REAL LIFE. REAL BENEFITS.

2017 SUMMARY OF MATERIAL MODIFICATIONS
Summary of Material Modifications for the IASIS Healthcare Welfare Benefit Plan

Effective January 1, 2017
Summary of Material Modification to the IASIS Healthcare, LLC Welfare Benefit Plan
Effective January 1, 2017

This Summary of Material Modification describes changes to the IASIS Healthcare, LLC Welfare Benefit Plan originally effective January 1, 2016. These changes are effective January 1, 2017 and will remain in effect until amended in writing by the Plan Administrator.

IASIS Healthcare, LLC is amending the Plan as follows:

1. ACI EAP has replaced MHSA as the Employee Assistance Program provider. Article XI. Benefit Programs and Providers has been amended by replacing MHSA with ACI EAP. The contact number for ACI EAP is 1-855-775-4357.
2. Amending the PPO section of the Summary Plan Description by applying the terms of the attached Tiered Summaries of Material Modification and Amendment #1 to the IASIS Healthcare, LLC Welfare Benefit Plan Group No. 14092.
3. Deleting Attachment B: Prescription Drug Schedule of Benefits and replacing it with the attached amended Attachment B: Prescription Drug Schedule of Benefits.
4. Deleting the Dental and Vision section of the Summary Plan Description and replacing it with the attached amended Dental and Vision section.
5. Deleting the EAP section of the Summary Plan Description and replacing it with the attached amended EAP section.
SUMMARY OF MATERIAL MODIFICATION AND AMENDMENT #1 TO THE IASIS HEALTHCARE, LLC WELFARE BENEFIT PLAN GROUP NO. 14092

This Summary of Material Modification and Amendment describes changes to the IASIS Healthcare, LLC Welfare Benefit Plan originally effective January 1, 2016. These changes are effective as of January 1, 2017 and will remain in effect until amended in writing by the Plan Administrator.

This document should be read carefully and attached to the Plan Document and Summary Plan Description. Please contact the Plan Administrator identified in the Summary Plan Description if you have any questions regarding the changes described in this Summary of Material Modification.

IASIS Healthcare, LLC (the “Plan Sponsor”) is amending the IASIS Healthcare, LLC Welfare Benefit Plan (the “Plan”) as follows:

1. The second paragraph under the General Overview of the Plan section is hereby deleted and not replaced.

2. The Prescription Drug Schedule of Benefits –Tiered $500 Plan, Prescription Drug Schedule of Benefits –Tiered $750 Plan, and the Prescription Drug Schedule of Benefits –Tiered $1,000 Plan are hereby deleted and replaced as shown in Exhibits A-C.

3. Item (G) under (a)-(iv) under number (36) - Preventive Services and Routine Care in the Eligible Medical Expenses section of the Plan is hereby deleted and replaced with the following:

ELIGIBLE MEDICAL EXPENSES

(36) Preventive Services and Routine Care: The following preventive services and routine care are paid as shown in the Medical Schedule of Benefits:

(G) Breastfeeding support, supplies and counseling in conjunction with each birth, including the following:

(1) Comprehensive lactation support and counseling by a trained provider during pregnancy and/or in the postnatal period (60 days from baby’s date of birth). Lactation consultation is limited to 6 cumulative visits per 12-month period.

(2) Breastfeeding equipment will be covered, subject to the following:

(i) Rental of a Hospital grade electric pump while the baby is Hospital confined; and

(ii) Purchase of a standard (non-Hospital grade) electric breast pump or manual breast pump if requested during pregnancy or during the duration of breastfeeding, provided the Covered Person has not received either a standard electric breast pump or a manual breast pump within the last 3 Calendar Years and provided the Covered Person remains continuously enrolled in the Plan.
(3) For women using a breast pump from a prior pregnancy, one new set of breast pump supplies will be covered at 100% with each subsequent pregnancy for initiation or continuation of breastfeeding.

4. **Number (64) - Surrogate** in the **General Exclusions and Limitations** section is hereby deleted and replaced with the following:

**GENERAL EXCLUSIONS AND LIMITATIONS**

(64) **Surrogate:** Expenses relating to a surrogate pregnancy of any person who is not covered under this Plan and for any Covered Person other than the Employee and Spouse will not be considered eligible, including but not limited to pre-pregnancy, conception, prenatal, childbirth and postnatal expenses. This exclusion does not apply to preventive services for any Covered Person as described under the Eligible Medical Expenses section of the Plan.

5. **The Subrogation, Third-Party Recovery and Reimbursement** section of the Plan is hereby deleted and replaced as shown in **Exhibit D**.

6. **The definition of Usual and Customary Charge (U&C)** under the **Definitions** section is hereby deleted and replaced with the following:

**DEFINITIONS**

**Usual and Customary Charge (U&C)** means, with respect to Non-Participating Providers, charges made for medical or dental services or supplies essential to the care of the individual that will be subject to a Usual and Customary determination. Subject to the rest of this definition, the Usual and Customary Charge means the lesser of the charge by other providers in the same geographic area or billed charges for the same or comparable service or supply. From time to time, the Plan may enter into an agreement with a Non-Participating Provider (directly or indirectly through a third party) which sets the rate the Plan will pay for a service or supply. In these cases the Usual and Customary Charge will be the rate established in such agreement with the Non-Participating Provider.

The Plan may reduce the Usual and Customary Charge by applying reimbursement policies administered by the Plan’s Third Party Administrator. These reimbursement policies address the appropriate billing of services, taking into account factors that are relevant to the cost of the service such as:

1. The duration and complexity of a service;
2. Whether multiple procedures are billed at the same time but no additional overhead is required;
3. Whether an Assistant Surgeon is involved and necessary for the service;
4. If follow up care is included;
5. Whether there are any other characteristics that may modify or make a particular service unique; and
6. When a charge includes more than one claim line, whether any services described by a claim line are part of or incidental to the primary service provided.

The reimbursement policies utilized are based on review of the policies developed for Medicare; the generally accepted standards of medical and dental practice, which are based on credible scientific evidence published in peer-reviewed literature generally recognized by the relevant medical or dental community or which are otherwise consistent with Physician or dental specialty society recommendations; and the views of Physicians and Dentists practicing in the relevant clinical areas.
7. The Enforce Your Rights section under Statement of ERISA Rights is hereby deleted and replaced with the following:

STATEMENT OF ERISA RIGHTS

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

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of Plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you a daily penalty up to the statutory maximum amount until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court. In addition, if you disagree with the Plan’s decision or lack thereof concerning the qualified status of a domestic relations order, a medical child support order or a national medical support notice, you may file suit in 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 would pay court costs and legal fees. If you are successful, the court may order the person you have 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 your claim is frivolous.

8. The Discrimination is Against the Law section is hereby added to the Plan as Exhibit E.

All other provisions of this Plan shall remain unchanged.

In Witness Whereof, IASIS Healthcare, LLC has caused this Amendment to take effect, be attached to, and form a part of their Welfare Benefit Plan.

____________________________________________  ____________________________  ____________________________
Authorized Signature                   Date                     Title

____________________________________________  ____________________________  ____________________________
Witness                               Date                     Title

14092-01-Tiered  3
## EXHIBIT A

### PRESCRIPTION DRUG SCHEDULE OF BENEFITS – TIERED $500 PLAN

<table>
<thead>
<tr>
<th>BENEFIT DESCRIPTION</th>
<th>BENEFIT</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>CALENDAR YEAR OUT-OF-POCKET MAXIMUM</strong> (includes Copays and Coinsurance - combined with major medical)</td>
<td></td>
</tr>
<tr>
<td>Single</td>
<td>$5,750</td>
</tr>
<tr>
<td>Family</td>
<td>$11,500</td>
</tr>
<tr>
<td><strong>Retail Pharmacy: 30-day supply</strong></td>
<td></td>
</tr>
<tr>
<td>Generic Drug</td>
<td>$15 Copay, then 100%</td>
</tr>
<tr>
<td>Brand Name Drug</td>
<td>30% Coinsurance up to $100 maximum</td>
</tr>
<tr>
<td>Specialty Drugs</td>
<td>30% Coinsurance up to $200 maximum</td>
</tr>
<tr>
<td>Preventive Drug (Prescription Drugs classified as a Preventive Drug by HHS)</td>
<td>100% ($0 Copay)</td>
</tr>
<tr>
<td><strong>Mail Order Pharmacy or 90 day Retail Pharmacy: 90-day supply</strong></td>
<td></td>
</tr>
<tr>
<td>Generic Drug</td>
<td>$37.50 Copay, then 100%</td>
</tr>
<tr>
<td>Brand Name Drug</td>
<td>30% Coinsurance up to $250 maximum</td>
</tr>
<tr>
<td>Preventive Drug (Prescription Drugs classified as a Preventive Drug by HHS)</td>
<td>100% ($0 Copay)</td>
</tr>
</tbody>
</table>

### Mandatory Generic Program

The Plan requires that pharmacies dispense Generic Drugs when available. Should a Covered Person choose a Brand Name Drug rather than the Generic equivalent, the Covered Person will also be responsible for the cost difference between the Generic and Brand Name Drug, even if a DAW (Dispense As Written) is written by the prescribing Physician. The cost difference is not covered by the Plan and will not accumulate toward your Out-of-Pocket Maximum.

### Mandatory Maintenance Drugs

All maintenance drugs must be filled at mail order or a participating 90-day retail pharmacy in order to be covered by the Plan.

**Preventive Drug** means items which have been identified by the U.S. Department of Health and Human Services (HHS) as a preventive service. You may view the guidelines established by HHS by visiting the following website:

https://www.healthcare.gov/what-are-my-preventive-care-benefits

For a paper copy, please contact the Plan Administrator.
EXHIBIT B

PRESCRIPTION DRUG SCHEDULE OF BENEFITS – TIERED $750 PLAN

<table>
<thead>
<tr>
<th>BENEFIT DESCRIPTION</th>
<th>BENEFIT</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>CALENDAR YEAR OUT-OF-POCKET MAXIMUM</strong></td>
<td></td>
</tr>
<tr>
<td>(includes Copays and Coinsurance - combined with major medical)</td>
<td></td>
</tr>
<tr>
<td>Single</td>
<td>$6,250</td>
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<tr>
<td>Family</td>
<td>$12,500</td>
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<tr>
<td><strong>Retail Pharmacy: 30-day supply</strong></td>
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<tr>
<td>Generic Drug</td>
<td>$15 Copay, then 100%</td>
</tr>
<tr>
<td>Brand Name Drug</td>
<td>30% Coinsurance up to $100 maximum</td>
</tr>
<tr>
<td>Specialty Drugs</td>
<td>30% Coinsurance up to $200 maximum</td>
</tr>
<tr>
<td>Preventive Drug (Prescription Drugs classified as a Preventive Drug by HHS)</td>
<td>100% ($0 Copay)</td>
</tr>
<tr>
<td><strong>Mail Order Pharmacy or 90 day Retail Pharmacy: 90-day supply</strong></td>
<td></td>
</tr>
<tr>
<td>Generic Drug</td>
<td>$37.50 Copay, then 100%</td>
</tr>
<tr>
<td>Brand Name Drug</td>
<td>30% Coinsurance up to $250 maximum</td>
</tr>
<tr>
<td>Preventive Drug (Prescription Drugs classified as a Preventive Drug by HHS)</td>
<td>100% ($0 Copay)</td>
</tr>
</tbody>
</table>

**Mandatory Generic Program**
The Plan requires that pharmacies dispense Generic Drugs when available. Should a Covered Person choose a Brand Name Drug rather than the Generic equivalent, the Covered Person will also be responsible for the cost difference between the Generic and Brand Name Drug, even if a DAW (Dispense As Written) is written by the prescribing Physician. The cost difference is not covered by the Plan and will not accumulate toward your Out-of-Pocket Maximum.

**Mandatory Maintenance Drugs**
All maintenance drugs must be filled at mail order or a participating 90-day retail pharmacy in order to be covered by the Plan.

**Preventive Drug** means items which have been identified by the U.S. Department of Health and Human Services (HHS) as a preventive service. You may view the guidelines established by HHS by visiting the following website:

https://www.healthcare.gov/what-are-my-preventive-care-benefits

For a paper copy, please contact the Plan Administrator.
EXHIBIT C
PRESCRIPTION DRUG SCHEDULE OF BENEFITS – TIERED $1,000 PLAN

<table>
<thead>
<tr>
<th>BENEFIT DESCRIPTION</th>
<th>BENEFIT</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>CALENDAR YEAR OUT-OF-POCKET MAXIMUM</strong> (includes Copays and Coinsurance - combined with major medical)</td>
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<tr>
<td>Single</td>
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<tr>
<td><strong>Retail Pharmacy: 30-day supply</strong></td>
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<tr>
<td>Generic Drug</td>
<td>$15 Copay, then 100%</td>
</tr>
<tr>
<td>Brand Name Drug</td>
<td>30% Coinsurance up to $100 maximum</td>
</tr>
<tr>
<td>Specialty Drugs</td>
<td>30% Coinsurance up to $200 maximum</td>
</tr>
<tr>
<td>Preventive Drug (Prescription Drugs classified as a Preventive Drug by HHS)</td>
<td>100% ($0 Copay)</td>
</tr>
<tr>
<td><strong>Mail Order Pharmacy or 90 day Retail Pharmacy: 90-day supply</strong></td>
<td></td>
</tr>
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**Mandatory Generic Program**
The Plan requires that pharmacies dispense Generic Drugs when available. Should a Covered Person choose a Brand Name Drug rather than the Generic equivalent, the Covered Person will also be responsible for the cost difference between the Generic and Brand Name Drug, even if a DAW (Dispense As Written) is written by the prescribing Physician. The cost difference is not covered by the Plan and will not accumulate toward your Out-of-Pocket Maximum.

**Mandatory Maintenance Drugs**
All maintenance drugs must be filled at mail order or a participating 90-day retail pharmacy in order to be covered by the Plan.

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For a paper copy, please contact the Plan Administrator.
EXHIBIT D

SUBROGATION, THIRD-PARTY RECOVERY AND REIMBURSEMENT

Payment Condition
(1) The Plan, in its sole discretion, may elect to conditionally advance payment of benefits in those situations where an Injury, Illness, disease or disability is caused in whole or in part by, or results from the acts or omissions of you and/or your Dependents, plan beneficiaries and/or their Dependents, beneficiaries, estate, heirs, guardian, personal representative, or assigns (collectively referred to hereinafter in this section as “Covered Person”) or a third party, where any party besides the Plan may be responsible for expenses arising from an incident, and/or other insurance or other funds are available, including but not limited to no-fault, uninsured motorist, underinsured motorist, medical payment provisions, third party assets, third party insurance, and/or guarantor(s) of a third party (collectively “Coverage”).

(2) The Covered Person, his or her attorney, and/or legal guardian of a minor or incapacitated individual agrees that acceptance of the Plan’s conditional payment of medical benefits is constructive notice of these provisions in their entirety and agrees to maintain 100% of the Plan’s conditional payment of benefits or the full extent of payment from any one or combination of first and third party sources in trust, without disruption except for reimbursement to the Plan or the Plan’s assignee. By accepting benefits the Covered Person agrees the Plan shall have an equitable lien on any funds received by the Covered Person and/or their attorney from any source and said funds shall be held in trust until such time as the obligations under this provision are fully satisfied. The Covered Person agrees to include the Plan’s name as a co-payee on any and all settlement drafts. Further, by accepting benefits the Covered Person understands that any recovery obtained pursuant to this section is an asset of the Plan to the extent of the amount of benefits paid by the Plan and that the Covered Person shall be a trustee over those Plan assets.

(3) In the event a Covered Person settles, recovers or is reimbursed by any Coverage, the Covered Person agrees to reimburse the Plan for all benefits paid or that will be paid by the Plan on behalf of the Covered Person. If the Covered Person fails to reimburse the Plan out of any judgment or settlement received, the Covered Person will be responsible for any and all expenses (fees and costs) associated with the Plan’s attempt to recover such money.

(4) If there is more than one party responsible for charges paid by the Plan, or may be responsible for charges paid by the Plan, the Plan will not be required to select a particular party from whom reimbursement is due. Furthermore, unallocated settlement funds meant to compensate multiple injured parties of which the Covered Person is/are only one or a few, that unallocated settlement fund is considered designated as an “identifiable” fund from which the Plan may seek reimbursement.

Subrogation
(1) As a condition to participating in and receiving benefits under this Plan, the Covered Person agrees to assign to the Plan the right to subrogate and pursue any and all claims, causes of action or rights that may arise against any person, corporation or entity and to any Coverage to which the Covered Person is entitled, regardless of how classified or characterized, at the Plan’s discretion, if the Covered Person fails to so pursue such rights or action.

(2) If a Covered Person receives or becomes entitled to receive benefits, an automatic equitable lien attaches in favor of the Plan to any claim, which any Covered Person may have against any Coverage and/or party causing the Illness or Injury to the extent of such conditional payment by the Plan plus reasonable costs of collection. The Covered Person is obligated to notify the Plan or its authorized representative of any settlement prior to finalization of the settlement, execution of a release, or receipt of applicable funds. The Covered Person is also obligated to hold any and all funds so received in trust on the Plan’s behalf and function as a trustee as it applies to those funds until the Plan’s rights described herein are honored and the Plan is reimbursed.
(3) The Plan may, at its discretion, in its own name or in the name of the Covered Person, commence a proceeding or pursue a claim against any party or Coverage for the recovery of all damages to the full extent of the value of any such benefits or conditional payments advanced by the Plan.

(4) The Covered Person authorizes the Plan to pursue, sue, compromise and/or settle any such claims in the Covered Persons and/or the Plan's name and agrees to fully cooperate with the Plan in the prosecution of any such claims if the Covered Person fails to file a claim or pursue damages against:

(a) The responsible party, its insurer or any other source on behalf of that party;

(b) Any first party insurance through medical payment coverage, personal injury protection, no-fault coverage, uninsured or underinsured motorist coverage;

(c) Any policy of insurance from any insurance company or guarantor of a third party;

(d) Workers' Compensation or other liability insurance company; or

(e) Any other source, including but not limited to crime victim restitution funds, any medical, disability or other benefit payments and school insurance coverage.

The Covered Person assigns all rights to the Plan or its assignee to pursue a claim and the recovery of all expenses from any and all sources listed above.

**Right of Reimbursement**

(1) The Plan shall be entitled to recover 100% of the benefits paid, without deduction for attorneys’ fees and costs or application of the common fund doctrine, make whole doctrine, or any other similar legal theory, without regard to whether the Covered Person is fully compensated by his or her recovery from all sources. The Plan shall have an equitable lien which supersedes all common law or statutory rules, doctrines, and laws of any State prohibiting assignment of rights which interferes with or compromises in any way the Plan’s equitable lien and right to reimbursement. The obligation to reimburse the Plan in full exists regardless of how the judgment or settlement is classified and whether or not the judgment or settlement specifically designates the recovery or a portion of it as including medical, disability, or other expenses. If the Covered Persons' recovery is less than the benefits paid, then the Plan is entitled to be paid all of the recovery achieved. Any funds received by the Covered Person are deemed held in constructive trust and should not be dissipated or disbursed until such time as the Covered Person’s obligation to reimburse the Plan has been satisfied in accordance with these provisions. The Covered Person is also obligated to hold any and all funds so received in trust on the Plan’s behalf and function as a trustee as it applies to those funds until the Plan’s rights described herein are honored and the Plan is reimbursed.

(2) No court costs, experts’ fees, attorneys’ fees, filing fees, or other costs or expenses of litigation may be deducted from the Plan’s recovery without the prior, express written consent of the Plan.

(3) The Plan’s right of subrogation and reimbursement will not be reduced or affected as a result of any fault or claim on the part of the Covered Person, whether under the doctrines of causation, comparative fault or contributory negligence, or other similar doctrine in law. Accordingly, any lien reduction statutes, which attempt to apply such laws and reduce a subrogating Plan’s recovery will not be applicable to the Plan and will not reduce the Plan’s reimbursement rights.

(4) These rights of subrogation and reimbursement shall apply without regard to whether any separate written acknowledgment of these rights is required by the Plan and signed by the Covered Person.

(5) This provision shall not limit any other remedies of the Plan provided by law. These rights of subrogation and reimbursement shall apply without regard to the location of the event that led to or caused the applicable Illness, Injury, Disease or disability.
Covered Person is a Trustee Over Plan Assets

(1) Any Covered Person who receives benefits and is therefore subject to the terms of this section is hereby deemed a recipient and holder of Plan assets and is therefore deemed a trustee of the Plan solely as it relates to possession of any funds which may be owed to the Plan as a result of any settlement, judgment or recovery through any other means arising from any Injury or Accident. By virtue of this status, the Covered Person understands that he/she is required to:

(a) Notify the Plan or its authorized representative of any settlement prior to finalization of the settlement, execution of a release, or receipt of applicable funds;

(b) Instruct his/her attorney to ensure that the Plan and/or its authorized representative is included as a payee on all settlement drafts;

(c) In circumstances where the Covered Person is not represented by an attorney, instruct the insurance company or any third party from whom the Covered Person obtains a settlement, judgment or other source of Coverage to include the Plan or its authorized representative as a payee on the settlement draft; and,

(d) Hold any and all funds so received in trust, on the Plan’s behalf, and function as a trustee as it applies to those funds, until the Plan’s rights described herein are honored and the Plan is reimbursed.

(2) To the extent the Covered Person disputes this obligation to the Plan under this section, the Covered Person or any of its agents or representatives is also required to hold any/all settlement funds, including the entire settlement if the settlement is less than the Plan’s interests, and without reduction in consideration of attorneys' fees, for which he/she exercises control, in an account segregated from their general accounts or general assets until such time as the dispute is resolved.

(3) No Covered Person, beneficiary, or the agents or representatives thereof, exercising control over plan assets and incurring trustee responsibility in accordance with this section will have any authority to accept any reduction of the Plan’s interest on the Plan’s behalf.

Excess Insurance

If at the time of Injury, Illness, disease or disability, there is available or potentially available any coverage (including but not limited to coverage resulting from a judgment at law or settlements), the benefits under this Plan shall apply only as an excess over such other sources of coverage, except as otherwise provided for under the Plan’s “Coordination of Benefits” section.

The Plan’s benefits shall be excess to any of the following:

(1) The responsible party, its insurer or any other source on behalf of that party;

(2) Any first party insurance through medical payment coverage, personal injury protection, no-fault coverage, uninsured or underinsured motorist coverage;

(3) Any policy of insurance from any insurance company or guarantor of a third party;

(4) Workers’ Compensation or other liability insurance company; or

(5) Any other source, including but not limited to crime victim restitution funds, any medical, disability or other benefit payments and school insurance coverage.

Separation of Funds

Benefits paid by the Plan, funds recovered by the Covered Person and funds held in trust over which the Plan has an equitable lien exist separately from the property and estate of the Covered Person, such that the death of the Covered Person or filing of bankruptcy by the Covered Person, will not affect the Plan’s equitable lien, the funds over which the Plan has a lien or the Plan’s right to subrogation and reimbursement.
Wrongful Death
In the event that the Covered Person dies as a result of his or her Injuries and a wrongful death or survivor claim is asserted against a third party or any Coverage, the Plan’s subrogation and reimbursement rights shall still apply, and the entity pursuing said claim shall honor and enforce these Plan rights and terms by which benefits are paid on behalf of the Covered Person(s) and all others that benefit from such payment.

Obligations
(1) It is the Covered Person’s obligation at all times, both prior to and after payment of medical benefits by the Plan:

(a) To cooperate with the Plan or any representatives of the Plan, in protecting its rights, including discovery, attending depositions and cooperating in trial to preserve the Plan’s rights;

(b) To provide the Plan with pertinent information regarding the Illness, disease, disability or Injury, including Accident reports, settlement information and any other requested additional information;

(c) To take such action and execute such documents as the Plan may require to facilitate enforcement of its subrogation and reimbursement rights;

(d) To do nothing to prejudice the Plan’s rights of subrogation and reimbursement;

(e) To promptly reimburse the Plan when a recovery through settlement, judgment, award or other payment is received;

(f) To notify the Plan or its authorized representative of any settlement prior to finalization of the settlement;

(g) To not settle or release, without the prior consent of the Plan, any claim to the extent that the Covered Person may have against any responsible party or coverage;

(h) To instruct his/her attorney to ensure that the Plan or its authorized representative is included as a payee on any settlement draft;

(i) In circumstances where the Covered Person is not represented by an attorney, instruct the insurance company or any third party from whom the Covered Person obtains a settlement to include the Plan or its authorized representative as a payee on the settlement draft; and

(j) To make good faith efforts to prevent disbursement of settlement funds until such time as any dispute between the Plan and Covered Person over settlement funds is resolved.

(2) If the Covered Person and/or his or her attorney fails to reimburse the Plan for all benefits paid or to be paid, as a result of said Injury or condition, out of any proceeds, judgment or settlement received, the Covered Person will be responsible for any and all expenses (whether fees or costs) associated with the Plan’s attempt to recover such money from the Covered Person.

(3) The Plan’s rights to reimbursement and/or subrogation are in no way dependent upon the Covered Persons’ cooperation or adherence to these terms.

Offset
If timely repayment is not made, or the Covered Person and/or his or her attorney fails to comply with any of the requirements of the Plan, the Plan has the right, in addition to any other lawful means of recovery, to deduct the value of the Covered Person’s amount owed to the Plan. To do this, the Plan may refuse payment of any future medical benefits and any funds or payments due under this Plan on behalf of the Covered Person in an amount equivalent to any outstanding amounts owed by the Covered Person to the Plan. This provision applies even if the Covered Person has disbursed settlement funds.
**Minor Status**

(1) In the event the Covered Person is a minor as that term is defined by applicable law, the minor’s parents or court-appointed guardian shall cooperate in any and all actions by the Plan to seek and obtain requisite court approval to bind the minor and his or her estate insofar as these subrogation and reimbursement provisions are concerned.

(2) If the minor’s parents or court-appointed guardian fail to take such action, the Plan shall have no obligation to advance payment of medical benefits on behalf of the minor. Any court costs or legal fees associated with obtaining such approval shall be paid by the minor’s parents or court-appointed guardian.

**Language Interpretation**

The Plan Sponsor retains sole, full and final discretionary authority to construe and interpret the language of this provision, to determine all questions of fact and law arising under this provision and to administer the Plan’s subrogation and reimbursement rights.

**Severability**

In the event that any section of this provision is considered invalid or illegal for any reason, said invalidity or illegality shall not affect the remaining sections of this provision and Plan. The section shall be fully severable. The Plan shall be construed and enforced as if such invalid or illegal sections had never been inserted in the Plan.

Notwithstanding anything contained herein to the contrary, to the extent this Plan is not governed by ERISA, the Plan’s right to subrogation and reimbursement may be subject to applicable State subrogation laws.
DISCRIMINATION IS AGAINST THE LAW

IASIS Healthcare, LLC (“IASIS”) complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. IASIS does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

IASIS:

(1) Provides free aids and services to people with disabilities to communicate effectively with us, such as:
   
   (a) Qualified sign language interpreters  
   (b) Written information in other formats (large print, audio, accessible electronic formats, other formats)

(2) Provides free language services to people whose primary language is not English, such as:
   
   (a) Qualified interpreters  
   (b) Information written in other languages

If you need these services, contact IASIS’ Civil Rights Coordinator, Ginger Walker, AVP of Benefits, whose contact information appears below.

If you believe that IASIS has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:

Ginger Walker, AVP of Benefits  
IASIS Healthcare LLC  
117 Seaboard Lane, Bldg E  
Franklin, TN 37067  
Telephone: (615) 844-2747  
Fax: (615) 467-1285  
Email: GWalker@iasishealthcare.com.

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, Ginger Walker, AVP of Benefits, is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services  
200 Independence Avenue, SW  
Room 509F, HHH Building  
Washington, D.C. 20201  
1-800-368-1019, 800-537-7697 (TDD)

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-866-209-2929.


注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-866-209-2929。

ATTENTION : Si vous parlez français, des services d'aide linguistique-vous sont proposés gratuitement. Appelez le 1-866-209-2929


注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-866-209-2929。

14092-01-Tiered 13
ATTACHMENT B: PRESCRIPTION DRUG SCHEDULE OF BENEFITS  
Effective Date: January 1, 2017

<table>
<thead>
<tr>
<th>Plan Level</th>
<th>Pharmacy Type</th>
<th>Preventive Drugs</th>
<th>Generic Drugs</th>
<th>Brand Drugs</th>
<th>Specialty Drugs</th>
<th>Out-of-pocket Maximum</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>$500 PPO and Preferred</strong></td>
<td>Any Network Pharmacy – Up to 30 Day Supply</td>
<td>100% ($0 copay)</td>
<td>$15.00, then 100%</td>
<td>30% up to $100 maximum</td>
<td>30% up to $200 maximum</td>
<td>Single: $5,750/ Family: $11,500</td>
</tr>
<tr>
<td>Mail Service or Network Pharmacy – Up to 90 Day Supply</td>
<td>100% ($0 copay)</td>
<td>$37.50, then 100%</td>
<td>30% up to $250 maximum</td>
<td>N/A</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>$750 PPO and Preferred</strong></td>
<td>Any Network Pharmacy – Up to 30 Day Supply</td>
<td>100% ($0 copay)</td>
<td>$15.00, then 100%</td>
<td>30% up to $100 maximum</td>
<td>30% up to $200 maximum</td>
<td>Single: $6,250/ Family: $12,500</td>
</tr>
<tr>
<td>Mail Service or Network Pharmacy – Up to 90 Day Supply</td>
<td>100% ($0 copay)</td>
<td>$37.50, then 100%</td>
<td>30% up to $250 maximum</td>
<td>N/A</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>$1000 PPO and Preferred</strong></td>
<td>Any Network Pharmacy – Up to 30 Day Supply</td>
<td>100% ($0 copay)</td>
<td>$15.00, then 100%</td>
<td>30% up to $100 maximum</td>
<td>30% up to $200 maximum</td>
<td>Single: $6,850/ Family: $13,700</td>
</tr>
<tr>
<td>Mail Service or Network Pharmacy – Up to 90 Day Supply</td>
<td>100% ($0 copay)</td>
<td>$37.50, then 100%</td>
<td>30% up to $250 maximum</td>
<td>N/A</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>$2000 PPO and Preferred</strong></td>
<td>Any Network Pharmacy – Up to 30 Day Supply</td>
<td>100% ($0 copay)</td>
<td>You pay 15% after deductible</td>
<td>You pay 15% after deductible</td>
<td>You pay 15% after deductible</td>
<td>Single: $6,850/ Family: $13,700</td>
</tr>
<tr>
<td>Mail Service or Network Pharmacy – Up to 90 Day Supply</td>
<td>100% ($0 copay)</td>
<td>You pay 15% after deductible</td>
<td>You pay 15% after deductible</td>
<td>N/A</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
GUARDIAN

YOUR GROUP INSURANCE
PLAN BENEFITS

IASIS HEALTHCARE, LLC
CLASS 0002
DENTAL, VISION
The enclosed certificate is intended to explain the benefits provided by the Plan. It does not constitute the Policy Contract. Your rights and benefits are determined in accordance with the provisions of the Policy, and your insurance is effective only if you are eligible for insurance and remain insured in accordance with its terms.
This Booklet Includes All Benefits For Which You Are Eligible.

You are covered for any benefits provided to you by the policyholder at no cost. But if you are required to pay all or part of the cost of insurance you will only be covered for those benefits you elected in a manner and mode acceptable to Guardian such as an enrollment form and for which premium has been received by Guardian.

"Please Read This Document Carefully".
CERTIFICATE OF COVERAGE

The Guardian
7 Hanover Square
New York, New York 10004

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

<table>
<thead>
<tr>
<th>Group Policy No.</th>
<th>Certificate No.</th>
<th>Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Issued To

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

The Guardian Life Insurance Company of America

Stuart Shaw
Vice President, Risk Mgt. & Chief Actuary
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IMPORTANT NOTICE FOR EMPLOYEES OF AN ARIZONA WORK LOCATION

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

B120.0082
GENERAL PROVISIONS

As used in this booklet:

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

“Covered person” means an employee or a dependent insured by this plan.

“Employer” means the employer who purchased this plan.

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

“Plan” means the Guardian plan of group insurance purchased by your employer.

“You” and “your” mean an employee insured by this plan.

Limitation of Authority

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

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

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

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

Accident and Health Claims Provisions

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

Notice

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

Proof of Loss

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

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

Late Notice of Proof

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

Payment of Benefits

We’ll pay benefits for loss of income once every 30 days for as long as we’re liable, provided you submit periodic written proof of loss as stated above. We’ll pay all other accident and health benefits to which you’re entitled as soon as we receive written proof of loss.
We pay all accident and health benefits to you, if you’re living. If you’re not living, we have the right to pay all accident and health benefits, except dismemberment benefits, to one of the following: (a) your estate; (b) your spouse; (c) your parents; (d) your children; (e) your brothers and sisters; and (f) any unpaid provider of health care services. See “Your Accidental Death and Dismemberment Benefits” for how dismemberment benefits are paid.

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

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

Workers’ Compensation
The accident and health benefits provided by this plan are not in place of, and do not affect requirements for coverage by Workers’ Compensation.
An Important Notice About Continuation Rights

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

CGP-3-R-NCC-87

B240.0064
All Options

YOUR CONTINUATION RIGHTS

Federal Continuation Rights

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

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

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

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

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

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

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

Extra Continuation for Disabled Qualified Continuees
If a qualified continuee is determined to be disabled under Title II or Title XVI of the Social Security Act on or during the first 60 days after the date his or her group health benefits would otherwise end due to your termination of employment or reduction of work hours, and such disability lasts at least until the end of the 18 month period of continuation coverage, he or she or any member of that person’s family who is a qualified continuee may elect to extend his or her 18 month continuation period explained above for up to an extra 11 months.
To elect the extra 11 months of continuation, a qualified continuee must give your employer written proof of Social Security’s determination of the disabled qualified continuee’s disability as described in "The Qualified Continuee’s Responsibilities". If, during this extra 11 month continuation period, the qualified continuee is determined to be no longer disabled under the Social Security Act, he or she must notify your employer within 30 days of such determination, and continuation will end, as explained in "When Continuation Ends."

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

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

### All Options

**If You Die While Insured**

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

CGP-3-R-COBRA-96-2

### All Options

**If Your Marriage Ends**

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

**If a Dependent Child Loses Eligibility**

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

**Concurrent Continuations**

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

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

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

The Qualified Continuee's Responsibilities

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

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

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

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

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

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

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

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

Your Employer’s Liability

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

Election of Continuation

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

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

The premium will be the total rate which would have been charged for the group health benefits had the qualified continuee stayed insured under the group plan on a regular basis. It includes any amount that would have been paid by your employer. Except as explained in "Extra Continuation for Disabled Qualified Continuees", an additional charge of two percent of the total premium charge may also be required by your employer.
If the qualified continuee fails to give your employer notice of his or her intent to continue, or fails to pay any required premiums in a timely manner, he or she waives his or her continuation rights.

**Grace in Payment of Premiums**

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

**When Continuation Ends**

A qualified continuee’s continued group health benefits end on the first of the following:

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

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

3. with respect to continuation upon your death, your legal divorce, or legal separation, or the end of an insured dependent’s eligibility, the end of the 36 month period which starts on the date the group health benefits would otherwise end;

4. the date the employer ceases to provide any group health plan to any employee;

5. the end of the period for which the last premium payment is made;

6. the date, after the date of election, he or she becomes covered under any other group health plan which does not contain any pre-existing condition exclusion or limitation affecting him or her; or

7. the date, after the date of election, he or she becomes entitled to Medicare.
Uniformed Services Continuation Rights

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

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

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

Employee Coverage

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

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

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

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

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

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

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

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

Your coverage ends on the date you die.
Employee Coverage (Cont.)

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

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

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

CGP-3-EC-90-3.0 B489.0090-R

All Options

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

Important Notice

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

If Your Group Coverage Would End

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

When Continuation Ends

Coverage may continue until the earliest of the following:

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

**Definitions**

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

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

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

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

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

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

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

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**Dependent Coverage**

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

**Adopted Children And Step-Children**

Your "dependent children" include your legally adopted children and, your step-children. We treat a child as legally adopted from the time the child is placed in your home for the purpose of adoption. We treat such a child this way whether or not a final adoption order is ever issued.

**Dependents Not Eligible**

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

CGP-3-DEP-90-3.0

B489.0463

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**Handicapped Children**

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

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

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

The child’s coverage ends when yours does.

CGP-3-DEP-90-4.0

B449.0042
All Options

Waiver Of Dental Late Entrants Penalty

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

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

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

CGP-3-DEP-90-5.0

All Options

When Dependent Coverage Starts

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

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

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

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

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

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

CGP-3-DEP-90-6.0
Dependent Coverage (Cont.)

All Options

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

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All Options

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

CGP-3-DEP-90-8.0 B489.0022

All Options

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

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

Dependent coverage also ends for all of your dependents when you stop being a member of a class of employees eligible for such coverage. And it ends when this plan ends, or when dependent coverage is dropped from this plan for all employees or for an employee’s class.
If you are required to pay all or part of the cost of dependent coverage, and you fail to do so, your dependent coverage ends. It ends on the last day of the period for which you made the required payments, unless coverage ends earlier for other reasons.

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

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

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

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

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

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

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

The domestic partner's dependent children will be eligible for coverage under this plan on the same basis as if the children were the employee's dependent children.
Coverage for the domestic partner and his or her dependent children ends when the domestic partner no longer meets the qualifications of a domestic partner as indicated above. Upon termination of a domestic partnership, a “Statement of Termination” must be completed and filed with the employer. Once the employee submits a "Statement of Termination," he or she may not enroll another domestic partner for a period of 12 months from the date of the previous termination.

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

a. survivor benefits upon the employee’s death as explained under the “When Dependent Coverage Ends” section; or

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

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

The Guardian Life Insurance Company of America

Vice President, Risk Mgt. & Chief Actuary

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

- **Benefit Year Cash Deductible for Non-Orthodontic Services**
  
  For Group I Services .......................... None 
  For Group II and III Services .......................... $50.00 

  for each covered person

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Dental Highlights (Cont.)

Options E, F

DENTAL HIGHLIGHTS

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

- **Benefit Year Cash Deductible for Preventive Services** ........ None

Options G, H

- **Payment Rates:**
  - For Group I Services .................................................. 100%
  - For Group II Services .................................................. 80%
  - For Group III Services .................................................. 50%
  - For Group IV Services .................................................. 50%

Options E, F

- **Payment Rates:**
  - For Group I Services .................................................. 100%

Options E, F

- **Benefit Year Payment Limit for Preventive Services** ........ Unlimited

Options G, H

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

- **Lifetime Payment Limit for Orthodontic Treatment**
  - For Group IV Services .................................................. Up to $1,500.00

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

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All Options

Once each year, during the group enrollment period, you may elect to enroll in one of the dental expense plan options offered by your employer. The group enrollment period is a time period agreed to by your employer and us. Coverage starts on the first day of the month that next follows the date of enrollment. You and your eligible dependents are not subject to late entrant penalties if they enroll during the group enrollment period.

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

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

DENTAL EXPENSE INSURANCE

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

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B498.0006
DENTAL EXPENSE INSURANCE

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

Covered Charges

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

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

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

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

We only pay benefits for covered charges incurred by a covered person while he or she is insured by this plan. All covered charges are incurred on the date the services are furnished. If a service is started while a covered person is insured, we’ll only pay benefits for services which are completed within 31 days of the date his or her coverage under this plan ends.
Covered Charges

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

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

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

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

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

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

Proof Of Claim

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

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

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

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

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

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

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

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Pre-Treatment Review (Cont.)

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

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

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

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

Benefits From Other Sources

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

The Benefit Provision - Qualifying For Benefits

During the first 6 months that a late entrant is covered by this plan, we won’t pay for the following services:

- All Group II Services.
The Benefit Provision - Qualifying For Benefits (Cont.)

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

- All Group III Services.

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

- All Group IV Services.

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

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

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

Options E, F

How We Pay Benefits For Group I Services

We pay for Group I covered charges at the applicable payment rate. These charges must be incurred while the covered person is insured.

CGP-3-DGY2K-BP B498.0183

Options G, H

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

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

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

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

CGP-3-DGY2K-BP B498.0187

Options E, F

All covered charges must be incurred while insured.

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All covered charges must be incurred while insured. And we limit what we pay each benefit year to $1,500.00.

The Benefit Provision - Qualifying For Benefits

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

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

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

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

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

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

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

The amounts of this plan’s Rollover Threshold, Reward, and Bank Maximum are:
- Rollover Threshold ........................................ $700.00
- Reward (if all benefits are for services provided by a preferred provider) ........................................ $500.00
- Reward (if any benefits are for services provided by a non-preferred provider) ............................... $350.00
- Bank Maximum .............................................. $1,250.00
If this plan’s dental coverage first becomes effective in October, November or December, this rollover provision will not apply until January 1 of the first full benefit year. And, if the effective date of a covered person’s dental coverage is in October, November or December, this rollover provision will not apply to the covered person until January 1 of the next full benefit year. In either case:

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

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

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

Definitions of terms used in this provision:

“Bank” means the amount of a covered person’s accrued Reward.

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

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

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

Options G, H

How We Pay Benefits For Group IV Orthodontic Services

This plan provides benefits for Group IV orthodontic services only for covered dependent children who are less than 26 years old when the active orthodontic appliance is first placed.

We pay for Group IV covered charges at the applicable payment rate.

Using the covered person’s original treatment plan, we calculate the total benefit we will pay. We divide the benefit into equal payments, which we will spread out over the shorter of: (a) the proposed length of treatment; or (b) two years.
We make the initial payment when the *active orthodontic* appliance is first placed. We make further payments at the end of each subsequent three month period, upon receipt of verification of ongoing treatment. But, treatment must continue and the *covered person* must remain covered by this *plan*. We limit what we pay for orthodontic services to the lifetime payment of $1,500.00. What we pay is based on all of the terms of this *plan*.

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

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

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**Options G, H**

**Non-Orthodontic Family Deductible Limit**

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

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**Options E, F**

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

- Benefits for Group I Services ........................................ 100%

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**Options G, H**

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

- Benefits for Group I Services ........................................ 100%
- Benefits for Group II Services ....................................... 80%
- Benefits for Group III Services ..................................... 50%
- Benefits for Group IV Services ..................................... 50%
Options G, H

After This Insurance Ends

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

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

CGP-3-DGY2K-END

Options E, F

After This Insurance Ends

We don’t pay for charges incurred after a covered person’s insurance ends.

CGP-3-DGY2K-END

All Options

Special Limitations

CGP-3-DGY2K-LMT

Options G, H

Teeth Lost, Extracted Or Missing Before A Covered Person Becomes Covered By This Plan

A covered person may have had one or more teeth lost or extracted before he or she became covered by this plan. We won’t pay for a dental prosthesis which replaces such teeth unless the dental prosthesis also replaces one or more eligible natural teeth lost or extracted after the covered person became covered by this plan.

CGP-3-DGY2K-TL
Options E, F

If This Plan Replaces The Prior Plan

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

- **Deductible Credit** - In the first benefit year of this plan, we reduce a covered person’s deductibles required under this plan, by the amount of covered charges applied against the prior plan’s deductible. The covered person must give us proof of the amount of the prior plan’s deductible which he or she has satisfied.

- **Benefit Year Non-Orthodontic Payment Limit Credit** - In the first benefit year of this plan, we reduce a covered person’s benefit year payment limits by the amounts paid or payable under the prior plan. The covered person must give us proof of the amounts applied toward the prior plan’s payment limits.

Options G, H

If This Plan Replaces The Prior Plan

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

- **Teeth Extracted While Insured By The Prior Plan** - The "Teeth Lost, Extracted or Missing Before A Covered Person Becomes Covered By This Plan" provision above, does not apply to a covered person’s dental prosthesis which replaces teeth: (a) that were extracted while the covered person was insured by the prior plan; and (b) for which extraction benefits were paid by the prior plan.

- **Deductible Credit** - In the first benefit year of this plan, we reduce a covered person’s deductibles required under this plan, by the amount of covered charges applied against the prior plan’s deductible. The covered person must give us proof of the amount of the prior plan’s deductible which he or she has satisfied.

- **Benefit Year Non-Orthodontic Payment Limit Credit** - In the first benefit year of this plan, we reduce a covered person’s benefit year payment limits by the amounts paid or payable under the prior plan. The covered person must give us proof of the amounts applied toward the prior plan’s payment limits.

- **Orthodontic Payment Limit Credit** - We reduce a covered person’s orthodontic payment limits by the amounts paid or payable under the prior plan. The covered person must give us proof of the amounts applied toward the prior plan’s payment limits.

CGP-3-DGY2K-PP B498.0129

Options E, F

**Exclusions**

We will not pay for:

- Any service or supply which is not specifically listed in this plan’s List of Covered Dental Services.
Exclusions (Cont.)

- Any procedure performed in conjunction with, as part of, or related to a procedure which is not covered by this plan.

- Educational services, including, but not limited to, oral hygiene instruction, plaque control, tobacco counseling or diet instruction.

- Precision attachments and the replacement of part of a precision attachment, magnetic retention or overdenture attachments.

- Overdentures and related services, including root canal therapy on teeth supporting an overdenture.

- Any restoration, procedure, appliance or prosthetic device used solely to: (1) alter vertical dimension; (2) restore or maintain occlusion, except to the extent that this plan covers orthodontic treatment; (3) treat a condition necessitated by attrition or abrasion; or (4) splint or stabilize teeth for periodontal reasons.

- The use of general anesthesia, intramuscular sedation, intravenous sedation, non-intravenous sedation or inhalation sedation, including but not limited to nitrous oxide, except when administered in conjunction with covered periodontal surgery, surgical extractions, the surgical removal of impacted teeth, apicoectomies, root amputations and services listed under the "Other Oral Surgical Procedures" section of this plan.

- The use of local anesthetic.

- Cephalometric radiographs, oral/facial images, including traditional photographs and images obtained by intraoral camera, except when performed as part of the orthodontic treatment plan and records for a covered course of orthodontic treatment.

- Replacement of a lost, missing or stolen appliance or dental prosthesis or the fabrication of a spare appliance or dental prosthesis.

- Prescription medication.

- Desensitizing medicaments and desensitizing resins for cervical and/or root surface.

- Duplication of radiographs, the completion of claim forms, OSHA or other infection control charges.

- Caries susceptibility tests.

- Bite registration or bite analysis.

- Gingival curettage.

- The localized delivery of chemotherapeutic agents.

- Tooth transplants.

- Maxillofacial prosthetics that repair or replace facial and skeletal anomalies, maxillofacial surgery, orthognathic surgery or any oral surgery requiring the setting of a fracture or dislocation.
Temporary or provisional *dental prosthesis* or *appliances* except interim partial dentures/stayplates to replace *anterior teeth* extracted while insured under this *plan*.

Any service or procedure associated with the placement, prosthodontic restoration or maintenance of a dental implant and any incremental charges to other covered services as a result of the presence of a dental implant.

Any service furnished solely for cosmetic reasons. This includes, but is not limited to: (1) characterization and personalization of a *dental prosthesis*; (2) facings on a *dental prosthesis* for any teeth posterior to the second bicuspid; (3) bleaching of discolored teeth; and (4) odontoplasty.

Replacing an existing *appliance* or *dental prosthesis* with a like or un-like *appliance* or *dental prosthesis*; unless (1) it is at least 10 years old and is no longer usable; or (2) it is damaged while in the *covered person’s* mouth in an *injury* suffered while insured, and can’t be made serviceable.

A fixed bridge replacing the extracted portion of a hemisected tooth or the placement of more than one unit of crown and/or bridge per tooth.

The replacement of extracted or missing third molars/wisdom teeth.

Treatment of congenital or developmental malformations, or the replacement of congenitally missing teeth.

Any endodontic, periodontal, crown or bridge abutment procedure or *appliance* performed for a tooth or teeth with a guarded, questionable or poor prognosis.

Any procedure or treatment method which does not meet professionally recognized standards of dental practice or which is considered to be experimental in nature.

Any procedure, *appliance*, *dental prosthesis*, modality or surgical procedure intended to treat or diagnose disturbances of the temporomandibular joint (TMJ).

Treatment needed due to: (1) an on-the-job or job-related *injury*; or (2) a condition for which benefits are payable by Worker’s Compensation or similar laws.

Treatment for which no charge is made. This usually means treatment furnished by: (1) the *covered person’s* employer, labor union or similar group, in its dental or medical department or clinic; (2) a facility owned or run by any governmental body; and (3) any public program, except Medicaid, paid for or sponsored by any governmental body.

Evaluations and consultations for non-covered services; detailed and extensive oral evaluations.

*Orthodontic treatment*, unless the benefit provision provides specific benefits for *orthodontic treatment*. 
Exclusions

We will not pay for:

- Any service or supply which is not specifically listed in this plan’s List of Covered Dental Services.
- Any procedure performed in conjunction with, as part of, or related to a procedure which is not covered by this plan.
- Educational services. This includes, but is not limited to: oral hygiene instruction; plaque control; tobacco counseling; or diet instruction.
- Precision attachments and the replacement of part of a precision attachment; magnetic retention; or overdenture attachments.
- Overdentures and related services. This includes root canal therapy on teeth that support an overdenture.
- Any restoration, procedure, or appliance or prosthetic device used solely to: (1) alter vertical dimension; (2) restore or maintain occlusion, except to the extent that this plan covers orthodontic treatment; (3) treat a condition necessitated by attrition or abrasion; or (4) splint or stabilize teeth for periodontal reasons.
- The use of: general anesthesia; intramuscular sedation; intravenous sedation; non-intravenous sedation; or inhalation sedation, which includes but is not limited to nitrous oxide. But, this does not apply when administered in conjunction with: covered periodontal surgery; surgical extractions; the surgical removal of impacted teeth; apicoectomies; root amputations; and services listed under the "Other Oral Surgical Procedures" section of this plan.
- The use of local anesthetic.
- Cephalometric radiographs; oral/facial images. This includes traditional photographs and images obtained by intraoral camera. But, these services are covered when performed as part of the orthodontic treatment plan and records for a covered course of orthodontic treatment.
- Replacement of a lost, missing or stolen appliance or dental prosthesis; or the fabrication of a spare appliance or dental prosthesis.
- Prescription medication.
- Duplication of radiographs; the completion of claim forms; OSHA or other infection control charges.
- Caries susceptibility tests.
- Bite registration; or bite analysis.
- Gingival curettage.
- Tooth transplants.
Maxillofacial prosthetics that repair or replace facial and skeletal anomalies; maxillofacial surgery; orthognathic surgery; or any oral surgery requiring the setting of a fracture or dislocation.

Temporary or provisional dental prosthesis or appliances. But, this does not include interim partial dentures/stayplates to replace anterior teeth extracted while insured under this plan.

Any service furnished solely for cosmetic reasons, unless the "List of Covered Dental Services" provides benefits for specific cosmetic services. Excluded cosmetic services include, but are not limited to: (1) characterization and personalization of a dental prosthesis; and (2) odontoplasty.

Replacing an existing appliance or dental prosthesis, denture, bridge and implants denture with any appliance or prosthesis, unless it is: (1) at least 10 years old and is no longer usable; or (2) damaged while in the covered person’s mouth in an injury suffered while insured, and can not be made serviceable.

Replacing an existing crown, inlay, onlay, labial veneer, post & core, implant crown with a like or un-like appliance or dental prosthesis; unless (1) it is at least 5 years old and is no longer usable; or (2) it is damaged while in the covered person’s mouth in an injury suffered while insured, and can’t be made serviceable.

A fixed bridge replacing the extracted portion of a hemisected tooth; or the placement of more than one unit of crown and/or bridge per tooth.

The replacement of extracted or missing third molars/wisdom teeth.

Treatment of congenital or developmental malformations.

Any endodontic, periodontal, crown or bridge abutment procedure or appliance performed for a tooth or teeth with a guarded, questionable or poor prognosis.

Any procedure or treatment method which does not meet professionally recognized standards of dental practice or which is considered to be experimental in nature.

Any procedure, appliance, dental prosthesis, modality or surgical procedure intended to treat or diagnose disturbances of the temporomandibular joint (TMJ).

Treatment needed due to: (1) an on-the-job or job-related injury; or (2) a condition for which benefits are payable by Workers’ Compensation or similar laws.

Treatment for which no charge is made. This usually means treatment furnished by: (1) the covered person’s employer, labor union or similar group, in its dental or medical department or clinic; (2) a facility owned or run by any governmental body; and (3) any public program, except Medicaid, paid for or sponsored by any governmental body.

Evaluations and consultations for non-covered services; detailed and extensive oral evaluations.
Exclusions (Cont.)

- The repair of an orthodontic appliance.
- The replacement of a lost or broken orthodontic retainer.

Options G, H

List of Covered Dental Services

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

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

Options E, F

List of Covered Dental Services

The services covered by this plan are named in this list. Group I is made up of preventive services.

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

All Options

Group I - Preventive Dental Services
(Non-Orthodontic)

Prophylaxis And Fluorides

Prophylaxis - limited to two prophylaxis procedures in a calendar year. Allowance includes scaling and polishing procedures to remove coronal plaque, calculus, and stains.

Periodontal maintenance procedure - limited to a total of 4 prophylaxis or periodontal maintenance procedures in a calendar year. Allowance includes periodontal pocket charting, scaling and polishing. Coverage for periodontal maintenance is considered upon evidence of completed active periodontal therapy (periodontal scaling and root planing or periodontal surgery).

- Adult prophylaxis covered age 12 and older.
Group I Preventive Dental Services (Cont.)
(Non-Orthodontic)

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

Fluoride treatment, topical application - limited to covered persons under age 19 and limited to one treatment in any calendar year.

Office Visits, Evaluations And Examination

Office visits, examinations or limited problem focused re-evaluations - limited to a total of 2 in any calendar year.

Emergency palliative treatment and other non-routine, unscheduled visits.

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

Diagnostic Services

Pulp vitality tests

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

Group I - Preventive Dental Services
(Non-Orthodontic)

Prophylaxis And Fluorides

Prophylaxis - limited to two prophylaxis procedures in a calendar year. Allowance includes scaling and polishing procedures to remove coronal plaque, calculus, and stains.

- Adult prophylaxis covered age 12 and older.

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

Fluoride treatment, topical application - limited to covered persons under age 19 and limited to one treatment in any calendar year.

Office Visits, Evaluations And Examination

Office visits, examinations or limited problem focused re-evaluations - limited to a total of 2 in any calendar year.

Emergency palliative treatment and other non-routine, unscheduled visits.

After hours office visit and other non-routine, unscheduled visits. Limited to a total of 1 in a 6 consecutive month period. Covered if no other treatment, other than radiographs, is performed during the same visit.
Group I Preventive Dental Services (Cont.)
(Non-Orthodontic)

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

CGP-3-DNTL-90-14 B498.9032

All Options

Space Maintainers
Space Maintainers - limited to covered persons under age 19 and limited to initial appliance only. Covered only when necessary to replace prematurely lost or extracted deciduous teeth. Allowance includes all adjustments in the first six months after insertion, limited to a maximum of one bilateral per arch or one unilateral per quadrant, per lifetime.
- Fixed - unilateral
- Fixed - bilateral
- Removable - bilateral
- Removable - unilateral

Recementation of space maintainer performed more than 12 months after the initial insertion
CGP-3-DNTL-90-14 B498.0164-R

All Options

Radiographs
Allowance includes evaluation and diagnosis.
Full mouth, complete series or panoramic radiograph - Either, but not both, of the following procedures, limited to one in any 60 consecutive month period.
- Full mouth series, of at least 14 films including bitewings
- Panoramic film, maxilla and mandible, with or without bitewing radiographs.

Other diagnostic radiographs:
- Bitewing films - limited to either a maximum of 4 bitewing films or a set (7-8 films) of vertical bitewings, in one visit, two per calendar year.
- Intraoral periapical or occlusal films - single films

CGP-3-DNTL-90-14 B498.8740-R

All Options

Dental Sealants
Dental Sealants - permanent molar teeth only - Topical application of sealants is limited to the unrestored, permanent molar teeth of covered persons under age 19 and limited to one treatment, per tooth, in any 60 consecutive month period.

Periodontal Services
Full mouth debridement - limited to once per lifetime.

CGP-3-DNTL-90-14 B498.0166-R
Group II - Basic Dental Services
(Non-Orthodontic)

Diagnostic Services  Allowance includes examination and diagnosis.

Consultations - Diagnostic consultations with a dentist other than the one providing treatment, limited to two consultations in a calendar year. Covered only when no other treatment, other than radiographs, is performed during the visit.

Diagnostic Services: Allowance includes examination and diagnosis.

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

Restorative Services  Multiple restorations on one surface will be considered one restoration. Also see the "Major Restorative Services" section.

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

Resin restorations - Allowance includes light curing, acid etching, adhesives, including resin bonding agents and local anesthetic.

Silicate cement, per restoration
Composite resin

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

CGP-3-DNTL-90-15

Crown And Prosthodontic Restorative Services  Also see the "Major Restorative Services" section.

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

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

Inlay or onlay
Crown
Bridge

Adding teeth to partial dentures to replace extracted natural teeth

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

Denture repairs, metal
Denture repairs, acrylic
Denture repair, no teeth damaged
Denture repair, replace one or more broken teeth
Replacing one or more broken teeth, no other damage
Denture rebase, full or partial denture - limited to once per denture in any 36 consecutive month period. Denture rebases done within 6 months are considered to be part of the denture placement when the rebase is done by the dentists who furnished the denture. Limited to rebase done more than 6 consecutive months after the insertion of the denture.

Denture reline, full or partial denture - limited to once per denture in any 36 consecutive month period. Denture relines done within 6 months are considered to be part of the denture placement when the reline is done by the dentists who furnished the denture. Limited to reline done more than 6 consecutive months after a denture rebase or the insertion of the denture.

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

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

Options G, H

Non-Surgical Extractions
Allowance includes the treatment plan, local anesthetic and post-treatment care.

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

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

Injectable antibiotics needed solely for treatment of a dental condition.

Application of desensitizing medicaments.
**Group III - Major Dental Services**
(Non-Orthodontic)

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

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

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

**Inlays**
- Onlays, including inlay
- Labial veneers

Posts and buildups - only when done in conjunction with a covered unit of crown or bridge and only when necessitated by substantial loss of natural tooth structure.
- Cast post and core in addition to a unit of crown or bridge, per tooth
- Prefabricated post and composite or amalgam core in addition to a unit of crown or bridge, per tooth
- Crown or core buildup, including pins
Implant supported prosthetics - Allowance includes the treatment plan and local anesthetic, when done in conjunction with a covered surgical placement of an implant, on the same tooth.
   Abutment supported crown
   Implant supported crown
   Abutment supported retainer for fixed partial denture
   Implant supported retainer for fixed partial denture
   Implant/abutment supported removable denture for completely edentulous arch
   Implant/abutment supported removable denture for partially edentulous arch
   Implant/abutment supported fixed denture for completely edentulous arch
   Implant/abutment supported fixed denture for partially edentulous arch
   Dental implant supported connecting bar
   Prefabricated abutment
   Custom abutment

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

Other Implant Services
   Bone replacement graft for ridge preservation, per site, when done in conjunction with a covered surgical placement of an implant in the same site, limited to once per tooth, per lifetime
   Radiographic/surgical implant index - limited to once per arch in any 24 month period
   Repair implant supported prosthesis
   Repair implant abutment
   Implant removal
Options G, H

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

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

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

Bridge Pontics
Resin with metal
Porcelain
Porcelain with metal
Full cast metal
3/4 cast metal crowns
3/4 porcelain crowns

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

Complete or Immediate dentures, upper or lower
Partial dentures - Allowance includes base, clasps, rests and teeth
  Upper, resin base, including any conventional clasps, rests and teeth
  Upper, cast metal framework with resin denture base, including any conventional clasps, rests and teeth
  Lower, resin base, including any conventional clasps, rests and teeth
  Lower, cast metal framework with resin denture base, including any conventional clasps, rests and teeth
  Interim partial denture (stayplate), upper or lower, covered on anterior teeth only
  Removable unilateral partial, one piece cast metal, including clasps and teeth

Simple stress breakers, per unit

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

Other Implant Services
Sinus augmentation.

Other Services
Occlusal guards are limited to once every 36 months.

Diagnostic Services
Cone beam imaging limited to once every 5 years.
Options G, H

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

- Pulp capping, limited to permanent teeth and limited to one pulp cap per tooth, per lifetime.
  - Pulp capping, direct
  - Pulp capping, indirect - includes sedative filling.
- Vital pulpotomy, only when root canal therapy is not the definitive treatment
- Gross pulpal debridement
- Pulpal therapy, limited to primary teeth only coinsurance

**Root Canal Treatment**
- Root canal therapy
- Root canal retreatment, limited to once per tooth, per lifetime
- Treatment of root canal obstruction, no-surgical access
- Incomplete endodontic therapy, inoperable or fractured tooth
- Internal root repair of perforation defects

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

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

- Periodontal maintenance procedure - limited to a total of 4 prophylaxis or periodontal maintenance procedures in a calendar year. Allowance includes periodontal pocket charting, scaling and polishing. (Also see "Prophylaxis under Preventive Services") Coverage for periodontal maintenance is considered upon evidence of completed active periodontal therapy (periodontal scaling and root planing or periodontal surgery).
- Scaling and root planing, per quadrant - limited to once per quadrant - in any 24 consecutive month period. Covered when there is radiographic and pocket charting evidence of bone loss.
- Full mouth debridement - limited to once in any 36 consecutive month period. Considered only when no diagnostic, preventive, periodontal service or periodontal surgery procedure has been performed in the previous 36 consecutive month period.

**Periodontal Surgery**
Allowance includes the treatment plan, local anesthetic and post-surgical care. Requires documentation of periodontal disease confirmed by both radiographs and pocket depth probings of each tooth involved.
The following treatment is limited to a total of one of the following, once per tooth in any 12 consecutive months.

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

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

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

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

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

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

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

Periodontal surgery related

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

**Surgical Extractions**
Allowance includes the treatment plan, local anesthetic and post-surgical care. Services listed in this category and related services, may be covered by your medical plan.
- Surgical removal of erupted teeth, involving tissue flap and bone removal
- Surgical removal of residual tooth roots
- Surgical removal of impacted teeth

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

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Options G, H

**Group IV - Orthodontic Services**

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

- Transseptal fiberotomy
- Surgical exposure of impacted or unerupted teeth in connection with orthodontic treatment - Allowance includes treatment and final radiographs, local anesthetics and post-surgical care.
- Treatment plan and records, including initial, interim and final records.
- Limited orthodontic treatment, Interceptive orthodontic treatment or Comprehensive orthodontic treatment, including fabrication and insertion of any and all fixed appliances and periodic visits.
- Orthodontic retention, including any and all necessary fixed and removable appliances and related visits - limited to initial appliance(s) only.

CGP-3-DNTL-90-8  B498.0071
ELIGIBILITY FOR VISION CARE EXPENSE COVERAGE

Employee Vision Care Expense Coverage

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

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

This plan’s vision open enrollment period occurs from November 1st to November 14th of each year.

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

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

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

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

Your coverage under this plan ends on the last day of the pay period in which your active service ends for any reason. Such reasons include disability, retirement, layoff, leave of absence and the end of employment.

Your coverage ends on the date you die.

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

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

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

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

Important Notice

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

If Your Group Coverage Would End

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

When Continuation Ends

Coverage may continue until the earliest of the following:

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

The end of the period for which the premium has been paid.

**Definitions**

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

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

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

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

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

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

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

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**Dependent Vision Care Expense Coverage**

**Eligible Dependents For Dependent Vision Care Benefits**

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

Adopted Children And Step-Children

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

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

CGP-3-DEP-90-3.0

All Options

Handicapped Children

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

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

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

The child's coverage ends when yours does.

CGP-3-DEP-90-4.0

All Options

When Dependent Coverage Starts

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

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

If you do this within 31 days of your eligibility date, date, your dependent coverage is scheduled to start on the date you become covered for employee coverage.
If you do this after the enrollment period ends, you can’t enroll your initial dependents until the next vision open enrollment period.

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

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

**All Options**

**Exception**

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

**Newborn Children**

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

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

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

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

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

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

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

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

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

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

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

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

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

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

The domestic partner’s dependent children will be eligible for coverage under this plan on the same basis as if the children were the employee's dependent children.
Coverage for the domestic partner and his or her dependent children ends when the domestic partner no longer meets the qualifications of a domestic partner as indicated above. Upon termination of a domestic partnership, a "Statement of Termination" must be completed and filed with the employer. Once the employee submits a "Statement of Termination," he or she may not enroll another domestic partner for a period of 12 months from the date of the previous termination.

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

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

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

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

The Guardian Life Insurance Company of America

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

CGP-3-A-DMST-96

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

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B505.0004
Options F, H

VISION CARE HIGHLIGHTS

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

**PPO Copayments**
- Examinations: $20.00
- Standard Frames and/or Standard Lenses: $20.00
- Contact Lenses: $20.00

**Non-PPO Cash Deductibles**
- Examinations: $20.00
- Standard Frames and/or Standard Lenses: $20.00
- Contact Lenses: $20.00

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

CGP-3-VSN-96-BEN3

Options F, H

CGP-3-VSN-96-BEN3
VISION CARE EXPENSE INSURANCE

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

CGP-3-VSN-96-VIS

Options E, G

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

Vision Service Plan

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

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

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

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

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

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

Choice Of Preferred Providers

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

Replacement Of Preferred Provider

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

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

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

CGP-3-VSN-96-PPOA

Options E, G

Pre-Treatment Review For Necessary Contact Lenses

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

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

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

CGP-3-VSN-96-PTR2

Options E, G

Claim Appeals

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

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

Any dispute or question arising between VSP and any covered person involving the application, interpretation or performance under this plan shall be settled, if possible, by amicable and informal negotiations, allowing such opportunity as may be appropriate under the circumstances for fact finding and mediation.
Grievances are handled by VSP’s Professional Relations Vice President for action. The grievance process is designed to address covered persons’ concerns quickly and satisfactorily. The following grievance procedures have been established:

(1) The patient’s written complaint will be referred to VSP’s Professional Relations Vice President for action.

(2) The complaint will be evaluated and, if deemed appropriate, the original examining doctor will be contacted.

(3) If the complaint can be resolved within fifteen (15) days, the disposition of the complaint will be forwarded to the covered person. Otherwise, a notice of receipt of the complaint will be forwarded to the covered person advising the time for resolution.

(4) Grievance procedures and complaint forms will be maintained in each preferred provider’s office.

(5) All complaints will be retained in the Professional Relations Department.

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

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

How This Plan Works

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

Services or Supplies From a Preferred Provider

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

Copayments

The covered person must pay a copayment when he or she receives services from a preferred provider. We pay benefits for the covered charges a covered person incurs in excess of the copayment. This plan's copayments are as follows:
For each vision examination from a preferred provider ........... $20.00
For each pair of standard frames and/or standard lenses from a preferred provider ......................... $20.00
For Necessary Contact Lenses from a preferred provider .......... $20.00

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

Payment Rates
Once a covered person has paid any applicable copayment, we pay benefits for covered charges under this plan as follows. What we pay is subject to all of the terms of this plan.
For covered charges ...................................................... 100%

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

For Prescription Glasses .......... 20% off of the preferred provider's usual and customary fee
For Non-Prescription Sunglasses .... 20% off of the preferred provider's usual and customary fee
For Contact Lens Evaluation and Fitting Costs ................. 15% off of the preferred provider's usual and customary fee

Services or Supplies From a Preferred Provider (Cont.)

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

Cash Deductible For Services Of A Non-Preferred Provider
There are separate cash deductibles for each covered service provided by a non-preferred provider. These cash deductibles are shown below. The covered person must have covered charges in excess of the cash deductible before we pay him or her any benefits for the service or supply.
For each vision examination provided by a non-preferred provider . . . $20.00
Services or Supplies From a Non-Preferred Provider (Cont.)

For each pair of standard frames and/or standard lenses from a non-preferred provider $20.00

For each pair of Necessary Contact Lenses from a non-preferred provider $20.00

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

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

For covered charges 100%

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Options E, G

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

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

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

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

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

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

And if a covered person uses a non-preferred provider, we limit what we pay for each vision examination to $45.00.

Options E, G

**Standard Lenses**

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

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

- $30.00 for each pair of single vision lenses
- $50.00 for each pair of bifocal lenses
- $65.00 for each pair of trifocal lenses and
- $100.00 for each pair of lenticular lenses.

Options E, G

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

Options E, G

**Standard Frames**

We cover charges for standard frames.

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

If a covered person uses a non-preferred provider, we limit what we pay for each set of standard frames to $70.00.

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

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

Necessary Contact Lenses

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

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

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

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

Options E, G

Elective Contact Lenses

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

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

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

If a covered person uses a non-preferred provider, we limit what we pay for elective contact lenses to $105.00.

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

Diabetic Eye Care Program

We pay benefits for covered charges for diabetic eye care from a Preferred Provider. The Covered Person must pay a $20.00 Copayment for each office visit. In order to be covered, the services for diabetic eye care must be within the scope of the Preferred Provider’s optometric license. We cover charges for the treatment of non-surgical medical eye conditions for Covered Persons with type 1 or type 2 diabetes. We cover charges for: Medical follow up exams, specialized screening and tests and medically necessary retinal imaging.
Options E, G

**Diabetic Eye Care Plus Program**

We pay benefits for covered charges for diabetic eye care from a Preferred Provider. The Covered Person must pay a $20.00 Copayment for each office visit. In order to be covered, the services for diabetic eye care must be within the scope of the Preferred Provider’s optometric license.

We cover charges for the treatment of non-surgical medical eye conditions for Covered Persons with type 1 or type 2 diabetes.

We cover charges for:

- Medical follow up exams.
- Specialized screenings and tests.
- Medically necessary retinal imaging.
Options E, G

**Services and Supplies Received from Affiliate Providers:** Vision care services and supplies that are covered by this Plan when received from a Preferred Provider or a Non-Preferred Provider may also be covered by this Plan when such services and supplies are received from, an Affiliate Provider, subject to the limitations and exclusions below.

If services and supplies are received from an Affiliate Provider, We pay benefits for covered charges after the Copayment, as shown below:

<table>
<thead>
<tr>
<th>SERVICES AND SUPPLIES</th>
<th>AFFILIATE PROVIDER - COSTCO</th>
<th>OTHER AFFILIATE PROVIDERS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Eye Exam - one in any one calendar year Period.</td>
<td>Covered In Full.</td>
<td>Covered In Full.</td>
</tr>
<tr>
<td>Standard Lenses - one pair in any one calendar year Period.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Single Vision</td>
<td>Covered In Full. (Not all lens types may be available at all locations.)</td>
<td>Covered In Full. (Not all lens types may be available at all locations.)</td>
</tr>
<tr>
<td>- Bifocal</td>
<td>Covered In Full. (Not all lens types may be available at all locations.)</td>
<td>Covered In Full. (Not all lens types may be available at all locations.)</td>
</tr>
<tr>
<td>- Trifocal</td>
<td>Covered In Full. (Not all lens types may be available at all locations.)</td>
<td>Covered In Full. (Not all lens types may be available at all locations.)</td>
</tr>
<tr>
<td>- Lenticular</td>
<td>Not Available.</td>
<td>Covered In Full. (Not all lens types may be available at all locations.)</td>
</tr>
<tr>
<td>Lens Options - once in any one calendar year Period.</td>
<td>Covered In Full. (Not all lens types may be available at all locations.)</td>
<td>Covered In Full. (Not all lens types may be available at all locations.)</td>
</tr>
<tr>
<td>Options E, G</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Standard Frames - one set in any 2 calendar year Period.</td>
<td>Covered In full up to $70.00.</td>
<td>Covered In full up to $130.00</td>
</tr>
<tr>
<td>- No discount available on charges in excess of the benefit amount.</td>
<td></td>
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</tbody>
</table>
DISTANCE AND REFRACTIVE ERROR CORRECTIVE LENSES

Elective Contact Lenses - one set in any one calendar year Period.

- Contact Lens (Materials Only) Covered In full up to $130.00. Covered In full up to $130.00

Options E, G

Limitations and Exclusions:

1. Limitations and exclusions of benefits described in the Plan for VSP Preferred Providers shall also apply to services and supplies received from Affiliate Providers.

2. If a service or supply is not covered by this Plan when received from a Preferred Provider or a Non-Preferred Provider, such service or supply is not covered by this Plan when received from an Affiliate Provider.

3. Services and supplies received from an Affiliate 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 an Affiliate Provider. Membership fees are not covered under this Plan.

Options E, G

4. We do not cover charges for:
   - Medically Necessary Contact Lenses.
   - Diabetic Eye Care Plus Program.

Definitions:

The following definition is added to the definitions shown in the Plan.

The term "Affiliate Provider" 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 section. Not all Affiliate 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 (800) 877-7195 for details.

The following definition replaces the definition of the term "Copayment" as it is shown in the Plan.

The term "Copayment" means a charge, expressed as a fixed dollar amount, required to be paid by, or on behalf of, a Covered Person to a Preferred Provider or an Affiliate Provider at the time covered vision services or supplies are received.

B505.1438

B505.1450

B505.1452

B505.1540

B505.1565
Special Limitations

If This VSP Plan Replaces Another VSP Plan

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

Options E, G

Exclusions

- We won’t pay for orthoptics or vision training and any associated supplemental testing.

- We won’t pay for medical or surgical treatment of the eyes.

- We won’t pay for any eye examination or corrective eyewear required by an employer as a condition of employment.

Options E, G

- We will not pay for plano lenses (lenses with less than a +/- .38 diopter power).

- We will not pay for two sets of glasses in lieu of bifocals.

- We will not pay for replacement of lenses and frames furnished under this plan which are lost or broken, except at normal intervals when services are otherwise available.

- We will not pay for cosmetic lenses or any cosmetic process, unless specifically shown as covered in the "Covered Services and Supplies" section.

- We will not pay for a frame that costs more than the plan allowance.

- We will not pay for refitting of contact lenses after the initial 90 day fitting period.

- We will not pay for routine maintenance of contact lenses such as polishing or cleaning.

- We will not pay for Corneal Refractive Therapy (CRT) or Orthokeratology (procedure using contact lenses to change the shape of the cornea in order to reduce myopia).
Options E, G

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

Options E, G

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

Options E, G

- We will not pay for the scratch resistant coating of the lens or lenses.

Options E, G

- We will not pay for blended lenses.

Options E, G

- We will not pay for high index lenses.

Options E, G

- We will not pay for the mirror/ski coating of the lens or lenses.

Options E, G

- We will not pay for oversized lenses.

Options E, G

- We will not pay for laminating of the lens or lenses.

Options E, G

- We will not pay for edge treatment.

Options E, G

- We will not pay for progressive lenses.
- We will not pay for progressive multifocal lenses.
Options E, G

● We will not pay for the anti-reflective coating of the lens or lenses.

B505.1025

Options E, G

● We will not pay for polycarbonate lenses.

B505.1026

Options E, G

CGP-3-VSN-09-EXC

B505.1027

Options E, G

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

CGP-3-VSN-96-EXC17

B505.0037
VISION CARE BENEFITS

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

CGP-3-DAVIS-05-VIS

This Plan’s Vision Care Preferred Provider Organization

Davis Vision: This plan is designed to provide a high quality vision care benefit while controlling the cost of such care. To do this, the plan encourages a covered person to seek vision care from doctors and vision care facilities that belong to Davis Vision’s Preferred Provider Network.

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

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

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

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

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

Choice of Preferred Providers

When a person becomes enrolled in this plan, he or she will receive information about Davis Vision preferred providers in his or her area. A covered person may receive vision services from any current Davis Vision preferred provider.

When a covered person wants to receive services from a preferred provider, he or she must contact the preferred provider before receiving treatment. The preferred provider will contact Davis Vision to verify the covered person’s eligibility before any treatment takes place.

It is not necessary to submit a claim for services or supplies from a preferred provider.
This Plan’s Vision Care Preferred Provider Organization (Cont.)

Non-Preferred Providers

If a covered person receives services or supplies from a non-preferred provider, he or she must submit a claim form along with the itemized bill to Davis for claims payment. All claims must be sent to Davis within 90 days of the date services are completed or supplies are received.

Claims for services or supplies from a non-preferred provider must be sent to:

Davis Vision - Vision Care Processing Unit
P.O. Box 1525
Latham, NY 12110

CGP-3-DAVIS-05-PPOA

Options F, H

Appeals Process

In the event that a claim is denied, Davis Vision will consult with the provider involved with the covered person’s vision care treatment. If the issue cannot be resolved, the provider or patient has the right to request a review of the adverse determination. The provider, covered person or patient may appeal denied authorizations or claim decisions. Should a covered person request a review of an authorization or claim decision, Davis Vision must notify the covered person, or his or her designee, within five (5) business days of receipt of the request and the review must be conducted by a clinical peer who was not involved in the original vision care determination. Pre-service review decisions are to be completed within fifteen (15) days and post-service review decisions are to be completed within thirty (30) days, or as required by state statute, from the date that Davis Vision receives notification from the covered person or his or her designee and be mailed within five (5) days of the date of decision. Denials can be appealed through Davis Vision’s Grievance Resolution Process or as per plan contract. A covered person has the right to appeal through an external review organization at any time during the grievance process. A covered person has the right to designate a representative, including his or her provider, to act on his or her behalf with regard to review of a vision care claim determination. Use of the Appeals Process does not waive the covered person’s legal rights.

Grievance Process

Registering a Complaint or Grievance

A covered person has the right to file a grievance or make an appeal to any claim decision at any time. The covered person has the right to designate a representative to file complaints and appeals on his or her behalf.

A covered person is entitled to a copy of the Grievance Resolution process upon request and a copy will be provided to a covered person should the determination be made that vision care benefits are not available.

Davis Vision defines a “grievance” as a complaint that may or may not require specific corrective action and is made:
1. via the telephone;
2. in writing to Davis Vision;
3. via the Davis Vision website.

A grievance or complaint can arise from and includes but is not limited to the following:

1. benefit denials.
2. an adverse determination as to whether a service is covered pursuant to the terms of the contract.
3. difficulty accessing or utilizing a benefit, and issues regarding the quality of vision care services.
4. challenges with vision care services or products received.
5. dissatisfaction with the resolution of a complaint/grievance or appeal.

Verbal Grievances and Telephone Communication

A covered person may file a verbal grievance by contacting Davis Vision. Registering a grievance by telephone will be considered filing a "formal grievance". A Davis Vision associate will acknowledge receipt of all complaints in writing within five (5) business days from the date the grievance or appeal is received.

A covered person has access to the Davis Vision toll free number twenty-four (24) hours a day seven (7) days a week to voice any concern or grievance and also has the right to contact their Human Resources Department or Benefits Administration Department. The Davis Vision Toll Free number is: 1 (800) 584-1487.

Written Grievances

Written notice of grievances received via e-mail, U.S. Mail or other written correspondence will be acknowledged within five (5) business days. All written correspondence should be addressed to:

Davis Vision
159 Express Street
Plainview, New York 11803
Attention: Quality Assurance/Patient Advocate Department

A covered person can register any concern or grievance by logging on to Davis’ website: www.davisvision.com and entering the "Contact Davis Vision" area.
Internal Grievance Procedure

**Appeal Level 1**

Upon receipt of a concern or grievance by a Davis Vision associate, the *covered person* is contacted by telephone, or in writing, within five (5) business days to confirm that the concern or grievance was received and is being investigated. Every attempt is made to contact the *covered person* or his or her designated representative. Contact may include but is not limited to telephone contact, e-mail or U.S. Mail. A designated Davis Vision associate reviews the appeal with the *covered person* and may request additional information. Details of the complaint are documented in the *covered person’s* file. The *covered person* is given the Associate’s name, phone number, department and the estimated time needed to perform the research. The *covered person* is informed of their right to have a representative, including their provider, present during the review of the concern and final outcome of the investigation. The *covered person* is informed of their right to appeal to an external review organization at any time during the grievance procedure or as required by state statute.

The review committee will include a licensed (peer) health care professional when grievances pertain to clinical decisions. All decisions are reviewed and approved by the Vice President of Professional Affairs, a licensed optometrist.

The investigation may involve contacting the provider or the point of service location to determine the cause of the concern. If necessary, the Regional Quality Assurance Representative (RQAR) or Professional Field Consultant (PFC) will be contacted and a site visit may be scheduled. Davis Vision will contact the *covered person* when further information is required and inform them of the status of the investigation or the need for more information.

**Options F, H**

The determination will be communicated to the *covered person* within fifteen (15) days for pre-service review decisions and within thirty (30) days for post-service review decisions, or as required by state statute. An additional ten (10) days may be requested in order to complete further research. The written decision will be mailed to the *covered person* within five (5) days of the decision. The appeal determination will include the following:

- the decision, and will include a summary of the facts related to the issue,
- the criteria that was used, summary of the evidence, including the documentation supporting the decision,
- a statement indicating that the decision will be final and binding unless the *covered person* appeals in writing to the Quality Assurance/Patient Advocate Department within fifteen (15) business days of the date of the notice of the decision,
- a copy of the appeals process, if applicable, and
- the name, position, phone number, and department of the person(s) responsible for the decision.
The decision of the Quality Assurance/Patient Advocate Department shall be final and binding unless appealed by the *covered person* to Davis Vision within fifteen (15) business days of the date of notice of the decision.

**Appeal Level 2**

Should Davis Vision uphold a denial, as the result of a Level 1 review, the *covered person* has the right to request a Level 2 appeal.

A Level 2 appeal will not include associate(s) or licensed (peer) health care professional(s) that were involved in the Level 1 review.

A Level 2 appeal requires the *covered person* to contact Davis Vision in writing or by telephone within fifteen (15) days following receipt of the Level 1 summary statement. The *covered person* requesting a Level 2 appeal must indicate the reason they believe the denial of coverage was incorrect. Davis Vision reserves the right to request further information from the *covered person* or provider.

Davis Vision has thirty (30) days, or as required by state statute, from the date the requested information is received, to respond to the Level 2 pre-service review. Davis Vision has thirty (30) days, or as required by state statute, from the date the requested information is received, to respond to the Level 2 post-service review. The Vice President of Professional Affairs will review all clinical appeals. A Davis Vision Associate(s) and a Regional Quality Assurance Representative(s) (RQAR), a licensed optometrist, not involved in the initial determination will review the Level 1 decision. If the Level 2 appeal upholds the Level 1 determination the *covered person* will be notified in writing of this decision. Notification will include, but not be limited to:

- the decision, and contain a summary stating the nature of the concern and the facts related to the issue,
- the criteria that was used, summary of the evidence, including documentation that was used to support the decision,
- a statement indicating that the decision will be final and binding unless the *covered person* appeals in writing or by telephone to the Quality Assurance/Patient Advocacy Department within forty-five (45) days of the date of the notice of the Level 2 decision,
- a copy of the appeals process, if applicable, and
- the name, position, phone number, and department of person(s) responsible for the decision.

**External Grievance Procedure**

**External Review**

A *covered person*, as required by state statute, has the right to request an impartial review of concerns that resulted in a denial of coverage. A *covered person* who has exhausted the internal appeals process may appeal the final decision if the denial for services was not deemed medically necessary or the requested service was deemed Investigational or Experimental.
An external review organization will refer the case for review by a neutral, independent practitioner experienced in vision care. Davis Vision will provide all requested documentation to the external review organization. The external review organizations will have up to thirty (30) days, or as required by state statute, to make their determination.

**External Review Process**

A *covered person* has the right to an external review of a denial of coverage. A *covered person* has the right to an external review of a final adverse decision under the following circumstances:

- the *covered person* has been denied a vision care service, which should have been covered under the terms of the contract.
- services were denied on the basis that requested services were not medically necessary.
- a treatment or service that will have a significant positive impact on the *covered person* has been denied and any alternative service or treatment will not affect the *Covered person’s* ocular health and/or produce a negative outcome.
- services denied are related to a current illness or injury.
- the cost of the requested services will not exceed that of any equally effective treatment.
- the denied service, procedure or treatment is a covered benefit under the *Covered person’s* policy.
- the *covered person* has exhausted all internal appeal processes with an adverse determination upheld at each level.

Investigational or Experimental Treatment means an approved ocular diagnostic procedure warranted by the ocular health of the *covered person* and the subsequent diagnostic findings could alter the *covered person’s* treatment plan. The risk of a negative outcome utilizing the approved treatment would be no greater than utilizing an alternative treatment.

The vision care provider may contact the appropriate State Agency to determine if other documentation may be required for the appeal process.

Once the determination is made, notification is made, in writing, within two (2) business days. This notification will include an explanation and the clinical criteria used in the decision.
How This Plan Works

We pay benefits for the covered charges a covered person incurs as follows. What we pay is subject to all of the terms of this plan. Read the entire plan to find out what we limit or exclude.

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

When a payment limit is for a pair of materials (such as lenses), the limit is halved if only one item is purchased.

Copays

A covered person must pay a copay each time he or she receives a vision examination. A covered person must pay a copay each time he or she receives any vision materials covered by this plan.

How We Cover Vision Examinations

A covered person must pay a $20.00 copay each time he or she receives a vision examination. If the vision examination is performed by a preferred provider, we pay benefits in full for the exam in excess of the copay. If the vision examination is performed by a non-preferred provider, we pay benefits in excess of the copay up to $50.00.

We pay benefits for one vision examination in any calendar year.

A vision examination includes:

- case history - chief complaint, eye and vision history, medical history;
- entrance distance acuities;
- external ocular evaluation including slit lamp examination;
- internal ocular examination;
- tonometry;
- distance refraction - objective and subjective;
- binocular coordination and ocular motility evaluation;
- evaluation of papillary function;
- biomicroscopy;
- gross visual fields;
- assessment and plan;
How This Plan Works (Cont.)

- advice to a Covered Person on matters pertaining to vision care;
- form completion - school, motor vehicle, etc.

If the doctor recommends vision correction, we cover the fitting of eyeglasses and follow-up adjustments.

Options F, H

How We Cover Vision Materials

We pay benefits for either glass or plastic prescription single vision, bifocal, trifocal or lenticular lenses. We pay benefits for frames. We pay benefits for prescription contact lenses.

In any calendar year period, we pay benefits for either one pair of standard lenses or one pair of contact lenses, but not both.

In any period of 2 calendar years, we pay benefits for one set of frames.

Options F, H

How We Cover Standard Lenses

A covered person must pay a $20.00 copay each time he or she purchases standard lenses. If the lenses are received from a preferred provider, we pay benefits in full for the lenses in excess of the copay. If the lenses are received from a non-preferred provider, we pay benefits in excess of the copay up to:

- $50.00 for single vision lenses;
- $75.00 for bifocal lenses;
- $100.00 for trifocal lenses; and
- $125.00 for lenticular lenses.

We cover one pair of standard lenses in any calendar year.

We cover charges for glass or plastic lenses in single vision, bifocal or trifocal prescriptions, including charges for the following cosmetic extras:

- oversized lenses;
- fashion and gradient tinting of plastic lenses;
- polycarbonate lenses (for children up to age 20 and monocular and Covered Persons with prescriptions of greater than +/-6.00 diopters);
- glass-grey #3 prescription sunglasses.

The following cosmetic lens extras are not covered. But if a covered person purchases his or her lenses from a preferred provider, the price will be discounted as follows:

- standard progressive addition lenses - $50
- premium progressives (Varilux, Kodak, Seiko, Rodenstock) - $90
How This Plan Works (Cont.)

- photochromatic lenses - single vision or multifocal - $20
- scratch resistant coating - single vision or multifocal - $20
- ultra violet coating - $12
- blended invisible bifocal lenses - $20
- intermediate Lenses - $30
- plastic photosensitive lenses - $65
- polarized lenses - $75
- hi-Index lenses - $55
- supershield (scratchguard) coating - $20
- glare resistant treatment (multi layer hydrophobic) - $35
- premium glare resistant treatment - $48

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Options F, H

How We Cover Elective Contact Lenses

We cover charges for standard, soft, daily-wear, disposable or planned replacement contact lenses, but only in lieu of standard lenses and frames.

If we cover charges for elective contact lenses, we will not cover charges for standard lenses and frames until the next following calendar year.

A covered person must pay a $20.00 copay each time he or she purchases elective contact lenses.

If the contact lenses are purchased from a non-preferred provider, we pay benefits in excess of the copay up to a maximum of $105.00.

If the contact lenses are purchased from a preferred provider, we pay benefits in excess of the copay as follows:

- If a preferred provider offers Davis’ elective contact lenses collection (the formulary), we cover any elective contact lenses selected from the formulary in full in excess of a $20.00 copay.
- We cover non-formulary elective contact lenses in full to the retail elective contact lenses allowance of $130.00. The copay is waived.
- If a covered person receives a vision examination from a preferred provider, he or she will receive a discount on the cost of a pair of non-formulary elective contact lenses, including evaluation and fitting, from the same preferred provider.
The discount is an amount equal to 15% of the preferred provider's usual and customary fee in excess of the copay and retail elective contact lenses allowance.

*At Wal-Mart locations, covered persons will receive Wal-Mart’s every day low price on purchases of elective contact lenses.

We cover one pair of elective contact lenses in any calendar year.

CGP-3-DAVIS-05-ECL

Options F, H

How We Cover Necessary Contact Lenses

We cover charges for necessary contact lenses, including charges for related professional services:

- only if the lenses are needed for the correction of keratoconus; and
- the covered person complies with the following requirements regarding prior notification.

The covered person or the provider must send a completed request to Davis Vision for necessary contact lenses for the correction of keratoconus before the lenses are dispensed. If the required notification is not obtained, no benefits will be paid for such lenses.

A covered person must pay a $20.00 copay each time he or she purchases necessary contact lenses. If the contact lenses are purchased from a preferred provider, we pay benefits in full for the lenses in excess of the copay. If the contact lenses are purchased from a non-preferred provider, we pay benefits in excess of the copay up to a maximum of $210.00.

CGP-3-DAVIS-05-NCL

Options F, H

How We Cover Frames

A covered person must pay a copay each time he or she purchases a set of frames.

If the frames are purchased from a non-preferred provider, we pay benefits in excess of a $20.00 copay up to $70.00.

If the frames are purchased from a preferred provider, we pay benefits in excess of the copay as follows:

- If a preferred provider offers Davis’ Tower designer frame collection (the Tower), we cover any Fashion or Designer Collection frame selected from the Tower in excess of a $20.00 copay. We cover any Premier Collection frame selected from the Tower in full in excess of a $45.00 copay.
- We cover a non-Tower frame in excess of a $20.00 copay up to the retail frame allowance of $130.00.
- If a covered person receives a vision examination from a preferred provider, he or she will receive a discount on the cost of purchasing a pair of non-Tower frames from the same preferred provider*.
The discount is an amount equal to 20% of the preferred provider’s usual and customary fee in excess of the copay and retail frame allowance.

*At Wal-Mart locations, covered persons will receive Wal-Mart’s every day low price on frame purchases.

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

Options F, H

Exclusions

- We won’t pay for orthoptics or vision training and any associated supplemental training.
- We won’t pay for medical or surgical treatment of the eyes.
- We won’t pay for any eye examination or corrective eyewear required by an employer as a condition of employment.
- We won’t pay for plano lenses (lenses with less than a +/-.38 diopter power).
- We won’t pay for two sets of glasses in lieu of bifocals.
- We won’t pay for replacement of lenses and frames furnished under this Plan which are lost or broken, except at normal intervals when services are otherwise available.
- We won’t pay for necessary contact lenses prescribed for a covered person affected with keratoconus for which prior notification was not sent to Davis Vision.
- We won’t pay for lens cosmetic extras that are not specifically listed in this Plan as covered.
CERTIFICATE AMENDMENT

Effective on the latter of (i) the original effective date of the Policy; or (ii) the effective date of the any applicable amendment requested by the Policyholder and approved by the Insurance Company, this rider amends the Dental Expense Insurance provisions of the Group Policy as follows:

The Major Restorative Services are modified to provide that titanium or high noble metal (gold) is covered when used in a dental prosthesis.

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

The Guardian Life Insurance Company of America

Vice President, Risk Mgt. & Chief Actuary

Stuart Shaw

CGP-3-A-DGOPT-10

B531.0025
CERTIFICATE AMENDMENT

Effective on the latter of (i) the original effective date of the Policy; or (ii) the effective date of any applicable amendment requested by the Policyholder and approved by the Insurance Company, this rider amends the Dental Expense Insurance provisions of the Group Policy as follows:

The Alternate Treatment provision is changed to read as follows when titanium or high noble metal (gold) is used in a dental prosthesis.

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

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

The Guardian Life Insurance Company of America

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

The certificate is amended as follows:

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

(a) your dependent child is a child under age 26;

(b) marital status, residency and financial dependency requirements do not apply to your dependent child; except as stated in item (c);

(c) your handicapped child can stay eligible for dependent coverage past age 26 if your child is unmarried and is unable to support himself or herself; and

(d) reference to an individual dependent’s coverage ending when he or she marries or is no longer dependent on you for support and maintenance, except as stated for a handicapped child past the age limit, is deleted.

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

The Guardian Life Insurance Company of America

Stuart Shaw
Vice President, Risk Mgt. & Chief Actuary

CGP-A-1
CERTIFICATE AMENDMENT

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

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

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

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

If you change your election, your covered dependents will automatically be switched to Davis Vision’s vision care plan at the same time as you.

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

The Guardian Life Insurance Company of America

Vice President, Risk Mgt. & Chief Actuary

Stuart J Shaw
CERTIFICATE AMENDMENT

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

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

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

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

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

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

The Guardian Life Insurance Company of America

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

CGP-A-1

All Options
**COORDINATION OF BENEFITS**

**Important Notice**  This section applies to all group dental benefits under this plan. It does not apply to any death, dismemberment, or loss of income benefits that may be provided under this plan.

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

**Definitions**

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

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

1. If a person is covered by two or more plans that compute their benefit payments on the basis of reasonable and customary charges, any amount in excess of the primary plan’s reasonable and customary charges for a specific benefit is **not** an allowable expense.
2. If a person is covered by two or more plans that provide benefits or services on the basis of negotiated fees, an amount in excess of the primary plan’s negotiated fees for a specific benefit is **not** an allowable expense.

If a person is covered by one plan that computes its benefits or services on the basis of reasonable and customary charges and another plan that provides its benefits or services on the basis of negotiated fees, the primary plan’s payment arrangements will be the allowable expense for all plans. However, if the provider has contracted with the secondary plan to provide the benefit or service for a specific negotiated fee or payment amount that is different than the primary plan’s payment arrangement and if the provider’s contract permits, the negotiated fee or payment shall be the allowable expense used by the secondary plan to determine its benefit.

**Claim**  This term means a request that benefits of a plan be provided or paid.

**Claim Determination Period**  This term means a calendar year. It does not include any part of a year during which a person has no coverage under this plan, or before the date this section takes effect.

**Coordination Of Benefits**  This term means a provision which determines an order in which plans pay their benefits, and which permits secondary plans to reduce their benefits so that the combined benefits of all plans do not exceed total allowable expenses.
Custodial Parent
This term means a parent awarded custody by a court decree. In the absence of a court decree, it is the parent with whom the child resides more than one half of the calendar year without regard to any temporary visitation.

Group-Type Contracts
This term means contracts: (a) which are not available to the general public; and (b) can be obtained and maintained only because of membership in or connection with a particular organization or group. This includes, but is not limited to, franchise and blanket coverage.

Hospital Indemnity Benefits
This term means benefits that are not related to expenses incurred. This term does not include reimbursement-type benefits even if they are designed or administered to give the insured the right to elect indemnity-type benefits at the time of claim.

Plan
This term means any of the following that provides benefits or services for dental care or treatment: (1) group insurance and group subscriber contracts; (2) uninsured arrangements of group or group-type coverage; (3) group or group-type coverage through health maintenance organizations (HMOs) and other prepayment, group practice and individual practice plans; (4) group-type contracts; (5) amounts of group or group-type hospital indemnity benefits in excess of $100.00 per day; (6) medical benefits under group, group-type, and individual automobile contracts; and (7) governmental benefits, except Medicare, as permitted by law.

This term does not include individual or family: (a) insurance contracts; (b) subscriber contracts; (c) coverage through HMOs; or (d) coverage under other prepayment, group practice and individual practice plans. This term also does not include: (i) amounts of group or group-type hospital indemnity benefits of $100.00 or less per day; (ii) school accident type coverage; or (iii) Medicare, Medicaid, and coverage under other governmental plans, unless permitted by law.

This term also does not include any plan that this plan supplements. Plans that this plan supplements are named in the benefit description.

Each type of coverage listed above is treated separately. If a plan has two parts and coordination of benefits applies only to one of the two, each of the parts is treated separately.

Primary Plan
This term means a plan that pays first without regard that another plan may cover some expenses. A plan is a primary plan if either of the following is true: (1) the plan either has no order of benefit determination rules, or its rules differ from those explained in this section; or (2) all plans that cover the person use the order of benefit determination rules explained in this section, and under those rules the plan pays its benefits first.

Secondary Plan
This term means a plan that is not a primary plan.

This Plan
This term means the group dental benefits provided under this group plan.
Order Of Benefit Determination

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

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

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

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

**Non-Dependent Or Dependent**

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

**Child Covered Under More Than One Plan**

The order of benefit determination when a child is covered by more than one plan is:

1. If the parents are married, or are not separated (whether or not they ever have been married), or a court decree awards joint custody without specifying that one party must provide coverage, the plan of the parent whose birthday is earlier in the year is primary. If both parents have the same birthday, the plan that covered either of the parents longer is primary. If a plan does not have this birthday rule, then that plan’s coordination of benefits provision will determine which plan is primary.

2. If the specific terms of a court decree state that one of the parents must provide coverage and the plan of the parent has actual knowledge of those terms, that plan is primary. This rule applies to claim determination periods that start after the plan is given notice of the court decree.

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

**Active Or Inactive Employee**

The plan that covers a person as an active employee, or as that person’s dependent, is primary. An active employee is one who is neither laid off nor retired. The plan that covers a person as a laid off or retired employee, or as that person’s dependent, is secondary. If a plan does not have this rule and as a result the plans do not agree on the order of benefit determination, this rule is ignored.
Order Of Benefit Determination (Cont.)

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

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

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

Effect On The Benefits Of This Plan

When This Plan Is Primary
When this plan is primary, its benefits are determined before those of any other plan and without considering any other plan’s benefits.

When This Plan Is Secondary
When this plan is secondary, it may reduce its benefits so that the total benefits paid or provided by all plans during a claim determination period are not more than 100% of total allowable expenses. When the benefits of this plan are reduced, each benefit is reduced in proportion. It is then charged against the applicable benefit limit of this plan.

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

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

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

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

As used here, the term "amount of the payments made" includes the reasonable cash value of any benefits provided in the form of services.
<table>
<thead>
<tr>
<th>Term</th>
<th>Definition</th>
<th>CGP-3-GLOSS-90</th>
<th>B900.0118</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Anisometropia</strong></td>
<td>means a condition of unequal refractive state for the two eyes, one eye requiring different lens correction than the other.</td>
<td>CGP-3-VSN-96-DEF1</td>
<td>B750.0457</td>
</tr>
<tr>
<td><strong>Active Orthodontic</strong></td>
<td>means an <em>appliance</em>, like a fixed or removable appliance, braces or a functional orthotic used for orthodontic treatment to move teeth or reposition the jaw.</td>
<td>CGP-3-GLOSS-90</td>
<td>B750.0663</td>
</tr>
<tr>
<td><strong>Anterior Teeth</strong></td>
<td>means the incisor and cuspid teeth. The teeth are located in front of the bicuspids (pre-molars).</td>
<td>CGP-3-GLOSS-90</td>
<td>B750.0664</td>
</tr>
<tr>
<td><strong>Appliance</strong></td>
<td>means any dental device other than a <em>dental prosthesis</em>.</td>
<td>CGP-3-GLOSS-90</td>
<td>B750.0665</td>
</tr>
<tr>
<td><strong>Benefit Period</strong></td>
<td>with respect to Vision Care Insurance, means the time period beginning when a covered service is received and extending to the date on which, according to the time limitations contained in this plan, the covered service is again available to a covered person.</td>
<td>CGP-3-VSN-96-DEF3</td>
<td>B750.0458</td>
</tr>
<tr>
<td><strong>Benefit Year</strong></td>
<td>means a 12 month period which starts on January 1st and ends on December 31st of each year.</td>
<td>CGP-3-GLOSS-90</td>
<td>B750.0666</td>
</tr>
<tr>
<td><strong>Blended Lenses</strong></td>
<td>means bifocals which do not have a visible dividing line.</td>
<td>CGP-3-VSN-96-DEF3</td>
<td>B750.0459</td>
</tr>
</tbody>
</table>
Options F, H

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

CGP-3-GLOSS-90

B750.0781

Options E, G

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

CGP-3-VSN-96-DEF3

B750.0460

Options F, H

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

CGP-3-GLOSS-90

B750.0782

Options E, G

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

CGP-3-VSN-96-DEF3

B750.0461

Options F, H

**Copay** means a charge, expressed as a fixed dollar amount, required to be paid by or on behalf of a **covered person** before any benefits are paid by this **plan**.

CGP-3-GLOSS-90

B750.0783

All Options

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

CGP-3-GLOSS-90

B750.0667

All Options

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

CGP-3-GLOSS-90

B750.0668

All Options

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

CGP-3-GLOSS-90

B750.0669
Options E, G

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

CGP-3-VSN-96-DEF3 B750.0462

Options F, H

Covered Person with respect to vision care insurance means an employee or eligible dependent who meets this plan’s eligibility criteria and who is covered under this plan.

CGP-3-GLOSS-90 B750.0784

Options E, G

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

CGP-3-VSN-96-DEF3 B750.0484

Options F, H

Customary means, when referring to a covered charge, that the charge for the covered vision condition is not more than the usual charge made by most other doctors with similar training and experience in the same geographic area.

CGP-3-GLOSS-90 B750.0785

Options E, G

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

CGP-3-VSN-96-DEF3 B750.0483

All Options

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

CGP-3-GLOSS-90 B750.0670
Dentist means any dental or medical practitioner we are required by law to recognize who: (a) is properly licensed or certified under the laws of the state where he or she practices; and (b) provides services which are within the scope of his or her license or certificate and covered by this plan.

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

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

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

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

Employer means IASIS HEALTHCARE, LLC.

Enrollment Period with respect to dependent coverage, means the 31 day period which starts on the date that you first become eligible for dependent coverage.
**Full-time** means the employee regularly works at least the number of hours in the normal work week set by the employer (but not less than 30 hours per week), at his employer's place of business.

CGP-3-GLOSS-90  B750.0229

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

CGP-3-VSN-96-DEF3  B750.0466

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

CGP-3-GLOSS-90  B900.0006

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

CGP-3-GLOSS-90  B750.0673

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

CGP-3-VSN-96-DEF11  B750.0467

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

CGP-3-GLOSS-90  B750.0786
Lenticular Lenses mean high-powered lenses with the desired prescription power found only in the central portion. The outer carrier portion has a front surface with a changing radius of curvature.

CGP-3-VSN-96-DEF11

Non-Preferred Provider with respect to vision care insurance, means any optometrist, ophthalmologist or optician or other licensed and qualified vision care provider who has not entered into a contract with Davis Vision to provide vision care services and/or vision care materials on behalf of the covered persons of the plan.

CGP-3-VSN-96-DEF14

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

CGP-3-GLOSS-90
Options E, F

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

CGP-3-GLOSS-90 B750.0685

Options E, G

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

CGP-3-VSN-96-DEF16 B750.0472

Options F, H

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

CGP-3-GLOSS-90 B750.0789

Options E, G

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

CGP-3-VSN-96-DEF17 B750.0489

Options F, H

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

CGP-3-GLOSS-90 B750.0790

All Options

**Part-time** means the employee regularly works at least half the number of hours that a full-time employee works (but not less than 30 hours per week), at your employer’s place of business.

CGP-3-GLOSS-90 B750.0011-R

All Options

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

CGP-3-GLOSS-90 B750.0676
Glossary (Cont.)

All Options

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

CGP-3-GLOSS-90

Options E, G

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

CGP-3-VSN-96-DEF17

Options F, H

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

CGP-3-GLOSS-90

All Options

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

CGP-3-GLOSS-90

All Options

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

CGP-3-GLOSS-90

Options E, G

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

CGP-3-VSN-96-DEF17

Options F, H

**Plan** means the Davis Vision plan of vision care services described herein.

CGP-3-GLOSS-90

Options E, G

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

CGP-3-VSN-96-DEF17

Options F, H

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

CGP-3-GLOSS-90
Options E, G

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

CGP-3-VSN-96-DEF14 B750.0488

Options F, H

Preferred Provider with respect to vision care insurance means an optometrist, ophthalmologist or optician or other licensed and qualified vision care provider who has entered into a contract with Davis Vision to provide vision care services and/or vision care materials on behalf of covered persons of the plan.

CGP-3-GLOSS-90 B750.0794

All Options

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

CGP-3-GLOSS-90 B750.0681

All Options

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

CGP-3-GLOSS-90 B750.0682

Options E, G

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

CGP-3-VSN-96-DEF17 B750.0478

Options F, H

Standard Lenses means regular glass or plastic lenses. See "Exclusions" for what we limit or exclude.

CGP-3-GLOSS-90 B750.0795

Options E, G

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

CGP-3-VSN-96-DEF17 B750.0479
Options E, G

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

CGP-3-VSN-96-DEF17

Options F, H

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

CGP-3-GLOSS-90

Options E, G

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

CGP-3-VSN-96-DEF17

Options F, H

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

CGP-3-GLOSS-90

Options E, G

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

CGP-3-VSN-96-DEF17

All Options

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

CGP-3-GLOSS-90
SUMMARY PLAN DESCRIPTION SUPPLEMENT TO CERTIFICATE

You participate in a single employer insured Welfare Plan. This supplement and your certificate of insurance constitute the Summary Plan Description as required by the Employee Retirement Income Security Act of 1974 (ERISA). This supplement should be retained with your certificate.

- **Name of Plan:**
  IASIS HEALTHCARE, LLC GROUP INSURANCE PLAN

- **Employer’s Name:** (Plan Sponsor)
  IASIS HEALTHCARE, LLC

  **Address:** 117 SEABOARD LANE
  FRANKLIN TN 37067

  **Phone Number:** 615-467-1231

- **IRS Employer Identification Number (EIN):** 201150104

- **Plan Number:** 501

- **Plan Administrator:** (if other than Plan Sponsor)
  IASIS HEALTHCARE, LLC

  **Address:** 117 SEABOARD LANE
  FRANKLIN TN 37067

  **Phone Number:** 615-467-1231

- **Agent for The Service of Legal Process:**
  IASIS HEALTHCARE, LLC

  **Address:** 117 SEABOARD LANE
  FRANKLIN TN 37067

  (Legal process may also be served on the Plan Administrator.)

- **Date of End of Plan Year:** One day prior to January 1st.

- Contributions to the plan are provided by the Employer and the Employee.

- The following class or classes of full-time and part-time employees are eligible to apply for insurance:

  **Class 0002**

  ALL ELIGIBLE EMPLOYEES LOCATED IN LOUISIANA, COLORADO & FLAGSTAFF, AZ

  provided they have completed the service waiting period established by the employer, if any. Qualified dependents of these employees may also be eligible for insurance. (Your certificate provides details).
STATEMENT OF ERISA RIGHTS

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

Receive Information About Your Plan and Benefits

(a) Examine, without charge, at the plan administrator’s office and at other specified locations, such as worksites and union halls, all documents governing the plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the plan with the U. S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

(b) Obtain, upon written request to the plan administrator, copies of documents governing the operation of the plan, including insurance contracts, collective bargaining agreements and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The administrator may make a reasonable charge for the copies.

(c) Receive a summary of the plan’s annual financial report. The plan administrator is required by law to furnish each participant with a copy of this summary annual report.

Continue Group Health Plan Coverage

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

Prudent Actions By Plan Fiduciaries

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

Enforcement Of Your Rights

If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.
Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report from the plan and do not receive them within 30 days, you may file suit in a state or Federal court. In such a case, the court may require the plan administrator to provide the materials and pay you up to $110.00 a day until you receive the material, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a federal court. If it should happen that plan fiduciaries misuse the plan’s money or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds that your claim is frivolous.

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

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

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

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

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

If you have questions about this statement, see the plan administrator.
The Guardian’s Responsibilities

All Options

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

All Options

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

All Options

The Guardian is located at 7 Hanover Square, New York, New York 10004.
If you seek benefits under the plan you should complete, execute and submit a claim form. Claim forms and instructions for filing claims may be obtained from the Plan Administrator.

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

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

Definitions

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

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

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

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

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

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

Timing For Initial Benefit Determination

The benefit determination period begins when a claim is received. Guardian will make a benefit determination and notify a claimant within a reasonable period of time, but not later than the maximum time period shown below. A written or electronic notification of any adverse benefit determination must be provided.
Urgent Care Claims. Guardian will make a benefit determination within 72 hours after receipt of an urgent care claim.

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

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

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

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

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

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

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

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

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

If Guardian extends the time period for making a benefit determination due to a claimant’s failure to submit information necessary to decide the claim, the claimant will be given at least 45 days to provide the requested information. The extension period will begin on the date on which the claimant responds to the request for additional information.
Concurrent Care Decisions. A reduction or termination of an approved ongoing course of treatment (other than by plan amendment or termination) will be regarded as an adverse benefit determination. This is true whether the treatment is to be provided (a) over a period of time; (b) for a certain number of treatments; or (c) without a finite end date. Guardian will notify a claimant at a time sufficiently in advance of the reduction or termination to allow the claimant to appeal.

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

Adverse Benefit Determination

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

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

Appeal of Adverse Benefit Determinations

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

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

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

- the opportunity to submit written comments, documents, records and other information relating to the claim;
Group Health Benefits Claims Procedure (Cont.)

- the opportunity, upon request and free of charge, for reasonable access to, and copies of, all documents, records and other information relating to the claim; and

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

In reviewing an appeal, Guardian will:

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

- in deciding an appeal based upon a medical judgment, consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment;

- identify medical or vocational experts whose advice was obtained in connection with an adverse benefit determination; and

- ensure that a health care professional engaged for consultation regarding an appeal based upon a medical judgment shall be neither the person who was consulted in connection with the adverse benefit determination, nor that person's subordinate.

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

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

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

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

**Alternative Dispute Options**

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

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

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

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

B800.0086
NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Effective: 9/23/2013

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

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

What is Protected Health Information (PHI):

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

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

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

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

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

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

Health Care Operations. Guardian may use and disclose your PHI to perform health care operations. For example, we may use your PHI for underwriting and premium rating purposes.

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

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

All Options

Guardian is required to use or disclose your PHI:

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

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

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

Other Uses and Disclosures .

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

- We may disclose your PHI to persons involved in your care, such as a family member or close personal friend, when you are incapacitated, during an emergency or when permitted by law.
- We may disclose your PHI for public health activities, such as reporting of disease, injury, birth and death, and for public health investigations.
- We may disclose your PHI to the proper authorities if we suspect child abuse or neglect; we may also disclose your PHI if we believe you to be a victim of abuse, neglect, or domestic violence.
- We may disclose your PHI to a government oversight agency authorized by law to conducting audits, investigations, or civil or criminal proceedings.
- We may disclose your PHI in the course of a judicial or administrative proceeding(e.g., to respond to a subpoena or discovery request).
- We may disclose your PHI to the proper authorities for law enforcement purposes.
- We may disclose your PHI to coroners, medical examiners, and/or funeral directors consistent with law.
- We may use or disclose your PHI for organ or tissue donation.
- We may use or disclose your PHI for research purposes, but only as permitted by law.
- We may use or disclose PHI to avert a serious threat to health or safety.
- We may use or disclose your PHI if you are a member of the military as required by armed forces services, and we may also disclose your PHI for other specialized government functions such as national security or intelligence activities.
- We may disclose your PHI to comply with workers’ compensation and other similar programs.
- We may disclose your PHI to third party business associates that perform services for us, or on our behalf (e.g. vendors).
- Guardian may use and disclose your PHI to federal officials for intelligence and national
security activities authorized by law. We also may disclose your PHI to authorized federal officials in order to protect the President, other officials or foreign heads of state, or to conduct investigations authorized by law.

- We may disclose your PHI to correctional institutions or law enforcement officials if you are an inmate or under the custody of a law enforcement official (e.g., for the institution to provide you with health care services, for the safety and security of the institution, and/or to protect your health and safety or the health and safety of other individuals).
- We may disclose your PHI to your employer under limited circumstances related primarily to workplace injury or illness or medical surveillance.

All Options

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

Under federal and state law, certain kinds of PHI will require enhanced privacy protections. These forms of PHI include information pertaining to:
- HIV/AIDS testing, diagnosis or treatment
- Venereal and/or communicable Disease(s)
- Genetic Testing
- Alcohol and drug abuse prevention, treatment and referral
- Psychotherapy notes

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

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

We ask that you submit your request in writing. Your request must state a requested time period not more than six years prior to the date when you make your request. Your request should indicate in what form you want the list (e.g., paper, electronically).

Your Right to Obtain a Paper Copy of This Notice. You have a right to request a paper copy of this notice even if you have previously agreed to accept this notice electronically.

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

Any exercise of the Rights designated below must be submitted to the Guardian in writing. Guardian may charge for reasonable costs associated with complying with your requests; in such a case, we will notify you of the cost involved and provide you the opportunity to modify your request before any costs are incurred.
Your Right to Request Restrictions. You have the right to request a restriction on the PHI we use or disclose about you for treatment, payment or health care operations as described in this notice. You also have the right to request a restriction on the medical information we disclose about you to someone who is involved in your care or the payment for your care.

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

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

All Options

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

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

How to Contact Us:

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

Attention:
Guardian Corporate Privacy Officer
National Operations

Address:
The Guardian Life Insurance Company of America
Group Quality Assurance - Northeast
P.O. Box 2457
Spokane, WA 99210-2457
# Employee Assistance/Work-Life Program

| **What is the Employee Assistance Program?** | The Employee Assistance/Work-Life Program (EAP) is a voluntary, confidential service that provides professional counseling and referral services designed to help with personal, job or family related problems. The EAP can help you and your family members identify, resolve and gain control over personal problems that may be interfering with work and daily life. |
| **Who is eligible?** | All IASIS Healthcare employees and household members are eligible for EAP services. The same services are available to everyone. |
| **What types of problems does the Employee Assistance Program handle?** | Professional counselors speak with you in private about concerns such as, but not limited to:  
marriage/relationship problems  
mental health/stress  
family issues  
legal referrals  
elder care  
financial issues  
alcohol or drug use  
grief issues  
parenting  
work-related issues  
gambling addiction |
| **How do I access the Employee Assistance Program?** | First, call the Employee Assistance Program hotline at 1-855-775-4357, to speak directly with a counselor about your issue. The counselor will assess the situation and provide you with options. The EAP is available 24 hours a day – seven days a week – 365 days a year. Some problems are resolved over the phone, or you may be referred to an ACI Specialty Benefits affiliated counselor in your geographic area. You and the counselor may find that a referral to ongoing counseling, treatment or other help is needed. If so, referral to qualified resources usually occurs in the first contact, or as soon as the problem is assessed. You are entitled to three short term face to face (3) sessions. |
Your EAP also offers a wealth of work-life resources through the Online EAP/Work-Life Resource Portal. You can find articles, podcasts, health and wellness, self assessments, financial and legal tools, eldercare and childcare.

Go to: http://rsli.acieap.com
Log in to myACIonline
Company Code: RSLI859

<table>
<thead>
<tr>
<th>Where are the EAP counseling sites?</th>
<th>The EAP has offices in your community and throughout the country. The counselor you speak with over the phone will help arrange a meeting in an office most convenient for you.</th>
</tr>
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<tbody>
<tr>
<td>Who pays for the Employee Assistance Program?</td>
<td>Your employer has paid for all direct EAP services. There is no cost to you for up to three (3) visits. The EAP is separate from the health insurance plan. If you are referred to resources outside of the EAP, there may be costs for which you or your health insurance plan are responsible. The EAP counselor can help you understand this.</td>
</tr>
<tr>
<td>Why use the Employee Assistance Program?</td>
<td>When you or any of your dependents have a problem, it can affect how you feel and act. Stress can impair your family life and work, but prompt help can restore your well being, both at home and on the job.</td>
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The EAP is confidential to the greatest extent the law allows.

When you need help, call
1-855-775-4357