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

Incorporated 1860 By The Laws of The State of New York

Amendment to Group Policy No. G- 00233673-HC

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

The Policyholder and the Insurance Company hereby agree that Group Policy No. G- 00233673-HC is hereby amended effective January 1, 2017 as follows:

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

THIS IS NOT INSURANCE

Discount Programs

Guardian planholders and covered persons can receive discounts on certain services and supplies from various companies.

These services and supplies are not covered by this plan. The entire discounted price must be paid directly to the company.

When this plan ends, access to these discounts for the planholder and for all covered persons end. When a covered person's coverage under this plan ends, his or her access to the discounts ends.

We reserve the right to change the terms of, or terminate, any of these programs at any time.

Planholders and covered persons will be provided with complete details regarding each program, including: (a) what is discounted, (b) the amount of the discounts; (c) how the discounts can be accessed; and (d) a telephone number to call with questions about the program.

The programs are:

Office Max - Discounts for planholders and covered persons on many office services and supplies.

Dell Computers - Discounts for planholders on computers and related equipment.

Epic Hearing Care - Discounts for planholders and covered persons on hearing exams and hearing aids.

1-800-Flowers - Discounts for planholders and covered persons on many floral products.

GP-1-VAP-07 P119.0004

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

Incorporated 1860 by the Laws of the State of New York

EMPLOYER RIDER

Group Policy Number: G-00233673-HC

Policyholder: Trustees of the Professional and Technical Services Industry Insurance Trust Fund

Participating Employer: TOWN OF CONCORD

Rider Effective Date: June 1, 1987

It is hereby agreed that the provisions which follow are added to the group policy, for the Participating Employer named above:

(A) Definitions:

(1) **"We", "us", "our"** and **"Guardian"** mean The Guardian Life Insurance Company of America.

(2) **"You"** and **"your"** mean the Participating Employer named above.

(3) **"Plan"** means the Guardian plan of group insurance you purchased.

(4) **"Policy Anniversary"** means December 1st , of each year, starting in 1999.

(B) Premium Payments: The first premium payment for this plan is due on the Rider Effective Date. Further payments are due on the the 1st of each month day of each month thereafter, as long as this plan stays in effect.

There is a 31 day grace period for all payments except the first. We must receive all payments within 31 days of the applicable premium due date. If we don't, this plan will automatically end at the end of the grace period. And you will owe us all unpaid premiums for the period this plan was in force.

(C-1) Term of Rider - Renewal Privilege: This rider is issued for an initial term which starts on the Rider Effective Date and ends on the day before the first policy anniversary date.

You can renew this rider for further one year terms on each policy anniversary, subject to all of the terms of the group policy and this rider. But we have the right to cancel this rider, or any coverage hereunder, on any policy anniversary date or premium due date, if, on that date, either:

(1) less than ten employees are insured under this Rider; or

(2) less than 75% of those employees who are eligible for insurance under this rider are insured.

If this rider also provides dependents coverage, we can cancel that coverage on any policy anniversary date or premium due date, if, on that date, less than 75% of those employees eligible for such dependents coverage are insured.

And, if we give you 31 days advance written notice, we may, as of the first day of any policy month, change the premium rates we charge for this plan.

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

(C-2) Incontestability: The group policy shall be incontestable after two years from its date of issue except for non-payment of premiums. With respect to a Participating Employer, this rider shall be incontestable based on statements made in the application after two years from the Rider Effective Date.

A covered person's insurance under this plan shall be incontestable after two years from his or her effective date, except for violation by the covered person of the conditions, if any, of this plan relative to military or naval service.

If this plan replaces the group plan of another insurer, we may rescind the Participating Employer's plan based on misrepresentations made in an employee's or the Participating Employer's signed application for up to two years from the Rider Effective Date.

(D) Associated Companies: An associated company is a firm affiliated with you through common ownership or control.

If you ask us in writing to include such a firm under this plan, and we give you our written approval, we'll treat employees of that firm like your employees. Our written approval will include the starting date of the firm's coverage by this plan. But each eligible employee of that firm must still meet all of the terms and conditions of this plan before he'll be insured.

You must notify us in writing when a firm stops being associated with you. On the date a firm stops being an associated company, this plan will end for all of that firm's employees, except those employed by you or another covered associated company as active full-time eligible employees on such date.

SCHEDULE OF INSURANCE AND PREMIUM RATES

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

Class Description

Class 0001 ALL ELIGIBLE EMPLOYEES

GP-1-SI P130.1566

Option Packages Available

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

GP-1-SI P130.1710

Members of Class 0001 may choose from benefit option packages A.

GP-1-SI P130.1568

Summary of Option Packages

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

GP-1-SI P130.1585

Option A Employee and Dependent Dental with benefits for preventive services paid at a rate of 100%, basic services paid at a rate of 100% and major services paid at a rate of 60%. A benefit year deductible of $50.00 applies to the services. A lower level of benefits is paid if the covered person does not use the services of a preferred provider.

GP-1-SI P130.1835

GP-1-SI *P130.9303*

Option A

Cash Deductible

PPO Benefit Year Cash Deductible for Non-Orthodontic Services:

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

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

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

GP-1-SI P130.1446

Option A

Payment Rates

Payment Rate for Services Furnished By A Preferred Provider:

Group 1 Services 100%
Group 2 Services 100%
Group 3 Services 60%

Payment Rate for Services **Not** Furnished By A Preferred Provider:

Group 1 Services 100%
Group 2 Services 80%
Group 3 Services 50%

GP-1-SI P130.1381

Option A

Payment Limits

Benefit Year Payment Limit
for Non-Orthodontic 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.

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

GP-1-SI P130.4987

GP-1-SI *P130.3343*

Option A

Changes in Insurance Amounts

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

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

- in the case of an Eligible Dependent confined to a hospital, on the day on which the dependent is discharged from the hospital (or the day on which his benefit period terminates, whichever is later).

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

GP-1-SI P130.9324

Schedule of Premium Rates

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

GP-1-SI P130.9260

Option A Premium Rates

Dental Expense Insurance

GP-1-SI *P130.2834*

Option A Class 0001

Rate per Employee with no Insured Dependents	per Insured Family (excluding Employee)
$ 50.84	$ 93.40

GP-1-SI P130.1539

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

GP-1-SI P130.9298

Option A

A specimen copy of the master group policy provisions which apply to the plan of insurance for the participating employer named on the first page of this rider, is attached hereto and incorporated herein. The originals of such provisions are part of the master group policy which was delivered in the State of Rhode Island to BankNewport (Trustee) as Policyholder.

GP-1-SI P130.0508

Option A

If this plan of insurance includes major medical, dental or prescription drug coverages, these coverages provide benefits for employees and dependents.

GP-1-SI P130.0516

Option A

This rider shall form a part of the group policy. You, the policyholder and the Guardian are all subject to all of the terms and conditions contained in the group policy and this rider.

Dated at Bethlehem, PA This 13th Day of February , 2017

The Guardian Life Insurance Company of America

Stuart J Shaw

Vice President, Risk Mgt. & Chief Actuary

GP-1-SI P130.9049

This is a specimen copy of master group policy provisions which apply to this plan of insurance. The originals of these provisions are part of a master group policy delivered to the Trustee as Policyholder in the State of Rhode Island.

Option A

Trustees. The term "trustees" shall mean BankNewport.

Participating Employers - Eligible Employer. An Eligible Employer may become a Participating Employer by filing, through the Trustees, with the Home Office of the Insurance Company an agreement executed by the employer adopting the terms of the Trust Agreement and by receiving the Insurance Company's approval, in writing, of its inclusion as a Participating Employer. The date the employer becomes a Participating Employer shall be stated in the Employer Rider pertaining to such Employer. "Employer Rider" as used any place in this Policy shall mean each separate rider or riders, attached to and forming part of this Policy, identifying and specifically applying to each employer who is a Participating Employer under this Policy and which contains details of the plan of insurance pertaining to the employees of each such Participating Employer.

"Eligible Employer" as used above shall mean any employer engaged in the industry covered under this Policy.

Participation Date. The date as of which an Employer becomes a Participating Employer is referred to herein as the Participation Date with respect to such Employer and its Employees.

Employees Eligible. Those employees identified in the Employee Riders are eligible for insurance under this Policy for the insurance coverages specified therein.

Termination of Employee Coverage. An Employee's insurance on behalf of himself under this Policy shall automatically terminate:

(1) If his employment terminates.

(2) If he ceases to be a member of the classes of employees eligible for the insurance.

(3) If this Policy terminates.

(4) If this Policy is discontinued with respect to the Employees of his Participating Employer.

Termination of employment shall be deemed to occur when the Employee ceases active service on a full-time basis with his Participating Employer, except to the extent this requirement is modified in the Employer Rider pertaining to each Participating Employer.

Schedule of Insurance and Premium Rates:

Schedule. This Group Policy, together with any amendments thereto, contains all the insurance coverages which may be provided by the Employer Rider. The insurance benefits, and the amount thereof, for which the employee is eligible under this Policy on behalf of himself, and on behalf of his dependents if they are covered under this Policy, shall be in accordance with the provisions of the Employer Rider pertaining to each Participating Employer. The classification of each individual Employee shall be determined by the Policyholder from time to time without discrimination among persons in like circumstance, and such determination shall be final and conclusive.

Option A

Premiums: Premiums under this Policy are due and payable, as specified on the first page of this Policy, by the Policyholder at an office of the Insurance Company or to an authorized representative. By mutual agreement between the Policyholder and the Insurance Company the interval of payment may be changed, with appropriate adjustment to provide for payment annually, semi-annually, quarterly, or monthly.

The premium due under this Policy on each premium due date shall be the sum of the premium charges for the insurance coverages provided for Participating Employers under this Policy and shall be based upon the rates set forth in the Employer Riders, provided that (a) on the first anniversary of any such Rider and on the

first day of any month thereafter, and (b) on any date the extent of coverage for a Participating Employer under any such Rider is changed by amendment to this Policy, or to such Rider, the Insurance Company may, by advance written notice to the Policyholder, change the rates at which further premiums due for the Insurance provided under such Rider shall be computed. Such change shall apply to premiums due on and after the effective date of the change stated in such notice. The Insurance Company, however, shall not have the right to change the rates under (a) above more than once during any twelve consecutive months, with respect to an Employer Rider.

Adjustment of Premiums Payable Other Than Monthly or Quarterly: If under the foregoing provisions, a premium rate is changed, (or if under the provision "Computation of Group Life Insurance Premiums", an average premium rate is changed) after an annual or semi-annual premium became payable with respect to coverage on or after the date of such change, such premium shall be adjusted by a proportionate increase or decrease for such unexpired period for which such premium became payable. If the adjustment results in a decrease in such premium which became payable the amount of the decrease for such unexpired period shall be payable to the Policyholder by the Insurance Company. If the adjustment results in an increase in such premium which became payable the amount of the increase for such unexpired period shall be considered a premium due on the date of such change, and the Policy provisions concerning grace period shall apply thereto.

Liability of Trustees to Pay Premiums: The Trustees (the Policyholder hereunder) shall be exempt from personal liability with respect to the premiums required by this Policy to be paid by them, but shall be liable for such premiums only in their fiduciary capacity.

Grace in Payment of Premiums - Termination of Policy: A grace period of thirty-one days, without interest charge, will be allowed the Policyholder for the payment of the premium due under this Policy on any due date except the first. If any premium with respect to the Employees of any Participating Employer is not paid before the expiration of the grace period, this Policy shall automatically terminate with respect to all Employees of such Participating Employer at the expiration of the grace period, except that if the Policyholder shall have given the Insurance Company written notice in advance of an earlier date of termination during the grace period, this Policy shall terminate with respect to all Employees of such Participating Employer as of such earlier date. The Policyholder shall be liable to the Insurance Company for all unpaid premiums with respect to the Employees of a Participating Employer for the period (including a pro-rata premium for the grace period or fraction thereof) during which this Policy was in force with respect to such Employees.

This Policy shall terminate immediately upon termination of an insurance coverage under this Policy if, as the result of the termination of such coverage, no benefits remain in effect under this Policy.

Term of Policy and Employer Riders - Renewal Privilege: This Policy is issued for a term of one (1) year from its effective date. All Policy years and Policy months shall be calculated from the effective date. All periods of insurance under the Employer Riders shall begin and end at 12:01 A.M. Standard Time at the Policyholder’s place of business.

The Policyholder may renew this Policy for a further term of one (1) year, on the first and each successive anniversary of its effective date; provided, however, that the Insurance Company has the right to: (A) decline to renew this Policy on any anniversary, and (B) to decline to renew a particular insurance coverage on the first anniversary, or on any premium due date thereafter, if with regard to (A) the number of Employees insured under this Policy, or with regard to (B) the number of Employees insured for such Coverage, shall be less than twenty-five. If, in accordance with the preceding paragraph, the Policy is not renewed, all Employer Riders shall thereupon terminate as of the date the Policy terminates. Subject to the foregoing, the renewability of the insurance provided under an Employer Rider shall be in accordance with the provisions of such Rider.

Renewal is conditioned upon payment of the premium then due, computed as provided in the Section entitled "Premiums".

Option A

The Contract: The Policy and any riders or amendments hereto, and the Application of the Participating Employer, a copy of which is attached hereto or endorsed hereon and made a part hereof, constitute the entire contract between the parties.

The Policy may be amended at any time, without the consent of the Employees insured hereunder or any other person having a beneficial interest therein, upon written request made by the Participating Employer and agreed to by the Insurance Company, but any such amendment shall be without prejudice to any claims arising prior to the date of the change. No agent is authorized to alter or amend this Policy, to waive any conditions or restrictions contained herein, to extend the time for paying a premium, or to bind the Insurance Company by making any promise or representation or by giving or receiving any information. No change in this Policy shall be valid unless evidenced by an endorsement or rider hereon signed by the President, a Vice President, a Secretary, the Actuary, an Associate Actuary, an Assistant Secretary or an Assistant Actuary of the Insurance Company, or by an amendment hereto signed by the Policyholder and by one of the aforesaid officers of the Insurance Company.

Wherever in this Policy a personal pronoun in the masculine gender is used or appears, it shall be taken to include the feminine also, unless the context clearly indicates the contrary.

Incontestability: This Policy shall be incontestable after two years from its date of issue except for non-payment of premiums. With respect to a Participating Employer, the policy shall be incontestable based on statements made in the application after two years from the Employer Rider Effective Date.

With respect to the insurance on an Employee and/or his eligible dependents, their insurance shall be incontestable after two years from his effective date, except for violation by the Employee of the conditions, if any, of this Policy relative to military or naval service.

Clerical Error - Misstatements: Neither clerical error by the Policyholder, a Participating Employer, or by the Insurance Company in keeping any records pertaining to insurance under this Policy, nor delays in making entries thereon, shall invalidate insurance otherwise validly in force or continue insurance otherwise validly terminated, but upon discovery of such error or delay an equitable adjustment of premiums shall be made.

If the age of an employee, or any other relevant facts, be found to have been misstated, and the premiums are thereby affected, an equitable adjustment of premiums shall be made, and if such misstatement affects the existence on the amount of insurance, the true facts shall be used in determining whether insurance is in force under the terms of this Policy and in what amount.

Statements: No statements shall avoid the insurance under this Policy, or be used in defense of a claim hereunder unless in the case of the Participating Employer, it is contained in the Application for this Policy, signed by him and in the case of an Employee, it is contained in a written request or application signed by him and a copy of which has been furnished to him or to his beneficiary.

All statements shall be deemed representations and not warranties.

Employee’s Certificate: The Insurance Company will issue to the Participating Employer, for delivery to each Employee insured hereunder, a copy of his application and certificate booklet which shall state the essential features of the insurance to which the Employee is entitled and to whom the benefits are payable, and in case of group life insurance, the provisions of the section "Conversion Privilege." Any such certificate shall not constitute a part of this Policy and shall in no way modify any of the terms and conditions set forth in this Policy.

In the event this Policy is amended by changes which affect the description of the essential features of the insurance contained in an Employee’s Certificate, a rider or revised certificate reflecting such changes will be issued to the Policyholder for delivery to the Employee.

This is a specimen copy of master group policy provisions which apply to this plan of insurance. The originals of these provisions are part of a master group policy delivered to the Trustee as Policyholder in the State of Rhode Island.

Option A

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

Any dividend under this Policy shall be paid to the Policyholder in cash, or at the option of the Policyholder it may be applied to the reduction of the premiums then due.

If the dividends under this Policy should be in excess of the Policyholder's cost of insurance, such excess shall be applied for the sole benefit of the Employees.

Payment of any dividend to the Policyholder shall completely discharge the liability of the Insurance Company with respect to the dividend so paid.

Assignment: The right of the Insured Employee to assign any interest under this policy shall be governed as follows:

(1) With respect to Group Term Life Insurance (Including Employee Basic Term Life Insurance and Employee Supplemental Term Life Insurance if provided under the Policy), the Insured Employee may, subject to the following conditions, assign all rights or interest of every kind which he now has, or hereafter may acquire, in such insurance, including, but not limited to, those stated under the applicable provisions in this Policy entitled "BENEFICIARY", "CONVERSION PRIVILEGE" and "OPTIONAL MODES OF SETTLEMENT", provided (a) such assignment be irrevocable and absolute in form, for no value, with the Insured Employee retaining no further interest in such insurance; and (b) the assignment be made to only ONE of the following: the spouse, child or grandchild, parent or grandparent, brother or sister of the Insured Employee, or the trustee of a trust established for the benefit of one or more of these.

(2) With respect to Accident and Health Insurance, neither the Insured Employee's certificate nor the right to insurance benefits hereunder is assignable, except that the benefits, if any, payable for hospital, surgical or medical expense may be assigned to the institution or person providing the service on account of which such benefits become payable.

The Insurance Company shall not be charged with notice of any assignment of interest under this Policy until the original assignment has been accepted and if filed with it at its Home Office. However, the Insurance Company assumes no responsibility for the validity or effect of any such assignment and its position with respect thereto is not altered by filing or recording the same, save as to notice thereof.

Records - Information to be Furnished: The Policyholder shall keep a record of Employees insured, containing, for each Employee, the essential particulars of the insurance. The Policyholder shall, as prescribed by the Insurance Company, periodically forward to the Insurance Company, on the Insurance Company's forms, such information concerning the Employees eligible for insurance under this Policy as may reasonably be considered to have a bearing on the administration of the insurance under this Policy and on the determination of premium rates, and any other information which the Insurance Company may reasonably require with regard to any matters pertaining to this Policy. Any records of the Policyholder, or of the Participating Employers, as may have a bearing on the insurance under this Policy shall be open for inspection by the Insurance Company at any reasonable time.

Claims of Creditors: Except so far as may be contrary to the laws of any state having jurisdiction in the premises, the insurance and other benefits under this Policy shall be exempt from execution, attachment, garnishment, or other legal or equitable process, for the debts or liabilities of the Employees or their beneficiaries.

Assignment by Trustees or Participating Employers: Assignment or transfer of the interest of the Policyholder or of any Participating Employer under this Policy shall not bind the Insurance Company without its written consent thereto.

This is a specimen copy of master group policy provisions which apply to this plan of insurance. The originals of these provisions are part of a master group policy delivered to the Trustee as Policyholder in the State of Rhode Island.

Option A

ATTACHED TO AND MADE PART OF GROUP INSURANCE POLICY NO. G -00233673-HC

issued by

The Guardian Life Insurance Company of America

to

Trustees of the Professional and Technical Services Industry Insurance Trust Fund
with respect to
TOWN OF CONCORD

As of June 1, 1987, this rider amends this Policy as follows:

(1) The following provisions of this Policy are hereby deleted and replaced by the revised corresponding provisions set forth below.

Premiums

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

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

However, we may change such rates:

- on the first day of any policy month;
- on any date the extent or terms of coverage for a participating Employer are changed by amendment of this Policy, or of the Employer Rider;
- on any date our obligation under this Policy with respect to a participating Employer is changed because of statutory or other regulatory requirements; or
- on any date our obligation under an Employer Rider is changed because of a change in the benefits: (a) with which the benefits provided by an Employer Rider are coordinated; or (b) which are supplemented by the benefits provided by an employer rider.

We must give the Participating Employer 31 days written notice of the rate change. Such change will apply to any premium due on and after the effective date of the change stated in such notice.

Adjustment of Premiums Payable Other Than Monthly or Quarterly

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

This is a specimen copy of master group policy provisions which apply to this plan of insurance. The originals of these provisions are part of a master group policy delivered to the Trustee as Policyholder in the State of Rhode Island.

Option A

Incontestability

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

A Participating Employer's insurance under this Policy shall be incontestable after two years from his Rider Effective Date, except for nonpayment of premiums.

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

If the Participating Employer's group plan replaces the group plan he had with another insurer, we may rescind his plan based on misrepresentations made by the Participating Employer or a covered person in a signed application for up to two years from the Rider Effective Date.

GP-1-A-GP-90-2 P150.0005

Option A

The Contract

The entire contract between the Guardian and the Participating Employer consists of this Policy and any amendments thereto which pertain to his plan of insurance, including the Participating Employer's Employer Rider, and the Participating Employer's application, a copy of which is attached hereto or endorsed hereon.

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

We can amend this Policy or an Employer Rider:

- upon written request made by the Participating Employer and agreed to by The Guardian;
- on any date our obligation under this Policy with respect to a Participating Employer is changed because of statutory or other regulatory requirements; or
- on any date our obligation under an Employer Rider is changed because of a change in the benefits: (a) with which the benefits provided by an Employer Rider are coordinated; or (b) which are supplemented by the benefits provided by an Employer Rider.

If we amend the Policy or an Employer Rider, except upon request made by the Participating Employer, we must give the Participating Employer written notice of such amendment.

Any amendments to this Policy or an Employer Rider will be without prejudice to any claim arising prior to the date of the change.

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

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

This is a specimen copy of master group policy provisions which apply to this plan of insurance. The originals of these provisions are part of a master group policy delivered to the Trustee as Policyholder in the State of Rhode Island.

Clerical Error - Misstatements

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

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

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

Statements

No statement will avoid the insurance under this Policy, or be used in defense of a claim hereunder unless:

- in the case of the Participating Employer, it is contained in the application signed by him; or
- in the case of a covered person, it is contained in a written instrument signed by him.

All statements will be deemed representations and not warranties.

GP-1-A-GP-90-3 P150.0154

Option A

Assignment

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

- No death benefits (including any basic term life, supplemental term life, optional term life or accidental death and dismemberment coverages) provided by this Policy, may be assigned.
- With respect to accident and health insurance, neither the employee's certificate nor his right to insurance benefits under this Policy are assignable. The employee may direct us, in writing, to pay hospital, surgical, major medical, or dental benefits to the recognized provider who provided the covered service for which benefits became payable. We may honor such direction at our option. But, such a direction is not considered an assignment of benefits and the employee may not assign his right to take legal action under this Policy to such provider. And we assume no responsibility as to the validity or effect of any such direction.

GP-1-A-GP-90-4 P150.0013

Option A

Records - Information To Be Furnished

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

(2) The following provisions are hereby added to this Policy:

Accident and Health Claims Provisions

An employee's right to make a claim under this Policy for any accident and health benefits provided under an Employer Rider, is governed as follows:

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

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

If an Employer Rider provides weekly loss of time benefits, the employee must send us written proof of loss within 90 days of the end of each period for which we're liable. If an Employer Rider provides long term disability income replacement benefits, the employee must send us written proof of loss within 90 days of the date we request it. For any other loss, the employee must send us written proof of loss within 90 days of the loss.

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

Payment of Benefits: If an Employer Rider provides benefits for loss of income, we'll pay them once every 30 days for as long as we're liable, provided the employee submits periodic written proof of loss as stated above. We'll pay all other accident and health benefits to which the employee is entitled under an Employer Rider as soon as we receive written proof of loss.

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

When an employee files proof of loss, he may direct us, in writing, to pay health care benefits to the recognized provider of health care who provided the covered service for which benefits became payable. But we can't tell the employee that a particular provider provide such care. And the employee may not assign his right to take legal action under this Policy to such provider.

Limitations of Actions: An employee can't bring a legal action against this Policy until 60 days from the date he files proof of loss. And he can't bring legal action against this Policy after three years from the date he files proof of loss.

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

This is a specimen copy of master group policy provisions which apply to this plan of insurance. The originals of these provisions are part of a master group policy delivered to the Trustee as Policyholder in the State of Rhode Island.

Option A

Examination and Autopsy

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

(3) As used in this rider:

"Accident and health" means any dental, dismemberment, hospital, long term disability, major medical, out-of-network point-of-service, prescription drug, surgical, or weekly loss-of-time insurance provided under an Employer Rider.

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

"Policy" means the master group policy of insurance.

(4) This Policy's provision entitled "Liability of Trustees to Pay Premiums" is hereby deleted.

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

Dated at _____ This _____ Day of _____ , ____

Trustees of the Professional and Technical Services Industry Insurance Trust Fund
Full or Corporate Name of Policyholder

_____ BY: _____
Witness Signature and Title

The Guardian Life Insurance Company of America

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

GP-1-A-GP-90-6 P150.0009

Option A

COORDINATION BETWEEN CONTINUATION SECTIONS

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

(a) start at the same time;

(b) run concurrently; and

(c) end independently, on their own terms.

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

(a) will not be entitled to duplicate benefits; and

(b) will not be subject to the premium requirements of more than one section at the same time.

GP-1-R-COC-87 P240.0038

Option A

AN IMPORTANT NOTICE ABOUT CONTINUATION RIGHTS

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

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

(b) the section applies to the employee.

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

Option A

Federal Continuation Rights

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

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

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

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

If an Employee's Group Health Benefits End: If an employee's group health benefits end due to his or her termination of employment or reduction of work hours, he or she may elect to continue such benefits for up to 18 months, if he or she was not terminated due to gross misconduct.

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

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

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

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

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

GP-1-R-COBRA-96-1 P235.0393

Option A

If an Employee Dies While Insured: If an employee dies while insured, any qualified continuee whose group health benefits would otherwise end may elect to continue such benefits. The continuation can last for up to 36 months, subject to "When Continuation Ends".

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

Option A

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

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

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

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

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

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

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

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

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

Option A

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

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

Upon receipt of notice of a qualifying event from an employer or from a qualified continuee, the plan administrator must notify a qualified continuee of the right to continue this plan's group health benefits no later than 14 days after receipt of notice.

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

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

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

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

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

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

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

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

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

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

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

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

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

(4) the date you cease to provide any group health plan to any employee;

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

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

(7) the date, after the date of election, he or she becomes entitled to Medicare.

Option A

Uniformed Services Continuation Rights

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

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

Coverage under this plan may be continued while the employee is in the military for up to a maximum period of 24 months beginning on the date of absence from work. Continued coverage will end if the employee fails to return to work in a timely manner after military service ends as provided under USERRA. You must provide the employee with details about this continuation provision including required premium payments.

Option A

CONTINUATION RIGHTS

A covered person's right to continue his coverage under this plan is governed as follows.

When Employees and Their Dependents Can Continue

If An Employee Leaves The Group: An employee who leaves the group covered by this plan will remain insured for all group benefits provided by this plan, except for group term life insurance, until the earlier of:

- the end of a 31 day period which starts on the day the employee's group benefits would otherwise end; or
- the date he becomes eligible for similar benefits.

Such employee's then insured dependents will also remain insured for such group benefits for the same time period the employee remains insured. But the dependents must remain eligible dependents, as defined in this plan.

If An Employee Is Laid Off: If an employee is involuntarily laid off from his employment for reasons other than a plant closing, the employee can elect to continue any hospital, surgical, or major medical expense benefits for which he is insured under this plan. He may not continue any other coverages. If the employee elects, this continuation may also cover his then insured dependents.

An employee and his then insured dependents can continue such benefits until the earliest of the following:

- the end of a 39 week period which starts on the date the employee's group benefits would otherwise end;
- the date he or his insured dependents become eligible under another group plan;
- the expiration of a period not longer than the period during which he was most recently insured under the group plan;
- the date the group plan ends, or is amended to end benefits for the class of employees to which the employee belongs;
- the end of the period for which the last premium payment was made; or
- with respect to each insured dependent, the date he is no longer an eligible dependent, as defined in this plan.

If An Employee's Plant Closes: If an employee is involuntarily laid off from his employment due to a plant closing or a covered partial plant closing as defined by Massachusetts state law, the employee may continue any hospital, surgical, or major medical expense benefits for which he is insured under this plan. He may not continue any other coverages. If the employee chooses, this continuation may also cover his then insured dependents.

The employee and his insured dependents can continue such benefits until the earliest of the following:

- the date the employee or his insured dependents become eligible under another plan;
- the end of the period for which the last premium payment was made;
- with respect to each of his insured dependents, the date he is no longer an eligible dependent as defined in this plan; or
- 90 days from the date this continuation started.

If An Employee's Marriage Ends: Unless the court judgment so provides to the contrary, in case of divorce or legal separation, subject to payment of premium, your insured former spouse remains eligible for any hospital, surgical, major medical or dental coverages for which he is insured by this plan. The continuation will cover the former spouse and any of the employee's dependent children whose group benefits would otherwise end.

The former spouse or dependent child can continue his benefits until the earliest of the following:

- the end of the period specified in the court judgement;
- the date of remarriage of either the employee or the employee's former spouse, unless the court judgement provides that, subject to payment of premiums, the former spouse has the right to continue to receive coverage after the employee's remarriage.
- the date the group plan ends, or is amended to end benefits for the class of employees to which the employee belongs;
- the end of the period for which the last premium payment is made; or
- the date he is no longer an eligible dependent, as defined in this plan, for reasons other than the marriage ending.

If The Employee Dies While Insured: If an employee dies while insured, his then insured surviving spouse and insured dependent children may elect to continue some of this plan's group benefits for up to 39 weeks as follows.

The continuation period: (a) will be limited to any hospital, surgical, or major medical coverages provided by this plan; (b) will be subject to a monthly premium, as explained in "The Premium" below; and (c) will end on the first of the following:

- the end of a 39 week period which starts on the date the dependent's group benefits would otherwise end;
- the date the dependent becomes eligible for similar group health benefits under another group plan;
- the expiration of a period not longer than the period during which the dependent was most recently insured under the group plan;
- the date the group plan ends, or is amended to end benefits for the class of employees to which the employee belongs;
- the end of the period for which the last premium payment was made; or
- the date a dependent is no longer an eligible dependent, as defined in this plan.

Option A

How Employees and Their Dependents Elect Continuation

Your Responsibilities: You must notify a laid off employee, a surviving dependent, or a divorced spouse, in writing, of:

- his right to continue specified group benefits;
- the monthly premium, if any, he must pay to continue the group benefits; and
- the time and manner in which premium payments must be made.

You must notify such person within seven days of the event which would otherwise cause his coverage to end.

Election of Continuation: With the exception of a divorced spouse, in order to continue this plan's benefits as described above, the covered person must give you written notice of his election to continue. And he must pay you the first month's premium. This must be done within 31 days of the date he receives the notice of continuation rights from you. If the covered person fails to do this, he waives his continuation rights.

The Premium: The monthly premium for continued coverage will be the total rate which would have been charged had the covered person stayed insured by the group plan on a regular basis.

With respect to an employee who continues upon leaving the group or losing his employment due to a total or partial plant closing, the monthly premium must be paid by you and the employee in the shares in which it was paid prior to the plant closing.

With respect to an employee who continues upon involuntary lay off, the total monthly premium amount must be paid by the employee.

With respect to a surviving dependent, the total monthly premium amount must be paid by the dependent.

With respect to a divorced or separated spouse, the total monthly premium amount must be paid by the employee.

All premium payments required of a covered person must be made at the times and in the manner you specify. Failure to pay any required premiums to you results in the termination of the covered person's continued group benefits.

Your Liability: You are liable to the same extent as, and in place of, us, if:

- you fail to notify the covered person of his continuation rights on time, as described above; or
- you fail to remit a covered person's timely premium payment to us on time, thereby causing the covered person's group benefits to end.

Multiple Continuations: A covered person may be eligible to continue his group benefits under more than one of the above sections at the same time. If he elects to continue under more than one section, or continuation is automatically provided, the continuations will be provided as follows:

If a covered person is eligible for the first 31 day continuation described in "If An Employee Leaves The Group," this continuation precedes any other continuations for which an employee may be eligible.

If an employee is eligible for, and elects to continue up to, 39 weeks as described in "If An Employee Is Laid Off," this continuation runs subsequent to any other continuations for which he may be eligible.

Conversion: If an insured employee remarries and the former spouse's continued group health benefits end, then the former spouse can convert to an individual health policy. And at the end of any other continuation provided under this provision, conversion rights, if any, to which an employee or his insured dependents may

be entitled, will be available. Read "Converting This Group Health Insurance" to find out if conversion is allowed under this plan, and how it works.

Option A

ELIGIBILITY FOR DENTAL COVERAGE

P489.0005

Option A

EMPLOYEE COVERAGE

Eligible Employees

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

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

Conditions of Eligibility

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

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

Option A

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

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

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

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

(c) divorce;

(d) death of his or her spouse; or

(e) termination of the other plan.

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

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

Option A

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

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

Option A

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

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

Option A for Class 0001

When Employee Coverage Starts

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

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

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

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

GP-1-EC-90-6.0 P180.0969

Option A for Class 0001

When Employee Coverage Ends

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

- the date an employee's active full-time service ends for any reason other than disability. Such reasons include death, retirement, lay-off, leave of absence, and the end of employment.
- the date an employee stops being an eligible employee under this plan.
- the date the group plan ends, or is discontinued for a class of employees to which the employee belongs.
- the last day of the period for which required payments are made for the employee.

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

GP-1-EC-90-8.0 P489.0024

Option A for Class 0001

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

- If an employee's active service ends because he is disabled you may continue his insurance subject to all of the terms of this plan.
- If an employee's active service ends because he goes on a leave of absence or is laid off, you may continue his insurance for the rest of the policy month in which the leave or layoff starts, plus 1 more full policy month(s). However, if the employee joins any armed force before this period ends, you may continue his insurance until the date he becomes a member of such armed force.
- If you continue an employee's benefits under this plan as set forth above, it must be based on a plan which prevents individual selection by you.
- And, any such continuation is subject to the payment of premiums, and to all of the other terms and conditions of this plan.
- The amount of an employee's insurance during any such continuation will be the amount in force on his last day of active service, subject to any reductions that would have otherwise applied if he had remained an active employee.

GP-1-EC-90-7.0 P489.0002

Option A

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

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

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

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

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

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

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

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

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

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

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

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

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

Option A

Definitions

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

Option A

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

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

Option A

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

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

Class 0001

Full-time means the employee regularly works at least the number of hours in the normal work week set by the employer (but not less than 20 hours per week), at his employer's place of business.

GP-1-EC-90-DEF-4 P180.0493

Option A

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

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

Option A

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

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

Option A

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

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

Option A

Dependent Coverage

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

Option A

Eligible Dependents For Dependent Dental Benefits: An employee's eligible dependents are: (a) his or her legal spouse; (b) his or her unmarried dependent children who are under age 23; and (c) his or her unmarried dependent children, from age 23 until their 25th birthday, who are enrolled as full-time students at accredited schools.

GP-1-DEP-90-2.0 P200.0528

Option A

Adopted Children, Step-Children and Foster Children: An employee's "unmarried dependent children" include his or her legally adopted children, foster children for whom petitions to adopt have been filed; and, if they depend on the employee for most of their support and maintenance, his or her step-children. We treat a child as legally adopted: (a) from the date the child is placed in the employee's home for the purpose of adoption; or (b) in the case of a foster child, from the date of the filing of the petition to adopt. We treat such children this way whether or not a final adoption order is ever issued.

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

GP-1-DEP-90-3.0 P489.0167

Option A

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

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

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

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

GP-1-DEP-90-4.0 P489.0030

Option A

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

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

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

(c) divorce;

(d) death of his or her spouse; or

(e) termination of the other plan.

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

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

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

Option A for Class 0001

When Dependent Coverage Starts: In order for an employee's dependent coverage to begin he or she must already be insured for employee coverage or enroll for employee and dependent coverage at the same time. Subject to the "Exception" stated below and to all of the terms of this plan, the date an employee's dependent coverage starts depends on when he or she elects to enroll his or her initial dependents and agrees to make any required payments.

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

If the employee does this within the enrollment period, the coverage is scheduled to start on the later of the date the employee signs the enrollment form; and the date the employee becomes insured for employee coverage.

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

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

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

GP-1-DEP-90-6.0 P489.0068

Option A

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

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

Option A

Newborn Children: We cover an employee's or a covered dependent's newborn child for dependent benefits, from the moment of birth if, within 31 days of the child's birth, the employee: (a) notifies us of the birth; or (b) submits a claim for payment of benefits on behalf of the child.

If the employee enrolls the newborn child more than 31 days after the child's birth, 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 the employee signs the enrollment form.

GP-1-DEP-90-8.0 P489.0091

Option A

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

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

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

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

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

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

GP-1-DEP-90-9.0 P489.0050

Option A

Definitions

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

Option A

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

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

Option A

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

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

Option A

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

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

Option A

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

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

Option A

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

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

Option A

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

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

Option A

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

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

Option A

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

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

Option A

DENTAL EXPENSE INSURANCE

P497.0867

Option A

This insurance will pay many of an employee's and his covered dependent's dental expenses. What we pay and the terms for payment are explained below.

GP-1-DNTL-90-1 P490.0036

Option A

DentalGuard Preferred - This Plan's Dental Preferred Provider Organization

This plan is designed to provide high quality dental care while controlling the cost of such care. To do this, the plan encourages a covered person to seek dental care from dentists and dental care facilities that belong to DentalGuard Preferred, a dental preferred provider organization (PPO).

This dental PPO is made up of preferred providers in the covered person's geographic area. A "dental preferred provider" is a dental practitioner or a dental facility that: (a) is a current member of the DentalGuard Preferred; and (b) has a participatory agreement in force with us.

Use of the dental PPO is voluntary. A covered person may receive dental treatment from any dental provider he chooses. And, he is free to change providers anytime. But, this plan usually pays more in benefits for covered treatment furnished by a preferred provider. Conversely, it usually pays less for covered treatment not furnished by a preferred provider.

When a covered person enrolls in this plan, he gets a dental plan ID card and information about current dental preferred providers. When he goes to a preferred provider, the covered person must present his ID card. Most preferred providers prepare necessary claim forms for the covered person, and submit the forms to us. We send the covered person an explanation of this plan's benefit payments.

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

The covered person can call The Guardian Group Claim Office if he has any questions after reading this material.

GP-1-DENT-PPO-AZ P497.0391

Option A

Covered Charges

Covered charges are reasonable and customary charges for the dental services named in the List of Covered Dental Services.

By reasonable, we mean the charge is the dentist's usual charge for the service furnished. But if more than one type of service can be used to treat a dental condition, we have the right to consider charges for the least expensive one which meets the accepted standards of dental practice. By customary, we mean the charge made for the given dental condition isn't more than the usual charge made by most other dentists with similar training and experience in the same geographic area.

We only pay for covered charges incurred by a covered person while he's insured. A covered charge for a crown, bridge or cast restoration is incurred on the date the tooth is prepared. A covered charge for any other prosthetic device is incurred on the date the master impression is made. A covered charge for root canal treatment is incurred on the date the pulp chamber is opened. All other covered charges are incurred on the date the services are furnished.

GP-1-DNTL-90-3 P490.0103

Option A

Pre-Treatment Review

When the expected cost of a proposed course of treatment is $300.00 or more, the covered person's dentist must send us a treatment plan before he starts. This must be done on a form acceptable to the 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. Dental X-rays, study models and whatever else we need to evaluate the treatment plan must be sent to us, too.

We review the treatment plan and estimate what we will pay. The estimate will be sent to the covered person's dentist. If we don't agree with a treatment plan, or if one is not sent in, we have the right to base our payments on treatment suited to the covered person's condition by accepted standards of dental practice.

Pre-treatment review is not a guarantee of what we will pay. It tells the covered person and his dentist, in advance, what we would pay for the covered dental services named in the treatment plan. But payment is conditioned on: (a) the work being done as proposed and while the covered person is insured; and (b) the deductible and payment limit provisions and all of the other terms of this plan.

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

GP-1-DNTL-90-4 P490.0104

Option A

APPEAL AND GRIEVANCE PROCESS

Definitions

Adverse decision means a utilization review determination that a proposed or delivered dental service which would otherwise be covered, is not or was not medically necessary, appropriate or efficient, resulting in non-coverage of the service. An adverse decision does not include a decision about a covered person's status as an insured.

Grievance means a written protest filed by a covered person, or his or her dentist, regarding an adverse decision.

Emergency means a situation where a covered person's dentist believes that the services are necessary to treat a condition that without immediate attention would seriously jeopardize: (a) the life or health of the covered person; or (b) his or her ability to regain maximum function.

Note: Covered persons who require emergency care may call the local pre- hospital emergency medical service system by dialing 911, or its local equivalent. No covered person will be denied coverage as a result of such use of emergency care.

Appeals and Grievances

Claim Review

If a claim is denied in whole or in part, a covered person or his or her dentist may appeal by writing to us at the address shown below.

The Guardian Life Insurance Company of America

Grievance Department
PO Box 2457
Spokane, WA 99210-2457
fax#: 509-468-6399

A decision and written notice will be completed within 30 working days of receipt of all documentation necessary to complete our review of the appeal. Written notice will be sent to the covered person and his or her dentist, if the claim is assigned or the dentist is a preferred provider. If the claim is not assigned, or the dentist is not a preferred provider, we will send notice to the covered person only.

Utilization Review

Within 30 working days of receipt of all necessary information, we will send written notice of an initial adverse decision, via US Mail, to the covered person and his or her dentist, if the claim is assigned or the dentist is a preferred provider. If the claim is not assigned, or the dentist is not a preferred provider, we will send notice to the covered person only. The notice will state the specific factual basis for the denial and specific criteria the adverse decision was based on.

Only a licensed dentist will render an adverse decision. In the case of an emergency, a covered person or his or her dentist may file an expedited request for a utilization review decision.

A covered person or his or her dentist may initiate a grievance of an adverse decision by writing to:

The Guardian Life Insurance Company of America

Grievance Department
PO Box 2457
Spokane, WA 99210-2457

fax#: 509-468-6399

A decision regarding a grievance of an adverse decision and written notice will be completed within 30 working days of receipt of all documentation necessary to complete the review. The notice of the decision will be sent, via US Mail, to the covered person and his or her dentist, if the claim is assigned or the dentist is a preferred provider. If the claim is not assigned, or the dentist is not a preferred provider, we will send notice to the covered person only. The notice will include the factual basis and specific criteria the decision was based on.

If sufficient information to complete the grievance process is not received with the filing, the covered person and his or her dentist will be notified, via US Mail, what information is required. If the information requested to complete our review is not received, the covered person and his or her dentist will be notified, via US Mail, that the grievance has been denied. Upon receipt of the requested information Guardian will reopen the grievance.

A grievance will be reviewed by a different dentist than the one who rendered the initial adverse decision. That dentist will be licensed in the same or similar specialty as the service being reviewed,.

In the case of an emergency request, the covered person and his or her dentist will receive oral notification of the decision, via telephone, within 24 hours of receipt of all necessary documentation to review the request. Written notice will be sent, via US Mail, within one working day of notice of the oral decision.

Accessibility

Guardian's Customer Response Unit Member Specialists are accessible by toll free number, 1-800-541-7846, not less than 40 hours per week during normal business hours to provide information and allow responses to phone requests.

The Customer Response Unit, Member Specialists are available from 6:00 a.m. to 6:00 p.m. Pacific Time. Telephone calls received during other than normal business hours will be provided instructions.

Guardian offers onsite interpreters for Spanish speaking insureds. An interpretation service is utilized for all other languages.

GP-1-R-DGRV-MA-06 P498.2881

Option A

Benefits From Other Sources

This plan supplements the medical plan you provide for your employees, if any.

This plan, and your medical plan, if any, may provide benefits for the same charges. If they do, we subtract what your medical plan, if any, pays from what we'd otherwise pay.

Other plans may furnish similar benefits, too. For instance, an employee may be covered by this plan and a similar plan through his spouse's employer. If he is, we coordinate our benefits with the benefits from these other plans. We do this so no one gets more in benefits than the charges he incurs. Read "Coordination of Benefits" to see how this works.

GP-1-DNTL-90-5 P497.0950

Option A

The Benefit Provision - Qualifying For Benefits

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 payment rate shown in the schedule.

The benefit year deductibles, shown in the schedule, apply to all Group II and III services. There are different benefit year deductible amounts for services provided by a PPO Provider and a Non-PPO Provider. Each covered person must have covered charges from these service groups which exceed each applicable deductible before we pay him any benefits for such charges. These charges must be incurred while the covered person is insured.

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

Once a covered person meets the deductible, we pay for his Group II and III covered charges above that amount at the payment rates shown in the schedule for the rest of that benefit year. There are different payment rates which apply to covered charges for services from a PPO Provider and a Non-PPO Provider.

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

GP-1-DNTL-92-7 P497.0054

Option A

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

GP-1-DG-ROLL-04-2.1 P498.2168

Option A

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

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

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

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

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

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

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

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

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

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

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

Definitions of terms used in this provision:

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

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

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

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

GP-1-DG-ROLL-04-2 P497.2135

Option A

Family Deductible Limit For Non-Orthodontic Services: No family must meet more than three benefit year deductibles in any benefit year. Once this happens, we pay for covered charges incurred by any covered person, at the payment rate shown in the schedule, for the rest of that benefit year. But the charges must be incurred while insured. And what we pay is subject to the benefit year payment limit shown in the schedule and to all of the other terms of this plan.

GP-1-DNTL-90-9 P490.0136

Option A

Emergency Care

If a covered person receives emergency care, as defined below, and cannot reasonably reach a preferred provider, payment for such care will be made at the same level and in the same manner as if the covered person had been treated by a preferred provider.

"Emergency care" means covered services provided after the sudden onset of a medical condition manifesting itself by acute symptoms, including severe pain, which are severe enough that the lack of immediate medical attention could reasonably be expected to result in:

(a) placing the patient's health in serious jeopardy;
(b) serious impairment of bodily functions; or
(c) serious dysfunction of any bodily organ or part.

GP-1-DNTL-93-MA P497.0437

Option A

After This Insurance Ends

We won't pay for charges incurred after this insurance ends. But we pay for the following if all work is finished in the 31 days after this insurance ends: (a) a crown, bridge or cast restoration, if the tooth is prepared before the insurance ends; (b) any other prosthetic device, if the master impression is made before the insurance ends; and (c) root canal treatment, if the pulp chamber is opened before the insurance ends.

GP-1-DNTL-90-10 P490.0139

Option A

Special Limitations

Penalty For Late Entrants: We won't cover charges incurred by a late entrant for: (1) Group II services until 6 months from the date he is insured by this plan; and (2) Group III services until 12 months from the date he is insured by this plan. However, this limitation will not apply to covered charges due solely to an injury suffered while insured.

Charges not covered due to this provision are not considered covered dental services and cannot be used to satisfy this plan's deductibles.

A late entrant is a person who: (1) becomes insured more than 31 days after he is eligible; or (2) becomes insured again, after his coverage lapsed because he did not make required payments.

GP-1-DNTL-90-11.0 P490.0141

Option A

Teeth Lost Before A Covered Person Became Insured By This Plan: A covered person may have lost one or more teeth before he became insured by this plan. Except as explained below, we won't pay for a prosthetic device which replaces such teeth unless the device also replaces one or more natural teeth lost or extracted after the covered person became insured by this plan.

If This Plan Replaces Another Plan: This plan may be replacing another plan you had with some other insurer.

We don't want anyone to lose benefits when this happens. So we pay for certain charges incurred before this plan starts, if: (1) the covered person was insured by the old plan; and (2) the old plan would have paid for such charges. But this plan must start right after the old plan ends. And the covered person must be insured by this plan from the start.

We limit what we pay to the lesser of: (1) what the old plan would have paid; or (2) what we would otherwise pay. And we deduct any benefits actually paid by the old plan under any extension provision.

In the first benefit year of this plan, we also reduce this plan's deductibles by the amount of covered charges applied against the old plan's deductible. And, in the first benefit year, we charge benefits which were paid by the old plan against this plan's payment limits.

GP-1-DNTL-90-11.1 P490.0053

Option A

Exclusions

- We won't pay for: (1) oral hygiene, plaque control or diet instruction; or (2) precision attachments.
- We won't pay for: (1) treatment which does not meet accepted standards of dental practice; or (2) treatment which is experimental in nature.
- We won't pay for orthodontic treatment.
- We won't pay for any appliance or prosthetic device used to: (1) change vertical dimension; (2) restore or maintain occlusion, except to the extent that this plan covers orthodontic treatment; (3) splint or stabilize teeth for periodontic reasons; (4) replace tooth structure lost as a result of abrasion or attrition; and (5) treat disturbances of the temporomandibular joint.
- We won't pay for any service furnished for cosmetic reasons. This includes, but is not limited to: (1) characterizing and personalizing prosthetic devices; and (2) making facings on prosthetic devices for any teeth in back of the second bicuspid.
- We won't pay for replacing an appliance or prosthetic device with a like appliance or device, unless (1) it is at least five years old and can't be made usable; or (2) it is damaged while in the covered person's mouth in an injury suffered while insured, and can't be fixed.
- We won't pay for: (1) replacing a lost, stolen or missing appliance or prosthetic device; or (2) making a spare appliance or device.
- We won't pay for 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.
- We won't pay for 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 government body. But if a charge is made and we are legally required to pay it, we will.

GP-1-DNTL-90-12 P490.0047

Option A

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 three groups. A separate payment rate applies to each group. Group I is made up of preventive services. Group II is made up of basic services. Group III is made up of major services.

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

GP-1-DNTL-90-13 P490.0147

Option A

Group I - Preventive Dental Services

(Non-Orthodontic)

Prophylaxis and Fluoride Treatments:

- Prophylaxis (limited to one treatment in any six consecutive month period) - Allowance includes examination, scaling and polishing.
- Topical application of fluoride (limited to covered persons under age 18 and limited to one treatment in any six consecutive month period) - Allowance includes examination and prophylaxis.

Space Maintainers: (limited to covered persons under age 16 and limited to initial appliance only) - Allowance includes all adjustments in the first six months after installation.

- Fixed, unilateral, band or stainless steel crown type.
- Fixed, unilateral, cast type.
- Removal, bilateral type.

Fixed and Removable Appliances To Inhibit Thumbsucking and Other Harmful Habits: (limited to covered persons under age 16 and limited to initial appliance only) - Allowance includes all adjustments in the first six months after installation.

Diagnostic Services: Allowance includes examination and diagnosis.

- X-rays.
    - Full mouth series of at least 14 films including bitewings, if needed (limited to once in any 36 consecutive month period).
    - Bitewing films (limited to a maximum of four films in any six consecutive month period).
    - Other intraoral periapical or occlusal films - single films.
    - Extraoral superior or inferior maxillary film.
    - Panoramic film, maxilla and mandible (limited to once in any 36 consecutive month period).

Dental Sealants:

- Limited to the unrestored permanent molars of covered persons under age 16 and limited to one treatment in any 36 consecutive month period.

Office Visits and Examinations:

- Initial or periodic oral examination (limited to one examination in any six consecutive month period).
- Emergency palliative treatment and other non-routine, unscheduled visits.

Option A

Group II - Basic Dental Services

(Non-Orthodontic)

Office Visits and Examinations:

- Diagnostic consultation with a dentist other than the one providing treatment (limited to one consultation for each dental specialty in any 12 consecutive month period) - We pay for this only if no other service is rendered during the visit.

Diagnostic Services: Allowance includes examination and diagnosis.

- Diagnostic casts.
- Biopsy and examination of oral tissue.

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

- Amalgam restorations.
    - Synthetic restorations.
        - Silicate cement.
        - Acrylic or plastic.
        - Composite resin.
    - Crowns.
        - Acrylic or plastic, without metal.
        - Stainless steel.
    - Pins.
        - Pin retention, exclusive of restorative material.
    - Recementation.
        - Inlay or onlay.
        - Crown.
        - Bridge.

Endodontic Services: Allowance includes routine x-rays and cultures, but excludes final restoration.

- Pulp capping, direct.
- Remineralization (Calcium Hydroxide), as a separate procedure.
- Vital pulpotomy.
- Apexification.
- Root canal therapy on non-vital (nerve-dead) teeth.
    - Traditional therapy.
    - Medicated paste therapy, N2 Sargenti.
- Apicoectomy, as a separate procedure or in conjunction with other endodontic procedures.

Periodontic Services: Allowance includes the treatment plan, local anesthetics and post-surgical care.

- Gingivectomy or gingivoplasty, per quadrant.
- Gingivectomy, per tooth (fewer than 6 teeth).
- Sub-gingival curettage and root planing, per quadrant (limited to a maximum of 4 quadrants in any 12 consecutive month period).
- Pedicle or free soft tissue grafts, including donor sites.
- Osseous surgery, including flap entry and closure, per quadrant.
- Osseous grafts, including flap entry, closure and donor sites.
- Muco-gingival surgery.
- Occlusal adjustment, not involving restorations and done in conjunction with periodontic surgery, per quadrant (limited to a maximum of 4 quadrants in any 12 consecutive month period).

Oral Surgery: Allowance includes routine x-rays, the treatment plan, local anesthetics and post-surgical care.

- Extractions.
    - Uncomplicated extraction, one or more teeth.
    - Surgical removal of erupted teeth, involving tissue flap and bone removal.
    - Surgical removal of impacted teeth.

Other Surgical Procedures:

- Alveolectomy, per quadrant.
- Stomatoplasty with ridge extension, per arch.
- Removal of mandibular tori, per quadrant.
- Excision of hyperplastic tissue.
- Excision of pericoronal gingiva, per tooth.
- Removal of palatal torus.
- Removal of cyst or tumor.
- Incision and drainage of abscess.
- Closure of oral fistula or maxillary sinus.
- Reimplantation of tooth.
- Frenectomy.
- Suture of soft tissue injury.
- Sialolithotomy for removal of salivary calculus.
- Closure of salivary fistula.
- Dilation of salivary duct.
- Sequestrectomy for osteomyelitis or bone abscess, superficial.
- Maxillary sinusotomy for removal of tooth fragment or foreign body.

Prosthodontic Services: specialized techniques and characterization are not covered. Also see "Major Prosthodontic Services".

- Denture repairs, acrylic.
    - Repairing dentures, no teeth damaged.
    - Repairing dentures and replace one or more broken teeth.
    - Replacing one or more broken teeth, no other damage.
- Denture repairs, metal - Allowance based on the extent and nature of damage and on the type of materials involved.
- Denture duplication, jump case (limited to once per denture in any 36 consecutive month period).
- Denture reline (limited to once per denture in any 12 consecutive month period).
    - Office reline, cold cure.
    - Laboratory reline.
- Denture adjustments (limited to adjustments by a dentist other than the one providing the denture, and adjustments are more than 6 months after the initial installation).
- Tissue conditioning (limited to a maximum of 2 treatments per arch in any 12 consecutive month period).
- Adding teeth to partial dentures to replace extracted natural teeth.
- Repairs to crowns and bridges - Allowance based on the extent and nature of damage and the type of materials involved.

Other Services:

- General anesthesia in connection with surgical procedures only.
- Injectable antibiotics needed solely for treatment of a dental condition.

Option A

Group III - Major Dental Services

(Non-Orthodontic)

Restorative Services: Cast restorations and crowns are covered only when needed because of decay or injury, and only when the tooth cannot be restored with a routine filling material. Also see "Basic Restorative Services".

- Inlays.
- Onlays, in addition to inlay allowance.
- Crowns and Posts.
    - Acrylic with metal.
    - Porcelain.
    - Porcelain with metal.
    - Full cast metal (other than stainless steel).
    - 3/4 cast metal (other than stainless steel).
    - Cast post and core, in addition to crown (not a thimble coping).
    - Steel post and composite or amalgam core, in addition to crown.
    - Cast dowel pin (one-piece cast with crown) - Allowance based on type of crown.

Prosthodontic Services: Specialized technique and characterizations are not covered.

- Fixed bridges - Each abutment and each pontic makes up a unit in a bridge.
- Bridge abutments - See inlays and crowns under "Major Restorative Services".
- Bridge Pontics.
    - Cast metal, sanitary.
    - Plastic or porcelain with metal.
    - Slotted facing.
    - Slotted pontic.
- Simple stress breakers, per unit.
- Removable bridges, unilateral partial, one piece chrome casting, clasp attachment, including pontics.
- Dentures - Allowance includes all adjustments done by the dentist furnishing the denture in the first 6 months after installation.
    - Full dentures, upper or lower.
    - Partial dentures - Allowance includes base, all clasps, Rests and teeth.
    - Upper, with two chrome clasps with rests, acrylic base.
    - Upper, with chrome palatal bar and clasps, acrylic base.
    - Lower, with two chrome clasps with rests, acrylic base.
    - Lower, with chrome lingual bar and clasps, acrylic base.
    - Stayplate base, upper or lower (anterior teeth only).

Implant supported prosthetics - Allowance includes the treatmen 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 edentulou 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 arc
- 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 extracte 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 onc 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

Option A

Definitions

As used in this dental plan, the following terms are defined as follows.

Appliance means any dental device other than a prosthetic device.

GP-1-R-DDEF-90-1 P490.0070

Option A

Benefit Year, with respect to this plan's dental expense insurance, means a 12 month period which starts on January 1st and ends on December 31st of each year.

GP-1-R-DDEF-90-2 P497.0046

Option A

Close Relative means: (a) a covered person's spouse, children, parents, brothers and sisters; and (b) any other person who is part of a covered person's household. We don't pay for services and supplies furnished by close relatives.

GP-1-R-DDEF-90-3 P490.0072

Option A

Covered Person, with respect to this plan's dental expense insurance, means an employee or any of his covered dependents.

GP-1-R-DDEF-90-4 P490.0073

Option A

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 practices; and (b) provides services which are within the scope of his license or certificate and covered by this plan.

GP-1-R-DDEF-90-5 P490.0075

Option A

Injury means all damage to a covered person's mouth due to an accident, and all complications rising from that damage. But the term injury does not include damage to teeth, appliances or prosthetic devices which results from chewing or biting food or other substances.

GP-1-R-DDEF-90-6 P490.0076

Option A

Orthodontic Treatment means the movement of one or more teeth by the use of active appliances. It includes: (a) diagnostic services; (b) the treatment plan; (c) the fitting, making and placement of an active appliance; and (d) all related office visits, including post-treatment stabilization. This plan does not pay for orthodontic treatment.

GP-1-R-DDEF-90-7 P490.0077

Option A

Plan means the Guardian group dental expense insurance plan you purchased.

GP-1-R-DDEF-90-8 P490.0079

Option A

Prosthetic Device means a device which is used to replace missing or lost teeth or tooth structure. It includes all types of dentures, crowns, bridges, pontics and cast restorations.

GP-1-R-DDEF-90-10 P490.0081

Option A

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

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

GP-1-DDEF-92-3 P490.0110

Option A

DISCOUNT - THIS IS NOT INSURANCE

Discounts on Dental Services Not Covered By This Plan

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

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

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

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

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

P499.0076

Option A

Discounts on Services Not Covered Due To Contractual Provisions

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

- Meeting the plan's benefit year payment limit provision;
- Frequency limitations; or

P499.0078-R

Option A

Discounts on Orthodontic Services

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

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

Discounted fees are not available for:

- Incremental charges for orthodontic appliances made with clear, ceramic, white, lingual brackets or other optional materials;
- Procedures, appliances or devices to guide minor tooth movement or to correct harmful habits;
- Retreatment of orthodontic cases, or changes in orthodontic treatment needed due to an accident;

- Extractions performed solely to facilitate orthodontic treatment;
- Orthognathic surgery and associated incremental charges;
- Replacement of lost or broken retainers.

P499.0080

Option A

Employee Vision Discount Program

An employee's eligibility for this vision discount program is contingent upon his or her eligibility for dental coverage under this plan.

If an employee is covered for dental coverage under this plan, he or she is eligible for this vision discount program.

If an employee is not covered under this plan's dental coverage, he or she is not eligible for this vision discount program.

An employee's participation in this vision discount program starts on the later of: (a) the effective date of this program; or (b) the date he or she becomes covered for dental benefits under this plan.

An employee's participation in this vision discount program ends on the earlier of: (a) the date this program ends; or (b) the date he or she is no longer covered for dental benefits under this plan.

GP-1-EC-90-1.0 P506.0002

Option A

Dependent Vision Discount Program

An employee's covered dependent's eligibility for this vision discount program is contingent upon his or her eligibility for dental coverage under this plan.

If a dependent is covered for dental coverage under this plan, he or she is eligible for this vision discount program.

If the dependent is not covered under this plan's dental coverage, he or she is not eligible for this vision discount program.

A dependent's participation in this vision discount program starts on the later of: (a) the effective date of this program; or (b) the date he or she becomes covered for dental benefits under this plan.

The dependent's participation in this vision discount program ends on the earlier of: (a) the date this program ends; or (b) the date he or she is no longer covered for dental benefits under this plan.

GP-1-DEP-90-1.0 P506.0003

Option A

This Is Not Insurance

Discounts on Vision Services and Supplies

A member of this program can receive discounts on vision care services or supplies from a vision provider who is under contract with Vision Service Plan's (VSP's) network, as described below. Discounts are not available from providers who are not members of VSP's network.

The member must pay the entire discounted fee directly to the VSP network doctor. There is no need to file a claim.

A member must make an appointment with a VSP network doctor. To find a VSP network doctor, the member can visit www.vsp.com or call 1-800-877-7195.

When a person is no longer a member of this program, access to the network discounts ends.

The discounts provided by this program are as follows:

Eye Exams - 20% off the VSP doctor's usual charge.

Glasses and Lenses: Discounts are given for an unlimited number of glasses or contact lens professional services visits, as long as the VSP network doctor has provided an eye exam to the member within the last 12 months.

- Standard lenses - 20% off the VSP doctor's usual charge, when a complete set of prescription glasses is purchased.
- Lens options - 20% off the VSP doctor's usual charge for all lens options, such as tints and coatings.
- Frames - 20% off the VSP doctor's usual charge when a complete set of prescription glasses is purchased.
- Elective contact lenses - 15% off the VSP doctor's usual charge for professional services. The lenses are not discounted.

VSP network doctors are not required to extend a discount if they have not provided an eye exam to the patient within the last 12 months.

No discounts will be given for:

- sundry items such as lens cleaners and solutions,
- artistically painted lenses,
- additional office visits associated with contact lens pathology,
- contact lens modification, polishing or cleaning,
- orthoptics or vision training and any associated supplemental testing,
- plano lenses,
- expenses associated with securing materials such as lenses and frames,
- medical or surgical treatment of the eyes except as described in the "Laser Surgery" section below.

Laser Surgery: The discount program provides access to a network of laser surgery centers where members and their dependents can obtain vision laser surgery at a discounted fee. Members save an average of 15% off the laser surgeon's usual charge. And, if the laser center is offering a temporary price reduction, the member will receive 5% off the promotional price if it is less than the usual discounted price.

No one will have to pay more than $1,800 per eye for laser-assisted in-situ keratomileusis (LASIK), and $1,500 per eye for photorefractive keratectomy (PRK), two of the most common procedures.

If a member or a member's dependent is interested in the discount program, he or she must schedule a screening and consultation with a VSP doctor to discuss whether vision laser surgery is an appropriate procedure.

If the member or dependent decides to proceed with the surgery, the doctor will refer him or her to a VSP laser surgeon for further evaluation.

The laser center's fee includes the fee for the initial screening and consultation, the surgery itself and all post-operative care.

If the doctor determines that the member or dependent is an appropriate candidate for the laser surgery, but he or she does not have the surgery performed, he or she must pay the fee for the screening and consultation directly to the VSP network doctor. If the doctor determines that the enrollee or dependent is not an appropriate candidate for laser surgery, no fee is charged for the consultation.

P506.0004

Option A

COORDINATION OF BENEFITS

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

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

Definitions

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

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

(1) If a person is confined in a private hospital room, the difference between the cost of a semi-private room in the hospital and the private room is **not** an allowable expense. This does not apply if: (a) the stay in the private room is medically necessary in terms of generally accepted medical practice; or (b) one of the plans routinely provides coverage for private hospital rooms.

(2) The amount a benefit is reduced by the primary plan because a person does not comply with the plan's provisions is **not** an allowable expense. Examples of these provisions are: (a) precertification of admissions and procedures; (b) continued stay reviews; and (c) preferred provider arrangements.

(3) If a person is covered by two or more plans that compute their benefit payments on the basis of reasonable and customary charges, any amount in excess of the primary plan's reasonable and customary charges for a specific benefit is **not** an allowable expense.

(4) If a person is covered by two or more plans that provide benefits or services on the basis of negotiated fees, an amount in excess of the primary plan's negotiated fees for a specific benefit is **not** an allowable expense.

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

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

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

Coordination Of Benefits: This term means a provision which determines an order in which plans pay their benefits, and which permits secondary plans to reduce their benefits so that the combined benefits of all plans do not exceed total allowable expenses.

Custodial Parent: This term means a parent awarded custody by a court decree. In the absence of a court decree, it is the parent with whom the child resides more than one half of the calendar year without regard to any temporary visitation.

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.

Hospital Indemnity Benefits: This term means benefits provided during hospital confinement on other than an expense incurred basis.

Plan: This term means any of the following that provides benefits or services for health care or treatment: (1) group insurance and group subscriber contracts; (2) uninsured arrangements of group coverage; (3) group 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 automobile contracts to the extent permitted by law; and (7) governmental benefits, except Medicare, as permitted by law.

This term does not include: (a) nongroup coverage, except group-type contracts, hospital indemnity benefits, and medical benefits under automobile contracts, as shown above; (b) amounts of group or group-type hospital indemnity benefits of $100.00 or less per day; (c) student accident type coverage, Qualifying Student Health Insurance Programs, or other student health plans when designated as "excess only" or "always secondary plan"; or (d) Medicare, Medicaid, and coverage under other governmental plans, unless permitted by law.

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

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

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

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

This Plan: This term means the group health benefits, except prescription drug and vision coverage, if any, provided under this group plan.

GP-1-R-COB-05 P555.0182

Option A

Order Of Benefit Determination

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Effect On The Benefits Of This Plan

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

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

Right To Receive And Release Needed Information

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

Facility Of Payment

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

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

Right Of Recovery

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

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

GP-1-R-COB-05 P555.0184

Option A

STATEMENT OF ERISA RIGHTS

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

Receive Information About The Plan and Benefits

(a) Examine, without charge, at the plan administrator's office and at other specified locations, such as worksites and union halls, all documents governing the plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the plan with the U. S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

(b) Obtain, upon written request to the plan administrator, copies of documents governing the operation of the plan, including insurance contracts, collective bargaining agreements and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The administrator may make a reasonable charge for the copies.

(c) Receive a summary of the plan's annual financial report. The plan administrator is required by law to furnish each participant with a copy of this summary annual report.

Continue Group Health Plan Coverage

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

Prudent Actions By Plan Fiduciaries

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

Enforcement Of An Employee's Rights

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

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

Assistance with Questions

If an employee has questions about the plan, he or she should contact the plan administrator. If an employee has questions about this statement or about his or her rights under ERISA, or if the employee needs assistance in obtaining documents from the plan administrator, he or she should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor listed in the telephone directory or the Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington D.C. 20210. An employee may also obtain certain publications about his or her rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

Qualified Medical Child Support Order

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

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

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

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

If an employee has questions about this statement, he or she should see the plan administrator.

P800.0066

Option A

The Guardian's Responsibilities

P800.0037

Option A

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

P800.0041

Option A

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

P800.0038

GROUP HEALTH BENEFITS CLAIMS PROCEDURE

If an employee seeks benefits under the plan he or she should complete, execute and submit a claim form. Claim forms and instructions for filing claims may be obtained from the Plan Administrator.

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

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

Definitions

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

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

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

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

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

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

Timing For Initial Benefit Determination

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Adverse Benefit Determination

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

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

Appeal of Adverse Benefit Determinations

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

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

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

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

In reviewing an appeal, Guardian will

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

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

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

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

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

Alternative Dispute Options

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

P800.0056

* * * * *

The foregoing amendment shall form a part of said Group Policy, provided both the Policyholder and the Insurance Company have hereto applied their respective signatures, and is subject to the agreements and covenants therein contained.

Dated at Bethlehem, PA This 13th Day of February , 2017

Trustees of the Professional and Technical Services Industry Insurance Trust Fund
Full or Corporate Name of Policyholder

_____ BY: _____
Witness Signature and Title

The Guardian Life Insurance Company of America

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

PLEASE RETAIN THIS COPY FOR YOUR RECORDS

GUR-1 P600.9002

END OF POLICY DOCUMENT