affect requirements for coverage by Worker's Compensation.

GP-1-R-AH-90

P140.0169-R

Options A, B, E and F

COORDINATION BETWEEN CONTINUATION SECTIONS

A covered person may be eligible to continue his group health benefits under this plan's "Federal Continuation Rights" section and under other continuation sections of this plan at the same time. If he chooses to continue his group health benefits under more than one section, the continuations:

- (a) start at the same time;
- (b) run concurrently; and
- (c) end independently, on their own terms.

A covered person covered under more than one of this plan's continuation sections:

- (a) will not be entitled to duplicate benefits; and
- (b) will not be subject to the premium requirements of more than one section at the same time.

GP-1-R-COC-87

P240.0038-R

Options A, B, E and F

AN IMPORTANT NOTICE ABOUT CONTINUATION RIGHTS

The following "Federal Continuation Rights" section may not apply to the employer's plan. The employee must contact his employer to find out if:

- (a) the employer is subject to the "Federal Continuation Rights" section, and therefore;
- (b) the section applies to the employee.

GP-1-R-NCC-87

P240.0058-R

Options A, B, E and F

Federal Continuation Rights

Important Notice: This notice contains important information about the right to continue group dental coverage. In addition to the continuation rights described below, other health coverage alternatives may be available through states' Health Insurance Marketplaces. Please read the information contained in this notice carefully.

This section applies only to any dental, out-of-network point-of-service medical, major medical, prescription drug or vision coverages which are part of this plan. In this section, these coverages are referred to as "group health benefits."

This section does not apply to any coverages which apply to loss of life, or to loss of income due to disability. These coverages can not be continued under this section.

Under this section, "qualified continuee" means any person who, on the day before any event which would qualify him or her for continuation under this section, is covered for group health benefits under this plan as: (a) an active, covered employee; (b) the spouse of an active, covered employee; or (c) the dependent child of an active, covered employee. A child born to, or adopted by, the covered employee during a continuation period is also a qualified continuee. Any other person who becomes covered under this plan during a continuation provided by this section is not a qualified continuee.

Conversion: Continuing the group health benefits does not stop a qualified continuee from converting some of these benefits when continuation ends. But, conversion will be based on any applicable conversion privilege provisions of this plan in force at the time the continuation ends.

If an Employee's Group Health Benefits End: If an employee's group health benefits end due to his or her termination of employment or reduction of work hours, he or she may elect to continue such benefits for up to 18 months, if he or she was not terminated due to gross misconduct.

The continuation: (a) may cover the employee or any other qualified continuee; and (b) is subject to "When Continuation Ends".

Extra Continuation for Disabled Qualified Continuees: If a qualified continuee is determined to be disabled under Title II or Title XVI of the Social Security Act on or during the first 60 days after the date his or her group health benefits would otherwise end due to the employee's termination of employment or reduction of work hours, and such disability lasts at least until the end of the 18 month period of continuation coverage, he or she or any member of that person's family who is a qualified continuee may elect to extend his or her 18 month continuation period explained above for up to an extra 11 months.

To elect the extra 11 months of continuation, a qualified continuee must give you written proof of Social Security's determination of the disabled qualified continuee's disability as described in "The Qualified Continuee's Responsibilities". If, during this extra 11 month continuation period, the qualified continuee is determined to be no longer disabled under the Social Security Act, he or she must notify you within 30 days of such determination, and continuation will end, as explained in "When Continuation Ends."

This extra 11 month continuation is subject to "When Continuation Ends".

An additional 50% of the total premium charge also may be required from all qualified continuees who are members of the disabled qualified continuee's family by you during this extra 11 month continuation period, provided the disabled qualified continuee has extended coverage.

GP-1-R-COBRA-96-1

P235.0399-R

Options A, B, E and F

If an Employee Dies While Insured: If an employee dies while insured, any qualified continuee whose group health benefits would otherwise end may elect to continue such benefits. The continuation can last for up to 36 months, subject to "When Continuation Ends".

GP-1-R-COBRA-96-2

P235.0096-R

Options A, B, E and F

If an Employee's Marriage Ends: If an employee's marriage ends due to legal divorce or legal separation, any qualified continuee whose group health benefits would otherwise end may elect to continue such benefits. The continuation can last for up to 36 months, subject to "When Continuation Ends".

If a Dependent Child Loses Eligibility: If a dependent child's group health benefits end due to his or her loss of dependent eligibility as defined in this plan, other than the employee's coverage ending, he or she may elect to continue such benefits. However, such dependent child must be a qualified continuee. The continuation can last for up to 36 months, subject to "When Continuation Ends".

Concurrent Continuations: If a dependent elects to continue his or her group health benefits due to the employee's termination of employment or reduction of work hours, the dependent may elect to extend his or her 18 month or 29 month continuation period to up to 36 months, if during the 18 month or 29 month continuation period, the dependent becomes eligible for 36 months of continuation due to any of the reasons stated above.

The 36 month continuation period starts on the date the 18 month continuation period started, and the two continuation periods will be deemed to have run concurrently.

Special Medicare Rule: If the employee becomes entitled to Medicare before a termination of employment or reduction of work hours, a special rule applies for a dependent. The continuation period for a dependent, after the employee's later termination of employment or reduction of work hours, will be the longer of: (a) 18 months (29 months if there is a disability extension) from the employee's termination of employment or reduction of work hours; or (b) 36 months from the date of the employee's earlier entitlement to Medicare. If Medicare entitlement occurs more than 18 months before termination of employment or reduction of work hours, this special Medicare rule does not apply.

The Qualified Continuee's Responsibilities: A person eligible for continuation under this section must notify you, in writing, of: (a) the legal divorce or legal separation of the employee from his or her spouse; (b) the loss of dependent eligibility, as defined in this plan, of an insured dependent child; (c) a second event that would qualify a person for continuation coverage after a qualified continuee has become entitled to continuation with a maximum of 18 or 29 months; (d) a determination by the Social Security Administration that a qualified continuee entitled to receive continuation with a maximum of 18 months has become disabled during the first 60 days of such continuation; and (e) a determination by the Social Security Administration that a qualified continuee is no longer disabled.

Notice of an event that would qualify a person for continuation under this section must be given to you by a qualified continuee within 60 days of the latest of: (a) the date on which the event occurs; (b) the date on which the qualified continuee loses (or would lose) coverage under this plan as a result of the event; or (c) the date the qualified continuee is informed of the responsibility to provide notice to you and this plan's procedures for providing such notice.

Notice of a disability determination must be given to you by a qualified continuee within 60 days of the latest of (a) the date of the Social Security Administration determination; (b) the date of the event that would qualify a person for continuation; (c) the date the qualified continuee loses or would lose coverage; or (d) the date the qualified continuee is informed of the responsibility to provide notice to you and this plan's procedures for providing such notice. But such notice must be given before the end of the first 18 months of continuation coverage.

Such notice must be given to you within 60 days of either of these events.

GP-1-R-COBRA-96-3

P235.0126-R

Options A, B, E and F

Your Responsibilities: A qualified continuee must be notified, in writing, of: (a) his or her right to continue this plan's group health benefits; (b) the premium he or she must pay to continue such benefits; and (c) the times and manner in which such payments must be made.

You must give notice of the following qualifying events to the plan administrator within 30 days of the event: (a) the employee's death; (b) the employee's termination of employment (other than for gross misconduct) or reduction in hours of employment; (c) the employee's Medicare entitlement; or (d) in the case of a retired employee, your bankruptcy proceeding under Title 11 of the United States Code.

Upon receipt of notice of a qualifying event from an employer or from a qualified continuee, the plan administrator must notify a qualified continuee of the right to continue this plan's group health benefits no later than 14 days after receipt of notice.

If you are also the plan administrator, in the case of a qualifying event for which an employer must give notice to a plan administrator, you must provide notice to a qualified continuee of the right to continue this plan's group health benefits within 44 days of the qualifying event.

If you determine that an individual is not eligible for continued group health benefits under this plan, you must notify the individual with an explanation of why such coverage is not available. This notice must be provided within the time frame described above.

If a qualified continuee's continued group health benefits under this plan are cancelled prior to the maximum continuation period, you must notify the qualified continuee as soon as practical following determination that the continued group health benefits shall terminate.

Your Liability: You will be liable for the qualified continuee's continued group health benefits to the same extent as, and in place of, us, if: (a) you fail to remit a qualified continuee's timely premium payment to us on time, thereby causing the qualified continuee's continued group health benefits to end; or (b) you fail to notify the qualified continuee of his or her continuation rights, as described above.

Election of Continuation: To continue his or her group health benefits, the qualified continuee must give you written notice that he or she elects to continue. This must be done by the later of: (a) 60 days from the date a qualified continuee receives notice of his or her continuation rights from you as described above; or (b) the date coverage would otherwise end. And the qualified continuee must pay his or her first premium in a timely manner.

The subsequent premiums must be paid to you, by the qualified continuee, in advance, at the times and in the manner specified by you. No further notice of when premiums are due will be given.

The premium will be the total rate which would have been charged for the group health benefits had the qualified continuee stayed insured under the group plan on a regular basis. It includes any amount that would have been paid by you. Except as explained in "Extra Continuation for Disabled Qualified Continuees", an additional charge of two percent of the total premium charge may also be required by you.

If the qualified continuee fails to give you notice of his or her intent to continue, or fails to pay any required premiums in a timely manner, he or she waives his or her continuation rights.

Grace in Payment of Premiums: A qualified continuee's premium payment is timely if, with respect to the first payment after the qualified continuee elects to continue, such payment is made no later than 45 days after such election. In all other cases, such premium payment is timely if it is made within 31 days of the specified due date. If timely payment is made to the plan in an amount that is not significantly less than the amount the plan requires to be paid for the period of coverage, then the amount paid is deemed to satisfy the requirement for the premium that must be paid; unless you notify the qualified continuee of the amount of the deficiency and grant an additional 30 days for payment of the deficiency to be made. Payment is calculated to be made on the date on which it is sent to you.

When Continuation Ends: A qualified continuee's continued group health benefits end on the first of the following:

- (1) with respect to continuation upon the employee's termination of employment or reduction of work hours, the end of the 18 month period which starts on the date the group health benefits would otherwise end;
- (2) with respect to a qualified continuee who has an additional 11 months of continuation due to disability, the earlier of: (a) the end of the 29 month period which starts on the date the group health benefits would otherwise end; or (b) the first day of the month which coincides with or next follows the date which is 30 days after the date on which a final determination is made that the disabled qualified continuee is no longer disabled under Title II or Title XVI of the Social Security Act;
- (3) with respect to continuation upon the employee's death, the employee's legal divorce, or legal separation, or the end of an insured dependent's eligibility, the end of the 36 month period which starts on the date the group health benefits would otherwise end;
- (4) the date you cease to provide any group health plan to any employee;
- (5) the end of the period for which the last premium payment is made;
- (6) the date, after the date of election, he or she becomes covered under any other group health plan which does not contain any pre-existing condition exclusion or limitation affecting him or her; or
- (7) the date, after the date of election, he or she becomes entitled to Medicare.

GP-1-R-COBRA-96-4

P235.0142-R

Options A, B, E and F

Uniformed Services Continuation Rights

An employee who enters or returns from military service, may have special rights under this plan as a result of the Uniformed Services Employment and Reemployment Rights Act of 1994 ("USERRA").

If an employee's group health benefits under this plan would otherwise end because he or she enters into active military service, this plan will allow the employee, or his or her dependents, to continue such coverage in accord with the provisions of USERRA. As used here, "group health benefits" means any dental, out-of-network point-of service medical, major medical, prescription drug or vision coverages which are part of this plan.

Coverage under this plan may be continued while the employee is in the military for up to a maximum period of 24 months beginning on the date of absence from work. Continued coverage will end if the employee fails to return to work in a timely manner after military service ends as provided under USERRA. You must provide the employee with details about this continuation provision including required premium payments.

GP-1-R-COBRA-96-4

P235.0139-R

Options E and F

ELIGIBILITY FOR LIFE COVERAGES

P264.0016-R

Options E and F

EMPLOYEE COVERAGE

Eligible Employees

Subject to the Conditions of Eligibility set forth below, and to all of the other conditions of the plan, all of your employees who are in an eligible class will be eligible if they are active full-time employees.

For purposes of this plan, we will treat partners and proprietors like employees if they meet this plan's conditions of eligibility.

Conditions of Eligibility

An employee is eligible for coverage if he or she is:

- (a) legally working in the United States.
- (b) regularly working at least the number of hours in the normal work week set by the employer (but not less than 30 hours per week), at:
 - (i) the employer's place of business;
 - (ii) some place where the employer's business requires the employee to travel; or
 - (iii) any other place the employee and the employer have agreed upon for performance of occupational duties.

Note: An employee working outside the United States on a temporary assignment who meets all other conditions of eligibility will be covered by this plan; except that: (1) if he or she is on an assignment exceeding one year; or (2) if he or she is assigned in a country or region that is under a travel warning issued by the US Department of State; coverage must be approved by us in writing.

Temporary or seasonal employees are not eligible.

GP-1-EC-90-1.0

P264.0520-R

Options E and F

Enrollment Requirement: If an employee must pay all or part of the cost of employee coverage, we won't insure him or her until he or she enrolls and agrees to make the required payments. If he or she does this: (a) more than 31 days after he or she first becomes eligible; or (b) after he or she previously had coverage which ended because he or she failed to make a required payment, we will ask for proof that he or she is insurable. And the employee won't be covered until we approve that proof in writing.

GP-1-EC-90-2.0

P264.0992-R

Options E and F

Proof of Insurability Requirements: Part or all of an employee's insurance amounts may be subject to proof that he or she is insurable. The Schedule of Insurance explains if and when we require proof. An employee won't be covered for any amount that requires such proof until he or she gives the proof to us and we approve that proof in writing.

An employee whose active full-time service ends before he or she meets any proof of insurability requirements that apply to him or her will still have to meet those requirements if he or she is later re-employed by you or an associated company.

GP-1-EC-90-3.0

P264.0066-R

Options E and F

The Waiting Period: Employees in an eligible class are eligible for life insurance under this plan after they complete the service waiting period established by the employer, if any.

GP-1-EC-90-4.0

P264.0019-R

Options E and F

Multiple Employment: If an employee works for both you and a covered associated company, or for more than one covered associated company, we will treat him as if only one firm employs him. And such an employee will not have multiple coverage under this plan. But, if this plan uses the amount of an employee's earnings to set the rates, determine class, figure benefit amounts, or for any other reason, such employee's earnings will be figured as the sum of his earnings from all covered employers.

GP-1-EC-90-5.0

P180.0328-R

Options E and F

When Employee Coverage Starts

An employee must be fully capable of performing the major duties of his or her regular occupation for the employer on a full-time basis at 12:01 A.M. Standard Time for his or her place of residence on the date his or her coverage is scheduled to start. Also he or she must have met all of the conditions of eligibility which apply to him or her. If an employee is not fully capable of performing the major duties of his or her regular occupation on his or her scheduled effective date, we will postpone the start of his or her coverage until he or she is so capable and is working his or her regular numbers of hours.

Sometimes, a scheduled effective date is not a regularly scheduled work day. If the scheduled effective date falls: on a holiday; on a vacation day; on a non-scheduled work day; or during an approved leave of absence, not due to sickness or injury, of 90 days or less; and if the employee was performing the major duties of his or her regular occupation and working his or her regular number of hours on his or her last regularly scheduled work day, that employee's coverage will start on the scheduled effective date. However, any coverage or part of coverage for which an employee must elect and pay all or part of the cost, will not start if the employee is on an approved leave and such coverage or part of coverage was not previously in force for the employee under a prior plan which this plan replaced.

Whether an employee must pay all or part of the cost of employee coverage, he or she must elect to enroll and agree to make the required payments within 31 days of his or her eligibility date. If he or she does this on or before the eligibility date, his or her coverage is scheduled to start on his or her eligibility date. If he or she does this within 31 days after his or her eligibility date, his or her coverage is scheduled to start on the date he or she signs his or her enrollment form. However, if he or she elects to enroll and agrees to make the required payments more than 31 days after his or her eligibility date, his or her coverage won't start until he or she sends us proof that he or she is insurable. Once we've approved it, his or her coverage is scheduled to start on the effective date shown in the endorsement section of his or her application.

Any part of an employee's coverage which is subject to proof that he or she is insurable won't start unless he or she sends this proof to us, and we approve it in writing. Once we have approved it, that part of his or her coverage is scheduled to start on the effective date shown in the endorsement section of his or her application.

GP-1-EC-90-6.0

P264.0526-R

Options E and F for Class 0002

When Employee Coverage Ends

When Employee Coverage Ends: Except as explained in the "When Active Service Ends" section of this plan, an employee's insurance will end on the first of the following dates:

- the date an employee's active full-time service ends for any reason. Such reasons include disability, death, retirement, lay-off, leave of absence, and the end of employment.
- the date an employee stops being an eligible employee under this plan.
- the date an employee is no longer working in the United States, unless he or she is on a temporary assignment: (1) not exceeding one year in a country or region that is not under a travel warning issued by the US Department of State; or (2) for which we have agreed, in writing, to provide coverage.
- the date the group plan ends, or is discontinued for a class of employees to which the employee belongs.
- the last day of the period for which required payments are made for the employee.

Also, an employee may have the right to continue certain group benefits for a limited time after his or her coverage would otherwise end. And an employee may have the right to replace certain group benefits with converted policies. The plan's benefit provisions explain these situations. Read the plan's provisions carefully.

GP-1-EC-90-8.0

P264.0531-R

Options E and F for Class 0002

When Active Service Ends: You may continue an employee's life insurance under this plan after his active service with you ends only as follows:

- If an employee's active service ends because he is disabled you may continue his insurance subject to all of the terms of this plan.
- If an employee's active service ends because he goes on a leave of absence or is laid off, you may continue his insurance for the rest of the policy month in which the leave or layoff starts, plus 01 more full policy month(s). However, if the employee joins any armed force before this period ends, you may continue his insurance until the date he becomes a member of such armed force.
- If you continue an employee's benefits under this plan as set forth above, it must be based on a plan which prevents individual selection by you.
- And, any such continuation is subject to the payment of premiums, and to all of the other terms and conditions of this plan.
- The amount of an employee's insurance during any such continuation will be the amount in force on his last day of active service, subject to any reductions that would have otherwise applied if he had remained an active employee.

GP-1-EC-90-7.0

P264.0024-R

Options E and F

An Employee's Right To Continue Group Insurance During A Family Leave Of Absence

Important Notice: This section may not apply to your plan. The employee must contact you to find out if you must allow for a leave of absence under federal law. In that case the section applies.

Which Coverages Can Be Continued: Insurance which applies to loss of life may be continued at your option. The employee must contact you to find out if he or she may continue these coverages.

If An Employee's Group Coverage Would End: Group life 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 life insurance coverage if the leave of absence has been granted: (a) to allow the employee to care for a seriously injured or ill spouse, child, or parent; (b) after the birth or adoption of a child; (c) due to the employee's own serious health condition; or (d) because of any serious injury or illness arising out of the fact that a spouse, child, parent, or next of kin, who is a covered servicemember, of the employee is on active duty (or has been notified of an impending call or order to active duty) in the Armed Forces in support of a contingency operation. The employee will be required to pay the same share of the premium as he or she paid before the leave of absence.

When Continuation Ends: Insurance may continue until the earliest of the following:

- The date the employee returns to active work.
- In the case of a leave granted to the employee 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 the employee under this section for all reasons. If the employee takes 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 the Employer's Plan is terminated or the employee is 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,

GP-1-EC-90-7.0

P264.1700-R

Options E and F

Definitions

GP-1-EC-90-DEF-1

P180.0155-R

Options E and F

Employee means a person who works for the employer at the employer's place of business, and whose income is reported for tax purposes using a W-2 form.

GP-1-EC-90-DEF-3

P180.0311-R

Class 0002

Full-time means the employee regularly works at least the number of hours in the normal work week set by the employer (but not less than 30 hours per week), at his employer's place of business.

GP-1-EC-90-DEF-4

P180.0158-R

Options E and F

Plan means the Guardian group plan purchased by the employer.

GP-1-EC-90-DEF-6

P180.0975-R

Options E and F

Proof or Proof of Insurability means an application for insurance showing that a person is insurable.

GP-1-EC-90-DEF-7

P180.0161-R

Options E and F

We, Us, Our and **Guardian** mean The Guardian Life Insurance Company of America.

GP-1-EC-90-DEF-9

P180.0163-R

Options E and F

You and **Your** means the employer who purchased this plan.

GP-1-EC-90-DEF-10

P180.0164-R

Options E and F

Employee Group Term Life Insurance

Basic Life Benefit: If an employee dies while insured for this benefit, we'll pay his beneficiary the amount shown in the schedule.

Proof of Death: We'll pay this insurance as soon as we receive written proof of death. This should be sent to us as soon as possible.

The Beneficiary: The employee decides who gets this insurance if he dies. He should have named his beneficiary on his enrollment form. The employee can change his beneficiary at any time by giving the employer written notice, unless he's assigned this insurance. But, the change won't take effect until the employer gives the employee written confirmation of the change.

If the employee named more than one person, but didn't tell us what their shares should be, they'll share equally. If someone he named dies before he does, that person's share will be divided equally by the beneficiaries still alive, unless the employee has told us otherwise.

If there is no beneficiary when an employee dies, we'll pay this insurance to one of the following: (a) his estate; (b) his spouse; (c) his parents; (d) his children; or (e) his brothers and sisters.

Assigning This Life Insurance: If an employee assigns this insurance, he permanently transfers all his rights under this insurance to the assignee. Only one of the following can be an assignee: (a) his spouse; (b) one of his parents or grandparents; (c) one of his children or grandchildren; (d) one of his brothers or sisters; or (e) the trustee(s) of a trust set up for the benefit of one or more of these relatives.

We suggest the employee speak to his lawyer before he makes any assignment. If he decides he wants to assign this insurance, he should ask the employer for details or write to us.

Payment to a Minor or Incompetent: If the employee's 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 his beneficiary.

Settlement Option: If the employee or his 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.

GP-1-R-LB-90

P270.0103-R

Options E and F

Portability Privilege

Applicability: This provision applies only to this plan's employee Basic group term life insurance. It does not apply to supplemental life insurance, if any is included in this plan. And it does not apply to Accidental Death and Dismemberment Insurance.

Important Restriction: The employee must provide proof of insurability satisfactory to us.

Portability of Basic Group Term Life Insurance: An employee may elect to continue all or part of his or her employee Basic group term life insurance, by choosing a portable certificate of coverage, subject to the following terms.

The employee may port his or her coverage if coverage under this plan ends because he or she: (a) has terminated employment; or (b) stops being a member of an eligible class of employees.

The employee may not port his or her coverage, if he or she: (a) has reached his or her 70th birthday on the day coverage under this plan ends; or (b) is eligible for this plan's Basic Group Term Life Insurance Extended Life Benefit.

The employee may not port his or her coverage if coverage under this plan ends due to: (a) failure to pay any required premium; or (b) the end of this group plan.

The employee may port: (a) the full amount(s) of his or her Basic term life insurance as of the day his or her coverage under this plan ends, or (b) 50% of such amount, if such amount under this plan is at least \$50,000.00.

The Portable Certificate of Coverage: The employee 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) the employee's rate class under this plan; and (b) the employee's age bracket as shown in the Basic Life Portability Coverage Premium Notice.

How to Port: To get a portable certificate of coverage, the employee must: (a) apply to us in writing; and (b) pay the required premium. He or she has 31 days from the date his or her coverage under this plan ends to do this. We require proof of insurability satisfactory to us.

Defined Term: As used in this provision, the term "port" means to choose a portable certificate of coverage which provides group term life insurance.

GP-1-R-LP-00

P270.0372-R

Options E and F

Information About Conversion and Portability

No covered person is allowed to convert his or her coverage, and elect a portable certificate of coverage at the same time. If a situation arises in which a covered person would be eligible to both convert and port, he or she may only exercise one of these privileges. A covered person may never be insured under both a converted policy and a portable certificate of coverage at the same time. The covered person should read his or her plan, as well as any related materials carefully before making an election.

GP-1-R-LPN-95

P270.0300-R

Options E and F

THE FOLLOWING PROVISION APPLIES TO EMPLOYEE BASIC TERM LIFE INSURANCE:

Options E and F

CONVERTING THIS GROUP TERM LIFE INSURANCE

If Employment or Eligibility Ends: The employee's group life insurance ends if: (a) his or her employment ends; or (b) he or she stops being a member of an eligible class of employees. If either happens, the employee can convert his or her group life insurance to an individual life insurance policy. Conversion choices are based on the employee's disability status.

If the employee is not disabled, as defined in the section labeled "Extended Life Benefit With Waiver of Premium", he or she can convert to a permanent life insurance policy. The employee can convert the amount for which he or she was covered under this plan, less any group life benefits he or she becomes eligible for in the 31 days after this insurance ends.

If the employee: (a) is disabled, as defined in the section labeled "Extended Life Benefit With Waiver of Premium"; and (b) has not yet been approved for the Extended Life Benefit, he or she 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". The employee can convert the full amount for which he or she was covered under this plan.

If the disabled employee is 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: The employee's 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 his or her class. If either happens, the employee may be eligible to convert as explained below. Conversion choices are based on the employee's disability status.

If the employee: (a) is not disabled, as defined in the section labeled "Extended Life Benefit With Waiver of Premium", when this coverage ends ; and (b) the employee has been insured by a Guardian group life plan for at least five years, he or she can convert to a permanent life insurance policy. But, the amount the employee can convert is limited to the lesser of: (a) \$2,000.00; or (b) the amount of his or her insurance under this plan, less any group life benefits he or she becomes eligible for in the 31 days after this insurance ends.

If the employee: (a) is disabled, as defined in the section labeled "Extended Life Benefit With Waiver of Premium"; and (b) has not yet been approved for the Extended Life Benefit, he or she can convert to: (a) a permanent life insurance policy; or (b) an interim term insurance policy. The employee can convert the full amount for which he or she was covered under this plan.

If the disabled employee is 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 the employee's 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 the employee: (a) is disabled, as defined in the section labeled "Extended Life Benefit With Waiver of Premium"; and (b) has not yet been approved for the Extended Life Benefit, the employee has the option to convert his or her 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 the employee becomes disabled. During this year, if the employee is approved for the Extended Life Benefit, the interim term insurance is cancelled, as of our approval date. If, after one year, we have not approved the employee for the Extended Life Benefit, he or she 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 the employee's age as of the date he or she converts from the interim term insurance policy.

How and When to Convert: To get a converted policy, the employee must apply to us in writing and pay the required premium. He or she has 31 days after his or her group life insurance ends to do this. We won't ask for proof that he or she is insurable.

Death During the Conversion Period: If an employee dies in the 31 days allowed for conversion, we'll pay his or her beneficiary the amount he or she could have converted. We'll pay whether or not he or she applied for conversion.

Notice of Conversion Right: If the employee 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 the employee by the employer; (b) mailed to the employee by the employer at the employee's last known address; or (c) mailed to the employee by us at the employee's last known address that is supplied to us by the employer.

This notice should be given at least 15 days before the end of the 31 day period allowed for conversion as described in "How and When to Convert." If the notice is not given at least 15 days before the end of such period, the employee will have an additional period of 25 days from the date notice is given to apply for the converted policy and pay the required premium. But, in no event shall the additional period extend more than 60 days beyond the 31 day period allowed for conversion as described above.

Options E and F

Extended Life Benefit With Waiver of Premium

Important Notice: This section applies to the employee's basic life benefit. But, it does not apply to his or her accidental death and dismemberment benefits; nor to any of his or her dependent's insurance under this group plan. In order to continue dependent basic life insurance, the employee must convert his or her dependent coverage to an individual permanent policy.

If an Employee is Disabled: An employee is disabled if he or she meets the definition of total disability, as stated below. If a disabled employee meets the requirements in the "How and When to Apply" provision, we'll extend his or her basic life insurance under this section without payment of premiums from you or the employee.

Total Disability or Totally Disabled means, due to sickness or injury, an employee is:

- (a) not able to perform any work for wages or profit; and
- (b) he or she is receiving regular doctor's care appropriate to the cause of disability.

How and When To Apply: To apply for this extension, the employee must submit satisfactory written medical proof of his or her 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) the employee lacked the legal capacity to file the claim; or (b) it was not reasonably possible for the employee to file the claim.

Also, in order to be eligible for this extension, the employee must:

- (a) become totally disabled before he or she reaches age 60 and while insured by the group plan; and
- (b) remain totally disabled for 09 continuous months.

The employee is encouraged to apply for this benefit immediately upon the onset of disability.

Continued Eligibility For Extended Life Benefit: We may require periodic written proof that the employee remains totally disabled to maintain this extension. This written proof of the employee's 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 the employee to 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 his or her life benefits. But after two years, we can't have the employee examined more than once a year.

Until We've Approved an Employee for this Extended Life Benefit: An employee's life insurance under the group plan may end after he or she's become totally disabled, but before we've approved him or her for this extension. During this time period, the employee may either:

- (a) continue group premium payments, including any portion which would have been paid by the employer until the employee is 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 the employee is totally disabled and eligible, but not yet approved, for this extended benefit, the employee must convert to an individual permanent or term policy and remain insured under such policy until he or she is approved by us for the extended benefit.

Converting does not stop the employee from claiming his or her rights under this section. But if he or she converts and we later approve him or her for this extended benefit, we'll cancel the converted policy as of our approval date. Once an employee is approved for this extended benefit, his or her group term life coverage will be reinstated at no further cost to you or the employee.

When This Extension Begins: Once approved by us, an employee's extended benefit will be effective on the later of:

- (a) 09 continuous months from the date active full-time service ends due to total disability; or
- (b) the date we approve the employee for this benefit.

GP-1-R-LW-TD-99-1

P275.0497-R

Options E and F

When This Extension Ends: An employee's extension will end on the earliest of:

- (a) the date he or she is no longer disabled;
- (b) the date we ask an employee to be examined by our doctor, and he or she refuses;
- (c) the date the employee does not give us the proof of disability we require;
- (d) the date the employee is no longer receiving regular doctor's care appropriate to the cause of disability;
or
- (e) the day before the date the employee reaches age 65.

If the extension ends, and the employee is not insured by the group plan again as an active full-time employee, the employee can convert as if his or her employment just ended. Read the section labeled "Converting This Group Term Life Insurance".

If an Employee Dies While Covered By This Extension: If an employee dies while covered by this extension we'll pay his or her beneficiary the amount for which he or she was covered as of his or her last day of active full-time work, subject to all reductions which would have applied had he or she stayed an active employee.

Proof of Death: We'll pay as soon as we receive:

- (a) written proof of the employee's death, that is acceptable to us; and
- (b) medical proof that the employee was continuously disabled until his or her death. This must be sent within one year of the employee's death.

GP-1-R-LW-TD-99-2

P275.0049-R

Options E and F

COMPUTATION OF GROUP LIFE INSURANCE PREMIUMS

Definitions:

"Plan" means the Guardian group life insurance plan purchased by the employer.

"We", "us", and "our" mean the Guardian Life Insurance Company of America.

"You" and "your" mean the employer who purchased this plan.

How Group Life Rates Are Computed:

The "Table of Individual Rates" shown below will, subject to our rating methods, be used in computing the premium charges for this plan's group life insurance. As stated in this plan's "Premiums" section, we can change that table.

When this plan's group life insurance starts, we'll compute a preliminary monthly rate. We do this by: (1) multiplying the individual rates by the amounts of insurance in force at the respective ages, nearest birthday, of all employees; and (2) dividing the result by the total amount of insurance in force. Using the characteristics of your group, and our rating methods, we'll modify such preliminary rate and compute your final premium rate.

We may also compute your final premium rate by any other method we and you agree upon, which produces approximately the same total premium.

If We Provide Supplemental Term Life Insurance: If we provide Supplemental Term Life Insurance, we'll use the employee's rated age to compute premium rates, if the employee is placed in a substandard class.

If You Pay Monthly Premiums: If you pay monthly premiums, each monthly payment will be equal to the product of the total amount of insurance in force on the premium's due date and the monthly rate in effect for each employee.

If You Pay Annual, Semi-Annual, or Quarterly Premiums: If you pay annual, semi-annual or quarterly premiums, we'll compute the applicable rate by multiplying the monthly rate so obtained by 11.823, 5.956, or 2.985, respectively.

Table of Individual Rates
Group Term Life Insurance
Monthly Premiums Per \$1,000.00 of Employee Life Insurance

<u>Age</u> <u>Nearest</u> <u>Birthday</u>	<u>Monthly</u> <u>Rate</u>	<u>Age</u> <u>Nearest</u> <u>Birthday</u>	<u>Monthly</u> <u>Rate</u>	<u>Age</u> <u>Nearest</u> <u>Birthday</u>	<u>Monthly</u> <u>Rate</u>	<u>Age</u> <u>Nearest</u> <u>Birthday</u>	<u>Monthly</u> <u>Rate</u>
15	\$.19	32	\$.28	49	\$.97	66	\$ 4.11
16	.20	33	.29	50	1.06	67	4.48
17	.21	34	.30	51	1.16	68	4.89
18	.22	35	.32	52	1.26	69	5.34
19	.23	36	.34	53	1.38	70	5.81
20	.23	37	.36	54	1.51	71	6.32
21	.24	38	.38	55	1.65	72	6.84
22	.24	39	.41	56	1.80	73	7.38
23	.25	40	.45	57	1.97	74	7.95
24	.25	41	.49	58	2.14	75	8.56
25	.25	42	.53	59	2.32	76	9.24
26	.25	43	.58	60	2.51	77	10.00
27	.26	44	.63	61	2.72	78	10.86

<u>Age Nearest Birthday</u>	<u>Monthly Rate</u>	<u>Age Nearest Birthday</u>	<u>Monthly Rate</u>	<u>Age Nearest Birthday</u>	<u>Monthly Rate</u>	<u>Age Nearest Birthday</u>	<u>Monthly Rate</u>
28	.26	45	.68	62	2.96	79	11.81
29	.26	46	.74	63	3.21	80	12.83
30	.27	47	.81	64	3.48		
31	.27	48	.89	65	3.78		

Upon request we will furnish rates for ages not shown.

Employee Contributions: Employees' required contributions towards the cost of this insurance may not vary solely by sex.

When Rates Can Be Changed: We or you may require appropriate rate changes on each Policy Anniversary after the effective date of this plan, or on any date on which the above table is changed.

GP-1-R-LRMP-86-1

P270.0023-R

Options A and E

ELIGIBILITY FOR DENTAL COVERAGE

P489.0005-R

Options A and E

EMPLOYEE COVERAGE

Eligible Employees

Subject to the Conditions of Eligibility set forth below, and to all of the other conditions of the plan, all of your employees who are in an eligible class will be eligible if they are active full-time employees.

For purposes of this plan, we will treat partners and proprietors like employees if they meet this plan's conditions of eligibility.

Conditions of Eligibility

Full-time Requirement: We won't insure an employee unless he or she is an active full-time employee.

GP-1-EC-90-1.0

P180.0168-R

Options A and E

Enrollment Requirement: If an employee must pay part of the cost of employee coverage, we won't insure him until he enrolls in the plan and agrees to make the required payments. If he does this: (a) more than 31 days after he first becomes eligible; or (b) after he previously had coverage which ended because he failed to make a required payment, we will consider the employee to be a late entrant.

If an employee initially waived dental coverage under this plan because he or she was covered under another group plan, and he or she now elects to enroll in the dental coverage under this plan, the Penalty for Late Entrants provision will not apply to him or her with regard to dental coverage provided his or her coverage under the other plan ends due to one of the following events:

- (a) termination of his or her spouse's employment;
- (b) loss of eligibility under his or her spouse's plan;
- (c) divorce;
- (d) death of his or her spouse; or
- (e) termination of the other plan.

But the employee must enroll in the dental coverage under this plan within 30 days of the date that any of the events described above occur.

GP-1-EC-90-2.0

P180.0963-R

Options A and E for Classes 0001 and 0002

Dental Plan Election Procedures: Since you offer your employees Managed DentalGuard as an alternative to this dental coverage, each employee who is enrolled in this coverage may change his or her election, and enroll in Managed DentalGuard as follows.

If the employee drops his or her coverage under this plan, at any time other than during an open enrollment period, he or she may not enroll in Managed DentalGuard until the open enrollment period which starts at least 12 months after the date coverage is dropped.

If the employee remains covered under this plan, he or she may change his or her election, and enroll in Managed DentalGuard during an open enrollment period. The employee's coverage under this plan ends on the date coverage under Managed DentalGuard begins.

An "open enrollment period" is a 30 day period occurring once every 12 months after this plan's effective date, or at time intervals agreed upon by the employer and us.

If an employee changes his or her election, the employee's covered dependents will automatically be switched to Managed DentalGuard at the same time as the employee.

GP-1-EC-90-2.0

P489.0108-R

Options A and E

The Waiting Period: Employees in an eligible class are eligible for dental insurance under this plan after they complete the service waiting period established by the employer, if any.

GP-1-EC-90-4.0

P489.0004-R

Options A and E

Multiple Employment: If an employee works for both you and a covered associated company, or for more than one covered associated company, we will treat him as if only one firm employs him. And such an employee will not have multiple coverage under this plan. But, if this plan uses the amount of an employee's earnings to set the rates, determine class, figure benefit amounts, or for any other reason, such employee's earnings will be figured as the sum of his earnings from all covered employers.

GP-1-EC-90-5.0

P180.0328-R

Options A and E for Classes 0001 and 0002

When Employee Coverage Starts

An employee must be actively at work, and working his regular number of hours, on the date his coverage is scheduled to start. And he must have met all of the conditions of eligibility which apply to him. If an employee is not actively at work on his scheduled effective date, we will postpone the start of his coverage until he returns to active work.

Sometimes, a scheduled effective date is not a regularly scheduled work day. But an employee's coverage will start on that date if he was actively at work, and working his regular number of hours, on his last regularly scheduled work day.

The scheduled effective date of an employee's coverage is as follows:

- If an employee must pay part of the cost of employee coverage, then he must elect to enroll and agree to make the required payments. If he does this on or before the eligibility date, his coverage is scheduled to start on his eligibility date. If he does this after his eligibility date, his coverage is scheduled to start on the date he signs his enrollment form.

- On non-contributory plans, subject to all the terms of this plan, an employee's coverage is scheduled to start on his eligibility date.

GP-1-EC-90-6.0

P180.0969-R

Options A and E for Classes 0001 and 0002

When Employee Coverage Ends

When Employee Coverage Ends: Except as explained in the "When Active Service Ends" section of this plan, an employee's insurance will end on the first of the following dates:

- the last day of the month in which an employee's active full-time service ends for any reason other than disability. Such reasons include retirement, layoff, leave of absence or the end of employment.
- the date an employee dies.
- the date the group plan ends, or is discontinued for a class of employees to which the employee belongs; or
- the day prior to the last premium due date for which required payments are made for the employee.
- the last day of the month in which an employee stops being an eligible employee under this plan for any reason not named above.

Also, an employee may have the right to continue certain group benefits for a limited time after his or her coverage would otherwise end. The plan's benefit provisions explain these situations. Read the plan's provisions carefully.

GP-1-EC-90-8.0

P489.0006-R

Options A and E for Classes 0001 and 0002

When Active Service Ends: You may continue an employee's dental expense insurance under this plan after his active service with you ends only as follows:

- If an employee's active service ends because he is disabled you may continue his insurance subject to all of the terms of this plan.
- If an employee's active service ends because he goes on a leave of absence, except as noted below, or is laid off, you may continue his insurance for the rest of the policy month in which the leave or layoff starts, plus 1 more full policy month(s). However, if the employee joins any armed force before this period ends, you may continue his insurance until the date he becomes a member of such armed force.
- If an employee's active service ends because she goes on leave for pregnancy, childbirth or a related medical condition you must continue the employee's coverage for up to four months during any twelve consecutive months.
- If you continue an employee's benefits under this plan as set forth above, it must be based on a plan which prevents individual selection by you.
- And, any such continuation is subject to the payment of premiums, and to all of the other terms and conditions of this plan. In regards to leave for pregnancy, childbirth or a related condition you may recover from the employee premium paid if: 1) the employee fails to return from leave after four months; and 2) the employee's failure to return is for a reason other than one of the following: (a) the employee taking leave under the Moore-Brown-Roberti Family Rights Act; (b) the continuation, recurrence, or onset of a health condition that entitles the employee to leave is beyond the control of the employee; or (c) if the employer is a state agency, the collective bargaining agreement will govern.
- The amount of an employee's insurance during any such continuation will be the amount in force on his last day of active service, subject to any reductions that would have otherwise applied if he had remained an active employee.

GP-1-EC-90-7.0

P489.0652-R

Options A and E

An Employee's Right To Continue Group Insurance During A Family Leave Of Absence

Important Notice: This section may not apply to your plan. The employee must contact you to find out if you must allow for a leave of absence under federal law. In that case the section applies.

If An Employee's Group Coverage Would End: Group coverage may normally end for an employee because he or she ceases work due to an approved leave of absence. But, the employee may continue his or her group coverage if the leave of absence has been granted: (a) to allow the employee to care for a seriously injured or ill spouse, child, or parent; (b) after the birth or adoption of a child; (c) due to the employee's own serious health condition; or (d) because of any serious injury or illness arising out of the fact that a spouse, child, parent, or next of kin, who is a covered servicemember, of the employee is on active duty (or has been notified of an impending call or order to active duty) in the Armed Forces in support of a contingency operation. The employee will be required to pay the same share of the premium as he or she paid before the leave of absence.

When Continuation Ends: Insurance may continue until the earliest of the following:

- The date the employee returns to active work.
- The end of a total leave period of 26 weeks in one 12 month period, in the case of an employee who cares for a covered servicemember. This 26 week total leave period applies to all leaves granted to the employee under this section for all reasons.
- The end of a total leave period of 12 weeks in: (a) any 12 month period, in the case of any other employee; or (b) any later 12 month period in the case of an employee who cares for a covered servicemember.
- The date on which the employee's coverage would have ended had the employee not been on leave.
- The end of the period for which the premium has been paid.

Definitions: As used in this section, the terms listed below have the meanings shown below:

- **Active Duty:** This term means duty under a call or order to active duty in the Armed Forces of the United States.
- **Contingency Operation:** This term means a military operation that: (a) is designated by the Secretary of Defense as an operation in which members of the armed forces are or may become involved in military actions, operations, or hostilities against an enemy of the United States or against an opposing military force; or (b) results in the call or order to, or retention on, active duty of members of the uniformed services under any provision of law during a war or during a national emergency declared by the President or Congress.
- **Covered Servicemember:** This term means a member of the Armed Forces, including a member of the National Guard or Reserves, who for a serious injury or illness: (a), is undergoing medical treatment, recuperation, or therapy; (b) is otherwise in outpatient status; or (c) is otherwise on the temporary disability retired list.
- **Next Of Kin:** This term means the nearest blood relative of the employee.
- **Outpatient Status:** This term means, with respect to a covered servicemember, that he or she is assigned to: (a) a military medical treatment facility as an outpatient; or (b) a unit established for the purpose of providing command and control of members of the Armed Forces receiving medical care as outpatients.

- **Serious Injury Or Illness:** This term means, in the case of a covered servicemember, an injury or illness incurred by him or her in line of duty on active duty in the Armed Forces that may render him or her medically unfit to perform the duties of his or her office, grade, rank, or rating,

GP-1-EC-90-7.0

P449.0523-R

Options A and E

Definitions

GP-1-EC-90-DEF-1

P180.0155-R

Options A and E

Eligible Dependent is defined in the provision entitled "Dependent Coverage".

GP-1-EC-90-DEF-2

P180.0156-R

Options A and E

Employee means a person who works for the employer at the employer's place of business, and whose income is reported for tax purposes using a W-2 form.

GP-1-EC-90-DEF-3

P180.0311-R

Classes 0001 and 0002

Full-time means the employee regularly works at least the number of hours in the normal work week set by the employer (but not less than 30 hours per week), at his employer's place of business.

GP-1-EC-90-DEF-4

P180.0158-R

Options A and E

Plan means the Guardian group plan purchased by the employer, except in the provision entitled "Coordination of Benefits" where "plan" has a special meaning. See that provision for details.

GP-1-EC-90-DEF-6

P180.0160-R

Options A and E

We, Us, Our and **Guardian** mean The Guardian Life Insurance Company of America.

GP-1-EC-90-DEF-9

P180.0163-R

Options A and E

You and **Your** means the employer who purchased this plan.

GP-1-EC-90-DEF-10

P180.0164-R

Options A and E

Dependent Coverage

GP-1-DEP-90-1.0

P200.0305-R

Options A and E

Eligible Dependents For Dependent Dental Benefits: An employee's eligible dependents are: (a) his or her legal spouse; (b) his or her dependent children who are under age 26.

GP-1-DEP-90-2.0

P489.0486-R

Options A and E

Adopted Children and Step-Children: An employee's "dependent children" include his or her legally adopted children and, his or her step-children.

We treat a child as legally adopted from the time the child is placed in the physical custody of the employee for the purpose of adoption. We treat such a child this way whether or not a final adoption order is ever issued. We cover an employee's adopted child from the moment of his or her placement if the employee is already covered for dependent child coverage when the child is placed for adoption. If the employee does not have dependent coverage when the child is placed for adoption, we cover the child for the first 31 days from the moment of his or her placement. To continue the child's coverage past the 31 days, the employee must enroll the child and agree to make any required premium payments within 31 days of the date of placement. If the employee fails to do this, the child's coverage will end at the end of the 31 days. The child won't be covered by this plan again until the employee enrolls the child. Then the child will be covered as of the date the employee signs the enrollment form and will be late entrant and subject to any applicable late entrant penalties.

If this plan has pre-existing restrictions, they will not apply to a minor child adopted by the employee after this plan starts.

Dependents Not Eligible: We exclude any dependent who is insured by this plan as an employee. And we exclude any dependent who is on active duty in any armed force.

GP-1-DEP-90-3.0

P489.0526-R

Options A and E

Handicapped Children: An employee may have an unmarried child with a mental or physical handicap, or developmental disability, who can't support himself or herself. Subject to all of the terms of this coverage and the plan, such a child may stay eligible for dependent benefits past this coverage's age limit.

The child will stay eligible as long as he or she stays unmarried and unable to support himself or herself, if: (a) his or her conditions started before he or she reached the age limit; (b) he or she became insured before he or she reached the age limit, and stayed continuously insured until he or she reached such limit; and (c) he or she depends on the employee for most of his or her support and maintenance.

But, for the child to stay eligible, the employee must send us written proof that the child is handicapped and depends on the employee for most of his or her support and maintenance. The employee has 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 the employee's does.

GP-1-DEP-90-4.0

P489.0030-R

Options A and E

Waiver of Dental Late Entrants Penalty: If an employee initially waived dental coverage for his or her spouse or eligible dependent children because they were covered under another group plan, and he or she now elects to enroll them in the dental coverage under this plan, the Penalty for Late Entrants provision will not apply to them with regard to dental coverage provided their coverage under the other plan ends due to one of the following events:

- (a) termination of his or her spouse's employment;
- (b) loss of eligibility under his or her spouse's plan;
- (c) divorce;
- (d) death of his or her spouse; or
- (e) termination of the other plan.

But the employee must enroll his or her spouse or eligible dependent children in the dental coverage under this plan within 30 days of the date that any of the events described above occur.

And, the Penalty for Late Entrants provisions for dental coverage will not apply to the employee's spouse or eligible dependent children if: (a) he or she is under legal obligation to provide dental coverage due to a court-order; and (b) he or she enrolls them in the dental coverage under this plan within 30 days of the issuance of the court-order.

GP-1-DEP-90-5.0

P200.0771-R

Options A and E for Classes 0001 and 0002

When Dependent Coverage Starts: In order for an employee's dependent coverage to begin he or she must already be insured for employee coverage or enroll for employee and dependent coverage at the same time. Subject to the "Exception" stated below and to all of the terms of this plan, the date an employee's dependent coverage starts depends on when he or she elects to enroll his or her initial dependents and agrees to make any required payments.

If the employee does this on or before his or her eligibility date, the dependent's coverage is scheduled to start on the later of the first of the month which coincides with or next follows the employee's eligibility date and the date the employee becomes insured for employee coverage.

If the employee does this within the enrollment period, the coverage is scheduled to start on the later of the first of the month which coincides with or next follows the date the employee signs the enrollment form; and the date the employee becomes insured for employee coverage.

If the employee does this after the enrollment period ends, each of an employee's initial dependents is a late entrant and is subject to any applicable late entrant penalties. The dependent's coverage is scheduled to start on the first of the month which coincides with or next follows the date the employee signs the enrollment form.

Once an employee has dependent coverage for his or her initial dependents, he or she must notify us when he or she acquires any new dependents and agree to make any additional payments required for their coverage.

If an employee does this within 31 days of the date the newly acquired dependent becomes eligible, the dependent's coverage will start on the date the dependent first becomes eligible. If an employee fails to notify us on time, the newly acquired dependent, when enrolled, is a late entrant and is subject to any applicable late entrant penalties. The late entrant's coverage is scheduled to start on the date the employee signs the enrollment form.

GP-1-DEP-90-6.0

P489.0063-R

Options A and E

Exception: If a dependent, other than a newborn child, is confined to a hospital or other health care facility; or is unable to carry-out the normal activities of someone of like age and sex on the date his or her dependent benefits would otherwise start, we'll postpone the effective date of such benefits until the day after his or her discharge from such facility; or until he or she resumes the normal activities of someone of like age and sex.

GP-1-DEP-90-7.0

P200.0708-R

Options A and E

Newborn Children: We cover an employee's newborn child from the moment of his or her birth if the employee is already covered for dependent child coverage when the child is born. If the employee does not have dependent coverage when the child is born, we cover the child for the first 31 days from the moment of his or her birth. To continue the child's coverage past the 31 days, the employee must enroll the child and agree to make any required premium payments within 31 days of the date the child is born. If the employee fails to do this, the child's coverage will end at the end of the 31 days. The child won't be covered by this plan again until the employee enrolls the child. Then the child will be covered as of the date the employee signs the enrollment form and will be a late entrant and subject to any applicable late entrant penalties.

GP-1-DEP-90-8.0

P489.0227-R

Options A and E

When Dependent Coverage Ends: Dependent coverage ends for all of an employee's dependents when his or her employee coverage ends. But if an employee dies while insured, we'll automatically continue dependent benefits for those of his or her dependents who were insured when he or she died. We'll do this for six months at no cost, provided: (a) the group plan remains in force; (b) the dependents remain eligible dependents; and (c) in the case of a spouse, the spouse does not remarry.

If a surviving dependent elects to continue his or her dependent benefits under this plan's "Federal Continuation Rights" provision, or under any other continuation provision of this plan, if any, this free continuation period will be provided as the first six months of such continuation. Premiums required to be paid by, or on behalf of a surviving dependent will be waived for the first six months of continuation, subject to restrictions (a), (b) and (c) above. After the first six months of continuation, the remainder of the continuation period, if any, will be subject to the premium requirements, and all of the terms of the "Federal Continuation Rights" or other continuation provisions.

Dependent coverage also ends for all of an employee's dependents when the employee stops being a member of a class of employees eligible for such coverage. And it ends when this plan ends, or when dependent coverage is dropped from this plan for all employees or for an employee's class.

If an employee is required to pay all or part of the cost of dependent coverage, and he or she fails to do so, his or her dependent coverage ends. It ends on the last day of the period for which he or she made the required payments, unless coverage ends earlier for other reasons.

An individual dependent's coverage ends when he or she stops being an eligible dependent. This happens to a child on the last day of the month in which the child attains this plan's age limit. It happens to a spouse on the last day of the month in which a marriage ends in legal divorce or annulment.

Read this plan carefully if dependent coverage ends for any reason. Dependents may have the right to continue certain group benefits for a limited time.

GP-1-DEP-90-9.0

P489.0492-R

Options A and E

Definitions

GP-1-DEP-90-DEF-1

P200.0210-R

Options A and E

Eligibility Date for dependent coverage is the earliest date on which: (a) the employee has dependents; and (b) is eligible for dependent coverage.

GP-1-DEP-90-DEF-2

P200.0211-R

Options A and E

Eligible Dependent is defined in the provision entitled "Dependent Coverage."

GP-1-DEP-90-DEF-3

P200.0212-R

Options A and E

Enrollment Period means the 31 day period which starts on the date that the employee is eligible for dependent coverage.

GP-1-DEP-90-DEF-4

P200.0213-R

Options A and E

Initial Dependents means those eligible dependents the employee has at the time he or she first becomes eligible for employee coverage. If at this time he or she does not have any eligible dependents, but later acquires them, the first eligible dependents he or she acquires are his or her initial dependents.

GP-1-DEP-90-DEF-8

P200.0217-R

Options A and E

Newly Acquired Dependent means an eligible dependent the employee acquires after he or she already has coverage in force for initial dependents.

GP-1-DEP-90-DEF-9

P200.0218-R

Options A and E

Plan means the Guardian group plan purchased by the employer, except in the provision entitled "Coordination of Benefits" where "plan" has a special meaning. See that provision for details.

GP-1-DEP-90-DEF-11

P200.0220-R

Options A and E

We, Us, Our and **Guardian** means The Guardian Life Insurance Company of America.

GP-1-DEP-90-DEF-14

P200.0223-R

Options A and E

You and **Your** means the employer who purchased this plan.

GP-1-DEP-90-DEF-15

P200.0224-R

Options A and E

ATTACHED TO AND MADE PART OF GROUP INSURANCE POLICY NO. G-00429264-

issued by

The Guardian Life Insurance Company of America

(herein called the Insurance Company)

to

HILTON WATERFRONT BEACH RESORT

(herein called the Policyholder)

Effective September 1, 2007, this rider amends the dependent coverage provisions as follows:

An employee's domestic partner will be eligible for coverage under this plan subject to all of the terms of this plan and the limitations below. "Domestic partner" means an adult who has chosen to share his or her life with the employee in an intimate and committed relationship of mutual caring.

To qualify for such coverage, the employee and his or her domestic partner must be either:

- (a) registered domestic partners; or
- (b) non-registered domestic partners.

As used here:

"Registered domestic partners" means an employee and his or her domestic partner who: (a) have filed a Declaration of Domestic Partnership with the California Secretary of State; (b) were registered as a domestic partner in the registry for those partnerships; and (c) were issued a copy of the registered form and a Certificate of Registered Domestic Partnership.

"Non-registered domestic partners" means an employee and his or her domestic partner who:

- are 18 years of age or older;
- are unmarried, constitute each other's sole domestic partner, and have not had another domestic partner in the last 12 months;
- share the same permanent address for at least 12 consecutive months and intend to do so indefinitely;
- share joint financial responsibility for basic living expenses including food, shelter and medical expenses;
- are not related by blood to a degree that would prohibit marriage in the employee's state of residence; and
- are financially interdependent which must be demonstrated by at least four of the following:
 - a. ownership of a joint bank account;
 - b. ownership of a joint credit account;
 - c. evidence of a joint mortgage or lease;
 - d. evidence of joint obligation on a loan;
 - e. joint ownership of a residence;
 - f. evidence of common household expenses such as utilities or telephone;
 - g. execution of wills naming each other as executor and/or beneficiary;
 - h. granting each other durable powers of attorney;

- i. granting each other health care powers of attorney;
- j. designation of each other as beneficiary under a retirement benefit account; or
- k. evidence of other joint financial responsibility.

An employee's registered domestic partner, or non-registered domestic partner, will be eligible for dental coverage under this plan.

To cover his or her non-registered domestic partner, the employee must complete a "Declaration of Domestic Partnership" attesting to the relationship and forward it to us.

A registered or non-registered domestic partner's dependent children will be eligible for coverage under this plan on the same basis as if the children were the employee's dependent children.

Coverage for a registered domestic partner and his or her dependent children ends when the domestic partnership is dissolved as provided under California law.

Coverage for a non-registered domestic partner and his or her dependent children ends when the domestic partner no longer meets the qualifications of a non-registered domestic partner as described above. Upon termination of a non-registered domestic partnership, a "Statement of Termination" must be completed and filed with the employer. Once the employee submits a "Statement of Termination", he or she may not enroll another non-registered domestic partner for a period of 12 months from the date of the previous termination.

A non-registered domestic partner and his or her children will not be eligible for:

- (a) survivor benefits upon the employee's death as explained under the "When Dependent Coverage Ends" section;
- (b) continuation of dental coverage as explained under the "Federal Continuation Rights" section and under any other continuation rights section of this plan, unless the employee is also eligible for and elects continuation.

A registered domestic partner will have all of the rights of a spouse under this plan except that the continuation of dental coverage as explained under the "Federal Continuation Rights" section is available to a registered domestic partner and his or her children only if the employee is also eligible for and elects continuation.

This rider is part of this plan. Except as stated in this rider, nothing contained in this rider changes or affects any other terms of this plan.

Dated at _____ This _____ Day of _____, _____

HILTON WATERFRONT BEACH RESORT
Full or Corporate Name of Policyholder

Witness BY: _____ Signature and Title

The Guardian Life Insurance Company of America



Michael Prestileo, Senior Vice President

Options A and E

DENTAL EXPENSE INSURANCE

This insurance will pay many of a *covered person's* dental expenses. We pay benefits for covered charges incurred by a *covered person*. What we pay and terms for payment are explained below.

GP-1-DG2000

P498.0007-R

Options A and E

DentalGuard Preferred - This Plan's Dental Preferred Provider Organization

This *plan* is designed to provide high quality dental care while controlling the cost of such care. To do this, the *plan* encourages a *covered person* to seek dental care from *dentists* and dental care facilities that are under contract with *Guardian's dental preferred provider organization (PPO)*, which is called DentalGuard Preferred.

The dental PPO is made up of *preferred providers* in a covered person's geographic area. Use of the dental PPO is voluntary. A *covered person* may receive dental treatment from any dental provider he or she chooses. And he or she is free to change providers anytime.

This *plan* usually pays a higher level of benefits for covered treatment furnished by a *preferred provider*. Conversely, it usually pays less for covered treatment furnished by a *non-preferred provider*.

When an *employee* enrolls in this *plan*, he or she and his or her dependents receive a dental plan ID card and information about current *preferred providers*.

A *covered person* must present his or her ID card when he or she uses a *preferred provider*. Most *preferred providers* prepare necessary claim forms for the *covered person*, and submit the forms to us. We send the *covered person* an explanation of this *plan's* benefit payments, but any benefit payable by us is sent directly to the *preferred provider*.

What we pay is based on all of the terms of this *plan*. Please read this *plan* carefully for specific benefit levels, deductibles, *payment rates* and *payment limits*.

A *covered person* may call the Guardian at the number shown on his or her ID card should he or she have any questions about this *plan*.

GP-1-DGY2K-PPO

P498.0169-R

Options A and E

Covered Charges

If a covered person uses the services of a *preferred provider*, covered charges are the charges listed in the fee schedule the *preferred provider* has agreed to accept as payment in full, for the dental services listed in this *plan's* List of Covered Dental Services.

If a *covered person* uses the services of a *non-preferred provider*, covered charges are reasonable and customary charges for the dental services listed in this *plan's* List of Covered Dental Services.

To be covered by this *plan*, a service must be: (a) necessary; (b) appropriate for a given condition; and (c) included in the List of Covered Dental Services.

We may use the professional review of a *dentist* to determine the appropriate benefit for a dental procedure or course of treatment.

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. A covered charge for *orthodontic treatment* is incurred on the date the *active orthodontic appliance* is first placed. All other covered charges are incurred on the date the services are furnished. If a service is started while a *covered person* is insured, we'll only pay benefits for services which are completed within 31 days of the date his or her coverage under this *plan* ends.

GP-1-DGY2K-CC

P498.0078-R

Options A and E

Alternate Treatment

If more than one type of service can be used to treat a dental condition, we have the right to base benefits on the least expensive service which is within the range of professionally accepted standards of dental practice as determined by us. For example, in the case of bilateral multiple adjacent teeth, or multiple missing teeth in both quadrants of an arch, the benefit will be based on a removable partial denture.

Proof of Claim

So that we may pay benefits accurately, the *covered person* or his or her *dentist* must provide us with information that is acceptable to us. This information may, at our discretion, consist of radiographs, study models, periodontal charting, narratives or other diagnostic materials that document *proof of claim* and support the necessity of the proposed treatment. If we don't receive the necessary information, we may pay no benefits, or minimum benefits. However, if we receive the necessary information within 15 months of the date of service, we will redetermine the *covered person's* benefits based on the new information.

GP-1-DGY2K-AT

P498.1096-R

Options A and E

Pre-Treatment Review

When the expected cost of a proposed course of treatment is \$300.00 or more, the *covered person's dentist* should send us a treatment plan before he or she starts. This must be done on a form acceptable to *Guardian*. The treatment plan must include: (a) a list of the services to be done, using the American Dental Association Nomenclature and codes; (b) the itemized cost of each service; and (c) the estimated length of treatment. In order to evaluate the treatment plan, dental radiographs, study models and whatever else will document the necessity of the proposed course of treatment, must be sent to us.

A treatment plan should always be sent to us before *orthodontic treatment* starts.

We review the treatment plan and estimate what we will pay. We will send the estimate to the *covered person* and/or the *covered person's dentist*. If the treatment plan is not consistent with accepted standards of dental practice, or if one is not sent to us, we have the right to base our benefit payments on treatment appropriate to the *covered person's* condition using accepted standards of dental practice.

The *covered person* and his or her *dentist* have the opportunity to have services or a treatment plan reviewed before treatment begins. Pre-treatment review is not a guarantee of what we will pay. It tells the *covered person*, and his or her *dentist*, in advance, what we would pay for the covered dental services listed in the

treatment plan. But, payment is conditioned on: (a) the services being performed as proposed and while the *covered person* is insured; and (b) the deductible, *payment rate* and *payment limits* provisions, and all of the other terms of this *plan*.

Emergency treatment, oral examinations, evaluations, dental radiographs and teeth cleaning are part of a course of treatment, but may be done before the pre-treatment review is made.

We won't deny or reduce benefits if pre-treatment review is not done. But what we pay will be based on the availability and submission of *proof of claim*.

GP-1-DGY2K-PTR

P498.0003-R

Options A and E

Benefits From Other Sources

Other plans may furnish benefits similar to the benefits provided by this *plan*. For instance, an employee may be covered by this *plan* and a similar plan through his or her spouse's employer. He or she may also 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.

GP-1-DGY2K-OS

P498.0005-R

Options A and E

The Benefit Provision - Qualifying For Benefits

GP-1-DGY2K-BEN

P498.0084-R

Options A and E

Penalty For Late Entrants: During the first 6 months that a late entrant is covered by this *plan*, we won't pay for the following services:

- All Group II Services

During the first 12 months a late entrant is covered by this *plan*, we won't pay for the following services:

- All Group III Services.

During the first 24 months a late entrant is covered by this *plan*, we won't pay for the following services:

- All Group IV Services.

Charges for the services we don't cover under this provision are not considered to be covered charges under this plan, and therefore can't be used to meet this *plan's* deductibles.

We don't apply a late entrant penalty to covered charges incurred for services needed solely due to an *injury* suffered by a *covered person* while insured by this *plan*.

A late entrant is a person who: (a) becomes covered by this dental *plan* more than 31 days after he or she is eligible; or (b) becomes covered again, after his or her coverage lapsed because he or she did not make required payments.

GP-1-DGY2K-LE

P498.0244-R

Options A and E

How We Pay Benefits For Group I, II and III Non-Orthodontic Services: There is no deductible for Group I services. We pay for Group I covered charges at the applicable *payment rate*.

The *benefit year* deductibles, shown in the schedule, apply to Group II and III services. There are different *benefit year* deductible amounts for services provided by a *preferred provider* and a *non preferred provider*. Each *covered person* must have covered charges from these service groups which exceed each applicable deductible before we pay him or her any benefits for such charges. These charges must be incurred while the *covered person* is insured.

Covered charges used to satisfy a *covered person's* Non-PPO deductible are also credited toward his or her PPO deductible. And covered charges used to satisfy a *covered person's* PPO deductible are also credited toward his or her Non-PPO deductible.

Once a *covered person* meets the deductible, we pay for his or her Group II and III covered charges above that amount at the applicable *payment rate* for the rest of that *benefit year*.

GP-1-DGY2K-BP

P498.0195-R

Options A and E

All covered charges must be incurred while insured. And what we pay is subject to the *benefit year payment limit* shown in the schedule and to all of the terms of this *plan*. There are different *benefit year payment limits* which apply to benefits paid for the services of a *preferred provider* and a *non preferred provider*.

Benefits applied to a *covered person's* Non-PPO *benefit year payment limit* are also applied to his or her PPO *benefit year payment limit*. And benefits applied to a *covered person's* PPO *benefit year payment limit* are also applied to his or her Non-PPO *benefit year payment limit*.

GP-1-DGY2K-BP

P498.0209-R

Options A and E

A *covered person* may be eligible for a rollover of a portion of his or her unused *benefit year* payment limit for Group I, II and III Non-Orthodontic Services. See "Rollover of Benefit Year Payment Limit for Group I, II and III Non-Orthodontic Services" for details.

GP-1-DG-ROLL-04-2.1

P498.2168-R

Options A and E

Rollover of Benefit Year Payment Limit for Group I, II and III Non-Orthodontic Services: A *covered person* may be eligible for a rollover of a portion of his or her unused *benefit year* payment limit for Group I, II and III Non-Orthodontic Services as follows:

If a *covered person* submits at least one claim for covered charges during a *benefit year* and, in that *benefit year*, receives benefits that are in excess of any deductible or co-pay fees, and that, in total, do not exceed the *Rollover Threshold*, he or she may be entitled to a *Reward*.

Note: If all of the benefits that a *covered person* receives in a *benefit year* are for services provided by a *preferred provider*, he or she may be entitled to a greater *Reward* than if any of the benefits are for services of a *non-preferred provider*.

Rewards can accrue and are stored in the *covered person's Bank*. If a *covered person* reaches his or her *benefit year* payment limit for Group I, II and III Non-Orthodontic Services, we pay benefits up to the amount stored in the *covered person's Bank*. The amount of *Reward* stored in the *Bank* may not be greater than the *Bank Maximum*.

A *covered person's Bank* may be eliminated, and the accrued *Reward* lost, if he or she has a break in coverage of any length of time, for any reason.

The amounts of this plan's *Rollover Threshold*, *Reward*, and *Bank Maximum* are:

- *Rollover Threshold* \$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 provisions of this *plan* called Penalty for Late Entrants, this rollover provision will not apply to the covered person until the end of such period. And, if such period ends within the three months prior to the start of this plan's next *benefit year*, this rollover provision will not apply to the *covered person* until the next *benefit year*, and:

- only claims incurred on or after the start of the next *benefit year* will count toward the *Rollover Threshold*; and
- *Rewards* will not be applied to a *covered person's Bank* until the *benefit year* that starts one year from the date the rollover provision first applies.

Definitions of terms used in this provision:

"Bank" means the amount of a *covered person's* accrued *Reward*.

"Bank Maximum" means the maximum amount of *Reward* that a *covered person* can store in his or her *Bank*.

"Reward" means the dollar amount which may be added to a *covered person's Bank* when he or she receives benefits in a *benefit year* that do not exceed the *Rollover Threshold*.

"Rollover Threshold" means the maximum amount of benefits that a *covered person* can receive during a *benefit year* and still be entitled to receive a *Reward*.

GP-1-DG-ROLL-04-2

P498.9356-R

Options A and E

How we pay benefits for Group IV Orthodontic Services: This *plan* provides benefits for Group IV orthodontic services.

We pay for Group IV covered charges at the applicable *payment rate*. There may be different *payment rates* which apply to covered charges for services from a *preferred provider* and a *non-preferred provider*.

Using the *covered person's* original treatment plan, we calculate the total benefit we will pay. We divide the benefit into equal payments, which we will spread out over the shorter of: (a) the proposed length of treatment; or (b) two years.

We make the initial payment when the *active orthodontic appliance* is first placed. We make further payments at the end of each subsequent three month period, upon receipt of verification of ongoing treatment. But, treatment must continue and the *covered person* must remain covered by this *plan*. We limit what we pay for orthodontic services to the lifetime payment limit shown in the schedule. What we pay is based on all of the terms of this *plan*.

We don't pay for orthodontic charges incurred by a *covered person* prior to being covered by this *plan*. We limit what we pay for *orthodontic treatment* started prior to a *covered person* being covered by this *plan* to charges determined to be incurred by the *covered person* while covered by this *plan*. Based on the original

treatment plan, we determine the portion of charges incurred by the *covered person* prior to being covered by this *plan*, and deduct them from the total charges. What we pay is based on the remaining charges. We limit what we consider of the proposed treatment plan to the shorter of the proposed length of treatment, or two years from the date the *orthodontic treatment* started.

The benefits we pay for *orthodontic treatment* won't be charged against a *covered person's benefit year payment limits* that apply to all other services.

The negotiated discounted fees for orthodontics performed by a *preferred provider* include: (a) treatment plan and records, including initial, interim and final records; (b) orthodontic retention, including any and all necessary fixed and removable appliances and related visits; and (c) limited, interceptive and comprehensive *orthodontic treatment*, with associated: (i) fabrication and insertion of any and all fixed appliances; and (ii) periodic visits.

There is a separate negotiated discounted fee for *orthodontic treatment* which extends beyond 24 consecutive months.

The negotiated discounted fee for orthodontics performed by a *preferred provider* does not include: (a) any incremental charges for orthodontic appliances made with clear, ceramic, white lingual brackets or other optional material; (b) procedures, appliances or devices to guide minor tooth movement or to correct harmful habits; (c) retreatment of orthodontic cases, or changes in orthodontic treatment necessitated by any kind of accident; (d) replacement or repair of orthodontic appliances damaged due to the neglect of the patient; (e) orthognathic surgery and associated incremental charges; (f) extractions performed solely to facilitate orthodontic treatment; and (g) orthodontic treatment started before the member was eligible for orthodontic benefits under this *plan*.

Whether or not a charge is based on a discounted fee, it will be counted toward a *covered person's* orthodontic lifetime payment limit under this *plan*.

GP-1-DGY2K-OR

P498.0069-R

Options A and E

Non-Orthodontic Family Deductible Limit: A *covered family* must meet no more than three individual *benefit year* deductibles in any *benefit year*. Once this happens, we pay benefits for covered charges incurred by any *covered person* in that *covered family*, at the applicable *payment rate* for the rest of that *benefit year*. The charges must be incurred while the person is insured. What we pay is based on this *plan's payment limits* and to all of the terms of this *plan*.

GP-1-DGY2K-FL

P498.0085-R

Options A and E

Payment Rates: Benefits for covered charges are paid at the following *payment rates*:

- Benefits for Group I Services performed by
a *preferred provider* 100%
- Benefits for Group I Services performed by
a *non-preferred provider* 100%
- Benefits for Group II Services performed by
a *preferred provider* 90%
- Benefits for Group II Services performed by
a *non-preferred provider* 80%
- Benefits for Group III Services performed by
a *preferred provider* 60%

- Benefits for Group III Services performed by
a *non-preferred provider* 50%
- Benefits for Group IV Services performed by
a *preferred provider* 50%
- Benefits for Group IV Services performed by
a *non-preferred provider* 50%

GP-1-DGY2K-PR

P498.0092-R

Options A and E

After This Insurance Ends: We don't pay for charges incurred after a *covered person's* insurance ends. But, subject to all of the other terms of this *plan*, we'll pay for the following if the procedure is finished in the 31 days after a *covered person's* insurance under this *plan* ends: (a) a bridge or cast restoration, if the tooth or teeth are prepared before the *covered person's* insurance ends; (b) any other *dental prosthesis*, if the master impression is made before the *covered person's* insurance ends; and (c) root canal treatment, if the pulp chamber is opened before the *covered person's* insurance ends.

We pay benefits for *orthodontic treatment* to the end of the month in which the *covered person's* insurance ends.

GP-1-DGY2K-END

P498.0137-R

Special Limitations

GP-1-DGY2K-LMT

P498.0140-R

Options A and E

Teeth Lost, Extracted or Missing Before A Covered Person Becomes Covered By This Plan: A *covered person* may have one or more congenitally missing teeth or may have had one or more teeth lost or extracted before he or she became covered by this *plan*. We won't pay for a *dental prosthesis* which replaces such teeth unless the *dental prosthesis* also replaces one or more eligible natural teeth lost or extracted after the *covered person* became covered by this *plan*.

GP-1-DGY2K-TL

P498.0149-R

Options A and E

If This Plan Replaces The Prior Plan: This *plan* may be replacing the *prior plan* you had with another insurer. If a *covered person* was insured by the *prior plan* and is covered by this *plan* on its effective date, the following provisions apply to such *covered person*.

- **Teeth Extracted While Insured By The Prior Plan** - The "Teeth Lost, Extracted or Missing Before A Covered Person Becomes Covered By This Plan" provision above, does not apply to a *covered person's dental prosthesis* which replaces teeth: (a) that were extracted while the *covered person* was insured by the *prior plan*; and (b) for which extraction benefits were paid by the *prior plan*.
- **Deductible Credit** - In the first *benefit year* of this *plan*, we reduce a *covered person's* deductibles required under this *plan*, by the amount of covered charges applied against the *prior plan's* deductible. The *covered person* must give us proof of the amount of the *prior plan's* deductible which he or she has satisfied.
- **Benefit Year Non-Orthodontic Payment Limit Credit** - In the first *benefit year* of this *plan*, we reduce a *covered person's benefit year payment limits* by the amounts paid or payable under the *prior plan*. The *covered person* must give us proof of the amounts applied toward the *prior plan's* payment limits.

- **Orthodontic Payment Limit Credit** - We reduce a *covered person's* orthodontic *payment limits* by the amounts paid or payable under the *prior plan*. The *covered person* must give us proof of the amounts applied toward the *prior plan's* payment limits.

GP-1-DGY2K-PP

P498.0141-R

Options A and E

Exclusions

We will not pay for:

- Any service or supply which is not specifically listed in this *plan's* list of Covered Dental Services.
- Any procedure performed in conjunction with, as part of, or related to a procedure which is not covered by this *plan*.
- Educational services. This includes, but is not limited to: oral hygiene instruction; plaque control; tobacco counseling; or diet instruction.
- Precision attachments and the replacement of part of a precision attachment; magnetic retention; or overdenture attachments.
- Overdentures and related services. This includes root canal therapy on teeth that support an overdenture.
- Any restoration, procedure, or *appliance* or prosthetic device used solely to: (1) alter vertical dimension; (2) restore or maintain occlusion, except to the extent that this *plan* covers *orthodontic treatment*; (3) treat a condition necessitated by attrition or abrasion; or (4) splint or stabilize teeth for periodontal reasons.
- The use of: general anesthesia; intramuscular sedation; intravenous sedation; non-intravenous sedation; or inhalation sedation, which includes but is not limited to nitrous oxide. But, this does not apply when administered in conjunction with: covered periodontal surgery; surgical extractions; the surgical removal of impacted teeth; apicoectomies; root amputations; and services listed under the "Other Oral Surgical Procedures" section of this *plan*.
- The use of local anesthetic.
- Cephalometric radiographs; oral/facial images. This includes traditional photographs and images obtained by intraoral camera. But, these services are covered when performed as part of the *orthodontic treatment* plan and records for a covered course of *orthodontic treatment*.
- Replacement of a lost, missing or stolen *appliance* or *dental prosthesis*; or the fabrication of a spare *appliance* or *dental prosthesis*.
- Prescription medication.
- Desensitizing medicaments; and desensitizing resins for cervical and/or root surface.
- Duplication of radiographs; the completion of claim forms; OSHA or other infection control charges.
- Pulp vitality tests; or caries susceptibility tests.
- Bite registration; or bite analysis.
- Gingival curettage.
- The localized delivery of chemotherapeutic agents.
- Tooth transplants.
- Maxillofacial prosthetics that repair or replace facial and skeletal anomalies; maxillofacial surgery; orthognathic surgery; or any oral surgery requiring the setting of a fracture or dislocation.
- Temporary or provisional *dental prosthesis* or *appliances*. But, this does not include interim partial dentures/stayplates to replace *anterior teeth* extracted while insured under this *plan*.

- Any service furnished solely for cosmetic reasons, unless the "List of Covered Dental Services" provides benefits for specific cosmetic services. Excluded cosmetic services include, but are not limited to: (1) characterization and personalization of a *dental prosthesis*; and (2) odontoplasty.
- Replacing an existing *appliance* or *dental prosthesis* with any *appliance* or prosthesis, unless it is: (1) at least 10 years old and is no longer usable; or (2) damaged while in the *covered person's* mouth in an *injury* suffered while insured, and can not be made serviceable.
- A fixed bridge replacing the extracted portion of a hemisected tooth; or the placement of more than one unit of crown and/or bridge per tooth.
- The replacement of extracted or missing third molars/wisdom teeth.
- Treatment of congenital or developmental malformations; or the replacement of congenitally missing teeth.
- Any endodontic, periodontal, crown or bridge abutment procedure or *appliance* performed for a tooth or teeth with a guarded, questionable or poor prognosis.
- Any procedure or treatment method which does not meet professionally recognized standards of dental practice or which is considered to be experimental in nature.
- Any procedure, *appliance*, *dental prosthesis*, modality or surgical procedure intended to treat or diagnose disturbances of the temporomandibular joint (TMJ).
- Treatment needed due to: (1) an on-the-job or job-related *injury*; or (2) a condition for which benefits are payable by Workers' Compensation or similar laws.
- Treatment for which no charge is made. This usually means treatment furnished by: (1) the *covered person's* employer, labor union or similar group, in its dental or medical department or clinic; (2) a facility owned or run by any governmental body; and (3) any public program, except Medicaid, paid for or sponsored by any governmental body.
- Evaluations and consultations for non-covered services; detailed and extensive oral evaluations.
- The repair of an orthodontic *appliance*.
- The replacement of a lost or broken orthodontic retainer.

GP-1-DGY2K-EXCH-01

P498.2295-R

Options A and E

List Of Covered Dental Services

The services covered by this plan are named in this list. Each service on this list has been placed in one of four groups. A separate payment rate applies to each group. Group I is made up of preventive services. Group II is made up of basic services. Group III is made up of major services. Group IV is made up of orthodontic services.

All covered dental services must be furnished by or under the direct supervision of a dentist. And they must be usual and necessary treatment for a dental condition.

GP-1-DNTL-90-13

P490.0048-R

Options A and E

Group I - Preventive Dental Services (Non-Orthodontic)

GP-1-DNTL-90-14

P498.8633-R

Options A and E

Prophylaxis and Fluorides

Prophylaxis - limited to a total of 1 prophylaxis or periodontal maintenance procedure (considered under "Periodontal Services") in any 6 consecutive month period. Allowance includes scaling and polishing procedures to remove coronal plaque, calculus, and stains.

- Adult prophylaxis covered age 12 and older.

Additional prophylaxis when needed as a result of a medical (i.e., a non-dental) condition - covered once in 12 months, and only when the additional prophylaxis is recommended by the dentist and is a result of a medical condition as verified in writing by the patient's medical physician. This does not include a condition which could be resolved by proper oral hygiene or that is the result of patient neglect.

Fluoride treatment, topical application - limited to 1 treatment(s) in any 6 consecutive month period.

Office Visits, Evaluations and Examination

Office visits, oral evaluations, examinations or limited problem focused re-evaluations - limited to a total of 1 in any 6 consecutive month period.

Emergency or problem focused oral evaluation - limited to a total of 1 in a 6 consecutive month period. Covered if no other treatment, other than radiographs, is performed in the same visit.

After hours office visit or emergency palliative treatment and other non-routine, unscheduled visits. Limited to a total of 1 in a 6 consecutive month period. Covered only when no other treatment, other than radiographs, is performed during the same visit.

GP-1-DNTL-90-14

P498.5009-R

Options A and E

Space Maintainers

Space Maintainers - limited to *covered persons* under age 16 and limited to initial *appliance* only. Covered only when necessary to replace prematurely lost or extracted deciduous teeth. Allowance includes all adjustments in the first six months after insertion, limited to a maximum of one bilateral per arch or one unilateral per quadrant, per lifetime.

- Fixed - unilateral
- Fixed - bilateral
- Removable - bilateral
- Removable - unilateral

Recementation of space maintainer performed more than 12 months after the initial insertion

Fixed and Removable Appliances

Fixed and Removable Appliances To Inhibit Thumbsucking - limited to *covered persons* under age 14 and limited to initial *appliance* only. Allowance includes all adjustments in the first 6 months after insertion.

GP-1-DNTL-90-15

P498.0182-R

Options A and E

Radiographs - Allowance includes evaluation and diagnosis. Also see BASIC DENTAL SERVICES, Radiographs.

Bitewing films - limited to either a maximum of 4 bitewing films or a set (7-8 films) of vertical bitewings, in one visit, once in any 12 consecutive month period.

GP-1-DNTL-90-14

P498.2169-R

Options A and E

Dental Sealants

- Dental Sealants - permanent molar teeth only - Topical application of sealants is limited to the unrestored, permanent molar teeth of *covered persons* under age 16 and limited to one treatment, per tooth, in any 36 consecutive month period.

GP-1-DNTL-90-14

P498.0184-R

Options A and E

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.

Adjunctive pre-diagnostic test that aids in detection of mucosal abnormalities including premalignant and malignant lesions, not to include cytology or biopsy procedures - limited to one test in any 24 consecutive month period for covered persons age 40 and older.

Restorative Services - Multiple restorations on one surface will be considered one restoration. Benefits for the replacement of existing amalgam and resin restorations will only be considered for payment if at least 12 months have passed since the previous restoration was placed if the *covered person* is under age 19, and 36 months if the *covered person* is age 19 and older. Also see the "Major Restorative Services" section.

Amalgam restorations - Allowance includes bonding agents, liners, bases, polishing and local anesthetic.

Resin restorations - Allowance includes light curing, acid etching, adhesives, including resin bonding agents and local anesthetic. Restorations on anterior teeth that do not involve the incisal edge are considered a single surface filling.

Silicate cement, per restoration

Composite resin

Stainless steel prefabricated resin, and resin based composite - limited to once per tooth in any 24 consecutive month period. Stainless steel, prefabricated resin and resin based composite crowns are considered to be a temporary or provisional procedure when done within 24 months of a permanent crown. Temporary and provisional crowns are considered to be part of the permanent restoration.

Pin retention, per tooth, covered only in conjunction with a permanent amalgam or composite restoration, exclusive of restorative material.

GP-1-DNTL-90-15

P498.2885-R

Options A and E

Crown and Prosthodontic Restorative Services - Also see the "Major Restorative Services" section.

Crown and bridge repairs - allowance based on the extent and nature of damage and the type of material involved.

Recementation, limited to recementations performed more than 12 months after the initial insertion.

- Inlay or onlay
- Crown
- Bridge

Adding teeth to partial dentures to replace extracted natural teeth

Denture repairs - Allowance based on the extent and nature of damage and on the type of materials involved.

- Denture repairs, metal
- Denture repairs, acrylic
- Denture repair, no teeth damaged
- Denture repair, replace one or more broken teeth
- Replacing one or more broken teeth, no other damage

Denture rebase, full or partial denture - limited to once per denture in any 24 consecutive month period. Denture rebases done within 12 months are considered to be part of the denture placement when the rebase is done by the *dentist* who furnished the denture. Limited to rebase done more than 12 consecutive months after the insertion of the denture.

Denture relines, full or partial denture - limited to once per denture in any 24 consecutive month period. Denture relines done within 12 months are considered to be part of the denture placement when the relines is done by the *dentist* who furnished the denture. Limited to relines done more than 12 consecutive months after a denture rebase or the insertion of the denture.

Denture adjustments - Denture adjustments done within 6 months are considered to be part of the denture placement when the adjustment is done by the *dentist* who furnished the denture. Limited to adjustments that are done more than 6 consecutive months after a denture rebase, denture relines or the initial insertion of the denture.

Tissue conditioning - Tissue conditioning done within 12 months is considered to be part of the denture placement when the tissue conditioning is done by the *dentist* who furnished the denture. Limited to a maximum of 1 treatment, per arch, in any 12 consecutive month period.

GP-1-DNTL-90-15

P498.1076-R

Options A and E

Endodontic Services - Allowance includes diagnostic, treatment and final radiographs, cultures and tests, local anesthetic and routine follow-up care, but excludes final restoration. Also see MAJOR DENTAL SERVICES, Endodontic Services.

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

Endodontic Therapy

- Root canal therapy on anterior and bicuspid teeth
- Root canal retreatment on anterior and bicuspid teeth, 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

GP-1-DNTL-90-15

P498.2171-R

Options A and E

Periodontal Services - Allowance includes the treatment plan, local anesthetic and post-treatment care. Requires documentation of periodontal disease confirmed by both radiographs and pocket depth probings of each tooth involved.

Periodontal maintenance procedure - limited to a total of 1 prophylaxis or periodontal maintenance procedure(s) in any 6 consecutive month period. Allowance includes periodontal pocket charting, scaling and polishing. (Also see Prophylaxis under "Preventive Services") Coverage for periodontal maintenance is considered upon evidence of completed active periodontal therapy (periodontal scaling and root planing or periodontal surgery).

Scaling and root planing, per quadrant - limited to once per quadrant in any 24 consecutive month period. Covered when there is radiographic and pocket charting evidence of bone loss.

Full mouth debridement - limited to once in any 36 consecutive month period. Considered only when no diagnostic, preventive, periodontal service or periodontal surgery procedure has been performed in the previous 36 consecutive month period.

GP-1-DNTL-90-15

P498.0220-R

Options A and E

Periodontal surgery - Allowance includes the treatment plan, local anesthetic and post-surgical care. Requires documentation of periodontal disease confirmed by both radiographs and pocket depth probings of each tooth involved.

The following treatment is limited to a total of one of the following, once per tooth in any 12 consecutive months.

- Gingivectomy, per tooth (less than 3 teeth)
- Crown lengthening - hard tissue

The following treatment is limited to a total of one of the following once per quadrant, in any 36 consecutive months.

- Gingivectomy or gingivoplasty, per quadrant
- Osseous surgery, including scaling and root planing, flap entry and closure, per quadrant
- Gingival flap procedure, including scaling and root planing, per quadrant
- Distal or proximal wedge, not in conjunction with osseous surgery
- Surgical revision procedure, per tooth

The following treatment is limited to a total of one of the following, once per quadrant in any 36 consecutive months.

Pedicle or free soft tissue grafts, including donor site, or subepithelial connective tissue graft procedure, when the tooth is present, or when dentally necessary as part of a covered surgical placement of an implant.

The following treatment is limited to a total of one of the following, once per area or tooth, per lifetime.

- Guided tissue regeneration, resorbable barrier or nonresorbable barrier Bone replacement grafts, when the tooth is present

Periodontal surgery related

Limited occlusal adjustment - limited to a total of two visits, covered only when done within a 6 consecutive month period after covered scaling and root planing or osseous surgery. Must have radiographic evidence of vertical defect or widened periodontal ligament space.

Occlusal guards, covered only when done within a 6 consecutive month period after osseous surgery, and limited to one per lifetime

GP-1-DNTL-90-15

P498.0221-R

Options A and E

Radiographs - Allowance includes evaluation and diagnosis. Also see PREVENTIVE DENTAL SERVICES, Radiographs.

Full mouth, complete series or panoramic radiograph - Either, but not both, of the following procedures, limited to one in any 60 consecutive month period.

- Full mouth series, of at least 14 films including bitewings
- Panoramic film, maxilla and mandible, with or without bitewing radiographs.

Other diagnostic radiographs:

- Intraoral periapical or occlusal films - single films

GP-1-DNTL-90-15

P498.2170-R

Options A and E

Non-surgical extractions - Allowance includes the treatment plan, local anesthetic and post-treatment care.

Uncomplicated extraction, one or more teeth

Root removal non-surgical extraction of exposed roots

Surgical Extractions - Allowance includes the treatment plan, local anesthetic and post-surgical care. Services listed in this category and related services, may be covered by your medical plan.

Surgical removal of erupted teeth, involving tissue flap and bone removal

Surgical removal of residual tooth roots

Surgical removal of impacted teeth

Other Oral Surgical Procedures - Allowance includes diagnostic and treatment radiographs, the treatment plan, local anesthetic and post-surgical care. Services listed in this category and related services, may be covered by your medical plan.

Alveoloplasty, per quadrant

Removal of exostosis, per site

Incision and drainage of abscess

Frenulectomy, Frenectomy, Frenotomy

Biopsy and examination of tooth related oral tissue

Surgical exposure of impacted or unerupted tooth to aid eruption

Excision of tooth related tumors, cysts and neoplasms

Excision or destruction of tooth related lesion(s)

Excision of hyperplastic tissue

Excision of pericoronal gingiva, per tooth

Oroantral fistula closure

Sialolithotomy

Sialodochoplasty

Closure of salivary fistula

Excision of salivary gland

Maxillary sinusotomy for removal of tooth fragment or foreign body

Vestibuloplasty

GP-1-DNTL-90-15

P498.1078-R

Options A and E

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.

GP-1-DNTL-90-15

P498.0224-R

Options A and E

Group III - Major Dental Services (Non-Orthodontic)

Major Restorative Services - Crowns, inlays, onlays, labial veneers, and crown buildups are covered only when needed because of decay or *injury*, and only when the tooth cannot be restored with amalgam or composite filling material. Facings on dental prostheses for teeth posterior to the second bicuspid are not covered. Post and cores are covered only when needed due to decay or *injury*. Allowance includes insulating bases, temporary or provisional restorations and associated gingival involvement. Limited to permanent teeth only. Also see the "Basic Restorative Services" section.

Single Crowns

- Resin with metal
- Porcelain
- Porcelain with metal
- Full cast metal (other than stainless steel)
- 3/4 cast metal crowns
- 3/4 porcelain crowns

Inlays

- Onlays, including inlay
- Labial veneers

Posts and buildups - only when done in conjunction with a covered unit of crown or bridge and only when necessitated by substantial loss of natural tooth structure.

Cast post and core in addition to a unit of crown or bridge, per tooth

Prefabricated post and composite or amalgam core in addition to a unit of crown or bridge, per tooth

Crown or core buildup, including pins

Implant supported prosthetics - Allowance includes the treatment plan and local anesthetic, when done in conjunction with a covered surgical placement of an implant, on the same tooth.

- Abutment supported crown
- Implant supported crown
- Abutment supported retainer for fixed partial denture
- Implant supported retainer for fixed partial denture
- Implant/abutment supported removable denture for completely edentulous arch
- Implant/abutment supported removable denture for partially edentulous arch
- Implant/abutment supported fixed denture for completely edentulous arch
- Implant/abutment supported fixed denture for partially edentulous arch
- Dental implant supported connecting bar
- Prefabricated abutment

Custom abutment

Implant services - Allowance includes the treatment plan, local anesthetic and post-surgical care. Limited to the replacement of permanent teeth only. The number of implants we cover is limited to the number of teeth extracted while insured under this plan.

- Surgical placement of implant body, endosteal implant

- Surgical placement, eposteal implant

- Surgical placement transosteal implant

Other Implant services

- Bone replacement graft for ridge preservation, per site, when done in conjunction with a covered surgical placement of an implant in the same site, limited to once per tooth, per lifetime

- Radiographic/surgical implant index - limited to once per arch in any 24 month period

- Repair implant supported prosthesis

- Repair implant abutment

- Implant removal

GP-1-DNTL-90-16

P498.1101-R

Options A and E

Prosthodontic Services - Specialized techniques and characterizations are not covered. Facings on dental prostheses for teeth posterior to the second bicuspid are not covered. Allowance includes insulating bases, temporary or provisional restorations and associated gingival involvement.

Fixed bridges - Each abutment and each pontic makes up a unit in a bridge

- Bridge abutments - See inlays, onlays and crowns under "Major Restorative Services"

- Bridge Pontics

- Resin with metal

- Porcelain

- Porcelain with metal

- Full cast metal

- 3/4 cast metal crowns

- 3/4 porcelain crowns

Dentures - Allowance includes all adjustments and repairs done by the dentist furnishing the denture in the first 6 consecutive months after installation and all temporary or provisional dentures. Temporary or provisional dentures, stayplates and interim dentures older than one year are considered to be a permanent *appliance*.

- Complete or Immediate dentures, upper or lower

- Partial dentures - Allowance includes base, clasps, rests and teeth

- Upper, resin base, including any conventional clasps, rests and teeth

- Upper, cast metal framework with resin denture base, including any conventional clasps, rests and teeth

- Lower, resin base, including any conventional clasps, rests and teeth

- Lower, cast metal framework with resin denture base, including any conventional clasps, rests and teeth

- Interim partial denture (stayplate), upper or lower, covered on anterior teeth only

- Removable unilateral partial, one piece cast metal, including clasps and teeth

- Simple stress breakers, per unit

GP-1-DNTL-90-16

P498.1099-R

Options A and E

Endodontic Services - Allowance includes diagnostic, treatment and final radiographs, cultures and tests, local anesthetic and routine follow-up care, but excludes final restoration. Also see BASIC DENTAL SERVICES, Endodontic Services.

Endodontic Therapy

Root canal therapy on molar teeth

Root canal retreatment on molar teeth, limited to once per tooth, per lifetime

GP-1-DNTL-90-16

P498.2172-R

Options A and E

Group IV - Orthodontic Services

Orthodontic Services

- Any covered Group I, II or III service in connection with *orthodontic treatment*.
- Transseptal fiberotomy
- Surgical exposure of impacted or unerupted teeth in connection with orthodontic treatment - Allowance includes treatment and final radiographs, local anesthetics and post-surgical care.
- Treatment *plan* and records, including initial, interim and final records.
- Limited *orthodontic treatment*, Interceptive orthodontic treatment or Comprehensive *orthodontic treatment*, including fabrication and insertion of any and all fixed *appliances* and periodic visits.
- Orthodontic retention, including any and all necessary fixed and removable *appliances* and related visits - limited to initial *appliance(s)* only.

GP-1-DNTL-90-17

P498.0083-R

Options A and E

Definitions

The terms that are italicized throughout this *plan*, are defined in this section.

Active Orthodontic means an *appliance*, like a fixed or removable appliance, braces or a functional orthotic used for orthodontic treatment to move teeth or reposition the jaw.

Anterior Teeth means the incisor and cuspid teeth. The teeth are located in front of the bicuspid (pre-molars).

Appliance means any dental device other than a *dental prosthesis*.

Benefit Year means a 12 month period which starts on January 1st and ends on December 31st of each year.

Covered Dental Specialty means any group of procedures which falls under one of the following categories, whether performed by a specialist *dentist* or a general *dentist*: restorative/prosthetic services; endodontic services, periodontic services, oral surgery and pedodontics.

GP-1-DGY2K-D1

P498.0008-R

Options A and E

Covered Family means an employee and those of his or her dependents who are covered by this *plan*.

Covered Person means an employee or any of his or her covered dependents.

Dental Prosthesis means a restorative service which is used to replace one or more missing or lost teeth and associated tooth structures. It includes all types of abutment crowns, inlays and onlays, bridge pontics, complete and immediate dentures, partial dentures and unilateral partials. It also includes all types of crowns, veneers, inlays, onlays, implants and posts and cores.

Dentist means any dental or medical practitioner we are required by law to recognize who: (a) is properly licensed or certified under the laws of the state where he or she practices; and (b) provides services which are within the scope of his or her license or certificate and covered by this *plan*.

Emergency Treatment means bona fide emergency services which: (a) are reasonably necessary to relieve the sudden onset of severe pain, fever, swelling, serious bleeding, severe discomfort, or to prevent the imminent loss of teeth; and (b) are covered by this *plan*.

Injury means all damage to a *covered person's* mouth due to an accident which occurred while he or she is covered by this *plan*, and all complications arising from that damage. But the term *injury* does not include damage to teeth, *appliances* or *dental prostheses* which results solely from chewing or biting food or other substances.

GP-1-DGY2K-D2

P498.0014-R

Options A and E

Non-Preferred Provider means a *dentist* or dental care facility that is not under contract with DentalGuard Preferred as a *preferred provider*.

Orthodontic Treatment means the movement of one or more teeth by the use of *active appliances*. It includes: (a) treatment plan and records, including initial, interim and final records; (b) periodic visits, limited orthodontic treatment, interceptive orthodontic treatment and comprehensive orthodontic treatment, including fabrication and insertion of any and all fixed appliances; (c) orthodontic retention, including any and all necessary fixed and removable appliances and related visits.

Payment Limit means the maximum amount this *plan* pays for covered services during either a *benefit year* or a *covered person's* lifetime, as applicable.

Payment Rate means the percentage rate that this *plan* pays for covered services.

Plan means the Guardian group dental plan purchased by the planholder.

Posterior Teeth means the bicuspid (pre-molars) and molar teeth. These are the teeth located behind the cuspids.

Preferred Provider means a *dentist* or dental care facility that is under contract with DentalGuard Preferred as a preferred provider.

Prior Plan means the planholder's plan or policy of group dental insurance which was in force immediately prior to this *plan*. To be considered a prior plan, this *plan* must start immediately after the prior coverage ends.

Proof of Claim means dental radiographs, study models, periodontal charting, written narrative or any documentation that may validate the necessity of the proposed treatment.

We, Us, Our and Guardian mean The Guardian Life Insurance Company of America.

GP-1-DGY2K-D3

P498.0016-R

Options A, B, E and F

ELIGIBILITY FOR VISION CARE EXPENSE COVERAGE

P505.0053-R

Options A, B, E and F

EMPLOYEE COVERAGE

Eligible Employees

Subject to the Conditions of Eligibility set forth below, and to all of the other conditions of the plan, all of your employees who are in an eligible class will be eligible if they are active full-time employees.

For purposes of this plan, we will treat partners and proprietors like employees if they meet this plan's conditions of eligibility.

Conditions of Eligibility

Full-time Requirement: We won't insure an employee unless he or she is an active full-time employee.

GP-1-EC-90-1.0

P180.0168-R

Options A, B, E and F

Vision Enrollment Requirement: An employee must enroll and agree to make required payments within 31 days of his or her eligibility date. If he or she fails to do so, he or she can't enroll until this plan's next vision open enrollment period.

This plan's vision open enrollment period occurs from August 1st to August 31st of each year.

Once an employee enrolls in this plan, he or she can't drop his or her vision coverage until this plan's next vision open enrollment period. And if he or she drops his or her vision coverage, he or she can't enroll again until the next vision open enrollment period.

If the employee initially waived vision coverage under this plan because he or she was covered for vision care benefits under another group plan, and he or she wishes to enroll in this plan because his or her coverage under the other plan ends, he or she may do so without waiting until the next vision open enrollment period. However, his or her coverage under the other plan must have ended due to one of the following events: (a) termination of a spouse's employment; (b) loss of eligibility under a spouse's plan; (c) divorce; (d) death of a spouse; or (e) termination of the other plan. But the employee must enroll in this plan within 30 days of the date that any of these events occur.

GP-1-EC-90-2.0

P505.0070-R

Classes 0001 and 0002

The Waiting Period: Employees in an eligible class are eligible for insurance under this plan after they complete the service waiting period established by the employer, if any.

GP-1-EC-90-4.0

P180.0936-R

Options A, B, E and F

Multiple Employment: If an employee works for both you and a covered associated company, or for more than one covered associated company, we will treat him as if only one firm employs him. And such an employee will not have multiple coverage under this plan. But, if this plan uses the amount of an employee's earnings to set the rates, determine class, figure benefit amounts, or for any other reason, such employee's earnings will be figured as the sum of his earnings from all covered employers.

GP-1-EC-90-5.0

P180.0328-R

Options A, B, E and F for Classes 0001 and 0002

When Employee Coverage Starts

An employee must be actively at work, and working his regular number of hours, on the date his coverage is scheduled to start. And he must have met all of the conditions of eligibility which apply to him. If an employee is not actively at work on his scheduled effective date, we will postpone the start of his coverage until he returns to active work.

Sometimes, a scheduled effective date is not a regularly scheduled work day. But an employee's coverage will start on that date if he was actively at work, and working his regular number of hours, on his last regularly scheduled work day.

The scheduled effective date of an employee's coverage is as follows:

- If an employee must pay part of the cost of employee coverage, then he must elect to enroll and agree to make the required payments. If he does this on or before the eligibility date, his coverage is scheduled to start on his eligibility date. If he does this after his eligibility date, his coverage is scheduled to start on the date he signs his enrollment form.
- On non-contributory plans, subject to all the terms of this plan, an employee's coverage is scheduled to start on his eligibility date.

GP-1-EC-90-6.0

P180.0969-R

Options A, B, E and F for Classes 0001 and 0002

When Employee Coverage Ends

When Employee Coverage Ends: Except as explained in the "When Active Service Ends" section of this plan, an employee's insurance will end on the first of the following dates:

- the last day of the month in which an employee's active full-time service ends for any reason other than disability. Such reasons include retirement, layoff, leave of absence or the end of employment.
- the date an employee dies.
- the date the group plan ends, or is discontinued for a class of employees to which the employee belongs; or
- the day prior to the last premium due date for which required payments are made for the employee.
- the last day of the month in which an employee stops being an eligible employee under this plan for any reason not named above.

Also, an employee may have the right to continue certain group benefits for a limited time after his or her coverage would otherwise end. The plan's benefit provisions explain these situations. Read the plan's provisions carefully.

GP-1-EC-90-8.0

P489.0006-R

Options A, B, E and F for Classes 0001 and 0002

When Active Service Ends: You may continue an employee's dental expense insurance under this plan after his active service with you ends only as follows:

- If an employee's active service ends because he is disabled you may continue his insurance subject to all of the terms of this plan.
- If an employee's active service ends because he goes on a leave of absence, except as noted below, or is laid off, you may continue his insurance for the rest of the policy month in which the leave or layoff starts, plus 1 more full policy month(s). However, if the employee joins any armed force before this period ends, you may continue his insurance until the date he becomes a member of such armed force.

- If an employee's active service ends because she goes on leave for pregnancy, childbirth or a related medical condition you must continue the employee's coverage for up to four months during any twelve consecutive months.
- If you continue an employee's benefits under this plan as set forth above, it must be based on a plan which prevents individual selection by you.
- And, any such continuation is subject to the payment of premiums, and to all of the other terms and conditions of this plan. In regards to leave for pregnancy, childbirth or a related condition you may recover from the employee premium paid if: 1) the employee fails to return from leave after four months; and 2) the employee's failure to return is for a reason other than one of the following: (a) the employee taking leave under the Moore-Brown-Roberti Family Rights Act; (b) the continuation, recurrence, or onset of a health condition that entitles the employee to leave is beyond the control of the employee; or (c) if the employer is a state agency, the collective bargaining agreement will govern.
- The amount of an employee's insurance during any such continuation will be the amount in force on his last day of active service, subject to any reductions that would have otherwise applied if he had remained an active employee.

GP-1-EC-90-7.0

P505.1353-R

Options A, B, E and F

An Employee's Right To Continue Group Insurance During A Family Leave Of Absence

Important Notice: This section may not apply to your plan. The employee must contact you to find out if you must allow for a leave of absence under federal law. In that case the section applies.

If An Employee's Group Coverage Would End: Group coverage may normally end for an employee because he or she ceases work due to an approved leave of absence. But, the employee may continue his or her group coverage if the leave of absence has been granted: (a) to allow the employee to care for a seriously injured or ill spouse, child, or parent; (b) after the birth or adoption of a child; (c) due to the employee's own serious health condition; or (d) because of any serious injury or illness arising out of the fact that a spouse, child, parent, or next of kin, who is a covered servicemember, of the employee is on active duty (or has been notified of an impending call or order to active duty) in the Armed Forces in support of a contingency operation. The employee will be required to pay the same share of the premium as he or she paid before the leave of absence.

When Continuation Ends: Insurance may continue until the earliest of the following:

- The date the employee returns to active work.
- The end of a total leave period of 26 weeks in one 12 month period, in the case of an employee who cares for a covered servicemember. This 26 week total leave period applies to all leaves granted to the employee under this section for all reasons.
- The end of a total leave period of 12 weeks in: (a) any 12 month period, in the case of any other employee; or (b) any later 12 month period in the case of an employee who cares for a covered servicemember.
- The date on which the employee's coverage would have ended had the employee not been on leave.
- The end of the period for which the premium has been paid.

Definitions: As used in this section, the terms listed below have the meanings shown below:

- **Active Duty:** This term means duty under a call or order to active duty in the Armed Forces of the United States.

- **Contingency Operation:** This term means a military operation that: (a) is designated by the Secretary of Defense as an operation in which members of the armed forces are or may become involved in military actions, operations, or hostilities against an enemy of the United States or against an opposing military force; or (b) results in the call or order to, or retention on, active duty of members of the uniformed services under any provision of law during a war or during a national emergency declared by the President or Congress.
- **Covered Servicemember:** This term means a member of the Armed Forces, including a member of the National Guard or Reserves, who for a serious injury or illness: (a), is undergoing medical treatment, recuperation, or therapy; (b) is otherwise in outpatient status; or (c) is otherwise on the temporary disability retired list.
- **Next Of Kin:** This term means the nearest blood relative of the employee.
- **Outpatient Status:** This term means, with respect to a covered servicemember, that he or she is assigned to: (a) a military medical treatment facility as an outpatient; or (b) a unit established for the purpose of providing command and control of members of the Armed Forces receiving medical care as outpatients.
- **Serious Injury Or Illness:** This term means, in the case of a covered servicemember, an injury or illness incurred by him or her in line of duty on active duty in the Armed Forces that may render him or her medically unfit to perform the duties of his or her office, grade, rank, or rating,

GP-1-EC-90-7.0

P449.0523-R

Options A, B, E and F

Definitions

GP-1-EC-90-DEF-1

P180.0155-R

Options A, B, E and F

Eligible Dependent is defined in the provision entitled "Dependent Coverage".

GP-1-EC-90-DEF-2

P180.0156-R

Options A, B, E and F

Employee means a person who works for the employer at the employer's place of business, and whose income is reported for tax purposes using a W-2 form.

GP-1-EC-90-DEF-3

P180.0311-R

Options A, B, E and F

Full-time means the employee regularly works at least the number of hours in the normal work week set by the employer (but not less than 30 hours per week), at his employer's place of business.

GP-1-EC-90-DEF-4

P180.0158-R

Options A, B, E and F

Plan means the Guardian group plan purchased by the employer, except in the provision entitled "Coordination of Benefits" where "plan" has a special meaning. See that provision for details.

GP-1-EC-90-DEF-6

P180.0160-R

Options A, B, E and F

We, Us, Our and **Guardian** mean The Guardian Life Insurance Company of America.

GP-1-EC-90-DEF-9

P180.0163-R

Options A, B, E and F

You and **Your** means the employer who purchased this plan.

GP-1-EC-90-DEF-10

P180.0164-R

Options A, B, E and F

Dependent Coverage

GP-1-DEP-90-1.0

P200.0305-R

Options A, B, E and F

Eligible Dependents For Dependent Vision Care Benefits: An employee's eligible dependents are: (a) his or her legal spouse; (b) his or her unmarried dependent children who are under age 26; and (c) his or her unmarried dependent children, from age 26 until their 26 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. The employee must provide written certification by a treating physician which states that the child is suffering from a serious illness or injury and that the leave of absence is medically necessary.

GP-1-DEP-90-2.0

P505.0642-R

Options A, B, E and F

Adopted Children and Step-Children: An employee's "unmarried dependent children" include his or her legally adopted children and, if they depend on him or her for most of their support and maintenance, his or her step-children.

We treat a child as legally adopted from the time the child is placed in the physical custody of the employee for the purpose of adoption. We treat such a child this way whether or not a final adoption order is ever issued. We cover an employee's adopted child from the moment of his or her placement if the employee is already covered for dependent child coverage when the child is placed for adoption. If the employee does not have dependent coverage when the child is placed for adoption, we cover the child for the first 31 days from the moment of his or her placement. To continue the child's coverage past the 31 days, the employee must enroll the child and agree to make any required premium payments within 31 days of the date of placement. If the employee fails to do this, the child's coverage will end at the end of the 31 days, and the child cannot be enrolled for this coverage until the plan's next open enrollment period.

Dependents Not Eligible: We exclude any dependent who is insured by this plan as an employee. And we exclude any dependent who is on active duty in any armed force.

GP-1-DEP-90-3.0

P505.0432-R

Options A, B, E and F

Handicapped Children: An employee may have an unmarried child with a mental or physical handicap, or developmental disability, who can't support himself or herself. Subject to all of the terms of this coverage and the plan, such a child may stay eligible for dependent benefits past this coverage's age limit.

The child will stay eligible as long as he or she stays unmarried and unable to support himself or herself, if: (a) his or her conditions started before he or she reached the age limit; (b) he or she became insured before he or she reached the age limit, and stayed continuously insured until he or she reached such limit; and (c) he or she depends on the employee for most of his or her support and maintenance.

But, for the child to stay eligible, the employee must send us written proof that the child is handicapped and depends on the employee for most of his or her support and maintenance. The employee has 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 the employee's does.

GP-1-DEP-90-4.0

P489.0030-R

Options A, B, E and F for Classes 0001 and 0002

When Dependent Coverage Starts: In order for an employee's dependent coverage to begin, he or she must already be insured for employee coverage, or enroll for employee and dependent coverage at the same time. Subject to the "Exception" stated below and to all of the terms of this plan, the date an employee's dependent coverage starts depends on when he or she elect to enroll all of his or her initial dependents and agree to make any required payments.

If the employee does this on or before his or her eligibility date, his or her dependent coverage is scheduled to start on the later of the date he or she signs the enrollment form and the date he or she becomes covered for employee coverage.

If the employee does this after the enrollment period ends, he or she can't enroll his or her initial dependents until the next vision open enrollment period.

Once the employee has coverage for his or her initial dependents, he or she must notify us when he or she acquires any new dependents, and agree to make any additional payments required for the coverage. If the employee does this within 31 days of the date the newly acquired dependent becomes eligible, the dependent's coverage will start on the date the dependent becomes eligible. If the employee fails to notify us on time, he or she can't enroll the newly acquired dependent until the next vision open enrollment period.

Once a dependent is enrolled for vision care expense insurance, the coverage can't be dropped until the next vision open enrollment period. And once coverage is dropped for a dependent, the dependent can't be enrolled again until the next vision open enrollment period.

GP-1-DEP-90-6.0

P505.0067-R

Options A, B, E and F

Exception: If a dependent, other than a newborn child, is confined to a hospital or other health care facility; or is unable to carry-out the normal activities of someone of like age and sex on the date his or her dependent benefits would otherwise start, we'll postpone the effective date of such benefits until the day after his or her discharge from such facility; or until he or she resumes the normal activities of someone of like age and sex.

GP-1-DEP-90-7.0

P200.0708-R

Options A, B, E and F

Newborn Children: We cover an employee's newborn child from the moment of his or her birth if the employee is already covered for dependent child coverage when the child is born. If the employee does not have dependent coverage when the child is born, we cover the child for the first 31 days from the moment of his or her birth. To continue the child's coverage past the 31 days, the employee must enroll the child and agree to make any required premium payments within 31 days of the date the child is born. If the employee fails to do this, the child's coverage will end at the end of the 31 days, and the child cannot be enrolled for this coverage until the plan's next open enrollment period.

GP-1-DEP-90-8.0

P505.0433-R

Options A, B, E and F

When Dependent Coverage Ends: Dependent coverage ends for all of an employee's dependents when his or her employee coverage ends. But if an employee dies while insured, we'll automatically continue dependent benefits for those of his or her dependents who were insured when he or she died. We'll do this for six months at no cost, provided: (a) the group plan remains in force; (b) the dependents remain eligible dependents; and (c) in the case of a spouse, the spouse does not remarry.

If a surviving dependent elects to continue his or her dependent benefits under this plan's "Federal Continuation Rights" provision, or under any other continuation provision of this plan, if any, this free continuation period will be provided as the first six months of such continuation. Premiums required to be paid by, or on behalf of a surviving dependent will be waived for the first six months of continuation, subject to restrictions (a), (b) and (c) above. After the first six months of continuation, the remainder of the continuation period, if any, will be subject to the premium requirements, and all of the terms of the "Federal Continuation Rights" or other continuation provisions.

Dependent coverage also ends for all of an employee's dependents when the employee stops being a member of a class of employees eligible for such coverage. And it ends when this plan ends, or when dependent coverage is dropped from this plan for all employees or for an employee's class.

If an employee is required to pay all or part of the cost of dependent coverage, and he or she fails to do so, his or her dependent coverage ends. It ends on the last day of the period for which he or she made the required payments, unless coverage ends earlier for other reasons.

An individual dependent's coverage ends when he or she stops being an eligible dependent. This happens to a child on the last day of the month in which the child attains this plan's age limit, when he or she marries, or when a step-child is no longer dependent on the employee for support and maintenance. It happens to a spouse on the last day of the month in which a marriage ends in legal divorce or annulment.

Read this plan carefully if dependent coverage ends for any reason. Dependents may have the right to continue certain group benefits for a limited time.

GP-1-DEP-90-9.0

P489.0266-R

Options A, B, E and F

Definitions

GP-1-DEP-90-DEF-1

P200.0210-R

Options A, B, E and F

Eligibility Date for dependent coverage is the earliest date on which: (a) the employee has dependents; and (b) is eligible for dependent coverage.

GP-1-DEP-90-DEF-2

P200.0211-R

Options A, B, E and F

Eligible Dependent is defined in the provision entitled "Dependent Coverage."

GP-1-DEP-90-DEF-3

P200.0212-R

Options A, B, E and F

Enrollment Period means the 31 day period which starts on the date that the employee is eligible for dependent coverage.

GP-1-DEP-90-DEF-4

P200.0213-R

Options A, B, E and F

Initial Dependents means those eligible dependents the employee has at the time he or she first becomes eligible for employee coverage. If at this time he or she does not have any eligible dependents, but later acquires them, the first eligible dependents he or she acquires are his or her initial dependents.

GP-1-DEP-90-DEF-8

P200.0217-R

Options A, B, E and F

Newly Acquired Dependent means an eligible dependent the employee acquires after he or she already has coverage in force for initial dependents.

GP-1-DEP-90-DEF-9

P200.0218-R

Options A, B, E and F

Plan means the Guardian group plan purchased by the employer.

GP-1-DEP-90-DEF-11

P264.0065-R

Options A, B, E and F

We, Us, Our and Guardian means The Guardian Life Insurance Company of America.

GP-1-DEP-90-DEF-14

P200.0223-R

Options A, B, E and F

You and Your means the employer who purchased this plan.

GP-1-DEP-90-DEF-15

P200.0224-R

Options A, B, E and F

ATTACHED TO AND MADE PART OF GROUP INSURANCE POLICY NO. G-00429264-

issued by

The Guardian Life Insurance Company of America

(herein called the Insurance Company)

to

HILTON WATERFRONT BEACH RESORT

(herein called the Policyholder)

Effective September 1, 2007, this rider amends the dependent coverage provisions as follows:

An employee's domestic partner will be eligible for coverage under this plan subject to all of the terms of this plan and the limitations below. "Domestic partner" means an adult who has chosen to share his or her life with the employee in an intimate and committed relationship of mutual caring.

To qualify for such coverage, the employee and his or her domestic partner must be either:

- (a) registered domestic partners; or
- (b) non-registered domestic partners.

As used here:

"Registered domestic partners" means an employee and his or her domestic partner who: (a) have filed a Declaration of Domestic Partnership with the California Secretary of State; (b) were registered as a domestic partner in the registry for those partnerships; and (c) were issued a copy of the registered form and a Certificate of Registered Domestic Partnership.

"Non-registered domestic partners" means an employee and his or her domestic partner who:

- are 18 years of age or older;
- are unmarried, constitute each other's sole domestic partner, and have not had another domestic partner in the last 12 months;
- share the same permanent address for at least 12 consecutive months and intend to do so indefinitely;
- share joint financial responsibility for basic living expenses including food, shelter and medical expenses;
- are not related by blood to a degree that would prohibit marriage in the employee's state of residence; and
- are financially interdependent which must be demonstrated by at least four of the following:
 - a. ownership of a joint bank account;
 - b. ownership of a joint credit account;
 - c. evidence of a joint mortgage or lease;
 - d. evidence of joint obligation on a loan;
 - e. joint ownership of a residence;
 - f. evidence of common household expenses such as utilities or telephone;
 - g. execution of wills naming each other as executor and/or beneficiary;
 - h. granting each other durable powers of attorney;

- i. granting each other health care powers of attorney;
- j. designation of each other as beneficiary under a retirement benefit account; or
- k. evidence of other joint financial responsibility.

An employee's registered domestic partner, or non-registered domestic partner, will be eligible for vision coverage under this plan.

To cover his or her non-registered domestic partner, the employee must complete a "Declaration of Domestic Partnership" attesting to the relationship and forward it to us.

A registered or non-registered domestic partner's dependent children will be eligible for coverage under this plan on the same basis as if the children were the employee's dependent children.

Coverage for a registered domestic partner and his or her dependent children ends when the domestic partnership is dissolved as provided under California law.

Coverage for a non-registered domestic partner and his or her dependent children ends when the domestic partner no longer meets the qualifications of a non-registered domestic partner as described above. Upon termination of a non-registered domestic partnership, a "Statement of Termination" must be completed and filed with the employer. Once the employee submits a "Statement of Termination", he or she may not enroll another non-registered domestic partner for a period of 12 months from the date of the previous termination.

A non-registered domestic partner and his or her children will not be eligible for:

- (a) survivor benefits upon the employee's death as explained under the "When Dependent Coverage Ends" section;
- (b) continuation of vision coverage as explained under the "Federal Continuation Rights" section and under any other continuation rights section of this plan, unless the employee is also eligible for and elects continuation.

A registered domestic partner will have all of the rights of a spouse under this plan except that the continuation of vision coverage as explained under the "Federal Continuation Rights" section is available to a registered domestic partner and his or her children only if the employee is also eligible for and elects continuation.

This rider is part of this plan. Except as stated in this rider, nothing contained in this rider changes or affects any other terms of this plan.

Dated at _____ This _____ Day of _____, _____

HILTON WATERFRONT BEACH RESORT
Full or Corporate Name of Policyholder

Witness BY: _____
Signature and Title

The Guardian Life Insurance Company of America



Michael Prestileo, Senior Vice President

Options A, B, E and F

VISION CARE BENEFITS

This insurance will pay many of an employee's and his or her covered dependent's vision care expenses. What we pay and the terms for payment are explained below.

GP-1-DAVIS-05-VIS

P505.0363-R

Options A, B, E and F

This Plan's Vision Care Preferred Provider Organization

Davis Vision: This plan is designed to provide a high quality vision care benefit while controlling the cost of such care. To do this, the plan encourages a covered person to seek vision care from doctors and vision care facilities that belong to Davis Vision's Preferred Provider Network.

This vision care preferred provider organization (PPO) is made up of preferred providers in a covered person's geographic area. A vision care preferred provider is a vision care practitioner or a vision care facility that: (a) is a credentialed provider in Davis Vision's network; and (b) has a current participatory agreement in force with Davis Vision.

Use of the vision care PPO is voluntary. A covered person may receive vision care from either a preferred provider or a non-preferred provider. And, he or she is free to change providers at any time. But, this plan usually pays more in benefits for covered services furnished by a vision care preferred provider. Conversely, it usually pays less for covered services not furnished by a vision care preferred provider.

When an employee and his or her dependents enroll in this plan, they will get an enrollment packet which will tell them how to obtain benefits and information about current vision care preferred providers.

What we pay is based on all of the terms of this plan. The covered person should read this material with care and have it available when seeking vision care. Read this plan carefully for specific benefit levels, frequencies, copayments and payment limits.

The covered person can call Davis Vision if he or she has any questions after reading this material.

Choice of Preferred Providers: When a person becomes enrolled in this plan, he or she will receive information about Davis Vision preferred providers in his or her area. A covered person may receive vision services from any current Davis Vision preferred provider.

When a covered person wants to receive services from a preferred provider, he or she must contact the preferred provider before receiving treatment. The preferred provider will contact Davis Vision to verify the covered person's eligibility before any treatment takes place.

It is not necessary to submit a claim for services or supplies from a preferred provider.

Non-Preferred Providers: If a covered person receives services or supplies from a non-preferred provider, he or she must submit a claim form along with the itemized bill to Davis for claims payment. All claims must be sent to Davis within 90 days of the date services are completed or supplies are received.

Claims for services or supplies from a non-preferred provider must be sent to:

Davis Vision - Vision Care Processing Unit
P.O. Box 1525
Latham, NY 12110

GP-1-DAVIS-05-PPOA

P505.0365-R

Options A, B, E and F

Appeals Process

In the event that a claim is denied, Davis Vision will consult with the provider involved with the covered person's vision care treatment. If the issue cannot be resolved, the provider or patient has the right to request a review of the adverse determination. The provider, covered person or patient may appeal denied authorizations or claim decisions. Should a covered person request a review of an authorization or claim decision, Davis Vision must notify the covered person, or his or her designee, within five (5) business days of receipt of the request and the review must be conducted by a clinical peer who was not involved in the original vision care determination. Pre-service review decisions are to be completed within fifteen (15) days and post-service review decisions are to be completed within thirty (30) days, or as required by state statute, from the date that Davis Vision receives notification from the covered person or his or her designee and be mailed within five (5) days of the date of decision. Denials can be appealed through Davis Vision's Grievance Resolution process or as per plan contract. A covered person has the right to appeal through an external review organization at any time during the grievance process. A covered person has the right to designate a representative, including his or her provider, to act on his or her behalf with regard to review of a vision care claim determination. Use of the Appeals Process does not waive the covered person's legal rights.

Grievance Process

Registering a Complaint or Grievance: A covered person has the right to file a grievance or make an appeal to any claim decision at any time. The covered person has the right to designate a representative to file complaints and appeals on his or her behalf.

A covered person is entitled to a copy of the Grievance Resolution process upon request and a copy will be provided to a covered person should the determination be made that vision care benefits are not available.

Davis Vision defines a "grievance" as a complaint that may or may not require specific corrective action and is made:

1. via the telephone.
2. in writing to Davis Vision.
3. via the Davis Vision Website.

A "grievance" or complaint can arise from and includes but is not limited to the following:

1. benefit denials;
2. an adverse determination as to whether a service is covered pursuant to the terms of the contract;
3. difficulty accessing or utilizing a benefit, and issues regarding the quality of vision care services;
4. challenges with vision care services or products received;
5. dissatisfaction with the resolution of a complaint/grievance or appeal.

Verbal Grievances and Telephone Communication: A covered person may file a verbal grievance by contacting Davis Vision. Registering a complaint or grievance by telephone will be considered filing a "formal grievance". A Davis Vision associate will acknowledge receipt of all complaints in writing within five (5) business days from the date the complaint or appeal is received.

A covered person has access to the Davis Vision toll free number twenty-four (24) hours a day seven (7) days a week to voice any concern or grievance and also has the right to contact his or her Human Resources Department or Benefits Administration Department. The Davis Vision Toll Free number is: **1 (800) 584-1487**

Written Grievances: Written notice of grievances received via e-mail, U.S. Mail or other written correspondence will be acknowledged within five (5) business days. All written correspondence should be addressed to:

Davis Vision

159 Express Street

Plainview, New York 11803

Attention: Quality Assurance/Patient Advocate Department

A covered person can register any concern or grievance by logging on to Davis' website: www.davisvision.com and entering the "Contact Davis Vision" area.

Internal Grievance Procedure

Appeal Level 1: Upon receipt of a concern or grievance by a Davis Vision associate, the covered person is contacted by telephone, or in writing, within five (5) business days to confirm that the concern or grievance was received and is being investigated. Every attempt is made to contact the covered person or his or her designated representative. Contact may include, but is not limited to, telephone contact, e-mail or U.S. Mail. A designated Davis Vision associate reviews the appeal with the covered person and may request additional information. Details of the complaint are documented in the covered person's file. The covered person is given the associate's name, phone number, department and the estimated time needed to perform the research. The covered person is informed of his or her right to have a representative, including his or her provider, present during the review of the concern and final outcome of the investigation. The covered person is informed of his or her right to appeal to an external review organization at any time during the grievance procedure or as required by state statute.

The review committee will include a licensed (peer) health care professional when grievances pertain to clinical decisions. All decisions are reviewed and approved by the Vice President of Professional Affairs, a licensed optometrist.

The investigation may involve contacting the provider or the point of service location to determine the cause of the concern. If necessary, the Regional Quality Assurance Representative (RQAR) or Professional Field Consultant (PFC) will be contacted and a site visit may be scheduled. Davis Vision will contact the covered person when further information is required and inform him or her of the status of the investigation or the need for more information.

The determination will be communicated to the covered person within fifteen (15) days for pre-service review decisions and within thirty (30) days for post-service review decisions, or as required by state statute. An additional ten (10) days may be requested in order to complete further research. The written decision will be mailed to the covered person within five (5) days of the decision. The appeal determination will include the following:

- the decision, and will include a summary of the facts related to the issue,
- the criteria that was used, summary of the evidence, including the documentation supporting the decision,
- a statement indicating that the decision will be final and binding unless the covered person appeals in writing to the Quality Assurance/Patient Advocate Department within fifteen (15) business days of the date of the notice of the decision,
- a copy of the appeals process, if applicable, and
- the name, position, phone number, and department of the person(s) responsible for the decision.

The decision of the Quality Assurance/Patient Advocate Department shall be final and binding unless appealed by the covered person to Davis Vision within fifteen (15) business days of the date of notice of the decision.

Options A, B, E and F

Appeal Level 2: Should Davis Vision uphold a denial, as the result of a Level 1 review, The covered person has the right to request a Level 2 appeal.

A Level 2 appeal will not include Associate(s) or licensed (peer) health care professional(s) that were involved in the Level 1 review.

A Level 2 appeal requires the covered person to contact Davis Vision in writing or by telephone within fifteen (15) days following receipt of the Level 1 summary statement. The covered person requesting a Level 2 appeal must indicate the reason they believe the denial of coverage/benefit was incorrect. Davis Vision reserves the right to request further information from the covered person or provider.

Davis Vision has thirty (30) days, or as required by state 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 will review the Level 1 decision. If the Level 2 appeal upholds the Level 1 determination, the covered person will be notified in writing of this decision. Notification will include, but not be limited to:

- the decision, and contain a summary stating the nature of the concern and the facts related to the issue,
- the criteria that was used, summary of the evidence, including documentation that was used to support the decision,
- a statement indicating that the decision will be final and binding unless the covered person appeals in writing or by telephone to the Quality Assurance/Patient Advocacy Department within forty-five (45) days of the date of the notice of the Level 2 decision,
- a copy of the appeals process, if applicable, and
- the name, position, phone number, and department of person(s) responsible for the decision.

External Grievance Procedure

External Review: A covered person, as required by state statute, has the right to request an impartial review of concerns that resulted in a denial of coverage. A covered person who has exhausted the internal appeals process may appeal the final decision if the denial for services was not deemed medically necessary or the requested service was deemed Investigational or Experimental.

An external review organization will refer the case for review by a neutral, independent practitioner experienced in vision care. Davis Vision will provide all requested documentation to the external review organization. The external review organizations will have up to thirty (30) days, or as required by state statute, to make their determination.

External Review Process: A covered person has the right to an external review of a denial of coverage. A covered person has the right to an external review of a final adverse decision under the following circumstances:

- the covered person has been denied a vision care service, which should have been covered under the terms of the contract.
- services were denied on the basis that requested services were not medically necessary.
- a treatment or service that will have a significant positive impact on the covered person has been denied and any alternative service or treatment will not affect the covered person's ocular health and/or produce a negative outcome.
- services denied are related to a current illness or injury.
- the cost of the requested services will not exceed that of any equally effective treatment.

- the denied service, procedure or treatment is a covered benefit under the covered person's policy.
- The covered person has exhausted all internal appeal processes with an adverse determination upheld at each level.

Investigational or Experimental Treatment means an approved ocular diagnostic procedure warranted by the ocular health of the covered person and the subsequent diagnostic findings could alter the covered person's treatment plan. The risk of a negative outcome utilizing the approved treatment would be no greater than utilizing an alternative treatment.

The vision care provider may contact the appropriate State Agency to determine if other documentation may be required for the appeal process.

Once the determination is made, notification is made, in writing, within two (2) business days. This notification will include an explanation and the clinical criteria used in the decision.

GP-1-DAVIS-05-APP-2

P505.0368-R

Options A, B, E and F

How This Plan Works

We pay benefits for the covered charges a covered person incurs as follows. What we pay is subject to all of the terms of this plan. Read the entire plan to find out what we limit or exclude.

Covered charges are the usual charges for the services and supplies described below. We pay benefits only for covered charges incurred by a covered person while he or she is insured by this plan. Charges in excess of any payment limits shown in this plan are not covered charges.

When a payment limit is for a pair of materials (such as lenses), the limit is halved if only one item is purchased.

GP-1-DAVIS-05-HPW

P505.0369-R

Options A, B, E and F

Copays: A covered person must pay a copay each time he or she receives a vision examination. A covered person must pay a copay each time he or she receives any vision materials covered by this plan.

GP-1-DAVIS-05-COP

P505.0371-R

Options A, B, E and F

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 \$46.00.

We pay benefits for one vision examination in any 12 month period.

A vision examination includes:

- case history - chief complaint, eye and vision history, medical history;
- entrance distance acuities;
- external ocular evaluation including slit lamp examination;
- internal ocular examination;
- tonometry;
- distance refraction - objective and subjective;
- binocular coordination and ocular motility evaluation;
- evaluation of papillary function;

- biomicroscopy;
- gross visual fields;
- assessment and plan;
- advice to a Covered Person on matters pertaining to vision care;
- form completion - school, motor vehicle, etc.

If the doctor recommends vision correction, we cover the fitting of eyeglasses and follow-up adjustments.

GP-1-DAVIS-05-VE

P505.0376-R

Options A, B, E and F

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 12 month period, we pay benefits for either one pair of standard lenses or one pair of contact lenses, but not both.

In any 24 month period, we pay benefits for one set of frames.

GP-1-DAVIS-05-VM

P505.0678-R

Options A, B, E and F

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:

- \$47.00 for single vision lenses;
- \$66.00 for bifocal lenses;
- \$85.00 for trifocal lenses; and
- \$125.00 for lenticular lenses.

We cover one pair of standard lenses in any 12 month period.

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

GP-1-DAVIS-05-SL

P505.0383-R

Options A, B, E and F

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 for at least 12 months.

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 \$135.00. The copay is waived.

We cover one pair of elective contact lenses in any 12 month period.

GP-1-DAVIS-05-ECL

P505.0697-R

Options A, B, E and F

How We Cover Necessary Contact Lenses: We cover charges for necessary contact lenses, including charges for related professional services:

- only if the lenses are needed for the correction of *keratoconus*; and
- the *covered person* complies with the following requirements regarding prior notification.

The *covered person* or the provider must send a completed request to Davis Vision for necessary contact lenses for the correction of *keratoconus* before the lenses are dispensed. If the required notification is not obtained, no benefits will be paid for such lenses.

A *covered person* must pay a \$25.00 copay each time he or she purchases necessary contact lenses. If the contact lenses are purchased from a *preferred provider*, we pay benefits in full for the lenses in excess of the copay. If the contact lenses are purchased from a *non-preferred provider*, we pay benefits in excess of the copay up to a maximum of \$210.00.

GP-1-DAVIS-05-NCL-TX

P505.0409-R

Options A, B, E and F

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 \$47.00.

If the frames are purchased from a preferred provider, we pay benefits in excess of the copay as follows:

- If a preferred provider offers Davis' Tower designer frame collection (the Tower), we cover any Fashion or Designer Collection frame selected from the Tower in excess of a \$25.00 copay. We cover any Premier Collection frame selected from the Tower in full in excess of a \$50.00 copay.
- We cover a non-Tower frame in excess of a \$25.00 copay up to the retail frame allowance of \$135.00.

We cover one set of frames in any 24 month period.

GP-1-DAVIS-05-FRM

P505.0387-R

Options A, B, E and F

Exclusions

- We won't pay for orthoptics or vision training and any associated supplemental training.
- We won't pay for medical or surgical treatment of the eyes.
- We won't pay for any eye examination or corrective eyewear required by an employer as a condition of employment.
- We won't pay for plano lenses (lenses with less than a +/- .38 diopter power).
- We won't pay for two sets of glasses in lieu of bifocals.
- We won't pay for replacement of lenses and frames furnished under this Plan which are lost or broken, except at normal intervals when services are otherwise available.
- We won't pay for necessary contact lenses prescribed for a covered person affected with keratoconus for which prior notification was not sent to Davis Vision.
- We won't pay for lens cosmetic extras that are not specifically listed in this Plan as covered.

GP-1-DAVIS-05-EXC

P505.0389-R

Options A, B, E and F

DEFINITIONS

"Blended Lenses" means bifocals which do not have a visible dividing line.

"Coated Lenses" means substance added to a finished lens on one or both surfaces.

"Copay" means a charge, expressed as a fixed dollar amount, required to be paid by or on behalf of a covered person before any benefits are paid by this plan.

"Covered Person" with respect to vision care insurance means an employee or eligible dependent who meets this plan's eligibility criteria and who is covered under this Plan.

"Customary" means, when referring to a covered charge, that the charge for the covered vision condition is not more than the usual charge made by most other doctors with similar training and experience in the same geographic area.

"Keratoconus" means a development or dystrophic deformity of the cornea in which it becomes cone shaped due to a thinning and stretching of the tissue in its central area.

"Lenticular Lenses" means high-powered lenses with the desired prescription power found only in the central portion. The outer carrier portion has a front surface with a changing radius of curvature.

"Non-Preferred Provider" with respect to vision care insurance, means any optometrist, ophthalmologist or optician or other licensed and qualified vision care provider who has not entered into a contract with Davis Vision to provide vision care services and/or vision care materials on behalf of the covered persons of the plan. "Orthoptics" means the teaching and training process for the improvement of visual perception and coordination of two eyes for efficient and comfortable binocular vision.

"Oversize Lenses" means larger than a standard lens blank to accommodate prescriptions.

"Photochromic Lenses" means lenses which change color with the intensity of sunlight.

"Plan" means the Davis Vision group policy of vision care services described herein.

"Plano Lenses" means lenses which have no refractive power (lenses with less than a +/- .38 diopter power).

"Preferred Provider" with respect to vision care insurance means an optometrist, ophthalmologist or optician or other licensed and qualified vision care provider who has entered into a contract with Davis Vision to provide vision care services and/or vision care materials on behalf of covered persons of the plan.

"Standard Lenses" means regular glass or plastic lenses. See "Exclusions" for what we limit or exclude.

"Tinted Lenses" means lenses which have an additional substance added to produce constant tint.

"Usual" means when referring to a covered charge that the charge is the doctor's standard charge for the service furnished. If more than one type of service can be used to treat a vision condition, "usual" refers to the charge for the least expensive type of service which meets the accepted standards of vision care practice.

GP-1-DAVIS-05-DEF

P505.0391-R

Options E and F

ATTACHED TO AND MADE PART OF GROUP INSURANCE POLICY NO. G -00429264-

issued by

The Guardian Life Insurance Company of America

(herein called the Insurance Company)

to

HILTON WATERFRONT BEACH RESORT

(herein called the Policyholder)

Effective October 21, 2015, this rider amends this plan's Life Insurance policy as follows:

1. The Examination Period provision as shown below is hereby added to the policy:

Examination Period

A person age 65 or older insured under the policy has the right to return the policy or certificate, by mail or other delivery method, within 30 days after its receipt, and to have the full premium and any policy or membership fee paid refunded.

2. The Continuation of Coverage During a Labor Dispute provision as shown below is hereby added to the policy:

Continuation Of Coverage During A Labor Dispute

Important Notice: This section does not apply to coverage which provide benefits for loss of income due to disability. All other coverages under the group plan are affected by this section, and are hereafter referred to as "group coverage."

If A Work Stoppage Occurs: A labor dispute may result in a work stoppage which causes an employee's group coverage to end. If this happens, an employee has the right to continue his health coverage for himself and his dependents during the work stoppage, for up to six months.

How To Continue Group Coverage: To continue his group coverage an employee must make timely payment of the total premium, including any portion of the premium the employer was paying before work stopped, to the Policyholder. If an employee fails to pay a premium on time, he waives his right to continue under this section.

The Responsibilities of the Policyholder: For an employee's group coverage to continue, the Policyholder must do the following:

- (a) collect the premium payments made by an employee; and
- (b) make timely payment of the collected premiums to us.

If Policyholder, after timely receipt of the employee's premium, fails to pay us on behalf of such employee, thereby causing the employee's group coverage to end, then Policyholder will be liable for the employee's benefits, to the same extent as, and in place of, us.

The Premium: The premium to be paid by an employee for continued group coverage will be at the rate that applies to the class of employees to which he belonged on the day work stopped. But, we have the right to increase this rate by up to 20%, or any higher amount approved by the Insurance Commissioner,

to allow for increased costs and risks caused by this continued coverage. We may do this at any time during the continuation. Nothing in this section alters our right to change premium rates according to the "Premiums" section of the group plan.

When This Continuation Starts: Group coverage continued under this section starts on the day work stopped. But, if a premium that was due before the work stoppage began is unpaid at the time work stopped, then payment of such premium before the next premium due date will be required for this continuation to take effect.

When This Continuation Ends: An employee's continued group coverage ends on the first of the following:

- (a) the end of the six month continuation period;
- (b) the day on which the number of employees covered under this section is less than 75% of those insured under the group plan on the day work stopped;
- (c) the day the work stoppage ends;
- (d) when the employee enters full-time employment with another employer;
- (e) at the end of the period for which the last premium payment is made, if the employee stops paying premium;
- (f) the date the employee stops being eligible as defined in this plan, for reasons other than not meeting "actively at work" or "full-time" requirements; and
- (g) with respect to a dependent, the date such dependent stops being an eligible dependent as defined in the group plan.

3. The Incontestability provision is hereby replaced, as follows:

Incontestability

The validity of the policy shall not be contested, except for non-payment of premiums, after it has been in force for two years from its date of issue. No statements made by any person insured under the policy relating to his or her insurability shall be used in contesting the validity of the insurance with respect to which the statement was made after the insurance has been in force prior to the contest for a period of two years during such person's lifetime nor unless it is contained in a written statement signed by such person.

If a photographic identification is presented during the application or enrollment process, and if an imposter is substituted for an insured person in any part of the application or enrollment process, with or without the knowledge of such person, then no contract between Guardian and such person is formed, and any purported insurance contract is void from its inception.

Application or enrollment process means any or all of the steps required of an insured person in applying for a certificate under a group policy of life insurance, including, but not limited to, executing any part of the application or enrollment form, submitting to medical or physical examination or testing, or providing a sample or specimen of blood, urine, or other bodily substance

Imposter means a person other than the insured person who participates in any manner in the application or enrollment process for a certificate under a group life insurance policy and represents himself or herself to be the insured person or represents that a sample or specimen of blood, urine, or other bodily substance is that of the insured person.

A Policyholder insurance under this policy shall be incontestable after two years from the Policyholder policy date of coverage under this policy, except for nonpayment of premiums.

If this policy replaces the group policy of another insurer, we may rescind this policy based on misrepresentations made in the policyholder's or insured person's signed application for up to two years from this policy's policy date.

4. The Contract provision is hereby replaced, as follows:

The Contract

The entire contract between the Guardian and the policyholder consists of this policy, the policyholder's application, a copy of which is attached hereto or endorsed hereon, and the individual applications, if any, of the employees.

We can amend this policy at any time, without the consent of the insured employees or any other person having a beneficial interest therein, as follows:

We can amend this policy: (a) upon written request made by the policyholder and agreed to by the Guardian; (b) on any date our obligation under this policy with respect to a policyholder is changed because of statutory or other regulatory requirements; or (c) if this policy supplements, or coordinates with benefits provided by any other insurer, non-profit hospital or medical service plan, or health maintenance organization, on any date our obligation under this policy is changed because of a change in such other benefits.

If we amend the policy, except upon request made by the policyholder, we must give the policyholder written notice of such amendment.

Any amendments to this policy will be without prejudice to any claim arising prior to the date of the change.

No person, except by a writing signed by the President, a Vice President or a Secretary of The Guardian, has the authority to act for us to: (a) determine whether any contract, policy or certificate of insurance is to be issued; (b) waive or alter any provisions of any insurance contract or policy, or any requirements of The Guardian; or (c) bind us by any statement or promise relating to the insurance contract issued or to be issued; or (d) accept any information or representation which is not in a signed application.

All personal pronouns in the masculine gender used in this policy, will be deemed to include the feminine also, unless the context clearly indicates the contrary.

This rider is part of this plan. Except as stated in this rider, nothing contained in this rider changes or affects any other terms of this plan.

Dated at _____ This _____ Day of _____ , _____

HILTON WATERFRONT BEACH RESORT
Full or Corporate Name of Policyholder

Witness BY: _____
Signature and Title

The Guardian Life Insurance Company of America



Michael Prestileo, Senior Vice President

P531.0613-R

Options A and E

ATTACHED TO AND MADE PART OF YOUR GROUP INSURANCE POLICY

issued by

The Guardian Life Insurance Company of America

to

HILTON WATERFRONT BEACH RESORT

Group Insurance Policy No. G-00429264-

POLICY AMENDATORY RIDER

This Rider amends the Policy as follows and for plans issued before 07/01/2017, is effective on the first Policy Anniversary following 07/01/2017. For plans issued after 07/01/2017, the rider is effective on the Policy Date.

The provision, **Timely Access to Care** is added:

Timely Access to Care

Covered dental services must be provided in a timely manner appropriate with the nature of a *covered person's* condition consistent with good professional dental practice.

Guardian's *dental preferred provider organization (PPO)* has adequate capacity and availability of *preferred providers* to offer appointments for covered dental services in accordance with the following Timely Access to Care requirements:

- Urgent appointments to be offered within 72 hours of the time of request for an appointment when consistent with the nature of a *covered person's* condition and as required by professionally recognized standards of dental practice.
- Non-urgent appointments (initial/routine) to be offered within 36 business days of the request for an appointment.
- Preventive dental care appointments to be offered within 40 business days of the request for an appointment.

The Timely Access to Care appointment wait time standards may not apply if a *covered person* is requesting a specific date and time. The applicable waiting time for a particular appointment may also be longer if the referring or treating *dentist*, acting within the scope of the *dentist's* practice and consistent with professionally recognized standards of dental practice, has determined and noted in the relevant record that a longer waiting time will not have a detrimental impact on a *covered person's* health.

When it is necessary for a *covered person's dentist* or a *covered person* to reschedule an appointment, the appointment will be promptly rescheduled by a *covered person's dentist* in a manner that is:

- Appropriate for a *covered person's* dental care needs;
- Ensures continuity of care consistent with good professional dental practices; and
- Meets California's standards regarding the accessibility of dental services in a timely manner.

Language and interpreter services are available for a *covered person* at no cost. Interpreter services, if requested, must be coordinated with scheduled appointments in a manner that ensures interpreter services are provided at the time of the appointment, consistent with California standards, without imposing a delay in scheduling.

Preferred providers are required to have an answering service or a telephone answering machine during

non-business hours. Their message must provide instructions regarding how a *covered person* may obtain urgent or emergency care, including how to contact another *dentist* who has agreed to be on-call to triage or screen by phone, or, if needed, deliver urgent or emergency care. If the *preferred provider* does not answer and a *covered person* has an emergency, a *covered person* may call 911 or go to the nearest hospital. Emergency/urgent services may be received by any *dentist*.

Telephone triage or screening services are to be provided in a timely manner appropriate for a *covered person's* condition. During normal business hours the waiting time for a *covered person* to speak by telephone with a knowledgeable and competent customer service representative regarding a *covered person's* questions and concerns will not exceed 10 minutes.

If a *covered person* has any questions or want to request an interpreter, please call Our Customer Response Unit at 1-800-541-7846 or the toll-free number on the *covered person's* ID card.

The provision, **Continuity Of Care** is added:

Continuity Of Care

At a *covered person's* request, we can arrange for the completion of covered services by a terminated *dentist* for the duration of an acute condition. A terminated *dentist* means a *dentist* whose contract to provide services to *covered persons* is terminated or not renewed by us or one of our contracting dental groups. A terminated *dentist* is not a *dentist* who voluntarily leaves us or our contracting dental group. A *covered person* must be undergoing a course of treatment for an acute condition and the *covered person's* coverage under the Policy must continue during the completion of covered services.

Acute condition: This term means a dental condition that involves a sudden onset of symptoms due to a dental problem that requires prompt dental attention and that has a limited duration.

This Rider amends the Policy regarding the term "**spouse**" as follows:

Reference to the term "spouse" within the contract, means the person to whom the Employee is legally married, or the Employee's registered domestic partner, civil union partner or equivalent as recognized and allowed by federal law, or state law in the Employee's state of residence or the state in which the marriage or the Employee's registered domestic partner, civil union partner or equivalent was recorded.

The **Eligible Dependents For Dependent Dental Benefits** provision is revised with the following:

An Employee's *eligible dependents* are: (a) his or her spouse; and (b) his or her dependent children including:

- A newborn child, natural child, stepchild or a child placed with the Employee for adoption or foster care who is under age 26.

The **Handicapped Children** provision is replaced in its entirety with the following:

Continuing Coverage Past the Child Age Limit

A child who is incapable of self-support because of a physically or mentally disabling injury, illness or condition. A dependent child may remain eligible for dependent benefits past the age limit, subject to the conditions below:

- The condition started before he or she reached the age limit; and
- The child remained continuously covered until he or she reached the age limit; and

- We will send notice to the Employee at least 90 days prior to the limiting age and the Employee must send us written proof that the child is dependent upon him or her for support and maintenance as is incapable of self- sustaining employment by reason of a physically or mentally disabling injury, illness, or condition. The Employee has 60 days from the date the child reaches the age limit to do this. We will continue coverage until a determination about the child's eligibility is made. We can ask for periodic proof that the child's condition continues, but we cannot ask for this proof more than once a year after the two-year period following the child's attainment of the limiting age.

The **Assignment** provision with respect to Accident and Health Insurance is replaced in its entirety with the following:

Assignment

The *employee's* Certificate and his or her right to benefits under this Policy are not assignable. But, the *employee* may direct *us*, in writing, to pay dental benefits to the recognized provider who provided the covered service for which benefits became payable. The amount of payment will not exceed the amount of benefit provided by the Policy and the amount of payments will not exceed the amount of expenses incurred. The *employee* may not assign his or her right to take legal action under this Policy to such provider. And, we assume no responsibility as to the validity or effect of any such direction.

Assignment or transfer of the *employee's* interest under this Policy will not bind *us* without *our* written consent.

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



Michael Prestileo, Senior Vice President

P531.0716-R

Options A and E

ATTACHED TO AND MADE PART OF GROUP INSURANCE POLICY NO. G -00429264-

issued by

The Guardian Life Insurance Company of America

(herein called the Insurance Company)

to

HILTON WATERFRONT BEACH RESORT

(herein called the Policyholder)

This Rider amends this Policy by adding the Reinstatement of Policy provision as shown below and is effective on its issue date.

Reinstatement Of Policy

If any renewal premium with respect to the Employee's of any Participating Employer is not paid within the time granted for payment, a subsequent acceptance of premium by Us or by any agent duly authorized by Us to accept such premium, without requiring in connection therewith an application for reinstatement, shall reinstate the Policy; provided, however, that if We or such agent requires an application for reinstatement and issues a conditional receipt for the premium tendered, the Policy will be reinstated upon approval of such application by Us or, lacking such approval, upon the forty-fifth day following the date of such conditional receipt unless We previously notified You in writing of Our disapproval of such application.

The reinstated Policy shall cover claims for Covered Services that occur after the reinstatement date. You shall have the same rights thereunder as You had under the Policy immediately before the due date of the defaulted premium, subject to any provisions in connection with the reinstatement. Any premium accepted in connection with a reinstatement shall be applied to a period for which premium has not been previously paid, but not to any period more than 60 days prior to the date of reinstatement.

This rider is part of this Policy. Except as stated in this rider, nothing contained in this rider changes or affects any other terms of this Policy.

Dated at _____ This _____ Day of _____ , _____

HILTON WATERFRONT BEACH RESORT
Full or Corporate Name of Policyholder

Witness BY: _____
Signature and Title



Harris Oliner, Senior Vice President,
Corporate Secretary



Michael Prestileo,
Senior Vice President

Options A, B, E and F

ATTACHED TO AND MADE PART OF GROUP INSURANCE POLICY NO. G -00429264-

issued by

The Guardian Life Insurance Company of America

(herein called the Insurance Company)

to

HILTON WATERFRONT BEACH RESORT

(herein called the Policyholder)

The Policyholder and the Insurance Company hereby agree that the Group Policy is hereby amended effective January 1, 2011 as follows:

The Vision Insurance eligibility provisions applicable to dependent coverage are modified to provide that:

- (a) an employee's dependent child is a child under age 26;
- (b) marital status, residency and financial dependency requirements do not apply to an employee's dependent child; except as stated in item (c);
- (c) a handicapped child can stay eligible for dependent coverage past age 26 if such 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 the employee for support and maintenance, except as stated for a handicapped child past the age limit, is deleted.

The foregoing amendment shall form a part of said Group Policy, provided both the Policyholder and the Insurance Company have hereto applied their respective signatures, and is subject to the agreements and covenants therein contained.

Dated at _____ This _____ Day of _____ , _____

HILTON WATERFRONT BEACH RESORT

Full or Corporate Name of Policyholder

Witness BY: _____
Signature and Title

The Guardian Life Insurance Company of America



Michael Prestileo, Senior Vice President

All Options

ATTACHED TO AND MADE PART OF GROUP INSURANCE POLICY NO. G -00429264-

issued by

THE GUARDIAN LIFE INSURANCE COMPANY OF AMERICA

(herein called Guardian)

to

HILTON WATERFRONT BEACH RESORT

(herein called the Policyholder)

This Rider amends the Policy as follows and is effective on its issue date:

- The "Non-Participating - No Dividends Payable" notice on the Policy face page is replaced with "Dividends Apportioned Annually, if Payable".
- The Dividends provision is added or replaced in its entirety within the General Provisions as shown below.

Dividends

The portion, if any, of the divisible surplus of Guardian allocable to this Policy at each Policy Anniversary will be determined annually by the Board of Directors of Guardian and will be credited to this Policy as a dividend on such anniversary, provided this Policy is continued in force by the payment of all premiums to such anniversary.

Any dividend under this Policy will be paid to the Policyholder in cash, or at the option of the Policyholder it may be applied to the reduction of the premiums then due.

In the event that the Employees are contributing toward the cost of the coverage under any group policy issued to the Policyholder and the aggregate dividends under this Policy and any other group policy or policies issued to the Policyholder are in excess of the Policyholder's share of the aggregate cost, such excess will be applied by the Policyholder for the sole benefit of the Employees.

Finally, please note that it is not expected that any dividends will be payable under this Policy.

This Rider is part of this Policy. Except as stated in this Rider, nothing contained in this Rider changes or affects any other terms of this Policy.

Dated at Spokane, WA This 9th Day of June, 2021



Harris Oliner, Senior Vice President,
Corporate Secretary



Michael Prestileo,
Senior Vice President

P070.0043

Options A and E

COORDINATION OF BENEFITS

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.

Definitions

Allowable Expense: This term means any necessary, reasonable, and customary item of health care expense that is covered, at least in part, by any of the plans which cover the person. This includes: (a) deductibles; (b) coinsurance; and (c) copayments. When a plan provides benefits in the form of services, the reasonable cash value of each service will be considered an allowable expense and a benefit paid.

An expense or service that is not covered by any of the plans is **not** an allowable expense. Examples of other expenses or services that are **not** allowable expenses are:

- (1) If a person is confined in a private hospital room, the difference between the cost of a semi-private room in the hospital and the private room is **not** an allowable expense. This does not apply if: (a) the stay in the private room is medically necessary in terms of generally accepted medical practice; or (b) one of the plans routinely provides coverage for private hospital rooms.
- (2) The amount a benefit is reduced by the primary plan because a person does not comply with the plan's provisions is **not** an allowable expense. Examples of these provisions are: (a) precertification of admissions and procedures; (b) continued stay reviews; and (c) preferred provider arrangements.
- (3) If a person is covered by two or more plans that compute their benefit payments on the basis of reasonable and customary charges, any amount in excess of the primary plan's reasonable and customary charges for a specific benefit is **not** an allowable expense.
- (4) If a person is covered by two or more plans that provide benefits or services on the basis of negotiated fees, an amount in excess of the primary plan's negotiated fees for a specific benefit is **not** an allowable expense.

If a person is covered by one plan that computes its benefits or services on the basis of reasonable and customary charges and another plan that provides its benefits or services on the basis of negotiated fees, the primary plan's payment arrangements will be the allowable expense for all plans. 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.

Plan: This term means any of the following that provides benefits or services for health care or treatment: (1) group, blanket or franchise insurance coverage; (2) service plan contracts, group practice, individual practice and other prepayment coverage; (3) any coverage under labor-management trustee plans, union welfare plans, employer organization plans, or employee benefit organization plans; and (4) governmental benefits, except Medicare, as permitted by law.

This term does not include: (a) individual or family insurance; (b) individual or family subscriber contracts; (c) school-type blanket accident and sickness insurance; (d) blanket accident insurance that is excess to other coverage; (e) medical benefit payments in traditional automobile contracts; or (f) 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.

GP-1-R-COB-05

P555.0225-R

Options A and E

Order Of Benefit Determination

The primary plan pays or provides its benefits as if the secondary plan or plans did not exist.

A plan may consider the benefits paid or provided by another plan to determine its benefits only when it is secondary to that other plan. If a person is covered by more than one secondary plan, the rules explained below decide the order in which secondary plan benefits are determined in relation to each other.

A plan that does not contain a coordination of benefits provision is always primary.

When all plans have coordination of benefits provisions, the rules to determine the order of payment are listed below. The first of the rules that applies is the rule to use.

Non-Dependent Or Dependent: The plan that covers the person other than as a dependent (for example, as an employee, member, subscriber, or retiree) is primary. The plan that covers the person as a dependent is secondary.

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:

- (1) If the parents are married, or are not separated (whether or not they ever have been married), or a court decree awards joint custody without specifying that one party must provide health care coverage, the plan of the parent whose birthday is earlier in the year is primary. If both parents have the same birthday, the plan that covered either of the parents longer is primary. If a plan does not have this

birthday rule, then that plan's coordination of benefits provision will determine which plan is primary.

- (2) If the specific terms of a court decree state that one of the parents must provide health care coverage and the plan of the parent has actual knowledge of those terms, that plan is primary. This rule applies to claim determination periods that start after the plan is given notice of the court decree.
- (3) In the absence of a court decree, if the parents are not married, or are separated (whether or not they ever have been married), or are divorced, the order of benefit determination is: (a) the plan of the custodial parent; (b) the plan of the spouse of the custodial parent; and (c) the plan of the noncustodial parent.

Active Or Inactive Employee: The plan that covers a person as an active employee, or as that person's dependent, is primary. An active employee is one who is neither laid off nor retired. The plan that covers a person as a laid off or retired employee, or as that person's dependent, is secondary. If a plan does not have this rule and as a result the plans do not agree on the order of benefit determination, this rule is ignored.

Continuation Coverage: The plan that covers a person as an active employee, member, subscriber, or retired employee, or as that person's dependent, is primary. The plan that covers a person under a right of continuation provided by federal or state law is secondary. If a plan does not have this rule and as a result the plans do not agree on the order of benefit determination, this rule is ignored.

Length Of Coverage: The plan that covered the person longer is primary.

Other: If the above rules do not determine the primary plan, the allowable expenses will be shared equally between the plans that meet the definition of plan under this section. But, this plan will not pay more than it would have had it been the primary plan.

Effect On The Benefits Of This Plan

When This Plan Is Primary: When this plan is primary, its benefits are determined before those of any other plan and without considering any other plan's benefits.

When This Plan Is Secondary: When this plan is secondary, it may reduce its benefits so that the total benefits paid or provided by all plans during a claim determination period are not more than 100% of total allowable expenses. When the benefits of this plan are reduced, each benefit is reduced in proportion. It is then charged against the applicable benefit limit of this plan.

Right To Receive And Release Needed Information

Certain facts about health care coverage and services are needed to apply these rules and to determine benefits payable under this plan and other plans. This plan may get the facts it needs from, or give them to, other organizations or persons to apply these rules and determine benefits payable under this plan and other plans which cover the person claiming benefits. This plan need not tell, or get the consent of, any person to do this. Each person claiming benefits under this plan must provide any facts it needs to apply these rules and determine benefits payable.

Facility Of Payment

A payment made under another plan may include an amount that should have been paid by this plan. If it does, this plan may pay that amount to the organization that made the payment. That amount will then be treated as though it were a benefit paid by this plan. This plan will not have to pay that amount again.

As used here, the term "payment made" includes the reasonable cash value of any benefits provided in the form of services.

Right Of Recovery

If the amount of the payments made by this plan is more than it should have paid under this section, it may recover the excess: (a) from one or more of the persons it has paid or for whom it has paid; or (b) from any other person or organization that may be responsible for benefits or services provided for the covered person.

As used here, the term "amount of the payments made" includes the reasonable cash value of any benefits provided in the form of services.

GP-1-R-COB-05

P555.0227-R

Options A and E

ATTACHED TO AND MADE PART OF GROUP INSURANCE POLICY NO. G-00429264-

issued by

The GUARDIAN Life Insurance Company of America

(herein called the Insurance Company)

to

HILTON WATERFRONT BEACH RESORT

(herein called the Policyholder)

Notwithstanding any provision in the Policy to the contrary, it is hereby agreed that the Group Policy is amended, effective September 1, 2007 so that,

- (A) A Covered Person may select any holder of a license issued under Section 2135, 1000, 1634 or 2948 of the California Business and Professions Code, to perform any covered service such holder is expressly authorized by law to perform.
- (B) A Covered Person may select a clinical social worker who is the holder of license issued under Section 9040 of the California Business and Professions Code, to perform any covered service which such social worker is expressly authorized by law to perform, provided such Covered Person is referred to such social worker by a licensed physician or surgeon.
- (C) A Covered Person may select an occupational therapist, regulated under Section 2570 of the California Business and Professions Code, to perform any covered service which such Occupational Therapist is expressly authorized by law to perform, provided such Covered Person is referred to such occupational therapist by a licensed physician or surgeon.
- (D) A Covered Person may select a speech pathologist or audiologist, licensed under Section 2530 of the California Business and Professions Code, to perform any covered service which such speech pathologist or audiologist is expressly authorized by law to perform, provided such Covered Person is referred to such speech pathologist or audiologist by a licensed physician or surgeon.
- (E) A Covered Person may select a marriage, family, and child counselor, licensed under Section 17805 of the California Business and Professions Code, to perform any covered service which such family, marriage, and child counselor is expressly authorized by law to perform, provided Covered Person is referred to such family, marriage, and child counselor by a licensed physician or surgeon.

This Rider shall form a part of the Policy. Except as stated in this Rider, nothing contained herein shall be held to alter or affect any of the provisions of the Policy, including any prior Riders, Amendments, or Endorsements.

Dated at _____ This _____ Day of _____, _____

HILTON WATERFRONT BEACH RESORT
Full or Corporate Name of Policyholder

Witness BY: _____
Signature and Title

The Guardian Life Insurance Company of America



Michael Prestileo, Senior Vice President

GP-1-A-CAL-PR

P590.9043-R

Options A and E

ATTACHED TO AND MADE A PART OF GROUP INSURANCE POLICY NO. G-00429264-

issued by

The Guardian Life Insurance Company of America

(herein called the Insurance Company)

to

HILTON WATERFRONT BEACH RESORT

(herein called the Policyholder)

As of September 1, 2007, this plan is amended, as explained below, with respect to any of this plan's provisions.

As used in this rider:

"Covered Person" means an employee or dependent, including the legal representative of a minor or incompetent, insured by this plan.

"Reasonable pro-rata Expenses" are those costs, such as lawyers fees and court costs, incurred to effect a third party payment, expressed as a percentage of such payment.

"Third Party" means anyone other than The Guardian, the employer or the covered person.

We will not pay any benefits under this plan, to or on behalf of a covered person, who has received payment in whole or in part from a third party, or its insurer for past or future medical or dental charges or loss of earnings, resulting from the negligence, intentional act, or no-fault tort liability of a third party.

If a covered person makes a claim to us for medical, dental or loss of earnings benefits under this plan prior to receiving payment from a third party or its insurer, the covered person must agree, in writing, to repay us from any amount of money they receive from the third party, or its insurer.

The repayment will be equal to the amount of benefits paid by us. However, the covered person may deduct the reasonable pro-rata expenses, incurred in effecting the third party payment, from the repayment to us.

The repayment agreement will be binding upon the covered person whether: (a) the payment received from the third party, or its insurer, is the result of a legal judgement, an arbitration award, a compromise settlement, or any other arrangement; or (b) the third party, or its insurer, has admitted liability for the payment; or (c) the medical or dental charges or loss of earnings are itemized in the third party payment.

This rider is a part of this plan. Except as stated in this rider, nothing contained in this rider changes or affects any other terms of this plan.

Dated at _____ This _____ Day of _____, _____

HILTON WATERFRONT BEACH RESORT
Full or Corporate Name of Policyholder

Witness BY: _____
Signature and Title

The Guardian Life Insurance Company of America



Michael Prestileo, Senior Vice President

GP-1-TPL-90

P600.0003-R

**The following Group Universal Life insurance plan
is provided by The Guardian Insurance & Annuity
Company, Inc.**

GROUP FLEXIBLE PREMIUM ADJUSTABLE LIFE TRUST INSURANCE POLICY

A Group Insurance Policy Providing On A Contributory Basis, The Flexible Premium Adjustable Life Insurance Described Herein.

The Guardian Insurance & Annuity Company, Inc., a stock company incorporated in the State of Delaware, (herein called GIAC), in consideration of the Policyholder's application and executed Trustee Agreement, the Employer's application, and of the payment of premiums as stated herein, agrees to pay benefits to persons entitled to insurance provided by this Group Flexible Premium Adjustable Life Trust Insurance Policy (herein called the Group Policy), subject to all of its terms and conditions.

Policyholder: Trustee of the GIAC General Services Industry Group Flexible
Premium Adjustable Life Insurance Trust Fund

Employer: HILTON WATERFRONT BEACH RESORT

Group Policy: G-00429264-J

Policy Effective Date: September 1, 2007

Policy Anniversary: September 1st of each year thereafter.

Executive Office: 7 Hanover Square
New York, New York 10004

This Group Policy takes effect on the Policy Effective Date specified above. In witness of this we cause this Group Policy to be executed as of its date of issue which is August 27, 2010.

This is a specimen copy of group policy provisions which apply to the plan of insurance. The originals of these provisions are part of a master group policy delivered in the State of Rhode Island to Citizens Bank of Rhode Island (Trustee) as Policyholder.

The Guardian Insurance & Annuity Company, Inc.



President

Non-Participating - No Dividends Payable

GP-GUL97

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DEFINITIONS

As used in this Group Policy, the following terms have the following meanings. When each defined term is used, it appears with the first letter of each word in capital letters.

**Active Work Or
Actively-At-Work** The performance by an Employee of all the duties that pertain to his or her work at the place where it is normally done, or where it is required to be done by his or her Employer.

Associated Company A corporation or other business entity affiliated with the Employer through common ownership of stock or assets.

Cash Surrender Value The Certificate Value less any surrender charges.

Certificate The certificate of insurance, including all applicable endorsements, additional benefit riders, and the Certificate Data, issued to a person who is insured by this Group Policy.

Certificate Account An account which reflects the amounts that are not loaned which are attributable to a Certificate Holder's Certificate. If there are no loans on a Certificate, the amount of its Certificate Account equals its Certificate Value. If there are loans on a Certificate, the amount of its Certificate Account is its Certificate Value less any amounts allocated to the Loan Collateral Account.

Certificate Data The form issued to each Certificate Holder which describes the particulars of insurance coverage that applies to each Certificate. These particulars include, but are not limited to, benefits, amounts of insurance, premiums, and charges.

Certificate Date The date that an Employee's insurance is scheduled to start under the Group Policy. The Certificate Date is shown in the Certificate Data. Certificate months, years and anniversaries are measured from the Certificate Date.

Certificate Holder The owner of each Certificate.

Certificate Value The sum of the amounts allocated to the Certificate Account and the Loan Collateral Account.

Employee A person who works for the Employer at the Employer's place of business, and whose income is reported for tax purposes using a W-2 form. This term will also include an Employee who has become insured and whose insurance remains in force in accord with the terms of his or her Certificate after: (a) he or she ceases to work for the Employer; (b) his or her Employer cancels its involvement with this Group Policy; or (c) this Group Policy is amended to discontinue the eligibility of a class of Employees to which he or she belongs.

Employer HILTON WATERFRONT BEACH RESORT

Full-time The Employee regularly works at least the number of hours in the normal work week set by the Employer (but not less than 30 hours per week) at his or her Employer's place of business.

GIAC The Guardian Insurance & Annuity Company, Inc.

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DEFINITIONS (Continued)

Good Order	Notice from the party authorized to initiate a transaction under this Group Policy, received at GIAC's Executive Office or as otherwise directed in a format satisfactory to GIAC, that includes all information required to process the transaction.
Group Policy	The Group Flexible Premium Adjustable Life Insurance Trust Policy
Initial Required Premium	The premium required to put the Certificate Holder's insurance in force. The Initial Required Premium is shown in the Certificate Holder's Certificate Data.
Loan Balance	All unpaid loans, plus accrued and unpaid loan interest.
Loan Collateral Account	An account to which amounts from a Certificate's Certificate Account are transferred when a loan is taken or when loan interest is capitalized. Amounts in a Loan Collateral Account earn interest from the date of transfer at a rate less than the loan interest rate.
Monthly Date	The same date of each calendar month as the Certificate Date, or the last date of a calendar month, if earlier.
Net Cash Surrender Value	The amount payable on the date GIAC receives at the Executive Office the Certificate and the Certificate Holder's written request for surrender in Good Order. The Net Cash Surrender Value on any date is the Cash Surrender Value less any Loan Balance.
Trustee	Citizens Bank of Rhode Island, or its successor, appointed under a Trustee Agreement which is approved and signed by GIAC.

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EMPLOYEE COVERAGE

Eligible Employees

Subject to the conditions of eligibility set forth below, and to all of the other conditions of this Group Policy, all of the Employer's Employees who are in an eligible class will be eligible if they are active Full-time Employees.

For the purposes of this Group Policy, GIAC will treat partners and proprietors like Employees if they meet this Group Policy's conditions of eligibility.

CLASS

Class 0001	GENERAL MANAGERS, CONTROLLERS, DIRECTORS, ASST. DIRECTORS, EXECUTIVE CHEF, EXECUTIVE HOUSEKEEPER, EXECUTIVE STEWARD, MANAGERS, ASST MANAGERS, PASTRY CHEF, BANQUET CHEF, SOUS CHEF, ASST EXECUTIVE HOUSEKEEPER, ASST CONTROLLER AND ACTIVITIES DIRECTOR
Class 0002	ALL OTHER ELIGIBLE EMPLOYEES***
Class 0003	ROBERT MAYER EMPLOYEES (CFO, CHAIRMAN, VICE CHAIRMAN, PRESIDENT, VICE PRESIDENT, CONTROLLER, EXECUTIVE ASSISTANT AND ACCOUNTING CLERK)

Conditions Of Eligibility

Full-Time Requirement	GIAC won't insure an Employee unless he or she is a Full-Time Employee.
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Application Requirement	GIAC won't insure an Employee until he or she applies for insurance under this Group Policy and pays the Initial Required Premium. If the Employee does this more than 31 days after he or she first becomes eligible, GIAC will ask for proof that he or she is insurable. The Employee won't be insured under this Group Policy until GIAC approves that proof in writing.
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Proof Of Insurability Requirements

We require proof for any amount of Optional Term Life Insurance, which, when combined with the amount for which the employee is insured under his or her GIAC Group Flexible Adjustable Life Insurance Certificate, exceeds \$200,00.00.

We require proof for any amount of Optional Term Life Insurance, which, when combined with the amount for which the employee is insured under his or her GIAC Group Flexible Premium Adjustable Life Insurance Certificate, exceeds \$10,000.00, if the employee's scheduled Optional Term Life effective date is after he or she reaches age 65.

We require proof for any amount of Dependent Optional Term Life Insurance, with respect to a dependent spouse, which, when combined with the amount for which the spouse is insured under the Spouse Term Life Rider to the employee's GIAC Group Flexible Adjustable Life Insurance Certificate, exceeds \$25,000.00.

We require proof for any amount of Dependent Optional Term Life Insurance, with respect to a dependent spouse, which, when combined with the amount for which the spouse is insured under the Spouse Term Life Rider to the employee's GIAC Group Flexible Premium Adjustable Life Insurance Certificate, exceeds \$5,000.00, if the dependent spouse's scheduled Optional Term Life effective date is after he or she reaches age 65.

EMPLOYEE COVERAGE (Continued)

We require proof for any amount of Dependent Optional Term Life Insurance, with respect to a dependent child, which, when combined with the amount for which the child is insured under the Child Term Life Rider to the employee's GIAC Group Flexible Premium Adjustable Life Insurance Certificate, exceeds \$10,000.00

The Waiting Period Employees in an eligible class are eligible for insurance under this Group Policy after they complete the service waiting period established by the Employer, if any.

Multiple Employment If an Employee works for both the Employer and a covered Associated Company, or for more than one covered Associated Company, GIAC will treat him or her as if only one firm employs him or her. Such an Employee will not have multiple coverage under this Group Policy. If this Group Policy uses the amount of an Employee's earnings to set rates, determine class, figure benefit amounts, or for any other reason, such Employee's earnings will be figured as the sum of his or her earnings from all covered firms.

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EMPLOYEE COVERAGE (Continued)

When Employee Insurance Starts

An Employee must be Actively-At-Work on a Full-time basis on the date his or her insurance is scheduled to start. This date is called the Certificate Date. And, he or she must have:

- met all of the conditions of eligibility which apply to him or her; and
- paid the Initial Required Premium.

If an Employee is not Actively-At-Work on a Full-time basis on his or her Certificate Date, GIAC will postpone the start of his or her insurance until he or she returns to Active Work on a Full-time basis. If an Employee does not return to Active Work on a Full-time basis within 90 days, a new application will be required.

Sometimes a Certificate Date is not a regularly scheduled work day. In that case, an Employee's insurance will start on the Certificate Date if he or she was Actively-At-Work on a Full-time basis on his or her last regularly scheduled work day.

The Certificate Date of an Employee's insurance is determined as follows:

- If an Employee applies for insurance and agrees to pay the required premiums on or before his or her eligibility date, his or her Certificate Date will be the eligibility date.
- If an Employee applies for insurance and agrees to pay the required premiums within 31 days after his or her eligibility date, his or her Certificate Date will be the date he or she applies for insurance.
- If an Employee applies for insurance and agrees to pay the required premiums more than 31 days after his or her eligibility date, he or she must send GIAC proof that he or she is insurable. In that case, the Employee's Certificate Date will be the date that GIAC approves his or her proof of insurability.

Any part of an Employee's insurance which is subject to proof of insurability will not start unless he or she sends the proof to GIAC, and GIAC approves it in writing. In that case, the Employee's Certificate Date will be the date that GIAC approves his or her proof of insurability.

If an Employee's Certificate Date would normally fall on the twenty-ninth, thirtieth, or thirty-first day of a month, it will be changed to the first day of the next month.

EMPLOYEE COVERAGE (Continued)

When Employee Insurance Ends

An Employee's insurance under the Group Policy ends when the first of the following events occurs:

- Except as provided in "Continuance Of Insurance":
 - The Employer cancels its involvement with this Group Policy; or
 - This Group Policy is amended to discontinue the eligibility of a class of Employees to which the Employee belongs.
- The Employee's insurance lapses.
- The Employee's Certificate is surrendered.

If an Employee ceases to be in an eligible class of Employees, his or her insurance will remain in force subject to the terms and conditions of the Certificate; provided the Certificate is not cancelled or surrendered by its Certificate Holder. The payment method for all such insurance that remains in force will be automatically changed from payroll deduction of premium status to GIAC direct billing status.

An Employee's insurance will stay in force even if the Certificate Holder stops paying premiums, as long as the Certificate's Net Cash Surrender Value is sufficient to cover the monthly deductions shown in his or her Certificate Data. If the Certificate's Net Cash Surrender Value is no longer sufficient to cover the monthly deductions, the "Grace Period" provision will apply.

Continuance Of Insurance

If the Employer cancels its involvement with this Group Policy, any insurance then in effect under Certificates will remain in force subject to the terms and conditions of the Certificates; provided the Certificates are not cancelled or surrendered by their Certificate Holders. No additional Employees will be insured under this Group Policy from the date the Employer cancels its involvement with this Group Policy.

If the Group Policy is amended to discontinue the eligibility of a class of Employees, any insurance then in effect under Certificates for such Employees will remain in force subject to the terms and conditions of the Certificates; provided the Certificates are not cancelled or surrendered by their Certificate Holders. No additional Employees who are members of such class will be insured under this Group Policy from the date the Group Policy is so amended.

If either of these events occur, the payment method for all such insurance that remains in force will be automatically changed from payroll deduction of premium status to GIAC direct billing status.

This Group Policy will finally terminate when there are no longer any Employees insured under it.

GENERAL PROVISIONS

Benefits

The benefits available under this Group Policy are described in the Incorporated Certificate Forms which are attached to and made part of this Group Policy. The applicable benefit limits are shown in the Schedule Of Insurance.

The benefits for which a person is insured are determined by the elections made in the Employee's application for insurance under this Group Policy and any later requests for changes made by the Certificate Holder as indicated in the Certificate Data and the records maintained in connection with this Group Policy.

Premiums

Premium Payments	The first premium payment for this Group Policy is due on the Policy Effective Date. Further premiums for the insurance of each Certificate Holder are due as stated in his or her Certificate.
Change In Monthly Cost Of Insurance	GIAC may set new monthly cost of insurance rates which will become effective at any time as provided for in the Certificate.
Liability Of Trustee	The Trustee shall be exempt from personal liability with respect to the premiums required by this Group Policy, but shall be liable for such premiums only in its fiduciary capacity.
Liability Of Employer	The Employer shall be liable for premiums required by this Group Policy in its fiduciary capacity.
Grace Period	Each Certificate Holder will be allowed a 62 day grace period after the Monthly Date that: (a) the Net Cash Surrender Value is not sufficient to cover monthly deductions when due; or (b) the Loan Balance exceeds the Cash Surrender Value and GIAC requires a loan repayment. GIAC will mail to the Certificate Holder a notice of the required premium or required loan repayment to keep his or her insurance in force. This notice will be mailed at least 30 days before the end of the grace period. Subject to the no lapse guarantee, if the required premium or required loan repayment is not paid by the end of the grace period, the grace period will end 62 days after it began, at which time the Certificate Holder's insurance will lapse without value.

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GENERAL PROVISIONS (Continued)

Term Of Policy And Certificates

Policy	The Employer can cancel his or her involvement under this Group Policy at any time by giving GIAC 31 days advance written notice. This notice must be sent to GIAC's Executive Office.
Certificates	The term and conditions of a Certificate Holder's coverage are described in his or her Certificate.

Other General Provisions

The Contract - Changes	The entire contract between the parties consists of the Group Policy, including any amendments to the Group Policy, the application of the Employer, the original applications and any subsequent applications for changes of persons insured under the Group Policy, the application of the Trustee, and the attachments to the Group Policy. GIAC can amend the Group Policy at any time by notifying the Employer and the Policyholder. GIAC will give the Employer and the Policyholder at least 31 days advance written notice of the change. The Employer can request an amendment of the Group Policy at any time. Only the President, a Vice President, or the Secretary of GIAC may make or modify this Group Policy. No agent has the authority to change the Group Policy, or to waive any of its terms or conditions.
Certificates	GIAC will give each Certificate Holder a Certificate. The Certificate will control: (a) benefit amounts, limits and other scheduled information; (b) benefit plan provisions; (c) effective date and termination rules; (d) exclusions and limitations; (e) premium and grace period provisions; and (f) other provisions pertaining to coverage, including state insurance requirements.
Clerical Error - Misstatements	A clerical error in keeping records pertaining to the Group Policy, or delays in making entries on those records, will not invalidate insurance otherwise validly in force or continue insurance otherwise validly terminated. This is true regardless of whether the error was made by the Policyholder, the Employer, a Certificate Holder, an insured, or GIAC. If the age of an insured person, or any other relevant fact, has been misstated, GIAC will use the true facts in determining whether insurance is in force under the terms of this policy and in what amount.
Statements	GIAC relied upon the applications in issuing the insurance provided under this Group Policy. All statements in the applications are assumed to be true to the best knowledge and belief of the persons making them. These statements are representations and not warranties. No statement will be used to avoid the insurance or be used in defense of a claim under this Group Policy unless: (a) in the case of the Employer, it is contained in a writing signed by him or her; and (b) in the case of a Certificate Holder, it is contained in a written request or application signed by the Certificate Holder, a copy of which has been furnished to him or her.

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GENERAL PROVISIONS (Continued)

Other General Provisions (Continued)

Conformity With State Statute	This Group Policy is governed by the laws of the state of Rhode Island. However, with respect to each Certificate Holder, any terms in his or her Certificate which are in conflict with any insurance statute or regulation of the state where he or she signs his or her application, are hereby amended to conform to the minimum requirements of such statute or regulation.
Incontestability	The Group Policy cannot be contested after it, or any rider or amendment subsequently added to it, has been in force for a period of two years.
Time Periods	All periods affecting the coverage under a Certificate begin and end at 12:01 a.m., standard time, at each Certificate Holder's address of record.
Associated Companies	If the Employer requests GIAC in writing to include an Associated Company under the Group Policy, and GIAC gives written approval, GIAC will treat Employees of that company like the Employer's Employees. GIAC's written approval will include the starting date of the Associated Company's coverage under this Group Policy. Each eligible Employee of that company must still meet all of the terms and conditions of this Group Policy before he or she will be insured. The Employer must notify GIAC in writing when a company stops being associated with the Employer.
Assignment	The right of a Certificate Holder to assign any interest under this Group Policy is described in the Certificate. Assignment or transfer of the interest of the Trustee or Employer under this Group Policy shall not bind GIAC without its written consent thereto.
Records - Information To Be Furnished	The Employer shall keep a record of Employees insured, containing, for each Employee, the essential particulars of the insurance. The Employer shall, as prescribed by GIAC, periodically forward to GIAC such information concerning the Employees eligible for insurance under this Group Policy as may reasonably be considered to have a bearing on the administration of the insurance under this Group Policy and on the determination of premium rates, and any other information which GIAC may reasonably require with regard to any matters pertaining to this Group Policy. Any records of the Policyholder, or of the Employer, as may have a bearing on the insurance under this Group Policy shall be open for inspection by GIAC at any reasonable time.
Claims Of Creditors	Except so far as may be contrary to the laws of any state having jurisdiction in the premises, the insurance and other benefits under this Group Policy shall be exempt from execution, attachment, garnishment, or other legal or equitable process, for the debts or liabilities of the Certificate Holders, Employees, or their beneficiaries.

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SCHEDULE OF INSURANCE

The benefit amounts available under this Group Policy are described below. The benefits that apply to any insured person are described in the Certificate under which such person is covered.

Basic Certificate

Specified Insurance Amount	The amount for which the Employee's life is insured under this Group Policy. The Employee may elect the Specified Insurance Amount in \$1,000.00 increments. The minimum Specified Insurance Amount available is \$10,000.00. The maximum Specified Insurance Amount available is \$1,000,000.00.
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Additional Benefit Riders

P998.0244-R

Accidental Death Benefit	The Employee may elect the Accidental Death Benefit in \$1,000.00 increments. The minimum Accidental Death Benefit available is \$10,000.00. The maximum Accidental Death Benefit available is \$1,000,000.00.
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Spouse's Term Life Insurance	The Employee may elect Spouse's Term Life Insurance in \$500.00 increments. The minimum Spouse's Term Life Insurance amount is \$5,000.00. The maximum Spouse's Term Life Insurance amount is \$250,000.00.
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In no event may the Spouse's Term Life Insurance amount exceed 50% of the Employee's Specified Insurance Amount.

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Children's Term Life Insurance	\$500.00 per child, for each insured child who is less than 6 months old; and not more than \$10,000.00 per child, in increments of \$100.00, for each insured child who is 6 months old or over.
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In no event may the Children's Term Life Insurance amount on the life of any insured child exceed 10% of the Employee's Specified Insurance Amount.

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INCORPORATION PROVISION

**Incorporated
Certificate Forms**

The following certificate forms are hereby added to and made part of the Group Policy:

CGP-GUL97 (Group Flexible Premium Adjustable Life Certificate of Insurance)

P998.0220-R

EAL-GUL97 (Accelerated Life Benefit Endorsement)

P998.0221-R

EWD-GUL97 (Disability Waiver of Monthly Deductions Benefit
Endorsement)

P998.0222-R

RAD-GUL97 (Accidental Death Benefit Rider)

P998.0223-R

RST-GUL97-03-CA (Spouse's Term Life Insurance Rider)

P998.1168-R

RCT-GUL97-03-CA (Children's Term Life Insurance Rider)

P998.1169-R

EMT-GUL97 (Monthly Cost of Insurance Endorsement)

P998.1181-R

CERTIFICATE OF INSURANCE

**The Guardian Insurance & Annuity Company, Inc.
A Stock Company Incorporated in the State of Delaware**

This is to certify that, subject to the terms of Group Policy No. G-00429264-J issued to the policyholder named below, the Insured named below is covered for the benefits described in this certificate.

Trustee of the GIAC General Services Industry Group Flexible Premium Adjustable Life
Insurance Trust Fund

Name Of Insured: As shown in the Certificate Data

Certificate Number: As shown in the Certificate Data

The Guardian Insurance & Annuity Company, Inc. (GIAC) will pay the death proceeds to the Beneficiary upon receipt of due proof in Good Order that the Insured died while the insurance evidenced by this certificate was in force. Claim forms may be obtained from the Executive Office or as otherwise directed.

The provisions on the pages which follow are a part of this certificate. This certificate is a summary of the major terms of the group policy. The group policy is the contract between the policyholder and GIAC.

THE DEATH PROCEEDS, CERTIFICATE VALUE AND CASH SURRENDER VALUE EVIDENCED BY THIS CERTIFICATE MAY INCREASE OR DECREASE, DEPENDING ON PREMIUMS PAID, THE AMOUNT OF INTEREST CREDITED, THE AMOUNT OF CHARGES DEDUCTED, AND WHETHER PARTIAL WITHDRAWALS OR LOANS ARE TAKEN.

THERE IS NO MINIMUM GUARANTEED CASH SURRENDER VALUE.

RIGHT TO CANCEL: The Owner has the right to examine this certificate and return it for cancellation to the Executive Office or as otherwise directed within 10 days after receiving it. The certificate and a written cancellation notice must be delivered or mailed to cancel this certificate. Any notice given by mail, either by the Owner or GIAC, is effective on being postmarked, properly addressed, and postage prepaid. If the certificate is cancelled during this period, GIAC will refund any amounts paid. The certificate will be void from the beginning.

The Guardian Insurance & Annuity Company, Inc.



President

Executive Office: 7 Hanover Square
New York, New York 10004

GROUP FLEXIBLE PREMIUM ADJUSTABLE LIFE

- Payable at death of Insured if certificate is in force
- With the right to change the specified insurance amount
- Flexible premiums payable during Insured's lifetime
- Non-Participating - No dividends payable

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CERTIFICATE SUMMARY

This summary outlines some of the major certificate and group policy provisions. It does not alter any of the certificate and group policy provisions. The actual group policy provisions set forth the full details and conditions of the insurance evidenced by this certificate. Only the actual group policy provisions will control.

The initial specified insurance amount is shown in the Certificate Data. If the Insured is alive while the insurance evidenced by this certificate is in force, the Owner may increase or decrease the specified insurance amount in accord with "Changing The Specified Insurance Amount". GIAC will pay the death proceeds to the Beneficiary if the Insured dies while the insurance evidenced by this certificate is in force. The actual death proceeds will be determined in accord with "Death Proceeds".

Premiums for the insurance evidenced by this certificate are flexible. However, the Target Premium is shown in the Certificate Data. This premium is not required, but may be paid as elected. The insurance evidenced by this certificate will not become effective unless the Initial Required Premium is paid. The payment of Target Premiums, however, does not guarantee that the insurance evidenced by this certificate will stay in force. The insurance evidenced by this certificate will stay in force as long as the Net Cash Surrender Value is sufficient to cover monthly deductions when due. Premiums may be paid at any time and for varying amounts, subject to the limits described in "Premium Limits".

The Certificate Value is the sum of the Certificate Account and the Loan Collateral Account. The Certificate Value may vary with the amount of interest credited and charges deducted. The Certificate Account will accrue interest at a guaranteed minimum effective interest rate of 4% per year. GIAC may declare an interest rate greater than 4% at its discretion (see "Interest Rate").

This certificate does not have a minimum guaranteed Cash Surrender Value. If this certificate has a Cash Surrender Value, the Owner may, subject to limitations:

- obtain a loan (see "Loans");
- make a partial withdrawal or surrender this certificate for cash (see "Partial Withdrawals And Surrender");
- use this certificate to provide life income (see "Payment Options").

Subject to the no lapse guarantee, if the Net Cash Surrender Value is not sufficient to pay monthly deductions when due, GIAC allows a 62 day grace period for premium payment (see "No Lapse Guarantee" and "Grace Period"). If the required premium is not paid by the end of the grace period, this certificate will lapse without value.

Any endorsements, additional benefit riders and applications which are attached to this certificate appear at the back.

DEFINITIONS

Certain important terms used in this certificate are defined below. When each defined term is used, it appears with the first letter of each word in capital letters. Additional terms, not explained here, are defined in other parts of this certificate.

Active Work and Actively-At-Work: The performance by an Employee of all the duties that pertain to his or her work at the place where it is normally done, or where it is required to be done by his or her Employer.

Attained Age: The Insured's Issue Age as shown in the Certificate Data plus the number of certificate years completed since the Certificate Date.

Basic Certificate: This certificate, including any endorsements and applications, but excluding any additional benefit riders.

Beneficiary: The Beneficiary is the person(s) named in the application or in any later change shown in GIAC's records to receive the death proceeds payable under this certificate.

Cash Surrender Value: The Certificate Value less any surrender charges.

Certificate Account: An account which reflects the amounts that are not loaned which are attributable to this certificate. If there are no loans, the amount of the Certificate Account equals the Certificate Value. If there are loans, the amount of the Certificate Account is the Certificate Value less any amounts allocated to the Loan Collateral Account.

Certificate Anniversary: The annual anniversary measured from the Certificate Date.

Certificate Date: The Certificate Date is shown in the Certificate Data. Certificate months, years and anniversaries are measured from the Certificate Date.

Certificate Value: The sum of the amounts allocated to the Certificate Account and the Loan Collateral Account.

Designated Premium: The periodic amount authorized by the Employee to be paid to GIAC. This includes premium attributable to the Basic Certificate and premium attributable to the cost of additional benefit riders.

Employee: A person who works for the Employer at the Employer's place of business, and whose income is reported for tax purposes using a W-2 form. This term will also include an Employee who has become insured and whose insurance remains in force in accord with the terms of this certificate after: (a) he or she ceases to work for the Employer; (b) his or her Employer cancels its involvement with the group policy; or (c) the group policy is amended to discontinue the eligibility of a class of Employees to which he or she belongs. GIAC will treat partners and proprietors like Employees if they meet the conditions of eligibility of the group policy.

Employer: The entity which employs the Employee. The Employer is named in the Certificate Data.

Full-Time: The Employee regularly works at least the number of hours in the normal work week set by the Employer (but not less than 30 hours per week) at his or her Employer's place of business.

GIAC: The Guardian Insurance & Annuity Company, Inc.

Good Order: Notice from the party authorized to initiate a transaction under this certificate, received at the Executive Office or as otherwise directed in a format satisfactory to GIAC, that includes all information required by GIAC to process a transaction under this certificate.

DEFINITIONS (Continued)

Initial Required Premium: The premium required to put the insurance evidenced by this certificate and any additional benefit riders in force. The Initial Required Premium is shown in the Certificate Data.

Insured: The person whose life insurance is evidenced by this certificate. The Insured is named in the Certificate Data.

Internal Revenue Code: The Internal Revenue Code of 1986, as amended, and the rules and regulations thereunder, and successor provisions thereto.

Issue Age: The Insured's age on the birthday preceding or coinciding with the Certificate Date. The Issue Age is shown in the Certificate Data.

Loan Balance: All unpaid loans, plus accrued and unpaid loan interest.

Loan Collateral Account: An account to which amounts from the Certificate Account are transferred when a loan is taken or when loan interest is capitalized. Amounts in the Loan Collateral Account earn interest from the date of transfer at a rate less than the loan interest rate.

Monthly Date: The same date of each calendar month as the Certificate Date, or the last date of a calendar month, if earlier.

Net Amount At Risk: The amount calculated as:

- the amount of death benefit provided under the Death Benefit Option in force;
- divided by 1.0032737;
- less the Certificate Value.

Net Cash Surrender Value: The amount payable on the date GIAC receives this certificate and the Owner's written request for surrender in Good Order. The Net Cash Surrender Value on any date is the Cash Surrender Value less any Loan Balance.

Owner: The person named in the application or in any later change shown in GIAC's records as the Owner of this certificate. The Owner is named in the Certificate Data.

Target Premium: The annual premium attributable to the Basic Certificate from which the maximum expense charges will be deducted. It is based on the Insured's specified insurance amount, Issue Age, and premium class. The payment of Target Premiums does not guarantee that the insurance evidenced by this certificate will stay in force. All premiums attributable to the Basic Certificate in a certificate year which exceed the Target Premium for that certificate year will be considered excess premiums. The Target Premium is shown in the Certificate Data.

Section 7702: The section of the Internal Revenue Code which defines life insurance.

WHEN INSURANCE STARTS

An Insured's insurance starts on the Certificate Date shown in the Certificate Data, provided he or she is Actively-At-Work on a Full-Time basis on that date and the Initial Required Premium is paid.

If the Insured is not Actively-At-Work on a Full-Time basis on the Certificate Date, his or her insurance and any insurance provided under additional benefit riders, if applicable, will not start until the date he or she returns to Active Work on a Full-Time basis. If the Employee does not return to Active Work on a Full-Time basis within 90 days, a new application will be required. Also see "Disability Exclusion".

Sometimes, the Certificate Date is not a regularly scheduled work day. In that case, insurance will start on the Certificate Date if the Insured was Actively-At-Work on a Full-Time basis on his or her last regularly scheduled work day.

WHEN INSURANCE ENDS

An Insured's insurance under the group policy ends when the first of the following events occurs:

- Except as provided in "Continuance of Insurance under the Group Policy":
 - the Employer cancels its involvement with the group policy; or
 - the group policy is amended to discontinue the eligibility of a class of Employees to which the Insured belongs.
- The Insured's insurance lapses.
- The Insured's certificate is surrendered for its Net Cash Surrender Value.

If an Insured ceases to be in an eligible class of Employees any insurance evidenced by this certificate will remain in force subject to the terms and conditions of this certificate; provided the certificate is not cancelled or surrendered by the Owner. The payment method for all such insurance that remains in force will be automatically changed from payroll deduction of premium status to direct billing status. See "Premiums".

The insurance evidenced by this certificate will stay in force even if the Owner stops paying premiums, as long as the Net Cash Surrender Value is sufficient to cover the monthly deductions. If the Net Cash Surrender Value is no longer sufficient to cover the monthly deductions, the "Grace Period" provision will apply.

CONTINUANCE OF INSURANCE UNDER THE GROUP POLICY

If the Employer cancels its involvement with the group policy, any insurance then in effect under this certificate will remain in force subject to the terms and conditions of this certificate; provided this certificate is not cancelled or surrendered by the Owner. No additional Employees will be insured under the group policy from the date the Employer cancels its involvement with the group policy.

If the group policy is:

- amended to discontinue the eligibility of a class of Employees; and
- this certificate was issued to an Employee in such class;

any insurance then in effect as evidenced by this certificate will remain in force subject to the terms and conditions of this certificate; provided this certificate is not cancelled or surrendered by the Owner. No additional Employees who are members of such class will be insured under the group policy from the date the group policy is so amended.

If either of these events occurs, the payment method for all insurance that remains in force will be automatically changed from payroll deduction of premium status to direct billing status. See "Premiums".

The group policy will finally terminate when there are no longer any persons insured under it.

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DEATH PROCEEDS

The death proceeds become payable to the Beneficiary upon GIAC's receipt at the Executive Office or as otherwise directed of due proof that the Insured died while the insurance evidenced by this certificate was in force. The death proceeds payable are the sum of the following as of the date of the Insured's death:

- the amount of death benefit provided under the Death Benefit Option then in force (see "Death Benefit Options"); and
 - any insurance on the Insured's life provided by additional benefit riders;
- less;
- any Loan Balance; and
 - any unpaid monthly deductions as of the certificate month of death.

GIAC will pay interest on the death proceeds from the date of death to the date the death proceeds are paid. The interest rate will be the same as for Payment Option 1, but not less than the rate required by law (see "Options Available").

Death Benefit Options

The Owner may elect the Death Benefit Option in the application. If no option is elected, Option 1 is the automatic option.

Option 1 (Level): The amount of death benefit provided under this option until the Insured's Attained Age 100 is the greater of:

- the specified insurance amount in effect on the date of death; or
- the minimum death benefit required under Section 7702 on the Monthly Date preceding or coinciding with the date of death.

Option 2 (Increasing): The amount of death benefit provided under this option until the Insured's Attained Age 100 is the greater of:

- the specified insurance amount in effect on the date of death plus the Certificate Value on the Monthly Date preceding or coinciding with the date of death; or
- the minimum death benefit required under Section 7702 on the Monthly Date preceding or coinciding with the date of death.

On or after the Insured's Attained Age 100, the death benefit under Options 1 and 2 will equal the Certificate Value. GIAC will not make monthly deductions.

DEATH PROCEEDS (Continued)

Section 7702 Minimum Death Benefit

To qualify as life insurance under the Internal Revenue Code, the amount of death benefit provided under Option 1 or Option 2 must equal at least the minimum death benefit required under Section 7702.

The minimum death benefit required on any Monthly Date is the Certificate Value on the Monthly Date multiplied by the factor shown in the Table Of Death Benefit Factors in the Certificate Data.

Changing The Death Benefit Option

While the Insured is living, the Owner may request to change the Death Benefit Option on the first Certificate Anniversary or any subsequent Certificate Anniversary. GIAC must receive the Owner's written request for the change in Good Order at least 30 days before a Certificate Anniversary.

If GIAC approves the change, it will take effect on the Certificate Anniversary; provided that the Insured is living on that date. The table of surrender charges will not be adjusted due to a change in Death Benefit Option.

Changing from Option 1 to Option 2: GIAC requires satisfactory evidence of insurability in Good Order for this change. The specified insurance amount will decrease by the amount of the Certificate Value on the effective date of change.

The specified insurance amount is decreased so that the amount of the death benefit remains the same on the effective date of change. After such decrease, the specified insurance amount must not be less than the minimum specified insurance amount shown in the Certificate Data. GIAC will not deduct a surrender charge from the Certificate Account for the decrease in specified insurance amount.

Changing from Option 2 to Option 1: The specified insurance amount will increase by the amount of the Certificate Value on the effective date of change.

The specified insurance amount is increased so that the amount of the death benefit remains the same on the effective date of change.

CHANGING THE SPECIFIED INSURANCE AMOUNT

Increases In Specified Insurance Amount

While the Insured is living, the Owner may request an increase in the specified insurance amount on the first Certificate Anniversary or any subsequent Certificate Anniversary until the Insured's Attained Age 70. GIAC must receive the Owner's written request for the increase in Good Order at least 30 days before a Certificate Anniversary. To process an increase in the specified insurance amount, GIAC requires that:

- the Insured is living on the date GIAC receives the Owner's written request;
- the increase is for at least \$10,000; and
- GIAC receives satisfactory evidence of the insurability of the Insured.

If GIAC approves the change, the increase will take effect on the Certificate Anniversary; provided that the Insured is living on that date.

During the first 10 certificate years, the table of surrender charges will be adjusted if the specified insurance amount is increased.

GIAC will send the Owner revised Certificate Data pages reflecting any changes caused by a change in the specified insurance amount.

Decreases In Specified Insurance Amount

The Owner may request a decrease in the specified insurance amount at any time after the first Certificate Anniversary. GIAC must receive the Owner's written request for the decrease in Good Order. To process a decrease in the specified insurance amount, GIAC requires that:

- the Insured is living on the date GIAC receives the Owner's written request;
- the decrease is for at least \$5,000; and
- the reduced specified insurance amount will not be less than the minimum specified insurance amount shown in the Certificate Data.

The decrease will take effect on the Monthly Date coinciding with or next following the date GIAC approves the change.

During the first 10 certificate years, GIAC will deduct a pro-rata surrender charge from the Certificate Account if the specified insurance amount is decreased. The table of surrender charges will be adjusted following such a decrease.

GIAC will send the Owner revised Certificate Data pages reflecting any changes caused by a change in the specified insurance amount.

OWNER AND BENEFICIARY

Owner

The Owner is named in the application or in any later change shown in GIAC's records. While the Insured is living and subject to any assignment on file with GIAC, the Owner alone has the right to receive all benefits and exercise all rights this certificate grants or GIAC allows.

Successor Owner

A numbered sequence may be used to name successor Owners. If the Owner dies, ownership passes to the next designated successor Owner then living. If none is then living, ownership passes to the Owner's estate. No successor Owner is permitted when the Insured and the Owner are the same person.

Joint Owner

If more than one person is named as Owner with no number or the same number, they are joint Owners. Except for transfers, any request for a certificate transaction or change must be signed by all of the joint Owners named in GIAC's records. Unless otherwise provided, if a joint Owner dies, ownership passes to the surviving joint Owner(s) equally. When the last joint Owner dies, ownership passes to that person's estate, unless otherwise provided.

Beneficiary

The Beneficiary is as named in the application or in any later change shown in GIAC's records. GIAC will pay the death proceeds to the Beneficiary. Unless otherwise provided, in order to receive the death proceeds at the Insured's death, a Beneficiary must be living on the earlier of:

- the date GIAC receives proof of the Insured's death at the Executive Office or as otherwise directed;
or
- the 15th day after the Insured's death.

Unless otherwise provided, if no designated Beneficiary is living on such earlier date, the Owner or the Owner's estate is the Beneficiary.

Contingent Beneficiary

A numbered sequence may be used to name contingent beneficiaries. The Beneficiary is the living person(s) designated by the lowest number in the sequence.

OWNER AND BENEFICIARY (Continued)

Concurrent Beneficiary

If more than one person is named as Beneficiary with no number or the same number, those persons are concurrent beneficiaries. Shares are equal, unless otherwise specified. If shares are equal, the share of a concurrent Beneficiary who dies before the Insured will be shared equally by the surviving concurrent beneficiaries. If unequal shares are specified and a concurrent Beneficiary dies before the Insured, the Beneficiary of that share will be the Owner or the Owner's estate.

Change Of Owner Or Beneficiary

The Owner may change the Owner or Beneficiary by written request in Good Order. The change will take effect as of the date the request is signed, whether or not the Insured is living when GIAC receives the request. However, the change will not apply to any payments made or actions taken by GIAC on or before the date the request is received.

Assignment

No assignment will bind GIAC unless the original, or a copy, is filed in Good Order. An assignment must be signed and dated by both the assignor and the assignee and, as applicable, by the Beneficiary. The rights of any Owner or Beneficiary and the insurance evidenced by the entire certificate will be subject to the assignment. GIAC will rely solely on the assignee's statement as to the amount of the assignee's interest. GIAC will not be responsible for the validity of any assignment. Unless otherwise provided, the assignee may exercise all rights this certificate grants except:

- the right to change the Owner or Beneficiary; and
- the right to elect a Payment Option.

Assignments are subject to all payments made or actions taken by GIAC on or before the date GIAC receives the assignment.

PREMIUMS

Any Basic Certificate premiums in a certificate year which exceed the Target Premium will be treated as excess premiums, but see "Crediting Payments".

If, for any reason, premiums for the insurance are no longer being deducted from wages, the Employee will be required to mail his or her premiums to the Executive Office or as otherwise directed. Upon request, GIAC will give the Owner a receipt signed by one of its officers. Premiums may be paid at any time while the insurance evidenced by this certificate is in force, subject to GIAC's premium limits.

Premium Limits

Section 7702 of the Internal Revenue Code limits the relationship of premiums to death benefit in order to qualify the insurance evidenced by this certificate as life insurance. If any premium paid violates Section 7702 limits, GIAC will refund the excess amount to the Owner within 60 days of receipt of such premium. The guideline premiums used to qualify the insurance are given in the Certificate Data.

GIAC reserves the right to refuse any premium that would result in an increase in the death proceeds as a result of Section 7702. However, such premium may be accepted if satisfactory evidence of insurability of the Insured is submitted to GIAC.

Crediting Payments

When a payment is received without being identified as a premium, such payment will be applied:

- first, to pay any unpaid loan principal;
- then, to pay any accrued and unpaid loan interest; and
- last, as a premium.

All payments will be credited as of the date of receipt.

No Lapse Guarantee

GIAC guarantees that this certificate will not lapse during the first two certificate years as long as the sum of the premiums paid is equal to or greater than the product of the Initial Required Premium multiplied by the number of completed certificate months. This is the case even if the Net Cash Surrender Value is insufficient to cover monthly deductions when due.

PREMIUMS (Continued)

Grace Period

GIAC allows a grace period of 62 days after the Monthly Date that: (a) the Net Cash Surrender Value is insufficient to cover monthly deductions when due; or (b) the Loan Balance exceeds the Cash Surrender Value and GIAC requires a loan repayment (see "Required Repayment" for details on required loan repayment). If this occurs, GIAC will mail to the Owner, at the Owner's last known address, a notice of the required premium or required loan repayment to keep the insurance evidenced by this certificate in force. This notice will be mailed at least 30 days before the end of the grace period.

If the no lapse guarantee is in effect, and the no lapse guarantee conditions are not met, the required premium must equal three times the Initial Required Premium shown in the Certificate Data. If the no lapse guarantee is not in effect, the required premium must equal three months of monthly deductions. The insurance evidenced by this certificate remains in force during the grace period. If the required premium or required loan repayment is not paid by the end of the grace period, this certificate will lapse without value.

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CERTIFICATE VALUES

All certificate values equal or exceed those required by any state statute. A detailed statement of the method of computing these values has been filed with each state insurance department.

Certificate Value

The Certificate Value is the sum of the amounts attributable to this certificate which are allocated to the Certificate Account and the Loan Collateral Account. The Certificate Value is expressed as a dollar amount.

GIAC deducts the expense charges shown in the Certificate Data from each premium before allocation to the Certificate Account.

Interest Rate

GIAC will credit interest on all amounts allocated or transferred to the Certificate Account. Interest will accrue daily at a minimum guaranteed effective annual rate of 4%. GIAC may declare interest rates greater than 4% at its discretion. There will be different declared interest rates based on the length of time the insurance evidenced by this certificate is in force. For the first 15 certificate years, the declared interest rate will be 0.6% less than such rate for later certificate years, subject to the minimum guaranteed effective annual rate shown above.

The annual statement to the Owner shows the interest rate in effect on a Certificate Anniversary. GIAC will provide the interest rate in effect on any other date upon request.

Monthly Deductions

On each Monthly Date, GIAC will make deductions from the Certificate Account. The total amount deducted for a certificate month is the sum of:

- the monthly administrative charges as shown in the Certificate Data; and
- the monthly cost of insurance charge for the Basic Certificate; and
- the monthly costs for any additional benefit riders.

CERTIFICATE VALUES (Continued)

Monthly Cost Of Insurance

The monthly cost of insurance charge on each Monthly Date is equal to the product of **(a)** and **(b)**; where:

- (a)** is the applicable cost of insurance rate in effect on that Monthly Date, divided by \$1,000; and
- (b)** is the Net Amount At Risk on that Monthly Date after the monthly deductions for the administrative charges and costs for any additional benefit riders.

Monthly cost of insurance rates are based on the Insured's premium class and Attained Age. GIAC has the right to change the monthly cost of insurance rates. However, these rates will never exceed the maximum monthly cost of insurance rates shown in the Certificate Data. Any such change will be on a uniform basis for Insureds who have the same premium class and Attained Age.

Any change in the monthly cost of insurance rates will be based on changes in future expectations for:

- mortality;
- expenses;
- persistency;
- federal income taxes; and
- GIAC's investment earnings in its general account.

Changes in the monthly cost of insurance rates:

- will be determined only prospectively;
- will not occur because of a deterioration in the Insured's health;
- will not be made so GIAC may recoup any prior losses;
- will apply to the insurance evidenced by all certificates that are issued on this form; and
- will comply with the procedures and standards on file with the insurance department for the jurisdiction where the group policy is delivered.

The maximum cost of life insurance rates for the insurance evidenced by this certificate are based on the Commissioners 1980 Standard Ordinary Mortality Table, male, smoker, non-smoker, age last birthday.

While the Insured is living, the Owner may request to change the Insured's premium class. GIAC must receive the Owner's written request for the change and satisfactory evidence of the Insured's insurability in Good Order. The change in premium class will take effect on the Monthly Date coinciding with or next following the date GIAC approves it. GIAC will send the Owner revised Certificate Data pages reflecting any changes caused by a change in premium class.

Surrender Charges

GIAC will make surrender charge deductions from the Certificate Account. See "Partial Withdrawals And Surrender" for a description of how and when surrender charges are calculated.

PARTIAL WITHDRAWALS AND SURRENDER

Partial Withdrawals

After the first certificate year and while the Insured is living, the Owner may request a partial withdrawal of the Net Cash Surrender Value, subject to the conditions described below. The minimum net partial withdrawal amount is shown in the Certificate Data.

For Death Benefit Option 1, a partial withdrawal will reduce the Certificate Value and the specified insurance amount by the amount of the partial withdrawal and any pro-rata surrender charge. For Death Benefit Option 2, a partial withdrawal will reduce the Certificate Value and the death proceeds by the amount of the partial withdrawal.

The partial withdrawal and any resulting reductions will take effect as of the date GIAC receives the request for the partial withdrawal. GIAC will send the Owner revised Certificate Data reflecting any reductions in benefits and values due to a partial withdrawal.

The conditions for taking a partial withdrawal are as follows:

- GIAC must receive the Owner's written request in Good Order;
- the specified insurance amount remaining after the reduction resulting from the partial withdrawal must not be less than the minimum specified insurance amount shown in the Certificate Data; and
- the Net Cash Surrender Value after a partial withdrawal must be sufficient to cover three months of monthly deductions.

The amount GIAC will deduct from the Certificate Account for a partial withdrawal will be the sum of:

- the amount requested; and
- a pro-rata surrender charge, adjusted to the date of the partial withdrawal (if such withdrawal results in a decrease in the specified insurance amount).

The table of surrender charges will be adjusted as described in "Surrender".

GIAC will not process any request for a partial withdrawal which exceeds the amount available.

PARTIAL WITHDRAWALS AND SURRENDER (Continued)

Surrender

The Owner may surrender this certificate for its Net Cash Surrender Value if GIAC receives this certificate and written request in Good Order. Upon surrender, this certificate will terminate and all insurance evidenced by this certificate will end.

During the first 10 certificate years, GIAC will deduct a surrender charge if:

- this certificate is surrendered for its Net Cash Surrender Value;
- the specified insurance amount is decreased; or
- a partial withdrawal reduces the specified insurance amount.

Any surrender charges will be deducted from the Certificate Account.

The table of surrender charges is shown in the Certificate Data. The table of surrender charges will be adjusted following an increase or a decrease in specified insurance amount during the first 10 certificate years. But see "Changing The Death Benefit Option". The Owner will be notified of the new surrender charges. The new charges will be effective as of the effective date of the change.

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LOANS

The Owner may obtain a loan at any time after the first certificate year if:

- the Insured is living; and
- GIAC receives the Owner's written request in Good Order.

This certificate must be assigned to GIAC. This is the only security needed.

Loan Value

The loan value is the maximum amount the Owner may borrow on this certificate. During the first certificate year, the loan value is zero. On or after the first Certificate Anniversary, the loan value on any date is the Net Cash Surrender Value on that date, reduced by an amount sufficient to cover three months of monthly deductions.

The minimum loan amount is shown in the Certificate Data.

Loan Interest

Loan interest accrues daily at the effective yearly rate shown in the Certificate Data. This interest is payable in arrears on each Certificate Anniversary, or on the due date of a required loan repayment (see "Required Repayment").

Loan Processing

The amount borrowed may not exceed the loan value described above. When the Owner takes a loan, GIAC establishes a Loan Collateral Account equal to the amount of the loan. The Loan Collateral Account is part of the Certificate Value.

At each Certificate Anniversary, loan interest may be paid by the Owner. If this occurs, the Loan Balance remains the same. If loan interest is not paid by the Owner when due, it may be borrowed. In this case the accrued loan interest is capitalized (added to the existing Loan Balance). But, the new Loan Balance may not exceed the Cash Surrender Value.

At any time the Owner may borrow more, up to the loan value. When this occurs, the following actions are taken:

- interest on the existing Loan Balance is capitalized; and
- the total amount of the Loan Balance is set equal to the capitalized existing Loan Balance plus the amount of the new loan.

At any time the Owner may repay all or any part of the Loan Balance, subject to the minimum loan repayment shown in the Certificate Data. When this occurs, the following actions are taken:

- interest on the existing Loan Balance is capitalized; and
- the total amount of the Loan Balance, if any, is set equal to the capitalized existing Loan Balance minus the amount of repayment.

Any outstanding Loan Balance may also be repaid within 60 days after the Insured's death if:

- the death proceeds have not been paid in one sum or applied under a payment option; or
- the insurance was in force on the date of the Insured's death.

LOANS (Continued)

Loan Collateral Account Processing

When the Owner takes a loan, GIAC transfers an amount equal to the loan from the Certificate Account to the Loan Collateral Account. The value of the Loan Collateral Account plus the Certificate Account gives the Certificate Value. Amounts transferred from the Certificate Account no longer earn the rate of interest which applies to amounts in the Certificate Account.

Amounts in the Loan Collateral Account earn interest from the date of the transfer at a minimum effective yearly rate of 2% less than the loan interest rate. GIAC may credit interest on amounts in the Loan Collateral Account at a higher rate at its discretion. No other charges or credits apply to amounts in the Loan Collateral Account except on Certificate Anniversaries and when new loans or loan repayments are made. The Certificate Value at any time is the total of the values of the Certificate Account and the Loan Collateral Account.

At following Certificate Anniversaries and when new loans or loan repayments are made, the Loan Collateral Account is reset to the amount of the current Loan Balance as described in "Loan Processing". If the amount of the Loan Collateral Account increases, GIAC transfers the amount of the increase from the Certificate Account to the Loan Collateral Account. If the amount of the Loan Collateral Account decreases, GIAC transfers the amount of the decrease from the Loan Collateral Account to the Certificate Account.

A Loan Balance reduces the death proceeds and the Net Cash Surrender Value.

Required Repayment

GIAC will require a loan repayment when the Loan Balance exceeds the Cash Surrender Value. GIAC will notify the Owner if a loan repayment is required. The notice will specify the amount and due date of a required loan repayment. The amount of the required loan repayment will be the amount by which the Loan Balance exceeds the Cash Surrender Value on the Monthly Date that GIAC identified the shortfall. At the same time, this certificate will enter the grace period because its Net Cash Surrender Value is insufficient to cover monthly deductions when due. See "Grace Period" for additional premiums required to keep the insurance evidenced by this certificate in force.

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PAYMENT OPTIONS

Payment Of Proceeds

The proceeds of the insurance evidenced by this certificate will be paid in one sum, unless otherwise provided. All or part of this sum may be applied under any payment option described below or in any other manner GIAC approves. The payee under any payment option must be a natural person.

Election Of Payment Options

During the Insured's lifetime, the Owner may choose any option for payment of the death proceeds. If no election is in force when the proceeds become payable, the payee may make an election subject to the following conditions:

- for death proceeds, election must be made within one year after the Insured's death; and
- for other proceeds, election must be made within 60 days after the proceeds become payable.

The Owner may appoint a secondary payee to receive any payments remaining after the death of the payee. Upon the death of any payee receiving payments under an option, the remaining payments will be continued to the secondary payee or paid in one sum as described in "Termination", whichever is elected.

Any election must be in a written form satisfactory to GIAC.

Options Available

Option 1 - Proceeds Left At Interest: GIAC will hold the proceeds, making monthly interest payments. The yearly interest rate will be at least 3%. Any additional interest will be determined yearly by GIAC and added to the monthly payment.

Option 2 - Payments Of A Specified Amount: GIAC will make monthly payments of a specified amount until the proceeds and interest are fully paid. The total amount paid each year must be at least 10% of the original proceeds. Interest will be added to the proceeds each year. The yearly interest rate will be at least 3%. Any additional interest will be determined yearly by GIAC.

Option 3 - Payments For A Specified Period: GIAC will make monthly payments for the number of years elected. The guaranteed payments shown in the Option 3 table include interest at 3% a year. GIAC also will make yearly payments of any additional interest.

Option 4 - Life Income With 10 Years Guaranteed: GIAC will make monthly payments for 10 years and for the remaining lifetime of the person on whose life the option is based. The minimum monthly payment will be based on the applicable amount in the Option 4 table. The table is based on 3% interest.

PAYMENT OPTIONS (Continued)

Options Available (Continued)

Option 5 - Refund Life Income: GIAC will make monthly payments until the total amount paid equals the proceeds settled, and for the remaining lifetime of the person on whose life the option is based. The minimum monthly payment will be based on the applicable amount shown in the Option 5 table. The table is based on 3% interest.

Option 6 - Joint And Survivor Income With 10 Years Guaranteed: GIAC will make monthly payments for 10 years, and for the remaining lifetime of either of the two persons on whose lives the option is based. The monthly payment will be at least the applicable amount shown in the Option 6 table. The table is based on 3% interest.

The Payment Option Tables are based on the Annuity 2000 Mortality Tables (female), projected 20 years to the year 2020 by 50% of female Scale G factors. Males and females have the same guaranteed annuity payment tables.

Payment Provisions

- At least \$5,000 must be applied under each option selected.
- Each periodic payment must be at least \$50.
- The effective date of any option is the date the proceeds become payable. This date is the option date. Death proceeds are payable as of the date of the Insured's death.
- After an option becomes effective, it cannot be terminated for payment in one sum, unless otherwise provided.
- The first payment under Option 1 is due one month after the option date. The first payment under Option 2, 3, 4, 5, or 6 is due on the option date.
- Option 1, 4, 5, or 6 must be based on the life of a natural person who is the Owner, Beneficiary, or payee. Under Option 6, the second life may be that of any natural person designated in the election. Satisfactory proof of age of such person(s) must be submitted before any payment is made.
- Under Option 4, 5, or 6, the present value of future benefits may not be withdrawn.

Termination

Upon termination of an option, any amount payable is:

- Under Option 1 or 2, any unpaid proceeds with any accrued interest.
- Under Option 3, the present value on the basis of 3% yearly compound interest of any unpaid payments for the specified period.
- Under Option 4, 5, or 6, the present value of any unpaid payments for the guaranteed period. This present value is derived using the interest rate which was used in computing the actual monthly payment.

PAYMENT OPTION TABLES

Option 3 - Payments For A Specified Period

**GUARANTEED MONTHLY PAYMENT
FOR EACH \$1000 OF PROCEEDS**

Years	1	2	3	4	5	6
Amount	\$ 84.47	\$ 42.86	\$ 28.99	\$ 22.06	\$ 17.91	\$ 15.14
Years	7	8	9	10	11	12
Amount	\$ 13.16	\$ 11.68	\$ 10.53	\$ 9.61	\$ 8.86	\$ 8.24
Years	13	14	15	16	17	18
Amount	\$ 7.71	\$ 7.26	\$ 6.87	\$ 6.53	\$ 6.23	\$ 5.96
Years	19	20	21	22	23	24
Amount	\$ 5.73	\$ 5.51	\$ 5.32	\$ 5.15	\$ 4.99	\$ 4.84
Years	25	26	27	28	29	30
Amount	\$ 4.71	\$ 4.59	\$ 4.47	\$ 4.37	\$ 4.27	\$ 4.18

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PAYMENT OPTION TABLES (Continued)

Options 4 And 5

GUARANTEED MONTHLY PAYMENT FOR EACH \$1000 OF PROCEEDS+

Attained Age			Attained Age		
	Option 4*	Option 5*		Option 4*	Option 5*
20	2.89	2.88	54	3.96	3.88
21	2.90	2.89	55	4.03	3.94
22	2.92	2.91	56	4.10	4.00
23	2.93	2.92	57	4.17	4.06
24	2.95	2.94	58	4.24	4.13
25	2.96	2.95	59	4.32	4.20
26	2.98	2.97	60	4.41	4.27
27	3.00	2.99	61	4.50	4.35
28	3.02	3.01	62	4.59	4.43
29	3.04	3.03	63	4.69	4.52
30	3.06	3.05	64	4.80	4.61
31	3.08	3.07	65	4.91	4.70
32	3.10	3.09	66	5.03	4.81
33	3.12	3.11	67	5.16	4.91
34	3.15	3.13	68	5.29	5.03
35	3.17	3.16	69	5.43	5.15
36	3.20	3.18	70	5.57	5.27
37	3.23	3.21	71	5.73	5.41
38	3.26	3.24	72	5.89	5.55
39	3.29	3.26	73	6.06	5.70
40	3.32	3.29	74	6.24	5.86
41	3.35	3.32	75	6.42	6.03
42	3.39	3.36	76	6.61	6.20
43	3.42	3.39	77	6.81	6.39
44	3.46	3.43	78	7.00	6.59
45	3.50	3.46	79	7.20	6.80
46	3.54	3.50	80	7.40	7.03
47	3.59	3.54	81	7.60	7.26
48	3.63	3.58	82	7.80	7.52
49	3.68	3.63	83	7.99	7.78
50	3.73	3.67	84	8.17	8.06
51	3.79	3.72	85	8.34	8.35
52	3.84	3.77			
53	3.90	3.82			

* Amount payable unless option is irrevocably elected before Insured's death to be automatically effective for death proceeds. If option is elected before Insured's death, add 2 years to annuitant's age at all ages.

+ Guaranteed monthly payments for any ages not shown will be furnished upon request.

PAYMENT OPTION TABLES (Continued)

Option 6

GUARANTEED MONTHLY PAYMENT FOR EACH \$1000 OF PROCEEDS+

Annuitant	Annuitant									
Attained Age	50	51	52	53	54	55	56	57	58	59
50	3.41	3.43	3.45	3.47	3.49	3.50	3.52	3.53	3.55	3.56
51	3.43	3.45	3.47	3.49	3.51	3.53	3.55	3.56	3.58	3.59
52	3.45	3.47	3.49	3.51	3.53	3.55	3.57	3.59	3.61	3.63
53	3.47	3.49	3.51	3.54	3.56	3.58	3.60	3.62	3.64	3.66
54	3.49	3.51	3.53	3.56	3.58	3.61	3.63	3.65	3.67	3.69
55	3.50	3.53	3.55	3.58	3.61	3.63	3.66	3.68	3.70	3.72
56	3.52	3.55	3.57	3.60	3.63	3.66	3.68	3.71	3.73	3.76
57	3.53	3.56	3.59	3.62	3.65	3.68	3.71	3.74	3.76	3.79
58	3.55	3.58	3.61	3.64	3.67	3.70	3.73	3.76	3.79	3.82
59	3.56	3.59	3.63	3.66	3.69	3.72	3.76	3.79	3.82	3.85
60	3.58	3.61	3.64	3.68	3.71	3.75	3.78	3.82	3.85	3.88
61	3.59	3.62	3.66	3.69	3.73	3.77	3.80	3.84	3.88	3.91
62	3.60	3.64	3.67	3.71	3.75	3.79	3.83	3.86	3.90	3.94
63	3.61	3.65	3.69	3.73	3.77	3.81	3.85	3.89	3.93	3.97
64	3.62	3.66	3.70	3.74	3.78	3.82	3.87	3.91	3.95	4.00
65	3.63	3.67	3.71	3.75	3.80	3.84	3.89	3.93	3.98	4.02
66	3.64	3.68	3.72	3.77	3.81	3.86	3.90	3.95	4.00	4.05
67	3.65	3.69	3.74	3.78	3.83	3.87	3.92	3.97	4.02	4.07
68	3.66	3.70	3.75	3.79	3.84	3.89	3.94	3.99	4.04	4.09
69	3.66	3.71	3.75	3.80	3.85	3.90	3.95	4.01	4.06	4.12
70	3.67	3.72	3.76	3.81	3.86	3.91	3.97	4.02	4.08	4.14

+ Guaranteed monthly payments for any ages not shown will be furnished upon request.

GUARANTEED MONTHLY PAYMENT FOR EACH \$1000 OF PROCEEDS+

Annuitant	Annuitant										
Attained Age	60	61	62	63	64	65	66	67	68	69	70
50	3.58	3.59	3.60	3.61	3.62	3.63	3.64	3.65	3.66	3.66	3.67
51	3.61	3.62	3.64	3.65	3.66	3.67	3.68	3.69	3.70	3.71	3.72
52	3.64	3.66	3.67	3.69	3.70	3.71	3.72	3.74	3.75	3.75	3.76
53	3.68	3.69	3.71	3.73	3.74	3.75	3.77	3.78	3.79	3.80	3.81
54	3.71	3.73	3.75	3.77	3.78	3.80	3.81	3.83	3.84	3.85	3.86
55	3.75	3.77	3.79	3.81	3.82	3.84	3.86	3.87	3.89	3.90	3.91
56	3.78	3.80	3.83	3.85	3.87	3.89	3.90	3.92	3.94	3.95	3.97
57	3.82	3.84	3.86	3.89	3.91	3.93	3.95	3.97	3.99	4.01	4.02
58	3.85	3.88	3.90	3.93	3.95	3.98	4.00	4.02	4.04	4.06	4.08
59	3.88	3.91	3.94	3.97	4.00	4.02	4.05	4.07	4.09	4.12	4.14
60	3.92	3.95	3.98	4.01	4.04	4.07	4.10	4.12	4.15	4.17	4.19
61	3.95	3.98	4.02	4.05	4.08	4.12	4.15	4.17	4.20	4.23	4.25
62	3.98	4.02	4.05	4.09	4.13	4.16	4.19	4.23	4.26	4.29	4.32
63	4.01	4.05	4.09	4.13	4.17	4.21	4.24	4.28	4.31	4.35	4.38
64	4.04	4.08	4.13	4.17	4.21	4.25	4.29	4.33	4.37	4.41	4.44
65	4.07	4.12	4.16	4.21	4.25	4.30	4.34	4.38	4.42	4.46	4.50
66	4.10	4.15	4.19	4.24	4.29	4.34	4.39	4.43	4.48	4.52	4.57
67	4.12	4.17	4.23	4.28	4.33	4.38	4.43	4.48	4.53	4.58	4.63
68	4.15	4.20	4.26	4.31	4.37	4.42	4.48	4.53	4.59	4.64	4.69
69	4.17	4.23	4.29	4.35	4.41	4.46	4.52	4.58	4.64	4.70	4.76
70	4.19	4.25	4.32	4.38	4.44	4.50	4.57	4.63	4.69	4.76	4.82

+ Guaranteed monthly payments for any ages not shown will be furnished upon request.

CGP-GUL97

P998.0194-R

GENERAL PROVISIONS

The Certificate - Changes

The entire certificate consists of the Basic Certificate, Certificate Data, any attached additional benefit riders and amendments, and copies of the Insured's original application and any subsequent applications for changes that are attached to this certificate.

GIAC can amend the group policy at any time by notifying the Employer and the Policyholder. GIAC will give the Employer and the Policyholder at least 31 days advance written notice of the change. The Employer can request an amendment of the group policy at any time.

If the group policy is amended by changes which affect the description of the essential features of insurance evidenced by this certificate, an amendment to this certificate or a revised certificate reflecting such changes will be issued by GIAC. In addition, if benefits described in this certificate are changed on request of the Owner, a new Certificate Data, or an amendment, or a revised certificate reflecting such change will be issued by GIAC.

Only the President, a Vice President, or the Secretary of GIAC may make or modify this certificate. No agent has the authority to change this certificate or to waive any of its terms or conditions.

GIAC will not be bound by any promise or statement made by any agent or other person except as stated above.

This certificate supersedes and replaces any previously issued certificate(s).

Clerical Error - Misstatements

A clerical error in keeping records pertaining to the group policy, or delays in making entries on those records, will not invalidate insurance otherwise validly in force or continue insurance otherwise validly terminated. This is true regardless of whether the error was made by the Policyholder, the Employer, the Owner, an Insured, or GIAC.

If the age of the Insured, or any other relevant fact, has been misstated, the amount of death benefit will be that which would be purchased by the most recent deduction for the cost of insurance at the correct age and facts.

GENERAL PROVISIONS (Continued)

Statements

GIAC relied upon the applications in issuing the insurance evidenced by this certificate. All statements in the applications are assumed to be true to the best knowledge and belief of the persons making them. These statements are representations and not warranties.

No statement will be used to avoid the insurance evidenced by this certificate or be used in defense of a claim under this certificate unless: (a) in the case of the Employer, it is contained in a writing signed by him or her; and (b) in the case of the Owner, it is contained in a written request or application signed by the Owner, a copy of which has been furnished to him or her.

Incontestability

The group policy cannot be contested after it, or any rider or amendment subsequently added to it, has been in force for a period of two years.

The insurance evidenced by this certificate cannot be contested after it has been in force during the Insured's lifetime for two years from its Certificate Date. If the Death Benefit Option is changed from 1 to 2, the amount of any increase in the death benefit cannot be contested after such increase has been in force during the Insured's lifetime for two years from the date the change takes effect. If the specified insurance amount has been increased, such increase cannot be contested after it has been in force during the Insured's lifetime for two years from the date the increase takes effect.

The contestable period of any endorsement or additional benefit rider attached to this certificate is stated in the endorsement or rider.

Suicide Exclusion

If the Insured commits suicide, while sane or insane, within two years from the Certificate Date shown in the Certificate Data, GIAC's liability will be limited to the greater of **(a)** or **(b)** as of the date of death, where:

(a) is:

- the sum of all premiums paid under this certificate;

less:

- any Loan Balance; and
- any partial withdrawals and related deductions.

(b) is the Net Cash Surrender Value.

If the Insured commits suicide, while sane or insane, within two years from the effective date of any increase in the specified insurance amount, GIAC's liability with respect to such increase will be limited to the cost of insurance for such increase.

If the Insured commits suicide, while sane or insane, within two years from the effective date of any change from Death Benefit Option 1 to Option 2, GIAC's liability with respect to such change will be limited to the increased cost of insurance for such change.

GENERAL PROVISIONS (Continued)

Disability Exclusion

The Insured may not be Actively-At-Work on a Full-Time basis due to an injury or sickness on his or her Certificate Date. In this case, his or her insurance will not start until he or she returns to Active Work on a Full-Time basis. See "When Insurance Starts".

In addition, if the Insured's death occurs:

- due to the same injury or sickness; and
- before he or she completes 10 consecutive days of Active Work on a Full-Time basis without missing a work day due to that injury or sickness;

GIAC's liability will be limited to the greater of **(a)** or **(b)** as of the date of death, where:

(a) is:

- the sum of all premiums paid under this certificate;

less:

- any Loan Balance; and
- any partial withdrawals and related deductions.

(b) is the Net Cash Surrender Value.

Deferment

GIAC may defer the following transactions for up to six months from the date GIAC receives the Owner's written request in Good Order:

- determination or payment of a partial withdrawal, surrender or death proceeds. GIAC will pay interest on deferred partial withdrawals and surrenders at a rate not less than 3% a year if any such payment is deferred 30 days or more. GIAC will pay interest on deferred death proceeds in accord with "Death Proceeds"; or
- determination or payment of loans.

Communications With GIAC

GIAC receives all communications only at the Executive Office or as otherwise directed. The group policy number, certificate number, the full names of the Owner and Insured, and the Owner's current address should be included in all correspondence with GIAC.

Payments By GIAC

All amounts payable by GIAC are payable at the Executive Office.

GENERAL PROVISIONS (Continued)

Annual Statement To The Owner

GIAC will provide a written statement to the Owner once each year. GIAC will send the statement soon after each Certificate Anniversary.

The statement will show the following information as of the most recent Certificate Anniversary:

- the amount of the current death benefit;
- the Certificate Value;
- the Net Cash Surrender Value and Cash Surrender Value;
- the premiums paid, and charges deducted since the last statement;
- any transfers or partial withdrawals and surrender charges assessed since the last statement; and
- any outstanding Loan Balance.

Time Periods

All periods affecting the insurance evidenced by this certificate begin and end at 12:01 a.m., standard time, at the Owner's address of record.

Certificate Changes - Applicable Tax Law

For the Owner and the Beneficiary to receive the tax treatment accorded to life insurance under federal law, the insurance evidenced by this certificate must qualify initially and continue to qualify as life insurance under the Internal Revenue Code or successor law. Therefore, to assure this qualification, GIAC reserves the right to make changes in the group policy, the insurance evidenced by this certificate, endorsements, or additional benefit riders, or to make distributions from the Certificate Account to the extent necessary to continue to qualify this insurance as life insurance. Any such changes will apply uniformly to the insurance evidenced by all certificates that are affected. The Owner will be given advance written notice of such changes.

Conformity With State Statute

The group policy is governed by the laws of the state of Rhode Island. However, with respect to this certificate, any terms which are in conflict with any insurance statute or regulation of the state where the Employee's application is signed, are hereby amended to conform to the minimum requirements of such statute or regulation.

ENDORSEMENT AL

Issue Date: August 27, 2010

This endorsement:

- is issued in consideration of the application and payment of the costs as provided;
- is attached to and made part of the certificate;
- is subject to all of the applicable provisions of the certificate; and
- supersedes and replaces any previously issued Accelerated Life Benefit endorsement(s).

The following provision is added.

ACCELERATED LIFE BENEFIT

Subject to the terms of this endorsement, upon receipt of the Owner's written request, The Guardian Insurance & Annuity Company, Inc. (GIAC) will make an accelerated benefit payment to the Owner if the Insured is Terminally Ill.

DISCLOSURES

- **This endorsement provides for the accelerated payment of life insurance death proceeds. This is not meant to cause the Owner to involuntarily access death proceeds ultimately intended to be payable to the designated Beneficiary. An accelerated benefit payment will be made available to the Owner on a voluntary basis only. Therefore; the Owner is not eligible to receive an accelerated benefit payment if he or she is:**
 - required by law to use this payment to meet the claims of any creditor(s), whether in bankruptcy or not; or
 - required by a government agency to use this payment in order to apply for, obtain, or keep Medicaid benefits or any other government benefit or entitlement.
- **Any accelerated benefit payment made under this endorsement may be taxable. The Owner should consult a competent tax advisor to determine the current tax consequences before requesting any Accelerated Proceeds.**
- **If an accelerated benefit payment is made, the specified insurance amount, Cash Surrender Value, Certificate Value, loan value, Target Premium and any outstanding Loan Balance under the certificate will be reduced. GIAC will modify the certificate to reflect the revised certificate values then in force.**
- **No accelerated benefit payment will be made if the certificate is assigned, except to GIAC as security for a loan.**

ACCELERATED LIFE BENEFIT (Continued)

Definitions

Additional terms, not explained here, are defined in the certificate.

Accelerated Proceeds: The portion of the Benefit Base requested by the Owner.

Benefit Base: The amount of eligible certificate death proceeds which can be accelerated. The minimum Benefit Base is the lesser of:

- 50% of the eligible certificate death proceeds; or
- \$10,000.00.

The maximum Benefit Base is the lesser of:

- 50% of the eligible certificate death proceeds; or
- \$250,000.00.

The eligible certificate death proceeds include the specified insurance amount of the certificate.

The eligible certificate death proceeds will not include:

- any insurance provided under the certificate on the life of someone other than the Insured;
- the amount of any accidental death benefit; or
- the amount of any scheduled increase(s) in specified insurance amount during the six month period after the date the Accelerated Proceeds are requested.

Insured: The person whose life insurance is evidenced by the certificate. The Insured is named in the Certificate Data. This term does not include other persons covered under additional benefit riders.

Terminally III: This means that the Insured is expected to die within six months.

Accelerated Benefit Payment

GIAC will make the accelerated benefit payment available to the Owner in a lump sum.

If the Insured dies before the accelerated benefit payment is made, the death proceeds payable under the certificate will be paid to the Beneficiary.

P998.0165-R

Amount Of Accelerated Benefit Payment

The amount of the accelerated benefit payment will be computed upon GIAC's receipt in Good Order of the Owner's written request and the required proof that the Insured is Terminally III. This amount will be computed based upon the following factors, when applicable:

- the amount of the Accelerated Proceeds;
- any Loan Balance and loan interest;
- the Certificate Value on the date the accelerated benefit payment is computed;
- the maximum adjustable policy loan interest rate permitted by law (this is not the same interest rate for loans as shown in the Certificate Data); and
- a processing charge of no more than \$250. This charge is directly associated with GIAC's administrative costs for processing an accelerated benefit payment to the Owner.

A proportionate amount of any outstanding Loan Balance will be allocated to the Accelerated Proceeds. The accelerated benefit payment will then be reduced by the amount applied toward repayment of the Loan Balance.

ACCELERATED LIFE BENEFIT (Continued)

The amount of the accelerated benefit payment will be less than the amount of the Accelerated Proceeds.

A detailed statement of the method of computing the amount of the accelerated benefit payment has been filed with each state insurance department. This statement is available from GIAC upon request.

Proof Of Terminal Illness

Before GIAC pays the accelerated benefit payment; the Owner must provide proof acceptable to GIAC that the Insured is Terminally Ill. This proof includes, but is not limited to, certification by a licensed physician who:

- has examined the Insured and is qualified to provide such certification; and
- is neither the Owner, the Insured, or a family member of the Owner or Insured.

GIAC may require a second opinion or an examination of the Insured by one of its medical examiners as part of any proof. Any such exam will be at GIAC's expense.

GIAC reserves the right to require proof which it considers acceptable of the Owner's mental competence on the date the Accelerated Proceeds are requested.

Effects On The Certificate

When the accelerated benefit payment is made; GIAC will permanently reduce the following in proportion to the amount of the Accelerated Proceeds:

- the specified insurance amount and Certificate Value; and
- any existing Loan Balance.

Conditions For Payment

GIAC will make the accelerated benefit payment to the Owner; subject to the following conditions:

- The certificate must be in force on the date the Accelerated Proceeds are requested.
- GIAC must receive the Owner's written request in Good Order for the Accelerated Proceeds. Any such request must be in a form acceptable to GIAC.
- The certificate must not be assigned, except to GIAC as security for a loan.
- Any irrevocable Beneficiary must consent in writing, in a form acceptable to GIAC, to the payment of Accelerated Proceeds, on the date such proceeds are requested. Such written consent must be received by GIAC in Good Order.

Values

This endorsement has no cash or loan value.

Issue Date

Unless otherwise shown, the Issue Date of this endorsement is the Certificate Date. If another Issue Date is shown above, the effective date of this endorsement is the Issue Date shown above. The contestable period is measured from the Issue Date.

Incontestability

The insurance evidenced by this endorsement cannot be contested after it has been in force during the Insured's lifetime for two years from its Issue Date.

ACCELERATED LIFE BENEFIT (Continued)

Termination

This endorsement will terminate on the earliest of:

- the date an accelerated benefit payment is made;
- the date of lapse, if any required premium for the certificate or this endorsement is in default beyond the end of the grace period; and
- the date the certificate terminates for any reason.

The Guardian Insurance & Annuity Company, Inc.



President

EAL-GUL97

P998.0164-R

ENDORSEMENT WMD

Issue Date: August 27, 2010

This endorsement:

- is issued in consideration of the application and payment of the costs as provided;
- is attached to and made part of the certificate;
- is subject to all of the applicable provisions of the certificate; and
- supersedes and replaces any previously issued Disability Waiver Of Monthly Deductions Benefit endorsement(s).

The following provision is added.

DISABILITY WAIVER OF MONTHLY DEDUCTIONS BENEFIT

Subject to the terms of this endorsement, upon receipt of the Owner's written request, The Guardian Insurance & Annuity Company, Inc. (GIAC) will waive the Monthly Deductions under this certificate but not beyond the Insured's Attained Age 70, in accord with the terms of this endorsement.

Definitions

Additional terms, not explained here, are defined in the certificate.

Monthly Deductions: For the purposes of this endorsement, the Monthly Deductions are the amounts listed below which are deducted from the Certificate Account as shown in the Certificate Data:

- the monthly administrative charges; and
- the monthly cost of insurance charges for the Basic Certificate, without regard to costs for additional benefit riders.

Total Disability or Totally Disabled: These terms mean the Insured:

- is unable to perform any work for wages or profit, due to a sickness or an injury, for which education, training, or experience qualifies him or her; and
- is under the regular care and treatment of a licensed physician.

P998.0159-R

Waiver Of Monthly Deductions

GIAC will waive Monthly Deductions under the certificate that become due on the later of:

- the end of a period of nine consecutive months after the date the Insured's Total Disability begins; and
- the date GIAC approves the waiver claim.

Before waiving any Monthly Deductions, GIAC must receive written notice of claim and proof at the Executive Office or as otherwise directed that Total Disability:

- began before the Insured's Attained Age 60; and
- has existed continuously for at least nine months.

Total Disability must also begin while this endorsement and the certificate are in force.

Prior to the approval of written notice of claim and proof of the Insured's Total Disability, GIAC will continue to make Monthly Deductions from the Certificate Account, as described in the certificate.

GIAC will accept certificate premiums while Monthly Deductions are being waived under the terms of this endorsement.

DISABILITY WAIVER OF MONTHLY DEDUCTIONS BENEFIT (Continued)

Notice Of Claim And Proof Of Total Disability

Before any Monthly Deductions are waived, GIAC must receive at the Executive Office or as otherwise directed written notice of claim and proof of the Insured's Total Disability. Such notice and proof must be received:

- while the Insured is alive and Totally Disabled;
- not later than one year after Total Disability began; and
- not later than one year after this endorsement terminates.

In order to determine the Insured's eligibility for this benefit, GIAC will require the following:

- certification of the extent and nature of the Insured's disability from any physician(s) who have treated the Insured for the cause of the disability; and
- authorization for release of data by the Insured's providers of medical and/or dental services.

Failure to give notice and proof within such time will not invalidate a claim if it is shown that each was given as soon as reasonably possible. However, GIAC will not waive any Monthly Deductions more than one year before receipt of notice and proof.

P998.0160-R

Proof Of Continuance Of Total Disability

Each year, GIAC requires written proof of continuance of the Insured's Total Disability and physician's care. Such proof must be provided to GIAC within 30 days of the date GIAC makes such request. GIAC may require that the Insured be examined once each year by one of its medical examiners as part of any proof. Any such exam will be at GIAC's expense.

If proof is not given as required, GIAC will deem the Insured no longer Totally Disabled and no further Monthly Deductions will be waived.

Certificate Changes And Additional Benefit Riders

While Monthly Deductions are being waived, GIAC will not allow:

- changes in the specified insurance amount;
- changes in the Death Benefit Option; and
- the addition of additional benefit riders.

Any portion of the deductions from the Certificate Account not waived under the terms of this endorsement will continue to be deducted, as described in the certificate.

Endorsement Cost

The monthly cost for this endorsement on each Monthly Date is equal to the product of **(a)** and **(b)** where:

- (a)** is the applicable cost of insurance rate in effect for this endorsement on that Monthly Date, divided by \$1,000; and
- (b)** is the Net Amount At Risk on that Monthly Date after deductions for the administrative charges and costs for any additional benefit riders.

GIAC has the right to change the monthly cost for this endorsement. However, this cost will never exceed the maximum cost of insurance rates for the Waiver Of Monthly Deductions shown in the Certificate Data. Any change in the monthly cost for this endorsement will be on the same basis as the changes to the cost of insurance rates shown in the certificate.

The cost for this endorsement is included in the monthly deduction for the cost of insurance charge for the Basic Certificate. Deductions for the cost of this endorsement will cease when this endorsement terminates.

DISABILITY WAIVER OF MONTHLY DEDUCTIONS BENEFIT (Continued)

When Waiver Of Monthly Deductions Ends

An Insured's waiver of Monthly Deductions will end on the earlier of:

- the date the Insured stops being Totally Disabled;
- the date the Insured refuses to be examined by our medical examiner when required;
- the date the Owner does not give GIAC the proof of disability it requires;
- the date the Insured is no longer under the regular care and treatment of a licensed physician; or
- the date the Insured reaches Attained Age 70.

Exclusions

GIAC will not waive Monthly Deductions under the certificate if Total Disability results from:

- an intentional self-injury, or attempted suicide within the first two years from the Issue Date of this endorsement;
- declared or undeclared war or act of war or armed aggression; or
- the Insured's membership in any armed force.

Values

This endorsement has no cash or loan value.

Issue Date

Unless otherwise shown, the Issue Date of this endorsement is the Certificate Date. If another Issue Date is shown above, the effective date of this endorsement is the Issue Date shown above. The contestable period is measured from the Issue Date.

Incontestability

GIAC will not contest this endorsement after it has been in force during the lifetime of the Insured for two years from its Issue Date, excluding any period during which the Insured is Totally Disabled. GIAC will not contest any waiver of Monthly Deductions for any increase in specified insurance amount after the increase has been in force during the lifetime of the Insured for two years from its effective date, excluding any period during which the Insured is Totally Disabled.

P998.0161-R

DISABILITY WAIVER OF MONTHLY DEDUCTIONS BENEFIT (Continued)

Termination

This endorsement will terminate on the earliest of:

- the date the Insured reaches Attained Age 60; however, this will not affect an eligible claim for waiver of Monthly Deductions for the Insured's Total Disability which occurred before that date;
- the date of lapse, if any required premium for the certificate or this endorsement is in default beyond the end of the grace period; or
- the date the certificate terminates for any reason.

The Guardian Insurance & Annuity Company, Inc.



President

EWD-GUL97

P998.0162-R

THE GUARDIAN INSURANCE & ANNUITY COMPANY, INC.

Issue Date: August 27, 2010

This is to certify that what follows is added to the certificate for an Insured electing this coverage as shown in the Certificate Data.

This rider:

- is issued in consideration of the application for it and payment of the costs as provided;
- is attached to and made part of the certificate;
- is subject to all of the applicable provisions of the certificate; and
- supersedes and replaces any previously issued Accidental Death Benefit Rider(s).

ACCIDENTAL DEATH BENEFIT RIDER

The Guardian Insurance & Annuity Company, Inc. (GIAC) will pay the accidental death benefit amount shown in the Certificate Data upon receipt of proof at its Executive Office or as otherwise directed that the Accidental Death of the Insured occurred while the certificate and this rider were in force.

Definitions

Additional terms, not explained here, are defined in the certificate.

Accidental Death: Accidental Death means death that:

- resulted from accidental bodily injury, directly and independently of all other causes;
- occurred within 90 days after the injury; and
- did not result from one of the Exclusions listed below.

There must be a visible wound or bruise, except in the case of drowning or internal injury revealed by autopsy.

Accidental Death Benefit

The amount of the accidental death benefit is shown in the Certificate Data.

The amount payable will be included in the death proceeds of the certificate.

P998.0146-R

Exclusions

This rider will not cover death caused directly or indirectly:

- by intentional self-injury, suicide, or attempted suicide;
- by infection, except septic infection of and through a visible wound accidentally sustained independent of all physical causes;
- by the Insured taking part in a riot or other civil disorder, or in the commission or attempted commission of a felony;
- by travel on any type of aircraft if the Insured is an instructor or crew member, or has any duties at all on that aircraft;
- by declared or undeclared war or act of war or armed aggression;
- while the Insured is a member of any armed force;
- while the Insured is the driver in an automobile accident, if he or she is legally intoxicated at such time; or
- by the Insured's voluntary use of a controlled substance, unless: (1) it was prescribed for the Insured

ACCIDENTAL DEATH BENEFIT RIDER (Continued)

by a legally qualified physician; and (2) it was used as prescribed. A controlled substance is anything called a controlled substance in Title II of the Comprehensive Drug Abuse Prevention and Control Act of 1970, as amended from time to time.

Autopsy

GIAC will have the right and opportunity to examine the Insured's body; and, unless prohibited by law, to make an autopsy.

Values

This rider has no cash or loan value.

Rider Cost

The monthly cost of this rider on each Monthly Date is equal to the product of **(a)** and **(b)** where:

- (a)** is the monthly cost of insurance rate in effect for this rider on that Monthly Date, divided by \$1,000; and
- (b)** is the amount of the accidental death benefit in force on that Monthly Date.

GIAC has the right to change the monthly cost of insurance rate for this rider. However, this cost will never exceed the maximum cost of insurance rate for the Accidental Death Benefit shown in the Certificate Data. Any change in the monthly cost for this rider will be on the same basis as the changes to the cost of insurance rates shown in the certificate.

The cost of this rider is included in the monthly deductions from the Certificate Account under the certificate. Deductions for the cost of this rider cease when this rider terminates.

RAD-GUL97

P998.0150-R

Issue Date

Unless otherwise shown, the Issue Date of this rider is the Certificate Date. If another Issue Date is shown above, the effective date of this rider is the Issue Date shown above. The contestable period is measured from the Issue Date.

Incontestability

The insurance evidenced by this rider cannot be contested after it has been in force during the Insured's lifetime for two years from its Issue Date.

ACCIDENTAL DEATH BENEFIT RIDER (Continued)

Termination

This rider will terminate on the earliest of:

- the date the Insured reaches Attained Age 70;
- the date of lapse, if any required premium for the certificate or this rider is in default beyond the end of the grace period;
- the date the certificate terminates for any reason;
- the Monthly Date coinciding with or next following GIAC's receipt of written request in Good Order for cancellation. This rider must be sent to GIAC for cancellation.

The Guardian Insurance & Annuity Company, Inc.



President

RAD-GUL97

P998.0151-R

THE GUARDIAN INSURANCE & ANNUITY COMPANY, INC.

Issue Date: August 27, 2010

This is to certify that what follows is added to the certificate for an Insured electing this coverage as shown in the Certificate Data.

This rider:

- is issued in consideration of the application for it and payment of the costs as provided;
- is attached to and made part of the certificate;
- is subject to all of the applicable provisions of the certificate; and
- supersedes and replaces any previously issued Spouse's Term Life Insurance Rider(s).

SPOUSE'S TERM LIFE INSURANCE RIDER

The Guardian Insurance & Annuity Company, Inc. (GIAC) will pay the Spouse's death benefit upon receipt of proof at its Executive Office or as otherwise directed that an Insured's Spouse died while the certificate and this rider were in force.

Definitions

Additional terms, not explained here, are defined in the certificate.

Spouse: A Spouse is the Insured's legal Spouse. This term does not include: (a) a spouse who is legally separated from the Insured; or (b) a Spouse who is eligible for insurance under the group policy as an Employee of the Employer.

On the date the person would otherwise become a Spouse insured under this rider, he or she may be:

- confined to a hospital or other health care facility; or
- unable to carry out the normal activities of someone of like age and sex.

In this case, such person will not become a Spouse insured under this rider until either of the following occurs:

- the day after his or her discharge from the hospital or other health care facility; or
- he or she resumes the normal activities of someone of like age and sex.

Spouse's Death Benefit

This rider provides level term insurance until the Certificate Anniversary coinciding with or next following the insured Spouse's 70th birthday. This is shown as the Expiry Date in the Certificate Data.

The Spouse's death benefit is the Spouse's term life insurance amount shown in the Certificate Data.

Beneficiary

Unless otherwise provided, the Beneficiary for the Spouse's death benefit is the Insured, if living. If the Insured dies before the insured Spouse, the Beneficiary is the insured Spouse's living children, in equal shares. Unless otherwise provided, if no Beneficiary is living when the insured Spouse dies, the insured Spouse's estate is the Beneficiary.

Unless otherwise provided, in order to receive any benefit payable at the insured Spouse's death, a Beneficiary must be living on the earlier of:

- the date proof of the insured Spouse's death is received at the Executive Office or as otherwise directed; or
- the 15th day after the insured Spouse's death.

SPOUSE'S TERM LIFE INSURANCE RIDER (Continued)

Change Of Beneficiary

During the insured Spouse's lifetime, the Owner may change the Beneficiary for this rider by written request satisfactory to GIAC. The change will take effect on the date the request is signed, whether or not the insured Spouse is living when GIAC receives the request at the Executive Office or as otherwise directed. However, the change will not apply to any payments made or actions taken by GIAC before the request is received.

Owner

The Owner of this rider is the Owner of the certificate. If the Insured is the Owner and dies before the insured Spouse dies, the insured Spouse will be the Owner of the insurance on his or her life.

Values

This rider has no cash or loan value.

P998.1170-R

Rider Cost

The monthly cost of this rider on each Monthly Date is equal to the product of **(a)** and **(b)** where:

- (a)** is the monthly cost of insurance rates in effect for this rider on that Monthly Date, divided by \$1,000; and
- (b)** is the amount of Spouse's term life insurance in force on that Monthly Date.

Monthly cost of insurance rates for this rider are based on the Spouse's premium class and the Insured's Attained Age. GIAC has the right to change the monthly cost of insurance rate for this rider. However, this cost will never exceed the maximum cost of insurance rate for Spouse's Term Life Insurance shown in the Certificate Data. Any change in the monthly cost for this rider will be on the same basis as the changes to the cost of insurance rates of the certificate.

The cost of this rider is included in the monthly deductions from the Certificate Account under the certificate. Deductions for the cost of this rider cease when this rider terminates.

While the insured Spouse is living, the Owner may request to change the insured Spouse's premium class. GIAC must receive the Owner's written request for the change and satisfactory evidence of the insured Spouse's insurability in Good Order. The change in premium class will take effect on the Monthly Date coinciding with or next following the date GIAC approves it. GIAC will send the Owner revised Certificate Data pages reflecting any changes caused by a change in premium class.

Issue Date

Unless otherwise shown, the Issue Date of this rider is the Certificate Date. If another Issue Date is shown above, the effective date of this rider is the Issue Date shown above. The contestable period is measured from the Issue Date.

Incontestability

The insurance on the insured Spouse cannot be contested after this rider has been in force during such insured Spouse's lifetime for two years from its Issue Date.

Misstatements

If the age of the Insured or Spouse, or any other relevant fact, has been misstated, GIAC will use the true facts in determining whether insurance is in force under the terms of this rider and in what amount.

SPOUSE'S TERM LIFE INSURANCE RIDER (Continued)

Termination

This rider will terminate on the earliest of:

- the date the certificate terminates for any reason;
- the date of lapse, if any required contribution for the certificate or this rider is in default beyond the end of the grace period;
- the date there is no longer an insured Spouse insured under this rider; or
- the Monthly Date coinciding with or next following GIAC's receipt of written request in Good Order for cancellation. This rider must be sent to GIAC for cancellation;

An insured Spouse's insurance will terminate on the earliest of the following:

- the Certificate Anniversary coinciding with or next following the date the insured Spouse reaches age 70;
- the Monthly Date coinciding with or next following the Spouse's legal separation or divorce from the Employee;
- the date the grace period expires, if GIAC has not received a contribution to cover at least the monthly deductions for this insurance;
- the date the Insured's insurance ends; or
- the date the insurance evidenced by this rider terminates.

Conversion

The insured Spouse may convert his or her insurance under this rider to a policy of individual life insurance within 31 days after the earlier of:

- the date of death of the Insured; or
- the date his or her insurance terminates.

The conversion policy will be issued provided an application and the first premium are received by GIAC or its affiliate.

The conversion policy will be:

- A whole life or endowment plan then issued by GIAC or its affiliate as of the conversion policy's policy date.
- Issued for the person's attained age in a standard premium class.
- At premium rates based on GIAC's or its affiliate's published rates which will depend on the plan, face amount, premium class, and the person's age and sex, if applicable.
- Issued without evidence of insurability unless the applied for amount is greater than the person's death benefit under this rider.

Notice of Conversion Right: If an insured Spouse 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 the Insured by the Employer;
- (b) mailed to the Insured by the Employer at the Insured's last known address; or
- (c) mailed to the Insured by GIAC at the Insured's last known address that is supplied to GIAC by the Employer.

SPOUSE'S TERM LIFE INSURANCE RIDER (Continued)

This notice should be given at least 15 days before the end of the 31 day period allowed for conversion as described above. If the notice is not given at least 15 days before the end of such period, you will have an additional period of 25 days from the date the 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.

Additional benefits will be available with the conversion policy only with GIAC's or its affiliate's consent. All riders on the conversion policy will be subject to GIAC's or its affiliate's rules on the effective date of the conversion policy. GIAC's affiliate is The Guardian Life Insurance Company of America (The Guardian).

The Guardian Insurance & Annuity Company, Inc.



President

P998.1171-R

THE GUARDIAN INSURANCE & ANNUITY COMPANY, INC.

Issue Date: August 27, 2010

This is to certify that what follows is added to the certificate for an Insured electing this coverage as shown in the Certificate Data.

This rider:

- is issued in consideration of the application for it and payment of the costs as provided;
- is attached to and made part of the certificate;
- is subject to all of the applicable provisions of the certificate; and
- supersedes and replaces any previously issued Children's Term Life Insurance Rider(s).

CHILDREN'S TERM LIFE INSURANCE RIDER

The Guardian Insurance & Annuity Company, Inc. (GIAC) will pay the child's death benefit upon receipt of proof at its Executive Office or as otherwise directed that an Insured Child died while the certificate and this rider were in force.

Definitions

Additional terms, not explained here, are defined in the certificate.

Insured Child: An Insured Child is an unmarried dependent child, stepchild, or legally adopted child of the Insured who:

- is between the ages of 14 days and 21 years (23 years if enrolled as a full-time student at an accredited school) on the date of the application for this rider and is named in the application; or
- after the effective date of the application, either attains 15 days of age or is legally adopted by the Insured before the child's 21st birthday.

On the date a child would otherwise become an Insured Child, he or she may be:

- confined to a hospital or other health care facility; or
- unable to carry out the normal activities of someone of like age and sex.

In this case, such child will not become an Insured Child until either of the following occurs:

- the day after his or her discharge from the hospital or other health care facility; or
- he or she resumes the normal activities of someone of like age and sex.

For the purposes of this rider, GIAC will consider a child to remain an Insured Child until the Certificate Anniversary coinciding with or next following the date he or she attains the applicable limiting age.

If an Insured and his or her spouse are both covered under the group policy as Employees, their child may only be insured as an Insured Child of either the Insured or the spouse.

Child's Death Benefit

The child's death benefit on the life of each Insured Child depends on the Insured Child's age on date of death. The child's death benefit is the applicable children's term life insurance amount shown in the Certificate Data.

If any Insured Child dies during the grace period of the certificate, the due and unpaid costs of this insurance will be deducted from the benefit then payable.

CHILDREN'S TERM LIFE INSURANCE RIDER (Continued)

Beneficiary

Unless otherwise provided, the Beneficiary for the child's death benefit is the Insured, if living. If the Insured dies before an Insured Child, the Beneficiary is the Insured's living spouse. If the Insured's spouse is not living, the Beneficiary is the Insured's living children, in equal shares. Unless otherwise provided, if no Beneficiary is living when an Insured Child dies, the Insured Child's estate is the Beneficiary.

Unless otherwise provided, in order to receive any benefit payable at an Insured Child's death, a Beneficiary must be living on the earlier of:

- the date proof of the Insured Child's death is received at the Executive Office or as otherwise directed; or
- the 15th day after the Insured Child's death.

Change Of Beneficiary

The Owner may change the Beneficiary for this rider by written request satisfactory to GIAC. The change will take effect on the date the request is signed, whether or not an Insured Child is living when GIAC receives the request at the Executive Office or as otherwise directed. However, the change will not apply to any payments made or actions taken by GIAC before the request is received.

Owner

The Owner of this rider is the Owner of the certificate. If the Insured is the Owner and dies before an Insured Child dies, the Insured Child will be the Owner of the insurance on his or her life.

Values

This rider has no cash or loan value.

RCT-GUL97-03-CA

P998.1172-R

Rider Cost

The monthly cost of this rider on each Monthly Date is shown in the Certificate Data.

GIAC has the right to change the monthly cost of insurance rate for this rider. However, this cost will never exceed a cost determined in accord with the maximum cost of insurance rate for Children's Term Life Insurance shown in the Certificate Data. Any change in the monthly cost for this rider will be on the same basis as the changes to the cost of insurance rates of the certificate.

The cost of this rider is included in the monthly deductions from the Certificate Account under the certificate. Deductions for the cost of this rider cease when this rider terminates.

Issue Date

Unless otherwise shown, the Issue Date of this rider is the Certificate Date. If another Issue Date is shown above, the effective date of this rider is the Issue Date shown above. The contestable period is measured from the Issue Date.

Incontestability

The insurance on any Insured Child cannot be contested after this rider has been in force on the life of such Insured Child for two years from its Issue Date.

CHILDREN'S TERM LIFE INSURANCE RIDER (Continued)

Misstatements

If the age of the Insured or of an Insured Child, or any other relevant fact, has been misstated, GIAC will use the true facts in determining whether insurance is in force under the terms of this rider and in what amount.

Termination

This rider will terminate on the earliest of:

- the date the certificate terminates for any reason;
- the date of lapse, if any required premium for the certificate or this rider is in default beyond the end of the grace period;
- the date there is no longer any Insured Child insured under this rider; or
- the Monthly Date coinciding with or next following GIAC's receipt of written request in Good Order for cancellation. This rider must be sent to GIAC for cancellation;

An Insured Child's insurance will terminate on the earliest of the following:

- the Certificate Anniversary coinciding with or next following the date the Insured Child reaches the applicable limiting age;
- the Monthly Date coinciding with or next following the date the Insured Child marries;
- the date the grace period expires, if GIAC has not received a premium to cover at least the monthly deductions for the cost of this rider;
- the date the Insured's insurance ends; or
- the date this rider terminates.

CHILDREN'S TERM LIFE INSURANCE RIDER (Continued)

Conversion

An Insured Child may convert his or her insurance under this rider to a policy of individual life insurance within 31 days after the earlier of:

- the date of death of the Insured; or
- the date the Insured Child's insurance terminates.

The conversion policy will be issued provided an application and the first premium are received by GIAC or its affiliate.

The conversion policy will be:

- A whole life or endowment plan then issued by GIAC or its affiliate as of the conversion policy's policy date.
- Issued for the person's attained age in a standard premium class.
- At premium rates based on GIAC's or its affiliate's published rates which will depend on the plan, face amount, premium class, and the person's age and sex, if applicable.
- Issued without evidence of insurability unless the applied for amount is greater than the person's death benefit under this rider.

Notice of Conversion Right: If an Insured Child 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 the Insured by the Employer;
- (b) mailed to the Insured by the Employer at the Insured's last known address; or
- (c) mailed to the Insured by the GIAC at the Insured's last known address that is supplied to GIAC by the Employer.

This notice should be given at least 15 days before the end of the 31 day period allowed for conversion as described above. If the notice is not given at least 15 days before the end of such period, you will have an additional period of 25 days from the date the 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.

Additional benefits will be available with the conversion policy only with GIAC's or its affiliate's consent. All riders on the conversion policy will be subject to GIAC's or its affiliate's rules on the effective date of the conversion policy. GIAC's affiliate is The Guardian Life Insurance Company of America (The Guardian).

The Guardian Insurance & Annuity Company, Inc.



President

ENDORSEMENT

Issue Date: Applicable to certificates issued on or after January 1, 2009.

This endorsement:

- Is attached to and made part of this certificate; and
- Is subject to all of the applicable provisions of the certificate.

The "Monthly Cost of Insurance" provision is modified to the extent that the reference to the Commissioners 1980 Standard Ordinary Mortality Table, male, smoker, non-smoker appearing therein is changed to the Commissioners 2001 Standard Ordinary Mortality Table, male, smoker, non-smoker.

EMT-GUL97

P998.1182-R

The Guardian Life Insurance Company of America

A Mutual Company - Incorporated 1860 by the State of New York
10 Hudson Yards, New York, New York 10001

GROUP INSURANCE POLICY

Term Life Coverage

POLICYHOLDER: HILTON WATERFRONT BEACH RESORT

GROUP POLICY NUMBER

G-00429264

DELIVERED IN

California

POLICY DATE

September 1, 2007

POLICY ANNIVERSARIES: September 1st of each year, beginning in 2008

GUARDIAN AGREES to pay benefits in accordance with and subject to the terms of this Policy. This promise is based on the Policyholder's application and payment of the required premiums.

This Policy is delivered in the jurisdiction shown above and is governed by its laws.

This Policy takes effect on the Policy Date shown above.

IN WITNESS OF WHICH, GUARDIAN has caused this Policy to be executed as of September 30, 2019 which is its date of issue.

The Guardian Life Insurance Company of America



Michael Prestileo, Senior Vice President

Non-Participating - No Dividends Payable

Please read this Policy carefully.

P030.1340-R

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GENERAL PROVISIONS

Options A, B, E and F

Incontestability

This Policy will be incontestable after two years from its Policy Date, except for non-payment of premiums.

This Policy may replace the group policy of another insurer. In that case, We may rescind this Policy based on misrepresentations made in Your or a Covered Person's signed application for up to two years from the Policy Date.

After a person's insurance has been in force under this Policy for two years during his or her lifetime, no statement in any application made by him or her will be used:

- to contest the validity of his or her insurance; or
- to deny a claim for a loss incurred by him or her.

P030.1882-R

Options A, B, E and F

Associated Companies

An associated company is a business entity affiliated with You through common ownership of stock or assets.

If You ask Us in writing to include such a company under this Policy, We will treat Employees of that company like Your Employees. We must give Our written approval. Our approval will show the starting date of the company's coverage under this Policy. Each eligible Employee of that company must still meet all of the terms and conditions of this Policy before he or she will be insured.

You must notify Us in writing when a company ceases to be an associated company. On the date a company ceases to be such a company, this Policy will end for all of that company's Employees, except those covered by You or another associated company as Employees on such date.

P030.0375-R

Options A, B, E and F

Premiums

Premiums are payable by You as follows:

- The first premium is due on the Policy Date; and
- Later premiums are, during the time this Policy remains in force, due on the 1st of each month.

Premiums due under this Policy must be paid by You:

- At a Guardian office; or
- To a representative that We have authorized.

The premiums must be paid as shown above, unless by agreement between You and Us, the interval of payment is changed. In that event, adjustment will be made for payment annually, semi-annually, or quarterly.

The premium due under this Policy on each due date will be the sum of the premium charges for the insurance provided under this Policy. The premium charges are based on the rates set forth in the Schedule Of Premium Rates.

We may change such rates:

- On the first day of any policy month;
- On any date the extent or terms of coverage for You are changed by amendment of this Policy;
- On any date Our obligation under this Policy with respect to You is changed because of statutory or other regulatory requirements; or
- On any date that a change in federal or state laws, insurance programs or retirement benefits would impact our liability.

We must give You 31 days written notice of the rate change. Such change will apply to any premium due on and after the effective date of the change stated in such notice.

P030.0376-R

Options A, B, E and F

Adjustment Of Premiums Payable Other Than Monthly Or Quarterly

A premium rate may be changed after an annual or semi-annual premium became payable with respect to insurance on and after the date of such change. In that case, the premium will be adjusted by a pro rata change for the rest of the period for which the premium became payable. If the adjustment results in a decrease, the amount of the decrease will be paid to You by Us. If the adjustment results in an increase, the amount of the increase will be considered a premium due on the date of the rate change. This Policy's grace period will apply to any such premium due.

P030.0379-R

Options A, B, E and F

Grace In Payment Of Premiums - Termination Of Policy

A grace period of 31 days, without interest charge, will be allowed for each premium payment except the first. If any premium with respect to the Employees is not paid before the end of the grace period, this Policy ends with respect to all Employees at the end of the grace period. If You give Us advance written notice of an earlier termination date during the grace period, this Policy will end as of such earlier date.

If this Policy ends during or at the end of the grace period, You will still owe Us premium for all the time this Policy was in force during the grace period.

This Policy ends on any date when a coverage under this Policy ends and, as a result, no benefits remain in effect under this Policy.

P030.2124-R

Options A, B, E and F

Term Of Policy - Renewal Privilege

This Policy is issued for a term of one year from the Policy Date shown on the face page. All policy years and policy months will be calculated from the Policy Date. All periods of insurance will begin and end at 12:01 A.M. Standard Time at Your place of business.

If this Policy provides insurance on a non-contributory basis, all of the Employees eligible for such insurance must be enrolled.

You may renew this Policy for a further term of one year on the first and each subsequent Policy Anniversary. All renewals are subject to the payment of premiums then due, computed as shown in Premiums.

P030.0383-R

This Policy is issued for a term of one year from the Policy Date shown on the face page. All policy years and policy months will be calculated from the Policy Date. All periods of insurance will begin and end at 12:01 A.M. Standard Time at Your place of business.

You may renew this Policy for a further term of one year on the first and each subsequent Policy Anniversary. All renewals are subject to the payment of premiums then due, computed as shown in Premiums.

P030.0384-R

Options A, B, E and F

We have the right to decline to renew this Policy, or any coverage under it, on any Policy Anniversary or premium due date, if, on that date the number of Employees is below Our minimum group size requirements.

P030.1824-R

With respect to dependent insurance, We may decline to renew such insurance on any Policy Anniversary or premium due date, if less than 25% of those Employees eligible for dependent insurance are insured.

P030.0397-R

You may cancel this Policy at any time by giving Us 31 days advance written notice. This notice must be sent to Our Home Office. You will owe Us all unpaid premiums for the period this Policy is in force. We may cancel this Policy by giving You 31 days advance written notice.

P030.0398-R

Options A, B, E and F

Reinstatement

If any renewal premium be not paid within the time granted the insured for payment, a subsequent acceptance of premium by Us, without requiring in connection therewith an application for reinstatement, shall reinstate this Policy; provided, however, that if We require an application for reinstatement and issue a conditional receipt for the premium tendered, this Policy will be reinstated upon approval of such application by Us, or, lacking such approval, upon the forty-fifth day following the date of such conditional receipt unless We have previously notified You in writing of its disapproval of such application. The reinstated Policy shall cover only loss resulting from such accidental injury as may be sustained after the date of reinstatement and loss due to such sickness as may begin more than 10 days after such date. In all other respects You and We shall have the same rights thereunder as they had under this Policy immediately before the due date of the defaulted premium, subject to any provisions endorsed hereon or attached hereto in connection with the reinstatement. Any premium accepted in connection with a reinstatement shall be applied to a period for which premium has not been previously paid, but not to any period more than 60 days prior to the date of reinstatement.

The Contract

The entire contract between You and Us consists of:

- This Policy;
- The Schedule of Premium Rates;
- The Certificate(s) which describe(s) the insurance for which Covered Persons are insured;
- Any attached riders, schedule of benefits or amendments; and
- Your application.

In the event of a conflict, the Policy shall reign.

We can amend this Policy at any time, without the consent of the insured Employees or any other person having a beneficial interest in it:

- Upon written request made by You and agreed to by Us; or
- On any date Our obligation under this Policy with respect to You is changed because of statutory or other regulatory requirements.

If We amend this Policy, except upon request made by You, We must give You written notice of such change.

Any amendments to this Policy will be without prejudice to any claim arising prior to the date of the change.

No person, except by a writing signed by the President, a Vice President or a Secretary of Guardian, has the authority to act for Us to:

- Determine whether any contract, policy or certificate is to be issued;
- Waive or alter any provisions of any contract or policy, or any of Our requirements;
- Bind Us by any statement or promise relating to the contract issued or to be issued; or
- Accept any information or representation which is not in a signed application.

P030.1884-R

Options A, B, E and F

Clerical Error - Misstatements of Age

Neither clerical error by You or Us in keeping any records on the insurance under this Policy, nor delays in making entries, will invalidate insurance otherwise validly in force or continue insurance otherwise validly terminated. On discovery of such error or delay, an equitable adjustment of premiums will be made.

Premium adjustments involving return of unearned premium to You will be limited to the period of 90 days before the date of Our receipt of evidence that such adjustments should be made.

The age of an Employee, or any other relevant facts, may be found to have been misstated. If premiums are affected due to this, an equitable adjustment of premiums will be made. If such misstatement involves whether or not an insurance risk would have been accepted by Us, or the amount of insurance, the true facts will be used to determine whether insurance is in force under the terms of this Policy, and in what amount.

P030.1885-R

Options A, B, E and F

Statements

No statement will void the insurance under this Policy, or be used in defense of a claim unless:

- in Your case, it is contained in the application signed by You;
- In the case of a Covered Person, it is contained in a written instrument signed by him or her.

All statements will be deemed representations and not warranties.

P030.0401-R

Options A, B, E and F

Assignment

An Employee's right to assign any interest under this Policy is governed as shown in the Certificate that describes the insurance for which he or she is insured.

Assignment or transfer of Your interest under this Policy will not bind Us without Our written consent.

P030.0402-R

Options A, B, E and F

Certificate

We will issue to You, for delivery to each insured Employee, a certificate of insurance. It will state the essential features of the insurance to which the Employee is entitled and to whom the benefits are payable. In the event this Policy is amended, and such amendment affects the material contained in the certificate, a rider or revised certificate reflecting such amendment will be issued to You for delivery to affected Employees .

P030.0403-R

Options A, B, E and F

New Entrants

Eligible new Employees may be added to the group originally insured in accordance with the terms of this Policy. Eligible new dependents may be added to the group of dependents originally insured in accordance with the terms of this Policy.

Notice

From time to time We may provide You with notices that are needed due to state or federal requirements. You must deliver copies of these notices to each of Your Employees.

P030.1886-R

Options A, B, E and F

Claims Of Creditors

Except when prohibited by the laws of the jurisdiction in which this Policy was issued, the insurance and other benefits under this Policy will be exempt from execution, garnishment, attachment, or other legal or equitable process, for the debts or liabilities of the Covered Persons or their beneficiaries.

P030.0405-R

Options A, B, E and F

Records - Information To Be Furnished

You must keep a record of the insured Employees containing, for each Employee, the essential details of the insurance which apply to him or her. You must periodically forward to Us, on Our forms, such information concerning the Employees in the classes eligible for insurance under this Policy as may reasonably be considered to have a bearing:

- On the administration of the insurance under this Policy; and
- On the determination of the premium rates.

For benefits which are based on an Employee's salary, changes in his or her salary must promptly be reported to Us. Your payroll and other such records which have a bearing on the insurance must be furnished to Us at Our request at any reasonable time.

P030.0406-R

Options A, B, E and F

Physical 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 Policy as often as We feel necessary. We have the right to have an autopsy performed in the case of death, where allowed by law. We will pay for all such examinations and autopsies.

P030.1887-R

Options A, B, E and F

Conformity With Law

If the provisions of this Policy do not conform to the requirements of any state or federal law or regulation that applies, any such provision is changed to conform with the requirements of that law or regulation.

P030.0408-R

Options A, B, E and F

When An Employee's Active Work Ends

You may continue an Employee's Life Insurance after his or her active service with You ends only as follows:

- If an Employee's active service ends because he or she is disabled, You may continue his or her insurance subject to all of the terms of this Policy.
- If an Employee's active service ends because he or she goes on a leave of absence, vacation, military leave, sabbatical or is temporarily laid off, You may continue his or her insurance for the rest of the policy month in which the leave or layoff starts, plus 1 more full policy month(s). But, if the Employee joins any armed force before this period ends, You may continue his or her insurance until the date he or she becomes a member of such armed force.

If You continue an Employee's coverage as set forth above, it must be on a policy which prevents individual selection.

Any such continuation is subject to the payment of premiums and to all of the other terms and conditions of this Policy.

The amount of an Employee's insurance during any such continuation will be the insurance amount in force on his or her last day of active service, subject to any reductions that would have otherwise applied if he or she had remained an active Employee.

P030.0410-R

Options A, B, E and F

An Employee's Right to Continue Life Insurance Coverage During A Family Leave of Absence

Important Notice: This section may not apply to Your Policy. The Employee must contact You to find out if You must allow for a family leave of absence under federal law. If You must allow for such leave, this section applies.

If Coverage Would End: An Employee's Life Insurance coverage would normally end because he or she ceases work due to an approved leave of absence. But, an Employee may continue coverage if the leave has been granted to: (1) allow an Employee to care for a seriously injured or ill spouse, child or parent; (2) after the birth or adoption of a child; (3) due to an Employee's own serious health condition; or (4) because of a serious Injury or illness arising out of the fact that an Employee's spouse, child, parent or next of kin who is a covered service member 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. To continue an Employee's coverage, he or she will be required to pay the same share of the premium as paid before the leave of absence.

When Continuation Ends: Continued coverage will end on the earliest of the following:

- The date an Employee returns to Active Work.
- In the case of a leave granted to an Employee to care for a covered service member, 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 an Employee under this section for all reasons. If an Employee takes 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 the Employer Plan is terminated or an Employee is no longer eligible for coverage under this Policy.

- The end of the period for which 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: (1) 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 (2) results in the call or order to, or retention on, active duty of members of the uniformed services under any provision of law or during a national emergency declared by the President or Congress.
- **Covered Service member:** 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 is: (1) undergoing medical treatment, recuperation or therapy; (2) otherwise in outpatient status; or (3) otherwise on the temporary disability retired list.
- **Next Of Kin:** This term means an Employee's nearest blood relative.
- **Outpatient Status:** This term means, in the case of a covered service member, that he or she is assigned to: (1) a military medical treatment facility as an outpatient; or (2) 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 service member, 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: (1) office; (2) grade; (3) rank; or (4) rating.

P030.0428-R

Definitions

The terms shown below have the meanings shown below.

Active Work or Actively at Work or Actively Working: These terms means the Employee is able to perform, and is performing, all of the regular duties of his or her work for the Employer at:

- One of the Employer's usual places of business;
- Some place where the Employer's business requires the Employee to travel; or
- Any other place the Employee and the Employer have agreed on for Your work.

Covered Person: This term means an Employee or dependent insured by this Policy.

Employee: This term means a person: (1) who works for You or an associated company at Your or such company's place of business; and (2) whose income is reported for tax purposes using a W-2 or 1099 form. This term may also include a Qualified Retiree.

Employer: This term means the entity that purchased the Policy.

Guardian, Our, Us and We: These terms mean The Guardian Life Insurance Company of America.

Life Insurance: This term means insurance on human lives.

Policy: This term means the Guardian group life insurance Policy purchased by You.

You and Your: As used in this Policy, these terms mean the Policyholder who purchased this group Policy. As used in the Certificate(s) attached to this Policy, these terms mean an insured Employee.

P030.0432-R

COMPUTATION OF GROUP LIFE INSURANCE PREMIUMS

How Group Life Insurance Rates Are Computed

We will use the mortality rates and factors in Our rate manual, subject to Our rating methods, to compute the premium charges for group Life Insurance. We can change rates as stated in Premiums.

When this Policy starts, We will compute a preliminary monthly rate. We do this by: (1) multiplying the individual rates by the amounts of insurance in force at the respective ages, nearest birthday, of all Employees; and (2) dividing the result by the total amount of insurance in force. We will use the characteristics of Your group and Our rating methods to modify such preliminary rate and compute Your final premium rate.

We may also compute Your final premium rate by any other method agreed to by You and Us which produces approximately the same total premium.

Voluntary Term Life Insurance: In the case of Voluntary Term Life Insurance, We will use the Employee's rated age to compute premium rates if he or she is placed in a substandard class.

Monthly Premiums: If You pay monthly premiums, each monthly payment will be equal to the product of the total amount of Life Insurance in force on the premium's due date and the monthly rate in effect for each Employee.

Annual, Semi-Annual, Or Quarterly Premiums: If You pay annual, semi-annual, or quarterly premiums, We will compute the applicable rate by multiplying the monthly premiums by: (1) 11.823 for annual premiums; (2) 5.956 for semi-annual premiums; or (3) 2.985 for quarterly premiums.

Employee Contributions: Employee contributions that You require for the cost of this insurance may not vary solely by sex.

When Rates Can Be Changed: We or You may require rate changes: (1) on each Policy Anniversary after the effective date of this Policy; or (2) on any date on which the rate manual is changed.

P030.0437-R

SCHEDULE OF OPTION PACKAGES

This Policy's classes are shown below. The benefit option packages which are available to Covered Persons who are members of each class are shown below.

Class Description

Class 0001 GENERAL MANAGERS, CONTROLLERS, DIRECTORS, ASST. DIRECTORS, EXECUTIVE CHEF, EXECUTIVE HOUSEKEEPER, EXECUTIVE STEWARD, MANAGERS, ASST MANAGERS, PASTRY CHEF, BANQUET CHEF, SOUS CHEF, ASST EXECUTIVE HOUSEKEEPER, ASST CONTROLLER AND ACTIVITIES DIRECTOR

Class 0002 ALL OTHER ELIGIBLE EMPLOYEES***

P020.0087-R

Benefit Option Packages

Employees may choose from the benefit packages available to members of their class. Coverage for a benefit will not become effective until the Covered Person satisfies the eligibility requirements. Coverage for a benefit that requires payment from the Employee will not become effective until the Employee: (1) elects it in a form; and (2) agrees to make any required payments. The benefits are described in the applicable Certificate(s) attached to and made a part of this Policy.

P030.1888-R

Members of Class 0001 may choose from benefits in option package(s) A and B.

P020.0090-R

Members of Class 0002 may choose from benefits in option package(s) E and F.

P020.0090-R

- Option A**
- Employee Basic Term Life
 - Employee Voluntary Term Life
 - Dependent Voluntary Term Life

P030.0533-R

- Option B**
- Employee Basic Term Life
 - Employee Voluntary Term Life
 - Dependent Voluntary Term Life

P030.0533-R

- Option E**
- Employee Voluntary Term Life
 - Dependent Voluntary Term Life

P030.0985-R

- Option F**
- Employee Voluntary Term Life
 - Dependent Voluntary Term Life

P030.0985-R

ATTACHED CERTIFICATES

The Certificate(s) shown below are added to and made part of this policy.

Class 0001 Option(s) A and B

P024.0662-R

Class 0002 Option(s) E and F

P024.0663-R

P024.0663-R

The Certificate(s) describe the Life Insurance benefits for which each class of Employees is eligible.

Each Employee's eligibility, effective date of insurance, plan of insurance, and termination date is determined by the option he or she has elected on his or her enrollment form, or other suitable document approved by Guardian, and the provisions of the Certificate that apply to that option.

Certificate(s) will include any changes made by rider or amendments to this Policy.

P020.0932-R

The Guardian Life Insurance Company of America
Schedule of Premium Rates
Life Insurance

The monthly premium rates, in U.S. dollars, for the benefits provided under the Policy are listed below. Guardian has the right to change any premium rate(s) set forth below at the times and in the manner set forth in the Premiums section of the Policy.

P030.0446-R

Options A and B

Premium Rates

Employee Basic Term Life Insurance

P030.0447-R

Options A and B Class 0001

The following set of rates represents the rate per \$1,000.00 of coverage.

Rate per Employee

\$ 0.13

P024.0722-R

Options A, B, E and F

Employee Voluntary Term Life Insurance

P024.0730-R

Options A, B, E and F Classes 0001 and 0002

The following set of rates represents the rate per \$1,000.00 of coverage.

"Age" means the employee's attained age in years as of this plan's anniversary date.

Age		Rate per Employee
From	Through	
15	29	\$ 0.09
30	34	\$ 0.10
35	39	\$ 0.13
40	44	\$ 0.22
45	49	\$ 0.34
50	54	\$ 0.53
55	59	\$ 0.90
60	64	\$ 1.48
65	69	\$ 2.39
70	74	\$ 3.82
75	79	\$ 6.48
80	84	\$ 14.45
85	89	\$ 19.37
90	94	\$ 24.71
95	99	\$ 31.54

P024.0733-R

Options A, B, E and F**Dependent Spouse Voluntary Term Life Insurance**

P024.0750-R

Options A, B, E and F Classes 0001 and 0002

The following set of rates represents the rate per \$1,000.00 of coverage.

"Age" means the employee's attained age in years as of this plan's anniversary date.

Age		Rate per Insured Spouse
From	Through	
15	29	\$ 0.09
30	34	\$ 0.10
35	39	\$ 0.13
40	44	\$ 0.22
45	49	\$ 0.34
50	54	\$ 0.53
55	59	\$ 0.90
60	64	\$ 1.48
65	69	\$ 2.39
70	74	\$ 3.82
75	79	\$ 6.48
80	84	\$ 14.45
85	89	\$ 19.37
90	94	\$ 24.71
95	99	\$ 31.54

P024.0753-R

Options A, B, E and F**Dependent Child Voluntary Term Life Insurance**

P024.0771-R

Options A, B, E and F Classes 0001 and 0002

The following set of rates represents the rate per \$1,000.00 of coverage.

Rate per Insured Child Unit

\$ 0.17

P024.0772-R

Options A, B, E and F

ATTACHED TO AND MADE PART OF GROUP INSURANCE POLICY NO. G -00429264-

issued by

THE GUARDIAN LIFE INSURANCE COMPANY OF AMERICA

(herein called Guardian)

to

HILTON WATERFRONT BEACH RESORT

(herein called the Policyholder)

This Rider amends the Policy as follows and is effective on its issue date:

- The "Non-Participating - No Dividends Payable" notice on the Policy face page is replaced with "Dividends Apportioned Annually, if Payable".
- The Dividends provision is added or replaced in its entirety within the General Provisions as shown below.

Dividends

The portion, if any, of the divisible surplus of Guardian allocable to this Policy at each Policy Anniversary will be determined annually by the Board of Directors of Guardian and will be credited to this Policy as a dividend on such anniversary, provided this Policy is continued in force by the payment of all premiums to such anniversary.

Any dividend under this Policy will be paid to the Policyholder in cash, or at the option of the Policyholder it may be applied to the reduction of the premiums then due.

In the event that the Employees are contributing toward the cost of the coverage under any group policy issued to the Policyholder and the aggregate dividends under this Policy and any other group policy or policies issued to the Policyholder are in excess of the Policyholder's share of the aggregate cost, such excess will be applied by the Policyholder for the sole benefit of the Employees.

Finally, please note that it is not expected that any dividends will be payable under this Policy.

This Rider is part of this Policy. Except as stated in this Rider, nothing contained in this Rider changes or affects any other terms of this Policy.

Dated at Spokane, WA This 18th Day of February, 2021



Harris Oliner, Senior Vice President,
Corporate Secretary



Michael Prestileo,
Senior Vice President

P070.0043-R

The Guardian Life Insurance Company of America

A Mutual Company - Incorporated 1860 by the State of New York
10 Hudson Yards, New York, New York 10001

GROUP INSURANCE POLICY

Accidental Death and Dismemberment Coverage

POLICYHOLDER: HILTON WATERFRONT BEACH RESORT

GROUP POLICY NUMBER

G-00429264

DELIVERED IN

California

POLICY DATE

September 1, 2007

POLICY ANNIVERSARIES: September 1st of each year, beginning in 2008

GUARDIAN AGREES to pay benefits in accordance with and subject to the terms of this Policy. This promise is based on the Policyholder's application and payment of the required premiums.

This Policy is delivered in the jurisdiction shown above and is governed by its laws.

This Policy takes effect on the Policy Date shown above.

IN WITNESS OF WHICH, GUARDIAN has caused this Policy to be executed as of September 30, 2019 which is its date of issue.

The Guardian Life Insurance Company of America



Michael Prestileo, Senior Vice President

Non-Participating - No Dividends Payable

Please read this Policy carefully.

P030.0881-R

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GENERAL PROVISIONS

Options A, B, E and F

Incontestability

Any statement made by the Policyholder, in the absence of fraud, will be deemed a representation and not a warranty. No statements will be used to avoid insurance, reduce benefits or defend a claim unless they are included in a written application or enrollment form that has been made a part of the Policy, and are material to the risk accepted or the hazard assumed by Us. We shall not contest this coverage after it has been in force during the Covered Person's lifetime for three years from the Policy Date.

P030.1905-R

Options A, B, E and F

Associated Companies

An associated company is a business entity affiliated with You through common ownership of stock or assets.

If You ask Us in writing to include such a company under this Policy, We will treat Employees of that company like Your Employees. We must give Our written approval. Our approval will show the starting date of the company's coverage under this Policy. Each eligible Employee of that company must still meet all of the terms and conditions of this Policy before he or she will be insured.

You must notify Us in writing when a company ceases to be an associated company. On the date a company ceases to be such a company, this Policy will end for all of that company's Employees, except those covered by You or another associated company as Employees on such date.

P030.0886-R

Options A, B, E and F

Premiums

Premiums are payable by You as follows:

- The first premium is due on the Policy Date; and
- Later premiums are, during the time this Policy remains in force, due on the 1st of each month.

Premiums due under this Policy must be paid by You:

- At a Guardian office; or
- To a representative that We have authorized.

The premiums must be paid as shown above, unless by agreement between You and Us, the interval of payment is changed. In that event, adjustment will be made for payment annually, semi-annually, or quarterly.

The premium due under this Policy on each due date will be the sum of the premium charges for the insurance provided under this Policy. The premium charges are based on the rates set forth in the Schedule Of Premium Rates.

We may change such rates:

- On the first day of any Policy month;
- On any date the extent or terms of coverage for You are changed by amendment of this Policy;

- On any date Our obligation under this Policy with respect to You is changed because of statutory or other regulatory requirements; or
- On any date that a change in federal or state laws, insurance programs or retirement benefits would impact our liability.

We must give You 31 days written notice of the rate change. Such change will apply to any premium due on and after the effective date of the change stated in such notice.

P030.0887-R

Premiums for Employee coverage must be paid solely from funds contributed by the Employer. No contributions toward the premium may be required of any Employee.

P030.0889-R

Options A, B, E and F

Adjustment Of Premiums Payable Other Than Monthly Or Quarterly

A premium rate may be changed after an annual or semi-annual premium became payable with respect to insurance on and after the date of such change. In that case, the premium will be adjusted by a pro rata change for the rest of the period for which the premium became payable. If the adjustment results in a decrease, the amount of the decrease will be paid to You by Us. If the adjustment results in an increase, the amount of the increase will be considered a premium due on the date of the rate change. This Policy's grace period will apply to any such premium due.

P030.0890-R

Options A, B, E and F

Grace In Payment Of Premiums - Termination Of Policy

A grace period of 31 days, without interest charge, will be allowed for each premium payment except the first. If any premium with respect to the Employees is not paid before the end of the grace period, this Policy ends with respect to all Employees at the end of the grace period. If You give Us advance written notice of an earlier termination date during the grace period, this Policy will end as of such earlier date.

If this Policy ends during or at the end of the grace period, You will still owe Us premium for all the time this Policy was in force during the grace period.

This Policy ends on any date when a coverage under this Policy ends and, as a result, no benefits remain in effect under this Policy.

P030.2130-R

Options A, B, E and F

Term Of Policy - Renewal Privilege

This Policy is issued for a term of one year from the Policy Date shown on the face page. All policy years and policy months will be calculated from the Policy Date. All periods of insurance will begin and end at 12:01 A.M. Standard Time at Your place of business.

If this Policy provides insurance on a non-contributory basis, all of the Employees eligible for such insurance must be enrolled.

You may renew this Policy for a further term of one year on the first and each subsequent Policy Anniversary. All renewals are subject to the payment of premiums then due, computed as shown in Premiums.

P030.0894-R

Options A, B, E and F

We have the right to decline to renew this Policy, or any coverage under it, on any Policy Anniversary or premium due date, if, on that date:

- Less than ten Employees are insured; or
- With respect to non-contributory insurance, all of those Employees eligible are not insured; or
- With respect to contributory insurance, less than 75% of those Employees eligible are insured.

P030.1832-R

You may cancel this Policy at any time by giving Us 31 days advance written notice. This notice must be sent to Our Home Office. You will owe Us all unpaid premiums for the period this Policy is in force. We may cancel this Policy by giving You 31 days advance written notice.

P030.0909-R

Options A, B, E and F

Reinstatement

If any renewal premium be not paid within the time granted the insured for payment, a subsequent acceptance of premium by Us, without requiring in connection therewith an application for reinstatement, shall reinstate this Policy; provided, however, that if We require an application for reinstatement and issue a conditional receipt for the premium tendered, this Policy will be reinstated upon approval of such application by Us, or, lacking such approval, upon the forty-fifth day following the date of such conditional receipt unless We have previously notified You in writing of its disapproval of such application. The reinstated Policy shall cover only loss resulting from such accidental injury as may be sustained after the date of reinstatement and loss due to such sickness as may begin more than 10 days after such date. In all other respects You and We shall have the same rights thereunder as they had under this Policy immediately before the due date of the defaulted premium, subject to any provisions endorsed hereon or attached hereto in connection with the reinstatement. Any premium accepted in connection with a reinstatement shall be applied to a period for which premium has not been previously paid, but not to any period more than 60 days prior to the date of reinstatement.

P030.1907-R

Options A, B, E and F

The Contract

The entire contract between You and Us consists of:

- This Policy;
- The Schedule of Premium Rates;
- The Certificate(s) which describe(s) the insurance for which Covered Persons are insured;
- Any attached riders, schedule of benefits or amendments; and
- Your application.

In the event of a conflict, the Policy shall reign.

We can amend this Policy at any time, without the consent of the insured Employees or any other person having a beneficial interest in it:

- Upon written request made by You and agreed to by Us; or
- On any date Our obligation under this Policy with respect to You is changed due to the requirements of state or federal law or regulation.

If We amend this Policy, except upon request made by You, We must give You written notice of such change.

Any amendments to this Policy will be without prejudice to any claim arising prior to the date of the change.

No person, except by a writing signed by the President, a Vice President or a Secretary of Guardian, has the authority to act for Us to:

- Determine whether any contract, policy or certificate is to be issued;
- Waive or alter any provisions of any contract or policy, or any of Our requirements;
- Bind Us by any statement or promise relating to the contract issued or to be issued; or
- Accept any information or representation which is not in a signed application.

P030.1908-R

Options A, B, E and F

Clerical Error - Misstatements Of Age

Neither clerical error by You or Us in keeping any records on the insurance under this Policy, nor delays in making entries, will invalidate insurance otherwise validly in force or continue insurance otherwise validly terminated. On discovery of such error or delay, an equitable adjustment of premiums will be made.

Premium adjustments involving return of unearned premium to You will be limited to the period of 90 days before the date of Our receipt of satisfactory evidence that such adjustments should be made.

The age of an Employee, or any other relevant facts, may be found to have been misstated. If premiums are affected due to this, an equitable adjustment of premiums will be made. If such misstatement involves whether or not an insurance risk would have been accepted by Us, or the amount of insurance, the true facts will be used to determine whether insurance is in force under the terms of this Policy, and in what amount.

P030.0911-R

Options A, B, E and F

Certificate

We will issue a Certificate to You for delivery to each insured Employee. It will state the essential features of the insurance to which the Employee is entitled and to whom the benefits are payable. In the event this Policy is amended, and such amendment affects the material contained in the Certificate, a rider or revised Certificate reflecting such amendment will be issued to You for delivery to affected Employees.

P030.0914-R

Options A, B, E and F

Notice

From time to time We may provide You with notices that are needed due to state or federal requirements. You must deliver copies of these notices to each of Your Employees.

New Entrants

Eligible new Employees may be added to the group originally insured in accordance with the terms of this Policy. Eligible new dependents may be added to the group of dependents originally insured in accordance with the terms of this Policy.

P030.1909-R

Options A, B, E and F

Claims Of Creditors

Except when prohibited by the laws of the jurisdiction in which this Policy was issued, the insurance and other benefits under this Policy will be exempt from execution, garnishment, attachment, or other legal or equitable process, for the debts or liabilities of the Covered Persons or their beneficiaries.

P030.0916-R

Options A, B, E and F

Records - Information To Be Furnished

You must keep a record of the insured Employees containing, for each Employee, the essential details of the insurance which apply to him or her. You must periodically forward to Us, on Our forms, such information concerning the Employees in the classes eligible for insurance under this Policy as may reasonably be considered to have a bearing on:

- The administration of the insurance under this Policy; and
- The determination of the premium rates.

For benefits which are based on an Employee's salary, changes in his or her salary must promptly be reported to Us. Your payroll and other such records which have a bearing on the insurance must be furnished to Us at Our request at any reasonable time.

P030.0917-R

Options A, B, E and F

Physical 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 Policy as often as We feel necessary. We have the right to have an autopsy performed in the case of death, where allowed by law. We will pay for all such examinations and autopsies.

P030.1910-R

Options A, B, E and F

Conformity With Law

If the provisions of this Policy do not conform to the requirements of any state or federal law or regulation that applies, any such provision is changed to conform with the requirements of that law or regulation.

P030.0919-R

Options A, B, E and F

When An Employee's Active Work Ends

You may continue an Employee's Accidental Death and Dismemberment Insurance after his or her active service with You ends only as follows:

- If an Employee's active service ends because he or she is disabled, You may continue his or her insurance subject to all of the terms of this Policy.
- If an Employee's active service ends because he or she goes on a leave of absence, vacation, military leave, sabbatical or is temporarily laid off, You may continue his or her insurance for the rest of the policy month in which the leave or layoff starts, plus 1 more full policy month(s). But, if the Employee joins any armed force before this period ends, You may continue his or her insurance until the date he or she becomes a member of such armed force.

If You continue an Employee's coverage as set forth above, it must be on a policy which prevents individual selection.

Any such continuation is subject to the payment of premiums and to all of the other terms and conditions of this Policy.

The amount of an Employee's insurance during any such continuation will be the insurance amount in force on his or her last day of active service, subject to any reductions that would have otherwise applied if he or she had remained an active Employee.

P030.0921-R

Definitions

The terms shown below have the meanings shown below.

Active Work or Actively at Work or Actively Working: These terms means the Employee is able to perform, and is performing, all of the regular duties of his or her work for the Employer at:

- One of the Employer's usual places of business;
- Some place where the Employer's business requires the Employee to travel; or
- Any other place the Employee and the Employer have agreed on for Your work.

Covered Person: This term means an Employee insured by this Policy.

Employee: This term means a person: (1) who works for You or an associated company at Your or such company's place of business; and (2) whose income is reported for tax purposes using a W-2 or 1099 form. This term may also include a Qualified Retiree.

Employer: This term means the entity that purchased the Policy.

Guardian, Our, Us and We: These terms mean The Guardian Life Insurance Company of America.

Policy: This term means the Guardian group life insurance Policy purchased by You.

You and Your: As used in this Policy, these terms mean the Policyholder who purchased this group Policy. As used in the Certificate(s) attached to this Policy, these terms mean an insured Employee.

P030.0927-R

SCHEDULE OF OPTION PACKAGES

This Policy's classes are shown below. The benefit option packages which are available to Covered Persons who are members of each class are shown below.

Class Description

Class 0001 GENERAL MANAGERS, CONTROLLERS, DIRECTORS, ASST. DIRECTORS, EXECUTIVE CHEF, EXECUTIVE HOUSEKEEPER, EXECUTIVE STEWARD, MANAGERS, ASST MANAGERS, PASTRY CHEF, BANQUET CHEF, SOUS CHEF, ASST EXECUTIVE HOUSEKEEPER, ASST CONTROLLER AND ACTIVITIES DIRECTOR

Class 0002 ALL OTHER ELIGIBLE EMPLOYEES***

P020.0087-R

Benefit Option Packages

Employees may choose from the benefit packages available to members of their class. Coverage for a benefit will not become effective until the Covered Person satisfies the eligibility requirements. Coverage for a benefit that requires payment from the Employee will not become effective until the Employee: (1) elects it in a form; and (2) agrees to make any required payments. The benefits are described in the applicable Certificate(s) attached to and made a part of this Policy.

P030.1911-R

Members of Class 0001 may choose from benefits in option package(s) A and B.

P030.0934-R

Members of Class 0002 may choose from benefits in option package(s) E and F.

P030.0934-R

Option A ● Employee Accidental Death and Dismemberment Insurance

P030.0935-R

Option B ● Employee Accidental Death and Dismemberment Insurance

P030.0935-R

Option E ● Employee Accidental Death and Dismemberment Insurance

P030.0935-R

Option F ● Employee Accidental Death and Dismemberment Insurance

P030.0935-R

ATTACHED CERTIFICATES

The Certificate(s) shown below are added to and made part of this policy.

Class 0001 Option(s) A and B

P030.0946-R

Class 0002 Option(s) E and F

P030.0947-R

P030.0947-R

The Certificate(s) describe the Accidental Death and Dismemberment Insurance benefits for which each class of Employees is eligible.

Each Employee's eligibility, effective date of insurance, plan of insurance, and termination date is determined by the option he or she has elected on his or her enrollment form, or other suitable document approved by Guardian, and the provisions of the Certificate that apply to that option.

Certificate(s) will include any changes made by rider amendments to this Policy.

P030.0948-R

The Guardian Life Insurance Company of America
Schedule of Premium Rates
Accidental Death and Dismemberment Insurance

The monthly premium rates, in U.S. dollars, for the benefits provided under the Policy are listed below. Guardian has the right to change any premium rate(s) set forth below at the times and in the manner set forth in the Premiums section of the Policy.

P030.0950-R

<u>Options A, B, E and F</u>	<u>Premium Rates</u>
<i>Employee Basic Accidental Death and Dismemberment Insurance</i>	

P030.0951-R

Options A, B, E and F Classes 0001 and 0002

The following set of rates represents the rate per \$1,000.00 of coverage.

Rate per Employee

\$ 0.02

P030.0952-R

Options A, B, E and F

ATTACHED TO AND MADE PART OF GROUP INSURANCE POLICY NO. G -00429264-

issued by

The Guardian Life Insurance Company of America

(herein called the Insurance Company)

to

HILTON WATERFRONT BEACH RESORT

(herein called the Policyholder)

This Rider amends this Policy by replacing the Incontestability provision with the Time Limit on Certain Defenses provision as shown below and is effective on its issue date.

Time Limit On Certain Defenses

After this Policy has been in force for a period of two years, no statements of the Policyholder contained in the application, and no statement relating to insurability made by any Employee eligible for coverage under the Policy shall be used to deny a claim or in contesting the validity of the insurance with respect to which such statement was made after the insurance has been in force prior to the contest for a period of two years during the lifetime of the person with respect to whom any such statement was made.

In the event a Covered Employee's insurance is rescinded due to a fraudulent statement made in his or her application, We will refund premiums paid for the periods such insurance is void. The premium paid by the Covered Employee will be sent to his or her last known address on file with You or Us. If You pay all or part of the cost of a Covered Employee's insurance Your part of the premium will be paid to You.

This rider is part of this Policy. Except as stated in this rider, nothing contained in this rider changes or affects any other terms of this Policy.

Dated at _____ This _____ Day of _____ , _____

HILTON WATERFRONT BEACH RESORT

Full or Corporate Name of Policyholder

Witness BY: _____
Signature and Title



Harris Oliner, Senior Vice President,
Corporate Secretary



Michael Prestileo,
Senior Vice President

Options A, B, E and F

ATTACHED TO AND MADE PART OF GROUP INSURANCE POLICY NO. G -00429264-

issued by

THE GUARDIAN LIFE INSURANCE COMPANY OF AMERICA

(herein called Guardian)

to

HILTON WATERFRONT BEACH RESORT

(herein called the Policyholder)

This Rider amends the Policy as follows and is effective on its issue date:

- The "Non-Participating - No Dividends Payable" notice on the Policy face page is replaced with "Dividends Apportioned Annually, if Payable".
- The Dividends provision is added or replaced in its entirety within the General Provisions as shown below.

Dividends

The portion, if any, of the divisible surplus of Guardian allocable to this Policy at each Policy Anniversary will be determined annually by the Board of Directors of Guardian and will be credited to this Policy as a dividend on such anniversary, provided this Policy is continued in force by the payment of all premiums to such anniversary.

Any dividend under this Policy will be paid to the Policyholder in cash, or at the option of the Policyholder it may be applied to the reduction of the premiums then due.

In the event that the Employees are contributing toward the cost of the coverage under any group policy issued to the Policyholder and the aggregate dividends under this Policy and any other group policy or policies issued to the Policyholder are in excess of the Policyholder's share of the aggregate cost, such excess will be applied by the Policyholder for the sole benefit of the Employees.

Finally, please note that it is not expected that any dividends will be payable under this Policy.

This Rider is part of this Policy. Except as stated in this Rider, nothing contained in this Rider changes or affects any other terms of this Policy.

Dated at Spokane, WA This 18th Day of February, 2021



Harris Oliner, Senior Vice President,
Corporate Secretary



Michael Prestileo,
Senior Vice President

P070.0043-R

The Guardian Life Insurance Company of America

A Mutual Company - Incorporated 1860 by the State of New York
10 Hudson Yards, New York, New York 10001

GROUP INSURANCE POLICY

Short Term Disability Income Coverage

POLICYHOLDER: HILTON WATERFRONT BEACH RESORT

GROUP POLICY NUMBER

G-00429264

DELIVERED IN

California

POLICY DATE

September 1, 2007

POLICY ANNIVERSARIES: September 1st of each year, beginning in 2008

GUARDIAN AGREES to pay benefits in accordance with, and subject to, the terms of this Policy. This promise is based on the Policyholder's application and payment of the required premiums.

This Policy is delivered in the jurisdiction shown above and is governed by its laws.

This Policy takes effect on the Policy Date shown above.

IN WITNESS OF WHICH, GUARDIAN has caused this Policy to be executed as of September 30, 2019 which is its date of issue.

The Guardian Life Insurance Company of America



Michael Prestileo, Senior Vice President

Non-Participating No Dividends Payable

Please read this Policy carefully.

P030.0072-R

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GENERAL PROVISIONS

Entire Contract; Changes

This Policy, the application of the Policyholder and the individual applications, if any, of the individuals insured shall constitute the entire contract between the parties, and any statements made by the Policyholder, or by the individuals insured shall, in the absence of fraud, be deemed representations and not warranties. No such statement shall be used in defense to a claim under the policy, unless it is contained in a written application.

No change in this policy shall be valid unless approved by an executive officer of Guardian and evidenced by endorsement hereon, or by amendment hereto signed by the Policyholder and by an executive officer of Guardian. No agent has authority to change this policy or waive any of its provisions.

Time Limit On Certain Defenses

After this Policy has been in force for a period of three years, no statements of the Policyholder contained in the application, and no statement relating to insurability made by any Employee eligible for coverage under the Policy shall be used to deny a claim or in contesting the validity of the insurance with respect to which such statement was made after the insurance has been in force prior to the contest for a period of three years during the lifetime of the person with respect to whom any such statement was made.

No claim for loss incurred or disability commencing after three years from the effective date of the insurance coverage with respect to which the claim is made shall be reduced or denied on the ground that a disease or physical condition, not excluded from coverage by name or specific description effective on the date of loss, had existed prior to the effective date of the coverage with respect to which the claim is made.

In the event a Covered Employee's insurance is rescinded due to a fraudulent statement made in his or her application, We will refund premiums paid for the periods such insurance is void. The premium paid by the Covered Employee will be sent to his or her last known address on file with You or Us. If You pay all or part of the cost of a Covered Employee's insurance Your part of the premium will be paid to You.

Grace Period

A grace period of 31 days will be granted for the payment of premiums accruing after the first premium, during which grace period the Policy shall continue in force, but the Policyholder shall be liable to Us for the payment of the premium accruing for the period the Policy continues in force. If any premium with respect to the Employees of any Participating Employer is not paid before the end of the grace period, this Policy ends with respect to all Employees of such Participating Employer at the end of the grace period. If You give Us advance written notice of an earlier termination date during the grace period, this Policy will end as of such earlier date.

If this Policy ends during or at the end of the grace period, You will still owe Us premium for all the time this Policy was in force during the grace period.

This Policy ends on any date when a coverage under this Policy ends and, as a result, no benefits remain in effect under this Policy.

Notice Of Claim

Written notice of claim must be given to the insurer within 20 days after the occurrence or commencement of any loss covered by the policy, or as soon thereafter as is reasonably possible.

Claims Forms

Upon receipt of a written notice of claim, We will furnish to the claimant the forms for filing proofs of loss. If such forms are not furnished within 15 days after the giving of such notice the claimant shall be deemed to have complied with the requirements of this Policy as to proof of loss upon submitting, within the time fixed in the Policy for filing proofs of loss, written proof covering the occurrence, the character and the extent of the loss for which claim is made.

Proof of Loss

Written proof of loss must be furnished to Us within 90 days after the date of such loss. Failure to furnish such proof within the time required shall not invalidate nor reduce any claim if it was not reasonably possible to give proof within such time, provided such proof is furnished as soon as reasonably possible and in no event, except in the absence of legal capacity of the Covered Person, later than one year from the time proof is otherwise required.

Time of Payment Of Claim

Subject to due written proof of loss, all indemnities for loss for which this Policy provides payment will be paid to the Covered Person as they accrue and any balance remaining unpaid at termination of the period of liability will be paid to the Covered Person immediately upon receipt of due written proof.

Legal Actions

No action at law or in equity shall be brought to recover on this Policy prior to the expiration of 60 days after written proof of loss has been furnished in accordance with the requirements of this Policy. No such action shall be brought after the expiration of three years after the time written proof of loss is required to be furnished.

Conformity With State Statutes

Any provision of this policy which, on its effective date, is in conflict with the statutes of the state in which this policy was delivered or issued for delivery is hereby amended to conform to the minimum requirements of such statute.

P030.1890-R

Options A and B

Associated Companies

An associated company is a business entity affiliated with You through common ownership of stock or assets.

If You ask Us in writing to include such a company under this Policy, We will treat Employees of that company like Your Employees. We must give Our written approval. Our approval will show the starting date of the company's coverage under this Policy. Each Eligible Employee of that company must still meet all of the terms and conditions of this Policy before he or she will be insured.

You must notify Us in writing when a company ceases to be an associated company. On the date a company ceases to be such a company, this Policy will end for all of that company's Employees, except those covered by You or another associated company as Employees on such date.

P030.0074-R

Options A and B

Premiums

Premiums are payable by You as follows:

- The first premium is due on the Policy Date; and
- Later premiums are, during the time this Policy remains in force, due on the the 1st of each month.

Premiums due under this Policy must be paid by You:

- At a Guardian office; or
- To a representative that We have authorized.

The premiums must be paid as shown above, unless by agreement between You and Us, the interval of payment is changed. In that event, adjustment will be made for payment annually, semi-annually, or quarterly.

The premium due under this Policy on each due date will be the sum of the premium charges for the insurance provided under this Policy. The premium charges are based on the rates set forth in the Schedule Of Premium Rates.

We may change such rates:

- On the first day of any Policy month;
- On any date the extent or terms of coverage for You are changed by amendment of this Policy; or
- On any date Our obligation under this Policy with respect to You is changed because of statutory or other regulatory requirements; or
- On any date that a change in federal or state laws, insurance programs or retirement benefits would impact Our Liability.

We must give You 31 days written notice of the rate change. Such change will apply to any premium due on and after the effective date of the change stated in such notice.

Premiums for Employee coverage must be paid solely from funds contributed by the Employer. No contributions toward the premium may be required of any Employee.

P030.0076-R

Options A and B

Adjustment Of Premiums Payable Other Than Monthly Or Quarterly

A premium rate may be changed after an annual or semi-annual premium became payable with respect to insurance on and after the date of such change. In that case, the premium will be adjusted by a pro rata change for the rest of the period for which the premium became payable. If the adjustment results in a decrease, the amount of the decrease will be paid to You by Us. If the adjustment results in an increase, the amount of the increase will be considered a premium due on the date of the rate change. This Policy's grace period will apply to any such premium due.

P030.0077-R

Options A and B

Term of Policy - Renewal Privilege

This Policy is issued for a term of one year from the Policy Date shown on the face page. All policy years and policy months will be calculated from the Policy Date. All periods of insurance will begin and end at 12:01 A.M. Standard Time at Your place of business.

If this Policy provides coverage on a non-contributory basis, all of the Employees eligible for such insurance must be enrolled.

You may renew this Policy for a further term of one year on the first and each subsequent Policy Anniversary. All renewals are subject to the payment of premiums then due, computed as shown in Premiums section of this Policy.

We have the right to decline to renew this Policy on any Policy Anniversary or premium due date, if, on that date:

- Less than 10 Employees are insured; or
- With respect to non-contributory insurance, all of those Employees eligible are not insured; or
- With respect to contributory insurance, less than 75% of those Employees eligible are insured.

We have the right to decline to renew this Policy on any Policy Anniversary or premium due date, if, on that date the number of Employees is below Our minimum group size requirements.

You may cancel this Policy at any time by giving Us 31 days advance written notice. This notice must be sent to Our Home Office. You will owe Us all unpaid premiums for the period this Policy is in force. We may cancel this Policy by giving You 31 days advance written notice.

P030.0079-R

Amendments

We can amend this Policy at any time, without the consent of the insured Employees or any other person having a beneficial interest in it:

- Upon written request made by You and agreed to by Us;
- On any date Our obligation under this Policy with respect to You is changed because of statutory or other regulatory requirements; or
- On any date on which Our contractual relationship with any vendor supplying services or supplies with respect to this Policy changes.

We must give You 31 days advance written notice of any amendments We make to this Policy.

Any amendments to this Policy will be without prejudice to any claim arising prior to the date of the change.

No person, except by a writing signed by the President, a Vice President or a Secretary of Guardian, has the authority to act for Us to:

- Determine whether any contract, policy or certificate is to be issued;
- Waive or alter any provisions of any contract or policy, or any of Our requirements;
- Bind Us by any statement or promise relating to the contract issued or to be issued; or
- Accept any information or representation which is not in a signed application.

P030.1891-R

Options A and B

Clerical Error

Neither clerical error by You or Us in keeping any records on the insurance under this Policy, nor delays in making entries, will invalidate insurance otherwise validly in force or continue insurance otherwise validly terminated. On discovery of such error or delay, an equitable adjustment of premiums will be made.

Premium adjustments involving return of unearned premium to You will be limited to the period of 90 days before the date of Our receipt of satisfactory evidence that such adjustments should be made.

P030.1892-R

Options A and B

Certificate

We will issue a Certificate to You for delivery to each insured Employee. It will state the essential features of the insurance to which the employee is entitled and to whom the benefits are payable. In the event this Policy is amended, and such amendment affects the material contained in the certificate, a rider or revised certificate reflecting such amendment will be issued to You for delivery to affected Employees.

P030.0084-R

Options A and B

Notice

From time to time We may provide You with notices that are needed due to state or federal requirements. You must deliver copies of these notices to each of Your Employees.

P030.0085-R

Options A and B

Claims Of Creditors

Except when prohibited by the laws of the jurisdiction in which this Policy was issued, the insurance and other benefits under this Policy will be exempt from execution, garnishment, attachment, or other legal or equitable process, for the debts or liabilities of the Covered Employees or their beneficiaries.

P030.0086-R

Options A and B

Records - Information To Be Furnished

You must keep a record of the insured Employees containing, for each Employee, the essential details of the insurance which apply to him or her. You must periodically forward to Us, on Our forms, such information concerning the Employees in the classes eligible for insurance under this Policy as may reasonably be considered to have a bearing on:

- The administration of the insurance under this Policy; and
- The determination of the premium rates.

For benefits which are based on an Employee's salary, changes in his or her salary must promptly be reported to Us. Your payroll and other such records which have a bearing on the insurance must be furnished to Us at our request at any reasonable time.

P030.0087-R

Options A and B

When Active Service Ends

You may not continue an Employee's short term disability income insurance after his or her active service with You ends.

P030.0092-R

Options A and B

Right To Continue Short Term Disability Income Coverage During A Family Leave Of Absence

Important Notice: This section may not apply to Your Policy. The Employee must contact You to find out if You must allow for a family leave of absence under federal law. If You must allow for such leave, this section applies.

If Your Coverage Would End: An Employee's Short Term Disability would normally end because an Employee ceases work due to an approved leave of absence. But, an Employee may continue coverage if the leave has been granted:

- To allow an Employee to care for a seriously injured or ill spouse, child or parent;
- After the birth or adoption of a child;
- Due to an Employee's own serious health condition; or
- Because of a Serious Injury Or Illness arising out of the fact that an Employee's spouse, child, parent or Next Of Kin who is a Covered Service Member 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.

To continue an Employee's coverage, an Employee will be required to pay the same share of the premium as paid before the leave of absence.

When Continuation Ends: Continued coverage will end on the earliest of the following:

- The date an Employee returns to Active Work;
- In the case of a leave granted to an Employee to care for a Covered Service Member, 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 an Employee under this section for all reasons. If an Employee takes 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 the Plan is terminated or an Employee is no longer eligible for coverage under this Policy; or
- The end of the period for which 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:
 - 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
 - Results in the call or order to, or retention on, Active Duty of members of the uniformed services under any provision of law or during a national emergency declared by the President or Congress.
- **Covered Service Member:** 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 is:

- Undergoing medical treatment, recuperation or therapy;
- Otherwise in Outpatient Status; or
- Otherwise on the temporary disability retired list.
- **Next Of Kin:** This term means an Employee s nearest blood relative.
- **Outpatient Status:** This term means, in the case of a Covered Service Member, that he or she is assigned to:
 - A military medical treatment facility as an Outpatient; or
 - 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 Service Member, 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.

P030.0094-R

Options A and B

Definitions

The terms shown below have the meanings shown below.

Active Work: These terms mean the Employee is able to perform, and is performing, all of the regular duties of his or her work for the Employer at:

- One of the Employer's usual places of business;
- Some place where the Employer's business requires the Employee to travel; or
- Any other place the Employee and the Employer have agreed on for the Employee's work.

Covered Employee: This term means an Employee insured by this Policy.

Employee: This term means a person who works for You at Your place of business and whose incomes is reported to the United States Internal Revenue Services, and/or a state for tax purposes. Partners and proprietors will also be treated as Employees if the eligibility requirements are met.

Employer: This term means the entity that purchased the plan.

Guardian, Our, Us and We: These terms mean The Guardian Life Insurance Company of America.

Policy: This term means the Guardian group Short Term Disability Income insurance Policy purchased by You.

You and Your: As used in this Policy, these terms mean the Policyholder who purchased this group Policy. As used in the Certificate(s) attached to this Policy, these terms mean an insured Employee.

P030.0095-R

SCHEDULE OF OPTION PACKAGES

This Policy's classes are show below. The benefit option packages which are available to Covered Employees who are members of each class are also shown below.

Class Description

Class 0001 GENERAL MANAGERS, CONTROLLERS, DIRECTORS, ASST. DIRECTORS, EXECUTIVE CHEF, EXECUTIVE HOUSEKEEPER, EXECUTIVE STEWARD, MANAGERS, ASST MANAGERS, PASTRY CHEF, BANQUET CHEF, SOUS CHEF, ASST EXECUTIVE HOUSEKEEPER, ASST CONTROLLER AND ACTIVITIES DIRECTOR

P030.0097-R

Benefit Option Packages

Employees may choose from the benefit packages available to members of their class. Coverage for a benefit will not become effective until the Covered Employee satisfies the eligibility requirements. Coverage for a benefit that requires payment from the Employee will not become effective until the Employee:

- Elects it in a form acceptable by Us; and
- Agrees to make any required payments.

The benefits are described in the applicable Certificate(s) attached to and made part of this Policy.

Members of Class 0001 may choose from benefit option packages A and B.

- Short Term Disability

P030.0099-R

ATTACHED CERTIFICATES

The Certificate(s) shown below are added to and made part of this Policy.

Class 0001 Option(s) A and B

The Certificate(s) describe the Short Term Disability Income Coverage benefits for which each class of Employees is eligible.

Each Employee's eligibility, effective date of insurance, plan of insurance, and termination date is determined by the option he or she has elected on his or her enrollment form, or other suitable document approved by Guardian, and the provisions of the Certificate that apply to that option.

Certificate(s) will include any changes made by amendments to this Policy.

P030.0100-R

Options A and B

The Guardian Life Insurance Company of America

Schedule Of Premium Rates

Short Term Disability Income Insurance

Effective: September 1, 2007, this Schedule of Premium Rates replaces any previously issued Schedule of Premium Rates for Short Term Disability.

The monthly premium rates, in U.S. dollars, for the benefits provided under the Policy are listed below. Guardian has the right to change any premium rate(s) set forth below at the times and in the manner set forth in the Premiums section of the Policy.

P030.0102-R

Options A and B Class 0001

The following set of rates represents the rate per \$10.00 of weekly benefit.

Rate per Employee

\$ 0.055

P030.0103-R

Options A and B

ATTACHED TO AND MADE PART OF GROUP INSURANCE POLICY NO. G -00429264-

issued by

The Guardian Life Insurance Company of America

(herein called the Insurance Company)

to

HILTON WATERFRONT BEACH RESORT

(herein called the Policyholder)

This Rider amends this Policy by adding the Reinstatement of Policy provision as shown below and is effective on its issue date.

Reinstatement Of Policy

If any renewal premium with respect to the Employee's of any Participating Employer is not paid within the time granted for payment, a subsequent acceptance of premium by Us or by any agent duly authorized by Us to accept such premium, without requiring in connection therewith an application for reinstatement, shall reinstate the Policy; provided, however, that if We or such agent requires an application for reinstatement and issues a conditional receipt for the premium tendered, the Policy will be reinstated upon approval of such application by Us or, lacking such approval, upon the forty-fifth day following the date of such conditional receipt unless We previously notified You in writing of Our disapproval of such application.

The reinstated Policy shall cover claims for Covered Services that occur after the reinstatement date. You shall have the same rights thereunder as You had under the Policy immediately before the due date of the defaulted premium, subject to any provisions in connection with the reinstatement. Any premium accepted in connection with a reinstatement shall be applied to a period for which premium has not been previously paid, but not to any period more than 60 days prior to the date of reinstatement.

This rider is part of this Policy. Except as stated in this rider, nothing contained in this rider changes or affects any other terms of this Policy.

Dated at _____ This _____ Day of _____ , _____

HILTON WATERFRONT BEACH RESORT
Full or Corporate Name of Policyholder

Witness BY: _____
Signature and Title



Harris Oliner, Senior Vice President,
Corporate Secretary



Michael Prestileo,
Senior Vice President

Options A and B

ATTACHED TO AND MADE PART OF GROUP INSURANCE POLICY NO. G -00429264-

issued by

The Guardian Life Insurance Company of America

(herein called the Insurance Company)

to

HILTON WATERFRONT BEACH RESORT

(herein called the Policyholder)

This Rider amends this Policy by replacing the Incontestability provision with the Time Limit on Certain Defenses provision as shown below and is effective on its issue date.

Time Limit On Certain Defenses

After this Policy has been in force for a period of two years, no statements of the Policyholder contained in the application, and no statement relating to insurability made by any Employee eligible for coverage under the Policy shall be used to deny a claim or in contesting the validity of the insurance with respect to which such statement was made after the insurance has been in force prior to the contest for a period of two years during the lifetime of the person with respect to whom any such statement was made.

In the event a Covered Employee's insurance is rescinded due to a fraudulent statement made in his or her application, We will refund premiums paid for the periods such insurance is void. The premium paid by the Covered Employee will be sent to his or her last known address on file with You or Us. If You pay all or part of the cost of a Covered Employee's insurance Your part of the premium will be paid to You.

This rider is part of this Policy. Except as stated in this rider, nothing contained in this rider changes or affects any other terms of this Policy.

Dated at _____ This _____ Day of _____ , _____

HILTON WATERFRONT BEACH RESORT

Full or Corporate Name of Policyholder

Witness BY: _____
Signature and Title



Harris Oliner, Senior Vice President,
Corporate Secretary



Michael Prestileo,
Senior Vice President

Options A and B

ATTACHED TO AND MADE PART OF GROUP INSURANCE POLICY NO. G -00429264-

issued by

THE GUARDIAN LIFE INSURANCE COMPANY OF AMERICA

(herein called Guardian)

to

HILTON WATERFRONT BEACH RESORT

(herein called the Policyholder)

This Rider amends the Policy as follows and is effective on its issue date:

- The "Non-Participating - No Dividends Payable" notice on the Policy face page is replaced with "Dividends Apportioned Annually, if Payable".
- The Dividends provision is added or replaced in its entirety within the General Provisions as shown below.

Dividends

The portion, if any, of the divisible surplus of Guardian allocable to this Policy at each Policy Anniversary will be determined annually by the Board of Directors of Guardian and will be credited to this Policy as a dividend on such anniversary, provided this Policy is continued in force by the payment of all premiums to such anniversary.

Any dividend under this Policy will be paid to the Policyholder in cash, or at the option of the Policyholder it may be applied to the reduction of the premiums then due.

In the event that the Employees are contributing toward the cost of the coverage under any group policy issued to the Policyholder and the aggregate dividends under this Policy and any other group policy or policies issued to the Policyholder are in excess of the Policyholder's share of the aggregate cost, such excess will be applied by the Policyholder for the sole benefit of the Employees.

Finally, please note that it is not expected that any dividends will be payable under this Policy.

This Rider is part of this Policy. Except as stated in this Rider, nothing contained in this Rider changes or affects any other terms of this Policy.

Dated at Spokane, WA This 18th Day of February, 2021



Harris Oliner, Senior Vice President,
Corporate Secretary



Michael Prestileo,
Senior Vice President

P070.0043-R

The Guardian Life Insurance Company of America

A Mutual Company - Incorporated 1860 by the State of New York
10 Hudson Yards, New York, New York 10001

GROUP INSURANCE POLICY
Long Term Disability Income Coverage

POLICYHOLDER: HILTON WATERFRONT BEACH RESORT

GROUP POLICY NUMBER	DELIVERED IN	POLICY DATE
G-00429264	California	September 1, 2007

POLICY ANNIVERSARIES: September 1st of each year, beginning in 2008

GUARDIAN AGREES to pay benefits in accordance with, and subject to, the terms of this Policy. This promise is based on the Policyholder's application and payment of the required premiums.

This Policy is delivered in the jurisdiction shown above and is governed by its laws.

This Policy takes effect on the Policy Date shown above.

IN WITNESS OF WHICH, GUARDIAN has caused this Policy to be executed as of September 30, 2019 which is its date of issue.

The Guardian Life Insurance Company of America



Michael Prestileo, Senior Vice President

Non-Participating - No Dividends Payable

Please read this Policy carefully.

P030.0128-R

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GENERAL PROVISIONS

Entire Contract; Changes

This Policy, the application of the Policyholder and the individual applications, if any, of the individuals insured shall constitute the entire contract between the parties, and any statements made by the Policyholder, or by the individuals insured shall, in the absence of fraud, be deemed representations and not warranties. No such statement shall be used in defense to a claim under the policy, unless it is contained in a written application.

No change in this policy shall be valid unless approved by an executive officer of Guardian and evidenced by endorsement hereon, or by amendment hereto signed by the Policyholder and by an executive officer of Guardian. No agent has authority to change this policy or waive any of its provisions.

Time Limit On Certain Defenses

After this Policy has been in force for a period of three years, no statements of the Policyholder contained in the application, and no statement relating to insurability made by any Employee eligible for coverage under the Policy shall be used to deny a claim or in contesting the validity of the insurance with respect to which such statement was made after the insurance has been in force prior to the contest for a period of three years during the lifetime of the person with respect to whom any such statement was made.

No claim for loss incurred or disability commencing after three years from the effective date of the insurance coverage with respect to which the claim is made shall be reduced or denied on the ground that a disease or physical condition, not excluded from coverage by name or specific description effective on the date of loss, had existed prior to the effective date of the coverage with respect to which the claim is made.

In the event a Covered Employee's insurance is rescinded due to a fraudulent statement made in his or her application, We will refund premiums paid for the periods such insurance is void. The premium paid by the Covered Employee will be sent to his or her last known address on file with You or Us. If You pay all or part of the cost of a Covered Employee's insurance Your part of the premium will be paid to You.

Grace Period

A grace period of 31 days will be granted for the payment of premiums accruing after the first premium, during which grace period the Policy shall continue in force, but the Policyholder shall be liable to Us for the payment of the premium accruing for the period the Policy continues in force. If any premium with respect to the Employees of any Participating Employer is not paid before the end of the grace period, this Policy ends with respect to all Employees of such Participating Employer at the end of the grace period. If You give Us advance written notice of an earlier termination date during the grace period, this Policy will end as of such earlier date.

If this Policy ends during or at the end of the grace period, You will still owe Us premium for all the time this Policy was in force during the grace period.

This Policy ends on any date when a coverage under this Policy ends and, as a result, no benefits remain in effect under this Policy.

Notice Of Claim

Written notice of claim must be given to the insurer within 20 days after the occurrence or commencement of any loss covered by the policy, or as soon thereafter as is reasonably possible.

Claims Forms

Upon receipt of a written notice of claim, We will furnish to the claimant the forms for filing proofs of loss. If such forms are not furnished within 15 days after the giving of such notice the claimant shall be deemed to have complied with the requirements of this Policy as to proof of loss upon submitting, within the time fixed in the Policy for filing proofs of loss, written proof covering the occurrence, the character and the extent of the loss for which claim is made.

Proof of Loss

Written proof of loss must be furnished to Us within 90 days after the date of such loss. Failure to furnish such proof within the time required shall not invalidate nor reduce any claim if it was not reasonably possible to give proof within such time, provided such proof is furnished as soon as reasonably possible and in no event, except in the absence of legal capacity of the Covered Person, later than one year from the time proof is otherwise required.

Time of Payment Of Claim

Subject to due written proof of loss, all indemnities for loss for which this Policy provides payment will be paid to the Covered Person as they accrue and any balance remaining unpaid at termination of the period of liability will be paid to the Covered Person immediately upon receipt of due written proof.

Legal Actions

No action at law or in equity shall be brought to recover on this Policy prior to the expiration of 60 days after written proof of loss has been furnished in accordance with the requirements of this Policy. No such action shall be brought after the expiration of three years after the time written proof of loss is required to be furnished.

Conformity With State Statutes

Any provision of this policy which, on its effective date, is in conflict with the statutes of the state in which this policy was delivered or issued for delivery is hereby amended to conform to the minimum requirements of such statute.

P030.1898-R

Options A, B and I

Associated Companies

An associated company is a business entity affiliated with You through common ownership of stock or assets.

If You ask Us in writing to include such a company under this Policy, We will treat Employees of that company like Your Employees. We must give Our written approval. Our approval will show the starting date of the company's coverage under this Policy. Each Eligible Employee of that company must still meet all of the terms and conditions of this Policy before he or she will be insured.

You must notify Us in writing when a company ceases to be an associated company. On the date a company ceases to be such a company, this Policy will end for all of that company's Employees, except those covered by You or another associated company as Employees on such date.

P030.0130-R

Options A, B and I

Premiums

Premiums are payable by You as follows:

- The first premium is due on the Policy Date; and
- Later premiums are, during the time this Policy remains in force, due on the the 1st of each month.

Premiums due under this Policy must be paid by You:

- At a Guardian office; or
- To a representative that We have authorized.

The premiums must be paid as shown above, unless by agreement between You and Us, the interval of payment is changed. In that event, adjustment will be made for payment annually, semi-annually, or quarterly.

The premium due under this Policy on each due date will be the sum of the premium charges for the insurance provided under this Policy. The premium charges are based on the rates set forth in the Schedule Of Premium Rates.

We may change such rates:

- On the first day of any Policy month;
- On any date the extent or terms of coverage for You are changed by amendment of this Policy; or
- On any date Our obligation under this Policy with respect to You is changed because of statutory or other regulatory requirements; or
- On any date that a change in federal or state laws, insurance programs or retirement benefits would impact Our Liability.

We must give You 31 days written notice of the rate change. Such change will apply to any premium due on and after the effective date of the change stated in such notice.

Premiums for Employee coverage must be paid solely from funds contributed by the Employer. No contributions toward the premium may be required of any Employee.

P030.0132-R

Options A, B and I

Adjustment Of Premiums Payable Other Than Monthly Or Quarterly

A premium rate may be changed after an annual or semi-annual premium became payable with respect to insurance on and after the date of such change. In that case, the premium will be adjusted by a pro rata change for the rest of the period for which the premium became payable. If the adjustment results in a decrease, the amount of the decrease will be paid to You by Us. If the adjustment results in an increase, the amount of the increase will be considered a premium due on the date of the rate change. This Policy's grace period will apply to any such premium due.

P030.0133-R

Options A, B and I

Term of Policy - Renewal Privilege

This Policy is issued for a term of one year from the Policy Date shown on the face page. All policy years and policy months will be calculated from the Policy Date. All periods of insurance will begin and end at 12:01 A.M. Standard Time at Your place of business.

If this Policy provides coverage on a non-contributory basis, all of the Employees eligible for such insurance must be enrolled.

You may renew this Policy for a further term of one year on the first and each subsequent Policy Anniversary. All renewals are subject to the payment of premiums then due, computed as shown in Premiums section of this Policy.

We have the right to decline to renew this Policy on any Policy Anniversary or premium due date, if, on that date:

- Less than 10 Employees are insured; or
- With respect to non-contributory insurance, all of those Employees eligible are not insured; or
- With respect to contributory insurance, less than 75% of those Employees eligible are insured.

We have the right to decline to renew this Policy on any Policy Anniversary or premium due date, if, on that date the number of Employees is below Our minimum group size requirements.

You may cancel this Policy at any time by giving Us 31 days advance written notice. This notice must be sent to Our Home Office. You will owe Us all unpaid premiums for the period this Policy is in force. We may cancel this Policy by giving You 31 days advance written notice.

P030.0136-R

Amendments

We can amend this Policy at any time, without the consent of the insured Employees or any other person having a beneficial interest in it:

- Upon written request made by You and agreed to by Us;
- On any date Our obligation under this Policy with respect to You is changed because of statutory or other regulatory requirements; or
- On any date on which Our contractual relationship with any vendor supplying services or supplies with respect to this Policy changes.

We must give You 31 days advance written notice of any amendments We make to this Policy.

Any amendments to this Policy will be without prejudice to any claim arising prior to the date of the change.

No person, except by a writing signed by the President, a Vice President or a Secretary of Guardian, has the authority to act for Us to:

- Determine whether any contract, policy or certificate is to be issued;
- Waive or alter any provisions of any contract or policy, or any of Our requirements;
- Bind Us by any statement or promise relating to the contract issued or to be issued; or
- Accept any information or representation which is not in a signed application.

P030.1899-R

Options A, B and I

Clerical Error

Neither clerical error by You or Us in keeping any records on the insurance under this Policy, nor delays in making entries, will invalidate insurance otherwise validly in force or continue insurance otherwise validly terminated. On discovery of such error or delay, an equitable adjustment of premiums will be made.

Premium adjustments involving return of unearned premium to You will be limited to the period of 90 days before the date of Our receipt of satisfactory evidence that such adjustments should be made.

P030.1900-R

Options A, B and I

Certificate

We will issue a Certificate to You for delivery to each insured Employee. It will state the essential features of the insurance to which the employee is entitled and to whom the benefits are payable. In the event this Policy is amended, and such amendment affects the material contained in the certificate, a rider or revised certificate reflecting such amendment will be issued to You for delivery to affected Employees.

P030.0141-R

Options A, B and I

Notice

From time to time We may provide You with notices that are needed due to state or federal requirements. You must deliver copies of these notices to each of Your Employees.

P030.0142-R

Options A, B and I

Claims Of Creditors

Except when prohibited by the laws of the jurisdiction in which this Policy was issued, the insurance and other benefits under this Policy will be exempt from execution, garnishment, attachment, or other legal or equitable process, for the debts or liabilities of the Covered Employees or their beneficiaries.

P030.0143-R

Options A, B and I

Records - Information To Be Furnished

You must keep a record of the insured Employees containing, for each Employee, the essential details of the insurance which apply to him or her. You must periodically forward to Us, on Our forms, such information concerning the Employees in the classes eligible for insurance under this Policy as may reasonably be considered to have a bearing on:

- The administration of the insurance under this Policy; and
- The determination of the premium rates.

For benefits which are based on an Employee's salary, changes in his or her salary must promptly be reported to Us. Your payroll and other such records which have a bearing on the insurance must be furnished to Us at our request at any reasonable time.

P030.0144-R

Options A, B and I

When Active Service Ends

You may not continue an Employee's Long Term Disability Income insurance after his or her active service with You ends.

P030.0149-R

Options A, B and I

Right To Continue Long Term Disability Income Coverage During A Family Leave Of Absence

Important Notice: This section may not apply to Your Policy. The Employee must contact You to find out if You must allow for a family leave of absence under federal law. If You must allow for such leave, this section applies.

If Your Coverage Would End: An Employee's Long Term Disability would normally end because an Employee ceases work due to an approved leave of absence. But, an Employee may continue coverage if the leave has been granted:

- To allow an Employee to care for a seriously injured or ill spouse, child or parent;
- After the birth or adoption of a child;
- Due to an Employee's own serious health condition; or
- Because of a Serious Injury Or Illness arising out of the fact that an Employee's spouse, child, parent or Next Of Kin who is a Covered Service Member 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.

To continue an Employee's coverage, an Employee will be required to pay the same share of the premium as paid before the leave of absence.

When Continuation Ends: Continued coverage will end on the earliest of the following:

- The date an Employee returns to Active Work;
- In the case of a leave granted to an Employee to care for a Covered Service Member, 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 an Employee under this section for all reasons. If an Employee takes 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 the Plan is terminated or an Employee is no longer eligible for coverage under this Policy; or
- The end of the period for which 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:
 - 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
 - Results in the call or order to, or retention on, Active Duty of members of the uniformed services under any provision of law or during a national emergency declared by the President or Congress.
- **Covered Service Member:** 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 is:

- Undergoing medical treatment, recuperation or therapy;
- Otherwise in Outpatient Status; or
- Otherwise on the temporary disability retired list.
- **Next Of Kin:** This term means an Employee's nearest blood relative.
- **Outpatient Status:** This term means, in the case of a Covered Service Member, that he or she is assigned to:
 - A military medical treatment facility as an Outpatient; or
 - 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 Service Member, 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.

P030.0150-R

Definitions

The terms shown below have the meanings shown below.

Active Work: These terms mean the Employee is able to perform, and is performing, all of the regular duties of his or her work for the Employer at:

- One of the Employer's usual places of business;
- Some place where the Employer's business requires the Employee to travel; or
- Any other place the Employee and the Employer have agreed on for the Employee's work.

Covered Employee: This term means an Employee insured by this Policy.

Employee: This term means a person who works for You at Your place of business and whose incomes is reported to the United States Internal Revenue Services, and/or a state for tax purposes. Partners and proprietors will also be treated as Employees if the eligibility requirements are met.

Employer: This term means the entity that purchased the plan.

Guardian, Our, Us and We: These terms mean The Guardian Life Insurance Company of America.

Policy: This term means the Guardian group Long Term Disability Income insurance Policy purchased by You.

You and Your: As used in this Policy, these terms mean the Policyholder who purchased this group Policy. As used in the Certificate(s) attached to this Policy, these terms mean an insured Employee.

P030.0151-R

SCHEDULE OF OPTION PACKAGES

This Policy's classes are show below. The benefit option packages which are available to Covered Employees who are members of each class are also shown below.

Class Description

- Class 0001** GENERAL MANAGERS, CONTROLLERS, DIRECTORS, ASST. DIRECTORS, EXECUTIVE CHEF, EXECUTIVE HOUSEKEEPER, EXECUTIVE STEWARD, MANAGERS, ASST MANAGERS, PASTRY CHEF, BANQUET CHEF, SOUS CHEF, ASST EXECUTIVE HOUSEKEEPER, ASST CONTROLLER AND ACTIVITIES DIRECTOR
- Class 0003** ROBERT MAYER EMPLOYEES (CFO, CHAIRMAN, VICE CHAIRMAN, PRESIDENT, VICE PRESIDENT, CONTROLLER, EXECUTIVE ASSISTANT AND ACCOUNTING CLERK)

P030.0153-R

Benefit Option Packages

Employees may choose from the benefit packages available to members of their class. Coverage for a benefit will not become effective until the Covered Employee satisfies the eligibility requirements. Coverage for a benefit that requires payment from the Employee will not become effective until the Employee:

- Elects it in a form acceptable by Us; and
- Agrees to make any required payments.

The benefits are described in the applicable Certificate(s) attached to and made part of this Policy.

Members of Class 0001 may choose from benefit option packages A and B.

- Long Term Disability

P030.0155-R

Benefit Option Packages

Employees may choose from the benefit packages available to members of their class. Coverage for a benefit will not become effective until the Covered Employee satisfies the eligibility requirements. Coverage for a benefit that requires payment from the Employee will not become effective until the Employee:

- Elects it in a form acceptable by Us; and
- Agrees to make any required payments.

The benefits are described in the applicable Certificate(s) attached to and made part of this Policy.

Members of Class 0003 may choose from benefit option packages I.

- Long Term Disability

P030.0155-R

ATTACHED CERTIFICATES

The Certificate(s) shown below are added to and made part of this Policy.

Class 0001 Option(s) A and B

The Certificate(s) describe the Long Term Disability Income Coverage benefits for which each class of Employees is eligible.

Each Employee's eligibility, effective date of insurance, plan of insurance, and termination date is determined by the option he or she has elected on his or her enrollment form, or other suitable document approved by Guardian, and the provisions of the Certificate that apply to that option.

Certificate(s) will include any changes made by amendments to this Policy

P030.0158-R

ATTACHED CERTIFICATES

The Certificate(s) shown below are added to and made part of this Policy.

Class 0003 Option(s) I

The Certificate(s) describe the Long Term Disability Income Coverage benefits for which each class of Employees is eligible.

Each Employee's eligibility, effective date of insurance, plan of insurance, and termination date is determined by the option he or she has elected on his or her enrollment form, or other suitable document approved by Guardian, and the provisions of the Certificate that apply to that option.

Certificate(s) will include any changes made by amendments to this Policy

P030.0158-R

Options A, B and I

The Guardian Life Insurance Company of America

Schedule Of Premium Rates

Long Term Disability Income Insurance

Effective: September 1, 2007, this Schedule of Premium Rates replaces any previously issued Schedule of Premium Rates for Long Term Disability.

The monthly premium rates, in U.S. dollars, for the benefits provided under the Policy are listed below. Guardian has the right to change any premium rate(s) set forth below at the times and in the manner set forth in the Premiums section of the Policy.

P030.0160-R

Options A, B and I Classes 0001 and 0003

The following set of rates represents the rate per \$100.00 of monthly covered payroll volume.

Rate per Employee

\$ 0.23

P030.0162-R

Options A, B and I

ATTACHED TO AND MADE PART OF GROUP INSURANCE POLICY NO. G -00429264-

issued by

The Guardian Life Insurance Company of America

(herein called the Insurance Company)

to

HILTON WATERFRONT BEACH RESORT

(herein called the Policyholder)

This Rider amends this Policy by adding the Reinstatement of Policy provision as shown below and is effective on its issue date.

Reinstatement Of Policy

If any renewal premium with respect to the Employee's of any Participating Employer is not paid within the time granted for payment, a subsequent acceptance of premium by Us or by any agent duly authorized by Us to accept such premium, without requiring in connection therewith an application for reinstatement, shall reinstate the Policy; provided, however, that if We or such agent requires an application for reinstatement and issues a conditional receipt for the premium tendered, the Policy will be reinstated upon approval of such application by Us or, lacking such approval, upon the forty-fifth day following the date of such conditional receipt unless We previously notified You in writing of Our disapproval of such application.

The reinstated Policy shall cover claims for Covered Services that occur after the reinstatement date. You shall have the same rights thereunder as You had under the Policy immediately before the due date of the defaulted premium, subject to any provisions in connection with the reinstatement. Any premium accepted in connection with a reinstatement shall be applied to a period for which premium has not been previously paid, but not to any period more than 60 days prior to the date of reinstatement.

This rider is part of this Policy. Except as stated in this rider, nothing contained in this rider changes or affects any other terms of this Policy.

Dated at _____ This _____ Day of _____ , _____

HILTON WATERFRONT BEACH RESORT
Full or Corporate Name of Policyholder

Witness BY: _____
Signature and Title



Harris Oliner, Senior Vice President,
Corporate Secretary



Michael Prestileo,
Senior Vice President

Options A, B and I

ATTACHED TO AND MADE PART OF GROUP INSURANCE POLICY NO. G -00429264-

issued by

The Guardian Life Insurance Company of America

(herein called the Insurance Company)

to

HILTON WATERFRONT BEACH RESORT

(herein called the Policyholder)

This Rider amends this Policy by replacing the Incontestability provision with the Time Limit on Certain Defenses provision as shown below and is effective on its issue date.

Time Limit On Certain Defenses

After this Policy has been in force for a period of two years, no statements of the Policyholder contained in the application, and no statement relating to insurability made by any Employee eligible for coverage under the Policy shall be used to deny a claim or in contesting the validity of the insurance with respect to which such statement was made after the insurance has been in force prior to the contest for a period of two years during the lifetime of the person with respect to whom any such statement was made.

No claim for loss incurred or disability commencing after two years from the effective date of the insurance coverage with respect to which the claim is made shall be reduced or denied on the ground that a disease or physical condition, not excluded from coverage by name or specific description effective on the date of loss, had existed prior to the effective date of the coverage with respect to which the claim is made.

A Participating Employer's insurance under this Policy will be incontestable after two years from the Participating Employer's Effective Date of coverage under this Policy, except for non-payment of premiums.

In the event a Covered Employee's insurance is rescinded due to a fraudulent statement made in his or her application, We will refund premiums paid for the periods such insurance is void. The premium paid by the Covered Employee will be sent to his or her last known address on file with You or Us. If You pay all or part of the cost of a Covered Employee's insurance Your part of the premium will be paid to You.

This rider is part of this Policy. Except as stated in this rider, nothing contained in this rider changes or affects any other terms of this Policy.

Dated at _____ This _____ Day of _____ , _____

HILTON WATERFRONT BEACH RESORT
Full or Corporate Name of Policyholder

Witness BY: _____
Signature and Title



Harris Oliner, Senior Vice President,
Corporate Secretary



Michael Prestileo,
Senior Vice President

GP-1-A-TLCD-19-CA

P030.2469-R

Options A, B and I

ATTACHED TO AND MADE PART OF GROUP INSURANCE POLICY NO. G -00429264-

issued by

THE GUARDIAN LIFE INSURANCE COMPANY OF AMERICA

(herein called Guardian)

to

HILTON WATERFRONT BEACH RESORT

(herein called the Policyholder)

This Rider amends the Policy as follows and is effective on its issue date:

- The "Non-Participating - No Dividends Payable" notice on the Policy face page is replaced with "Dividends Apportioned Annually, if Payable".
- The Dividends provision is added or replaced in its entirety within the General Provisions as shown below.

Dividends

The portion, if any, of the divisible surplus of Guardian allocable to this Policy at each Policy Anniversary will be determined annually by the Board of Directors of Guardian and will be credited to this Policy as a dividend on such anniversary, provided this Policy is continued in force by the payment of all premiums to such anniversary.

Any dividend under this Policy will be paid to the Policyholder in cash, or at the option of the Policyholder it may be applied to the reduction of the premiums then due.

In the event that the Employees are contributing toward the cost of the coverage under any group policy issued to the Policyholder and the aggregate dividends under this Policy and any other group policy or policies issued to the Policyholder are in excess of the Policyholder's share of the aggregate cost, such excess will be applied by the Policyholder for the sole benefit of the Employees.

Finally, please note that it is not expected that any dividends will be payable under this Policy.

This Rider is part of this Policy. Except as stated in this Rider, nothing contained in this Rider changes or affects any other terms of this Policy.

Dated at Spokane, WA This 18th Day of February, 2021



Harris Oliner, Senior Vice President,
Corporate Secretary



Michael Prestileo,
Senior Vice President

P070.0043-R

Managed Dental Care of California

605 E. Holland Avenue, Suite 300
Spokane, WA 99218
1-800-273-3330

**GROUP BENEFIT POLICY
MANAGED DENTAL CARE PLAN
Group Contract For Prepaid Dental Services**

Managed Dental Care (MDC) of California is a California corporation, licensed as a Knox-Keene Health Care Service Plan under applicable California law whose primary purpose is to operate a dental care service plan.

POLICYHOLDER: HILTON WATERFRONT BEACH RESORT

GROUP POLICY NUMBER:

DELIVERED IN:

**POLICY EFFECTIVE
DATE:**

G-00429264

California

September 1, 2007

POLICY ANNIVERSARIES: September 1st of each year, beginning in 2008

**PLEASE READ THIS ENTIRE POLICY CAREFULLY. IT DESCRIBES THE
BENEFITS AVAILABLE UNDER THE GROUP POLICY. IT IS YOUR
RESPONSIBILITY TO UNDERSTAND WHAT IT COVERS, LIMITS AND
EXCLUDES.**

MANAGED DENTAL CARE OF CALIFORNIA AGREES to provide benefits in accordance with, and subject to, the terms of this Policy. This promise is based on the Policyholder's application and payment of the required premiums.

This Policy is delivered in the jurisdiction shown above and is governed by its laws.

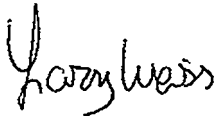
This Policy takes effect on the Policy Effective Date shown above.

IN WITNESS OF WHICH, Managed Dental Care of California has caused this Policy to be executed as of June 9, 2021 which is its date of issue.

Managed Dental Care of California



Eric Krohne, President



Larry Weiss, Assistant Vice President
and Controller

Please read this Policy carefully.

P060.0216

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Options B and F

GENERAL PROVISIONS

P060.0005

Options B and F

Associated Companies

An associated company is a business entity affiliated with You through common ownership of stock or assets.

If You ask Us in writing to include such a company under this Policy, We will treat Employees of that company like Your Employees. We must give Our written approval. Our approval will show the starting date of the company's coverage under this Policy. Each eligible Employee of that company must still meet all of the terms and conditions of this Policy before he or she will be covered.

You must notify Us in writing when a company ceases to be an associated company. On the date a company ceases to be such a company, this Policy will end for all of that company's Employees, except those covered by You or another associated company as Employees on such date.

P060.0009

Options B and F

Premiums

Premiums are payable by You as follows:

- The first premium is due on the Policy Effective Date; and
- Later premiums are, during the time this Policy remains in force, due the 1st of each month.

Premiums due under this Policy must be paid by You:

- At Our office; or
- To a representative that We have authorized.

The premiums must be paid as shown above, unless by agreement between You and Us, the interval of payment is changed. In that event, adjustment will be made for payment annually, semi-annually, or quarterly.

The premium due under this Policy on each due date will be the sum of the premium charges for the coverage provided under this Policy.

We may change such rates:

- On the first day of any Policy month;
- On any date the extent or terms of coverage for You are changed by amendment of this Policy; or
- On any date Our obligation under this Policy with respect to You is changed because of statutory or other regulatory requirements; or
- On any date that a change in federal or state laws, coverage programs or retirement benefits would impact Our liability.

We must give You 31 days written notice of the rate change. Such change will apply to any premium due on and after the effective date of the change stated in such notice.

P060.0124

Options B and F

Adjustment Of Premiums Payable Other Than Monthly Or Quarterly

A premium rate may be changed after an annual or semi-annual premium became payable with respect to coverage on and after the date of such change. In that case, the premium will be adjusted by a pro rata change for the rest of the period for which the premium became payable. If the adjustment results in a decrease, the amount of the decrease will be paid to You by Us. If the adjustment results in an increase, the amount of the increase will be considered a premium due on the date of the rate change. This Policy's grace period will apply to any such premium due.

P060.0015

Options B and F

Term of Policy - Renewal Privilege

This Policy is issued for a term of one year from the Policy Date shown on face page. All Policy years and Policy months will be calculated from the Policy Date. All periods of coverage will begin and end at 12:01 A.M. Standard Time at Your place of business.

You may renew this Policy for a further term of one year on the first and each subsequent Policy Anniversary. All renewals are subject to the payment of premiums then due, computed as shown in the Premiums section of this Policy.

We have the right to decline to renew this Policy on any Policy Anniversary or premium due date, if, on that date:

- Less than two Employees are covered; or
- With respect to non-contributory coverage, all of those Employees eligible are not covered; or
- With respect to contributory coverage, less than 75% of those Employees are eligible.

With respect to dependent coverage, We may decline to renew such coverage on any Policy Anniversary or premium due date, if:

- With respect to non-contributory coverage, all eligible dependents are not enrolled for such coverage; or
- With respect to contributory coverage, less than 75% of those Employees eligible for dependent coverage are covered for such.

Termination of Policy

In the event of cancellation by either Us (except in the case of fraud or deception in the use of services or facilities of MDC or knowingly permitting such fraud or deception by another) or You, We shall within 30 days return to You any pro rata portion of fees paid by You which corresponds to any unexpired period for which payment has been received, together with amounts due on claims, if any, less any amounts due.

Termination by Policyholder

You may cancel your coverage at any time during the grace period outlined below or by giving Us 31 days advance written notice. This notice must be sent to Our office. You will owe Us all unpaid premiums for the period this Policy is in force.

Termination by MDC

We shall have the right to cancel this Policy upon providing written notice to You, which You shall promptly send to all Subscribers, in the following circumstances:

- Termination by MDC for Non-payment of Premium. We may cancel or decline to renew Your coverage for cause if You fail to pay all premiums in accordance with the following terms and conditions:
 - A grace period of 30 days, starting after the last date of paid coverage, will be allowed for outstanding premium payments. We will send You a written notice stating the start and end dates of the grace period.

- If You, or another party acting on Your behalf, makes the necessary premium payment and that payment is received on or before the last day of the grace period, We shall ensure that coverage is not cancelled or not renewed on account of non-payment of such premiums.
- If any premium with respect to the Subscribers of any Participating Employer is not paid before the end of the grace period, this Policy ends with respect to all Subscribers of such Participating Employer immediately following the end of the grace period. We shall send You a written notice of end of coverage no later than five (5) business days following the last day of paid coverage. You shall promptly send said end of coverage notice to each Member.
- If You give Us advance written notice of an earlier termination date during the grace period, this Policy will end as of such earlier date.
- If this Policy ends during or at the end of the grace period, You will still owe Us premium for all the time the Policy was in force during the grace period.
- Termination by MDC for Intentional Misrepresentation of Material Fact by Policyholder. We may cancel or decline to renew this Policy if We demonstrate an intentional misrepresentation of a material fact by You in obtaining this Policy. We shall provide you with 30 days' advance written notice of cancellation, which you shall promptly send to each Member.
- Termination by MDC for Violation of Material Provision Relating to Employer Contributions or Group Participation Rates. We may cancel or decline to renew this Policy if You violate a material provision of this Policy relating to employer contributions or group participation rates as outlined above. We shall provide you with 30 days' advance written notice of cancellation, which you shall promptly send to each Member.
- Termination by MDC Due to Cessation of Services in the State or Withdrawal of Policy from the Market. Subject to providing 180 days' advance written notice to You, which You shall promptly send to each Member, and the Director of the Department of Managed Health Care, We may discontinue or terminate this Policy if the cancellation or nonrenewal is due to MDC ceasing to provide or arrange for the provision of health benefits for new plan contracts in the individual or group market in this State pursuant to Health and Safety Code section 1365(a)(5). Subject to providing 90 days' advance written notice to You, which You shall promptly send to each Member, and the Director of the Department of Managed Health Care, We may discontinue or terminate this Policy if the MDC withdraws the health benefit plan from the market pursuant to Health and Safety Code section 1365(a)(6).

If You believe that Your coverage has been or will be improperly canceled, rescinded, or not renewed, You may file request a review by the Department of Managed Health Care, within 180 days of receipt of the notice of cancellation, pursuant to Section 1368 of the Health and Safety Code. Such request for review may be submitted directly to the Department of Managed Health Care by mail to the attention of the Help Center, Department of Managed Health Care, 980 Ninth Street, Suite 500, Sacramento, CA 95814- 2725; by phone at 1-888-466-2219/TDD 1-877-688-9891; by fax at 1-916-255- 5241; or online at www.healthhelp.ca.gov. Such review shall be in accordance with Sections 1368 and 1365(b) of the Health and Safety Code.

P060.0222

Options B and F

The Contract

The entire contract between You and Us consists of:

- This Policy;
- The Evidence of Coverage(s) which describe(s) the coverage for which Members are covered;
- Any attached riders, schedule of benefits or amendments; and
- Your application.

In the event of a conflict, the Policy shall reign.

We can amend this Policy at any time, without the consent of the covered Employees or any other person having a beneficial interest in it:

- Upon written request made by You and agreed to by Us;
- On any date Our obligation under this Policy with respect to You is changed because of statutory or other regulatory requirements; or
- On any date on which Our contractual relationship with any vendor supplying services or supplies with respect to this Policy changes.

We must give You 31 days advance written notice of any amendments We make to this Policy unless a shorter timeframe is required by law or if both parties agree to waive the 31 days advance notice requirement.

Any amendments to this Policy will be without prejudice to any claim arising prior to the date of the change.

No person, except by a writing signed by Our President, a Vice President or a Secretary has the authority to act for Us to:

- Determine whether any contract, Policy or Evidence of Coverage is to be issued;
- Waive or alter any provisions of any contract or Policy, or any of Our requirements;
- Bind Us by any statement or promise relating to the contract issued or to be issued; or
- Accept any information or representation which is not in a signed application.

P060.0226

Options B and F

Public Policy Committee

We maintain a Public Policy Committee composed of at least three members, one Contracted Dentist and one member of Our Board of Directors. Employee's may call Us for more information about the Committee.

P060.0184

Options B and F

Clerical Error - Misstatements Of Age

Neither clerical error by You or Us in keeping any records on the coverage under this Policy, nor delays in making entries, will invalidate coverage otherwise validly in force or continue coverage otherwise validly terminated. On discovery of such error or delay, an equitable adjustment of premiums will be made.

Premium adjustments involving return of unearned premium to You will be limited to the period of 90 days before the date of Our receipt of satisfactory evidence that such adjustments should be made.

The age of the Employee, or any other relevant facts, may be found to have been misstated. If premiums are affected due to this, an equitable adjustment of premiums will be made. If such misstatement involves whether or not a coverage risk would have been accepted by Us, or the amount of coverage, the true facts will be used to determine whether coverage is in force under, and subject to, the terms of this Policy, and in what amount.

Incontestability Statements Made By You

No statement contained in any application form for this Policy will void the coverage under this Policy after it has been in force for two years from its Policy Effective Date.

Within the first two years of issuance of this Policy, We may rescind this Policy or use in defense of a claim any fraudulent statement and/or intentional misrepresentation of material fact made in Your or a Members signed application or a Participation Agreement signed by a Participating Employer.

All statements will be deemed representations and not warranties.

In the event a Members coverage is rescinded due to a fraudulent statement made in his or her application, We will refund premiums paid for the periods such coverage is void. The premium paid by the Member will be sent to his or her last known address on file with You or Us. If You pay all or part of the cost of a Members coverage Your part of the premium will be paid to You.

P060.0232

Options B and F

Assignment

The Employee's Evidence of Coverage and his or her right to benefits under this Policy are not assignable. But, the Employee may direct Us, in writing, to pay dental benefits to the recognized provider who provided the covered service for which benefits became payable. We may honor such request at Our option. The Employee may not assign his or her right to take legal action under this Policy to such provider. And, We assume no responsibility as to the validity or effect of any such direction.

P060.0187

Options B and F

Employee's Combined Evidence of Coverage and Disclosure Form

We will issue to You, for delivery to each Employee covered under this Policy, a Combined Evidence of Coverage and Disclosure Form. The Form will state the essential features of the coverage to which the Employee is entitled and to whom the benefits are payable. The Form does not constitute as part of this Policy and will in no way modify any of the terms and conditions set forth in this Policy.

In the event this Policy is amended, and such amendment affects the material contained in the Combined Evidence of Coverage and Disclosure Form, a rider or revised Form reflecting such amendment will be issued to You for delivery to affected Employee.

Notice

From time to time We may provide You with notices that are needed due to state or federal requirements. You must deliver copies of these notices to each of Your Employees.

Any cancellation of this Policy by MDC will be in writing, and Policyholder shall, upon receipt of such cancellation, promptly mail to each Subscriber a legible true copy of said notice, including a clear statement of any applicable individual conversion rights. Unless otherwise required by law or as provided in the notice, cancellation will be effective thirty (30) days from the date the notice is mailed to the Policyholder.

Conformity With Statutes

This Policy is subject to the requirements of Chapter 2.2 of Division 2 of the Health and Safety Code (the Act) and Chapter 2 of Title 28 of the California Code of Regulations (the Regulations), and any provisions required to be in this Policy by either of the above will bind Us whether or not provided in this Policy.

In the event that the Act or Regulations under the Act set forth any requirement which is not included in this Policy or is contrary to this Policy, it will supersede the applicable provisions of this Policy and will be binding unto the parties to this Policy.

Claims Of Creditors

Except when prohibited by the laws of the jurisdiction in which this Policy was issued, the coverage and other benefits under this Policy will be exempt from execution, garnishment, attachment, or other legal or equitable process, for the debts or liabilities of the Members or their beneficiaries.

Records - Information To Be Furnished

You must keep a record of the insured Employees containing, for each Employee, the essential details of the coverage which apply to him or her. You must periodically forward to Us, on Our forms, such information concerning the Employees in the classes eligible for coverage under this Policy as may reasonably be considered to have a bearing on:

- The administration of the coverage under this Policy; and
- The determination of the premium rates.

For benefits which are based on the Employee's salary, changes in his or her salary must promptly be reported to Us. Your payroll and other such records which have a bearing on the coverage must be furnished to Us at Our request at any reasonable time.

P060.0234

Options B and F

Examination

We have the right to have a doctor of Our choice examine the person for whom a claim is being made under this Policy as often as We feel necessary. We will pay for all such examinations.

P060.0035

Options B and F

Conformity With Law

If the provisions of this Policy do not conform to the requirements of any state or federal law or regulation that applies, any such provision is changed to conform to the requirements of that law or regulation.

P060.0036

Options B and F

When Active Work Ends

If the Employee's Active Work ends or he or she is disabled, You may continue his or her Dental Coverage during a temporary layoff, leave of absence, vacation, military leave, retirement. Eligibility for benefits will be governed by all of the terms described in the Evidence of Coverage under Conditions of Eligibility For Dental Coverage.

If You continue the Employee's coverage as set forth above, it must be on a policy which prevents individual selection.

Any such continuation is subject to the payment of premiums and to all of the other terms and conditions of this Policy.

The amount of the Employee's coverage during any such continuation will be the coverage amount in force on his or her last day of Active Work, subject to any reductions that would have otherwise applied if he or she had remained an active Employee.

P060.0192

Options B and F

Right To Continue Dental Insurance Coverage During A Family Leave Of Absence

Important Notice: This section may not apply to Your Policy. The Employee must contact You to find out if You must allow for a family leave of absence under federal law. If You must allow for such leave, this section applies.

If the Employee's Coverage Would End: Coverage would normally end because the Employee ceases work due to an approved leave of absence. But, the Employee may continue coverage if the leave has been granted:

- To allow the Employee to care for a seriously injured or ill spouse, child, or parent;
- After the birth or adoption of a child;
- Due to the Employee's own serious health condition; or
- Because of a Serious Injury Or Illness arising out of the fact that the Employee's spouse, child, parent, or Next Of Kin, who is a Covered Service Member 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.

To continue coverage, the Employee will be required to pay the same share of the premium as paid before the leave of absence.

When Continuation Ends: Continued coverage will end on the earliest of the following:

- The date the Employee returns to Active Work.
- In the case of a leave granted to the Employee to care for a Covered Service member, 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 the Employee under this section for all reasons. If the Employee takes 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 the Policy is terminated or the Employee is no longer eligible for coverage under this Policy; or
- 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:
 - 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
 - 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 Service Member:** 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 is:
 - Undergoing medical treatment, recuperation, or therapy;
 - Otherwise in Outpatient Status; or
 - Otherwise on the temporary disability retired list.
- **Next Of Kin:** This term means the Employee's nearest blood relative.
- **Outpatient Status:** This term means, in the case of a Covered Service Member, that he or she is assigned to:
 - A military medical treatment facility as an outpatient; or
 - 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 Service Member, 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.

P060.0040

Options B and F

DEFINITIONS

The terms used in this Policy have the meanings shown below.

P060.0041

Options B and F

Act: This term means the Knox-Keene Health Care Service Plan of 1975 (California Health and Safety Code Sections 1340 et seq).

P060.0194

Options B and F

Active Work: This term means the Employee is able to perform, and is performing, all of the regular duties of his or her work for the Employer at:

- One of the Employer's usual places of business;
- Some place where the Employer's business requires the Employee to travel; or
- Any other place the Employee and the Employer have agreed on for the Employee's work.

P060.0043

Options B and F

Code: This term means the California Health and Safety Code.

P060.0195

Options B and F

Combined Evidence of Coverage and Disclosure Form: This term means this booklet issued to you, which summarizes the essential terms of this Policy.

P060.0196

Options B and F

Employee: This term means a person who works for You at Your place of business and whose income is reported to the United States Internal Revenue Service, and/or a state for tax purposes. Partners and proprietors will also be treated as Employees if the eligibility requirements are met.

P060.0119

Options B and F

Employer: This term means the entity that purchased the Policy.

P060.0120

Options B and F

Evidence of Coverage: This term means any certificate, agreement, contract, brochure, or letter of entitlement issued to a Employee or Member setting forth the coverage to which they are entitled.

P060.0198

Options B and F

MDC, Our, Us and We: These terms mean Managed Dental Care of California.

P060.0199

Options B and F

Member: This term means the Employee or dependent covered by this Policy.

P060.0074

Options B and F

Policy: This term means the Managed Dental Care Group Dental Coverage Policy purchased by You.

P060.0049

Options B and F

You and Your: As used in this Policy, these terms mean the Policyholder who purchased this group Policy. As used in the Evidence of Coverage(s) attached to this Policy, these terms mean a covered Employee.

P060.0201

SCHEDULE OF OPTION PACKAGES

This Policy's classes are shown below. The benefit option packages which are available to Employees who are members of each class are also shown below.

Class Description

Class 0001 EXEMPT MANAGERS/DIRECTORS

Class 0002 ALL OTHER ELIGIBLE EMPLOYEES

P060.0056

Benefit Option Packages

Employees may choose from the benefit packages available to members of their class. Coverage for a benefit will not become effective until the Employee satisfies the eligibility requirements. Coverage for a benefit that requires payment from the Employee will not become effective until the Employee:

- Elects it in a form acceptable by Us; and
- Agrees to make any required payments.

The benefits are described in the applicable Evidence of Coverage(s) attached to and made a part of this Policy.

P060.0203

Members of Class 0001 may choose from benefits in option package(s) B.

P060.0058

Members of Class 0002 may choose from benefits in option package(s) F.

P060.0058

Option B Group Dental Coverage

P060.0060

Option F Group Dental Coverage

P060.0060

ATTACHED EVIDENCE OF COVERAGES

The Evidence of Coverage(s) shown below are added to and made part of this Policy.

P060.0204

Class 0001 Option(s) B

P060.0062

Class 0002 Option(s) F

P060.0062

The Evidence of Coverage(s) describe the Group Dental Coverage benefits for which each class of Employees is eligible.

Each Employee's eligibility, effective date of coverage, plan of coverage and termination date is determined by the option he or she has elected on his or her enrollment form, or other suitable document approved by Us and the provisions of the Evidence of Coverage that apply to that option.

Evidence of Coverage(s) will include any changes made by amendments to this Policy.

P060.0206

Options B and F

The Guardian Life Insurance Company of America
Schedule Of Premium Rates
Group Dental Coverage

P060.0064

The monthly premium rates, in U.S. dollars, for the benefits provided under the Policy are listed below. We have the right to change any premium rate(s) set forth below at the times and in the manner set forth in the Premiums section of the Policy.

P060.0065

Employee Dental Coverage

Options B and F Classes 0001 and 0002

Rate per Employee	per Employee and One Insured Dependent	per Employee and Two Insured Dependents	per Employee and Three or More Insured Dependents
\$ 14.11	\$ 25.91	\$ 38.65	\$ 38.65

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P060.0069

END OF POLICY DOCUMENT

