



YOUR GROUP INSURANCE PLAN BENEFITS

HOPE COLLEGE

CLASS 0001

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.state.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 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 July 1, 2026. 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.

Policyholder: HOPE COLLEGE
Group Policy Number: 00096812

The Guardian Life Insurance Company of America



Matthew Darula, Head of Product, Strategy
and Offerings

B400.3114

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GENERAL PROVISIONS

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 acceptable manner and mode, such as 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.

Limitation Of Authority

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

- Determine whether any contract, Policy or Certificate is to be issued;
- Waive or alter any contract or Policy provisions, 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.

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

Incontestability

This Certificate 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 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.

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.

B400.3116

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

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 Your Eligibility Date. 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.

B400.3129

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

The Delayed Eligibility Date provision will not apply if You are covered under the Transfer Business Exception as stated below.

Transfer Business Exception

If due to sickness or injury You are not Actively at Work and not working the minimum number of hours of an Employee in Your eligible class, on Your scheduled Eligibility Date, You will be insured for this Group Term Life insurance if:

- You were insured under the Employer's prior insurer's group term life plan at the time the prior insurer's group term life plan ended and the group term life plan became effective with Us, with no break in group coverage;
- You were a member of an eligible class under the Employer's prior insurer's group term life plan and are eligible under this Certificate;

- Premiums for You were paid up to date for the Employer's prior insurer's group term life plan and this Certificate;
- Premiums are not currently being waived under the Waiver of Premium Rider, or You were not eligible, under the terms of the Employer's prior insurer's group term life plan, to have premiums waived under the Waiver of Premium provision; and
- You are not receiving or eligible to receive benefits under the Employer's prior insurer's group term life plan.

Any Group Term Life benefit payable will be the lesser of:

- The Group Term Life benefit payable under this Certificate; or
- The group term life benefit payable under the Employer's prior insurer's group term life plan had it remained in force; reduced by any amount paid by the prior insurer's group term life plan.

If You are covered under the Exception to When Coverage Starts, You will not be eligible for the Waiver of Premium Benefit provision under this Certificate until such a time You are Actively At Work as defined by this Certificate.

If You meet the conditions stated above, You will remain insured under this provision until the first of the following to occur:

- The date You are fully capable of performing the major duties of Your regular occupation for the Employer, and capable of doing so for the minimum number of hours of an Employee in Your eligible class;
- The date insurance terminates for one of the reasons stated in When Employee Coverage Ends;
- The last day of a period of 12 consecutive months which begins on this Certificate's Effective Date;
- The date You become eligible for the Waiver of Premium Benefit provision under the prior insurer's group life policy; or
- The last day You would have been covered under the prior insurer's group term life plan, had the prior plan not terminated.

B400.3133

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 basic and 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.

B400.3138

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 and;
- dependent children from birth; and dependent children who are enrolled as full-time students at accredited schools, from age 26, until they reach age 26.

B400.3199

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 depend on You for at least 50% of their 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.

B400.3200

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 independent living by reason of a mental, physical, or developmental disability; and
- Is/are primarily 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 a mental, physical, or developmental disability 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 independent living; and
 - 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 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.

B400.3202

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 unable to perform two or more Activities of Daily Living (ADLs).

In that case, We will postpone the Eligibility Date of his or her coverage until the day after the date he or she no longer requires assistance with two or more Activities of Daily Living.

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.

B400.3206

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.

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.

B400.3207

EMPLOYEE TERM LIFE INSURANCE

B400.3211

All Options

Basic Term Life Insurance

If You die while covered for Group Term Life insurance, We will pay Your beneficiary the amount shown in the Schedule Of Benefits.

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.

The Beneficiary You decide who receives this benefit when You die. Your beneficiary designation should be provided in a means acceptable by Us.

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.

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 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.

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.

Unless otherwise specified by You, the assignment shall take effect on the date the notice of assignment is signed by You, subject to any payments made or actions taken by Us prior to receipt of the notice.

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.

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 will 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.

B400.3212

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.

Payment Of Benefits Subject to all of the terms of this Certificate, We will pay this insurance as soon as We receive written Proof of Loss as shown in the Claims Provisions section of this Certificate.

B400.3213

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 at any time, subject to any of this Certificate's Proof Of Insurability requirements. You must notify the Employer of any desired switch.

B400.3215

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. The name of the beneficiary appears in the enrollment or similar form unless changed by You. Your beneficiary designation should be provided in a means acceptable by Us.

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.

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.

B400.3217

CONVERTING THIS EMPLOYEE BASIC AND 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 basic and voluntary life insurance to a permanent life insurance policy.

You can apply to convert up to the full amount of basic and 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 basic and 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 basic and 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 basic and 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 basic and 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 basic and 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.

B400.8584

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.

Payment Of Benefits Subject to all of the terms of this Certificate, We will pay this insurance as soon as We receive written Proof of Loss which is acceptable to Us. This should be sent to Us as soon as possible. We will pay this benefit in a lump sum.

B400.3238

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 at any time, subject to any of this Certificate's Proof Of Insurability requirements. You must notify the Employer of any desired switch.

B400.3244

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.

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.

B400.3495

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:

Authority We have discretionary authority to:

- Interpret the terms of this Certificate; and
- Determine Your eligibility for coverage and benefits under this Certificate.

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 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 14334

Lexington, KY 40512

Payment of Benefits We will pay the Group Term Life insurance benefit as soon as We receive 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 six years from the date of the final benefit determination.

B400.8271

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

Activities Of Daily Living This term means the ability to independently perform the following, with or without equipment or adaptive devices:

- **Bathing:** wash in a tub or shower; or take a sponge bath; and towel dry.
- **Dressing:** put on and take off all clothes; and those medically necessary braces or prosthetic limbs usually worn; and fasten or unfasten them.
- **Toileting:** get to and from and on and off the toilet; to maintain personal hygiene; and care for clothes.
- **Transferring:** move in and out of a chair or bed.
- **Continence:** control bowel and bladder function; or, in the event of incontinence, maintain personal hygiene.
- **Eating:** get food into the body by any means once it has been prepared and made available.

B400.3505

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 basic and voluntary life insurance ends.

B400.3512

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

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 HOPE COLLEGE .

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

Insured Earnings Only Your earnings from the Employer will be included as Insured Earnings.

- **For Partners And S Corporation Shareholders** Insured Earnings means the sum of the amounts listed below:
 - Your compensation as an Employee or S Corporation shareholder, as reported on Your Federal Income Tax Return(s), Form 1040, for the prior calendar year, less the gross total of unadjusted Employee business expenses as included on the corresponding Schedule A Itemized Deductions.
 - Your non-passive income(loss) from trade of business as reported on Schedule E - Part II of Your Federal Income Tax Return(s), Form 1040, for the prior calendar year, less any expenses incurred and reported elsewhere on Your Return; and
 - Your contributions during the prior calendar year, deposited into a:
 - Cash or deferred compensation plan, or salary reduction plan, qualified under IRC section 401(k), 403(b), 457 or similar plan; and
 - Elective Employee pre-tax deferrals to a Section 125 plan or flexible spending account.

If You are not a partner or S Corporation shareholder for the full prior calendar year. Your earnings will be based on the annualized sum of the listed amounts for the period of time that You are a partner or S Corporation shareholder during that calendar year.

- **For Sole Proprietors:** Insured Earnings means the sum of the amounts listed below.
 - Your annual net profit as determined from Schedule C - Part II of Your Federal Income Tax Return(s), Form 1040 for the prior calendar year and
 - Your annual contribution during the prior calendar year deposited into a:
 - Cash or deferred compensation plan, or salary reduction plan, qualified under IRC section 401(k), 403(b), 457 or similar plan; and
 - Elective Employee pre-tax deferrals to a Section 125 plan or flexible spending account.

Annual net profit is calculated as gross income less total expenses.

If You are not a sole proprietor for the full prior calendar year. We will calculate annual net profit and annual contributions using the full number of months that You are a sole proprietor during such time.

- **For Employees Who Are Compensated On Less Than A 12 Month Basis:** Insured Earnings means annual earnings determined from Your annual contract salary. If You do not have an annual contract salary, Insured Earnings means Your salary for the prior calendar year.

Your base annual salary will include shift differential.

The term also includes Your contributions deposited into a:

- Cash or deferred compensation plan, or salary reduction plan, qualified under IRC section 401(k), 403(b), 457 or similar plan; and
- Elective Employee pre-tax deferrals to a Section 125 plan or flexible spending account.

Earnings based on excluded income and Employer contributions deposited into such 401(k), 403(b), 457 or similar plan are not included.

The term does not include:

- Bonuses;
- Overtime pay;
- Expense accounts;
- Stock options; and
- Any other extra compensation.

If You are paid hourly, We calculate Insured Earnings based on actual hours worked or billed in the 12 months before the date you ceased working your normally scheduled hours.

We do not include pay for hours worked or billed over 40 per week.

- **For Employees Whose Income Is Reported On A IRS Form 1099:** Insured Earnings means Your annual earnings as figured from the 1099 form(s) received from the Employer for the prior calendar year.

Earnings are calculated as Your earned income as reported on the 1099 form(s) minus business expenses as reported on Schedule C - Part II of Your Federal Income Tax Return(s), Form 1040.

The term also includes Your contributions deposited into a:

- Cash or deferred compensation plan, or salary reduction plan, qualified under IRC section 401(k), 403(b), 457 or similar plan; and
- Elective Employee pre-tax deferrals to a Section 125 plan or flexible spending account.

B400.3527

All Options

- **For Any Other Employee Who Receives Base Salary Only:** Insured Earnings means Your base annual salary from the Employer.

Your base annual salary will include shift differential.

The term also includes Your annual contributions deposited into a:

- Cash or deferred compensation plan, or salary reduction plan, qualified under IRC section 401(k), 403(b), 457 or similar plan; and
- Elective Employee pre-tax deferrals to a Section 125 plan or flexible spending account.

Earnings based on excluded income and Employer contributions deposited into such 401(k), 403(b), 457 or similar plan are not included. The term does not include:

- Bonuses;
- Commissions;
- Overtime pay;
- Expense accounts;
- Stock options; and

- Any other extra compensation.

If You are paid hourly, We calculate Insured Earnings based on actual hours worked or billed in the 12 months before the date you ceased working your normally scheduled hours.

We do not include pay for hours worked or billed over 40 per Week.

B400.3528

All Options

- **For Any Other Employee Who Receives Base Salary Only:** Insured Earnings means Your base annual salary from the Employer.

Your base annual salary will include shift differential.

The term also includes Your annual contributions deposited into a:

- Cash or deferred compensation plan, or salary reduction plan, qualified under IRC section 401(k), 403(b), 457 or similar plan; and
- Elective Employee pre-tax deferrals to a Section 125 plan or flexible spending account.

Earnings based on excluded income and Employer contributions deposited into such 401(k), 403(b), 457 or similar plan are not included. The term does not include:

- Bonuses;
- Commissions;
- Overtime pay;
- Expense accounts;
- Stock options; and
- Any other extra compensation.

If You are paid hourly, We calculate Insured Earnings based on actual hours worked or billed in the 12 months before the date you ceased working your normally scheduled hours.

We do not include pay for hours worked or billed over 40 per Week.

B400.4112

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 are deemed acceptable for purposes of substantiating a claim. Acceptable Proof of Loss includes:

- 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.

B400.3543

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 medically required, according to generally accepted medical standards, to effectively manage these conditions; and
- Are receiving the most appropriate treatment, according to generally accepted medical standards, designed to achieve maximum medical improvement in these conditions.

Treatment must be provided by a Doctor or Doctors whose specialty is most appropriate according to generally accepted medical standards for You:

- Disability; and
- Any other conditions which left untreated would adversely affect Your disabling condition.

Generally accepted medical standards are those supported by nationally recognized authorities in the health care field including:

- The American Medical Association (AMA);
- The AMA Board of Medical Specialties;
- The Food and Drug Administration;
- The Centers for Disease Control;
- The National Cancer Institute;
- The National Institutes of Health;
- The Department of Health and Human Services; and
- Any other agency of similar repute.

B400.3546

All Options

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

B400.3547

All Options

Total Disability and Totally Disabled This term means that, due to sickness or injury, the Covered Person is:

- Not able to perform any work for wages or profit; and
- Receiving Regular and Appropriate Care for the cause of disability.

B400.3548

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 Basic Term Life Insurance Schedule

B400.4200

All Options

Basic Term Life Insurance Amount

An amount equal to 150% of Your Insured Earnings, rounded to the next higher \$1,000.00, if not already a multiple of that amount, to a maximum of \$250,000.00.

B400.4223

All Options

Redetermination

Subject to any of the Policy's proof of Insurability requirements, Your basic life insurance amount will be redetermined on the date a change in Your Insured Earnings occurs, to an amount determined in accordance with the formula shown above, on the basis of Your then current Insured Earnings. Your Employer must report updates to your Insured Earnings as they occur. If you are not Actively At Work on a Full-time basis on that date, Your insurance amount will be redetermined on the date you return to Active Full-time Work. But, if Your basic life insurance amount was previously reduced because of an age or retirement reduction, it will not be redetermined due the change in earnings.

B400.4349

All Options

Reduction of Basic 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. 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 basic life 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. This reduction also applies to Your initial insurance amount if Your insurance starts after You reach age 70.

With respect to any of the reductions described above, the reduced insurance amount is in place of the amount which otherwise applies to Your classification.

B400.4361

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."

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
- 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 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 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.

B400.4376

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 at any time, subject to any of this Policy's Proof Of Insurability requirements. You must notify the Employer of any desired switch.

B400.4494

All Options

Voluntary Term Life Insurance Amount *Plan A*

An amount equal to 100% of Your Insured Earnings, rounded to the next higher \$1,000.00, if not already a multiple of that amount, to a maximum of \$500,000.00, but not less than \$10,000.00.

B400.4504

All Options

Voluntary Term Life Insurance Amount *Plan B*

An amount equal to 200% of Your Insured Earnings, rounded to the next higher \$1,000.00, if not already a multiple of that amount, to a maximum of \$500,000.00, but not less than \$10,000.00.

B400.4504

All Options

Voluntary Term Life Insurance Amount *Plan C*

An amount equal to 300% of Your Insured Earnings, rounded to the next higher \$1,000.00, if not already a multiple of that amount, to a maximum of \$500,000.00, but not less than \$10,000.00.

B400.4504

All Options

Voluntary Term Life Insurance Amount *Plan D*

An amount equal to 400% of Your Insured Earnings, rounded to the next higher \$1,000.00, if not already a multiple of that amount, to a maximum of \$500,000.00, but not less than \$10,000.00.

B400.4504

All Options

Voluntary Term Life Insurance Amount *Plan E*

An amount equal to 500% of Your Insured Earnings, rounded to the next higher \$1,000.00, if not already a multiple of that amount, to a maximum of \$500,000.00, but not less than \$10,000.00.

B400.4504

All Options

Voluntary Term Life Insurance Amount *Plan F*

An amount equal to 600% of Your Insured Earnings, rounded to the next higher \$1,000.00, if not already a multiple of that amount, to a maximum of \$500,000.00, but not less than \$10,000.00.

B400.4504

All Options

Voluntary Term Life Insurance Amount *Plan G*

An amount equal to 700% of Your Insured Earnings, rounded to the next higher \$1,000.00, if not already a multiple of that amount, to a maximum of \$500,000.00, but not less than \$10,000.00.

B400.4504

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

Redetermination Subject to any of the Policy's Proof Of Insurability requirements, Your Voluntary life insurance amount will be redetermined on the date a change in Your Insured Earnings occurs, to an amount determined in accordance with the formula shown above, on the basis of Your then current Insured Earnings. Your Employer must report updates to Your Insured Earnings as they occur. If You are not Actively At Work on a Full-Time basis on that date, Your insurance amount will be redetermined on the date You return to active Full-Time service. But, if Your Voluntary life insurance amount was previously reduced because of an age or retirement reduction, it will not be redetermined due to the change in earnings.

B400.4703

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

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

All Options

We require Proof of Insurability for amounts of Voluntary Term Life Insurance which exceed \$200,000.00.

B400.4912

All Options

We require Proof of Insurability before We will insure You if You were previously declined or would have been considered a late enrollee under a group Voluntary Term Life Insurance plan which this Policy replaced.

We require Proof of Insurability before We will insure You for an amount greater than the amount for which You were insured under the group Voluntary Term Life Insurance plan which this Policy replaced.

B400.5406

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
Amount You may elect amounts of voluntary dependent spouse term life insurance in increments of \$5,000.00, but the amount may not be less than \$5,000.00 and may not exceed \$250,000.00.

B400.5550

All Options

Voluntary Plan A
Dependent Child
Insurance Amount **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;
less than 26 years if a full-time student \$5,000.00

B400.6708

All Options

Voluntary Dependent Child Insurance Amount	Plan B 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; less than 26 years if a full-time student	\$10,000.00
		B400.6708

All Options

In no event may the insurance amount of a dependent Spouse exceed 50% of Your insurance amount.

B400.6002

All Options

In no event may the insurance amount of a dependent child exceed 100% of Your insurance amount.

B400.9361

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

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

- 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 who was previously declined or would have been considered a late enrollee under a group Term Life Insurance plan providing dependent coverage which this Policy replaced;
- 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.

B400.6016

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

All Options

We require Proof of Insurability for any amount of dependent Voluntary Term Life Insurance in excess of \$50,000.00 with respect to a dependent Spouse.

B400.6051

All Options

We require Proof of Insurability before We will insure any dependent Spouse who was previously declined or would have been considered a late enrollee under a group dependent Voluntary Term Life Insurance plan which this Policy replaced.

We require Proof of Insurability before We will insure any dependent Spouse for an amount greater than the amount for which he or she was insured under the group Voluntary dependent Term Life Insurance plan which this Policy replaced.

B400.6056

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

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

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 Basic 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 "How To Apply");
- 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 6 months from the date We receive Your application 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) 75% of Your amount of Group Term Life Insurance.

The maximum benefit amount is the lesser of: (1) \$250,000.00; or (2) 75% 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 6 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 application 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.

How To Apply You must send Us 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.

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 application 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 Basic 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 6 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 Basic 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 Basic Group term life insurance that is due within the 6 month period after the date You apply for the Accelerated Life Benefit.
- **Terminal Condition:** This term means a medical condition that is expected to result in death within 6 months from the date You apply for the Accelerated Life Benefit.

The Guardian Life Insurance Company of America



Matthew Darula, Head of Product, Strategy
and Offerings

B400.3552

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 "How To Apply");
- 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 6 months from the date We receive Your application 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) 80% of Your amount of Group Term Life Insurance.

The maximum benefit amount is the lesser of: (1) \$500,000.00; or (2) 80% 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 6 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 application 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.

How To Apply You must send Us 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.

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 application 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 6 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 6 month period after the date You apply for the Accelerated Life Benefit.
- **Terminal Condition:** This term means a medical condition that is expected to result in death within 6 months from the date You apply for the Accelerated Life Benefit.

The Guardian Life Insurance Company of America



Matthew Darula, Head of Product, Strategy
and Offerings

B400.3554

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 Basic and Voluntary Term Life Insurance and
Dependent Voluntary Term Life Insurance
Seatbelt and Airbag Benefit**

This rider applies to Your Basic and 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.

Proof that You were properly wearing a seatbelt must be provided. 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 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 Basic and Voluntary term life insurance and Basic Accidental Death and Dismemberment insurance may not exceed \$30,000.

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 the driver in an automobile Accident, if Your driver's license has been suspended or revoked or if You are unlicensed;
- While You are legally intoxicated as determined by the laws in the jurisdiction in which the accident occurred; 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;
- 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;
- During Your participation in any sport for compensation or profit; or
- During Your racing an automobile in an organized event or street race.

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 the driver in an automobile Accident, if his or her driver's license is suspended or revoked or if the driver is unlicensed;
- While Your dependent is legally intoxicated as determined by the laws in the jurisdiction in which the accident occurred; 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;
- 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;
- During Your dependent's participation in any sport for compensation or profit; or
- During Your dependent's racing an automobile in an organized event or street race.

The Guardian Life Insurance Company of America



Matthew Darula, Head of Product, Strategy
and Offerings

B400.8302

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 Basic and Voluntary Term Life Insurance
Waiver Of Premium Benefit**

Important Notice This rider applies to Your Basic and 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 Basic and Voluntary life insurance without payment of premiums from You or the Employer in an amount equal to the amount of Basic and 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 6 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 Basic and 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 Basic and 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 6 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 Your Social Security Normal Retirement Age, as defined in the most current amendment to the Social Security Act. The following chart applies when the Waiver of Premium Benefit ends upon Your reaching Social Security Normal Retirement Age:

Year of Birth

Normal Retirement Age

1937 and prior

65

1938	65 and 2 months
1939	65 and 4 months
1940	65 and 6 months
1941	65 and 8 months
1942	65 and 10 months
1943 - 54	66
1955	66 and 2 months
1956	66 and 4 months
1957	66 and 6 months
1958	66 and 8 months
1959	66 and 10 months
1960 and later	67

Note: Persons born on January 1 of any year should refer to the Normal Retirement Age for the previous year.

If Your Waiver of Premium Benefit ends and You do not return to Active Work, You will have the option to convert the Employee Basic and Voluntary life insurance that was in effect on the date the Waiver of Premium Benefit ends.

Please read "Converting This Employee Basic and 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 Basic and 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.

B400.7287

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 medically required, according to generally accepted medical standards, to effectively manage these conditions; and
- Are receiving the most appropriate treatment, according to generally accepted medical standards, designed to achieve maximum medical improvement in these conditions.

Treatment must be provided by a Doctor or Doctors whose specialty is most appropriate according to generally accepted medical standards for Your:

- Disability; and
- Any other conditions which left untreated would adversely affect Your disabling condition.

Generally accepted medical standards are those supported by nationally recognized authorities in the health care field including:

- The American Medical Association(AMA);
- The AMA Board of Medical Specialties;
- The Food and Drug Administration;
- The Centers for Disease Control;
- The National Cancer Institute;

- The National Institutes of Health;
- The Department of Health and Human Services; and
- Any other agency of similar repute.

"Total Disability" and "Totally Disabled": This term means that, due to sickness or injury, You are:

- Not able to perform any work for wages or profit; and
- Receiving Regular and Appropriate Care for the cause of Your Total Disability.

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



Matthew Darula, Head of Product, Strategy
and Offerings

B400.7290

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 Basic 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 Basic 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
- In order to Port, You must provide Proof Of Insurability.

Portability Options

You may Port the full amount of Your Basic 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.

**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 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 age bracket as shown in the Life Portability Coverage Premium Notice.

The Portable Certificate of Coverage ends at age 70.

How To Port You must:

- Apply to Us in writing; and
- Pay the required premium.

You must do this within 31 days from the date Your coverage under the Certificate ends. In order to Port Your Basic term life insurance, We require Proof of Insurability.

Portability And Conversion

If You 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 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



Matthew Darula, Head of Product, Strategy and Offerings

B400.3877

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



Matthew Darula, Head of Product, Strategy
and Offerings

B400.3884

CERTIFICATE AMENDATORY RIDER - Dependent Termination

This Rider amends the Certificate as follows and is effective on the Policy Date. If this Rider is added after the Policy Date, the Rider becomes effective on its issue date.

The **When Dependent Coverage Ends** provision is replaced in its entirety with the following:

**When Dependent
Coverage Ends**

Dependent coverage ends for all of Your dependent(s) as follows:

- When Your Employee coverage ends;
- When You stop being a member of a class of Employees eligible for such coverage;
- When this Certificate ends, or dependent coverage is discontinued for a class of Employees to which You belong;
- On the last day of the period for which required payments are made for Your dependent(s);
- For Your child, on the last day of the month in which he or she attains the age limit or no longer qualifies under Continuing Coverage For Dependent Children Past the Age Limit.
- It also happens at 12:01 AM on the date Your stepchild is no longer dependent on You for at least 50% of his or her support and maintenance.
- For Your Spouse, at 12:01 A.M. on the date Your marriage is lawfully terminated.
- On the date Your dependent dies.

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

**Continuing
Coverage For
Dependent Children
Past the Age Limit**

An unmarried child that meets all of the conditions below may continue coverage past the child age limit:

- The child must be incapable of living independently due to a mental, physical, or developmental disability;
- The child must be primarily dependent upon You for support and maintenance;
- The child's mental, physical, or developmental disability must have begun before he or she reached the age limit; and
- The child must have been covered by this Certificate, or the prior carrier's group plan that it replaced, before he or she reached the age limit, and remained continuously covered until he or she reached the age limit.

You will have to send us documentation that your child meets these requirements within 31 days of the date the age limit was reached.

After two years has passed from the date the age limit was reached, we may periodically ask for documentation that your child continues to meet these requirements. We won't ask for this more than once a year.

Any coverage provided under this section ends when Your coverage ends, or your child no longer meets the conditions above.

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

A handwritten signature in black ink, appearing to read 'MD', with a stylized, flowing script.

Matthew Darula, Head of Product, Strategy and Offerings

B438.0779

The Guardian Life Insurance Company of America 10 Hudson Yards, New York, NY 10001

CERTIFICATE AMENDATORY RIDER

This Rider is effective on the Policy Date. If this Rider is added after the Policy Date, the Rider becomes effective on its issue date.

The **Redetermination** provision(s) in the Certificate Schedule of Benefits are replaced in their entirety with the following:

Redetermination Your basic life insurance amount will be redetermined on the date Your earning's change in accordance with the formula shown in the Schedule of Benefits for basic life insurance and based on Your Insured Earnings on the date of the redetermination.

Redetermination Requirements

Your Employer must report your current Insured Earnings to us for the redetermination to take place.

An increase in Your life insurance amount may be subject to the Proof of Insurability requirements. Please refer to the Proof of Insurability section of the Schedule of Benefits for more information.

If You are not Actively at Work on the redetermination date, the redetermination will not take effect until the date You return to Active Work.

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



Matthew Darula, Head of Product, Strategy and Offerings

B438.1120

The Guardian Life Insurance Company of America 10 Hudson Yards, New York, NY 10001

CERTIFICATE AMENDATORY RIDER

This Rider is effective on the Policy Date. If this Rider is added after the Policy Date, the Rider becomes effective on its issue date.

The **Redetermination** provision(s) in the Certificate Schedule of Benefits are replaced in their entirety with the following:

Redetermination Your voluntary life insurance amount will be redetermined on the date Your earning's change in accordance with the formula shown in the Schedule of Benefits for voluntary life insurance and based on Your Insured Earnings on the date of the redetermination.

Redetermination Requirements

Your Employer must report your current Insured Earnings to us for the redetermination to take place.

An increase in Your life insurance amount may be subject to the Proof of Insurability requirements. Please refer to the Proof of Insurability section of the Schedule of Benefits for more information.

If You are not Actively at Work on the redetermination date, the redetermination will not take effect until the date You return to Active Work.

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



Matthew Darula, Head of Product, Strategy and Offerings

B438.1125

All Options

The Guardian Life Insurance Company of America 10 Hudson Yards, New York, NY 10001

Certificate amendatory rider

This rider amends the Group Term Life Insurance Certificate as follows and is effective on the certificate date. If this rider is added after the certificate effective date, the rider becomes effective on its issue date.

The suicide exclusion that appears in the Certificate for dependents won't apply to your dependent children as of the effective date of this amendment. The suicide exclusion will continue to apply to your spouse.

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

A handwritten signature in black ink, appearing to read 'MD', with a stylized flourish extending from the bottom right.

Matthew Darula, Head of Product, Strategy and Offerings

B439.0635

**The Guardian Life Insurance Company of America
10 Hudson Yards, New York, NY 10001**

Certificate amendatory rider

This rider amends your Group Term Life Insurance Certificate of Coverage and its Waiver of Premium Benefit. (The Waiver of Premium Benefit is called the Extended Life Benefit with Waiver of Premium in some Certificates.)

This rider is effective on the certificate effective date. If this rider is added after the certificate effective date, the rider becomes effective on its issue date.

What this rider changes

This rider changes your options for keeping your life insurance in place if you stop working because you're Totally Disabled.

If you're Totally Disabled, the Waiver of Premium Benefit allows you to keep some or all of your life insurance in place without having to continue to pay premiums.

The Waiver of Premium Benefit doesn't begin immediately after you stop working. It has a waiting period. You must remain Totally Disabled during this waiting period before the benefit begins and your premiums are waived. See the Waiver of Premium Benefit in your Certificate for how long you must be Totally Disabled and its other requirements.

You can obtain interim coverage

If your employment ends because you're Totally Disabled, your coverage will end on the date specified in the Certificate. If you'd like to keep your insurance in place until the date the Waiver of Premium Benefit begins, you must do all of the following:

- Apply for interim coverage during the Conversion Period
- Apply for the Waiver of Premium Benefit before or during the Conversion Period
- Pay the premium within the time required in the Certificate

You must pay the full cost of the interim coverage, including any part that had previously been paid by your Employer or Policyholder. You'll need to send the premiums directly to us. The cost of interim coverage may be different than the cost when you were working. Premiums will be based on your age at the time the interim coverage begins.

We won't ask for proof that you're insurable to obtain interim coverage.

What happens when you convert to interim coverage

Once you apply and pay the required premiums, we'll send you written confirmation that your interim coverage is in place.

Interim coverage will be provided through this same Certificate. It will be subject to all the terms, conditions and limitations of the Certificate unless specifically changed by this rider.

The interim coverage won't include any additional benefits for accidental death and dismemberment that may have been offered by this Certificate.

Your beneficiary designation will remain the same unless you elect to change it.

When your interim coverage begins and ends

Your interim coverage will begin immediately after the Conversion Period ends.

Interim coverage is temporary. It's intended to cover you only between the date you stop working and the date the Waiver of Premium Benefit begins.

Your interim coverage will continue for the period specified in the Certificate, even if the group policy ends.

What happens if you don't obtain interim coverage

If you don't obtain interim coverage, you can still apply for the Waiver of Premium Benefit. You must apply while living and within the time allowed by the Certificate.

If you don't apply for interim coverage and you die after the end of the Conversion Period but before the date the Waiver of Premium Benefit begins, you'll have no life insurance in place. Benefits will only be available if you were eligible to apply for the Waiver of Premium Benefit and we can confirm you were Totally Disabled from the date you stopped working through the date of your death.

If we determine benefits are payable, we'll pay the full amount of life insurance you had in place under the Certificate on your last day of work. This amount will be subject to any deductions that would've taken place had you remained working.

We'll also reduce the benefits by the amount of premium owed for the period between your last day of work and the date you die.

Other things you should know about interim coverage

If the Waiver of Premium Benefit applies to some but not all of your life insurance benefits under this Certificate, you'll be able to obtain interim coverage for only those coverage amounts to which the Waiver of Premium Benefit applies. This could happen if you purchased extra coverage under the group policy.

For any coverage amounts not covered by the Waiver of Premium Benefit, you can convert that portion of your life insurance to a permanent life insurance policy as explained below.

Converting your life insurance when you're not eligible for the Waiver of Premium Benefit

If you stop working due to disability, you can convert your coverage to an individual permanent life insurance policy when any of the following occur:

- You aren't eligible for the Waiver of Premium Benefit because you're not Totally Disabled.
- You aren't eligible for the Waiver of Premium Benefit because of your age.
- Some portion of your life insurance didn't have the Waiver of Premium Benefit. This could happen if you purchased additional coverage under the group policy. If you're eligible for the Waiver of Premium Benefit, only the coverage amounts that didn't have the Waiver of Premium Benefit can be converted to a permanent life insurance policy.

In the situations described above, you must apply for the permanent life insurance policy during the Conversion Period listed in the Certificate.

You can also convert your coverage to a permanent life insurance policy when either of the following occur:

- Your eligibility for the Waiver of Premium Benefit ends.
- Your interim coverage ends.

You'll have 31 days from the date we notify you that you're no longer eligible for the Waiver of Premium Benefit to convert to a permanent life insurance policy.

You'll have 31 days from the date the interim coverage ends to convert to a permanent life insurance policy.

See the Certificate for more information on how to apply for a permanent life insurance policy.

While you can't convert your coverage to a permanent life insurance policy simply because your Waiver of Premium Benefit claim is pending, you can obtain interim coverage as stated in the You can obtain interim coverage section above.

Other terms, limits and rules

This amendment changes the terms of this Certificate only as specifically listed above. All the other terms, limits, rules and exclusions of the Certificate and Waiver of Premium Benefit (called the Extended Life Benefit with Waiver of Premium in some Certificates), remain in place.

Nothing in this rider will serve to increase your benefits beyond that already listed in the Certificate and the Waiver of Premium Benefit. In no event will the total amount of life insurance benefits available through these conversion options exceed the total amount of life insurance benefits you had in place under the Certificate on your last day of work. This total amount will be subject to any deductions that would've taken place had you remained working.

This rider doesn't change the options your spouse and children have for continuing any life insurance they may have in place. Please refer to the Certificate for their continuation options.

If the conversion and Waiver of Premium Benefit provisions being amended by this rider also appear in the group insurance Policy issued to your Employer or Policyholder, this rider also amends the group insurance Policy to include these changes.

The Guardian Life Insurance Company of America

A handwritten signature in black ink, appearing to read 'MD', with a stylized, cursive flourish.

Matthew Darula, Head of Product, Strategy and Offerings

B438.1143

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 responsible for interpretation of 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 will 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.

B997.0384

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.

B997.0385

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.

B997.0386

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 July 1, 2026. 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.

Policyholder: HOPE COLLEGE
Group Policy Number: 00096812

The Guardian Life Insurance Company of America



Harris Oliner
Senior Vice President &
Corporate Secretary



Matthew Darula
Head of Product,
Strategy and Offerings

B439.0024

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GENERAL PROVISIONS

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

Limitation Of Authority

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

- Determine whether any contract, Policy or Certificate is to be issued;
- Waive or alter any contract or Policy provisions, 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.

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

Incontestability

This Certificate is incontestable after three years from its date of issue, except for non-payment of premiums.

No statement in any application, except a fraudulent statement, 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 three 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 three years from the Effective Date of the Policy.

Examination And Autopsy

We have the right to have a doctor of Our choice examine the person at reasonable times and as frequently as reasonably required during the pendency of a claim under this Certificate. 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.

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.

B439.0026

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

All Options

Transfer Business Exception If due to sickness or injury, You are not Actively At Work and not working the minimum number of hours of an Employee in Your eligible class, on Your scheduled Eligibility Date, You will be insured for this Accidental Death and Dismemberment insurance if:

- You were insured under the Employer's prior insurer's group accidental death and dismemberment plan at the time the prior insurer's group accidental death and dismemberment plan ended and the group accidental death and dismemberment plan became effective with Us, with no break in group coverage;
- You were a member of an eligible class under the Employer's prior insurer's group accidental death and dismemberment plan and are eligible under this Certificate;
- Premiums for You were paid up to date for the Employer's prior insurer's group plan and this Certificate;
- Premiums are not currently being waived under the Waiver of Premium Rider, or You were not eligible, under the terms of the Employer's prior insurer's group accidental death and dismemberment plan, to have premiums waived under the Waiver of Premium provision; and
- You are not receiving or eligible to receive benefits under the Employer's prior insurer's group accidental death and dismemberment plan.

Any Accidental Death and Dismemberment benefit payable will be the lesser of:

- The Accidental Death and Dismemberment benefit payable under this Certificate; or
- The accidental death and dismemberment benefit payable under the Employer's prior insurer's group accidental death and dismemberment plan had it remained in force; reduced by any amount paid by the prior insurer's group accidental death and dismemberment plan.

If You are covered under the Exception to When Coverage Starts, You will not be eligible for the Waiver of Premium Benefit provision under this Certificate until such a time You are Actively At Work as defined by this Certificate.

If You meet the conditions stated above, You will remain insured under this provision until the first to occur of:

- The date You are fully capable of performing the major duties of Your occupation for the Employer, and capable of doing so for the minimum number of hours of an Employee in Your eligible class;
- The date insurance terminates for one of the reasons stated in When Employee Coverage Ends;

- The last day of a period of 12 consecutive months which begins on this Certificate's Effective Date;
- The date You become eligible for the Waiver of Premium Benefit provision under the prior insurer's group accidental death and dismemberment plan; or
- The last day You would have been covered under the prior insurer's group accidental death and dismemberment plan, had the prior plan not terminated.

B400.1004

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. 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 And Catastrophic Loss Benefits**

B400.6136

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 direct result of the Accident;
- Be independent of all other causes; 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 which is acceptable to Us. This should be sent to Us as soon as possible.

The Beneficiary You decide who receives this benefit when You die. Your beneficiary designation should be provided in a means acceptable by Us.

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.

Consent of a beneficiary is not required to surrender the Policy, for the assignment of the Policy, to change a beneficiary, or to make any other changes in the Policy.

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.

B439.0027

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".

CATASTROPHIC LOSS BENEFITS

Loss of speech and hearing	100% of Your AD&D insurance amount.
Loss of speech or hearing	50% of Your AD&D insurance amount.
Quadriplegia	100% 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".

Paraplegia	75% of Your AD&D insurance amount.
Hemiplegia	50% of Your AD&D insurance amount.
Uniplegia	25% of Your AD&D insurance amount
Loss of cognitive function	100% of Your AD&D insurance amount.
Comatose state, in excess of one month	100% of Your AD&D insurance amount.
Loss of one arm or leg	75% of Your AD&D insurance amount.
Third degree burns covering 75% or more of the body	75% of Your AD&D insurance amount
Third degree burns covering 50% or more but less than 75% of the body	50% of Your AD&D insurance amount

B400.6144

All Options

As used here:

- "Loss of cognitive function" means a significant decline or loss in intellectual aptitude. Such loss must result from an Accidental injury. And, it must be supported by clinical proof or standardized tests that precisely measure decline in the areas of:
 - Short term memory;
 - Orientation to time, place and person;
 - Deductive or abstract reasoning; and
 - Judgement as it relates to awareness of safety.
- "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 hearing" means that hearing in both ears is lost entirely.
- "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.
- "Loss of one arm" means the arm is completely severed at or above the elbow.
- "Loss of one leg" means the leg is completely severed at or above the knee.
- "Loss of speech" means that speech is lost entirely.
- "Hemiplegia" means total paralysis of upper and lower limbs, unilaterally.
- "Paraplegia" means total paralysis of both lower limbs.
- "Quadriplegia" means total paralysis of upper and lower limbs, bilaterally.
- "Uniplegia" means paralysis of one arm or one leg

B400.6150

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

Exclusions Conditions that are not considered Covered Losses and that are not covered under the terms of this Certificate can be found in the definition of "Accident". Please refer to the Definitions section of this Certificate.

B400.6153

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

All Options

Helmet Benefit If You die as a result of a Motorcycle Accident while properly wearing a Helmet and You are the driver and hold a valid driver's license with a Motorcycle endorsement and We determine an Accidental Death and Dismemberment benefit is payable, We will increase Your benefit by the lesser of:

- 50% of the benefit amount; or
- \$25,000.

We must receive satisfactory evidence that the Employee's death resulted from a Motorcycle Accident, and that the Employee was wearing a Helmet at the time of the Accident. A copy of the police report is required.

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

Helmet: This term means a protective head covering made of a hard material to resist impact and that conforms to the Department Of Transportation helmet certification.

Motorcycle: This term means a motor vehicle licensed for use on public highways which requires a Motorcycle endorsement on a driver's license to operate the vehicle.

B400.6158

All Options

Workplace Assault If You suffer a Covered Loss due to an Accidental bodily injury caused directly by a Felonious Act of Violence and We determine that an Accidental Death and Dismemberment Benefit is payable, We will pay a Workplace Assault benefit subject to all the terms below:

- A benefit is payable under the Certificate's Employee Basic Accidental Death and Dismemberment and Catastrophic Loss Benefit due to a Covered Loss;
- The Felonious Act of Violence must occur while You are working for Your Employer, at Your Employer's usual place of business, at an alternative work site at the direction of Your Employer, including Your home or a location to which the job requires You to travel;
- The loss did not occur while You were committing a felonious act; and
- The Felonious Act of Violence was not committed by members of Your family or household.

What We Pay: Subject to all the terms of this Certificate, the Workplace Assault Benefit pays the lesser of: (a) 10% of the benefit amount; or (b) \$25,000.

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

- **A Felonious Act of Violence:** This term includes but is not limited to robbery, theft, hijacking, assault and battery, sniping, murder or civil disturbance. The Workplace Assault benefit is subject to all the exclusions under the Accidental Death and Dismemberment benefit, including act of war language.

B400.6162

All Options

Rehabilitation Benefit If You suffer a Covered Loss other than loss of life due to an Accidental bodily injury and We determine an Accidental Death and Dismemberment Benefit is payable, We will pay a Rehabilitation Benefit subject to all of the terms below:

- A benefit is payable under this Certificate's Employee Basic Accidental Death and Dismemberment and Catastrophic Loss Benefit due to a Covered Loss other than loss of life;
- You require rehabilitative training, for which there is an Incurred Expense, due to Your Accidental bodily injury;
- You are trained for another occupation because You cannot perform Your occupation due to the Accidental bodily injury; and
- The expense is incurred within one year of the date of the Accident.

What We Pay: Subject to all the terms of this Certificate, the Rehabilitation Benefit pays the lesser of:

- The expense incurred for rehabilitative training; or

- 5% of the benefit amount payable for the Covered Loss; or
- \$2,500. We pay this benefit in arrears, upon receipt of incurred expense for training. Proof must be submitted within 90 days of the Incurred Expense.

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

Incurred Expense: This term means the actual cost of the

- Training; and
- Materials needed for the training.

B400.6166

All Options

Adaptive Home & Vehicle Benefit

If You suffer a Covered Loss other than loss of life due to an Accidental bodily injury and We determine that an Accidental Death and Dismemberment Benefit is payable, We will pay an Adaptive Home and Vehicle Benefit subject to all of the terms below:

- A benefit is payable under this Certificates Employee Basic Accidental Death and Dismemberment and Catastrophic Loss Benefit due to a Covered Loss other than loss of life; and
- The home alteration must be:
 - Made to Your principal residence;
 - Made by a licensed contractor that is not You, Your Spouse, child, parent, sibling or business associate; and
 - Reasonable based on Your residual capabilities; and
- The vehicle modification must be:
 - Made to Your Private Automobile; and
 - Carried out by a licensed technician that is not You, Your Spouse, child, parent, sibling or business associate; and
 - Approved by the Motor Vehicle Department; and
- The expense is incurred within one year of the date of the Accident.

What We Pay: Subject to all the terms of this Policy, the Adaptive Home and Vehicle Benefit pays the lesser of:

- 5% of the Insurance Amount; or
- \$2,500; or
- The actual one-time cost.

We pay this benefit in arrears, upon receipt of incurred expense for the alteration or modification. Proof must be submitted within 90 days of the incurred expense.

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

Incurred Expense: This term means the actual cost (materials and labor) of the alteration and modification.

Private Automobile: This term means a four-wheeled, private passenger car, station wagon, pick-up truck, van or jeep-type automobile which is not being used as a public conveyance.

B400.6159

All Options

Spousal Education And Retraining Benefit

If You suffer a Specified Loss due to an Accidental bodily injury, We will pay a Spousal Education and Retraining Benefit subject to all of the terms shown below.

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

- **Hemiplegia:** This term means total paralysis of upper and lower limbs, unilaterally.
- **Institute Of Higher Learning:** This term includes, but is not limited to:
 - Universities;
 - Colleges;
 - Trade schools; and
 - Professional schools.

It does not include graduate level programs.

- **Loss Of Cognitive Function:** This term means a significant decline or loss in intellectual aptitude. Such loss must result from an Accidental injury. And, it must be supported by clinical proof or standardized tests that precisely measure decline in the areas of:
 - Short term memory;
 - Orientation to time, place and person;
 - Deductive or abstract reasoning; and
 - Judgment as it relates to awareness of safety.
- **Net Tuition Expense:** This term means Tuition Expense less any scholarships or grants to which the Spouse is entitled.
- **Paraplegia:** This term means total paralysis of both lower limbs.
- **Quadriplegia:** This term means total paralysis of upper and lower limbs, bilaterally.

- **Specified Loss:** This term means:
 - Loss of life;
 - A comatose state which lasts for a period in excess of one month;
 - Spinal cord injury which results in Hemiplegia, Paraplegia or Quadriplegia; or
 - Severe head injury which results in Loss of Cognitive Function.
- **Tuition Expense:** This term means charges incurred for courses or lab fees. It does not include:
 - Cost of books;
 - Cost of other related course materials;
 - Student activity fees; or
 - Room and board.

When And How The Spousal Education And Retraining Benefit Begins

We will pay a Spousal Education and Retraining Benefit when all of the conditions shown below are met:

- A benefit is payable under this Certificate's Basic Accidental Death and Dismemberment Insurance and Catastrophic Loss Insurance due to a Specified Loss;
- You and Your Spouse share the same place of residence on the date of the Accidental injury which results in the Specified Loss; and
- We receive proof of Your enrollment in an Institute Of Higher Learning. You must:
 - Be enrolled on the date of the Accidental injury which results in the Specified Loss; or
 - Enroll within 12 months of that date.

What We Pay

Subject to all the terms of this Policy, this benefit per academic term will be equal to the lesser of:

- Your Net Tuition Expense for the term;
- 5% of the Basic Accidental Death and Dismemberment Insurance benefit and Catastrophic Loss Insurance Benefit paid as a result of the Specified Loss; and
- \$2,500 And, this benefit is subject to a lifetime maximum of \$20,000.

We pay this benefit to the person who has primary responsibility for these expenses.

This benefit is paid per academic term. The maximum number of benefit payments is based on whether You are enrolled in a part-time or full-time course of study. For full-time study, the maximum number of benefit payments is eight. For part-time study, the maximum number of benefit payments is four.

Continued Eligibility For The Spousal Education And Retraining Benefit We require periodic proof of Your continued enrollment in an Institute Of Higher Learning. And, You must maintain a grade point average of at least 2.0 on a 4.0 scale, or its equivalent. We also require proof, per academic term of:

- Your Tuition Expenses; and
- Any scholarships and grants to which You are entitled.

When The Spousal Education And Retraining Benefit Ends This benefit ends on the earliest of the dates shown below:

- The date You are no longer enrolled in an Institute Of Higher Learning;
- The date You fail to maintain a minimum grade point average as shown above;
- The date You fail to furnish any required proof as shown above;
- The date the lifetime maximum benefit is paid; and
- The date the maximum number of benefit payments have been made.

If you die as a result of an Accidental bodily injury and the Spousal Education and Retraining benefit is in effect on the date You die and there is no qualified dependent Spouse who could qualify for this benefit, we will pay a one time benefit of \$500 to the beneficiary in one sum.

B400.6165

All Options

Dependent Child Education Benefit

If You suffer a Specified Loss due to an Accidental bodily injury, We will pay a Dependent Child Education Benefit on behalf of a Qualified Dependent Child subject to all of the terms shown below.

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

- **Hemiplegia:** This term means total paralysis of upper and lower limbs, unilaterally.
- **Institute Of Higher Learning:** This term includes, but is not limited to:
 - Universities;
 - Colleges;
 - Trade schools; and
 - Professional schools.

It does not include graduate level programs

- **Loss Of Cognitive Function:** This term means a significant decline or loss in intellectual aptitude. Such loss must result from an Accidental injury. And, it must be supported by clinical proof or standardized tests that precisely measure decline in the areas of: (1) short term memory; (2) orientation to time, place and person; (3) deductive or abstract reasoning; and (4) judgement as it relates to awareness of safety.
- **Net Tuition Expense:** This term means Tuition Expense less any scholarships or grants to which the dependent child is entitled.
- **Paraplegia:** This term means total paralysis of both lower limbs.
- **Quadriplegia:** This term means total paralysis of upper and lower limbs, bilaterally.
- **Qualified Dependent Child:** This term means a child who is:
 - Your biological child, lawfully adopted child, stepchild, or any other child who is living with You in a regular parent-child relationship; and
 - Dependent on You for his or her chief support and maintenance.
- **Specified Loss:** This term means:
 - Loss of life;
 - A comatose state which lasts for a period in excess of one month;
 - Spinal cord injury which results in Hemiplegia, Paraplegia or Quadriplegia; or
 - Severe head injury which results in Loss of Cognitive Function.
- **Tuition Expense:** This term means charges incurred for courses or lab fees. It does not include:
 - Cost of books;
 - Cost of other related course materials;
 - Student activity fees; or
 - Room and board.

**When And How The
Dependent Child
Education Benefit
Begins**

We will pay a dependent child education benefit when all of the conditions shown below are met:

- A benefit is payable under this Certificate's Basic Accidental Death and Dismemberment and Catastrophic Loss Insurance due to a Specified Loss;
- On the date of the Accidental injury which results in the Specified Loss, the Qualified Dependent Child must be 22 years of age or younger; and
- We receive proof of the Qualified Dependent Child's enrollment in an Institute Of Higher Learning. He or she must be a full-time student, as defined by the institute. And, he or she must:

- Be enrolled on the date of the Accidental injury which results in the Specified Loss; or
- Be in the 12th grade and enroll within 12 months of that date.

What We Pay Subject to all the terms of this Policy, this benefit per academic term will be equal to the lesser of:

- The Qualified Dependent Child's Net Tuition Expense for the term;
- 5% of the Basic Accidental Death and Dismemberment Benefit and Catastrophic Loss Insurance Benefit paid as a result of the Specified Loss; and
- \$2,500 And, this benefit is subject to a lifetime maximum of \$20,000.

We pay this benefit to the person who has primary responsibility for these expenses.

This benefit is paid per academic term. The maximum number of benefit payments is eight.

Continued Eligibility For The Dependent Child Education Benefit We require periodic proof that a child remains a Qualified Dependent Child as shown above. We also require proof, per academic term of:

- His or her Tuition Expenses; and
- Any scholarships and grants to which he or she is entitled.

When The Dependent Child Education Benefit Ends

This benefit ends on the earliest of the dates shown below:

- The date the child is no longer a Qualified Dependent Child as shown above;
- The date the child is no longer enrolled in an Institute Of Higher Learning;
- The date the child fails to furnish any required proof as shown above;
- The date the lifetime maximum benefit is paid; and
- The date the maximum number of benefit payments have been made.
- The end of a period of six years from the date the first child education benefit payment is made.

If you die as a result of an Accidental bodily injury and the Dependent Child Education benefit is in effect on the date You die and there is no Qualified Dependent Child who could qualify for this benefit, we will pay a one time benefit of \$500 to the beneficiary in one sum.

B400.6171

Day Care Expense Benefit

If You suffer a Specified Loss due to an Accidental bodily injury, We will pay a Day Care Expense Benefit subject to all of the terms shown below.

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

- **Hemiplegia:** This term means total paralysis of upper and lower limbs, unilaterally.
- **Loss Of Cognitive Function:** This term means a significant decline or loss in intellectual aptitude. Such loss must result from an Accidental injury. And, it must be supported by clinical proof or standardized tests that precisely measure decline in the areas of:
 - Short term memory;
 - Orientation to time, place and person;
 - Deductive or abstract reasoning; and
 - Judgement as it relates to awareness of safety.
- **Paraplegia:** This term means total paralysis of both lower limbs.
- **Quadriplegia:** This term means total paralysis of upper and lower limbs, bilaterally.
- **Qualified Day Care Program:** This term means a program of child care which:
 - Is provided in a facility that is licensed as a day care center or is operated by a licensed day care provider; and
 - Charges a fee for the care of children.

The term does not include child care provided by a:

- Parent;
- Stepparent;
- Grandparent;
- Sibling;
- Aunt; or
- Uncle.
- **Qualified Dependent Child:** This term means a child who is:
 - Your biological child, lawfully adopted child, stepchild, or any other child who is living with You in a regular parent-child relationship; and
 - Dependent on You for his or her chief support and maintenance.

- **Specified Loss:** This term means:
 - Loss of life
 - A comatose state which lasts for a period in excess of one month;
 - Spinal cord injury which results in Hemiplegia, Paraplegia or Quadriplegia; or
 - Or severe head injury which results in Loss of Cognitive Function.

**When And How The
Day Care Expense
Benefit Begins**

We will pay a day care expense benefit when all of the conditions shown below are met:

- A benefit is payable under this Certificate's Basic Accidental Death and Dismemberment and Catastrophic Loss due to a Specified Loss;
- On the date of the Accidental injury which results in the Specified Loss, the Qualified Dependent Child must be under the age of seven of age or younger; and
- We receive proof of the Qualified Dependent Child's enrollment in a Qualified Day Care Program. His or her enrollment must start within 12 months of the date of the Accidental injury which results in the Specified Loss.

What We Pay

Subject to all the terms of this Policy, this benefit will be equal to the lesser of:

- \$10,000 per year; and
- The actual yearly day care expenses for all of Your Qualified Dependent Children.

If this benefit is payable as both an Employee Accidental Death and Dismemberment Benefit and a Dependent Accidental Death and Dismemberment Benefit under this Certificate, the total benefit paid will not exceed the yearly day care expenses for all of Your Qualified Dependent Children.

We pay this benefit to the person who has primary responsibility for these expenses.

**Continued Eligibility
For The Day Care
Expense Benefit**

We require periodic proof:

- That a child remains enrolled in a Qualified Day Care Program; and
- Of the child's day care expenses.

**When The Day Care
Expense Benefit
Ends**

This benefit ends on the earliest of the dates shown below:

- The date the child is no longer a Qualified Dependent Child as shown above;
- The date the child is no longer enrolled in a Qualified Day Care Program;

- The date We do not receive any required proof as shown above; and
- The end of a period of four years from the date the first day care expense benefit was paid.

If you die as a result of an Accidental bodily injury and the Day Care Expense benefit is in effect on the date You die and there is no Qualified Dependent Child who could qualify for this benefit, we will pay a one time benefit of \$500 to the beneficiary in one sum.

B400.6174

CLAIM PROVISIONS

Your right to make a claim for Group Accidental Death and Dismemberment Insurance Benefits provided by this Certificate is governed as follows:

Authority We have the authority to:

- Interpret the terms of this Certificate; and
- Determine Your eligibility for coverage and benefits under this Certificate.

Notice of Claim Written notice of claim must be given to Us within 20 days after the occurrence or commencement of a loss covered by the Plan, or as soon after the loss as is reasonably possible. Notice given by or on behalf of You or the beneficiary to Us at the claims office designated below, or to any authorized agent, with information sufficient to identify You or Your dependent, is considered notice to Us. This notice should include Your name 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 the proof of loss within the time required does not invalidate or reduce the claim if it was not reasonably possible to give proof within the time required, if the proof is furnished as soon as reasonably possible and, unless the claimant is legally incapacitated, not later than 1 year after 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 14334
Lexington, KY 40512

Payment of Benefits We will pay the Group Accidental Death & Dismemberment Insurance Benefit as soon as We receive 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.

B439.0028

DEFINITIONS

This section defines certain terms appearing in Your Certificate.

B400.7183

All Options

Accident This term means an event or occurrence, resulting in bodily injury or death, independent of all other causes, while a Covered Person is insured by this Certificate. Accident does not include:

- 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;
- Engaging in an illegal occupation or other willful criminal activity at the level of a misdemeanor or a felony, including operating a vehicle while intoxicated.

As used in this section:

(a) "Willful criminal activity" includes, but is not limited to, any of the following:

(i) Operating a vehicle while intoxicated in violation of section 625 of the Michigan vehicle code, 1949 PA 300, MCL 257.625, or similar law in a jurisdiction outside of this state.

(ii) Operating a methamphetamine laboratory. As used in this subdivision, "methamphetamine laboratory" means that term as defined in section 1 of 2006 PA 255, MCL 333.26371.

(b) "Willful criminal activity" does not include a civil infraction or other activity that does not rise to the level of a misdemeanor or felony.

- 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 a driver in a motor vehicle Accident, if his or her driver's license has been suspended, revoked or has been expired for more than 90 days, or if the driver is unlicensed.

B439.0029

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

Activities Of Daily Living This term means the ability to independently perform the following, with or without equipment or adaptive devices:

- **Bathing:** wash in a tub or shower; or take a sponge bath; and towel dry.
- **Dressing:** put on and take off all clothes; and those medically necessary braces or prosthetic limbs usually worn; and fasten or unfasten them.
- **Toileting:** get to and from and on and off the toilet; to maintain personal hygiene; and care for clothes.
- **Transferring:** move in and out of a chair or bed.
- **Continence:** control bowel and bladder function; or, in the event of incontinence, maintain personal hygiene.
- **Eating:** get food into the body by any means once it has been prepared and made available.

B400.7187

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

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 HOPE COLLEGE .

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

Insured Earnings Only Your earnings from the Employer will be included as Insured Earnings.

- **For Partners And S Corporation Shareholders** Insured Earnings means the sum of the amounts listed below:
 - Your compensation as an Employee or S Corporation shareholder, or guaranteed payments as a Partner, as reported on Your Federal Income Tax Return(s), Form 1040, for the prior calendar year, less the gross total of unadjusted Employee business expenses as included on the corresponding Schedule A Itemized Deductions.
 - Your non-passive income (loss) from trade of business as reported on Schedule E - Part II of Your Federal Income Tax Return(s), Form 1040, for the prior calendar year, less any expenses incurred and reported elsewhere on Your Return; and
 - Your contributions during the prior calendar year, deposited into a:
 - Cash or deferred compensation plan, or salary reduction plan, qualified under IRC section 401(k), 403(b), 457 or similar plan; and
 - Elective Employee pre-tax deferrals to a Section 125 plan or flexible spending account.

If You are not a partner or S Corporation shareholder for the full prior calendar year, Your earnings will be based on the annualized sum of the listed amounts for the period of time that You were a partner or S Corporation shareholder during that calendar year.

- **For Sole Proprietors:** Insured Earnings means the sum of the amounts listed below.
 - Your annual net profit as determined from Schedule C - Part II of Your Federal Income Tax Return(s), Form 1040 for the prior calendar year
 - Your contribution during the prior calendar year deposited into a:
 - Cash or deferred compensation plan, or salary reduction plan, qualified under IRC section 401(k), 403(b), 457 or similar plan; and
 - Elective Employee pre-tax deferrals to a Section 125 plan or flexible spending account.

Annual net profit is calculated as gross income less total expenses.

If You are not a sole proprietor for the prior calendar year. In that case, We will calculate annual net profit and annual contributions using the full number of months that You were a sole proprietor during such time.

- **For Employees Who Are Compensated On Less Than A 12 Month Basis:** Insured Earnings means annual earnings determined from Your annual contract salary. If You do not have an annual contract salary, Insured Earnings means Your prior calendar year salary.

Your annual contract salary will include shift differential.

The term also includes Your contributions deposited into a:

- Cash or deferred compensation plan, or salary reduction plan, qualified under IRC section 401(k), 403(b), 457 or similar plan; and
- Elective Employee pre-tax deferrals to a Section 125 plan or flexible spending account.

Earnings based on excluded income and Employer contributions deposited into such 401(k), 403(b), 457 or similar plan are not included. The term also does not include:

- Bonuses;
- Overtime pay;
- Expense accounts;
- Stock options; and
- Any other extra compensation.

If You are paid hourly, We calculate Insured Earnings based on actual hours worked or billed in the 12 months before earlier of the the date you ceased working your normally scheduled hours and the date of Your covered loss or death.

We do not include pay for hours worked or billed over 40 per week.

- **For Employees Whose Income Is Reported On A IRS Form 1099:**

Insured Earnings means Your annual earnings as figured from the 1099 form(s) received from the Employer for the prior calendar year. Earnings are calculated as Your earned income as reported on the 1099 form(s) minus business expenses as reported on Schedule C - Part II of Your Federal Income Tax Return(s), Form 1040. The term also includes Your contributions deposited into a:

- Cash or deferred compensation plan, or salary reduction plan, qualified under IRC section 401(k), 403(b), 457 or similar plan; and
- Elective Employee pre-tax deferrals to a Section 125 plan or flexible spending account.

B400.7200

All Options

- **For Any Other Employee Who Receives Base Salary Only:** Insured Earnings means Your base annual salary from the Employer.

Your base annual salary includes shift differential.

The term also includes Your annual contributions deposited into a:

- Cash or deferred compensation plan, or salary reduction plan, qualified under IRC section 401(k), 403(b), 457 or similar plan; and
- Elective Employee pre-tax deferrals to a Section 125 plan or flexible spending account.

Earnings based on excluded income and Employer contributions deposited into such 401(k), 403(b), 457 or similar plan are not included. The term also does not include:

- Bonuses;
- Commissions;
- Overtime pay;
- Expense accounts;
- Stock options; and
- Any other extra compensation.

If You are paid hourly, We calculate Insured Earnings based on actual hours worked or billed in the 12 months before the earlier of the date you ceased working your normally scheduled hours and the date of Your covered loss or death.

We do not include pay for hours worked or billed over 40 per Week.

B400.7201

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 term means the completion of an evidence of insurability form, acceptable to Us, which shows that a person is insurable.

B400.7224

All Options

Proof of Loss This term means the documents that are deemed acceptable for purposes of substantiating a life claim. Acceptable Proof of Loss includes:

- 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.

B400.7225

All Options

Third degree Burn This term means a burn involving the full thickness of skin including the tissue beneath the skin; burns in which both the epidermis and dermis are destroyed with damage extending into underlying tissues.

B400.7227

All Options

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

B400.7228

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

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 An amount equal to 150% of Your Insured Earnings, rounded to the next higher \$1,000.00, if not already a multiple of that amount, to a maximum of \$250,000.00.

B400.7870

All Options

Redetermination Subject to any of the Policy's proof of insurability requirements, Your Basic Accidental Death and Dismemberment Insurance amount will be redetermined on the date a change in Your Insured Earnings occurs, to an amount determined in accordance with the formula shown above, on the basis of Your then current Insured Earnings. Your Employer must report updates to your Insured Earnings as they occur. If You are not actively at work on a Full-Time basis on that date, Your insurance amount will be redetermined on the date You return to active Full-Time service. But, if Your Basic Accidental Death and Dismemberment Insurance amount was previously reduced because of an age or retirement reduction, it will not be redetermined due to the change in earnings.

B400.7883

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.

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."

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 direct 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 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 Accidental Death and Dismemberment Benefit amount by an additional \$5,000, for a total increase of \$15,000.

Proof that You were properly wearing a seatbelt must be provided. 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 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 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 Basic Accidental Death and Dismemberment Insurance and Basic and Voluntary Group Term Life Insurance and may not exceed \$30,000.

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 the driver in an automobile Accident, if Your driver's license has been suspended or revoked or if You are unlicensed;
- While engaging in an illegal occupation or other willful criminal activity at the level of a misdemeanor or a felony, including operating a vehicle while intoxicated.

As used in this section:

(a) "Willful criminal activity" includes, but is not limited to, any of the following:

(i) Operating a vehicle while intoxicated in violation of section 625 of the Michigan vehicle code, 1949 PA 300, MCL 257.625, or similar law in a jurisdiction outside of this state.

(ii) Operating a methamphetamine laboratory. As used in this subdivision, "methamphetamine laboratory" means that term as defined in section 1 of 2006 PA 255, MCL 333.26371.

(b) "Willful criminal activity" does not include a civil infraction or other activity that does not rise to the level of a misdemeanor or felony.

- During Your participation in any sport for compensation or profit; or
- During Your racing an automobile in an organized event or street race.

The Guardian Life Insurance Company of America

A handwritten signature in black ink, appearing to read 'MD', with a stylized, cursive flourish extending from the bottom right.

Matthew Darula, Head of Product, Strategy
and Offerings

B439.0053

The Guardian Life Insurance Company of America 10 Hudson Yards, New York, NY 10001

CERTIFICATE AMENDATORY RIDER

This Rider is effective on the Policy Date. If this Rider is added after the Policy Date, the Rider becomes effective on its issue date.

The **Redetermination** provision(s) in the Certificate Schedule of Benefits are replaced in their entirety with the following:

Redetermination Your basic accidental death and dismemberment insurance amount will be redetermined on the date Your earning's change in accordance with the formula shown in the Schedule of Benefits for basic accidental death and dismemberment insurance and based on Your Insured Earnings on the date of the redetermination.

Redetermination Requirements

Your Employer must report your current Insured Earnings to us for the redetermination to take place.

An increase in Your accidental death and dismemberment insurance amount may be subject to the Proof of Insurability requirements. Please refer to the Proof of Insurability section of the Schedule of Benefits for more information.

If You are not Actively at Work on the redetermination date, the redetermination will not take effect until the date You return to Active Work.

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



Matthew Darula, Head of Product, Strategy and Offerings

B439.0631

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 responsible for the interpretation of 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 will 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.

B997.0390

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.

B997.0391

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.

B997.0392

All Options

Important Notice

You may not be covered by all of the options in this Member Guide

This Member Guide contains all the benefits and options that are available under this Plan. 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.



The Guardian Life Insurance Company of America
10 Hudson Yards, New York, New York 10001

Dental insurance member guide

Welcome to Guardian!

We've been selected by your organization to provide group dental insurance. We'd like to welcome you to our company!

This is the member guide

This guide explains how this insurance coverage works and gives important details about the coverage.

We're here to help. Contact us if you have any questions or want to talk about any part of this guide.

1-800-627-4200

guardianlife.com

Planholder: HOPE COLLEGE

Plan Number: 00096812

B650.0004

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Guide basics

This Member Guide is part of a group insurance Plan

We've entered into an agreement with the Planholder listed on the first page to provide this insurance coverage. The details of the agreement are contained in the Policy we've issued to the Planholder. Check with your Planholder to determine if this coverage is available to you.

This Member Guide is part of the Policy we've issued to the Planholder. Although this is considered a certificate of insurance, we usually refer to this simply as the guide. This guide is important because it tells you how this insurance coverage works.

Unless we specifically say otherwise, when we mention "you" and "your" in this guide, we're referring to you, a member of the organization listed on the first page as the Planholder. Where we say "we" and "us", we're referring to The Guardian Life Insurance Company of America. We usually refer to ourselves simply as Guardian.

How this guide is organized

This guide has five sections. Here's what you'll find in each section:

- **Your benefits**
This section explains the benefit options that are available to you. This section will help you understand the details of your coverage and how much we'll pay when you receive dental care.
- **Using your benefits**
This is where you'll find how benefits are paid and how you or your dentist can submit a claim for benefits.
- **Member coverage & family coverage**
Here's where we explain who's eligible for this coverage and what you need to do to obtain coverage. We also explain what can end your eligibility for coverage.
- **Other things you should know**
You should review and understand these other items that are also important to your coverage.
- **Covered Services Guide**
This may be a separate document but is considered part of this guide. It lists the different dental services covered by this guide and explains any limits or requirements you need to know.

B650.0005

Option A

Your benefits

This section explains the benefits available through this guide, including:

- Dental services that are covered
- How much we'll pay
- Any waiting periods, deductibles and benefit maximums

When we mention family and family members in this section, we're referring to family members who are covered by this guide.

This guide uses the term "benefit year". This is the 12-month period that begins on 07/01 and ends on 06/30.

Covered dental services

There are many different dental services you can receive from your dentist. The services for which benefits are available are grouped into one of the categories listed below. These categories will help you understand what we'll pay, as well as any deductibles that must be met.

This list is a summary. For a detailed list of covered services, and the requirements or limits that apply to them, see the Covered Services Guide.

B650.0013

Option A

What we pay

Preventive services

- In-network dentist 100%
- Out of network dentist 100%

Option A

Basic services

- In-network dentist 75%
- Out of network dentist 75%

Option A

Major services

- In-network dentist 50%
- Out of network dentist 50%

Option B

Your benefits

This section explains the benefits available through this guide, including:

- Dental services that are covered
- How much we'll pay
- Any waiting periods, deductibles and benefit maximums

When we mention family and family members in this section, we're referring to family members who are covered by this guide.

This guide uses the term "benefit year". This is the 12-month period that begins on 07/01 and ends on 06/30.

Covered dental services

There are many different dental services you can receive from your dentist. The services for which benefits are available are grouped into one of the categories listed below. These categories will help you understand what we'll pay, as well as any deductibles that must be met.

This list is a summary. For a detailed list of covered services, and the requirements or limits that apply to them, see the Covered Services Guide.

B650.0013

Option B

What we pay

Preventive services

- In-network dentist 100%
- Out of network dentist 100%

Option B

Basic services

- In-network dentist 75%
- Out of network dentist 75%

Option B

Major services

- In-network dentist 50%
- Out of network dentist 50%

Option B

Orthodontic care

- In-network dentist 50%
- Out of network dentist 50%

All Options

Using a network dentist can save you money

We have a network of dentists to help lower your dental expenses. Our network is called DentalGuard Preferred.

You can go to any dentist you choose, but you can save money by using a dentist in our network. As you can see in the **What we pay** table above, we usually pay a higher percentage of the dentist's fee when you use a dentist in our network.

Also, because dentists in our network will discount their fees for many services, any amount you're responsible for paying may be less if you go to a dentist in our network. This could mean lower out-of-pocket costs for you.

Some states allow dentists in our network to charge the full, undiscounted amount for dental services that aren't covered by this guide. This means if your dentist provides a service that isn't covered by this guide, you won't receive any benefits and you might not receive a discount.

We may pay benefits based on a less expensive alternative treatment or service. We'll do this when the lower cost service would be appropriate based on professionally accepted standards of dental practice.

B650.0146

All Options

What happens when you use a dentist that isn't in our network

If you use a dentist that isn't in our network, the benefits we pay will be based on the amount a dentist that's in our network has agreed to accept for the same service.

We may pay benefits based on a less expensive alternative treatment or service. We'll do this when the lower cost service would be appropriate based on professionally accepted standards of dental practice.

B650.0150

All Options

Deductibles

Option A

Annual deductible

- In-network dentist \$50.00
- Out of network dentist \$50.00

Option A

Must the deductible be met for preventive services?

- In-network dentist No
- Out of network dentist No

Option A

Must the deductible be met for basic services?

- In-network dentist Yes
- Out of network dentist Yes

Option A

Must the deductible be met for major services?

- In-network dentist Yes
- Out of network dentist Yes

Option B

Annual deductible

- In-network dentist \$50.00
- Out of network dentist \$50.00

Option B

Must the deductible be met for preventive services?

- In-network dentist No
- Out of network dentist No

Option B

Must the deductible be met for basic services?

- In-network dentist Yes
- Out of network dentist Yes

Option B

Must the deductible be met for major services?

- In-network dentist Yes
- Out of network dentist Yes

All Options

The annual deductible is the amount you're responsible for paying for the dental services you receive during a benefit year before benefits will be available. The annual deductible is listed in the table above.

The annual deductible must be met by you and each of your family members separately. Benefits will be available to you once you've met this deductible. Benefits will be available to a family member when that family member has met this deductible.

When a total of 2 people in your family have each met the annual deductible, we'll consider everyone in the family to have met it.

Benefits for some dental services are available without any deductible having to be met. This is also listed in the table above.

Only dental expenses that are otherwise covered and that would be paid by this guide can be used to meet your deductible. In other words, only the amount in benefits that would be paid if there was no deductible will be applied to the deductible. You won't be reimbursed for any expenses that are applied to the deductible.

B650.0250

All Options

In-network vs. out of network

Any fees applied to the deductible when you use a DentalGuard Preferred dentist will also be applied to the deductible for services you receive from a dentist that isn't in our network. Similarly, any fees applied to the deductible when you use a dentist that isn't in our network will also be applied to the deductible for services you receive from a DentalGuard Preferred dentist.

B650.0288

All Options

Deductible(s) satisfied under a prior plan

If this Plan replaced a prior plan, we'll give you credit for any portion of the annual deductible that had already been met for the same benefit year. Documentation of the expenses applied to the prior plan's deductible will be required.

A prior plan is the plan that your Planholder had immediately before this Plan. For it to be considered a prior plan, it must have ended the day before this Plan began.

B650.0293

Option A

Benefit maximums

A benefit maximum is the most we'll pay for dental services received during a specific period of time, such as a benefit year or during your lifetime on this Plan. Once we've paid this amount, no additional benefits will be available for services received during that period.

B650.0300

Option A

Annual maximum

- In-network dentist \$1,500.00
- Out of network dentist \$1,500.00

Option B

Benefit maximums

A benefit maximum is the most we'll pay for dental services received during a specific period of time, such as a benefit year or during your lifetime on this Plan. Once we've paid this amount, no additional benefits will be available for services received during that period.

B650.0300

Option B

Annual maximum

- In-network dentist \$1,500.00
- Out of network dentist \$1,500.00

Option B

Orthodontic lifetime maximum

- In-network dentist \$1,500.00
- Out of network dentist \$1,500.00

All Options

The annual maximum is the most we'll pay in benefits for dental services you receive during a benefit year. The annual maximum is listed in the table above.

This maximum applies to you and each of your family members separately. This means you each have an annual maximum in the amount listed in the table above.

B650.0386

Option B

Orthodontic care lifetime maximum

Orthodontic care has its own lifetime maximum. This is the most we'll pay in benefits for orthodontic care received during your lifetime on this Plan. The orthodontic care lifetime maximum is listed in the table above.

This maximum applies to each person that receives orthodontic care benefits separately. This means each person eligible to receive orthodontic care benefits has a lifetime maximum in the amount listed in the table above.

Benefits paid for orthodontic care will count toward the orthodontic care lifetime maximum, but not the annual maximum for other services listed above.

B650.0397

All Options

In-network vs. out of network

The maximum benefits available may depend on the type of dentist you use. This is listed in the above table.

Benefits paid for services received from a DentalGuard Preferred dentist will also count toward the maximum amount available for services received from a dentist that isn't in our network. Similarly, any benefits paid for services received from a dentist that isn't in our network will also count toward the maximum amount available for services you receive from a DentalGuard Preferred dentist.

B650.0428

Option B

Benefits paid under a prior plan

If this Plan replaced a prior plan, any benefits paid for dental services received during the same benefit year will be deducted from the annual maximum listed above. Documentation of benefits paid under the prior plan will be required.

Any benefits paid under a prior plan for orthodontic care will be deducted from this Plan's orthodontic care lifetime maximum.

A prior plan is the plan that your Planholder had immediately before this Plan. For it to be considered a prior plan, it must have ended the day before this Plan began.

B650.0433

Option A

Benefits paid under a prior plan

If this Plan replaced a prior plan, any benefits paid for dental services received during the same benefit year will be deducted from the annual maximum listed above. Documentation of benefits paid under the prior plan will be required.

A prior plan is the plan that your Planholder had immediately before this Plan. For it to be considered a prior plan, it must have ended the day before this Plan began.

B650.0435

All Options

Benefit maximum rollover

A portion of benefits that you don't use in one benefit year can be carried over for future use. If you reach the annual maximum in a benefit year, you can use any benefits that were previously rolled over to help pay for your dental care.

We'll roll over a portion of unused benefits at the beginning of a new benefit year if:

- We paid benefits for dental services you received during the previous benefit year.
- The benefits we paid for dental services you received during the previous benefit year didn't exceed the rollover threshold of \$700.00.
- You were eligible to receive benefits for major services during the previous benefit year.

The amount that will be rolled over each benefit year is \$350.00.

The maximum amount you can have rolled over at any one time is \$1,250.00.

Bonus rollover reward

We'll add a bonus rollover reward of \$500.00 if you used an in-network dentist for all the dental services you received during the benefit year.

B650.0438

Option B

Using the rollover

If you reach your annual maximum during a benefit year, we'll use the rollover amount to continue to pay benefits for dental services received during the same benefit year. When all the rolled over benefits have been used, no additional benefits will be available for dental services you receive in that benefit year.

The rollover benefits can't be used to pay for orthodontic care.

Any rolled over benefits will be lost if your coverage under this Plan ends, or if there's any break in coverage.

The rollover benefit applies to you and each of your family members separately. This means the benefits paid and the amounts rolled over are calculated for each person separately.

B650.0441

Option A

Using the rollover

If you reach your annual maximum during a benefit year, we'll use the rollover amount to continue to pay benefits for dental services received during the same benefit year. When all the rolled over benefits have been used, no additional benefits will be available for dental services you receive in that benefit year.

Any rolled over benefits will be lost if your coverage under this Plan ends, or if there's any break in coverage.

The rollover benefit applies to you and each of your family members separately. This means the benefits paid and the amounts rolled over are calculated for each person separately.

B650.0443

All Options

Special dental programs

From time to time, we may offer you access to various dental health programs and services. These programs and services may offer you access to oral health care products.

You can contact your Planholder or call us at 800-541-7846 for more information.

These programs and services are available to all members covered by this Plan. These offerings may be changed at any time without notice.

B650.1584

Option A

Waiting period if you join the Plan after it began

If your coverage started after the Plan began, benefits for some dental services won't be available until after you've met a waiting period. You won't receive any benefits for the following dental services if they're received during the waiting period listed:

Dental service

B650.0445

Option A

- Major services 12 months

Option A

Dental services received within the waiting period won't be covered and can't be used to meet the deductible.

B650.0457

Option A

Waiting period if you enroll late

If you don't enroll for coverage within the time allowed benefits for some dental services won't be available until after you've met a waiting period. You won't receive any benefits for the following dental services if they're received during the waiting period listed:

Dental service

B650.0454

Option A

- Basic services 6 months

Option A

- Major services 12 months

Option A

The same waiting periods must be satisfied by each family member that's enrolled late.

The waiting periods listed above are in addition to any other waiting periods included under this Plan. This means the waiting periods for enrolling late will not begin until any other waiting period for the same dental service has been satisfied.

Dental services received within the waiting period won't be covered and can't be used to meet the deductible.

See the **You must enroll within the time allowed** section for more information.

B650.0468

Option B

Waiting period if you join the Plan after it began

If your coverage started after the Plan began, benefits for some dental services won't be available until after you've met a waiting period. You won't receive any benefits for the following dental services if they're received during the waiting period listed:

Dental service

B650.0445

Option B

- Major services 12 months

Option B

- Orthodontic care 12 months

Option B

Dental services received within the waiting period won't be covered and can't be used to meet the deductible.

B650.0457

Option B

Waiting period if you enroll late

If you don't enroll for coverage within the time allowed benefits for some dental services won't be available until after you've met a waiting period. You won't receive any benefits for the following dental services if they're received during the waiting period listed:

Dental service

B650.0454

Option B

- Basic services 6 months

Option B

- Major services 12 months

Option B

- Orthodontic care 12 months

Option B

The same waiting periods must be satisfied by each family member that's enrolled late.

The waiting periods listed above are in addition to any other waiting periods included under this Plan. This means the waiting periods for enrolling late will not begin until any other waiting period for the same dental service has been satisfied.

Dental services received within the waiting period won't be covered and can't be used to meet the deductible.

See the **You must enroll within the time allowed** section for more information.

B650.0468

All Options

Using your benefits

Paying your dentist

When you receive dental care, your dentist might submit your claim and wait to see what we pay before asking you to pay anything. Or your dentist could ask that you pay for the services at the time you receive them. Then, either you or your dentist can submit your claim for benefits under this Plan.

See the **What you should do when you have a claim** section for more information on how to send us your claim.

What you're responsible for paying

You're responsible for paying your dentist for any dental expenses that aren't covered by this guide. This includes any deductibles and any other amounts we don't pay. For example, if we pay 80% of a covered service, this means you must pay the other 20%. This is sometimes referred to as "coinsurance".

You're also responsible for paying any fees for services that exceed what's allowed by this guide.

If you use an in-network dentist, you don't need to pay any amounts that are over the discounted amount your dentist agreed to accept. See the **Using a network dentist can save you money** section for more information.

Pre-treatment review of proposed dental services

If you'd like to know how much we'll pay for a dental service before you receive it, we encourage you to have your dentist submit a pre-treatment review. We'll compare the services proposed to the benefits available under this guide and tell you how much we expect to pay. You'll then know how much of the dentist's fee you'll have to pay.

Although these reviews are completely optional, they're a good way to avoid surprises.

Please keep in mind, the amount we tell you we expect to pay is an estimate. The amount we'll pay when you receive the service can change because of factors such as the maximum benefits remaining, your dentist's participation in our network and you continuing to be covered under this Plan.

Your dentist can submit a pre-treatment review in the same way that a claim is submitted. If you have any questions on how to do this, contact your dentist or visit us at guardianlife.com.

Once you've received the proposed services, a claim will need to be submitted so we can pay any benefits available. See the **What you should do when you have a claim** section for more information.

What you should do when you have a claim

Your dentist might submit your claim for you. If your dentist doesn't submit your claim, you can do it yourself by following these simple steps:

Step 1 - Start your claim

When you have a claim, you'll need to complete a claim form. Part of the form will have to be filled out by your dentist. When it's complete, you or your dentist should send it to us, within 20 days is preferred.

You can print a claim form by going to guardianlife.com.

You can also call us at 800-541-7846 to request a claim form.

You can also write to us to tell us you have a claim. Our address for claims is:

Guardian

Group Dental Claims Department
P.O. Box 981572
El Paso, TX 79998-1572

If we don't send you a claim form within 15 days of when you asked for it, you can still submit your claim. To do so, mail us a copy of the dentist's bill. This should identify who you are and include the date(s) and details about the services received. Send this to the address listed above.

Step 2 - Submit your claim

If you're submitting a paper claim, the completed claim form should be mailed to:

Guardian

Group Dental Claims Department
P.O. Box 981572
El Paso, TX 79998-1572

Be sure to include all the information and copies of any documents the instructions indicate are necessary. The claim form and supporting documents are referred to as "proof of loss".

You or your dentist or someone you authorize should submit your proof of loss at the address shown above as soon as you can, within 90 days is preferred, but you must submit it within 15 months of the date you received the dental services for which you're seeking benefits.

We'll only consider claims submitted after this 15 month period if you were legally incapacitated and unable to submit it within the time allowed.

What we'll do when we receive your claim

We'll review your claim to make sure it's complete

- We'll conduct a full and fair review of your claim.
- We'll complete our review of your claim within 30 days of receiving your proof of loss.
- In the event we need more time to consider your claim, which might be the case if we need more information, we can extend this review period by an additional 60 days. We'll notify you in writing if this happens and we'll explain the reason(s) more time is needed.
- If we need more information to consider your claim, we may request this information directly from your dentist. We may need to obtain X-rays, periodontal charting, narratives and other diagnostic information to consider your claim. Your dentist must provide us with the information we need to evaluate your treatment and determine the benefits payable.
- We may use the professional review of a dentist to determine the appropriate benefit for a dental service or course of treatment.
- If we need additional information from you, we'll let you know.

We'll determine if benefits are payable

- We'll make a decision within 30 days of our receiving the information needed to consider your claim.
- If benefits are payable, we'll pay the amount specified in this guide.
- If we deny any part of your claim, we'll provide a written explanation of the specific reason(s) your claim wasn't paid. We'll also include information on how you can appeal our decision.

When we'll pay

If we determine benefits are payable, they'll be paid promptly when we receive the information needed to make the decision on your claim.

Who we'll pay

If an in-network dentist provided your dental services, we'll pay the benefits directly to your dentist.

If a dentist that isn't in our network provided your dental services, we'll pay the benefits to you unless you instruct us to pay your dentist directly.

If you're no longer living, we'll pay benefits to any person you have named as a beneficiary. You may change your beneficiary at any time. You don't need their consent to do so. If you haven't named a beneficiary, we'll pay your benefits to your estate.

If benefits are payable to your estate, and the amount is \$1,000 or less, we can pay someone related to you by blood or marriage who we believe is entitled to the benefits. Any such payment will meet our obligations under this Plan.

B650.0973

All Options

What happens if your claim is denied

If we deny your claim or a part of your claim, we'll provide a written explanation within 30 days of our receiving the information we needed to make the decision. This explanation will include the specific reasons the claim was denied.

If we deny your claim because you or your dentist didn't reply to our requests for information, we'll provide a written explanation within 30 days of the date the information was due. This explanation will list the information you or your dentist were asked to submit.

We'll also provide instructions listing your rights to appeal your claim. These will explain the following:

- You'll need to submit a written appeal within 180 days of receiving our claims decision. The appeal should include any additional information or documentation you or your dentist think would be important for us to consider. Send your appeal to the address listed in the appeal instructions.
- We'll conduct a full and fair review of your appeal.
- We'll complete our review within:
 - 30 days of our receipt of your appeal if it's sent before a service is performed or
 - 60 days of our receipt of your appeal if it's sent after a service is performed.
- In the event we need more time to consider your appeal, which might happen if we need additional information, we can extend this review period by another 10 days from when we get the additional information. We'll let you know if additional time or information is needed.
- We'll let you know of our decision in writing. If we deny your appeal (an adverse determination), we'll provide the specific reasons for the denial.

You should refer to the instructions included with any denial for more information on the appeals process.

What you can do if you have a complaint or grievance

If you have a complaint or grievance, you can call us at 800-541-7846.

You may also contact the Department of Insurance and Financial Services, a state agency which enforces Michigan's insurance laws, and file a grievance or complaint. You may file a grievance complaint electronically with them at:

Department of Insurance and Financial Services

Office of General Counsel - Appeals Section (by mail)

P.O. Box 30220 Lansing MI 48909-7720 (by courier/delivery)

530 W. Allegan Street, 7th Floor Lansing MI 48933

Online Portal: <https://difs.state.mi.us/Complaints/ExternalReview.aspx>

E-mail: DIFS-HealthAppeal@michigan.gov

Phone: (877) 999-6442

Fax: (517) 284-8838

If you have a grievance, it means that you aren't satisfied with a service or claims response under this Plan.

If we make an adverse benefit determination, you or someone you authorize have the right to file a request for an internal grievance and external review within 127 days.

If you do file a request for an external review, you'll need to authorize the release of any medical records that may be needed to make a decision about your grievance.

You may be entitled to an expedited review. This applies if a grievance has been submitted to us in writing; and a dentist tells us or writes to us certifying that waiting 30 days for a standard review would seriously jeopardize your life or health, or your ability to regain maximum function. If this happens, we'll make a determination within 72 hours after we receive the request for an expedited review. We'll let you know of our decision. If we tell you our decision verbally, we'll send you written confirmation within two business days.

You can call us at 800-541-7846 and we'll provide you with detailed instructions on how to file a grievance.

Other things you should know about claims

Who pays first when you're covered by more than one plan

Because you and any family members covered by this Plan may have other dental coverage, we need to determine which plan is responsible for paying first. We coordinate benefits with other plans, so the total amount of benefits paid doesn't exceed the allowable amount for the services received.

This Plan will pay any benefits available for the covered services you receive before any other dental plan.

For covered services your spouse receives, the plan that will pay any benefits available first will be:

- Your spouse's plan if your spouse is covered as an active employee (not a laid off employee, or covered under a state or federal continuation).
- The plan that's been in place the longest if the above rule doesn't apply.

For covered services your child receives, the plan that will pay any benefits available first will be:

- Any other plan covering your child which doesn't have rules for coordinating benefits.
- Your child's plan if your child is covered as an active employee (not a laid off employee, or covered under a state or federal continuation) under another plan.
- For a child whose parents are living together:
 - The plan of the parent whose birthday is earlier in the year. If both parents have the same birthday (month and day) then the plan of the parent that has been in effect longest pays first.
- For a child whose parents are separated and not living together:
 - The plan of the parent identified by any applicable court order.
 - If a court order says that both parents are responsible, the plan whose parent birthday is earlier in the year. If both parents have the same birthday (month and day) then the plan of the parent that has been in effect longest pays first.
 - If there isn't a court order that says which plan pays first, the dental services will be paid in the following order:
 - The plan of a biological parent with custody pays first.
 - The plan of a stepparent with custody pays second.
 - The plan of a biological parent without custody pays third.
 - The plan of a stepparent without custody pays fourth.
- If more than one plan covers a person as an employee, or more than one plan covers a person as a dependent, and none of the rules apply, the plan that has covered the person longer will pay first.
- If none of the above rules apply, then all plans will share expenses equally.

Coordinating benefits

When this Plan pays benefits first, we'll calculate the benefits payable as if you have no other dental coverage.

When another plan pays benefits first, the benefits available under this Plan will be calculated so that the total amount of benefits paid between all of your plans combined doesn't exceed the allowable amount for the services received. We also won't pay more in benefits than we'd pay if this Plan paid first.

A dentist that's in a network has agreed to charge a certain amount for specific dental services. These amounts are listed in what we call a fee schedule. We apply the following rules when determining the benefits available:

- When both plans use a fee schedule, the schedule allowing the higher fee will be used.
- When the plan that pays first is the only plan that uses a fee schedule, that plan's fee schedule will be used.
- When another plan pays first and doesn't use a fee schedule, the fee schedule for this Plan will be used.
- When neither plan uses a fee schedule, the highest allowable amount offered by either plan will be used.

Overpayments

If we find we paid more in benefits than this guide offers, you'll have to return the amount of the overpayment to us. We may ask you to send us the overpayment, or we might deduct the overpayment from future benefits.

Legal action

You can't bring a legal action under this Plan until 60 days after you've submitted proof of loss. You also can't bring a legal action more than three years from the time proof of loss is required, or the date we make a decision on your claim, whichever is later.

Examination

While we're reviewing your claim or appeal, we may require that you be examined by a medical or dental practitioner of our choice as often as reasonably necessary. We can also request an autopsy.

We'll pay for any examination or autopsy we require.

Insurance fraud

We can terminate this coverage if you or your representative commits fraud with respect to a claim.

B650.0975

All Options

Member coverage

Who's eligible

To be eligible for coverage under the Plan, you must meet the following requirements:

You must be in an eligible class of members

Your Planholder may choose to offer coverage to all members or only to those in certain job classifications.

A job classification or class of members is a group of members that fit into the same category. For example, a Planholder could have one class for hourly employees and another class for salaried employees.

If only certain classes are eligible for coverage, you must be in one of these classes to obtain coverage. If you have any questions about your eligibility, please contact your Planholder.

You must meet the minimum number of working hours required

You need to be actively working and performing the regular duties of your job. You must be working the number of hours your Planholder requires for your class, and not less than 30 hours per week.

You must wait to be eligible for coverage

Your Planholder has a waiting period that new members must meet before they can be eligible for this coverage. Your Planholder can tell you if you must meet a waiting period and how long it lasts.

B650.0474

All Options

How to get coverage

If you meet the eligibility rules listed above, you must also do the following to obtain coverage:

You must enroll within the time allowed

You must enroll within 31 days of the date you first become eligible for coverage.

You can also enroll when you have a qualifying life event

If you don't enroll within the time allowed, you can enroll within 31 days of a qualifying life event. This includes:

- Your coverage ending under another dental plan
- Your legal separation or divorce or dissolution of a civil union or domestic partnership
- Your loss of coverage under your spouse's dental plan
- An event required by state or federal law or specified by your Planholder's guidelines

What happens if you enroll late

If you don't enroll within the time allowed, you'll be able to enroll during the next open enrollment period.

Enrollment periods usually occur once every year. We agree with your Planholder on when open enrollment periods happen, and how long they last.

If you have any questions about the open enrollment periods or when you can enroll, please contact your Planholder.

You may have to satisfy a waiting period if you enroll late. See the **Waiting period if you enroll late** section for more information.

Your premium must be paid

We must receive the required premium for your coverage.

B650.0478

All Options

When your coverage begins

If you're eligible for coverage and have done what's required to obtain coverage, as explained under **How to get coverage**, your coverage begins at 12:01 AM EST on the first day you became eligible for coverage.

You must be actively at work, performing the major duties of your regular job and working the required number of hours at the location required by your Planholder on the date your coverage is scheduled to begin. If you don't meet this requirement, your coverage won't begin until you return to being actively at work, performing the major duties of your regular job and working the required number of hours at the location required by your Planholder.

Your coverage may be scheduled to begin on or during one of the following:

- A holiday
- A vacation day
- A day you're not scheduled to work

If this happens, coverage will still begin on that same day if you were actively at work, performing the major duties of your regular job and working the required number of hours at the location required by your Planholder on your last regularly scheduled workday.

B650.0479

All Options

When your coverage ends

Your coverage will end at 11:59 PM EST on the earliest of the following:

- The last day of the month in which you're no longer eligible under this guide.
- The date this coverage is no longer available to the class of members to which you belong.
- The last day of the period or which the required premiums have been paid.
- The day you die.
- The day this Plan ends.

B650.0480

All Options

COBRA continuation rights

If your coverage ends, or a family member's coverage ends, you may be able to keep this coverage under the Consolidated Omnibus Budget Reconciliation Act of 1985, (COBRA). If you have any questions, please contact your Planholder or visit us at guardianlife.com.

B650.0484

All Options

Family leave of absence - Family & Medical Leave Act (FMLA) & Uniformed Services Employment & Re-employment Rights Act (USERRA)

These options are available only if your Planholder is legally required to allow for a family leave of absence. You can confirm with your Planholder if these options are available.

If these options are available to you, you can keep this coverage when you take a leave of absence approved by your Planholder for one of the following reasons:

- To care for a seriously injured or ill spouse, child, or parent
- Within 12 months following the birth or adoption of a child
- Due to your own serious health condition
- To care for a spouse, child, parent or next of kin, who's your closest blood relative, that suffered a sickness or injury while on active duty in the US Armed Forces

You can keep this coverage while on leave for up to 12 weeks in any 12-month period. However, if the leave is to care for a family member who was injured or became ill while on active duty, as explained above, you'll be able to keep this coverage for up to 26 weeks of leave in a 12-month period.

If you take a family leave for any other reason during this same 12-month period, this will count toward the 26-week maximum.

Any subsequent leave to care for a service member will be limited to 12 weeks.

B650.0485

All Options

Family coverage

Who's eligible

The following family members are eligible for coverage:

- Your spouse or civil union partner

A spouse is the person to whom you're legally married or your civil union partner.

B650.0489

All Options

- Your child, who's
 - Under the age of 26

Your child is one of the following:

- Your biological child
- Your stepchild
- A child placed with you for adoption or foster care
- A child for whom you've been appointed a legal guardian and who you claim as a dependent on your federal income taxes

A child who's incapable of self-support because of mental, physical, or developmental disability may be able to keep this coverage past the maximum age. See the **Keeping this coverage for a child who reaches the age limit** section.

B650.0491

All Options

Family members that aren't eligible

- A family member who's on active duty in the armed forces.
- A family member who's also eligible for coverage as a member under this Plan can't be covered more than once.

B650.1199

All Options

How to get coverage for your family

If your family member(s) are eligible, you must do the following to obtain coverage:

You must be enrolled

In order to enroll your family members, you must already be enrolled for coverage, or you must enroll yourself when you enroll them.

You must enroll your family members

You can enroll your eligible family members when they first become eligible.

You can enroll family members when there's a qualifying life event

You can also enroll an eligible family member within 31 days of a qualifying event. This includes:

- Your marriage
- Your legal separation or divorce or dissolution of a civil union

- The death of your spouse
- The birth or adoption of your child or your assuming legal responsibility for a foster child
- Your spouse's loss of coverage under another dental plan
- Your spouse's loss of employment

Your biological children are automatically covered for the first 31 days following their birth. Your adopted children and foster children are automatically covered for the first 31 days from the date they are placed in your care.

You must enroll biological, adopted, and foster children and pay the required premium within this 31-day period or their coverage will end when the 31 days are over.

What happens if you enroll family members late

If you didn't enroll your eligible family members within the time allowed, you'll be able to enroll them during the next open enrollment period.

They may have to satisfy a waiting period because you enrolled them late. See the **Waiting period if you enroll late** section for more information.

The premium must be paid

We must receive the required premium for family coverage.

B650.0498

All Options

When family coverage begins

If you enrolled your family members when you enrolled yourself, their coverage begins at the same time your coverage begins. If you did not enroll your family members at the same time you enrolled yourself, their coverage will begin at 12:01 AM EST on the date you enroll them.

B650.0499

All Options

When family coverage ends

Coverage for your family member will end at 11:59 PM EST on the earliest of the following:

- The date your coverage ends.
- The date you stop being a member of a class that's eligible for family member coverage.
- The last day of the period for which the required premiums were paid.
- For a spouse, the last day of the month in which your marriage ends in divorce or annulment or your civil union is dissolved.
- For a child, the last day of the month in which your child reaches the maximum age or no longer meets the conditions listed under **Keeping this coverage for a child who reaches the age limit**.
- The date the family member becomes ineligible for any of the reasons listed in the **Family members that aren't eligible** section.
- The date the family member dies.

If your coverage ends because of your death, your family members may continue their coverage in accordance with the **Family survivorship benefit**. See the **Family survivorship benefit** for more information.

B650.0516

All Options

Keeping this coverage for a child who reaches the age limit

A child may keep this coverage past the age limit if the child is all the following:

- Unable to live independently due to a mental, physical, or developmental disability which began before reaching the maximum age
- Primarily dependent upon you for financial support
- Continuously covered by this Plan, or by the group plan this Plan replaced, through the time the maximum age was reached

You'll have to send us proof that your child meets these requirements within 31 days of the date the maximum age was reached.

After two years have passed from the date the maximum age was reached, we may periodically ask for documentation that your child continues to meet these requirements. We won't ask for this more than once a year.

Coverage extended in accordance with this section will end when your child no longer meets the conditions above. Even when your child does meet the requirements listed above, this coverage can end due to any of the reasons, other than reaching the maximum age, listed under the **When family coverage ends** section.

B650.0500

All Options

Family survivorship benefit

If you die while you're covered by this Plan, we'll continue to provide coverage to any family members that were covered by this guide at the time of your death. This continued coverage will be provided at no cost to them.

We'll continue to cover your family members for 6 months after the date of your death. Coverage will end on the date this 6-month period ends.

This coverage will end sooner:

- For any family member whose coverage ends for other reasons - see the **Family coverage** section for more information
- For your spouse, upon remarriage
- If this Plan ends

Coverage will end on the date any of above occur.

If a family member elects to keep coverage under COBRA, the family survivorship benefit will be provided during the first 6 months of the continuation. See **COBRA continuation rights** for more information.

B650.0501

All Options

Other things you should know

Paying the premiums

For your insurance coverage to be in place, the required premiums must be paid. We worked with your Planholder to decide how and when the premium payments must be made.

The premiums can be changed at any time. We'll give your Planholder 31 days advance notice of any change in premiums.

If you have any questions about premium payments, please contact the Planholder.

Be sure to give us complete and accurate information

If we asked you to provide personal, health or medical information about yourself or your family members at the time of enrollment, it's important that the information you provided was complete and accurate. If it wasn't, we have the right to challenge a claim for benefits. This means we can deny a claim that might otherwise be covered.

If you don't give us complete and accurate information, we may also have the right to rescind this coverage. This means we would declare your guide to be null and void as of its effective date. In that case, we'd refund all the premiums paid and it would be as though your insurance coverage had never been issued.

During the first three years this guide is effective, we can rescind it if any material information you provided in or with an enrollment form or application was missing or inaccurate. Information is considered material if it would have caused us to:

- Not issue any coverage
- Issue your guide with different coverage or benefit amounts
- Issue your guide with different premium amounts

After this guide has been in place for more than three years:

- We can only rescind it if you committed fraud
- We won't reduce or deny any claim for a condition that is otherwise covered under the guide just because of a condition that existed before you or your family members became covered under the guide.

We won't challenge a claim or contest whether this coverage is valid unless the statement in question was made in writing and signed by you.

Any increase in benefits will be subject to these same requirements, with the two years described above beginning on the effective date of the increase.

Review the information you provided at the time of enrollment or application to make sure it's complete and accurate. If you find anything is missing or inaccurate, you must immediately notify us in writing at the address listed on the first page of this guide.

Misstatement of age

If your age or a family member's age is found to be incorrect, we may need to make an adjustment in the coverage and the premiums.

If the true age would have prevented us from issuing any coverage, this coverage will be terminated from the beginning and a refund of premiums will be made. Any benefits previously paid will be deducted from the refund.

B650.0977



The Guardian Life Insurance Company of America
10 Hudson Yards, New York, New York 10001

Covered services guide

This is the covered services guide

This guide explains the dental services that are covered and how much we'll pay.

We're here to help. Contact us if you have any questions or want to talk about any part of this guide.

1-800-541-7846

guardianlife.com

Planholder: HOPE COLLEGE

Plan Number: 00096812

B651.0004

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Guide basics

Covered dental services

For a dental service to be considered for benefits:

- The service must be provided while you're covered by this Plan. If the service is for a family member, it must be provided while the family member is covered by this Plan. Unless we say otherwise in this guide, the date the dental service is performed will be the date we use to determine the benefits available.
- The service must be provided by a dental or medical practitioner who's properly licensed or certified by the state where the services are provided, and who provides dental services within the scope of this license or certification.
- The service must be provided within the professionally accepted standards of dental practices and be necessary and appropriate for your dental condition.
- The service must be covered by this guide.

There are many different dental services you can receive. This Covered Services Guide lists the most common services, but there can be other dental services not listed here that may also be covered. You or your dentist can contact us with any questions about any dental service you don't see in this guide.

Your dentist will give us a CDT (Current Dental Terminology) code to tell us which service you received. These CDT codes are approved by the American Dental Association and are used by all dentists.

Because dental terminology is updated from time to time, the most current dental terminology may not be reflected in this guide. We'll use the most current dental terminology when we receive your claim and determine the benefits payable.

Some dental services involve more than one procedure. Each procedure will be considered part of the overall service when we determine the benefits payable.

You and your dentist have the right and responsibility to decide upon the best course of treatment for you based on your dental needs, regardless of what benefits may be available. If more than one dental service can be used to treat your dental condition, we'll use the least costly option when we determine the benefits payable.

What we pay

In the Member Guide, we told you about deductibles and benefit maximums. In this guide, we'll give you the details on how much of the dentist's fees we'll pay.

How often

This is where we tell you how often you can have the service and receive the benefits available for that service.

Other things you should know

Here, we'll give you a brief description of each service and tell you other things you need to know about the benefits available.

B651.0006

Office Visits, X-rays & Cleanings - Diagnostic & Preventive Care

Office visits & evaluations

This section explains the benefits available when you go to the dentist for an office visit or evaluation.

Office visits, oral evaluations & comprehensive evaluations Preventive

What we pay:

- When you use an in-network dentist 100%
- When you use an out of network dentist 100%

How often:

- 2 time(s) every 12 months
- 1 time every 36 months for comprehensive evaluations per dentist

Other things you should know:

- These include any regular check-ups and dental evaluations.
- Office visits and evaluations count toward the same maximum number allowed.

Emergency problem-focused evaluations Preventive

What we pay:

- When you use an in-network dentist 100%
- When you use an out of network dentist 100%

How often:

- 1 time every 6 months

Other things you should know:

- This type of evaluation may be needed when there is a specific dental problem that needs attention right away.
- This benefit is available when no other services besides X-rays are performed during the visit. If other services are performed, refer to those services for the benefits available.

After-hours office visits & palliative treatment visits Preventive

What we pay:

- When you use an in-network dentist 100%
- When you use an out of network dentist 100%

How often:

- 1 time every 6 months

Other things you should know:

- After-hours visits take place outside normal office hours.
- Palliative treatment is provided to relieve pain or discomfort.
- After-hours visits and palliative treatment visits count toward the same maximum number allowed.
- This benefit is available when no other services besides X-rays are performed during the visit. If other services are performed, refer to those services for the benefits available.

X-rays - radiographic images

This section explains the benefits available for the various types of X-rays or images your dentist may take during your dental visit. Your dentist may refer to X-rays as radiographic images.

Complete series & panoramic X-rays Preventive

What we pay:

- When you use an in-network dentist **100%**
- When you use an out of network dentist **100%**

How often:

- 1 time(s) every 60 months

Other things you should know:

- A complete series captures an image of every tooth.
- A panoramic X-ray shows all the teeth, surrounding bone and other structures in the mouth.
- Complete series X-rays and panoramic X-rays count toward the same maximum number allowed.

Bitewing X-rays Preventive

What we pay:

- When you use an in-network dentist **100%**
- When you use an out of network dentist **100%**

How often:

- 1 time(s) every 12 months

Other things you should know:

- These X-rays show gum disease and cavities between the teeth.
- This benefit is available for a total of 4 bitewing images, or vertical bitewing images in 1 visit.

Intraoral periapical X-rays Preventive

What we pay:

- When you use an in-network dentist **100%**
- When you use an out of network dentist **100%**

How often:

- As needed

Other things you should know:

- A periapical X-ray is a single X-ray that shows the whole tooth, including the roots.

Occlusal X-rays Preventive

What we pay:

- When you use an in-network dentist **100%**
- When you use an out of network dentist **100%**

How often:

- As needed

Other things you should know:

- An occlusal X-ray is a single X-ray that shows the roof or floor of the mouth.

Dental cleanings, preventive care & other diagnostic services

This section explains the benefits available for cleanings and other types of preventive care aimed at keeping your teeth and gums healthy.

Dental cleanings Preventive

What we pay:

- When you use an in-network dentist **100%**
- When you use an out of network dentist **100%**

How often:

- 2 time(s) every 12 months
- 1 time every 12 months for a medically necessary cleaning

Other things you should know:

- This removes plaque, tartar, and stains from the teeth. It can be performed by a dentist or dental hygienist. Your dentist may call this a prophylaxis.
- Periodontal maintenance visits will count toward the number of dental cleanings allowed. Dental cleanings will also count toward the number of periodontal maintenance visits allowed.
- This benefit for an additional cleaning is available if the cleaning is needed because of health conditions.
- We may ask that your physician provide a written explanation of why an additional cleaning is needed.

Fluoride Preventive

What we pay:

- When you use an in-network dentist **100%**
- When you use an out of network dentist **100%**

How often:

- 2 time(s) every 12 months

Other things you should know:

- This helps prevent cavities by strengthening the outer surface of the teeth. Fluoride can be applied to the teeth as a mouth rinse, gel, or foam.

Sealants Preventive

What we pay:

- When you use an in-network dentist **100%**
- When you use an out of network dentist **100%**

How often:

- 1 time(s) per tooth every 36 months

Other things you should know:

- These are thin, protective resin coatings that adhere to the chewing surface of the back teeth to help prevent cavities.
- This benefit is only available for those under the age of 16.
- This benefit is only available for adult (permanent) molar teeth that don't already have fillings or other treatments on the tooth.

Space maintainer Preventive

What we pay:

- When you use an in-network dentist **100%**
- When you use an out of network dentist **100%**

How often:

- 1 appliance during the lifetime of this plan

Other things you should know:

- This appliance helps preserve space for adult (permanent) teeth when 1 or more baby (primary) teeth are lost too early.
- This benefit is available only for those under the age of 16.
- This benefit is available for 1 bilateral space maintainer for the upper teeth and 1 for the lower teeth, or 1 unilateral space maintainer per quadrant.
- The upper teeth and the lower teeth are each divided into 2 quadrants, a right side, and a left side.
- All services associated with the space maintainer, including adjustments made within 6 months and re-cementations made within 12 months of the space maintainer being inserted, will be considered part of the space maintainer.

Harmful habit appliance Preventive

What we pay:

- When you use an in-network dentist **100%**
- When you use an out of network dentist **100%**

How often:

- 1 appliance during the lifetime of this plan

Other things you should know:

- This appliance is temporarily cemented to certain teeth to prevent a child from sucking a thumb, finger, or pacifier.
- This benefit is available only for those under the age of 14.

Dental model Basic

What we pay:

- When you use an in-network dentist **75%**
- When you use an out of network dentist **75%**

How often:

- 1 model

Other things you should know:

- These are replicas of the upper or lower teeth and are made of stone or plaster. Your dentist may call this a diagnostic cast.
- This benefit is only available when 3 or more of the following are needed at the same time for both the upper and lower teeth:
 - Dentures
 - Crowns
 - Bridges
 - Onlays
 - Full mouth adjustment of the bite

Fillings, Crowns & Other Repairs - Tooth Restorations

Fillings

This section explains the benefits available for dental fillings.

Fillings **Basic**

What we pay:

- When you use an in-network dentist **75%**
- When you use an out of network dentist **75%**

How often:

- 1 time per tooth surface every 12 months for those under the age of 19 and 1 time per tooth surface every 36 months for those age 19 and older.

Other things you should know:

- These are used to restore a tooth damaged by decay or when part of a tooth has broken off. Your dentist may call a silver-colored filling an amalgam restoration. Your dentist may call a tooth-colored filling a resin or composite restoration.
- All services associated with a filling, such as bonding agents, liners, bases, polishing, bite adjustments, and local anesthetic, will be considered part of the filling.

Crowns

This section explains the benefits available when you have a crown placed on a tooth.

Crowns Major

What we pay:

- When you use an in-network dentist **50%**
- When you use an out of network dentist **50%**

How often:

- 1 time per tooth every 5 years
- For a replacement, the crown must be at least 5 years old, damaged, no longer useable, and not repairable.

Other things you should know:

- When a tooth has been damaged by decay or part of a tooth has broken and it can't be repaired with a filling, the tooth may be restored to normal function with a crown. This is sometimes called a cap.
- A crown can be made of metal, porcelain (a tooth-colored material), or both, where porcelain covers the metal underneath.
- This benefit is available only when the crown is needed because of decay or missing tooth structure and the tooth can't be restored with a filling.
- This benefit is available for adult (permanent) teeth only.
- The benefit for a porcelain crown is available for anterior and bicuspid teeth only. These are all the teeth except for the molars. For a crown placed on a molar tooth, what we pay will be based on the cost of an all-metal crown.
- The benefit for a noble metal crown is available for all teeth. If a more expensive material is used, what we pay will be based on the cost of a noble metal crown.
- A crown that's damaged from an injury that occurs while you're covered by this Plan can be replaced if it's no longer useable and it can't be repaired. Damage that results from chewing or biting food or another substance won't be considered damage from an injury.
- All services associated with a crown, such as insulating bases, temporary or provisional restorations, local anesthetic or associated gingival involvement, will be considered part of the crown.
- The day the tooth is prepared for the crown will be considered the date the service is performed.

Prefabricated crowns Basic

What we pay:

- When you use an in-network dentist **75%**
- When you use an out of network dentist **75%**

How often:

- 1 time per tooth every 24 months

Other things you should know:

- When a tooth has been damaged by decay or part of a tooth has broken and it can't be repaired with a filling, the tooth may be restored to normal function with a prefabricated crown. Prefabricated crowns are usually used on baby (primary) teeth.
- A crown can be made of stainless steel, porcelain (a tooth-colored material), resin (also a tooth-colored material) or a combination, where porcelain covers the metal underneath.
- When a prefabricated crown is replaced within 24 months by a permanent crown, the prefabricated crown will be considered temporary and part of the permanent restoration.

Other tooth restoration services

This section explains the benefits available for other types of restorations or repairs your teeth may need.

Onlays & labial veneers Major

What we pay:

- When you use an in-network dentist 50%
- When you use an out of network dentist 50%

How often:

- 1 time per tooth every 5 years
- For a replacement, the restoration must be at least 5 years old, damaged, no longer useable, and not repairable.

Other things you should know:

- These are used when a filling can't be used to restore a tooth damaged by decay or replace a part of the tooth that has broken off.
- Onlays are like crowns, but instead of covering the entire tooth, they cover only the damaged part of the tooth.
- A veneer is a tooth-colored material that's placed on the front of the tooth. These are used on anterior teeth only. These are the incisor and cuspid teeth located in the front of the mouth.
- This benefit is available only when the restoration is needed because of decay or missing tooth structure and the tooth can't be restored with a filling.
- This benefit is available for adult (permanent) teeth only.
- The benefit for a porcelain onlay is available for anterior and bicuspid teeth only. These are all the teeth except for the molars. For an onlay placed on a molar tooth, what we pay will be based on the cost of an all-metal onlay
- The benefit for a noble metal onlay is available for all teeth. If a more expensive material is used, what we pay will be based on the cost of a noble metal onlay.
- An onlay or veneer that's damaged from an injury that occurs while you're covered by this Plan can be replaced if it's no longer useable and can't be repaired. Damage that results from chewing or biting food or another substance won't be considered damage from an injury.
- All services associated with the restoration, such as insulating bases, temporary or provisional restorations, local anesthetic or associated gingival involvement, will be considered part of the restoration.
- The day the tooth is prepared for the restoration will be considered the date the service is performed.

Core buildup & post & core Major

What we pay:

- When you use an in-network dentist **50%**
- When you use an out of network dentist **50%**

How often:

- 1 time per tooth every 5 years
- For a replacement, the restoration must be at least 5 years old, damaged, no longer useable, and not repairable.

Other things you should know:

- A core buildup and a post and core are done to strengthen a tooth that has been broken or damaged by decay so a crown can be placed.
- This benefit is available only when this service is done with a covered crown or bridge retainer and when needed because of substantial loss of tooth structure.
- This benefit is available for adult (permanent) teeth only.

Crown & restoration repairs Basic

What we pay:

- When you use an in-network dentist **75%**
- When you use an out of network dentist **75%**

How often:

- As needed

Other things you should know:

- Sometimes a crown, onlay or veneer can be repaired instead of replaced.

Re-cement & re-bond Basic

What we pay:

- When you use an in-network dentist **75%**
- When you use an out of network dentist **75%**

How often:

- As needed

Other things you should know:

- Sometimes a crown, onlay or veneer may need to be re-cemented or re-bonded.
- This benefit is available if the re-cement or re-bond is done more than 12 months after the placement of the restoration.

Root Canals & Related Services - Endodontic Care

Root canals

This section explains the benefits available when you have a root canal performed.

Root canal - anterior & bicuspid teeth Basic

What we pay:

- When you use an in-network dentist 75%
- When you use an out of network dentist 75%

How often:

- 1 time per tooth
- If a tooth needs to be retreated, this benefit is available 1 time per tooth.

Other things you should know:

- This is done to remove the nerve inside the tooth. A filling is placed where the nerve used to be. Your dentist may call this endodontic therapy.
- This benefit is available for adult (permanent) teeth only.
- All services associated with a root canal, such as X-ray images, cultures and tests, local anesthetic, the protective restoration, and routine follow up care, will be considered part of the root canal.
- The day the tooth is initially opened for a root canal will be considered the date the service is performed.

Root canal - molar teeth Basic

What we pay:

- When you use an in-network dentist 75%
- When you use an out of network dentist 75%

How often:

- 1 time per tooth
- If a tooth needs to be retreated, this benefit is available 1 time per tooth.

Other things you should know:

- This is done to remove the nerve inside the tooth. A filling is placed where the nerve used to be. Your dentist may call this endodontic therapy.
- This benefit is available for adult (permanent) teeth only.
- All services associated with a root canal, such as X-ray images, cultures and tests, local anesthetic, the protective restoration, and routine follow up care, will be considered part of the root canal.
- The day the tooth is initially opened for a root canal will be considered the date the service is performed.

Other endodontic services

This section explains the benefits available for other endodontic procedures.

Pulp cap Basic

What we pay:

- When you use an in-network dentist **75%**
- When you use an out of network dentist **75%**

How often:

- 1 time per tooth

Other things you should know:

- This is a special material placed underneath a filling to protect the nerve inside the tooth.
- This benefit is available for adult (permanent) teeth only.
- All services associated with a pulp cap, such as X-rays, cultures and tests, local anesthetic, temporary filling, and routine follow up care, will be considered part of the pulp cap.

Pulpotomy Basic

What we pay:

- When you use an in-network dentist **75%**
- When you use an out of network dentist **75%**

How often:

- As needed

Other things you should know:

- This involves removing the nerve inside the tooth.
- When a root canal is the final treatment, this service will be considered part of the root canal.
- All services for treatment associated with a pulpotomy, such as diagnosis, X-rays, cultures and tests, local anesthetic, protective restoration, and routine follow up care, will be considered part of the pulpotomy.

Apicoectomy, retrograde filling & root amputation Basic

What we pay:

- When you use an in-network dentist **75%**
- When you use an out of network dentist **75%**

How often:

- 1 time per tooth root for each procedure

Other things you should know:

- An apicoectomy is the surgical removal of the tip of the tooth root.
- A retrograde filling is used to seal the site of the root tip removal.
- A root amputation is the surgical removal of a root from a tooth that has multiple roots.
- All services associated with these procedures, such as diagnosis, X-rays, cultures and tests, local anesthetic, protective restoration, and routine follow up care, will be considered part of the procedure.

Periodontal Care - Treatment of Gum Disease & Related Services

Non-surgical periodontal services

This section explains the benefits available when you receive periodontic care that doesn't involve surgery.

Periodontal maintenance Preventive

What we pay:

- When you use an in-network dentist **100%**
- When you use an out of network dentist **100%**

How often:

- You can have periodontal maintenance 2 time(s) every 12 months, but not more than a combined total of 2 dental cleanings and periodontal maintenance visits in the same 12 months.

Other things you should know:

- This is a specialized cleaning that may be needed after any type of previous periodontal treatment. Your dentist may call this a periodontal prophylaxis or periodontal cleaning.
- Periodontal maintenance visits will count toward the number of dental cleanings allowed. Dental cleanings will also count toward the number of periodontal maintenance visits allowed.
- All services associated with periodontal maintenance, including the treatment plan, charting, scaling, polishing, local anesthetic, and post- treatment care, will be considered part of the periodontal maintenance.

Scaling & root planing Basic

What we pay:

- When you use an in-network dentist **75%**
- When you use an out of network dentist **75%**

How often:

- 1 time(s) per quadrant every 24 months

Other things you should know:

- This is a cleaning of tooth surfaces both above and below the gumline. It may be necessary when there's periodontal disease and chronic inflammation in the gum tissue around the teeth that causes a breakdown in some of the nearby bone.
- This benefit will be available only when there's periodontal disease documented by charting of pockets in the gums and bone loss that's verified by X-ray.
- The upper teeth and the lower teeth are each divided into 2 quadrants, a right side, and a left side.
- All services associated with the scaling and root planing, including the treatment plan, charting, scaling, polishing, local anesthetic, and post-treatment care, will be considered part of the scaling and root planing.

Full mouth debridement Basic

What we pay:

- When you use an in-network dentist **75%**
- When you use an out of network dentist **75%**

How often:

- 1 time during the lifetime of this plan

Other things you should know:

- This is an extensive cleaning needed when the teeth can't be examined because of a significant amount of plaque and buildup on them.
- All services associated with the debridement, including the treatment plan, charting, scaling, polishing, local anesthetic, and post-treatment care, will be considered part of the debridement.

Periodontal surgery

This section explains the benefits available when you have periodontic surgery.

Gingivectomy, gingivoplasty (1 to 3 teeth) & crown lengthening Basic

What we pay:

- When you use an in-network dentist **75%**
- When you use an out of network dentist **75%**

How often:

- 1 surgical procedure per tooth every 12 months

Other things you should know:

- A gingivectomy and gingivoplasty removes excess or inflamed gum tissue.
- Crown lengthening removes a small amount of bone and gum tissue around a tooth to make a crown fit better.
- This benefit will be available only when there's periodontal disease documented by charting of pockets in the gums and bone loss that's verified by X-ray. This benefit will be available for a gingivectomy of 1 tooth when there is documented inflammation of the gum tissue.
- All services associated with these surgical procedures, including the treatment plan, charting, irrigation, local anesthetic, suturing and post-surgical care, will be considered part of the surgical procedure.

Gingivectomy, gingivoplasty (4 or more teeth), osseous surgery, gingival flap procedure, mesial/distal wedge procedure & surgical revision procedure Basic

What we pay:

- When you use an in-network dentist **75%**
- When you use an out of network dentist **75%**

How often:

- 1 surgical procedure per quadrant every 36 months

Other things you should know:

- A gingivectomy and gingivoplasty removes excess or inflamed gum tissue.
- Osseous surgery reshapes the bone around the tooth.
- Gingival flap, mesial/distal wedge and surgical revision procedures reshape the gum tissue around a tooth, teeth, or spaces without teeth.
- This benefit will be available only when there's periodontal disease documented by charting of pockets in the gums and bone loss that's verified by X-ray.
- All services associated with these surgical procedures, including the treatment plan, charting, irrigation, local anesthetic, suturing and post-surgical care, will be considered part of the surgical procedure.

Tissue graft Basic

What we pay:

- When you use an in-network dentist **75%**
- When you use an out of network dentist **75%**

How often:

- 1 time(s) per tooth or site every 36 months

Other things you should know:

- This involves replacing gum tissue that has been lost around the root area of a tooth.
- This benefit is available only when there's documentation of progressive loss of gum tissue due to disease.
- This benefit is available only when the tooth is present.
- This benefit is available only when this procedure is necessary as part of a covered implant placement.
- All services associated with the graft, including the treatment plan, charting, irrigation, suturing, local anesthetic, and post-surgical care, will be considered part of the graft.

Guided tissue regeneration Basic

What we pay:

- When you use an in-network dentist **75%**
- When you use an out of network dentist **75%**

How often:

- 1 time(s) per tooth or site

Other things you should know:

- This is used to replace gum tissue. It's frequently done with a bone graft to replace bone that has been lost.
- This benefit will be available only when there's periodontal disease documented by charting of pockets in the gums and bone loss that's verified by X-ray.
- This benefit is available only when the tooth is present.
- All services associated with the regeneration, including the treatment plan, charting, irrigation, suturing, local anesthetic, and post-surgical care will be considered part of the regeneration.

Bone replacement graft Basic

What we pay:

- When you use an in-network dentist **75%**
- When you use an out of network dentist **75%**

How often:

- 1 time(s) per tooth or site

Other things you should know:

- This involves replacing bone tissue that has been destroyed by periodontal disease.
- This benefit will be available only when there's periodontal disease documented by charting of pockets in the gums and bone loss that's verified by X-ray.
- This benefit is available only when the tooth is present.
- All services associated with the bone graft, including the treatment plan, charting, irrigation, suturing, local anesthetic, and post-surgical care, will be considered part of the bone graft.

Periodontal related services

This section explains the benefits available for other periodontal related services.

Limited occlusal adjustment **Basic**

What we pay:

- When you use an in-network dentist **75%**
- When you use an out of network dentist **75%**

How often:

- 2 visits

Other things you should know:

- This is a minor adjustment of the biting surfaces of 1 or more teeth.
- This benefit will be available only for adjustments made within 6 months after osseous surgery and scaling and root planing.

Occlusal guard **Basic**

What we pay:

- When you use an in-network dentist **75%**
- When you use an out of network dentist **75%**

How often:

- 1 appliance during the lifetime of this Plan

Other things you should know:

- This appliance covers some or all the teeth. There are different types of guards used for different types of treatment.
- This benefit is available only when the guard is received within 6 months after osseous surgery.

Bridges & Dentures - Prosthodontics

Bridges

This section explains the benefits available when you have a bridge made and placed.

Bridges **Major**

What we pay:

- When you use an in-network dentist **50%**
- When you use an out of network dentist **50%**

How often:

- 1 time per tooth every 5 years
- For a replacement, the bridge must be at least 5 years old, damaged, no longer useable, and not repairable.

Other things you should know:

- This a fixed prosthetic that replaces 1 or more missing teeth and is held in place by adjacent teeth. Your dentist may refer to the false teeth as pontics and to the adjacent teeth as abutments.
- This benefit is available for adult (permanent) teeth only.
- The benefit for a porcelain bridge is available for anterior and bicuspid teeth only. These are all the teeth except for the molars. For a bridge placed on molar teeth, what we pay will be based on the cost of an all-metal bridge.
- The benefit for a noble metal bridge is available for all teeth. If a more expensive material is used, what we pay will be based on the cost of a noble metal bridge.
- A bridge that's damaged from an injury that occurs while you're covered by this Plan can be replaced if it's no longer useable and can't be repaired. Damage that results from chewing or biting food or another substance won't be considered damage from an injury.
- All services associated with a bridge, including insulating bases, temporary or provisional restorations, local anesthetic, or gingival involvement, will be considered part of the bridge.
- The day the tooth is initially prepared for the bridge will be considered the date the service is performed.

Dentures

This section explains the benefits available when you have a denture made and placed.

Dentures - partial & complete Major

What we pay:

- When you use an in-network dentist 50%
- When you use an out of network dentist 50%

How often:

- 1 time every 5 years for each denture
- For a replacement, the denture must be at least 5 years old, damaged, no longer useable, and not repairable.

Other things you should know:

- These are removable dental prostheses used to replace missing teeth. A partial denture replaces 1 or more upper teeth or 1 or more lower teeth. A complete denture replaces all the upper teeth or all the lower teeth.
- This benefit is available to replace adult (permanent) teeth only.
- The day the final impression is taken for the denture will be considered the date the service is performed.
- If a temporary, interim, or provisional denture is in place for more than 1 year, it will be considered a permanent denture.
- All services associated with a denture, including a temporary denture and adjustments made in the first 6 months after the denture is placed, will be considered part of the denture.
- A denture that's damaged from an injury that occurs while you're covered by this Plan can be replaced if it's no longer useable and can't be repaired. Damage that results from chewing or biting food or another substance won't be considered damage from an injury.

Bridge & denture repairs & maintenance

This section explains the benefits available when a bridge or denture needs to be repaired or modified.

Bridge repairs Basic

What we pay:

- When you use an in-network dentist 75%
- When you use an out of network dentist 75%

How often:

- As needed

Other things you should know:

- A bridge may need to be repaired due to wear or other damage.

Denture repairs Basic

What we pay:

- When you use an in-network dentist 75%
- When you use an out of network dentist 75%

How often:

- As needed

Other things you should know:

- A denture may need to be repaired due to wear or other damage.

Denture adjustments Basic

What we pay:

- When you use an in-network dentist **75%**
- When you use an out of network dentist **75%**

How often:

- As needed

Other things you should know:

- Adjustments involve making changes to the denture to ensure a proper fit.
- Any charges for denture adjustment done within 6 months after the denture was placed will be considered part of the fee for the denture if it's done by the same dentist that provided the denture.
- This benefit is available only when the adjustment is done more than 6 months after the denture was placed or more than 6 months after the most recent denture rebase or denture reline.

Adding teeth to partial dentures Basic

What we pay:

- When you use an in-network dentist **75%**
- When you use an out of network dentist **75%**

How often:

- As needed

Other things you should know:

- A partial denture may need to be modified if additional teeth are lost after it was first placed.

Denture rebase Basic

What we pay:

- When you use an in-network dentist **75%**
- When you use an out of network dentist **75%**

How often:

- 1 time per denture every 24 months

Other things you should know:

- This involves replacing the entire acrylic denture base without replacing the artificial teeth.
- Any charges for a denture rebase done within 12 months after the denture was placed will be considered part of the fee for the denture if it's done by the same dentist that provided the denture.
- This benefit is available only when the rebase is done more than 12 months after the denture was placed.

Denture reline Basic

What we pay:

- When you use an in-network dentist **75%**
- When you use an out of network dentist **75%**

How often:

- 1 time per denture every 24 months

Other things you should know:

- This involves reshaping the denture base to make it more comfortable.
- Any charges for a denture reline done within 12 months after the denture was placed will be considered part of the fee for the denture if its done by the same dentist that provided the denture.
- This benefit is available only when the reline is done more than 12 months after the denture was placed.

Tissue conditioning Basic

What we pay:

- When you use an in-network dentist **75%**
- When you use an out of network dentist **75%**

How often:

- 1 time for the upper denture and 1 time for the lower denture every 12 months

Other things you should know:

- This is a temporary cushion placed inside a denture to improve fit and comfort following an extraction or other surgical procedure.
- Any charges for tissue conditioning done within 12 months after the denture was placed will be considered part of the fee for the denture if it's done by the same dentist that provided the denture.

Dental Implants

Implants

This section explains the benefits available when you have a dental implant placed.

Radiographic/surgical implant index Major

What we pay:

- When you use an in-network dentist 50%
- When you use an out of network dentist 50%

How often:

- 1 time for the upper teeth and 1 time for the lower teeth every 24 months

Other things you should know:

- This is a customized template used to guide the correct placement of the implant.

Surgical placement of implant Major

What we pay:

- When you use an in-network dentist 50%
- When you use an out of network dentist 50%

How often:

- 1 time per tooth every 5 years
- For a replacement, the implant must be at least 5 years old, damaged, no longer useable, and not repairable.

Other things you should know:

- An implant is like a post and is surgically placed into the jawbone.
- This benefit is available for adult (permanent) teeth only.
- All services associated with an implant, such as the treatment plan, local anesthetic, and post-surgical care, will be considered part of the implant.
- An implant crown that's damaged from an injury that occurs while you're covered by this Plan can be replaced if it's no longer useable and can't be repaired. Damage that results from chewing or biting food or another substance won't be considered damage from an injury.

Other implant related services

This section explains the benefits available for other services related to dental implants.

Implant abutments - prefabricated & custom fabricated Major

What we pay:

- When you use an in-network dentist **50%**
- When you use an out of network dentist **50%**

How often:

- 1 time per tooth every 5 years
- For a replacement, the implant abutment must be at least 5 years old, damaged, no longer useable, and not repairable.

Other things you should know:

- These attach to the implant and connect the implant to the implant crown, bridge, or denture.
- An implant abutment that's damaged from an injury that occurs while you're covered by this Plan can be replaced if it's no longer useable and can't be repaired. Damage that results from chewing or biting food or another substance won't be considered damage from an injury.

Implant/abutment-supported crowns Major

What we pay:

- When you use an in-network dentist **50%**
- When you use an out of network dentist **50%**

How often:

- 1 time per tooth every 5 years
- For a replacement, the implant crown must be at least 5 years old, damaged, no longer useable, and not repairable.

Other things you should know:

- These are screwed or cemented onto the abutment to replace the missing tooth.
- This benefit is available for adult (permanent) teeth only.
- The benefit for a porcelain crown is available for anterior and bicuspid teeth only. These are all the teeth except for the molars. For a crown placed on a molar tooth, what we pay will be based on the cost of an all-metal crown.
- The benefit for a noble metal crown is available for all teeth. If a more expensive material is used, what we pay will be based on the cost of a noble metal crown.
- An implant crown that's damaged from an injury that occurs while you're covered by this Plan can be replaced if it's no longer useable and can't be repaired. Damage that results from chewing or biting food or another substance won't be considered damage from an injury.

Implant/abutment-supported dentures Major

What we pay:

- When you use an in-network dentist **50%**
- When you use an out of network dentist **50%**

How often:

- 1 time per denture every 5 years
- For a replacement, the implant denture must be at least 5 years old, damaged, no longer useable, and not repairable.

Other things you should know:

- These are used to replace missing teeth. A partial denture replaces 1 or more upper teeth or 1 or more lower teeth. A complete implant denture replaces all the upper teeth or lower teeth.
- This benefit is available to replace adult (permanent) teeth only.
- An implant denture that's damaged from an injury that occurs while you're covered by this Plan can be replaced if it's no longer useable and can't be repaired. Damage that results from chewing or biting food or another substance won't be considered damage from an injury.

Bone replacement graft for ridge preservation Major

What we pay:

- When you use an in-network dentist **50%**
- When you use an out of network dentist **50%**

How often:

- 1 time per tooth or area

Other things you should know:

- This involves replacing bone tissue that has been lost because of an extraction or implant removal.
- This benefit is available only when the procedure is done with a covered dental implant in the same site.

Implant repairs & removal

This section explains the benefits available when you have an implant abutment, crown or denture that needs to be repaired or an implant that needs to be removed.

Implant crown & implant denture repairs Major

What we pay:

- When you use an in-network dentist 50%
- When you use an out of network dentist 50%

How often:

- As needed

Other things you should know:

- An implant supported crown or denture may need to be repaired due to wear or other damage.

Implant abutment repairs Major

What we pay:

- When you use an in-network dentist 50%
- When you use an out of network dentist 50%

How often:

- As needed

Other things you should know:

- An implant abutment may need to be repaired due to wear or other damage.

Implant removal Major

What we pay:

- When you use an in-network dentist 50%
- When you use an out of network dentist 50%

How often:

- 1 time per tooth

Other things you should know:

- This involves removing an implant from the jaw.

Tooth Extractions & Oral Surgery

Extractions

This section explains the benefits available when you have a tooth removed.

Non-surgical extractions Basic

What we pay:

- When you use an in-network dentist 75%
- When you use an out of network dentist 75%

How often:

- As needed

Other things you should know:

- This is done to remove a tooth or root that's above the gumline.
- All services associated with the extraction, such as the treatment plan, local anesthetic, and post-treatment care, will be considered part of the extraction.

Complex surgical extractions Basic

What we pay:

- When you use an in-network dentist 75%
- When you use an out of network dentist 75%

How often:

- As needed

Other things you should know:

- This is done when the extraction involves cutting the gums or bone to remove the tooth or roots.
- All services associated with the extraction, such as the treatment plan, local anesthetic, suturing and post-surgical care, will be considered part of the extraction.
- These procedures may be covered by your medical plan. See the **Other things you should know about claims** section of the Member Guide for more information.

Other oral surgery services

This section explains the benefits available for other oral surgery procedures.

Other complex oral surgeries Basic

What we pay:

- When you use an in-network dentist 75%
- When you use an out of network dentist 75%

How often:

- As needed

Other things you should know:

- Other types of oral surgery may be needed to treat oral diseases, injuries, and defects.
- All services associated with the surgery, such as X-rays, the treatment plan, local anesthetic, suturing, and post-surgical care, will be considered part of the surgery.
- These procedures may be covered by your medical plan. See the **Other things you should know about claims** section of the Member Guide for more information

Other Dental Services

This section explains the benefits available when you receive one of the following services.

Anesthesia Basic

What we pay:

- When you use an in-network dentist 75%
- When you use an out of network dentist 75%

How often:

- As needed

Other things you should know:

- This is a drug administered during procedures to reduce pain or discomfort. This includes:
 - Deep sedation/general anesthesia
 - Intravenous conscious sedation
 - Non-intravenous conscious sedation
 - Nitrous oxide
- This benefit is available only when the anesthesia is administered with a covered surgical service.

Consultations Basic

What we pay:

- When you use an in-network dentist 75%
- When you use an out of network dentist 75%

How often:

- 1 time for each dental specialty every 12 months

Other things you should know:

- This is an examination performed by a specialty dentist or a dentist other than your usual dentist.
- This benefit is available only when the dentist providing the consultation isn't the same dentist providing your treatment.
- This benefit is available only when no other services, other than X-rays, are performed during the consultation. If other services are performed, refer to those services for the benefits available.

What isn't covered - exclusions

This section explains the services that aren't covered by this Plan.

No benefits are available for:

- Any service for which there is no charge
- Any service that's needed because of an on-the-job or job-related injury or that's covered by Worker's Compensation or similar laws
- Any service that doesn't meet professionally recognized standards of dental practice or that's considered to be experimental
- Any service that's performed in conjunction with or related to a service that isn't covered by this guide
- Any service on a tooth with a guarded, questionable, or poor prognosis
- Any service that's used solely to:
 - Alter occlusal vertical dimensions
 - Restore or maintain occlusion
 - Treat a condition resulting from attrition, abrasion, erosion or abfraction
 - Splint or stabilize teeth for periodontal reasons
- Replacing extracted or missing wisdom teeth
- Localized use of antimicrobial agents into diseased crevicular tissue
- Any service that's provided solely for cosmetic reasons, such as teeth whitening, characterization, or personalization of a dental prosthesis, or odontoplasty. Benefits are available for cosmetic services needed to treat medically diagnosed congenital and developmental malformations for a newborn or newly adopted child.
- Replacement of a lost, missing, or stolen appliance or dental prosthesis, or the fabrication of a spare appliance or dental prosthesis
- Upgrading from one appliance or dental prosthesis to another appliance or dental prosthesis, such as replacing a bridge with a dental implant or replacing a denture with a bridge
- A temporary or provisional appliance or dental prosthesis, unless it's an interim partial denture that replaces anterior teeth extracted while this coverage was in place. These are the incisor and cuspid teeth located in the front of the mouth.
- A bridge that replaces the extracted portion of a hemisected tooth
- The placement of more than one crown or bridge unit per tooth
- Overdentures and related services, including root canal therapy on teeth supporting the overdenture
- Detailed and extensive oral evaluations
- Any service that's educational or instructional, such as oral hygiene instruction, tobacco counseling or nutritional counseling
- Bite registration, bite analysis or occlusion analysis - mounted case
- Duplication of X-rays
- Completion of claim forms
- OSHA or other infection control measures
- Cephalometric X-rays
- Cone beam images
- Oral or facial photographs
- Prescription medication
- Application of desensitizing medications and resins
- Separate charges for local anesthesia
- Pulp vitality tests
- Caries susceptibility tests
- Specialized techniques
- Precision attachments

- Maxillofacial prosthetics to repair facial or skeletal anomalies, maxillofacial surgery, orthognathic surgery, or any oral surgery requiring the setting of a fracture or dislocation that results from or is incidental to a medical condition
- Treatment of congenital or developmental malformations or the replacement of congenitally missing teeth. Benefits are available for cosmetic services needed to treat medically diagnosed congenital and developmental malformations for a newborn or newly adopted child
- Any service intended to treat or diagnose disorders of the temporomandibular joint (TMJ)
- Any service coded by the dentist as unspecified
- The isolation of a tooth with a rubber dam
- Gingival irrigation
- Medications dispensed in a dental office for home use

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The Guardian Life Insurance Company of America
10 Hudson Yards, New York, New York 10001

Covered services guide

This is the covered services guide

This guide explains the dental services that are covered and how much we'll pay.

We're here to help. Contact us if you have any questions or want to talk about any part of this guide.

1-800-541-7846

guardianlife.com

Planholder: HOPE COLLEGE

Plan Number: 00096812

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Option B

Guide basics

Covered dental services

For a dental service to be considered for benefits:

- The service must be provided while you're covered by this Plan. If the service is for a family member, it must be provided while the family member is covered by this Plan. Unless we say otherwise in this guide, the date the dental service is performed will be the date we use to determine the benefits available.
- The service must be provided by a dental or medical practitioner who's properly licensed or certified by the state where the services are provided, and who provides dental services within the scope of this license or certification.
- The service must be provided within the professionally accepted standards of dental practices and be necessary and appropriate for your dental condition.
- The service must be covered by this guide.

There are many different dental services you can receive. This Covered Services Guide lists the most common services, but there can be other dental services not listed here that may also be covered. You or your dentist can contact us with any questions about any dental service you don't see in this guide.

Your dentist will give us a CDT (Current Dental Terminology) code to tell us which service you received. These CDT codes are approved by the American Dental Association and are used by all dentists.

Because dental terminology is updated from time to time, the most current dental terminology may not be reflected in this guide. We'll use the most current dental terminology when we receive your claim and determine the benefits payable.

Some dental services involve more than one procedure. Each procedure will be considered part of the overall service when we determine the benefits payable.

You and your dentist have the right and responsibility to decide upon the best course of treatment for you based on your dental needs, regardless of what benefits may be available. If more than one dental service can be used to treat your dental condition, we'll use the least costly option when we determine the benefits payable.

What we pay

In the Member Guide, we told you about deductibles and benefit maximums. In this guide, we'll give you the details on how much of the dentist's fees we'll pay.

How often

This is where we tell you how often you can have the service and receive the benefits available for that service.

Other things you should know

Here, we'll give you a brief description of each service and tell you other things you need to know about the benefits available.

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Office Visits, X-rays & Cleanings - Diagnostic & Preventive Care

Office visits & evaluations

This section explains the benefits available when you go to the dentist for an office visit or evaluation.

Office visits, oral evaluations & comprehensive evaluations Preventive

What we pay:

- When you use an in-network dentist 100%
- When you use an out of network dentist 100%

How often:

- 2 time(s) every 12 months
- 1 time every 36 months for comprehensive evaluations per dentist

Other things you should know:

- These include any regular check-ups and dental evaluations.
- Office visits and evaluations count toward the same maximum number allowed.

Emergency problem-focused evaluations Preventive

What we pay:

- When you use an in-network dentist 100%
- When you use an out of network dentist 100%

How often:

- 1 time every 6 months

Other things you should know:

- This type of evaluation may be needed when there is a specific dental problem that needs attention right away.
- This benefit is available when no other services besides X-rays are performed during the visit. If other services are performed, refer to those services for the benefits available.

After-hours office visits & palliative treatment visits Preventive

What we pay:

- When you use an in-network dentist 100%
- When you use an out of network dentist 100%

How often:

- 1 time every 6 months

Other things you should know:

- After-hours visits take place outside normal office hours.
- Palliative treatment is provided to relieve pain or discomfort.
- After-hours visits and palliative treatment visits count toward the same maximum number allowed.
- This benefit is available when no other services besides X-rays are performed during the visit. If other services are performed, refer to those services for the benefits available.

X-rays - radiographic images

This section explains the benefits available for the various types of X-rays or images your dentist may take during your dental visit. Your dentist may refer to X-rays as radiographic images.

Complete series & panoramic X-rays Preventive

What we pay:

- When you use an in-network dentist **100%**
- When you use an out of network dentist **100%**

How often:

- 1 time(s) every 60 months

Other things you should know:

- A complete series captures an image of every tooth.
- A panoramic X-ray shows all the teeth, surrounding bone and other structures in the mouth.
- Complete series X-rays and panoramic X-rays count toward the same maximum number allowed.

Bitewing X-rays Preventive

What we pay:

- When you use an in-network dentist **100%**
- When you use an out of network dentist **100%**

How often:

- 1 time(s) every 12 months

Other things you should know:

- These X-rays show gum disease and cavities between the teeth.
- This benefit is available for a total of 4 bitewing images, or vertical bitewing images in 1 visit.

Intraoral periapical X-rays Preventive

What we pay:

- When you use an in-network dentist **100%**
- When you use an out of network dentist **100%**

How often:

- As needed

Other things you should know:

- A periapical X-ray is a single X-ray that shows the whole tooth, including the roots.

Occlusal X-rays Preventive

What we pay:

- When you use an in-network dentist **100%**
- When you use an out of network dentist **100%**

How often:

- As needed

Other things you should know:

- An occlusal X-ray is a single X-ray that shows the roof or floor of the mouth.

Dental cleanings, preventive care & other diagnostic services

This section explains the benefits available for cleanings and other types of preventive care aimed at keeping your teeth and gums healthy.

Dental cleanings Preventive

What we pay:

- When you use an in-network dentist **100%**
- When you use an out of network dentist **100%**

How often:

- 2 time(s) every 12 months
- 1 time every 12 months for a medically necessary cleaning

Other things you should know:

- This removes plaque, tartar, and stains from the teeth. It can be performed by a dentist or dental hygienist. Your dentist may call this a prophylaxis.
- Periodontal maintenance visits will count toward the number of dental cleanings allowed. Dental cleanings will also count toward the number of periodontal maintenance visits allowed.
- This benefit for an additional cleaning is available if the cleaning is needed because of health conditions.
- We may ask that your physician provide a written explanation of why an additional cleaning is needed.

Fluoride Preventive

What we pay:

- When you use an in-network dentist **100%**
- When you use an out of network dentist **100%**

How often:

- 2 time(s) every 12 months

Other things you should know:

- This helps prevent cavities by strengthening the outer surface of the teeth. Fluoride can be applied to the teeth as a mouth rinse, gel, or foam.

Sealants Preventive

What we pay:

- When you use an in-network dentist **100%**
- When you use an out of network dentist **100%**

How often:

- 1 time(s) per tooth every 36 months

Other things you should know:

- These are thin, protective resin coatings that adhere to the chewing surface of the back teeth to help prevent cavities.
- This benefit is only available for those under the age of 16.
- This benefit is only available for adult (permanent) molar teeth that don't already have fillings or other treatments on the tooth.

Space maintainer Preventive

What we pay:

- When you use an in-network dentist **100%**
- When you use an out of network dentist **100%**

How often:

- 1 appliance during the lifetime of this plan

Other things you should know:

- This appliance helps preserve space for adult (permanent) teeth when 1 or more baby (primary) teeth are lost too early.
- This benefit is available only for those under the age of 16.
- This benefit is available for 1 bilateral space maintainer for the upper teeth and 1 for the lower teeth, or 1 unilateral space maintainer per quadrant.
- The upper teeth and the lower teeth are each divided into 2 quadrants, a right side, and a left side.
- All services associated with the space maintainer, including adjustments made within 6 months and re-cementations made within 12 months of the space maintainer being inserted, will be considered part of the space maintainer.

Harmful habit appliance Preventive

What we pay:

- When you use an in-network dentist **100%**
- When you use an out of network dentist **100%**

How often:

- 1 appliance during the lifetime of this plan

Other things you should know:

- This appliance is temporarily cemented to certain teeth to prevent a child from sucking a thumb, finger, or pacifier.
- This benefit is available only for those under the age of 14.

Dental model Basic

What we pay:

- When you use an in-network dentist **75%**
- When you use an out of network dentist **75%**

How often:

- 1 model

Other things you should know:

- These are replicas of the upper or lower teeth and are made of stone or plaster. Your dentist may call this a diagnostic cast.
- This benefit is only available when 3 or more of the following are needed at the same time for both the upper and lower teeth:
 - Dentures
 - Crowns
 - Bridges
 - Onlays
 - Full mouth adjustment of the bite

Fillings, Crowns & Other Repairs - Tooth Restorations

Fillings

This section explains the benefits available for dental fillings.

Fillings	Basic
What we pay:	
• When you use an in-network dentist	75%
• When you use an out of network dentist	75%
How often:	
• 1 time per tooth surface every 12 months for those under the age of 19 and 1 time per tooth surface every 36 months for those age 19 and older.	
Other things you should know:	
• These are used to restore a tooth damaged by decay or when part of a tooth has broken off. Your dentist may call a silver-colored filling an amalgam restoration. Your dentist may call a tooth-colored filling a resin or composite restoration.	
• All services associated with a filling, such as bonding agents, liners, bases, polishing, bite adjustments, and local anesthetic, will be considered part of the filling.	

Crowns

This section explains the benefits available when you have a crown placed on a tooth.

Crowns Major

What we pay:

- When you use an in-network dentist **50%**
- When you use an out of network dentist **50%**

How often:

- 1 time per tooth every 5 years
- For a replacement, the crown must be at least 5 years old, damaged, no longer useable, and not repairable.

Other things you should know:

- When a tooth has been damaged by decay or part of a tooth has broken and it can't be repaired with a filling, the tooth may be restored to normal function with a crown. This is sometimes called a cap.
- A crown can be made of metal, porcelain (a tooth-colored material), or both, where porcelain covers the metal underneath.
- This benefit is available only when the crown is needed because of decay or missing tooth structure and the tooth can't be restored with a filling.
- This benefit is available for adult (permanent) teeth only.
- The benefit for a porcelain crown is available for anterior and bicuspid teeth only. These are all the teeth except for the molars. For a crown placed on a molar tooth, what we pay will be based on the cost of an all-metal crown.
- The benefit for a noble metal crown is available for all teeth. If a more expensive material is used, what we pay will be based on the cost of a noble metal crown.
- A crown that's damaged from an injury that occurs while you're covered by this Plan can be replaced if it's no longer useable and it can't be repaired. Damage that results from chewing or biting food or another substance won't be considered damage from an injury.
- All services associated with a crown, such as insulating bases, temporary or provisional restorations, local anesthetic or associated gingival involvement, will be considered part of the crown.
- The day the tooth is prepared for the crown will be considered the date the service is performed.

Prefabricated crowns Basic

What we pay:

- When you use an in-network dentist **75%**
- When you use an out of network dentist **75%**

How often:

- 1 time per tooth every 24 months

Other things you should know:

- When a tooth has been damaged by decay or part of a tooth has broken and it can't be repaired with a filling, the tooth may be restored to normal function with a prefabricated crown. Prefabricated crowns are usually used on baby (primary) teeth.
- A crown can be made of stainless steel, porcelain (a tooth-colored material), resin (also a tooth-colored material) or a combination, where porcelain covers the metal underneath.
- When a prefabricated crown is replaced within 24 months by a permanent crown, the prefabricated crown will be considered temporary and part of the permanent restoration.

Other tooth restoration services

This section explains the benefits available for other types of restorations or repairs your teeth may need.

Onlays & labial veneers Major

What we pay:

- When you use an in-network dentist 50%
- When you use an out of network dentist 50%

How often:

- 1 time per tooth every 5 years
- For a replacement, the restoration must be at least 5 years old, damaged, no longer useable, and not repairable.

Other things you should know:

- These are used when a filling can't be used to restore a tooth damaged by decay or replace a part of the tooth that has broken off.
- Onlays are like crowns, but instead of covering the entire tooth, they cover only the damaged part of the tooth.
- A veneer is a tooth-colored material that's placed on the front of the tooth. These are used on anterior teeth only. These are the incisor and cuspid teeth located in the front of the mouth.
- This benefit is available only when the restoration is needed because of decay or missing tooth structure and the tooth can't be restored with a filling.
- This benefit is available for adult (permanent) teeth only.
- The benefit for a porcelain onlay is available for anterior and bicuspid teeth only. These are all the teeth except for the molars. For an onlay placed on a molar tooth, what we pay will be based on the cost of an all-metal onlay
- The benefit for a noble metal onlay is available for all teeth. If a more expensive material is used, what we pay will be based on the cost of a noble metal onlay.
- An onlay or veneer that's damaged from an injury that occurs while you're covered by this Plan can be replaced if it's no longer useable and can't be repaired. Damage that results from chewing or biting food or another substance won't be considered damage from an injury.
- All services associated with the restoration, such as insulating bases, temporary or provisional restorations, local anesthetic or associated gingival involvement, will be considered part of the restoration.
- The day the tooth is prepared for the restoration will be considered the date the service is performed.

Core buildup & post & core Major

What we pay:

- When you use an in-network dentist **50%**
- When you use an out of network dentist **50%**

How often:

- 1 time per tooth every 5 years
- For a replacement, the restoration must be at least 5 years old, damaged, no longer useable, and not repairable.

Other things you should know:

- A core buildup and a post and core are done to strengthen a tooth that has been broken or damaged by decay so a crown can be placed.
- This benefit is available only when this service is done with a covered crown or bridge retainer and when needed because of substantial loss of tooth structure.
- This benefit is available for adult (permanent) teeth only.

Crown & restoration repairs Basic

What we pay:

- When you use an in-network dentist **75%**
- When you use an out of network dentist **75%**

How often:

- As needed

Other things you should know:

- Sometimes a crown, onlay or veneer can be repaired instead of replaced.

Re-cement & re-bond Basic

What we pay:

- When you use an in-network dentist **75%**
- When you use an out of network dentist **75%**

How often:

- As needed

Other things you should know:

- Sometimes a crown, onlay or veneer may need to be re-cemented or re-bonded.
- This benefit is available if the re-cement or re-bond is done more than 12 months after the placement of the restoration.

Root Canals & Related Services - Endodontic Care

Root canals

This section explains the benefits available when you have a root canal performed.

Root canal - anterior & bicuspid teeth Basic

What we pay:

- When you use an in-network dentist 75%
- When you use an out of network dentist 75%

How often:

- 1 time per tooth
- If a tooth needs to be retreated, this benefit is available 1 time per tooth.

Other things you should know:

- This is done to remove the nerve inside the tooth. A filling is placed where the nerve used to be. Your dentist may call this endodontic therapy.
- This benefit is available for adult (permanent) teeth only.
- All services associated with a root canal, such as X-ray images, cultures and tests, local anesthetic, the protective restoration, and routine follow up care, will be considered part of the root canal.
- The day the tooth is initially opened for a root canal will be considered the date the service is performed.

Root canal - molar teeth Basic

What we pay:

- When you use an in-network dentist 75%
- When you use an out of network dentist 75%

How often:

- 1 time per tooth
- If a tooth needs to be retreated, this benefit is available 1 time per tooth.

Other things you should know:

- This is done to remove the nerve inside the tooth. A filling is placed where the nerve used to be. Your dentist may call this endodontic therapy.
- This benefit is available for adult (permanent) teeth only.
- All services associated with a root canal, such as X-ray images, cultures and tests, local anesthetic, the protective restoration, and routine follow up care, will be considered part of the root canal.
- The day the tooth is initially opened for a root canal will be considered the date the service is performed.

Other endodontic services

This section explains the benefits available for other endodontic procedures.

Pulp cap Basic

What we pay:

- When you use an in-network dentist **75%**
- When you use an out of network dentist **75%**

How often:

- 1 time per tooth

Other things you should know:

- This is a special material placed underneath a filling to protect the nerve inside the tooth.
- This benefit is available for adult (permanent) teeth only.
- All services associated with a pulp cap, such as X-rays, cultures and tests, local anesthetic, temporary filling, and routine follow up care, will be considered part of the pulp cap.

Pulpotomy Basic

What we pay:

- When you use an in-network dentist **75%**
- When you use an out of network dentist **75%**

How often:

- As needed

Other things you should know:

- This involves removing the nerve inside the tooth.
- When a root canal is the final treatment, this service will be considered part of the root canal.
- All services for treatment associated with a pulpotomy, such as diagnosis, X-rays, cultures and tests, local anesthetic, protective restoration, and routine follow up care, will be considered part of the pulpotomy.

Apicoectomy, retrograde filling & root amputation Basic

What we pay:

- When you use an in-network dentist **75%**
- When you use an out of network dentist **75%**

How often:

- 1 time per tooth root for each procedure

Other things you should know:

- An apicoectomy is the surgical removal of the tip of the tooth root.
- A retrograde filling is used to seal the site of the root tip removal.
- A root amputation is the surgical removal of a root from a tooth that has multiple roots.
- All services associated with these procedures, such as diagnosis, X-rays, cultures and tests, local anesthetic, protective restoration, and routine follow up care, will be considered part of the procedure.

Periodontal Care - Treatment of Gum Disease & Related Services

Non-surgical periodontal services

This section explains the benefits available when you receive periodontic care that doesn't involve surgery.

Periodontal maintenance Preventive

What we pay:

- When you use an in-network dentist **100%**
- When you use an out of network dentist **100%**

How often:

- You can have periodontal maintenance 2 time(s) every 12 months, but not more than a combined total of 2 dental cleanings and periodontal maintenance visits in the same 12 months.

Other things you should know:

- This is a specialized cleaning that may be needed after any type of previous periodontal treatment. Your dentist may call this a periodontal prophylaxis or periodontal cleaning.
- Periodontal maintenance visits will count toward the number of dental cleanings allowed. Dental cleanings will also count toward the number of periodontal maintenance visits allowed.
- All services associated with periodontal maintenance, including the treatment plan, charting, scaling, polishing, local anesthetic, and post- treatment care, will be considered part of the periodontal maintenance.

Scaling & root planing Basic

What we pay:

- When you use an in-network dentist **75%**
- When you use an out of network dentist **75%**

How often:

- 1 time(s) per quadrant every 24 months

Other things you should know:

- This is a cleaning of tooth surfaces both above and below the gumline. It may be necessary when there's periodontal disease and chronic inflammation in the gum tissue around the teeth that causes a breakdown in some of the nearby bone.
- This benefit will be available only when there's periodontal disease documented by charting of pockets in the gums and bone loss that's verified by X-ray.
- The upper teeth and the lower teeth are each divided into 2 quadrants, a right side, and a left side.
- All services associated with the scaling and root planing, including the treatment plan, charting, scaling, polishing, local anesthetic, and post-treatment care, will be considered part of the scaling and root planing.

Full mouth debridement Basic

What we pay:

- When you use an in-network dentist **75%**
- When you use an out of network dentist **75%**

How often:

- 1 time during the lifetime of this plan

Other things you should know:

- This is an extensive cleaning needed when the teeth can't be examined because of a significant amount of plaque and buildup on them.
- All services associated with the debridement, including the treatment plan, charting, scaling, polishing, local anesthetic, and post-treatment care, will be considered part of the debridement.

Periodontal surgery

This section explains the benefits available when you have periodontic surgery.

Gingivectomy, gingivoplasty (1 to 3 teeth) & crown lengthening Basic

What we pay:

- When you use an in-network dentist **75%**
- When you use an out of network dentist **75%**

How often:

- 1 surgical procedure per tooth every 12 months

Other things you should know:

- A gingivectomy and gingivoplasty removes excess or inflamed gum tissue.
- Crown lengthening removes a small amount of bone and gum tissue around a tooth to make a crown fit better.
- This benefit will be available only when there's periodontal disease documented by charting of pockets in the gums and bone loss that's verified by X-ray. This benefit will be available for a gingivectomy of 1 tooth when there is documented inflammation of the gum tissue.
- All services associated with these surgical procedures, including the treatment plan, charting, irrigation, local anesthetic, suturing and post-surgical care, will be considered part of the surgical procedure.

Gingivectomy, gingivoplasty (4 or more teeth), osseous surgery, gingival flap procedure, mesial/distal wedge procedure & surgical revision procedure Basic

What we pay:

- When you use an in-network dentist **75%**
- When you use an out of network dentist **75%**

How often:

- 1 surgical procedure per quadrant every 36 months

Other things you should know:

- A gingivectomy and gingivoplasty removes excess or inflamed gum tissue.
- Osseous surgery reshapes the bone around the tooth.
- Gingival flap, mesial/distal wedge and surgical revision procedures reshape the gum tissue around a tooth, teeth, or spaces without teeth.
- This benefit will be available only when there's periodontal disease documented by charting of pockets in the gums and bone loss that's verified by X-ray.
- All services associated with these surgical procedures, including the treatment plan, charting, irrigation, local anesthetic, suturing and post-surgical care, will be considered part of the surgical procedure.

Tissue graft Basic

What we pay:

- When you use an in-network dentist **75%**
- When you use an out of network dentist **75%**

How often:

- 1 time(s) per tooth or site every 36 months

Other things you should know:

- This involves replacing gum tissue that has been lost around the root area of a tooth.
- This benefit is available only when there's documentation of progressive loss of gum tissue due to disease.
- This benefit is available only when the tooth is present.
- This benefit is available only when this procedure is necessary as part of a covered implant placement.
- All services associated with the graft, including the treatment plan, charting, irrigation, suturing, local anesthetic, and post-surgical care, will be considered part of the graft.

Guided tissue regeneration Basic

What we pay:

- When you use an in-network dentist **75%**
- When you use an out of network dentist **75%**

How often:

- 1 time(s) per tooth or site

Other things you should know:

- This is used to replace gum tissue. It's frequently done with a bone graft to replace bone that has been lost.
- This benefit will be available only when there's periodontal disease documented by charting of pockets in the gums and bone loss that's verified by X-ray.
- This benefit is available only when the tooth is present.
- All services associated with the regeneration, including the treatment plan, charting, irrigation, suturing, local anesthetic, and post-surgical care will be considered part of the regeneration.

Bone replacement graft Basic

What we pay:

- When you use an in-network dentist **75%**
- When you use an out of network dentist **75%**

How often:

- 1 time(s) per tooth or site

Other things you should know:

- This involves replacing bone tissue that has been destroyed by periodontal disease.
- This benefit will be available only when there's periodontal disease documented by charting of pockets in the gums and bone loss that's verified by X-ray.
- This benefit is available only when the tooth is present.
- All services associated with the bone graft, including the treatment plan, charting, irrigation, suturing, local anesthetic, and post-surgical care, will be considered part of the bone graft.

Periodontal related services

This section explains the benefits available for other periodontal related services.

Limited occlusal adjustment **Basic**

What we pay:

- When you use an in-network dentist **75%**
- When you use an out of network dentist **75%**

How often:

- 2 visits

Other things you should know:

- This is a minor adjustment of the biting surfaces of 1 or more teeth.
- This benefit will be available only for adjustments made within 6 months after osseous surgery and scaling and root planing.

Occlusal guard **Basic**

What we pay:

- When you use an in-network dentist **75%**
- When you use an out of network dentist **75%**

How often:

- 1 appliance during the lifetime of this Plan

Other things you should know:

- This appliance covers some or all the teeth. There are different types of guards used for different types of treatment.
- This benefit is available only when the guard is received within 6 months after osseous surgery.

Bridges & Dentures - Prosthodontics

Bridges

This section explains the benefits available when you have a bridge made and placed.

Bridges **Major**

What we pay:

- When you use an in-network dentist **50%**
- When you use an out of network dentist **50%**

How often:

- 1 time per tooth every 5 years
- For a replacement, the bridge must be at least 5 years old, damaged, no longer useable, and not repairable.

Other things you should know:

- This a fixed prosthetic that replaces 1 or more missing teeth and is held in place by adjacent teeth. Your dentist may refer to the false teeth as pontics and to the adjacent teeth as abutments.
- This benefit is available for adult (permanent) teeth only.
- The benefit for a porcelain bridge is available for anterior and bicuspid teeth only. These are all the teeth except for the molars. For a bridge placed on molar teeth, what we pay will be based on the cost of an all-metal bridge.
- The benefit for a noble metal bridge is available for all teeth. If a more expensive material is used, what we pay will be based on the cost of a noble metal bridge.
- A bridge that's damaged from an injury that occurs while you're covered by this Plan can be replaced if it's no longer useable and can't be repaired. Damage that results from chewing or biting food or another substance won't be considered damage from an injury.
- All services associated with a bridge, including insulating bases, temporary or provisional restorations, local anesthetic, or gingival involvement, will be considered part of the bridge.
- The day the tooth is initially prepared for the bridge will be considered the date the service is performed.

Dentures

This section explains the benefits available when you have a denture made and placed.

Dentures - partial & complete Major

What we pay:

- When you use an in-network dentist 50%
- When you use an out of network dentist 50%

How often:

- 1 time every 5 years for each denture
- For a replacement, the denture must be at least 5 years old, damaged, no longer useable, and not repairable.

Other things you should know:

- These are removable dental prostheses used to replace missing teeth. A partial denture replaces 1 or more upper teeth or 1 or more lower teeth. A complete denture replaces all the upper teeth or all the lower teeth.
- This benefit is available to replace adult (permanent) teeth only.
- The day the final impression is taken for the denture will be considered the date the service is performed.
- If a temporary, interim, or provisional denture is in place for more than 1 year, it will be considered a permanent denture.
- All services associated with a denture, including a temporary denture and adjustments made in the first 6 months after the denture is placed, will be considered part of the denture.
- A denture that's damaged from an injury that occurs while you're covered by this Plan can be replaced if it's no longer useable and can't be repaired. Damage that results from chewing or biting food or another substance won't be considered damage from an injury.

Bridge & denture repairs & maintenance

This section explains the benefits available when a bridge or denture needs to be repaired or modified.

Bridge repairs Basic

What we pay:

- When you use an in-network dentist 75%
- When you use an out of network dentist 75%

How often:

- As needed

Other things you should know:

- A bridge may need to be repaired due to wear or other damage.

Denture repairs Basic

What we pay:

- When you use an in-network dentist 75%
- When you use an out of network dentist 75%

How often:

- As needed

Other things you should know:

- A denture may need to be repaired due to wear or other damage.

Denture adjustments Basic

What we pay:

- When you use an in-network dentist 75%
- When you use an out of network dentist 75%

How often:

- As needed

Other things you should know:

- Adjustments involve making changes to the denture to ensure a proper fit.
- Any charges for denture adjustment done within 6 months after the denture was placed will be considered part of the fee for the denture if it's done by the same dentist that provided the denture.
- This benefit is available only when the adjustment is done more than 6 months after the denture was placed or more than 6 months after the most recent denture rebase or denture relines.

Adding teeth to partial dentures Basic

What we pay:

- When you use an in-network dentist 75%
- When you use an out of network dentist 75%

How often:

- As needed

Other things you should know:

- A partial denture may need to be modified if additional teeth are lost after it was first placed.

Denture rebase Basic

What we pay:

- When you use an in-network dentist 75%
- When you use an out of network dentist 75%

How often:

- 1 time per denture every 24 months

Other things you should know:

- This involves replacing the entire acrylic denture base without replacing the artificial teeth.
- Any charges for a denture rebase done within 12 months after the denture was placed will be considered part of the fee for the denture if it's done by the same dentist that provided the denture.
- This benefit is available only when the rebase is done more than 12 months after the denture was placed.

Denture reline Basic

What we pay:

- When you use an in-network dentist **75%**
- When you use an out of network dentist **75%**

How often:

- 1 time per denture every 24 months

Other things you should know:

- This involves reshaping the denture base to make it more comfortable.
- Any charges for a denture reline done within 12 months after the denture was placed will be considered part of the fee for the denture if its done by the same dentist that provided the denture.
- This benefit is available only when the reline is done more than 12 months after the denture was placed.

Tissue conditioning Basic

What we pay:

- When you use an in-network dentist **75%**
- When you use an out of network dentist **75%**

How often:

- 1 time for the upper denture and 1 time for the lower denture every 12 months

Other things you should know:

- This is a temporary cushion placed inside a denture to improve fit and comfort following an extraction or other surgical procedure.
- Any charges for tissue conditioning done within 12 months after the denture was placed will be considered part of the fee for the denture if it's done by the same dentist that provided the denture.

Dental Implants

Implants

This section explains the benefits available when you have a dental implant placed.

Radiographic/surgical implant index Major

What we pay:

- When you use an in-network dentist **50%**
- When you use an out of network dentist **50%**

How often:

- 1 time for the upper teeth and 1 time for the lower teeth every 24 months

Other things you should know:

- This is a customized template used to guide the correct placement of the implant.

Surgical placement of implant Major

What we pay:

- When you use an in-network dentist **50%**
- When you use an out of network dentist **50%**

How often:

- 1 time per tooth every 5 years
- For a replacement, the implant must be at least 5 years old, damaged, no longer useable, and not repairable.

Other things you should know:

- An implant is like a post and is surgically placed into the jawbone.
- This benefit is available for adult (permanent) teeth only.
- All services associated with an implant, such as the treatment plan, local anesthetic, and post-surgical care, will be considered part of the implant.
- An implant crown that's damaged from an injury that occurs while you're covered by this Plan can be replaced if it's no longer useable and can't be repaired. Damage that results from chewing or biting food or another substance won't be considered damage from an injury.

Other implant related services

This section explains the benefits available for other services related to dental implants.

Implant abutments - prefabricated & custom fabricated Major

What we pay:

- When you use an in-network dentist **50%**
- When you use an out of network dentist **50%**

How often:

- 1 time per tooth every 5 years
- For a replacement, the implant abutment must be at least 5 years old, damaged, no longer useable, and not repairable.

Other things you should know:

- These attach to the implant and connect the implant to the implant crown, bridge, or denture.
- An implant abutment that's damaged from an injury that occurs while you're covered by this Plan can be replaced if it's no longer useable and can't be repaired. Damage that results from chewing or biting food or another substance won't be considered damage from an injury.

Implant/abutment-supported crowns Major

What we pay:

- When you use an in-network dentist **50%**
- When you use an out of network dentist **50%**

How often:

- 1 time per tooth every 5 years
- For a replacement, the implant crown must be at least 5 years old, damaged, no longer useable, and not repairable.

Other things you should know:

- These are screwed or cemented onto the abutment to replace the missing tooth.
- This benefit is available for adult (permanent) teeth only.
- The benefit for a porcelain crown is available for anterior and bicuspid teeth only. These are all the teeth except for the molars. For a crown placed on a molar tooth, what we pay will be based on the cost of an all-metal crown.
- The benefit for a noble metal crown is available for all teeth. If a more expensive material is used, what we pay will be based on the cost of a noble metal crown.
- An implant crown that's damaged from an injury that occurs while you're covered by this Plan can be replaced if it's no longer useable and can't be repaired. Damage that results from chewing or biting food or another substance won't be considered damage from an injury.

Implant/abutment-supported dentures Major

What we pay:

- When you use an in-network dentist **50%**
- When you use an out of network dentist **50%**

How often:

- 1 time per denture every 5 years
- For a replacement, the implant denture must be at least 5 years old, damaged, no longer useable, and not repairable.

Other things you should know:

- These are used to replace missing teeth. A partial denture replaces 1 or more upper teeth or 1 or more lower teeth. A complete implant denture replaces all the upper teeth or lower teeth.
- This benefit is available to replace adult (permanent) teeth only.
- An implant denture that's damaged from an injury that occurs while you're covered by this Plan can be replaced if it's no longer useable and can't be repaired. Damage that results from chewing or biting food or another substance won't be considered damage from an injury.

Bone replacement graft for ridge preservation Major

What we pay:

- When you use an in-network dentist **50%**
- When you use an out of network dentist **50%**

How often:

- 1 time per tooth or area

Other things you should know:

- This involves replacing bone tissue that has been lost because of an extraction or implant removal.
- This benefit is available only when the procedure is done with a covered dental implant in the same site.

Implant repairs & removal

This section explains the benefits available when you have an implant abutment, crown or denture that needs to be repaired or an implant that needs to be removed.

Implant crown & implant denture repairs Major

What we pay:

- When you use an in-network dentist 50%
- When you use an out of network dentist 50%

How often:

- As needed

Other things you should know:

- An implant supported crown or denture may need to be repaired due to wear or other damage.

Implant abutment repairs Major

What we pay:

- When you use an in-network dentist 50%
- When you use an out of network dentist 50%

How often:

- As needed

Other things you should know:

- An implant abutment may need to be repaired due to wear or other damage.

Implant removal Major

What we pay:

- When you use an in-network dentist 50%
- When you use an out of network dentist 50%

How often:

- 1 time per tooth

Other things you should know:

- This involves removing an implant from the jaw.

Tooth Extractions & Oral Surgery

Extractions

This section explains the benefits available when you have a tooth removed.

Non-surgical extractions Basic

What we pay:

- When you use an in-network dentist 75%
- When you use an out of network dentist 75%

How often:

- As needed

Other things you should know:

- This is done to remove a tooth or root that's above the gumline.
- All services associated with the extraction, such as the treatment plan, local anesthetic, and post-treatment care, will be considered part of the extraction.

Complex surgical extractions Basic

What we pay:

- When you use an in-network dentist 75%
- When you use an out of network dentist 75%

How often:

- As needed

Other things you should know:

- This is done when the extraction involves cutting the gums or bone to remove the tooth or roots.
- All services associated with the extraction, such as the treatment plan, local anesthetic, suturing and post-surgical care, will be considered part of the extraction.
- These procedures may be covered by your medical plan. See the **Other things you should know about claims** section of the Member Guide for more information.

Other oral surgery services

This section explains the benefits available for other oral surgery procedures.

Other complex oral surgeries Basic

What we pay:

- When you use an in-network dentist 75%
- When you use an out of network dentist 75%

How often:

- As needed

Other things you should know:

- Other types of oral surgery may be needed to treat oral diseases, injuries, and defects.
- All services associated with the surgery, such as X-rays, the treatment plan, local anesthetic, suturing, and post-surgical care, will be considered part of the surgery.
- These procedures may be covered by your medical plan. See the **Other things you should know about claims** section of the Member Guide for more information

Other Dental Services

This section explains the benefits available when you receive one of the following services.

Anesthesia Basic

What we pay:

- When you use an in-network dentist 75%
- When you use an out of network dentist 75%

How often:

- As needed

Other things you should know:

- This is a drug administered during procedures to reduce pain or discomfort. This includes:
 - Deep sedation/general anesthesia
 - Intravenous conscious sedation
 - Non-intravenous conscious sedation
 - Nitrous oxide
- This benefit is available only when the anesthesia is administered with a covered surgical service.

Consultations Basic

What we pay:

- When you use an in-network dentist 75%
- When you use an out of network dentist 75%

How often:

- 1 time for each dental specialty every 12 months

Other things you should know:

- This is an examination performed by a specialty dentist or a dentist other than your usual dentist.
- This benefit is available only when the dentist providing the consultation isn't the same dentist providing your treatment.
- This benefit is available only when no other services, other than X-rays, are performed during the consultation. If other services are performed, refer to those services for the benefits available.

Orthodontic Care

This section explains the benefits available when you have your teeth straightened or realigned.

Orthodontic services Orthodontic

What we pay:

- When you use an in-network dentist **50%**
- When you use an out of network dentist **50%**

How often:

- As needed

Other things you should know:

- These services correct the position of the teeth and jaw.
- This benefit is available only for children under the age of 19 when the orthodontic appliances are first placed.
- This benefit is available for the orthodontic treatment plan and records, including impressions, X-rays, photographs, study models, braces or clear aligners, periodic visits, and retainers.
- This benefit will be divided into equal payments and will be made over the length of the treatment plan or 2 years, whichever is shorter. The first payment will be made when the appliances are initially placed. The remaining payments will be made at the end of every quarter.
- If the orthodontic treatment began before your coverage under this Plan started, the treatment will be pro-rated. For example, if 40% of the treatment was completed before coverage under this Plan began, only the remaining 60% will be considered.
- The day the appliances are first placed will be considered the date the service begins.
- Any benefits that were paid for orthodontic services under a prior plan will reduce the orthodontic lifetime maximum by an equal amount. See the Benefit maximums section of the Member Guide for more information.
- Discounts offered by dentists in our network aren't available for:
 - Additional charges for optional orthodontic appliances
 - Replacement or repair of an orthodontic appliance needed due to neglect
 - Orthodontic treatment plans that began before you became eligible for benefits for orthodontic services under this plan.
- There's a maximum amount of benefits that will be paid for orthodontic care. See the **Benefit maximums** section for this amount.

What isn't covered - exclusions

This section explains the services that aren't covered by this Plan.

No benefits are available for:

- Any service for which there is no charge
- Any service that's needed because of an on-the-job or job-related injury or that's covered by Worker's Compensation or similar laws
- Any service that doesn't meet professionally recognized standards of dental practice or that's considered to be experimental
- Any service that's performed in conjunction with or related to a service that isn't covered by this guide
- Any service on a tooth with a guarded, questionable, or poor prognosis
- Any service that's used solely to:
 - Alter occlusal vertical dimensions
 - Restore or maintain occlusion
 - Treat a condition resulting from attrition, abrasion, erosion or abfraction
 - Splint or stabilize teeth for periodontal reasons
- Replacing extracted or missing wisdom teeth
- Localized use of antimicrobial agents into diseased crevicular tissue
- Any service that's provided solely for cosmetic reasons, such as teeth whitening, characterization, or personalization of a dental prosthesis, or odontoplasty. Benefits are available for cosmetic services needed to treat medically diagnosed congenital and developmental malformations for a newborn or newly adopted child.
- Replacement of a lost, missing, or stolen appliance or dental prosthesis, or the fabrication of a spare appliance or dental prosthesis
- Upgrading from one appliance or dental prosthesis to another appliance or dental prosthesis, such as replacing a bridge with a dental implant or replacing a denture with a bridge
- A temporary or provisional appliance or dental prosthesis, unless it's an interim partial denture that replaces anterior teeth extracted while this coverage was in place. These are the incisor and cuspid teeth located in the front of the mouth.
- A bridge that replaces the extracted portion of a hemisected tooth
- The placement of more than one crown or bridge unit per tooth
- Overdentures and related services, including root canal therapy on teeth supporting the overdenture
- Detailed and extensive oral evaluations
- Any service that's educational or instructional, such as oral hygiene instruction, tobacco counseling or nutritional counseling
- Bite registration, bite analysis or occlusion analysis - mounted case
- Duplication of X-rays
- Completion of claim forms
- OSHA or other infection control measures
- Cephalometric X-rays
- Cone beam images
- Oral or facial photographs
- Prescription medication
- Application of desensitizing medications and resins
- Separate charges for local anesthesia
- Pulp vitality tests
- Caries susceptibility tests
- Specialized techniques
- Precision attachments

- Maxillofacial prosthetics to repair facial or skeletal anomalies, maxillofacial surgery, orthognathic surgery, or any oral surgery requiring the setting of a fracture or dislocation that results from or is incidental to a medical condition
- Treatment of congenital or developmental malformations or the replacement of congenitally missing teeth. Benefits are available for cosmetic services needed to treat medically diagnosed congenital and developmental malformations for a newborn or newly adopted child
- Any service intended to treat or diagnose disorders of the temporomandibular joint (TMJ)
- Any service coded by the dentist as unspecified
- The isolation of a tooth with a rubber dam
- Gingival irrigation
- Medications dispensed in a dental office for home use

B651.1223

All Options

Here is a notice to help you better understand your rights if your Plan is governed by ERISA. The notice isn't part of the group insurance policy or member guide.

B651.1025

All Options

Statement of ERISA Rights

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

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

ERISA provides that all plan participants shall be entitled to:

Receive Information about Your Plan and Benefits

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

Prudent Actions by Plan Fiduciaries

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

Enforcement of Your Rights

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

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report from the plan and do not receive them within 30 days, you may file suit in a state or Federal court. In such a case, the court may require the plan administrator to provide the materials and pay you up to \$110.00 a day until you receive the materials, 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 required that group health plans provide medical coverage for a dependent child pursuant to a qualified medical child support order (QMCSO). A dependent child also includes a child for whom you must provide Dental Insurance due to a QMCSO as defined in the ERISA Section 609(a) United States Employee Retirement Income Security Act of 1974, as amended.

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

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

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

Dental Benefits Claims Procedure

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

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

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

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 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 Benefit Determination nor that person's subordinate;

- In deciding an appeal based upon a dental or medical judgement, 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;
- 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.

B651.1026

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 Vision Insurance Coverage described in this Certificate is attached to the group Policy effective July 1, 2026. This Certificate replaces any Certificate previously issued under the Policy or under any other plan providing similar or identical benefits issued to the Policyholder by Guardian.

GROUP VISION INSURANCE 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) all required premium payments must have been made by or on behalf of the Employee; and (d) satisfy any necessary Proof of Insurability requirements.

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: HOPE COLLEGE

Group Policy Number: 00096812

Effective Date: July 1, 2026

The Guardian Life Insurance Company of America



Harris Oliner
Senior Vice President &
Corporate Secretary



Matthew Darula
Head of Product,
Strategy and Offerings

B435.0856

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GENERAL PROVISIONS

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

Limitation of Authority

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

- Determine whether any contract, Policy or Certificate is to be issued;
- Waive or alter any contract or Policy provisions, or any of Our requirements;
- Bind Us by any statement or promise relating to any contract 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.

Incontestability

This Certificate is incontestable after three years from its date of issue, except for non-payment of premiums.

In the event Your insurance is rescinded, We will refund premiums paid for the periods such insurance is void.

Examination

We have the right to have a doctor of Our choice examine the person for whom a claim is being made at reasonable times and as frequently as reasonably required during the pendency of a claim under this Policy. We will pay for all such examinations.

B435.1372

CONDITIONS OF ELIGIBILITY FOR GROUP VISION INSURANCE COVERAGE

B435.0005

All Options

Employee Eligibility

You are eligible for vision coverage if You are:

- In an eligible class of Employees;
- An active Full-Time Employee or Qualified Retiree; 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 vision 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 Certificate.

Enrollment: If You must pay all or part of the cost of Employee coverage, You must enroll and agree to make required payments within 31 days of Your eligibility date. If You fail to do this, You cannot enroll until the plan's next vision open Enrollment Period. "Open Enrollment period" means an annual open enrollment period set up by the Employer and agreed to by Us.

This plan's vision open Enrollment Period occurs from June 1st to June 30th of each year.

Once You enroll in this plan, You cannot drop Your or Your dependent's vision coverage until this plan's next vision open Enrollment Period. Once You drop Your or Your dependent's vision coverage, You will not be permitted to enroll again until the next vision open Enrollment Period which starts after the date coverage is dropped.

If You initially waived vision coverage under this plan because You were covered under another group vision care plan, and You wish to enroll in this plan because Your coverage under the other plan ended, You may do so without waiting until the next vision open Enrollment Period. But, Your coverage under the other plan must have ended due to one of the events listed below:

- Termination of Your Spouse's employment.
- Loss of eligibility under Your Spouse's vision plan.
- Divorce.
- Death of Your Spouse.
- Termination of the other vision plan.

In that case, You must enroll in the vision coverage under this plan within 30 days of the date that any of the events listed above occurs.

B435.0971

All Options

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-support because of a physical or mental incapacity. 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
 - You send Us written proof, and We approve such 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.

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

B435.0034

All Options

Eligibility Waiting Period

You and Your dependents are eligible under this Certificate after You complete the eligibility waiting period, if any, established by the Employer.

B400.0087

All Options

When Coverage Starts

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

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

B435.0036

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;

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 Certificate replaced.

B400.0094

All Options

Family Status Change

You may request the addition of Vision 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 the addition of Vision Insurance Coverage for which You were not previously insured. You must provide proof of the Family Status Change and request the addition of Vision Insurance Coverage in writing within 31 days after the date of the Family Status Change as described above.

Refer to the When Coverage Starts section for information regarding when this coverage is effective.

B435.0981

All Options

When Your Coverage Ends

Your coverage will end on the first of the following events:

- The last day of the month in which Your Active Full-Time Work ends for any reason, except as shown below under Continuation of Coverage.
- The last day of the month in which You stop being an eligible Employee under this Certificate.

- 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 or by You.
- The date You die.

B435.1015

All Options

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 Certificate.
- The date the group Certificate 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.

B400.0115

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 Certificate carefully for details and discuss with Your Employer or administrator.

Continuation Rights

You may be eligible to continue Your group vision coverage under more than one Continuation Rights section at the same time. If You choose to continue Your group vision 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.

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 vision coverage under the 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.

COBRA Continuation Rights

If vision insurance for You or Your dependents ends, You or Your dependents may qualify for continuation of such insurance under the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended (COBRA). For more information, You may contact Your Employer or visit Our website at www.guardianlife.com.

Family Medical Leave Of Absence (FMLA)

There are certain leaves of absence that may qualify for continuation of insurance 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.

B435.0038

All Options

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 vision 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.

B435.0040

VISION CLAIM PROVISIONS

You may visit any provider. After VSP pays its portion of the covered charges, You are responsible for the rest. This includes any Deductible, Copayment, and amounts above any coverage maximum, as well as, any remaining charges up to the provider's total charge for services received.

Your reimbursement will be based on VSP's fee schedule for Your specific Policy. Please refer to Your Schedule of Benefits.

B435.0520

Filing A Claim

If You have services performed by a Preferred Provider, Your claim will be submitted for You and the payment will be sent directly to Your Preferred Provider.

Submitting your Claim: If You have services performed by a Non-Preferred Provider, You will need to submit Your own claim.

Administration: We have the responsibility to fairly, thoroughly, objectively and timely investigate, evaluate and determine a Covered Person's eligibility for benefits under this Certificate. 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 Proof of Loss.
- Consider and interpret the terms of this Certificate 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 Certificate and applicable 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: You must send Us written notice for which a claim is being made within 20 days of the service. We will not void or reduce Your claim if You cannot send Us notice of claim within the required time. In that case, You must send Us notice of claim as soon as reasonably possible. This notice should include his or her name and the Policy number. If the claim is being made for any other Covered Person, his or her name should also be shown.

Claim Forms: We will furnish You with forms for filing proof of loss within 15 days of receipt of notice. If We do not furnish the forms on time, You will be considered to have complied with the requirements of the Certificate as to proof of loss and We will accept a written description and adequate proof of the service 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. To obtain a claim form visit Our website at www.guardianlife.com.

Proof Of Loss: You must send written proof of loss to Our designated office within 90 days of the loss. We will not void or reduce Your claim if You cannot send Us proof of loss within the required time. In that case, You must send Us proof as soon as reasonably possible. However, under no circumstances will We pay benefits if written proof of loss is delayed for more than one year, unless You are unable to provide proof of loss because You are not legally competent or You lack legal capacity.

Payment Of Benefits: We will pay Vision benefits as soon as We receive written proof of loss, subject to all the terms and conditions of this Policy.

Unless otherwise required by law or regulation, We pay all Vision benefits to You if You are living. If You are not living, We have the right to pay all Vision benefits to one of the following:

Your

- Estate;
- Spouse;
- Parents;
- Children; or
- Brothers and sisters.

All claims must be sent to VSP within one year of the date services are completed or supplies are received. To obtain a claim form visit Our website at www.guardianlife.com.

Proof of Loss and other claim data should be submitted to:

The Guardian Life Insurance Company of America

Vision Service Plan
P.O. Box 385018
Birmingham, AL 35238-5018

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 3 years from the date of the final benefit determination.

Workers' Compensation: The Vision benefits provided by this Certificate are not in place of and do not affect requirements for coverage by Workers' Compensation.

B435.1378

All Options

VISION EXPENSE BENEFITS

This coverage will pay many of a Covered Person's vision care expenses. We pay benefits for Covered Charges incurred by a Covered Person. What We pay and the terms for payment are explained below.

This Certificate includes the Schedule(s) of Benefits. Your class and benefit options are shown in the Schedule of Benefits that applies to You.

B435.0043

All Options

Vision Service Plan (VSP) - This Plan's Vision Care Preferred Provider Organization

The Policy is designed to provide high quality vision care while controlling the cost of such care. To do this, the Policy encourages a Covered Person to seek vision care from vision care practitioners and vision care facilities that belong to VSP, a vision care Preferred Provider Organization (PPO).

The vision care PPO is made up of Preferred Providers in a Covered Person's geographic area. When a Covered Person is enrolled in the Policy, he or she will get an enrollment packet. The packet will: (1) explain how to obtain benefits; and (2) contain information about current vision care Preferred Providers. He or she will also receive information on how to obtain a list of VSP Preferred Providers in his or her area.

A Covered Person may receive vision services from any VSP Preferred Provider. If a Preferred Provider ends 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 another VSP Preferred Provider.

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

What We pay is based on all of the terms of the Policy. Please read this Certificate carefully for specific benefit levels, Copayments, Deductibles, Payment Rates and Payment Limits.

A Covered Person may call VSP should he or she have any questions about the vision coverage.

VSP Customer Care

877-814-8970

Obtaining Services from a Preferred Provider

When a Covered Person wishes to receive services from a Preferred Provider, he or she must contact the Preferred Provider before receiving the services. The Preferred Provider will contact VSP to verify the Covered Person's coverage.

What We pay for charges for covered services is subject to all of the terms of this Certificate.

B435.0989

All Options

How This Plan Works

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

Covered charges are the Usual and Customary charges for the services and supplies described below. We pay benefits only for covered charges Incurred by a Covered Person while he or she is covered by this Certificate. Charges in excess of any Payment Limits shown in this Certificate are not covered.

If a Covered Person plans to use the services of a Preferred Provider, the Preferred Provider must receive authorization from VSP. See Obtaining Services from a Preferred Provider. If authorization is not received, benefits will be paid as if services and supplies were received from a Non-Preferred Provider.

If a Covered Person receives services or supplies from a Non-Preferred Provider, he or she must submit the itemized bill to VSP for claims payment. Please refer to Vision Claim Provisions in this Certificate.

Copayments: A Covered Person must pay a Copayment each time he or she receives a vision examination. And, he or she must pay a Copayment each time he or she receives lenses or a frame or a complete pair of eyeglasses covered by this Certificate. We pay benefits for the covered charges a Covered Person incurs in excess of the Copayment. This Certificate's Copayments are shown in the Schedule Of Benefits.

Cash Deductibles: There are separate cash Deductibles for each covered service furnished by a Non-Preferred Provider. These cash Deductibles are shown in the Schedule of Benefits. The Covered Person must have covered charges in excess of the cash Deductible before We pay benefits for the service or supply. The cash Deductible will be subtracted from the reimbursement to the member.

Payment Limits: Payment limits, durational or monetary, are shown in the Covered Services and Supplies. When a monetary Payment Limit is set for a pair of materials, the limit is halved if only one item is purchased.

Payment Rates: Once a Covered Person has paid any applicable Copayment or Deductible, We pay benefits for covered charges under this Certificate at the Payment Rate shown in the Schedule Of Benefits. What We pay is subject to all of the terms of this Certificate.

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 to purchase an unlimited number of prescription glasses from the same Preferred Provider. He or she may also receive a discount on the costs to evaluate and fit contact lenses. No discount applies to contact lenses or materials. The discount is available for 12 months after the initial examination from the same Preferred Provider. Discounts may not be available at all locations, check with Your Preferred Provider.

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 exam (evaluation and fitting) 15% off of the Preferred Provider's Usual and Customary fee

B435.0993

All Options

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 Certificate. Read the entire Certificate to find out what We limit or exclude.

B435.0048

All Options

Vision Examinations: We cover charges for comprehensive vision care examinations of visual functions and prescription of corrective eyewear. We only cover charges for one vision examination for each Covered Person in any one calendar year Benefit Period. The comprehensive vision care examination does not include a contact lens exam (evaluation and fitting).

If a Covered Person receives a vision examination from a Preferred Provider, We pay benefits in full for the covered charges for that examination.

If a Covered Person receives a vision examination from a Non-Preferred Provider, We pay benefits for the covered charges for that examination, up to \$39.00.

B435.0049

All Options

Vision Materials We cover charges for either glass or plastic prescription single vision, bifocal, trifocal or Lenticular Lenses. We cover charges for frames. And, We cover charges for prescription contact lenses. Benefit allowances provide no remaining balance for future use within the same Benefit Period, except for Contact Lens benefit.

In any one calendar year Benefit Period We cover charges for either glasses or contact lenses, but not both.

B435.0060

All Options

Standard Lenses: We cover charges for single vision, bifocal, trifocal or Lenticular Lenses. They must be glass or plastic lenses or for dependent children to age 19, Polycarbonate Lenses.

B435.0578

All Options

We only cover charges for one pair of Standard Lenses in any one calendar year Benefit Period.

B435.0583

All Options

If a Covered Person uses a Non-Preferred Provider, We limit what We pay to: (1) \$23.00 for each pair of single vision lenses; (2) \$37.00 for each pair of bifocal lenses; (3) \$49.00 for each pair of trifocal lenses; and (4) \$64.00 for each pair of Lenticular Lenses.

B435.0590

All Options

If the Covered Person chooses elective contact lenses, We do not cover Standard Lenses for one calendar year from the date the elective contact lenses are purchased.

B435.0597

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 \$200.00. Most Preferred Providers discount any amount over the allowance by 20%. Discounts may not be available at all locations, check with Your Preferred Provider.

If a Covered Person uses a Non-Preferred Provider, We limit what we pay for each set of Standard Frames to \$46.00.

We only cover charges for one set of Standard Frames in any one calendar year Benefit Period.

If the Covered Person chooses elective contact lenses, We do not cover Standard Frames for one calendar year from the date the elective contact lenses are purchased.

B435.1069

All Options

Necessary Contact Lenses: We cover charges for necessary contact lenses but only in place of all other lens and frame benefits available herein. This means that utilization of contact lens benefits exhausts all of the Covered Person's lens and frame benefits for the current Benefit Period, and future eligibility for lenses and frames will be determined as if spectacle lenses and frames were obtained in the current Benefit Period. We cover necessary contact lenses and charges for related professional services but only if the lenses are needed: (1) following cataract surgery; (2) to correct extreme visual acuity problems that cannot be corrected with spectacle lenses; (3) for certain conditions of: Anisometropia or Keratoconus.

And, We only cover charges for one pair of necessary contact lenses in any one calendar year Benefit Period.

If a Covered Person receives necessary contact lenses from a Preferred Provider, We pay 100% of the covered charges.

If a Covered Person receives necessary contact lenses from a Non-Preferred Provider, We limit what We pay for covered charges for such lenses to \$210.00 in any one calendar year Benefit Period.

B435.0616

All Options

Elective Contact Lenses: We cover charges for elective contact lenses, but only in place of all other lens and frame benefits available herein. This means that utilization of contact lens benefits exhausts all of the Covered Person's lens and frame benefits for the current Benefit Period, and future eligibility for lenses and frames will be determined as if spectacle lenses and frames were obtained in the current Benefit Period. We cover charges for hard, rigid gas permeable, soft, disposable, 30-day extended wear, daily-wear and planned replacement elective contact lenses.

If the Covered Person chooses elective contact lenses, We do not cover charges for Standard Lenses for one calendar year and Standard Frames for one calendar year from the date the elective contact lenses are purchased.

If a Covered Person uses a Preferred Provider, We limit what We pay for elective contact lenses to \$200.00

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 one calendar year Benefit Period.

Charges are covered up to the contact lens allowance. The allowance may be applied towards an elective contact lens Fitting and Evaluation at some provider locations.

B435.1116

All Options

Low Vision Benefits: We pay benefits for the covered charges at the Payment Rates shown in the Schedule of Benefits provided to a Covered Person who has severe visual problems which cannot be corrected with Standard Lenses.

Low Vision services are Low Vision Supplementary Testing and Low Vision Supplemental Care.

If a Covered Person receives Low Vision Supplementary Testing, We pay benefits for the covered charges for the testing up to \$125.00 per test.

We cover no more than two Low Vision Supplementary Test(s) per Covered Person in any 24 month Benefit Period.

We limit what We pay for all covered Low Vision services, including any amount paid for Low Vision Supplementary Testing, to \$1,000.00 per Covered Person in any 24 month Benefit Period.

B435.1126

All Options

Claims Appeals and Grievance Procedures

If a service is denied in whole or part, VSP will provide You with a written notification that includes:

- the specific reason why the service was denied in whole or part;
- reference to the specific Policy provisions(s) on which the determination was based;
- a description of any additional material or information necessary to reconsider the service; and

You or Your authorized representative have the right to appeal a claim determination by submitting an appeal in writing to VSP's Appeals and Grievance Department within 1 year of an adverse determination or within 1 year of learning of an adverse determination, whichever is later.

Vision Appeals
PO Box 2350
Rancho Cordova, CA 95741

Your appeal will be reviewed by VSP's internal review team. None of the individuals reviewing Your appeal will have been involved in the initial determination. Our specific guidelines and protocols are available for Your review upon request. For more information, call 1-844-557-2646.

We will decide the outcome of the appeal and notify You within the following timeframes:

Standard Appeals: In writing, within 30 calendar days of receipt of Your pre-service Grievance and 60 calendar days of receipt of a post-service Grievance.

Copies of all grievances and responses are maintained by VSP Appeals at its principal business office. These records are available at Guardian's Home Office, upon request, for inspection by the Director of the Michigan Department of Insurance and Financial Services for two (2) years following the year the grievance was filed.

Grievance Procedure

Definitions:

Adverse Determination: means any of the following (1) The denial, reduction, termination, or failure to provide or make payment, in whole or in part, for a benefit based on a determination by an insurer of a Covered Person's eligibility for coverage from the insurer. (2) A prospective review or retrospective review determination that denies, reduces, or terminates or fails to provide or make payment, in whole or in part, for a benefit. (3) A rescission of coverage determination (4) Failure to respond in a timely manner to a request for a determination.

Appeal: A written request for consideration of an adverse determination.

Grievance: A written complaint submitted by You or Your authorized representative regarding: (1) the availability, delivery or quality of vision services; or (2) claim payment, handling or reimbursement for vision services; or (3) matters pertaining to the contractual relationship between You and Guardian.

If You are not satisfied with the resolution of Your grievance after completing Appeals procedures, You may request a review by the Michigan Department of Insurance and Financial Services. You may direct Appeals to the Department of Insurance and Financial Services (Department) at the following address and telephone number:

Department of Insurance and Financial Services ("DIFS")
Office of General Counsel - Appeals Section Mail:
P.O. Box 30220
Lansing, Michigan 48909-7720
(877) 999-6442
DIFS-HealthAppeal@michigan.gov
<http://difs.state.mi.us/Complaints/ExternalReview.aspx>
Delivery service:
Office of General Counsel - Health Care Appeals Section
Department of Insurance and Financial Services
530 W. Allegan St., 7th Floor
Lansing, MI 48933-1521

Standard External Grievance Review Process

A Covered Person or his or her authorized representative may submit a written request to the Department for an external review within 127 days of the date of receipt of an Adverse Determination.

Upon receipt of the request for external review, the Department will notify and send a copy of the request to VSP immediately.

Within 5 business days of receipt of the request for external review, the Department will complete a preliminary review of the request to determine:

- a. if the person was a Covered Person under this Policy at the time the Health Care Service was requested or was provided.
- b. if the Health Care Service reasonably appears to be a covered service under this Policy.
- c. if the Covered Person has exhausted all levels of the internal grievance process, unless not required to do so as set forth above.
- d. if the Covered Person has provided all information and forms required by the Department to process an external review, including the health information release form.

Upon completion of the preliminary review, the Department immediately will provide written notice to the Covered Person or his or her authorized representative whether the request for external review is complete and has been accepted for external review.

If the request is not accepted because the request is not complete, the Department will inform the Covered Person or his or her authorized representative what information or materials are needed to make the request complete. If the request is not accepted for external review, the Department will provide written notice to the Covered Person or his or her authorized representative and to VSP of the reasons the request was not accepted.

B435.1385

All Options

If the request for external review is accepted, the Department will:

- a. provide written notice to the Covered Person or his or her authorized representative that the Covered Person or his or her authorized representative may submit to the Department, in writing, within seven (7) days of receipt of the notice, additional information and supporting documentation to be considered by the assigned IRO when conducting the external review. The Department will forward this information to the IRO and to VSP.
- b. immediately provide written notice to VSP that the request for external review has been accepted.

- c. If a request is not accepted for external review because the request is not complete, the Department shall inform the Covered Person and, if applicable, his or her authorized representative what information or materials are needed to make the request complete. The Covered Person or his or her authorized representative shall provide the information or materials identified by the Department within 30 days after receiving the notification. If a request is not accepted for external review, the Department shall provide written notice to the Covered Person or his or her authorized representative, and VSP of the reasons for its nonacceptance.

If the request for external review is accepted regarding the contractual provisions of this Policy, the Department may:

- a. keep the request and conduct his or her own external review; or
- b. assign an approved IRO to conduct the external review and provide a written recommendation to the Department whether to uphold or reverse the Adverse Determination.

If the Department keeps a request for external review:

- a. he or she will review the request and issue a decision to uphold or reverse the Adverse Determination within 14 days of the decision to keep the request.
- b. he or she will be subject to all the other time frames and requirements applicable to requests assigned to IROs, as set forth below.
- c. he or she will immediately assign an approved IRO to conduct the external review if, at any time during the Department's review of the request, it is determined that the request does appear to involve issues of medical necessity or clinical review criteria.

Within seven (7) business days of receipt of the written notice that the request for external review has been accepted, VSP must provide to the assigned IRO any documents and information considered in making the Adverse Determination. If the IRO notifies the Department that VSP has failed to provide this information within the required time frame, the Department may end the external review and render a decision to reverse the Adverse Determination. The Department will immediately notify the IRO, the Covered Person or his or her authorized representative and VSP of this decision.

In making its recommendation, the IRO will review the following:

- a. all of the documents and information received from VSP.
- b. any information submitted in writing to the Department by the Covered Person or his or her authorized representative and forwarded to the IRO by the Department.
- c. any of the following that are available and which the IRO deems appropriate:
 - (i) any relevant medical records;
 - (ii) the treating health care provider's recommendation;

- (iii) consulting reports from appropriate health care professionals and other documents submitted by VSP, the Covered Person or his or her Authorized Representative, and the treating health care provider;
- (iv) the relevant terms of coverage of this Policy;
- (v) the most appropriate practice guidelines, which may include generally accepted practice guidelines, evidence-based practice guidelines or any other practice guidelines, developed by the federal government; or national or professional medical societies, boards or associations; and
- (vi) any applicable clinical review criteria developed and used by VSP or its designated URO.

In reaching a recommendation, the IRO is not bound by any decisions or conclusions reached during VSP's utilization review process or internal Grievance process.

The IRO will provide its recommendation to the Director within 14 calendar days of the date the Director accepted the request for external review. The recommendation will include:

- (a) a general description of the reason for the request for external review.
- (b) the date the IRO was assigned by the Director to conduct the external review.
- (c) the date the external review was conducted.
- (d) the date of the IRO's recommendation.
- (e) the principal reason or reasons for its recommendation.
- (f) the rationale for its recommendation.
- (g) references to the evidence or documentation, including practice guidelines, considered in reaching its recommendation.

Upon receipt of the IRO's recommendation, the Director will:

- (a) review the recommendation to ensure that it is not contrary to the terms of coverage of this Policy.
- (b) provide, within seven (7) business days of receipt of the IRO's recommendation, written notice the Covered Person or his or her Authorized Representative and VSP of the decision to uphold or reverse the Adverse Determination. This notice will include:
 - (i) the principal reason or reasons for the decision, including the information provided by the IRO.
 - (ii) if applicable, the principal reason or reasons why the Director did not follow the IRO's recommendation.

Upon receipt of notice of a decision to reverse an Adverse Determination, VSP immediately will approve the coverage that was the subject of the external review.

Expedited External Review

The Covered Person or his or her Representative may submit a written request to the Director for an expedited external review within 10 days of the date of receipt of an Adverse Determination if: (1) the Covered Person has a medical condition where the timeframe for completion of the expedited review under the internal Grievance procedures would seriously jeopardize the Covered Person's life or health or Covered Person's ability to regain maximum function, as certified by a doctor, either orally or in writing; and (2) the Covered Person or his or her Authorized Representative have requested an internal expedited review. Expedited external reviews are not available for Adverse Determinations of Health Care Services that already have been provided to the Covered Person.

Upon receipt of a request for an expedited external review, the Director will notify and send a copy of the request to VSP. The Director will review the request to determine if it is acceptable.

If the request for expedited external review is accepted, the Director will assign an approved IRO to conduct the expedited external review and provide a written recommendation to the Director whether to uphold or reverse the Adverse Determination. If the Covered Person has not already completed the internal expedited review process, the assigned IRO will immediately determine whether the Covered Person will be required to complete the internal expedited review. If the IRO determines that the Covered Person must first complete the internal expedited review, the IRO will immediately notify the Covered Person or his or her Authorized Representative of that determination and will not proceed with the expedited external review until the internal expedited review is completed.

Within 12 hours of receipt of the written notice that the request for external review has been accepted, VSP or its designated URO must provide to the assigned IRO, by the most expeditious method available, i.e. electronically, or by telephone or facsimile, any documents and information considered in making the Adverse Determination.

In making its recommendation, the IRO will review all of the documents and information received from VSP or its designated URO and any of the following that are available and which the IRO deems appropriate:

- (a) any relevant medical records;
- (b) the treating health care provider's recommendation;
- (c) consulting reports from appropriate health care professionals and other documents submitted by VSP, the Covered Person or his or her Authorized Representative, and the treating health care provider;
- (d) the relevant terms of coverage of this Policy;
- (e) the most appropriate practice guidelines, which may include generally accepted practice guidelines, evidence-based practice guidelines or any other practice guidelines, developed by the federal government; or national or professional medical societies, boards or associations; and

- (f) any applicable clinical review criteria developed and used by VSP or its designated URO.

The IRO will provide its recommendation to the Director as expeditiously as the Member's medical condition or circumstances require, but not later than 36 hours after the Director received the request for expedited external review.

Upon receipt of the IRO's recommendation, the Director will:

- (a) review the recommendation to ensure that it is not contrary to the terms of coverage of this Policy.
- (b) provide notice to the Covered Person or his or her Authorized Representative and to VSP as expeditiously as the Covered Person's medical condition or circumstances require, but not later than 24 hours after receipt of the IRO's recommendation, of the decision to uphold or reverse the Adverse Determination. If the notice was not in writing, written confirmation of the decision will be provided to the Covered Person within two (2) business days after the notice was provided and will include:
 - (i) the principal reason or reasons for the decision, including the information provided by the IRO.
 - (ii) if applicable, the principal reason or reasons why the Director did not follow the IRO's recommendation.

Upon receipt of notice of a decision to reverse an Adverse Determination, VSP immediately will approve the coverage that was the subject of the external review.

The Covered Person or his or her Authorized Representative may not request another external review of the same Adverse Determination for which an external review decision already has been rendered.

Reconsideration

VSP may reconsider an Adverse Determination that is the subject of an external review. Such reconsideration does not delay or terminate the external review. The external review will only be terminated if VSP decides, after completing its reconsideration, to reverse its Adverse Determination and to provide the coverage or payment for the Health Care Service that was the subject of the external review. Immediately upon making the decision to reverse its Adverse Determination, VSP will notify the Covered Person or his or her Authorized Representative, the IRO and the Director in writing. The Director or IRO will terminate the external review upon receipt of the notice.

Annual Reporting Requirements

We will keep summary data on the number and types of complaints and Grievances filed with Us. Each year, by April 15th, summary data for the prior calendar year will be filed with the Director on forms provided by the Director.

B435.1386

Exclusions

No benefits will be paid for services or materials connected with, or charges arising from:

- Orthoptics or vision training and any associated supplemental testing.
- Aniseikonic lenses.
- Medical and/or surgical treatment of the eyes or supporting structures.
- Any vision examination or corrective eyewear or safety eyewear required by an employer as a condition of employment unless specifically covered under this Certificate.
- Services provided as a result of any Workers' Compensation law, or similar legislation, or required by any governmental agency or program whether federal, state or subdivisions thereof.
- Services or materials provided by any other group benefit plan providing vision care.
- Plano Lenses (non-prescription lenses with less than a +/- .50 diopter power).
- Plano contact lenses to change eye color cosmetically or artistically painted contact lenses.
- Non-prescription sunglasses.
- Two sets of glasses in lieu of bifocals.
- Replacement of lenses, frames, glasses or contact lenses furnished under this Certificate which are lost or broken, except at normal intervals when services are otherwise available.
- Refitting of contact lenses after the initial 90 day fitting period.
- Routine maintenance of contact lenses, such as polishing or cleaning or modifications to contact lenses.
- Corneal refractive therapy (CRT) or orthokeratology (using contact lenses to change the shape of the cornea to reduce myopia).
- A frame that costs more than this Certificate allowance.
- Unused allowance amounts cannot be banked for future use. The allowance must be used during the same office visit.
- Benefits cannot be split. Frames and lenses must be purchased during the same office visit.

B435.1127

All Options

- Progressive Multi-Focal Lenses.

B435.0089

All Options

- Anti-Reflective Coating of the lens or lenses.

B435.0090

All Options

- Photochromic Lenses.

B435.0092

All Options

- Ultraviolet Coating of lenses.

B435.0093

All Options

- Scratch Resistant Coating.

B435.0095

All Options

- High Index Lenses.

B435.0096

All Options

- Polycarbonate Lenses for adults.

B435.0097

All Options

- Polarized/Laminated Lenses.

B435.0098

All Options

- Oversize Lenses.

B435.0636

All Options

- Mirror and Ski Coating.

B435.0099

All Options

- Edge Treatment.

B435.0100

All Options

- Tinted Lenses.

B435.0637

All Options

- Blended Lenses.

B435.0101

All Options

Charges not covered due to these exclusions are not considered charges for covered vision services and cannot be used to satisfy this Certificate's Copayments or Deductibles, if any.

B435.0147

All Options

DEFINITIONS

This section defines certain terms appearing in Your Certificate.

B040.0004

All Options

**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.

B435.0102

All Options

Anisometropia: This term means a condition in which two eyes have unequal refractive power. Each eye can be nearsighted (myopia), farsighted (hyperopia), or a combination of both, which is called antimetropia. Generally a difference in power of two diopters or more is the accepted threshold to label the condition anisometropia.

B435.1044

All Options

**Anti-Reflective
Coating:** This term means a clear lens coating that limits light reflection by allowing the maximum amount of light to pass through the lens.

B435.0105

All Options

Benefit Period: This term means the time period beginning when a covered service is received and extending for the period shown in this Certificate, during which benefits for the covered service are available to a Covered Person.

B040.0846

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

B040.0847

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

B435.0108

Copayment: This term 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 services are received.

B435.0109

All Options

Corneal Disorders: This term means any condition (other than Keratoconus) of congenital, pathological or surgical etiology causing compromised integrity of the corneal curvature or media resulting in best correctable acuity of 20/70 or less with spectacles in one or both eyes.

B435.0110

All Options

Covered Person: This term means You, if You are covered by the Policy, and any of Your covered dependents.

B435.0185

All Options

Deductible: This term means a fixed dollar amount the Covered Person is responsible for paying before Guardian will begin paying the cost of covered benefits.

B435.0111

All Options

Edge Treatment: This term means a cosmetic service to make the sides of a cut lens look clear rather than a milky white.

B435.0112

All Options

Effective Date: The date the Policy goes into force and effect as stated on the cover page of the Certificate 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 Certificate of Coverage.

B435.0113

All Options

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

B435.0114

All Options

Employee: This term means the member of the group determined to be eligible by the Employer.

B435.0115

All Options

Employer: This term means the entity that purchased the Policy.

B435.0116

All Options

Enrollment Period: This term means the 31 day period which starts on the date You first become eligible for dependent coverage.

B040.0856

All Options

Fitting and Evaluation: This term means an examination for the proper fit of contacts and evaluating vision with the contacts. Includes prescription, fitting, evaluation, modification and/or dispensing of contact lenses.

B435.0117

All Options

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 Employer in Your Eligible class (but not less than 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 Your job.

B435.0145

All Options

High Index Lenses: This term means material that is used to create thinner lenses than normal plastic. The material does not contain the impact-resistant qualities of polycarbonate.

B435.0120

All Options

High Myopia: Refractive error greater than plus or minus 10.00 diopters of correction; best correctable visual acuity with spectacles of 20/40 or less in either eye; at least two lines improvement in best correctable visual acuity (as measured with standard Snellen chart) with contact lenses.

B435.0121

All Options

Incurred, or Incurred Date: These terms mean: (1) the placing of an order for lenses, frames or contact lenses; or (2) the date on which such an order was placed.

B040.0860

All Options

Irregular Astigmatism: This term means greater than or equal to 2.00 diopters of astigmatism in either eye where the principal meridians are separated by less than 90 degrees, resulting in best correctable acuity of 20/70 or less in the affected eye with spectacles.

B435.0123

All Options

Keratoconus: This term 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. Diagnosis confirmed by keratometric readings, or corneal topography best correctable visual acuity with spectacles of 20/40 or less in either eye; at least two lines improvement in best correctable visual acuity (as measured with standard Snellen chart) with rigid contact lenses.

B435.0124

All Options

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

B040.0862

All Options

Low Vision: This term means a partial loss of vision; a loss of acuity or sharpness or a loss of side/peripheral vision; and that the Covered Person's most favorable corrected visual acuity is 20/70 or worse in one or both eyes.

B435.1046

All Options

Low Vision Supplemental Care: This term means subsequent Low Vision therapy, when visually necessary or appropriate.

B435.1047

All Options

Low Vision Supplementary Testing: This term means a Low Vision analysis and diagnosis. The analysis and diagnosis includes: (a) a comprehensive examination of visual functions; and (b) the prescription of corrective eyewear or vision aids, when required.

B435.1048

All Options

Mirror and Ski Coating: This term means a thin deposit of appropriate material to the front surface of a lens, causing a portion of the light striking the lens to reflect directly from the front surface.

B435.0125

All Options

Non-Preferred Provider: This term means any optometrist, optician, ophthalmologist, or other licensed and qualified vision care provider that is not under contract, directly or indirectly, with VSP as a Preferred Provider.

B435.0692

All Options

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

B040.0865

All Options

Oversize Lenses: This term means larger than a standard lens blank, to accommodate prescriptions.

B040.0866

All Options

Payment Limit: This term means the maximum amount this Certificate pays for covered services and supplies during a specified Benefit Period.

B435.0128

All Options

Payment Rate: This term means the percentage rate that this Certificate pays for covered services and supplies.

B435.0129

All Options

Photochromic Lenses: This term means lenses which change color with the intensity of sunlight.

B040.0870

All Options

Plano Lenses: This term means lenses which have no refractive power (lenses with less than a greater than or equal to .38 diopter power).

B435.0130

All Options

Polarized/Laminated Lenses: This term means lenses that block light reflected from horizontal surfaces such as water, in order to reduce glare.

B435.0131

All Options

Policy: This term means the group Vision Insurance Coverage described in the Policy and this Certificate.

B435.0132

All Options

Polycarbonate Lenses: This term means the highest impact-resistant lens material available. Its high-index properties result in lenses 20-25% thinner than regular plastic. This material is often used for safety and children's eyewear as well as for sports and cosmetic purposes.

B435.0133

All Options

Preferred Provider: This term means an optometrist, optician, ophthalmologist or other licensed and qualified vision care provider who has entered into a contract, directly or indirectly with VSP to provide vision care services and or Vision Materials to Covered Persons.

B435.0638

All Options

Progressive Multi-Focal Lenses: This term means lenses that have no line, but progresses from distance, to intermediate, to near vision.

B435.0135

All Options

Qualified Retiree: This term means Qualified Retirees are covered as outlined in Your company's benefit provisions. Please see your Plan Administrator for details.

B040.0875

All Options

Registered Reciprocal Beneficiaries: This term means an employee and his or her reciprocal beneficiary: (a) who have filed a Declaration of Reciprocal Beneficiary Relationship with the Director of Health of the State of Hawaii as provided in section 572C-5 of the Hawaii Revised Statutes; (b) the declaration has been registered by the Director; and (c) a certificate of reciprocal beneficiary relationship has been provided to each party named on the declaration.

B435.1984

All Options

Reciprocal Beneficiary: This term means an adult who is a party to a valid reciprocal beneficiary relationship and who meets the following requirements for such a relationship:

- Each of the parties must be at least eighteen years old.
- Neither of the parties can be married nor a party to another reciprocal beneficiary relationship.
- The parties must be legally prohibited from marrying one another under chapter 572 of the Hawaii Revised Statutes.
- Consent of either party to the reciprocal beneficiary relationship has not been obtained by force, duress, or fraud.
- Each of the parties must sign a Declaration of Reciprocal Beneficiary Relationship.

B435.1985

All Options

Scratch Resistant Coating: This term means a coating applied to spectacle lenses to increase the scratch resistance of the lens surface.

B435.0136

All Options

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

B435.0798

All Options

Standard Frames: This term means frames valued up to the limit published by VSP which is given to Preferred Providers.

B435.0639

All Options

Standard Lenses: This term means regular glass or plastic lenses.

B435.0139

All Options

Tinted Lenses: This term means lenses which have an additional substance added to produce constant tint.

B040.0878

All Options

Ultraviolet Coating (UV): This term means a coating that blocks ultraviolet rays.

B435.0141

All Options

Usual And Customary: This term means that the charge for the covered vision condition: (1) is the provider's standard charge for the service furnished; and (2) is not more than the usual charge made by most other providers with similar training and experience in the same geographic area. 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.

B040.0879

All Options

Vision Materials: This term means (1) Elective Contact Lenses; or (2) Standard Lenses, Standard Frames or a complete pair of eyeglasses (lenses and frames).

B435.0142

All Options

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

B435.0143

All Options

You, Your or Your: These terms mean the covered Employee.

B435.0144

STATEMENT OF ERISA RIGHTS

The Guardian Life Insurance Company of America

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

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

ERISA provides that all plan participants shall be entitled to:

Receive Information about Your Plan and Benefits

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

Prudent Actions by Plan Fiduciaries

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

Enforcement of Your Rights

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

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

Assistance with Questions

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

Qualified Medical Child Support Order and Qualified Domestic Relations Order

Federal law required that group health plans provide medical coverage for a dependent child pursuant to a qualified medical child support order (QMCSO). A dependent child also includes a child for whom You must provide Vision 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.

Vision 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 responsible for interpretation of 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 will 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.

B435.0858

All Options

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 30 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 30-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 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 Benefit Determination nor that person's subordinate;
- In deciding an appeal based upon a vision 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 vision or medical experts whose advice was obtained in connection with an Adverse Benefit Determination;
- 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 30 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 30 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 30-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.

If You are still dissatisfied, You may contact the Michigan Department of Insurance and Financial Services at:

Mail:
Office of General Counsel - Health Care Appeals Section
Department of Insurance and Financial Services
P.O. Box 30220
Lansing, MI 48909-7720

Delivery service:
Office of General Counsel - Health Care Appeals Section
Department of Insurance and Financial Services
530 W. Allegan St., 7th Floor
Lansing, MI 48933-1521

Toll Free Telephone: 877-999-6442
FAX: 517-284-8838

B435.0854

All Options

VISION INSURANCE COVERAGE SCHEDULE OF BENEFITS

This Schedule of Benefits is attached to the Certificate and is effective the later of: 1) the Policy Effective Date; or 2) the Effective Date of any amendment. This Schedule of Benefits replaces any previously issued Schedule of Benefits.

B435.1131

All Options

Initial Election You may choose to be covered under one of the plans of vision expense coverage offered by Your Employer. You may only be covered under one plan at a time. You must notify the Employer of Your election and pay the required premium.

B435.0151

All Options

Group Enrollment Period A group enrollment period is held each year from June 1st to June 30th. During this period, You may choose to enroll for vision insurance coverage under the Policy. In that case, coverage is scheduled to start on the date determined by Your Employer that next follows the date You enroll.

B435.0155

All Options

PPO Copayments Examinations \$10.00
Standard Frames and/or Standard Lenses \$10.00
Necessary Contact Lenses \$10.00
Low Vision Examinations and Services None
Low Vision Materials None

Non-PPO Cash Deductibles Examinations \$10.00
Standard Frames and/or Standard Lenses \$10.00
Necessary Contact Lenses \$10.00
Low Vision Examinations and Services None
Low Vision Materials None

Payment Rates For Covered Charges 100%
For Low Vision Supplementary Testing furnished by a Preferred Provider 100%
For Low Vision Supplementary Testing furnished by a Non-Preferred Provider 100%
For Low Vision Supplementary Care furnished by a Preferred Provider 75%
For Low Vision Supplementary Care furnished by a Non-Preferred Provider 75%

B435.1134

All Options

Changes in Coverage Amounts If You are not Actively At Work on a Full-Time basis, any change in Your amount of coverage or the amount of coverage on a covered dependent will not become effective until the date You return to Active Work on a Full-Time basis.

Changes In Insurance Classification If Your classification changes, coverage will not be changed to the new amount until the first day on which You are: (1) Actively At Work on a Full-Time basis; and (2) make a contribution, if required, for the new classification.

If a contribution is required for the new classification for which a larger amount of coverage is provided, You must make the required contribution for the amount within 31 days of the change.

B435.1139

All Options

CERTIFICATE RIDER

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:

Services and Supplies Received from Participating Retail Chain Providers

Vision care services and supplies that are covered by the Certificate when received from a Preferred Provider or a Non-Preferred Provider may also be covered by the Certificate when such services and supplies are received from a Participating Retail Chain Provider, subject to the limitations and exclusions below.

If services and supplies are received from a Participating Retail Chain Provider, We pay benefits for covered charges, after the Copayment, as shown below:

SERVICES AND SUPPLIES

PARTICIPATING RETAIL CHAIN PROVIDER - COSTCO, WALMART and SAM'S CLUB

OTHER PARTICIPATING RETAIL CHAIN PROVIDERS

Eye Exam - one in any one
calendar year Benefit Period.

Covered In Full.

Covered In Full.

B435.1387

All Options

Standard Lenses - one
pair in any one calendar
year Benefit Period.

- Single Vision

Covered In Full.
(Not all lens types may be
available at all locations.)

Covered In Full.
(Not all lens types may be
available at all locations.)

- Bifocal

Covered In Full.
(Not all lens types may be
available at all locations.)

Covered In Full.
(Not all lens types may be
available at all locations.)

- Trifocal

Covered In Full.
(Not all lens types may be
available at all locations.)

Covered In Full.
(Not all lens types may be
available at all locations.)

- Lenticular

Not Available.

Covered In Full.
(Not all lens types may be
available at all locations.)

Lens Options - once
in any one calendar
year Benefit Period.

Covered In Full.
(Not all lens options may be
available at all locations.)

Covered In Full.
(Not all lens options may be
available at all locations.)

B435.0668

All Options

SERVICES AND SUPPLIES

Standard Frames - one set in any one calendar year Benefit Period.

PARTICIPATING RETAIL CHAIN PROVIDER - COSTCO, WALMART and SAM'S CLUB

Covered In Full up to \$110.00.
No discount available on charges in excess of the benefit amount.

OTHER PARTICIPATING RETAIL CHAIN PROVIDERS

Covered In Full up to \$200.00.

B435.1388

All Options

Elective Contact Lenses - one pair in any one calendar year Benefit Period.

- Contact Lens (Materials Only)

Covered In Full up to \$200.00.

Covered In Full up to \$200.00.

B435.0672

All Options

LIMITATIONS

- Limitations and exclusions of benefits described in the Certificate for VSP Preferred Providers shall also apply to services and supplies received from Participating Retail Chain Provider Providers.
- If a service or supply is not covered by the Certificate when received from a Preferred Provider or a Non-Preferred Provider, such service or supply is not covered by the Certificate when received from a Participating Retail Chain Provider.
- Services and supplies received from a Participating Retail Chain Provider are in lieu of services and supplies received from a VSP Preferred Provider or a Non-Preferred Provider. Membership may be required in order to access benefits through a Participating Retail Chain Provider. Membership fees are not covered under the Certificate.

B435.1160

All Options

EXCLUSIONS

- We do not cover charges for:
 - Medically Necessary Contact Lenses.
 - Safety Glasses.
 - Interim Benefits.
 - Primary Eye Care.
 - Diabetic Eye Care Plus Program.

B435.1161

All Options

DEFINITIONS

This section defines certain terms appearing in this Rider. Additional terms, not listed here, are defined in the Certificate.

Participating Retail Chain Provider: This term means vision care providers who are not contracted as VSP Preferred Providers but who have agreed to bill VSP directly for covered vision services and supplies provided as set forth in this rider. Not all Participating Retail Chain Providers may be able to provide all such covered vision services and supplies. Covered Persons should discuss requested services with their provider or contact VSP Customer Care at (877) 814-8970 for details.

The following definition replaces the definition of the term "Copayment" as it is shown in the Certificate.

Copayment: This term 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 or a Participating Retail Chain Provider at the time covered vision services or supplies are received.

This Rider is a 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

A handwritten signature in black ink, appearing to read 'MD', with a stylized flourish extending from the bottom right.

Matthew Darula, Head of Product, Strategy and Offerings

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