**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:** MIDLAND COUNTY

| GROUP POLICY NUMBER | DELIVERED IN | POLICY DATE |
|---|---|---|
| G-00520283 | Texas | January 1, 2016 |

**POLICY ANNIVERSARIES:** January 1st of each year, beginning in 2017

**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 January 7, 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

***Option A***

**POLICY RIDER**

**ATTACHED TO AND MADE PART OF GROUP INSURANCE POLICY NO. G -00520283-**

issued by

## The Guardian Life Insurance Company of America

(herein called the Insurance Company)

to

**MIDLAND COUNTY**

(herein called the Policyholder)

Effective January 3, 2011 this rider amends this policy by the addition of the discount programs as described below:

When this policy ends, access to these discount programs for the policyholder and for all *covered persons* ends. When a covered person's coverage under this policy 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. Termination of these programs will become effective 30 days from amendatory notice.

Policyholders and *covered persons* will be provided with complete details regarding each program, including: (a) what is discounted,(b) the amount of the discounts; and (c) how the discounts can be accessed.

The programs are:

1. **Comprehensive Employee Assistance Program (EAP) Services.** EAP provides counseling services, legal and financial services, and training resources through telephonic assistance and referrals to local counselors.
2. **COBRA Administration Services.** ADP COBRA Services (ADP) administers federal COBRA continuance for you including sending required notifications to qualified beneficiaries, determination of eligibility and collection of required premium.
3. **FlexPlan Premium Only Plan (FlexPlan) Fee Waiver.** Waiver of the annual fee applicable to a FlexPlan Premium Only Plan when you purchase 3 or more qualified lines of coverage from us.

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

Dated at _____ This _____ Day of _____ , ____

MIDLAND COUNTY
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-NONI-TX-08 P119.0007

**IMPORTANT NOTICE**

1) To obtain information or make a complaint:

2) You may call The Guardian's toll-free telephone number for information or to make a complaint at:

1-800-459-9401

3) You may also write to The Guardian at:

The Guardian Life Insurance
Company of America
East 777 Magnesium Road
Spokane, Washington 99208-5884

4) You may contact the Texas Department of Insurance on companies, coverages, rights, or complaints at:

1-800-252-3439

5) You may write the Texas
Department of Insurance
P.O. Box 149104
Austin, TX 78714-9104
FAX # (512) 475-1771
Web: http://www.tdi.state.tx.us
E-mail: ConsumerProtection@tdi.state.us

6) **PREMIUM OR CLAIM DISPUTES:** Should you have a dispute concerning your premium or about a claim, you should contact The Guardian Life Insurance Company first. If the dispute is not resolved, you may contact the Texas Department of Insurance.

7) **ATTACH THIS NOTICE TO YOUR POLICY:** This notice is for information only and does not become a part or condition of the attached document.

**AVISO IMPORTANTE**

Para obtener informacion o para someter una queja:

Usted puede llamar al numero de telefono gratis de The Guardian's para informacion o para someter una queja al:

1-800-459-9401

Usted tambien puede escribir a The Guardian:

The Guardian Life Insurance
Company of America
East 777 Magnesium Road
Spokane, Washington 99208-5884

Puede comunicarse con el Departamento de Seguros de Texas para obtener informacion acerca de companias, coberturas, derechos o quejas al:

1-800-252-3439

Puede escribir al Departamento de
Seguros de Texas
P.O. Box 149104
Austin, TX 78714-9104
FAX # (512) 475-1771
Web: http://www.tdi.state.tx.us
E-mail: ConsumerProtection@tdi.state.us

**DISPUTAS SOBRE PRIMAS O RECLAMOS:** Si tiene una disputa concerniente a su prima o a un reclamo, debe comunicarse con el The Guardian Life Insurance Company primero. Si no se resuelve la disputa, puedo entonces comunicarse con el departamento (TDI).

**UNA ESTE AVISO A SU POLIZA:** Este aviso es solo para proposito de informacion y no se convierte en parte o condicion del documento adjunto.

GP-1-R-DISC-TX-92 P120.0062

## IMPORTANT NOTICE

**This is not a policy of Workers' Compensation insurance. The employer does not become a subscriber to the Workers' Compensation system by purchasing this policy, and if the employer is a non-subscriber, the employer loses those benefits which would otherwise accrue under the Workers' Compensation laws. The employer must comply with the Workers' Compensation law as it pertains to non-subscribers and the required notifications that must be filed and posted.**

GP-1-R-COMP-TX-92 P120.0014

## 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 AND QUALIFIED RETIREES

GP-1-SI P130.1566

### Option Packages Available

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

GP-1-SI P130.1710

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

GP-1-SI P130.1568

### Summary of Option Packages

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

GP-1-SI P130.1585

***Option A*** Employee and Dependent 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 A* Schedule of Benefits

***Employee and Dependent Vision Expense***

*GP-1-SI* *P130.3506*

***Option A***

***PPO Copayments***

| | |
|---|---|
| Examinations | $10.00 |
| Standard Frames and/or Standard Lenses | $25.00 |
| Necessary Contact Lenses | $25.00 |

***Option A***

***Non-PPO Cash Deductibles***

| | |
|---|---|
| Examinations | $10.00 |
| Standard Frames and/or Standard Lenses | $25.00 |
| Necessary Contact Lenses | $25.00 |

***Option A***

***Payment Rates***

| | |
|---|---|
| For Covered Charges | 100% |

GP-1-SI P130.3516

***Option A***

***Changes in Insurance Amounts***

Any increase or decrease in the amount of insurance on any individual shall become effective on the effective date of a change in the classification of an Employee or a Qualified Retiree, except that any increase in the amount of insurance on an Employee, a Qualified Retiree 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 a Qualified Retiree or an Eligible Dependent confined to a hospital, on the day on which the Retiree or 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. In no event shall the insurance of an Eligible Dependent of a Qualified Retiree who is confined to a hospital be increased or decreased prior to the day on which the Qualified Retiree is discharged from the hospital.

GP-1-SI P130.7391

## Schedule of Premium Rates

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

GP-1-SI P130.9260

## *Option A* Premium Rates

***Vision Care Expense Insurance***

*GP-1-SI* *P130.3517*

***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 |
|---|---|---|---|
| $ 11.38 | $ 19.16 | $ 19.54 | $ 30.92 |

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

***Option A***

## 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

***Option A***

### 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

***Option A***

### 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

***Option A***

### Premiums

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

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

However, we may change such rates: (a) on the first day of any policy month; (b) on any date the extent or terms of coverage for a policyholder are changed by amendment of this policy; (c) on any date our obligation under this policy with respect to a policyholder is changed because of statutory or other regulatory requirements; or (d) if this policy supplements, or coordinates with benefits provided by any other insurer, non-profit hospital or medical service plan, or health maintenance organization, on any date our obligation under this policy is changed because of a change in such other benefits.

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

## Adjustment of Premiums Payable Other Than Monthly or Quarterly

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

## Grace in Payment of Premiums - Termination of Policy

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

If this policy ends during or at the end of the grace period, the policyholder will still owe us premium for all the time this policy was in force during the grace period.

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

GP-1-R-PREM-90 P140.0529

***Option A***

## Term of Policy - Renewal Privilege

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

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

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

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

P140.0626

- with respect to contributory Vision Care Expense insurance, less than 25% of those employees who are eligible for insurance under this plan are insured; or

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

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

## The Contract

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

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

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

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

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

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

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

GP-1-R-TERM-90 P140.0627

***Option A***

## Clerical Error - Misstatements

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

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

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

## Statements

No statement will void the insurance under this policy, or be used in defense of a claim hereunder unless: (a) in the case of the policyholder, it is contained in the application signed by him; or (b) in the case of a covered person, it is contained in a written instrument signed by him.

All statements will be deemed representations and not warranties.

GP-1-R-CE-90 P140.0309

***Option A***

## Assignment

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

- Any death benefits (including any basic term life, supplemental term life, optional term life or accidental death and dismemberment coverages) provided by this policy, may not be assigned.
- With respect to accident and health insurance, both the employee's certificate and his right to insurance benefits under this policy are not assignable. However, the employee may direct us, in writing, to pay hospital, surgical, major medical, or dental benefits to the recognized provider who provided the covered service for which benefits became payable. We may honor such request at our option. But, the employee may not assign his right to take legal action under this policy to such provider. And we assume no responsibility as to the validity or effect of any such direction.

## Assignment By Policyholder

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

GP-1-R-ASSIGN-90 P140.0165

***Option A***

## 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

***Option A***

## Employee's Certificate

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

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

## Claims of Creditors

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

## Records - Information To Be Furnished.

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

GP-1-R-CERT-90 P140.0167

***Option A***

## Accident And Health Claims Provisions

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

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

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

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

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

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

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

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

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

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

GP-1-R-AH-90 P140.0169

***Option A***

## COORDINATION BETWEEN CONTINUATION SECTIONS

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

(a) start at the same time;

(b) run concurrently; and

(c) end independently, on their own terms.

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

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

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

***Option A***

**AN IMPORTANT NOTICE ABOUT CONTINUATION RIGHTS**

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

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

(b) the section applies to the employee.

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

***Option A***

## Federal Continuation Rights

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

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

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

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

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

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

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

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

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

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

**Special Continuance for Retired Employees and their Dependents:** If an employee's group health benefits end due to a bankruptcy proceeding under Title 11 of the United States Code involving the employer, he or she may elect to continue such benefits, provided that:

(a) the employee is or becomes a retired employee on or before the date group health benefits end; and

(b) that employee and his or her dependents were covered for group health benefits under this plan on the day before the bankruptcy proceeding under Title 11 of the United States Code.

The continuation can last for the employee's lifetime. After the employee's death, the continuation period for a dependent can last for up to 36 months.

For purposes of this special continuance, a substantial elimination of coverage for the employee and his or her dependents within one year before or after the start of such proceeding will be considered loss of coverage.

If the employee dies before the bankruptcy proceeding under Title 11 of the United States Code, the surviving spouse and dependent children may elect to continue group health benefits on their own behalf, provided they were covered on the day before such proceeding. The continuation can last for the surviving spouse's lifetime.

This special continuance starts on the later of: (a) the date of the proceeding under Title 11; or (b) the day after the date group health benefits would have ended. It ends as described in "When Continuation Ends", except that a person's entitlement to Medicare will not end such continuance.

GP-1-R-COBRA-96-1 P235.0376

***Option A***

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

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

***Option A***

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

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

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

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

**Special Medicare Rule:** If the employee becomes entitled to Medicare before a termination of employment or reduction of work hours, a special rule applies for a dependent. The continuation period for a dependent, after the employee's later termination of employment or reduction of work hours, will be the longer of: (a) 18 months (29 months if there is a disability extension) from the employee's termination of employment or

reduction of work hours; or (b) 36 months from the date of the employee's earlier entitlement to Medicare. If Medicare entitlement occurs more than 18 months before termination of employment or reduction of work hours, this special Medicare rule does not apply.

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

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

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

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



***Option A***

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

***Option A***

## Uniformed Services Continuation Rights

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

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

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

GP-1-R-COBRA-96-4 P235.0139

***Option A***

## ELIGIBILITY FOR VISION CARE EXPENSE COVERAGE

P505.0053

***Option A***

## EMPLOYEE COVERAGE

### Eligible Employees

Subject to the Conditions of Eligibility set forth below, and to all of the other conditions of the plan, all of your employees who are in an eligible class will be eligible if: (a) they are active full-time employees; or (b) qualified retirees.

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, or a qualified retiree.

GP-1-EC-90-1.0 P180.0173

***Option A***

**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 December 1st to December 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

***Class 0001***

**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

***Option A***

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

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

***Option A for Class 0001***

## When Employee Coverage Starts

An employee must be actively at work, and working his or her regular number of hours, on the date his or her coverage is scheduled to start. And he or she must have met all of the conditions of eligibility which apply to him or her . If an employee is not actively at work on his or her scheduled effective date, we will postpone the start of his or her coverage until he or she 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 or she was actively at work, and working his or her regular number of hours, on his or her 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 or she must elect to enroll and agree to make the required payments. If he or she does this on or before the eligibility date, or within 31 days of the eligibility date, his or her coverage is scheduled to start on his or her eligibility date. If he or she does this more than 31 days after his or her eligibility date, his or her coverage is scheduled to start on the date he or she signs his or her enrollment form.
- On non-contributory plans, subject to all the terms of this plan, an employee's coverage is scheduled to start on his or her eligibility date.

GP-1-EC-90-6.0 P505.0605

***Option A for Class 0001***

## When Employee Coverage Ends

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

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

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

GP-1-EC-90-8.0 P489.0026-R

***Option A for Class 0001***

**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.



***Option A***

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

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

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

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

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

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

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

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

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

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

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

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

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

***Option A***

## Definitions

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

***Option A***

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

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

***Option A***

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

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

***Option A***

**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

***Option A***

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

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

***Option A***

**Qualified Retirees** are covered as outlined in your company's benefit provisions. Please see your Plan Administrator for details.

GP-1-EC-90-DEF-8 P180.0331

***Option A***

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

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

***Option A***

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

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

***Option A***

## Dependent Coverage

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

***Option A***

**Eligible Dependents For Dependent Vision Care Benefits:** An employee's eligible dependents are: (a) his or her legal spouse; (b) his or her unmarried dependent children who are under age 25; and (c) his or her unmarried dependent children, from age 25 until their 26th birthday, who are enrolled as full-time students at accredited schools.

An unmarried dependent child who is not able to remain enrolled as a full-time student due to a medically necessary leave of absence may continue to be an eligible dependent until the earlier of: (a) the date that is one year after the first day of the medically necessary leave of absence; or (b) the date on which coverage would otherwise end under this plan. 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 P505.0652

***Option A***

**Adopted Children, Step-Children and Grandchildren:** An employee's "unmarried dependent children" include: (a) his or her legally adopted children; (b) his or her grandchildren who are dependents for federal income tax purposes at the time application for coverage of the grandchildren are made; and (c) 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-90-3.1 P505.0143

***Option A***

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

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

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

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

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

***Option A for Class 0001***

**When Dependent Coverage Starts:** In order for an employee's dependent coverage to begin, he or she must already be insured for employee coverage, or enroll for employee and dependent coverage at the same time. Subject to the "Exception" stated below and to all of the terms of this plan, the date an employee's dependent coverage starts depends on when he or she 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 during the enrollment period, his or her dependent coverage is scheduled to start on the date the employee becomes insured 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 P505.0606

***Option A***

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

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

***Option A***

**Newborn Children:** We cover an employee's 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

***Option A***

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

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

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

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

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

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

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

***Option A***

## Definitions

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

***Option A***

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

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

***Option A***

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

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

***Option A***

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

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

***Option A***

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

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

***Option A***

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

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

***Option A***

**Plan** means the Guardian group plan purchased by the employer.

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

***Option A***

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

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

***Option A***

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

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

***Option A***

**ATTACHED TO AND MADE A PART OF GROUP INSURANCE POLICY NO. G-00520283-**

issued by

**The Guardian** Life Insurance Company of America

(herein called the Insurance Company)

to

**MIDLAND COUNTY**

(herein called the Policyholder)

Effective January 1, 2016, this rider amends the "Dependent Coverage" provision cares as follows:

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

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

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

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

The domestic partner's dependent children will be eligible for coverage under this plan on the same basis as if the children were the employee's dependent children.

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

But, at the end of such coverage, continuation and conversion rights, if any, to which the domestic partner and his or her dependent children may be entitled, will be available. Read "Continuation Rights" and "Converting This Group Health Insurance" to find out what is allowed under this plan and how it works. The domestic partner and his or her children will be not eligible for survivor benefits upon the employee's death as explained under the "When Dependent Coverage Ends" section.

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 _____ , ____

MIDLAND COUNTY
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-DMST-96-WI P505.0094

***Option A***

## 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

***Option A***

## 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, and annually thereafter, 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-PPOATX P505.0305

***Option A***

**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 will request approval for Necessary Contact Lenses from VSP.

If Contact Lenses are not found to be medically necessary, and a Covered Person receives Contact Lenses under this Policy, they will be treated as Elective Contact Lenses and the provisions of the Elective Contact Lenses section of this Policy will not apply.

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

GP-1-VSN-96-PTR2TX P505.0307

***Option A***

**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

***Option A***

## 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 will receive approval from VSP prior to providing the Covered Person with any service or supply. See the "Pre-Authorization of Preferred Provider Services" section of this Plan for specific requirements.

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

For each vision examination from a Preferred Provider . . . . . $10.00

For each pair of Standard Frames and/or Standard Lenses from a Preferred Provider . . . . . $25.00

For Necessary Contact Lenses from a Preferred Provider . . . . . $25.00

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

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

For Covered Charges . . . . . 100%

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

***Option A***

## Services or Supplies From a Non-Preferred Provider

If a Covered Person uses the services of a Non-Preferred Provider, the Covered Person must submit the itemized bill to VSP for claims payment. All claims must be sent to VSP within 90 days of the date services are completed or supplies are received, or as soon as reasonably possible. 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 . . . . . $25.00

For each pair of Necessary Contact Lenses from a Non-Preferred Provider . . . . . $25.00

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

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

For Covered Charges . . . . . 100%



***Option A***

## Covered Charges

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

## Covered Services and Supplies

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

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

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

- prescribing and ordering of proper lenses;
- assisting in the selection of frames;
- verifying the accuracy of finished lenses;
- proper fitting and adjustment of frames;

- subsequent adjustments to frames to maintain comfort and efficiency; and
- progress or follow-up work as necessary.

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

And if a Covered Person uses a Non-Preferred Provider, we limit what we pay for each vision examination to $39.00.

GP-1-VSN-96-LIST1 P505.0755

***Option A***

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

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

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

GP-1-VSN-09-SL P505.0837

***Option A***

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

GP-1-VSN-09-SL P505.0858

***Option A***

**Standard Frames:** We cover charges for standard frames.

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

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

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

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

GP-1-VSN-15-SF P505.1457

***Option A***

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

(a) following cataract surgery;

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

(c) for certain conditions of Anisometropia; or

(d) for Keratoconus.

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

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

GP-1-VSN-96-LIST7 P505.0897

***Option A***

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

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

If a covered person uses a non-preferred provider, we limit what we pay for elective contact lenses to $100.00.

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

GP-1-VSN-09-ECL P505.0919

***Option A***

## 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

***Option A***

## 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

***Option A***

- We will not pay for plano lenses (lenses with less than a +/- .38 diopter power).
- We will not pay for two sets of glasses in lieu of bifocals.
- We will not pay for replacement of lenses and frames furnished under this plan which are lost or broken, except at normal intervals when services are otherwise available.
- We will not pay for cosmetic lenses or any cosmetic process, unless specifically shown as covered in the "Covered Services and Supplies" section.
- We will not pay for a frame that costs more than the plan allowance.
- We will not pay for refitting of contact lenses after the initial 90 day fitting period.
- We will not pay for routine maintenance of contact lenses such as polishing or cleaning.
- We will not pay for Corneal Refractive Therapy (CRT) or Orthokeratology (procedure using contact lenses to change the shape of the cornea in order to reduce myopia).

GP-1-VSN-09-EXC P505.0921

***Option A***

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

P505.0922

***Option A***

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

P505.0923

***Option A***

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

P505.0924

***Option A***

- We will not pay for blended lenses.

P505.0925

***Option A***

- We will not pay for high index lenses.

P505.0926

***Option A***

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

P505.0927

***Option A***

- We will not pay for oversized lenses.

P505.0928

***Option A***

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

P505.0929

***Option A***

- We will not pay for edge treatment.

P505.0930

***Option A***

- We will not pay for progressive lenses.
- We will not pay for progressive multifocal lenses.

P505.0931

***Option A***

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

P505.0932

***Option A***

- We will not pay for polycarbonate lenses.

P505.0933

GP-1-VSN-09-EXC P505.0934

***Option A***

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

***Option A***

## 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

***Option A***

**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

***Option A***

**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

***Option A***

**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

***Option A***

**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

***Option A***

**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

***Option A***

**ATTACHED TO AND MADE PART OF GROUP INSURANCE POLICY NO. G -00520283-**

issued by

**The Guardian** Life Insurance Company of America

(herein called the Insurance Company)

to

**MIDLAND COUNTY**

(herein called the Policyholder)

The Policyholder and the Insurance Company hereby agree that the Group Policy is hereby amended effective January 1, 2016 as follows:

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

(a) an employee's dependent child is a child under age 26;

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

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

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

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

Dated at _____ This _____ Day of _____ , ____

MIDLAND COUNTY
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

GUR-1 P505.1197

***Option A***

## STATEMENT OF ERISA RIGHTS

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

**Receive Information About The Plan and Benefits**

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

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

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

**Continue Group Health Plan Coverage**

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

## Prudent Actions By Plan Fiduciaries

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

## Enforcement Of An Employee's Rights

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

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

## Assistance with Questions

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

## Qualified Medical Child Support Order

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

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

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

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

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

P800.0066

***Option A***

## The Guardian's Responsibilities

P800.0037

***Option A***

The 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

***Option A***

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

P800.0038

# GROUP HEALTH BENEFITS CLAIMS PROCEDURE

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

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

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

## Definitions

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

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

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

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

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

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

## Timing For Initial Benefit Determination

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

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

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

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

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

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

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

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

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

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

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

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

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

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

## Adverse Benefit Determination

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

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

## Appeal of Adverse Benefit Determinations

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

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

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

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

In reviewing an appeal, Guardian will

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

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

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

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

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

## Alternative Dispute Options

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

P800.0056

*END OF POLICY DOCUMENT*