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- 00404483-

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

The Policyholder and the Insurance Company hereby agree that Group Policy No. G- 00404483- is hereby amended effective November 1, 2016 as follows:

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

The Guardian Life Insurance Company of America

A Mutual Company - Incorporated 1860 by the State of New York
7 Hanover Square, New York, New York 10004

POLICYHOLDER: OUTSTAFFING, INC.

GROUP POLICY NUMBER	DELIVERED IN	POLICY DATE
G-00404483	Virginia	August 1, 2005

POLICY ANNIVERSARIES: August 1st of each year, beginning in 2006

THE GUARDIAN LIFE INSURANCE COMPANY OF AMERICA (herein called the Insurance Company) in consideration of the Application for this Policy and of the payment of premiums as stated herein, **AGREES** to pay benefits in accordance with and subject to the terms of this Policy.

Premiums are payable by the Policyholder as hereinafter provided. The first premium is due on the Policy Date, and subsequent premiums are, during the continuance of this Policy, due on the 1st of each month

This Policy is delivered in the jurisdiction specified above and is governed by the laws thereof.

The provisions set forth on the following pages are part of this Policy.

This Policy takes effect on the Policy Date specified above.

IN WITNESS WHEREOF, THE GUARDIAN LIFE INSURANCE COMPANY OF AMERICA has caused this Policy to be executed as of November 24, 2016 which is its date of issue.

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

GROUP INSURANCE POLICY
PROVIDING
BENEFITS AS DESCRIBED HEREIN

Dividends Apportioned Annually

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

IMPORTANT INFORMATION REGARDING YOUR INSURANCE

In the event you need to contact someone about this insurance for any reason please contact your agent. If no agent was involved in the sale of this insurance, or if you have additional questions you may contact the insurance company issuing this insurance at the following address and telephone number:

The Guardian Sales Office
6800 Paragon Place, Suite 534
Richmond, VA 23230
Telephone: (804) 289-1000
(800) 695-0891
Fax: (804) 289-1010

If you have been unable to contact or obtain satisfaction from the company or the agent, you may contact:

Virginia State Corporation Commission
Bureau of Insurance
P.O. Box 1157
Richmond, VA 23218
Telephone: (800) 552-7945

Written correspondence is preferable so that a record of your inquiry is maintained. When contacting your agent, company or the Bureau of Insurance, have you policy number available.

If a covered person has a complaint pertaining to the availability, delivery, or quality of health care services including adverse decisions, claims payments, the handling or reimbursement for such service(s), or any other matter, he or she may contact:

Office of Licensure and Certification
Virginia Department of Health
9960 Maryland Drive - Suite 401
Richmond, VA 23233-1463

Telephone: (804) 367-2106 (Richmond Metro Area)
(800) 955-1819

Fax: (804) 527-4503
E-mail: mchip@vdh.virginia.gov

A covered person has the right to file a complaint and will not be penalized for exercising these rights.

GP-1-R-VADISC-97 P120.0064

All Options

NOTICE OF PROTECTION PROVIDED BY VIRGINIA LIFE, ACCIDENT AND SICKNESS INSURANCE GUARANTY ASSOCIATION

This notice provides a **brief summary**of the Virginia Life, Accident and Sickness Insurance Guaranty Association ("the Association") and the protection it provides for policyholders. This safety net was created under Virginia law, which determines who and what is covered and the amounts of coverage.

The Association was established to provide protection in the unlikely event that a life, annuity or health insurance company licensed in the Commonwealth of Virginia becomes financially unable to meet its obligations and is taken over by its Insurance Department. If this should happen, the Association will typically arrange to continue coverage and pay claims, in accordance with Virginia law, with funding from assessments paid by other life and health insurance companies licensed in the Commonwealth of Virginia.

The basic protections provided by the Association are:

- Life Insurance

- $300,000 in death benefits
- $100,000 in cash surrender or withdrawal values

- Health Insurance

- $500,000 in hospital, medical and surgical insurance benefits
- $300,000 in disability income insurance benefits
- $300,000 in long-term care insurance benefits
- $100,000 in other types of health insurance benefits

- Annuities

- $250,000 in withdrawal and cash values

The maximum amount of protection for each individual, regardless of the number of policies or contracts, is $350,000, except for hospital, medical and surgical insurance benefits, for which the limit is increased to $500,000.

Note: Certain policies and contracts may not be covered or fully covered. For example, coverage does not extend to any portion(s) of a policy or contract that the insurer does not guarantee, such as certain investment additions to the account value of a variable life insurance policy or a variable annuity contract. There are also various residency requirements and other limitations under Virginia law.

To learn more about the above protections, please visit the Association's website at www.valifega.org or contact:

VIRGINIA LIFE, ACCIDENT AND SICKNESS
INSURANCE GUARANTY ASSOCIATION
c/o APM Management Services, Inc.
8001 Franklin Farms Drive, Suite 235
Henrico, VA 23229
804-282-2240

STATE CORPORATION COMMISSION
Bureau of Insurance
P.O. Box 1157
Richmond, VA 23218
804-371-9741
Toll Free Virginia only: 1-800-552-7945
http://www.scc.virginia.gov/division/boi/index.htm

Insurance companies and agents are not allowed by Virginia law to use the existence of the Association or its coverage to encourage you to purchase any form of insurance. When selecting an insurance company, you should not rely on Association coverage. If there is any inconsistency between this notice and Virginia law, then Virginia law will control.

GP-1-R-VADISC-11 P120.0066

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 and B.

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 80% and major services paid at a rate of 25%. 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

Employee and Dependent Vision Care Expense Insurance with various copayments for services and supplies from PPO providers, and various deductibles for services and supplies from Non-PPO providers.

GP-1-SI P130.3656

Option B Employee and Dependent Dental with benefits for preventive services paid at a rate of 100%, basic services paid at a rate of 90% 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

Employee and Dependent Vision Care Expense Insurance with various copayments for services and supplies from PPO providers, and various deductibles for services and supplies from Non-PPO providers.

GP-1-SI P130.3656

All Options

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	80%
Group 3 Services	25%

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

Group 1 Services	100%
Group 2 Services	80%
Group 3 Services	0%

GP-1-SI P130.1381

Option B

Payment Rates

Payment Rate for Services Furnished By A Preferred Provider:

Group 1 Services	100%
Group 2 Services	90%
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 . . . . . $ 1,000.00

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

GP-1-SI P130.9318

Option B

Payment Limits

PPO Benefit Year Payment Limit
for Non-Orthodontic Services - up to $2,000.00

Non-PPO 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 P130.4991

All Options

DentalGuard Preferred Plus

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

GP-1-SI P130.9093

All Options

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

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

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

GP-1-SI P130.8676

All Options

PPO Copayments

Examinations $10.00
Standard Frames and/or Standard Lenses $20.00
Necessary Contact Lenses $20.00

All Options

Non-PPO Cash Deductibles

Examinations	$10.00
Standard Frames and/or Standard Lenses	$20.00
Necessary Contact Lenses	$20.00

All Options

Payment Rates

For Covered Charges	100%

All Options

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.

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

All Options — Premium Rates

Dental Expense Insurance

GP-1-SI *P130.2834*

Option A Class 0001

Rate per Employee	per Employee and Insured Spouse with no Insured Child	per Employee and Insured Child(ren) with no Insured Spouse	per Employee and Insured Family
$ 31.34	$ 63.24	$ 70.08	$ 102.05

GP-1-SI P130.1539

Option B Class 0001

Rate per Employee	per Employee and Insured Spouse with no Insured Child	per Employee and Insured Child(ren) with no Insured Spouse	per Employee and Insured Family
$ 57.03	$ 110.89	$ 122.40	$ 176.36

GP-1-SI P130.1539

All Options — Premium Rates

Vision Care Expense Insurance

GP-1-SI *P130.3517*

All Options All Classes

Rate per Employee	per Employee and Insured Spouse with no Insured Child	per Employee and Insured Child(ren) with no Insured Spouse	per Employee and Insured Family
$ 12.52	$ 21.06	$ 21.48	$ 34.00

GP-1-SI P130.3518

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

All Options

GENERAL PROVISIONS

Definitions

As used in this policy:

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

"Plan" means this group insurance policy.

"Covered person" means an employee or dependent insured by this policy.

GP-1-R-GENPRO-90 P140.0136

All Options

Incontestability

This Policy shall be incontestable after two years from its policy date, except for non-payment of premiums.

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

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

GP-1-R-INCY-90 P140.0150

All Options

Associated Companies

An associated company is a corporation or other business entity affiliated with the policyholder through common ownership of stock or assets.

If the policyholder asks us in writing to include an associated company under this policy, and we give our written approval, we'll treat employees of that company like the policyholder's employees. Our written approval will include the starting date of the company's coverage under this policy. But each eligible employee of that company must still meet all of the terms and conditions of this policy before he'll be insured.

The policyholder must notify us in writing when a company stops being associated with him. On the date a company stops being an associated company, this policy will end for all of that company's employees, except those employed by the policyholder or another covered associated company as eligible employees, on such date.

GP-1-R-AC-90 P140.0151

All Options

Premiums

Premiums due under this policy must be paid by the Participating Employer at an office of Guardian or to a representative that we have authorized. The premiums must be paid as specified on the first page of this policy, unless by agreement between the policyholder and 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 this policy. The premium charges are based upon the rates set forth in this policy's "Schedule of Insurance and Premium Rates" section.

However, we may change such rates:

(a) on the first day of any policy month;

(b) on any date the extent or terms of coverage for a policyholder are changed by amendment of this policy;

(c) on any date our obligation under this policy with respect to a policyholder is changed because of statutory or other regulatory requirements; or

(d) if this policy supplements, or coordinates with benefits provided by any other insurer, non-profit hospital or medical service plan, or health maintenance organization, on any date our obligation under this policy is changed because of a change in such other benefits.

We must give the Participating Employer 31 days written notice of the rate change. If the change in premium rates increases the annual premiums by more than thirty-five (35) percent we must give the Participating Employer at least sixty (60) days advance written notice. Such change will apply to any premium due on and after the effective date of the change stated in such notice.

Adjustments of Premiums Payable Other Than Monthly or Quarterly

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

Grace In Payment of Premiums - Termination of Policy

- A grace period of 31 days, without interest charge, will be allowed the policyholder for each premium payment except the first. If any premium is not paid before he end of the grace period, this policy automatically ends at the end of the grace period. However, if the policyholder gives us advance written notice in advance of an earlier termination date during the grace period, this policy will end as of such earlier date.
- If this policy ends during or at the end of the grace period, the policyholder will still owe us premium for all the time this policy was in force during the grace period.

This policy ends immediately on any date when an insurance coverage under this policy ends and, as a result, no benefits remain in effect under this policy.

GP-1-R-PREM-VA-02 P140.0547

All Options

Term of Policy - Renewal Privilege

This policy is issued for a term of one (1) year from the policy date shown on the first page of this policy. All policy years and policy months will be calculated from the policy date. All periods of insurance hereunder will begin and end at 12:01 A.M. Standard Time at the policyholder's place of business.

If this policy provides coverage on a non-contributory basis, 100% of the employees eligible for insurance must be enrolled for coverage. If dependent coverage is provided on a non-contributory basis, all eligible dependents must be enrolled.

The policyholder may renew this policy for a further term of one (1) year, on the first and each subsequent policy anniversary. All renewals are subject to the payment of premiums then due, computed as provided in this policy's "Premiums" section.

However, we have the right to decline to renew this policy, or any coverage hereunder on any policy anniversary or premium due date, if, on that date: (a) less than 10 employees are insured under this policy; or (b) with respect to a non-contributory policy, less than 100% of those employees eligible are insured under this policy; or (c) with respect to a contributory policy, less than 75% of those employees eligible are insured under this policy.

If this policy provides dependents coverage, we may decline to renew such coverage on any policy anniversary or premium due date, if: (a) with respect to a non-contributory policy, less than 100% of all eligible dependents are enrolled for coverage under this policy; or (b) with respect to a contributory policy, less than 75% of those employees eligible for dependents coverage are insured as such.

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

The Contract

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

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

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

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

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

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

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

GP-1-R-TERM-90 P140.0161

All Options

Clerical Error - Misstatements

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

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

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

Statements

No statement will void the insurance under this policy, or be used in defense of a claim hereunder unless: (a) in the case of the policyholder, it is contained in the application signed by him; or (b) in the case of a covered person, it is contained in a written instrument signed by him, a copy of which has been furnished to him or his beneficiary or his personal representative.

All statements will be deemed representations and not warranties.

GP-1-R-CE-90-VA P140.0689

All Options

Assignment

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

- Any death benefits(including any basic term, life, supplemental term life, optional term life or accidental death and dismemberment coverages) provided by this policy, may not be assigned.
- With respect to accident and health insurance, the employee's certificate is not assignable. However, the employee may direct us, in writing, to pay hospital, surgical, major medical, or dental benefits to the recognized provider who provided the covered service for which benefits became payable. We assume no responsibility as to the validity or effect of any such direction.

Assignment By Policyholder

Assignment or transfer of the interest of the policyholder under this policy will not bind us without our written consent thereto.

GP-1-R-ASSIGN-VA-02 P140.0322

All Options

Dividends

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

Any dividend under this policy will be paid to the policyholder in cash, or at the option of the policyholder it may be applied to the reduction of the premiums then due.

In the event that the employees are contributing toward the cost of the coverage under any group policy issued to the policyholder and the aggregate dividends under this policy and any other group policy or policies issued to the policyholder are in excess of the policyholder's share of the aggregate cost, such excess will be applied by the policyholder for the sole benefit of the employees.

Payment of any dividend to the policyholder will completely discharge our liability with respect to the dividend so paid.

GP-1-R-DIV-90 P140.0168

All Options

Employee's Certificate

We will issue to the policyholder, for delivery to each employee insured under this policy, a certificate of coverage. The certificate will state the essential features of the insurance to which the employee is entitled and to whom the benefits are payable. But the certificate does not constitute a part of this policy and will in no way modify any of the terms and conditions set forth in this policy.

In the event this policy is amended, and such amendment affects the material contained in the certificate of coverage, a rider or revised certificate reflecting such amendment will be issued to the policyholder for delivery to affected employees.

Claims of Creditors

Except when prohibited by the laws of the jurisdiction in which this policy was issued, the insurance and other benefits under this policy will be exempt from execution, garnishment, attachment, or other legal or equitable process, for the debts or liabilities of the covered persons or their beneficiaries.

Records - Information To Be Furnished.

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

All Options

Accident and Health Claims Provisions

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

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

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

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

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

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

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

When an employee files proof of loss, he or she 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 an employee that a particular provider must provide such care. And the employee may not assign his or her right to take legal action under this plan to such provider.

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

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

All Options

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

All Options

Federal Continuation Rights

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

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

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

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

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

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

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

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

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

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

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

GP-1-R-COBRA-96-1 P235.0399

All Options

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

All Options

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.

All Options

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.

All Options

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.

All Options

ELIGIBILITY FOR DENTAL COVERAGE

P489.0005

All Options

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

All Options

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

All Options

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

All Options

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

All Options for All Classes

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

All Options for All Classes

When Employee Coverage Ends

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

- the last day of the month in which an employee's active full-time service ends for any reason other than disability. Such reasons include retirement, layoff, leave of absence or the end of employment.
- the date an employee dies.
- the date the group plan ends, or is discontinued for a class of employees to which the employee belongs; or
- the day prior to the last premium due date for which required payments are made for the employee.
- the last day of the month in which an employee stops being an eligible employee under this plan for any reason not named above.

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

GP-1-EC-90-8.0 P489.0006

All Options for All Classes

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

All Options

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

All Options

Definitions

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

All Options

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

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

All Options

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

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

All Classes

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

GP-1-EC-90-DEF-4 P180.0158

All Options

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

All Options

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

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

All Options

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

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

All Options

Dependent Coverage

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

All Options

Eligible Dependents For Dependent Dental Benefits: An employee's eligible dependents are: (a) his or her legal spouse; (b) his or her dependent children who are under age 20; and (c) his or her dependent children, from age 20 until their 26th birthday, who are enrolled as full-time students at accredited schools.

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

GP-1-DEP-90-2.0 P489.0315

All Options

Adopted Children and Step-Children: An employee's "dependent children" include his or her legally adopted children and, if they depend on him or her for most of their support and maintenance, his or her step-children. We treat a child as legally adopted from the time the child is placed in the home for the purpose of adoption. We treat such a child this way whether or not a final adoption order is ever issued.

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

GP-1-DEP-90-3.0 P489.0280

All Options

Handicapped Children: An employee may have a child who is: (i) incapable of self-sustaining employment by reason of intellectual disability or physical handicap; and (ii) chiefly dependent on the employee for support and maintenance. Subject to all of the terms of this coverage and the plan, such a child may stay eligible for dependent benefits past this coverage's age limit.

The child will stay eligible as long as he or she is 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-VA P449.0672

All Options

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

All Options for All Classes

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

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

If the employee does this within the enrollment period, the coverage is scheduled to start on the later of the first of the month which coincides with or next follows the date the employee signs the enrollment form; and the date the employee becomes insured for employee coverage.

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

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

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

GP-1-DEP-90-6.0 P489.0063

All Options

Exception: If a dependent, other than a newborn child, is confined to a hospital or other health care facility; or is unable to carry-out the normal activities of someone of like age and sex on the date his or her dependent benefits would otherwise start, we'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

All Options

Newborn Children: We cover an employee's newborn child for dependent benefits, from the moment of birth if: (a) the employee is already covered for dependent child coverage when the child is born; or (b) the employee enrolls the child and agrees to make any required premium payments within 31 days of the date the child is born. If the employee fails to do this, once the child is enrolled, the child is a late entrant, is subject to any applicable late entrant penalties, and will be covered as of the date the employee signs the enrollment form.

GP-1-DEP-90-8.0 P489.0098

All Options for All Classes

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 coverage's age limit 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 P489.0320

All Options

Definitions

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

All Options

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

All Options

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

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

All Options

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

All Options

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

All Options

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

All Options

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

All Options

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

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

All Options

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

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

All Options

DENTAL EXPENSE INSURANCE

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

GP-1-DG2000 P498.0007

All Options

DentalGuard Preferred - This Plan's Dental Preferred Provider Organization

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

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

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

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

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

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

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

GP-1-DGY2K-PPO P498.0169

All Options

Covered Charges

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

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

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

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

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

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

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

All Options

Complaint & Appeal Process

Definitions

As used in this section:

"Adverse Determination" means a determination by the *utilization review entity* that based upon information provided, a request for a benefit upon application of any utilization review technique does not meet the managed care health insurance plan's requirements for medical necessity, appropriateness, health care setting, level of care, or effectiveness or is determined to be experimental or investigational and the requested benefit is therefore denied, reduced or terminated or payment is not provided or made, in whole or in part, for the benefit.

"Appeal" means a formal request by a covered person or a provider on behalf of a covered person for reconsideration of a determination such as a utilization review recommendation, a benefit payment, an administrative action, or a quality-of-care or service issue.

"Appellant" means: (i) the covered person; (ii) the covered person's parent, guardian, legal custodian, or other individual authorized by law to act on behalf of the covered person, if the covered person is a minor; (iii) the covered person's spouse, parent, committee, legal guardian, or other individual authorized by law to act on behalf of the covered person if the covered person is not a minor but is incompetent or incapacitated; or (iv) the covered person's treating health care provider acting with the consent of the covered person, the covered person's parent, guardian, legal custodian, or other individual authorized by law to act on behalf of the covered person, if the covered person is a minor, or the covered person's spouse, parent, committee, legal guardian, or other individual authorized by law to act on behalf of the covered person, if the covered person is not a minor but is incompetent or incapacitated.

"Complaint" means a written communication primarily expressing a grievance. A complaint may pertain to the availability, delivery, or quality of health care services including *adverse determinations,* claims payments, the handling or reimbursement for such service(s), or any other matter pertaining to the covered person's contractual relationship with the Managed Care Health Insurance Plan (MCHIP).

"Concurrent review" means *utilization review* conducted during a patient's stay or course of treatment in a facility, the office of a health care professional, or other inpatient or outpatient health care setting.

"Final adverse determination" means an *adverse determination* involving a covered benefit that has been upheld by a managed care health insurance plan, or it's designee *utilization review entity,* at the completion of the managed care health insurance plan's internal appeal process.

"Independent review organization" means an organization selected by the Bureau of Insurance that conducts external reviews of *adverse determinations* and *final adverse determinations.*

"Managed care health insurance plan" or *"MCHIP"* means an arrangement for the delivery of health care in which Guardian undertakes to provide, arrange for, pay for, or reimburse any of the costs of health care services for a covered person on a prepaid or insured basis which: i) contains one or more incentive arrangements, including any credentialing requirements intended to influence the cost or level of health care services between the health carrier and one or more providers with respect to the delivery of health care services; and ii) requires or creates benefit payment differential incentives for covered persons to use providers that are directly or indirectly managed, owned, under contract with or employed by the health carrier. For the purposes of this definition, the prohibition of balance billing by a provider shall not be deemed a benefit payment differential incentive for covered persons to use providers who are directly or indirectly managed, owned, under contract with or employed by the health carrier. A single managed care health insurance plan may encompass multiple types of benefit payment differentials; however, a single managed care health insurance plan shall encompass only one provider network or set of provider networks.

"Medically necessary" means appropriate and necessary health care services which are rendered for any condition which, according to generally accepted principles of good medical practice, requires the diagnosis or direct care and treatment of an illness, injury, or pregnancy-related condition, and are not provided only as a convenience.

"Peer of the treating health care provider" means a physician or other health care professional who holds a non-restricted license in the Commonwealth of Virginia or under a comparable licensing law of a state of the United States and in the same or similar specialty as typically manages the medical condition, procedure or treatment under review.

"Physician advisor" means a physician licensed to practice medicine in the Commonwealth of Virginia or under a comparable licensing law of a state of the United States who provides medical advice or information to a private review agent or a *utilization review entity* in connection with its *utilization review* activities.

"Prospective review" means *utilization review* conducted prior to an admission or a course of treatment.

"Retrospective review" means a review of medical necessity conducted after services have been provided to a patient, but does not include the review of a claim that is limited to an evaluation of reimbursement levels, veracity of documentation, accuracy of coding, or adjustment for payment.

"Timely" means the provision of services so as not to impair or jeopardize the integrity of the covered person's diagnosis or outcomes of illness.

"Treating health care provider" or *"Provider"* means:

a) a licensed health care provider who renders or proposes to render health care services to a covered person; and

b) for purposes of this provision, is acting on behalf of the covered person.

"Urgent Care Appeal" means an *appeal* for medical care or treatment with respect to which the application of the time periods for making non-urgent care determinations (i) could seriously jeopardize the life or health of the covered person or the ability of the covered person to regain maximum function; or (ii) in the opinion of the treating health care professional with knowledge of the covered person's medical condition, would subject the covered person to severe pain that cannot be adequately managed without the care or treatment that is the subject of the appeal. an *urgent care appeal* shall not be available for any post-service claim or retrospective adverse determination.

"Utilization Review" means a system for reviewing the necessity, appropriateness and efficiency of hospital, medical or other health care services rendered or proposed to be rendered to a covered person for the purpose of determining whether such services should be covered. Utilization review includes, but is not limited to, preadmission, concurrent and retrospective medical necessity determination, and review related to the appropriateness of the site at which services were or are to be delivered. Utilization review also includes determinations of medical necessity based upon contractual limitations regarding "experimental" or "investigational" procedures, by whatever terms designated in the evidence of coverage. Utilization review does not include any: (i) denial of benefits for a procedure which is explicitly excluded pursuant to the terms of the contract or evidence of coverage; (ii) review of issues concerning contractual restrictions on facilities to be used for the provision of services; or (iii) determination by an insurer as to the reasonableness and necessity of services for the treatment and care of an injury suffered by an insured for which reimbursement is claimed under a contract of insurance covering any other classes of insurance.

"Utilization review entity" or *"entity"* means an insurer or managed care health insurance plan licensee that performs utilization review or upon whose behalf utilization review is performed with regard to the health care or proposed health care that is the subject of the final adverse determination.

All Options

Internal Appeal Procedures

Complaint Process

If a covered person has concerns regarding a quality of care issue, he or she may file a *complaint* as follows:

In Writing: Center for Quality Health Care Services and Consumer Protection
Virginia Department of Health
3600 W. Broad Street Suite 216
Richmond, VA 23230

Telephone: 804-367-2104 (Richmond Metro Area)
800-955-1819

Fax: 804-367-2149
E-mail: mchip@vdh.state.va.us

If a covered person or his or her *treating health care provider* does not agree with a *utilization review* determination, his or her provider may file, within 180 days of receipt of the *determination,* a *complaint* to request reconsideration of the *adverse determination.*

A *complaint* for reconsideration of a *utilization review* determination made by Guardian should be made to:

For Dental Claims

Guardian
Group Quality Assurance-WRO
PO Box 2457
Spokane, WA 99210-2457

The *provider's* written *complaint* requesting reconsideration should provide the *utilization review entity* with any added information which: (a) relates to the case; and (b) may impact on the first determination. A determination on reconsideration will be made by a *physician advisor,* peer of the treating health care provider, or a panel of other appropriate health care providers with at least one *physician advisor* or *peer of the treating health care provider* on the panel.

Resolution of the *complaint,* and written notification of such determination will be provided to the covered person and the *treating health care provider* no later than ten (10) working days after receipt of the *complaint.*

The written notification of such determination will include the criteria used and the clinical reason for the *adverse determination,* and, if any, the alternate length of treatment of the alternate treatment setting(s) that the *utilization review entity* deems to be appropriate.

If the reconsideration results in a *final adverse determination,* the covered person, his or her *provider,* or a representative of the covered person may *appeal* the *final adverse determination.*

Appeals of Adverse Determinations

Except as explained below for an urgent care appeal, a covered person, his or her *treating health care provider,* or a representative of the covered person may make a written request for an *appeal* of an *adverse determination* or a *final adverse determination* made by the *utilization review entity.*

For Dental Claims

Guardian
Group Quality Assurance-WRO
PO Box 2457
Spokane, WA 99210-2457

The request for *appeal* of a determination should provide the *utilization review entity* with any additional evidence for consideration (e.g., pertinent medical records of the covered person's *provider,* the pertinent records of any facility in which health care is provided to the covered person, etc.).

Any information provided to the *utilization review entity* to support an *appeal* will be reviewed by a *physician advisor* or a peer of the *treating health care provider.* With the exception of expedited appeals, a *physician advisor* must be:

a) a *peer of the treating health care provider* who proposes the care under review or who was primarily responsible for the care under review;

b) board certified; and

c) specialized in a discipline pertinent to the issue under review.

A *physician advisor* or *peer of the treating health care provider* who renders a decision on *appeal* must:

a) not have participated in the adverse decision or any prior reconsideration thereof;

b) not be employed by or be a director of the *utilization review entity;* and

c) be licensed to practice in Virginia, or under a comparable licensing law of a state of the United States, as a *peer of the treating health care provider.*

In the appeals process, consideration will be given to the availability or non-availability of alternative health care services proposed by the *utilization review entity.*

Except for *urgent care appeals,* written notification of the results of the *appeal* process will be provided to the covered person, his or her *treating health care provider,* or the representative of the covered person who filed the *appeal.* Notification for *prospective reviews* will be provided no later than thirty (30) working days after receiving all required documentation. Notification for *retrospective reviews* will be no later than sixty (60) working days after receiving all required documentation. Notification for *concurrent care reviews* will be provided sufficiently in advance of a reduction or termination of a benefit after receipt of the claim to allow the *appellant* to *appeal* and obtain a determination on review before the benefit is reduced or terminated but in no case will this be less than thirty (30) working days after receiving all required documentation. The notification of all decisions will state the criteria used and the clinical reason for the decision.

Urgent Care Appeals of Adverse Determinations

When the *treating health care provider* believes that an *adverse determination* or adverse reconsideration warrants an immediate *appeal,* the *treating health care provider* shall have the opportunity to *appeal* on an urgent care basis.

An *urgent care appeal* may be requested only when the regular reconsideration and *appeals* process would delay the rendering of health care in a manner that would be detrimental to the health of the covered person. Both the *utilization review entity* and the *treating health care provider* must attempt to share the maximum information by telephone, facsimile machine, or otherwise to resolve the *urgent care appeal* in a satisfactory manner.

A written or oral *appeal* for urgent care reconsideration of an *adverse determination* or a *final adverse determination* made by Guardian should be made to:

For Dental Claims

Guardian
Group Quality Assurance-WRO
PO Box 2457
Spokane, WA 99210-2457
Phone: 1-800-541-7846
Fax: 1-509-468-6399

If additional information is needed to make a determination, the *appellant* will be notified of the specified information needed as soon as possible but not later than twenty-four (24) hours after receipt of the request for appeal. Such notice will be provided orally or, if requested by the *appellant,* it shall be provided in writing and shall state what specified information is needed. The *appellant* must provide the requested information within forty-eight (48) hours.

Any decision of an *urgent care appeal* must be made by a *physician advisor, peer of the treating health care provider,* or a panel of other appropriate health care providers with at least one *physician advisor* on the panel. A decision on a prospective *urgent care appeal* will be made by the *utilization review entity* no later than seventy-two (72) hours after receipt by the *utilization review entity* of all information necessary to make such a determination. A decision on an concurrent *urgent care appeal* will be made by the *utilization review entity* no later than seventy-two (72) hours after receipt by the *utilization review entity* of all information necessary to make such a determination, but the request to continue treatment must be received at least twenty-four (24) hours prior to the expiration of the prescribed period of time or number of treatments.

An *urgent care appeal* determination may be further appealed through the *utilization review entity's* standard appeal process If:

a) all material information and documentation was not reasonably available to the provider and to the *utilization review entity* at the time of the *expedited review appeal;*

b) the *physician advisor* reviewing the case under an *urgent care review appeal:* i) was not a *peer of the treating health care provider;* and ii) was not board certified or board eligible, and specialized in a discipline pertinent to the issue under review.

If the review of an *urgent care appeal by a utilization review entity* results in a *final adverse determination,* the *utilization review entity* will immediately notify the person who requested the *urgent* care appeal of the *final adverse determination.*

GP-1-C&A.2-VA-12 P498.9049

All Options

Consumer Assistance

If you have any questions regarding an appeal or grievance concerning the health care services that you have been provided that have not been satisfactorily addressed by your plan, you may contact the Office of the Managed Care Ombudsman for assistance.

The Office of the Managed Care Ombudsman is charged with protecting the interests of *covered persons* under *MCHIP's* in the Commonwealth of Virginia. For purposes of this plan, the Office of The Managed Care Ombudsman must:

1) assist *covered persons* in understanding their rights and the processes available to them according to their *managed care health insurance plan;*

2) answer inquiries from *covered persons,* their *treating health care providers,* and any representative of the *covered person* received via telephone, mail, electronic mail or in person;

3) provide to *covered persons,* their *treating health care providers,* and any representative of the *covered person* information concerning *managed health care insurance plans* and other *utilization review entities* upon request;

4) upon request, assist *covered persons* in using the procedures and processes available to them from their *managed care health insurance plan,* including all *utilization review appeals.* Such assistance may require the review of insurance and health care records of a covered person, which shall be done only with the express written consent of the *covered person.* The confidentiality of all such information shall be maintained in accordance with the laws of the Commonwealth of Virginia.

5) ensure that *covered persons* have access to the services provided through the Office and that the *covered persons* receive timely responses from the representatives of the Office to the inquiries.

The address, telephone number, or E-mail address shown below should be used in order to obtain assistance with any questions regarding an *appeal* or *complaint* concerning the health care services provided which have not been satisfactorily addressed by the *utilization review entity.*

Address: Office of the Managed Care Ombudsman
Bureau of Insurance
P.O. Box 1157
Richmond, Virginia 23218

Telephone: 1-877-310-6560 toll-free
1-804-371-9032 in the Richmond Metropolitan Area

Ombudsman E-mail: ombudsman@scc.virginia.gov

Bureau of Insurance Website: www.scc.virginia.gov

GP-1-C&A.3-VA-14 P490.0217

All Options

Alternate Treatment

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

Proof of Claim

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

GP-1-DGY2K-AT P498.0002

All Options

Pre-Treatment Review

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

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

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

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

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

GP-1-DGY2K-PTR P498.0004

All Options

Benefits From Other Sources

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

GP-1-DGY2K-OS P498.0005

All Options

The Benefit Provision - Qualifying For Benefits

GP-1-DGY2K-BEN P498.0084

All Options

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

- All Group II Services.

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

- All Group III Services.

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

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

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

GP-1-DGY2K-LE P498.0245

All Options

How *We* Pay Benefits For Group I, II and III Non-Orthodontic Services: There is no deductible for Group I services. *We* pay for Group I covered charges at the applicable *payment rate.*

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

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

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

GP-1-DGY2K-BP P498.0195

Option A

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

GP-1-DGY2K-BP P498.0210

Option B

All covered charges must be incurred while insured. And what *we* pay is subject to the *benefit year payment limit* shown in the schedule and to all of the terms of this *plan.* There are different *benefit year payment limits* which apply to benefits paid for the services of a *preferred provider* and a *non preferred provider.*

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

GP-1-DGY2K-BP P498.0209

Option B

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 B

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 P498.9356

All Options

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

GP-1-DGY2K-FL P498.0085

Option A

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

- Benefits for Group I Services performed by a *preferred provider* 100%
- Benefits for Group I Services performed by a *non-preferred provider* 100%
- Benefits for Group II Services performed by a *preferred provider* 80%
- Benefits for Group II Services performed by a *non-preferred provider* 80%
- Benefits for Group III Services performed by a *preferred provider* 25%

- Benefits for Group III Services performed by a *non-preferred provider* . . . . . none

GP-1-DGY2K-PR P498.0090

Option B

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

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

GP-1-DGY2K-PR P498.0090

All Options

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

GP-1-DGY2K-END P498.0138

Special Limitations

GP-1-DGY2K-LMT P498.0140

All Options

Teeth Lost, Extracted or Missing Before A *Covered Person* Becomes Covered By This *Plan:* A *covered person* may have one or more congenitally missing teeth or may have had one or more teeth lost or extracted before he or she became covered by this *plan. We* won't pay for a *dental prosthesis* which replaces such teeth unless the *dental prosthesis* also replaces one or more eligible natural teeth lost or extracted after the *covered person* became covered by this *plan.*

GP-1-DGY2K-TL P498.0149

All Options

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

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

All Options

Exclusions

We will not pay for:

- Any service or supply which is not specifically listed in this *plan's* List of Covered Dental Services.
- Any procedure performed in conjunction with, as part of, or related to a procedure which is not covered by this *plan.*
- Educational services, including, but not limited to, oral hygiene instruction, plaque control, tobacco counseling or diet instruction.
- Precision attachments and the replacement of part of a precision attachment, magnetic retention or overdenture attachments.
- Overdentures and related services, including root canal therapy on teeth supporting an overdenture.
- Any restoration, procedure, *appliance* or *prosthetic device* used solely to: (1) alter vertical dimension; (2) restore or maintain occlusion, except to the extent that this *plan* covers *orthodontic treatment;* (3) treat a condition necessitated by attrition or abrasion; or (4) splint or stabilize teeth for periodontal reasons.
- The use of general anesthesia, intramuscular sedation, intravenous sedation, non-intravenous sedation or inhalation sedation, including but not limited to nitrous oxide, except when administered in conjunction with covered periodontal surgery, surgical extractions, the surgical removal of impacted teeth, apicoectomies, root amputations and services listed under the "Other Oral Surgical Procedures" section of this *plan.*
- The use of local anesthetic.
- Cephalometric radiographs, oral/facial images, including traditional photographs and images obtained by intraoral camera, except when performed as part of the *orthodontic treatment* plan and records for a covered course of *orthodontic treatment.*
- Replacement of a lost, missing or stolen *appliance* or *dental prosthesis* or the fabrication of a spare *appliance* or *dental prosthesis.*
- Prescription medication.
- Desensitizing medicaments and desensitizing resins for cervical and/or root surface.
- Duplication of radiographs, the completion of claim forms, OSHA or other infection control charges.

- Pulp vitality tests or caries susceptibility tests.
- Bite registration or bite analysis.
- Gingival curettage.
- The localized delivery of chemotherapeutic agents.
- Tooth transplants.
- Maxillofacial prosthetics that repair or replace facial and skeletal anomalies, maxillofacial surgery, orthognathic surgery or any oral surgery requiring the setting of a fracture or dislocation.
- Temporary or provisional *dental prosthesis* or *appliances* except interim partial dentures/stayplates to replace *anterior teeth* extracted while insured under this *plan* .
- Any service or procedure associated with the placement, prosthodontic restoration or maintenance of a dental implant and any incremental charges to other covered services as a result of the presence of a dental implant.
- Any service furnished solely for cosmetic reasons. This includes, but is not limited to: (1) characterization and personalization of a *dental prosthesis;* (2) facings on a *dental prosthesis* for any teeth posterior to the second bicuspid; (3) bleaching of discolored teeth; and (4) odontoplasty.
- Replacing an existing *appliance* or *dental prosthesis* with a like or unlike *appliance* or *dental prosthesis;* unless (1) it is at least 10 years old and is no longer usable; or (2) it is damaged while in the *covered person's* mouth in an *injury* suffered while insured, and can't be made serviceable.
- A fixed bridge replacing the extracted portion of a hemisected tooth or the placement of more than one unit of crown and/or bridge per tooth.
- The replacement of extracted or missing third molars/wisdom teeth.
- Treatment of congenital or developmental malformations, or the replacement of congenitally missing teeth.
- Any endodontic, periodontal, crown or bridge abutment procedure or *appliance* performed for a tooth or teeth with a guarded, questionable or poor prognosis.
- Any procedure or treatment method which does not meet professionally recognized standards of dental practice or which is considered to be experimental in nature.
- Any procedure, *appliance, dental prosthesis,* modality or surgical procedure intended to treat or diagnose disturbances of the temporomandibular joint (TMJ).
- Treatment needed due to: (1) an on-the-job or job-related *injury;* or (2) a condition for which benefits are payable by Worker's Compensation or similar laws.
- Treatment for which no charge is made. This usually means treatment furnished by: (1) the *covered person's* employer, labor union or similar group, in its dental or medical department or clinic; (2) a facility owned or run by any governmental body; and (3) any public program, except Medicaid, paid for or sponsored by any governmental body.
- Evaluations and consultations for non-covered services; detailed and extensive oral evaluations.
- *Orthodontic treatment,* unless the benefit provision provides specific benefits for *orthodontic treatment.*

All Options

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

All Options

Group I - Preventive Dental Services (Non-Orthodontic)

GP-1-DNTL-90-14 P498.8633

All Options

Prophylaxis and Fluorides

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

- Adult prophylaxis covered age 12 and older.

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

Fluoride treatment, topical application - limited to *covered persons* under age 14 and limited to 1 treatment(s) in any 6 consecutive month period.

Office Visits, Evaluations and Examination

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

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

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

GP-1-DNTL-90-14 P498.5008

All Options

Space Maintainers

Space Maintainers - limited to *covered persons* under age 16 and limited to initial *appliance* only. Covered only when necessary to replace prematurely lost or extracted deciduous teeth. Allowance includes all adjustments in the first six months after insertion, limited to a maximum of one bilateral per arch or one unilateral per quadrant, per lifetime.

- Fixed - unilateral
- Fixed - bilateral
- Removable - bilateral
- Removable - unilateral

Recementation of space maintainer performed more than 12 months after the initial insertion

Fixed and Removable Appliances

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

GP-1-DNTL-90-15 P498.0182

All Options

Radiographs

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

Other diagnostic radiographs:

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

GP-1-DNTL-90-15 P498.0183

All Options

Dental Sealants

- Dental Sealants - permanent molar teeth only - Topical application of sealants is limited to the unrestored, permanent molar teeth of *covered persons* under age 16 and limited to one treatment, per tooth, in any 36 consecutive month period.

GP-1-DNTL-90-14 P498.0184

All Options

Group II - Basic Dental Services
(Non-Orthodontic)

Diagnostic services - Allowance includes examination and diagnosis.

Consultations - Diagnostic consultation with a dentist other than the one providing treatment, limited to one consultation for each *covered dental specialty* in any 12 consecutive month period. Covered only when no other treatment, other than radiographs, is performed during the visit.

Diagnostic Services: Allowance includes examination and diagnosis.

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

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

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

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

Resin restorations - limited to *anterior teeth* only. Coverage for resins on *posterior teeth* is limited to the corresponding amalgam benefit. Allowance includes light curing, acid etching, adhesives, including resin bonding agents and local anesthetic. Restorations that do not involve the incisal edge are considered a single surface filling.

Silicate cement, per restoration
Composite resin

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

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

GP-1-DNTL-90-15 P498.1077

All Options

Non-surgical extractions - Allowance includes the treatment plan, local anesthetic and post-treatment care.

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

GP-1-DNTL-90-15 P498.0222

All Options

Other Services

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

Injectable antibiotics needed solely for treatment of a dental condition.

All Options

Group III - Major Dental Services
(Non-Orthodontic)

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

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

Inlays
Onlays, including inlay
Labial veneers
Posts and buildups - only when done in conjunction with a covered unit of crown or bridge and only when necessitated by substantial loss of natural tooth structure.

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

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

Crown or core buildup, including pins
Implant supported prosthetics - Allowance includes the treatment plan and local anesthetic.
- Abutment supported crown
- Implant supported crown
- Abutment supported retainer for fixed partial denture
- Implant supported retainer for fixed partial denture
- Implant/abutment supported fixed denture for completely edentulous arch
- Implant/abutment supported fixed denture for partially edentulous arch

All Options

Prosthodontic Services - Specialized techniques and characterizations are not covered. Allowance includes insulating bases, temporary or provisional restorations and associated gingival involvement. Limited to permanent teeth only.

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

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

Bridge Pontics

Resin with metal
Porcelain
Porcelain with metal
Full cast metal

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

Complete or Immediate dentures, upper or lower

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

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

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

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

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

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

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

Simple stress breakers, per unit

All Options

Crown and Prosthodontic Restorative Services - Also see the "Major Restorative Services" section.

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

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

Inlay or onlay
Crown
Bridge

Adding teeth to partial dentures to replace extracted natural teeth

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

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

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

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

Denture adjustments - Denture adjustments done within 12 months are considered to be part of the denture placement when the adjustment is done by the *dentist* who furnished the denture. Limited to adjustments that are done more than 6 consecutive months after a denture rebase, denture reline or the initial insertion of the denture.

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

All Options

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

Pulp capping, limited to permanent teeth and limited to one pulp cap per tooth, per lifetime.
- Pulp capping, direct
- Pulp capping, indirect - includes sedative filling.

Vital pulpotomy, only when root canal therapy is not the definitive treatment
Gross pulpal debridement
Pulpal therapy, limited to primary teeth only coinsurance
Root Canal Treatment
- Root canal therapy
- Root canal retreatment, limited to once per tooth, per lifetime
- Treatment of root canal obstruction, no-surgical access
- Incomplete endodontic therapy, inoperable or fractured tooth
- Internal root repair of perforation defects

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

All Options

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

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

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

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

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

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

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

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

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

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

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

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

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

Periodontal surgery related

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

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

All Options

Surgical Extractions - Allowance includes the treatment plan, local anesthetic and post-surgical care. Services listed in this category and related services, may be covered by your medical plan.

Surgical removal of erupted teeth, involving tissue flap and bone removal
Surgical removal of residual tooth roots
Surgical removal of impacted teeth

Other Oral Surgical Procedures - Allowance includes diagnostic and treatment radiographs, the treatment plan, local anesthetic and post-surgical care. Services listed in this category and related services, may be covered by your medical plan.

Alveoloplasty, per quadrant
Removal of exostosis, per site

Incision and drainage of abscess
Frenulectomy, Frenectomy, Frenotomy
Biopsy and examination of tooth related oral tissue
Surgical exposure of impacted or unerupted tooth to aid eruption
Excision of tooth related tumors, cysts and neoplasms
Excision or destruction of tooth related lesion(s)
Excision of hyperplastic tissue
Excision of pericoronal gingiva, per tooth
Oroantral fistula closure
Sialolithotomy
Sialodochoplasty
Closure of salivary fistula
Excision of salivary gland
Maxillary sinusotomy for removal of tooth fragment or foreign body
Vestibuloplasty

GP-1-DNTL-90-16 P498.1079

All Options

Definitions

The terms that are italicized throughout this *plan,* are defined in this section.

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

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

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

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

GP-1-DGY2K-D1 P498.0009

All Options

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

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

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

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

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

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

GP-1-DGY2K-D2 P498.0014

All Options

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

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

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

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

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

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

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

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

Proof of Claim means dental radiographs, study models, periodontal charting, written narrative or any documentation that may validate the necessity of the proposed treatment.

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

GP-1-DGY2K-D3 P498.0017

All Options

ATTACHED TO AND MADE PART OF GROUP INSURANCE POLICY NO. G -00404483-

issued by

The Guardian Life Insurance Company of America

(herein called the Insurance Company)

to

OUTSTAFFING, INC.

(herein called the Policyholder)

Effective October 1, 2010 or the first renewal thereafter, this rider amends this plan's dental expense Appeals section to include the following:

Any case under appeal must be reviewed by a peer of the treating health care provider who proposes the care under review or who was primarily responsible for the care under review. With the exception of expedited appeals, a physician advisor who reviews cases under appeal must be: (a) a peer of the treating health care provider; (b) board certified in the same or similar specialty as the treating health care provider; and (c) specialized in a discipline pertinent to the issue under review.

A physician advisor or peer of the treating health care provider who renders a decision on appeal must: (a) not have participated in the adverse decision or any prior reconsideration concerning it; (b) not be employed by or a director of the health care review organization (HCRO); and (c) be licensed to practice in Virginia, or under a comparable licensing law of a state of the United States, as a peer of the treating health care provider.

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

Dated at _____ This _____ Day of _____ , ____

OUTSTAFFING, INC.
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-AP-VA-10 P500.0034

All Options

ELIGIBILITY FOR VISION CARE EXPENSE COVERAGE

P505.0053

All Options

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

All Options

Vision Enrollment Requirement: An employee must enroll and agree to make required payments within 31 days of his or her eligibility date. If he or she fails to do so, he or she can't enroll until this plan's next vision open enrollment period.

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

Once an employee enrolls in this plan, he or she can't drop his or her vision coverage until this plan's next vision open enrollment period. And if he or she drops his or her vision coverage, he or she can't enroll again until the next vision open enrollment period.

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

GP-1-EC-90-2.0 P505.0070

All Classes

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

GP-1-EC-90-4.0 P180.0936

All Options

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

All Options for All Classes

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

All Options for All Classes

When Employee Coverage Ends

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

- the last day of the month in which an employee's active full-time service ends for any reason other than disability. Such reasons include retirement, layoff, leave of absence or the end of employment.
- the date an employee dies.
- the date the group plan ends, or is discontinued for a class of employees to which the employee belongs; or
- the day prior to the last premium due date for which required payments are made for the employee.
- the last day of the month in which an employee stops being an eligible employee under this plan for any reason not named above.

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

GP-1-EC-90-8.0 P489.0006

All Options for All Classes

When Active Service Ends: You may continue an employee's vision 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 P505.0073

All Options

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

All Options

Definitions

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

All Options

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

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

All Options

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

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

All Options

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

GP-1-EC-90-DEF-4 P180.0158

All Options

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

All Options

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

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

All Options

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

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

All Options

Dependent Coverage

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

All Options

Eligible Dependents For Dependent Vision Care Benefits: An employee's eligible dependents are: (a) his or her legal spouse; (b) his or her dependent children who are under age 20; and (c) his or her dependent children, from age 20 until their 26th birthday, who are enrolled as full-time students at accredited schools.

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

GP-1-DEP-90-2.0 P505.0656

All Options

Adopted Children and Step-Children: An employee's "dependent children" include his or her legally adopted children and, if they depend on him or her for most of their support and maintenance, his or her step-children. We treat a child as legally adopted from the time the child is placed in the home for the purpose of adoption. We treat such a child this way whether or not a final adoption order is ever issued.

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

GP-1-DEP-90-3.0 P505.0624

All Options

Handicapped Children: An employee may have a child who is: (i) incapable of self-sustaining employment by reason of intellectual disability or physical handicap; and (ii) chiefly dependent on the employee for support and maintenance. Subject to all of the terms of this coverage and the plan, such a child may stay eligible for dependent benefits past this coverage's age limit.

The child will stay eligible as long as he or she is 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-VA P449.0672

All Options for All Classes

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

If the employee does this on or before his or her eligibility date, his or her dependent coverage is scheduled to start on the later of the date he or she signs the enrollment form and the date he or she becomes covered for employee coverage.

If the employee does this after the enrollment period ends, he or she can't enroll his or her initial dependents until the next vision open enrollment period.

Once the employee has coverage for his or her initial dependents, he or she must notify us when he or she acquires any new dependents, and agree to make any additional payments required for the coverage. If the employee does this within 31 days of the date the newly acquired dependent becomes eligible, the dependent's coverage will start on the date the dependent becomes eligible. If the employee fails to notify us on time, he or she can't enroll the newly acquired dependent until the next vision open enrollment period.

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

GP-1-DEP-90-6.0 P505.0067

All Options

Exception: If a dependent, other than a newborn child, is confined to a hospital or other health care facility; or is unable to carry-out the normal activities of someone of like age and sex on the date his or her dependent benefits would otherwise start, we'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

All Options

Newborn Children: We cover an employee's newborn child from the moment of birth if the employee is already insured for dependent vision coverage, and he or she notifies us within 31 days of the child's birth. If the employee fails to notify us on time, he or she can't enroll the child until the next vision open enrollment period.

If the newborn child is the employee's first eligible dependent, we cover the child from the moment of birth if the employee enrolls for dependent coverage and agrees to make any required payments within 31 days of the child's birth. If the employee fails to enroll on time, he or she can't enroll the child until the next vision open enrollment period.

If the newborn child is not the employee's first eligible dependent, but the employee did not previously enroll his or her other eligible dependents for vision care expense coverage, the employee can enroll the child during the next vision open enrollment period, if he or she also enrolls all of his or her other eligible dependents at this time.

GP-1-DEP-90-8.0 P505.0068

All Options for All Classes

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 coverage's age limit 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 P505.0661

All Options

Definitions

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

All Options

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

All Options

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

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

All Options

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

All Options

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

All Options

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

All Options

Plan means the Guardian group plan purchased by the employer.

GP-1-DEP-90-DEF-11 P264.0065

All Options

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

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

All Options

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

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

All Options

VISION CARE EXPENSE INSURANCE

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

GP-1-VSN-96-VIS P505.0010

All Options

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

Vision Service Plan: This Plan is designed to provide high quality vision care while controlling the cost of such care. To do this, the Plan encourages a Covered Person to seek vision care from doctors and vision care facilities that belong to Vision Service Plan (VSP), a vision care Preferred Provider Organization (PPO).

This vision care PPO is made up of Preferred Providers in a Covered Person's geographic area. A vision care Preferred Provider is a vision care practitioner or a vision care facility that: (a) is a current provider of VSP; and (b) has a participatory agreement in force with VSP.

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

When an Employee and his or her dependents enroll in this Plan, they will get an enrollment packet which will tell them how to obtain benefits and information about current vision care Preferred Providers.

What we pay is based on all the terms of this Plan. The Covered Person should read this material with care, and have it available when seeking vision care. Read this Plan carefully for specific benefit levels, Copayments, Deductibles, payment rates and payment limits.

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

Choice Of Preferred Providers: When a person becomes enrolled in this Plan, he or she will receive a list of VSP Preferred Providers in his or her area. A Covered Person may receive vision services from any VSP Preferred Provider.

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

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

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

GP-1-VSN-96-PPOA P505.0012

All Options

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

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

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

GP-1-VSN-96-PTR2 P505.0017

All Options

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

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

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

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

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

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

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

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

(4) Grievance procedures and complaint forms will be maintained in each Preferred Provider's office.

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

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

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

GP-1-VSN-96-APP P505.0018

All Options

Complaint & Appeal Process

Definitions

As used in this section:

"Adverse Determination" means a determination by the *utilization review entity* that based upon information provided, a request for a benefit upon application of any utilization review technique does not meet the managed care health insurance plan's requirements for medical necessity, appropriateness, health care setting, level of care, or effectiveness or is determined to be experimental or investigational and the requested benefit is therefore denied, reduced or terminated or payment is not provided or made, in whole or in part, for the benefit.

"Appeal" means a formal request by a covered person or a provider on behalf of a covered person for reconsideration of a determination such as a utilization review recommendation, a benefit payment, an administrative action, or a quality-of-care or service issue.

"Appellant" means: (i) the covered person; (ii) the covered person's parent, guardian, legal custodian, or other individual authorized by law to act on behalf of the covered person, if the covered person is a minor; (iii) the covered person's spouse, parent, committee, legal guardian, or other individual authorized by law to act on behalf of the covered person if the covered person is not a minor but is incompetent or incapacitated; or (iv) the covered person's treating health care provider acting with the consent of the covered person, the covered person's parent, guardian, legal custodian, or other individual authorized by law to act on behalf of the covered person, if the covered person is a minor, or the covered person's spouse, parent, committee, legal guardian, or other individual authorized by law to act on behalf of the covered person, if the covered person is not a minor but is incompetent or incapacitated.

"Complaint" means a written communication primarily expressing a grievance. A complaint may pertain to the availability, delivery, or quality of health care services including *adverse determinations,* claims payments, the handling or reimbursement for such service(s), or any other matter pertaining to the covered person's contractual relationship with the Managed Care Health Insurance Plan (MCHIP).

"Concurrent review" means *utilization review* conducted during a patient's stay or course of treatment in a facility, the office of a health care professional, or other inpatient or outpatient health care setting.

"Final adverse determination" means an *adverse determination* involving a covered benefit that has been upheld by a managed care health insurance plan, or it's designee *utilization review entity,* at the completion of the managed care health insurance plan's internal appeal process.

"Independent review organization" means an organization selected by the Bureau of Insurance that conducts external reviews of *adverse determinations* and *final adverse determinations.*

"Managed care health insurance plan" or *"MCHIP"* means an arrangement for the delivery of health care in which Guardian undertakes to provide, arrange for, pay for, or reimburse any of the costs of health care services for a covered person on a prepaid or insured basis which: i) contains one or more incentive arrangements, including any credentialing requirements intended to influence the cost or level of health care services between the health carrier and one or more providers with respect to the delivery of health care services; and ii) requires or creates benefit payment differential incentives for covered persons to use providers that are directly or indirectly managed, owned, under contract with or employed by the health carrier. For the purposes of this definition, the prohibition of balance billing by a provider shall not be deemed a benefit payment differential incentive for covered persons to use providers who are directly or indirectly managed, owned, under contract with or employed by the health carrier. A single managed care health insurance plan may encompass multiple types of benefit payment differentials; however, a single managed care health insurance plan shall encompass only one provider network or set of provider networks.

"Medically necessary" means appropriate and necessary health care services which are rendered for any condition which, according to generally accepted principles of good medical practice, requires the diagnosis or direct care and treatment of an illness, injury, or pregnancy-related condition, and are not provided only as a convenience.

"Peer of the treating health care provider" means a physician or other health care professional who holds a non-restricted license in the Commonwealth of Virginia or under a comparable licensing law of a state of the United States and in the same or similar specialty as typically manages the medical condition, procedure or treatment under review.

"Physician advisor" means a physician licensed to practice medicine in the Commonwealth of Virginia or under a comparable licensing law of a state of the United States who provides medical advice or information to a private review agent or a *utilization review entity* in connection with its *utilization review* activities.

"Prospective review" means *utilization review* conducted prior to an admission or a course of treatment.

"Retrospective review" means a review of medical necessity conducted after services have been provided to a patient, but does not include the review of a claim that is limited to an evaluation of reimbursement levels, veracity of documentation, accuracy of coding, or adjustment for payment.

"Timely" means the provision of services so as not to impair or jeopardize the integrity of the covered person's diagnosis or outcomes of illness.

"Treating health care provider" or *"Provider"* means:

a) a licensed health care provider who renders or proposes to render health care services to a covered person; and

b) for purposes of this provision, is acting on behalf of the covered person.

"Urgent Care Appeal" means an *appeal* for medical care or treatment with respect to which the application of the time periods for making non-urgent care determinations (i) could seriously jeopardize the life or health of the covered person or the ability of the covered person to regain maximum function; or (ii) in the opinion of the treating health care professional with knowledge of the covered person's medical condition, would subject the covered person to severe pain that cannot be adequately managed without the care or treatment that is the subject of the appeal. an *urgent care appeal* shall not be available for any post-service claim or retrospective adverse determination.

"Utilization Review" means a system for reviewing the necessity, appropriateness and efficiency of hospital, medical or other health care services rendered or proposed to be rendered to a covered person for the purpose of determining whether such services should be covered. Utilization review includes, but is not limited to, preadmission, concurrent and retrospective medical necessity determination, and review related to the appropriateness of the site at which services were or are to be delivered. Utilization review also includes determinations of medical necessity based upon contractual limitations regarding "experimental" or "investigational" procedures, by whatever terms designated in the evidence of coverage. Utilization review does not include any: (i) denial of benefits for a procedure which is explicitly excluded pursuant to the terms of the contract or evidence of coverage; (ii) review of issues concerning contractual restrictions on facilities to be used for the provision of services; or (iii) determination by an insurer as to the reasonableness and necessity of services for the treatment and care of an injury suffered by an insured for which reimbursement is claimed under a contract of insurance covering any other classes of insurance.

"Utilization review entity" or *"entity"* means an insurer or managed care health insurance plan licensee that performs utilization review or upon whose behalf utilization review is performed with regard to the health care or proposed health care that is the subject of the final adverse determination.

All Options

Internal Appeal Procedures

Complaint Process

If a covered person has concerns regarding a quality of care issue, he or she may file a *complaint* as follows:

In Writing: Center for Quality Health Care Services and Consumer Protection
Virginia Department of Health
3600 W. Broad Street Suite 216
Richmond, VA 23230

Telephone: 804-367-2104 (Richmond Metro Area)
800-955-1819

Fax: 804-367-2149
E-mail: mchip@vdh.state.va.us

If a covered person or his or her *treating health care provider* does not agree with a *utilization review* determination, his or her provider may file, within 180 days of receipt of the *determination,* a *complaint* to request reconsideration of the *adverse determination.*

A *complaint* for reconsideration of a *utilization review* determination made by Guardian should be made to:

For Vision Claims

Vision Services Plan, Inc.
Professional Relations VP
3333 Quality Drive
Rancho Cordova, CA 95670

The *provider's* written *complaint* requesting reconsideration should provide the *utilization review entity* with any added information which: (a) relates to the case; and (b) may impact on the first determination. A determination on reconsideration will be made by a *physician advisor,* peer of the treating health care provider, or a panel of other appropriate health care providers with at least one *physician advisor* or *peer of the treating health care provider* on the panel.

Resolution of the *complaint,* and written notification of such determination will be provided to the covered person and the *treating health care provider* no later than ten (10) working days after receipt of the *complaint.*

The written notification of such determination will include the criteria used and the clinical reason for the *adverse determination,* and, if any, the alternate length of treatment of the alternate treatment setting(s) that the *utilization review entity* deems to be appropriate.

If the reconsideration results in a *final adverse determination,* the covered person, his or her *provider,* or a representative of the covered person may *appeal* the *final adverse determination.*

Appeals of Adverse Determinations

Except as explained below for an urgent care appeal, a covered person, his or her *treating health care provider,* or a representative of the covered person may make a written request for an *appeal* of an *adverse determination* or a *final adverse determination* made by the *utilization review entity.*

For Vision Claims

Vision Services Plan, Inc.
Professional Relations VP
3333 Quality Drive
Rancho Cordova, CA 95670

The request for *appeal* of a determination should provide the *utilization review entity* with any additional evidence for consideration (e.g., pertinent medical records of the covered person's *provider,* the pertinent records of any facility in which health care is provided to the covered person, etc.).

Any information provided to the *utilization review entity* to support an *appeal* will be reviewed by a *physician advisor* or a peer of the *treating health care provider.* With the exception of expedited appeals, a *physician advisor* must be:

a) a *peer of the treating health care provider* who proposes the care under review or who was primarily responsible for the care under review;

b) board certified; and

c) specialized in a discipline pertinent to the issue under review.

A *physician advisor* or *peer of the treating health care provider* who renders a decision on *appeal* must:

a) not have participated in the adverse decision or any prior reconsideration thereof;

b) not be employed by or be a director of the *utilization review entity;* and

c) be licensed to practice in Virginia, or under a comparable licensing law of a state of the United States, as a *peer of the treating health care provider.*

In the appeals process, consideration will be given to the availability or non-availability of alternative health care services proposed by the *utilization review entity.*

Except for *urgent care appeals,* written notification of the results of the *appeal* process will be provided to the covered person, his or her *treating health care provider,* or the representative of the covered person who filed the *appeal.* Notification for *prospective reviews* will be provided no later than thirty (30) working days after receiving all required documentation. Notification for *retrospective reviews* will be no later than sixty (60) working days after receiving all required documentation. Notification for *concurrent care reviews* will be provided sufficiently in advance of a reduction or termination of a benefit after receipt of the claim to allow the *appellant* to *appeal* and obtain a determination on review before the benefit is reduced or terminated but in no case will this be less than thirty (30) working days after receiving all required documentation. The notification of all decisions will state the criteria used and the clinical reason for the decision.

Urgent Care Appeals of Adverse Determinations

When the *treating health care provider* believes that an *adverse determination* or adverse reconsideration warrants an immediate *appeal,* the *treating health care provider* shall have the opportunity to *appeal* on an urgent care basis.

An *urgent care appeal* may be requested only when the regular reconsideration and *appeals* process would delay the rendering of health care in a manner that would be detrimental to the health of the covered person. Both the *utilization review entity* and the *treating health care provider* must attempt to share the maximum information by telephone, facsimile machine, or otherwise to resolve the *urgent care appeal* in a satisfactory manner.

A written or oral *appeal* for urgent care reconsideration of an *adverse determination* or a *final adverse determination* made by Guardian should be made to:

For Vision Claims

Vision Services Plan, Inc.
Professional Relations VP
3333 Quality Drive
Rancho Cordova, CA 95670
Phone: 1-800-622-7444
Fax: 1-916-851-5131

If additional information is needed to make a determination, the *appellant* will be notified of the specified information needed as soon as possible but not later than twenty-four (24) hours after receipt of the request for appeal. Such notice will be provided orally or, if requested by the *appellant,* it shall be provided in writing and shall state what specified information is needed. The *appellant* must provide the requested information within forty-eight (48) hours.

Any decision of an *urgent care appeal* must be made by a *physician advisor, peer of the treating health care provider,* or a panel of other appropriate health care providers with at least one *physician advisor* on the panel. A decision on a prospective *urgent care appeal* will be made by the *utilization review entity* no later than seventy-two (72) hours after receipt by the *utilization review entity* of all information necessary to make such a determination. A decision on an concurrent *urgent care appeal* will be made by the *utilization review entity* no later than seventy-two (72) hours after receipt by the *utilization review entity* of all information necessary to make such a determination, but the request to continue treatment must be received at least twenty-four (24) hours prior to the expiration of the prescribed period of time or number of treatments.

An *urgent care appeal* determination may be further appealed through the *utilization review entity's* standard appeal process If:

a) all material information and documentation was not reasonably available to the provider and to the *utilization review entity* at the time of the *expedited review appeal;*

b) the *physician advisor* reviewing the case under an *urgent care review appeal:* i) was not a *peer of the treating health care provider;* and ii) was not board certified or board eligible, and specialized in a discipline pertinent to the issue under review.

If the review of an *urgent care appeal by a utilization review entity* results in a *final adverse determination,* the *utilization review entity* will immediately notify the person who requested the *urgent* care appeal of the *final adverse determination.*

GP-1-C&A.2-VA-12 P505.1295

All Options

Consumer Assistance

If you have any questions regarding an appeal or grievance concerning the health care services that you have been provided that have not been satisfactorily addressed by your plan, you may contact the Office of the Managed Care Ombudsman for assistance.

The Office of the Managed Care Ombudsman is charged with protecting the interests of *covered persons* under *MCHIP's* in the Commonwealth of Virginia. For purposes of this plan, the Office of The Managed Care Ombudsman must:

1) assist *covered persons* in understanding their rights and the processes available to them according to their *managed care health insurance plan;*

2) answer inquiries from *covered persons,* their *treating health care providers,* and any representative of the *covered person* received via telephone, mail, electronic mail or in person;

3) provide to *covered persons,* their *treating health care providers,* and any representative of the *covered person* information concerning *managed health care insurance plans* and other *utilization review entities* upon request;

4) upon request, assist *covered persons* in using the procedures and processes available to them from their *managed care health insurance plan,* including all *utilization review appeals.* Such assistance may require the review of insurance and health care records of a covered person, which shall be done only with the express written consent of the *covered person.* The confidentiality of all such information shall be maintained in accordance with the laws of the Commonwealth of Virginia.

5) ensure that *covered persons* have access to the services provided through the Office and that the *covered persons* receive timely responses from the representatives of the Office to the inquiries.

The address, telephone number, or E-mail address shown below should be used in order to obtain assistance with any questions regarding an *appeal* or *complaint* concerning the health care services provided which have not been satisfactorily addressed by the *utilization review entity.*

Address: Office of the Managed Care Ombudsman
Bureau of Insurance
P.O. Box 1157
Richmond, Virginia 23218

Telephone: 1-877-310-6560 toll-free
1-804-371-9032 in the Richmond Metropolitan Area

Ombudsman E-mail: ombudsman@scc.virginia.gov

Bureau of Insurance Website: www.scc.virginia.gov

GP-1-C&A.3-VA-14 P505.1429

All Options

How This Plan Works

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

Services or Supplies From a Preferred Provider

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

Copayments: The Covered Person must pay a Copayment when he or she receives services from a Preferred Provider. We pay benefits for the covered charges a Covered Person incurs in excess of the Copayment. This Plan's Copayments are as follows:

For each vision examination from a Preferred Provider $10.00

For each pair of Standard Frames and/or Standard Lenses from a Preferred Provider $20.00

For Necessary Contact Lenses from a Preferred Provider $20.00

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

Payment Rates: Once a Covered Person has paid any applicable Copayment, we pay benefits for covered charges under this Plan as follows. What we pay is subject to all of the terms of this Plan.

For Covered Charges 100%

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

The discounts are:

For Prescription Glasses . . . . . 20% off of the Preferred Provider's Usual and Customary Fee

For Non-Prescription Sunglasses . . . . . 20% off of the Preferred Provider's Usual and Customary Fee

For Contact Lens Evaluation and Fitting Costs . . . . . 15% off of the Preferred Provider's Usual and Customary Fee

If a Covered Person receives a vision examination, and lenses or frames from a Preferred Provider, he or she will receive a discount on the cost of purchasing an unlimited number of additional prescription glasses and non-prescription sunglasses from the same Preferred Provider on the same day.

The discounts are:

For Prescription Glasses . . . . . 30% off of the Preferred Provider's Usual and Customary Fee

For Non-Prescription Sunglasses . . . . . 30% off of the Preferred Provider's Usual and Customary Fee

GP-1-VSN-96-BEN1 P505.0757

All Options

Services or Supplies From a Non-Preferred Provider

If a Covered Person uses the services of a Non-Preferred Provider, the Covered Person must submit the itemized bill to VSP for claims payment. All claims must be sent to VSP within 180 days of the date services are completed or supplies are received. The benefits we pay are subject to all of the terms of this Plan.

Cash Deductible For Services of a Non-Preferred Provider: There are separate cash Deductibles for each covered service provided by a Non-Preferred Provider. These cash Deductibles are shown below. The Covered Person must have covered charges in excess of the cash Deductible before we pay him or her any benefits for the service or supply.

For each vision examination provided by a Non-Preferred Provider $10.00

For each pair of Standard Frames and/or Standard Lenses from a Non-Preferred Provider $20.00

For each pair of Necessary Contact Lenses from a Non-Preferred Provider $20.00

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

Payment Rates: Once a Covered Person has met any applicable Deductible, we pay benefits for Covered Charges under this Plan as follows. What we pay is subject to all of the terms of this Plan.

For Covered Charges 100%

GP-1-VSN-96-BEN2 P505.0024

All Options

Covered Charges

Covered charges are the Usual and Customary charges for the services and supplies described below. We pay benefits only for covered charges Incurred by a Covered Person while he or she is insured by this Plan. Charges in excess of any payment limits shown in this Plan are not covered charges.

Covered Services and Supplies

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

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

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

- prescribing and ordering of proper lenses;
- assisting in the selection of frames;

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

We don't cover more than one vision examination in any 12 month period.

And if a Covered Person uses a Non-Preferred Provider, we limit what we pay for each vision examination to $46.00.

GP-1-VSN-96-LIST1 P505.0028

All Options

Standard Lenses: We cover charges for single vision, bifocal, trifocal or lenticular lenses. We cover glass, plastic or for dependent children to age 20, polycarbonate lenses.

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

- $47.00 for each pair of single vision lenses
- $66.00 for each pair of bifocal lenses
- $85.00 for each pair of trifocal lenses and
- $125.00 for each pair of lenticular lenses.

GP-1-VSN-05-SL P505.0333

All Options

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

GP-1-VSN-05-SL P505.0335

All Options

Standard Frames: We cover charges for standard frames.

If a covered person uses a preferred provider, we cover charges up to a retail frame allowance of $120.00, plus 20% of any amount over the allowance

If a covered person uses a non-preferred provider, we limit what we pay for each set of standard frames to $47.00.

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

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

GP-1-VSN-05-SF P505.1167

All Options

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

(a) following cataract surgery;

(b) to correct extreme visual acuity problems that cannot be corrected with spectacle lenses;

(c) for certain conditions of Anisometropia; or

(d) for Keratoconus.

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

If a Covered Person receives Necessary Contact Lenses from a Preferred Provider, we pay 100% of covered charges. If he or she receives Necessary Contact Lenses from a Non-Preferred Provider, we limit what we pay to $210.00 in any 12 month period.

GP-1-VSN-96-LIST7 P505.0031

All Options

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

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

We limit what we pay for elective contact lenses to $120.00 once every 12 months.

GP-1-VSN-05-ECL P505.0347

All Options

Special Limitations

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

GP-1-VSN-96-SL1 P505.0035

All Options

Exclusions

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

GP-1-VSN-96-EXC1 P505.0037

All Options

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

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

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

We will not pay for blended lenses.

We will not pay for oversized lenses.

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

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

We will not pay for UV (ultraviolent protected lenses).

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

We will not pay for progressive multifocal lenses.

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

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

GP-1-VSN-05-EXC P505.0348

All Options

Charges not covered due to this provision are not considered covered vision services and cannot be used to satisfy this Plan's Copayments or Deductibles, if any.

GP-1-VSN-96-EXC17 P505.0040

All Options

Definitions

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

GP-1-VSN-96-DEF1 P505.0041

All Options

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

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

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

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

Covered Person with respect to vision care insurance, means an Employee or eligible dependent who meets this Plan's eligibility criteria and who is covered under this Plan.

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

Deductible means any amount which a Covered Person must pay before he or she is reimbursed for covered services provided by a Non-Preferred Provider.

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

GP-1-VSN-96-DEF2 P505.0042

All Options

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

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

GP-1-VSN-96-DEF3 P505.0046

All Options

Preferred Provider with respect to vision care insurance, means an optometrist, ophthalmologist or optician or other licensed and qualified vision care provider who has contracted with the Plan to provide vision care services and/or vision care materials on behalf of Covered Persons of the Plan.

Non-Preferred Provider with respect to vision care insurance, means any optometrist, optician, ophthalmologist, or other licensed and qualified vision care provider who has not contracted with the Plan to provide vision care services and/or vision care materials to Covered Persons of the Plan.

GP-1-VSN-96-DEF6 P505.0048

All Options

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

GP-1-VSN-96-DEF7 P505.0050

All Options

Oversize Lenses mean larger than a Standard Lens blank, to accommodate prescriptions.

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

Plan means the Vision Service Plan group policy of vision care services described herein.

Plan Benefits with respect to vision care insurance, mean the vision care services and vision care materials which a Covered Person is entitled to receive by virtue of coverage under this Plan.

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

Standard Frames mean frames valued up to the limit published by VSP which is given to Preferred Providers.

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

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

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

Visually Necessary or Appropriate means medically or visually necessary to for the restoration or maintenance of a Covered Person’s visual acuity and health and for which there is no less expensive professionally acceptable alternative.

GP-1-VSN-96-DEF8 P505.0051

All Options

ATTACHED TO AND MADE PART OF GROUP INSURANCE POLICY NO. G -00404483-

issued by

The Guardian Life Insurance Company of America

(herein called the Insurance Company)

to

OUTSTAFFING, INC.

(herein called the Policyholder)

Effective October 1, 2010 or the first renewal thereafter, this rider amends this plan's vision expense Appeals section to include the following:

Any case under appeal must be reviewed by a peer of the treating health care provider who proposes the care under review or who was primarily responsible for the care under review. With the exception of expedited appeals, a physician advisor who reviews cases under appeal must be: (a) a peer of the treating health care provider; (b) board certified in the same or similar specialty as the treating health care provider; and (c) specialized in a discipline pertinent to the issue under review.

A physician advisor or peer of the treating health care provider who renders a decision on appeal must: (a) not have participated in the adverse decision or any prior reconsideration concerning it; (b) not be employed by or a director of the health care review organization (HCRO); and (c) be licensed to practice in Virginia, or under a comparable licensing law of a state of the United States, as a peer of the treating health care provider.

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

Dated at _____ This _____ Day of _____ , ____

OUTSTAFFING, INC.
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-AP-VA-10 P505.1199

All Options

ATTACHED TO AND MADE PART OF GROUP INSURANCE POLICY NO. G -00404483-

issued by

THE GUARDIAN LIFE INSURANCE COMPANY OF AMERICA

7 Hanover Square
New York, New York 10004

to

OUTSTAFFING, INC.

(herein called the Policyholder)

Effective the later of (i) January 1, 2015, (ii) your first renewal date thereafter or (iii) the effective date of this amendment requested by the Policyholder and approved by Guardian, this rider amends *your plan* as follows:

ADDITIONAL SERVICES

Guardian has arranged to make available selected services for eligible Guardian policyholders and/or covered persons who may be entitled to receive certain services and supplies from various companies.

The additional services and supplies identified below, and agreed to by the providers of these services, are not provided by Guardian. Guardian assumes no liability for the services or supplies provided under these programs, nor for the amounts charged by the companies providing such service and supplies.

Policyholders and/or covered persons will be provided with complete details regarding available services and supplies; associated fees or charges; discounts; eligibility requirements; and conditions, terms and limitations and a telephone number to call with questions about the service.

The policyholder and/or covered persons may be eligible for the following service(s) and/or discounts:

- College Tuition Benefit.

When this plan ends, access to the services ends for the policyholder and for all persons covered under the plan. When a policyholder no longer meets the conditions for eligibility for a service, access to that service ends for the policyholder and for all persons covered under the plan.

When a covered person's coverage under this plan ends, access to the services ends for that person. When a covered person no longer meets the conditions for eligibility for a service, access to that service ends for the covered person.

Guardian reserves the right to terminate, modify or replace any service at any time.

Dated at _____ This _____ Day of _____ , ____

OUTSTAFFING, INC.
Full or Corporate Name of Policyholder

_____ BY: _____
Witness Signature and Title

The Guardian Life Insurance Company of America

Raymond Marra, Senior Vice President, Group Products and Marketing

GP-1-A-VAP-14 P531.0187

All Options

ATTACHED TO AND MADE PART OF GROUP INSURANCE POLICY NO. G -00404483-

issued by

The Guardian Life Insurance Company of America

(herein called the Insurance Company)

to

OUTSTAFFING, INC.

(herein called the Policyholder)

Effective August 1, 2005, this rider amends this policy by adding the following to the "Term of Policy - Renewal Privilege" provision:

We have the right to decline to renew this policy, or any coverage hereunder on any policy anniversary or premium due date, if, on that date

- with respect to contributory Vision Care Expense insurance, less than 25% of those employees eligible are insured under this plan.
- with respect to contributory Dental Expense insurance, less than 35% of those employees eligible are insured under this plan.

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

Dated at _____ This _____ Day of _____ , ____

OUTSTAFFING, INC.
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-VPCT-VA-11 P531.0053

All Options

COORDINATION OF BENEFITS

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

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

Definitions

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

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

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

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

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

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

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

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

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

Closed Panel Plan: This term means a health maintenance organization (HMO), preferred provider organization (PPO), exclusive provider organization (EPO), or other plan that provides health benefits to covered persons primarily in the form of services through a panel of providers that have contracted with or are employed by the plan; and that limits or excludes benefits for services provided by other providers, except in cases of emergency or referral by a panel member.

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

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

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

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

Plan: This term means any of the following that provides benefits or services for health care or treatment: (1) group insurance; (2) closed panel or other forms of group or group-type coverage, whether insured or uninsured; (3) group-type contracts; (4) amounts of group or group-type hospital indemnity benefits in excess of $200.00 per day; (5) medical components of group long-term care contracts such as skilled nursing care; and (6) governmental benefits, except Medicare, as permitted by law.

This term does not include: (a) individual or family insurance; (b) closed panel or other individual coverage, (c) amounts of group or group-type hospital indemnity benefits of $200.00 or less per day; (d) school accident type coverage; (e) benefits for non-medical components of group long-term care policies; (f) medical expense or medical payments insurance provided in conjunction with liability coverage; or (g) Medicare, Medicare supplement policies, 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.

All Options

Order Of Benefit Determination

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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.

Closed Panel Plans: If the primary plan is a closed panel plan and the secondary plan is not a closed panel plan, the secondary plan will pay or provide benefits as if it were primary when a covered person uses a non-panel provider; except for emergency services or authorized referrals that are paid or provided by the primary plan.

A person may be covered by two or more closed panel plans. If, for any reason including the provision of service by a non-panel provider, benefits are not payable by one closed panel plan, coordination of benefits will not apply between that plan and other closed panel plans.

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.

All Options

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

All Options

The Guardian's Responsibilities

P800.0037

All Options

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

P800.0041

All Options

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

P800.0043

All Options

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 Appleton, WI This 24th Day of November , 2016

OUTSTAFFING, INC.
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