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

NON-PEDIATRIC SCHEDULE OF BENEFITS

This Policy includes pediatric dental services as required under the federal Patient Protection and Affordable Care Act.

The Policy refers to various dollar and percentage amounts, as well as other benefit information that may be specific to Pediatric Dental Benefits. This Schedule summarizes benefit information and the date these benefits take effect. You selected some of these benefits when You applied for this Policy. As Your needs change over the time You own this Policy, You may change some of these benefits without replacing or purchasing a new Policy. Some of the provisions of this Policy require automatic changes. For example, when a Dependent no longer qualifies for coverage under this Policy due to their age, that Dependent’s coverage will terminate.

Please read the entire Policy, along with this Schedule of Benefits, to fully understand all terms, conditions, limitations and exclusions that apply.

POLICYOWNER Refer to Your ID Card
POLICY NUMBER Refer to Your ID Card
EFFECTIVE DATE The Effective Date Approved by Us
POLICY ANNIVERSARIES: The Anniversary of the Effective Date, Each Year.

Cash Deductible Information

Deductible per Insured per Benefit Year
(When 3 Insureds meet the Deductible, no additional Deductibles will be required to be met for that Benefit Year.)

Preferred Provider Benefit Year Cash Deductible:
Group I, Group II and Group III Services ................................................................. $75.00

Non-Preferred Provider Benefit Year Cash Deductible:
Group I, Group II and Group III Services ................................................................. $150.00

Payment Rates

Preferred Provider Payment Rate for services provided by a DentalGuard Preferred Provider:

Group I Services ........................................................................................................ 100%
Group II Services .................................................................................................... 50%
Group III Services ................................................................................................... 50%
Group IV (Orthodontic) Services ............................................................................ 0%

Non-Preferred Provider Payment Rate for:

Group I Services ........................................................................................................ 100%
Group II Services .................................................................................................... 50%
Group III Services ................................................................................................... 50%
Group IV (Orthodontic) Services ............................................................................ 0%
Maximums and Waiting Periods

Preferred Provider & Non-Preferred Provider Annual Maximum
Annual Maximum per Covered Person ................................................................. $1,000.00

Preferred Provider & Non-Preferred Provider Waiting Periods
Group I Services .................................................................................................... None
Group II Services .................................................................................................. 6 Months
Group III Services ............................................................................................... 12 Months

How It Works

This Policy is designed to provide high quality dental care while controlling the cost of such care. To do this, this Policy encourages a Covered Person to seek dental care from Dentists and dental care facilities that are under contract with Guardian’s dental preferred provider organizations (PPOs), which is called DentalGuard Preferred.

The dental PPO is made up of Preferred Providers in a Covered Person’s geographic area. Use of the dental PPO is voluntary. A Covered Person may receive dental treatment from any dental provider he or she chooses. And he or she is free to change providers at any time. When You enroll in this Policy, You and Your covered dependents receive: (1) a dental insurance ID card; and (2) information about current Preferred Providers.

This Policy usually pays a higher level of benefits for covered treatment furnished by a Preferred Provider. Conversely, it usually pays less for covered treatment furnished by a Non-Preferred Provider.

A Covered Person must present his or her ID card when he or she uses a Preferred Provider. Most Preferred Providers prepare necessary claim forms, and submit the forms to Us. We send the Covered Person an explanation of this Policy’s benefit payments. But, any benefit payable by Us is sent directly to the Preferred Provider.

What We pay is based on all of the terms of this Policy. Please read this Policy carefully. A Covered Person may call Guardian at the number shown on his or her ID card should he or she have any questions about this Policy.

Please review the coverage, exclusions and limitations. Some services require prior authorization.

Covered charges are the charges listed in the applicable fee schedule the Preferred Provider Dentist has agreed to accept as payment in full, for the dental services included in the List of Covered Dental Services below.

How to Reach Us

<table>
<thead>
<tr>
<th>Claim Dept.</th>
<th>Member Services Line</th>
<th>On the Web</th>
</tr>
</thead>
<tbody>
<tr>
<td>P O Box 981587 El Paso, TX 79998-1587</td>
<td>(844) 561-5600</td>
<td>dentalexchange.guardianlife.com</td>
</tr>
</tbody>
</table>
NON-PEDIATRIC DENTAL SERVICES

List Of Covered Non-Pediatric Dental Services
The services covered by this Plan are named in this list. In order to be covered, the service must be furnished by, or under the direct supervision of, a Dentist. And, it must be usual and necessary treatment for a dental condition.

Group I Services – (Diagnostic & Preventive)

Prophylaxis/Cleaning and Fluorides
Prophylaxis/cleaning: Limited to a total of one prophylaxis/cleaning or periodontal maintenance procedure in any six consecutive month period. Allowance includes scaling and polishing procedures to remove coronal plaque, calculus and stains. Also see Periodontal Maintenance under Group II Services (Basic).

Additional prophylaxis/cleaning when needed as a result of a medical (i.e., a non-dental) condition: Covered once in any 12 consecutive month period, and only when the additional prophylaxis/cleaning is recommended by the Dentist and is a result of a medical condition as verified in writing by the Covered Person's medical physician. This does not include a condition which could be resolved by proper oral hygiene or that is the result of patient neglect.

Office Visits, Evaluations and Examination
Comprehensive oral evaluation – limited to once every 36 consecutive months per Dentist. All office visits, oral evaluations, examinations or limited problem focused re-evaluations: Limited to a total of one in any six consecutive month period.

Limited oral evaluation – problem focused or emergency oral evaluation: Limited to a total of one in any six consecutive month period. After-hours office visit or emergency palliative treatment limited to a total of one in any six consecutive month period. Covered only when no other treatment, other than radiographs, is performed in the same visit.

Fixed and Removable Appliances
Fixed and removable Appliances to inhibit thumbsucking: Limited to Covered Persons under age 14 and limited to initial Appliance only. Allowance includes all adjustments in the first six months after insertion.

Radiographs
Allowance includes evaluation and diagnosis.

Full mouth, complete series or panoramic radiograph: Either but not both of the following procedures, limited to one in any 60 consecutive month period.

- Full mouth series, of at least 14 images including bitewings.
- Panoramic image, maxilla and mandible, with or without bitewing radiographs.

Bitewing images: Limited to either a maximum of four bitewing images or a set (seven - eight images) of vertical bitewings, in one visit, once in any 12 consecutive month period.

Intraoral periapical or occlusal images- single images.

Group II Services (Basic)

Restorative Services
Multiple restorations on one surface will be considered one restoration. Replacement of existing amalgam and resin restorations will only be covered if at least 12 months have passed since the previous restoration was placed if the Covered Person is under age 19, and 36 months have passed since the previous restoration was placed if the Covered Person is age 19 or older.
Amalgam restorations: Allowance includes bonding agents, liners, bases, polishing and local anesthetic.

Resin restorations: Limited to Anterior Teeth only. Coverage for resins on Posterior Teeth is limited to the corresponding amalgam benefit. Allowance includes light curing, acid etching, adhesives, including resin bonding agents, and local anesthetic.

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

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

Diagnostic Services

Allowance includes examination and diagnosis.

Consultations: Diagnostic consultation with a Dentist other than the one providing treatment, limited to one consultation for each Covered Dental Specialty in any 12 consecutive month period. This dental Plan covers a consultation only when no other treatment, other than radiographs, is performed during the visit.

Diagnostic casts when needed to prepare a treatment plan for three or more of the following performed at the same time in more than one arch: (1) dentures; (2) crowns; (3) bridges; (4) inlays or onlays.

Accession of tissue: Accession of exfoliative cytologic smears are considered when performed in conjunction with a biopsy of tooth related origin. Consultation for oral pathology laboratory is considered if done by a Dentist other than the one performing the biopsy.

Non-Surgical Extractions

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

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

Other Services

Injectable antibiotics needed solely for treatment of a dental condition.

Group III Services (Major)

Restorative Services

Crowns, inlays, onlays, labial veneers and crown buildups are covered only when needed because of decay or Injury, and only when the tooth cannot be restored with amalgam or resin based composite filling material. Facings on dental prostheses for teeth posterior to the second bicuspid are not covered. Post and cores are covered only when needed due to decay or Injury. Allowance includes insulating bases, temporary or provisional restorations and associated gingival involvement. Temporary Appliances older than one year are considered be a permanent Appliance. Limited to permanent teeth only. Also see Exclusions sections for replacement and limitations. Single Crowns:

- Resin with metal.
- Porcelain.
- Porcelain with metal.
- Full cast metal (other than stainless steel).
- Titanium.
• 3/4 cast metal crowns.
• 3/4 porcelain crowns.

Inlays.

Onlays, including inlay.

Labial veneers.

Posts and buildups: Only when done in conjunction with a covered unit of crown or bridge and only when necessitated by substantial loss of natural tooth structure.

• Cast post and core in addition to a unit of crown or bridge, per tooth.
• Prefabricated post and core in addition to a unit of crown or bridge, per tooth.
• Crown or core buildup, including pins.

Implant supported prosthetics: Allowance includes the treatment plan and local anesthetic, when done in connection with a covered surgical placement of an implant on the same tooth.

• Abutment supported crown.
• Implant supported crown.
• Abutment supported retainer for fixed partial denture.
• Implant supported retainer for fixed partial denture.
• Implant/abutment supported removable denture for completely edentulous arch.
• Implant/abutment supported removable denture for partially edentulous arch.
• Implant/abutment supported fixed denture for completely edentulous arch.
• Implant/abutment supported fixed denture for partially edentulous arch.

**Prosthodontic Services**

Specialized techniques and characterizations are not covered. Facings on dental prostheses for teeth posterior to the second bicuspid are not covered. Allowance includes insulating bases, temporary or provisional restorations and associated gingival involvement. Limited to permanent teeth only. Also, see the Special Limitations section and Exclusions.

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

Bridge abutments:

• Resin with metal
• Porcelain
• Porcelain with metal
• Full cast metal
• Titanium
• 3/4 cast metal
• 3/4 porcelain

Bridge Pontics:

• Resin with metal
• Porcelain
• Porcelain with metal.
- Full cast metal
- Titanium

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

Complete or immediate dentures, upper or lower.

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

Simple stress breakers, per unit.

Crown and Prosthodontic Restorative Services

Crown and bridge repairs: Allowance based on the extent and nature of damage and the type of material involved.

Recementation: Limited to recementations performed more than 12 months after the initial insertion.
- Inlay or onlay.
- Crown.
- Bridge.

Adding teeth to partial dentures to replace extracted natural teeth.

Denture repairs: Allowance based on the extent and nature of damage and on the type of materials involved.
- Denture repairs, metal.
- Denture repairs, acrylic.
- Denture repair, no teeth damaged.
- Denture repair, replace one or more broken teeth.
- Replacing one or more broken teeth, no other damage.

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

Denture reline, full or partial denture: Limited to once per denture in any 24 consecutive month period. Denture rebases done within 12 months are considered to be part of the denture placement when the reline is done by the Dentist who furnished the denture. Limited to rebase done more than 12 consecutive months after the insertion of the denture.
Denture adjustments: Denture adjustments done within six months are considered to be part of the denture placement when the adjustment is done by the Dentist who furnished the denture. Limited to adjustments that are done more than six consecutive months after a denture rebase, denture reline or the initial insertion of the denture.

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

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

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

Pulpotomy: Only when root canal therapy is not the definitive treatment.

Pulpal debridement.

Pulpal therapy: Limited to primary teeth only.
- Root canal treatment  Root canal retreatment Limited to once per tooth, per lifetime.
- Treatment of root canal obstruction, no surgical access.
- Incomplete endodontic therapy, inoperable or fractured tooth.
- Internal root repair of perforation defects.
- Apexification: Limited to a maximum of three visits.
- Apicoectomy: Limited to once per root, per lifetime.
- Root amputation: Limited to once per root, per lifetime.
- Retrograde filling: Limited to once per root, per lifetime.
- Hemisection, including any root removal: Once per tooth.

Periodontal Services
Periodontal maintenance: Limited to a total of one periodontal maintenance or prophylaxis/cleaning in any six month period. Allowance includes periodontal charting, scaling and polishing. Also see Prophylaxis/cleaning under Prophylaxis/Cleaning And Fluorides in Group I Services (Basic).

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

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

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

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

- Gingivectomy or gingivoplasty, per tooth (less than three teeth).
- Crown lengthening, hard tissue.

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

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

The treatment listed below is limited to a total of one of the following, once per quadrant in any 36 consecutive month period, when the tooth is present, or when dentally necessary as part of a covered surgical placement of an implant.

- Pedicle or free soft tissue grafts, including donor site.
- Subepithelial connective tissue graft procedure.

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

- Guided tissue regeneration, resorbable barrier or nonresorbable barrier.
- Bone replacement grafts.

**Periodontal Surgery Related**

Limited occlusal adjustment: Limited to a total of two visits, covered only when done within a six consecutive month period after covered scaling and root planing or osseous surgery.

Occlusal guards: Covered only when done within a six consecutive month period after osseous surgery, and limited to one per lifetime.

**Surgical Extractions**

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

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

**Other Oral Surgical Procedures**

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

- Alveoloplasty, per quadrant.
- Removal of exostosis, per site.
- Incision and drainage of abscess.
- Frenulectomy, frenectomy, frenotomy.
Biopsy and examination of tooth related oral tissue.

Brush biopsy
Surgical exposure of impacted or unerupted tooth to aid eruption.
Excision of tooth related tumors, cysts and neoplasms.
Excision or destruction of tooth related lesion(s).
Excision of hyperplastic tissue.
Excision of pericoronal gingiva, per tooth.
Oroantral fistula closure.
Sialolithotomy.
Sialodochoplasty.
Closure of salivary fistula. Excision of salivary gland.
Maxillary sinusotomy for removal of tooth fragment or foreign body.
Vestibuloplasty.

Other Services

General anesthesia, intramuscular sedation, intravenous sedation, non-intravenous sedation or inhalation sedation, nitrous oxide, when administered in connection with covered periodontal surgery, surgical extractions, the surgical removal of impacted teeth, apicoectomies, root amputations and services listed under Other Surgical Procedures.

Waiting Periods For Certain Services

The following services when furnished by a Preferred Provider or Non-Preferred Provider are not considered covered charges during the waiting period shown in the Schedule of Benefits:

Group II Services
Group III Services

The services shown above are not covered charges under this Policy, and cannot be used to meet this Policy's Deductibles.

Limitations

Teeth Lost, Extracted or Missing Before A Covered Person Becomes Covered By This Policy: A Covered Person may have one or more congenitally missing teeth or may have had one or more teeth lost or extracted before he or she became covered by this Policy. We do not cover charges for a Dental Prosthesis which replaces such teeth unless the Dental Prosthesis also replaces one or more eligible natural teeth lost or extracted after he or she became covered by this Policy.

Exclusions

We will not pay for:

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

- Treatment for which benefits are paid by Worker’s Compensation or similar laws.

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

- Any procedure performed in conjunction with, as part of, or related to a procedure which is not covered by this Plan.
• Any service furnished solely for cosmetic reasons, unless this Plan provides benefits for a specific cosmetic services. Excluded cosmetic services include but are not limited to: (1) characterization and personalization of a Dental Prosthesis; and (2) odontoplasty.

• Maxillofacial prosthetics that repair or replace facial and skeletal anomalies, maxillofacial surgery, orthognathic surgery or any oral surgery requiring the setting of a fracture or dislocation; that is incidental to or results from a medical condition.

• Replacing an existing Appliance or Dental Prosthesis with a like or unlike Appliance or Dental Prosthesis unless: (1) it is at least ten years old and is no longer usable; or (2) it is damaged while in the Covered Person’s mouth in an Injury suffered while covered, and cannot be made serviceable.

• Any procedure, Appliance, Dental Prosthesis, modality or surgical procedure intended to treat or diagnose disturbances of the temporomandibular joint (TMJ) that are incidental to or result from a medical condition.

• Educational services, including, but not limited to: (1) oral hygiene instruction; (2) plaque control; (3) tobacco counseling; or (4) diet instruction.

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

• Any restoration, procedure, Appliance or prosthetic device used solely to: (1) alter vertical dimension; (2) restore or maintain occlusion; (3) treat a condition necessitated by attrition or abrasion; or (4) splint or stabilize teeth for periodontal reasons.

• Bite registration or bite analysis.

• Precision attachments and the replacement of part of a: (1) precision attachment; or (2) magnetic retention or overdenture attachment.

• Replacement of a lost, missing or stolen Appliance or Dental Prosthesis or the fabrication of a spare Appliance or Dental Prosthesis.

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

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

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

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

• Temporary or provisional Dental Prosthesis or Appliances except interim partial dentures/stayplates to replace Anterior Teeth extracted while covered under this Plan.

• Cephalometric radiographs, oral/facial images, including traditional photographs and images obtained by intraoral camera.

• Orthodontic Treatment, unless the benefit provision provides specific benefits for Orthodontic Treatment.

• Prescription medication.

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

• Pulp vitality tests or caries susceptibility tests.

• The localized delivery of antimicrobial agents via a controlled release vehicle into diseased crevicular tissue.

• Tooth transplants.
• Evaluations and consultations for non-covered services, or detailed and extensive oral evaluations.

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

• Treatment of congenital or developmental malformations, or the replacement of congenitally missing teeth.
Discounts on Non-Orthodontic Dental Services Not Covered By This Plan

A Covered Person under this Policy can receive discounts on certain services not covered by this Policy, as described below, if:

(a) he or she receives services or supplies from a Dentist that is under contract with Guardian’s dental preferred provider organizations (PPOs) network; and

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

The services described in this provision are not covered by this Policy. The Covered Person must pay the entire discounted fee directly to the Dentist. There is no need to file a claim.

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

Discounts on Services Not Covered Due To Contractual Provisions

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

(a) meeting the plan’s benefit year payment limit provision;

(b) frequency limitations; or

(c) policy exclusions, such as dental implants.

Discounts on Orthodontic Services

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

(a) pre-orthodontic treatment visit;

(b) limited orthodontic treatment;

(c) interceptive orthodontic treatment, including fabrication and insertion of fixed appliances and periodic visits;

(d) comprehensive orthodontic treatment, including fabrication and insertion of fixed appliances and periodic visits;

(e) periodic comprehensive orthodontic treatment visit (as part of a contract); or

(f) orthodontic retention, including fixed and removable initial appliances and related visits.

Discounted fees are not available for:

- incremental charges for orthodontic appliances made with clear, ceramic, white, lingual brackets or other optional materials;
- procedures, appliances or devices to guide minor tooth movement or to correct harmful habits;
- retreatment of orthodontic cases, or changes in orthodontic treatment needed due to an accident;
- extractions performed solely to facilitate orthodontic treatment;
- orthognathic surgery and associated incremental charges; and
- replacement of lost or broken retainers.
Notice Informing Individuals about Nondiscrimination and Accessibility Requirements

Discrimination is Against the Law

Guardian and its subsidiaries comply with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Guardian and its subsidiaries does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Guardian and its subsidiaries provide free aids and services to people with disabilities to communicate effectively with us, such as: qualified sign language interpreters; written information in other formats (large print, audio, accessible electronic formats); and provides free language services to people whose primary language is not English, such as: qualified interpreters and Information written in other languages.

If you need these services, call 1-844-561-5600.

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

Guardian Civil Rights Coordinator  
ATTN: Manager Compliance Metrics, Corporate Compliance  
Guardian Life Insurance Company of America  
7 Hanover Square - 23F  
New York, New York 10004

212-919-3162

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, Guardian’s Civil Rights Coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at:

https://ocrportal.hhs.gov/ocr/portal/lobby.jsf

or by mail or phone at:

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

Complaint forms are available at:

### IMPORTANT NOTICE REGARDING LANGUAGE ASSISTANCE & DISCRIMINATION

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<tr>
<td><strong>English</strong></td>
<td>If you or the person you are helping has questions about your insurance benefits, claims, or coverage, you have the right to help and information in your language at no cost. To talk to an interpreter: if you have insurance from your employer, call the telephone number on your identification card; for all other members, please call 844-561-5600. The Guardian and its subsidiaries* comply with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.</td>
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<tr>
<td><strong>Spanish</strong></td>
<td>Si usted o la persona que está ayudando tiene preguntas acerca de su seguro, las reclamaciones o cobertura, usted tiene derecho a obtener ayuda e información en su idioma sin costo alguno. Para hablar con un intérprete: si tiene seguro de su empleador, llame al número de teléfono que aparece en su tarjeta de identificación; para todos los demás miembros, por favor llame al 844-561-5600. The Guardian y sus subsidiarias * cumplir con las leyes federales aplicables de derechos civiles y no discrimina por motivos de raza, color, origen nacional, edad, discapacidad, o sexo.</td>
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<tr>
<td><strong>Chinese</strong></td>
<td>如果你或你正在帮助的人拥有你的保险利益，索赔或覆盖的问题，你有没有成本，以获取帮助和信息在你的语言的权利。要交谈的解释：如果您从您的雇主有保险，打电话给你的身份证上的电话号码;所有其他成员，请致电 844-561-5600。卫报及其子公司*遵守适用的联邦民权法和种族，肤色，国籍，年龄，残疾，或性的基础上歧视。</td>
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<tr>
<td><strong>Vietnamese</strong></td>
<td>Nếu bạn hoặc người bạn đang giúp đỡ có câu hỏi về bảo hiểm, yêu cầu hoặc bảo hiểm, bạn có quyền được trợ giúp và thông tin trong ngôn ngữ của bạn miễn phí. Để nói chuyện với một người nói tiếng Việt nam: nếu bạn có bảo hiểm từ công ty của bạn, hãy gọi số điện thoại trên thẻ danh công của bạn; cho tới cuối cùng bạn hiểu, xin vui lòng gọi 844-561-5600. The Guardian và các công ty con của nó * tuân thủ pháp luật quyền dân sự liên bang áp dụng và không phân biệt đối xử trên cơ sở chủng tộc, màu da, nguồn gốc quốc gia, tuổi tác, tình trạng sức khỏe hoặc quan hệ tình dục.</td>
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<tr>
<td><strong>Tagalog</strong></td>
<td>Kung ikaw o ang taong ikaw ay pagtulong ay may mga katanungan tungkol sa iyong mga benepisyos sa insurance, claims, o coverage, ikaw ay may karapatan upang makakaya ng tulong at impormasyon sa iyong wika nang walang gastos. Upang makipag-usap sa isang interpreter: kung mayroon kang insurance mula sa iyong tagapag-employo, tawagan ang numero ng telepono sa iyong identification card; para sa lahat ng iba pang mga miyembro, mangyaring tumawag sa 844-561-5600. The Guardian at ang mga subsidiaries * sumusunod sa naaangkop na mga Pederal na batas sa mga karapatang sibil at hindi maaabot ng iba pang mga miyembro, mangyaring tumawag sa 844-561-5600.</td>
</tr>
<tr>
<td><strong>Korean</strong></td>
<td>당신이나 당신이 도움이 되고 사정이 당신의 책임 범위, 정규, 또는 범위에 대한 질문이 있는 경우, 당신은 무료로 귀하의 언어로 도움과 정보를 얻을 수 있는 권리가 있습니다. 정규 기대하려면, 당신은 당신의 고용주로부터 정보를 얻을 수 있는 경우, 귀하의 ID 카드에 전화번호로 전화; 다른 모든 구성원에 대해, 844-561-5600으로 전화해 주십시오.</td>
</tr>
<tr>
<td><strong>Russian</strong></td>
<td>Если вы или человек, которому вы помогаете есть вопросы по поводу вашего страхового выплат, претензий, или покрытия, вы имеете право получить помощь и информацию на вашем языке без каких-либо затрат. Для того, чтобы поговорить с переводчиком: если у вас есть страхование от Вашего работодателя, позвоните по номеру телефона на вашей идентификационной карточке; для всех остальных членов, просьба звонить по телефону 844-561-5600. The Guardian и его дочерние компании * соответствуют действующим федеральным законам о гражданских правах и не допускают дискриминации по признакам расы, цвета кожи, национального происхождения, возраста, инвалидности или пола.</td>
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<tr>
<td><strong>Arabic</strong></td>
<td>إذا كنت أو الشخص الذي يساعدت أنت أو الشخص الذي يساعدتك يعانون من مشكلات أو تحديات، فإنك بالفعل تمتلك الحقوق في الحصول على الدعم والمعلومات在床上 Ayrıca ذكرت. <strong>ترجمة:</strong> إذا كان لديك الأشخاص من مصادر العمل الخاص بك الأصول، أنت بالفعل على إطلاع عبَّارة عن مبادئ المعايير الخاصة بالقيم. لجميع الأعضاء، نحن نهتم بالجميع، لا سيما في مجال حقوق الإنسان، أو الإعاقة، أو الجنس.</td>
</tr>
<tr>
<td><strong>French Creole-Haitian Creole</strong></td>
<td>Si ou menm osou moun nan w ap ede gen kesyon sou benefis asirans ou, reklamasyon, osou pwoteksyon, ou gen dwa pou jwenn ed ak enfòmasyon nan lang ou a pa koute. Pou pale ak yon entèpre: si ou gen asirans nan men anplwayè ou, rele nimewo telefon sou kat idantifikasyon ou; pou tout lòt mamn, tanpri rele 844-561-5600. The Guardian ak filiales li yo * konfòm yo avèk lwa sou dwa sivil Federal aplikab yo, epi fa ët diskriminasyon sou baz ras, koulè, orijin nasyonal, laj, andikap, oswa fè sèks.</td>
</tr>
<tr>
<td><strong>Polish</strong></td>
<td>Jeśli Ty lub osoba, do której pomóc ma pytania dotyczące świadczeń z ubezpieczenia, roszczenia lub pokrycia, masz prawo do uzyskania pomocy i informacji w swoim języku, bez żadnych kosztów. Aby rozmawiać z tłumaczą: jeśli masz ubezpieczenie od pracodawcy, należy zadzwonić pod numer telefonu na karcie identyfikacyjnej; dla wszystkich pozostałych członków, zadzwonić 844-561-5600. The Guardian i jej spółki zależne * przestrzegają obowiązujących przepisów federalnych praw obywatelskich i nie dyskryminacji ze względu na rasę, kolor skóry, pochodzenie narodowe, wiek, niepełnosprawność, czy płeć.</td>
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</tbody>
</table>
Si vous ou la personne que vous aidez a des questions sur vos prestations d’assurance, les prétentions ou la couverture, vous avez le droit d’obtenir de l’aide et de l’information dans votre langue, sans frais. Pour parler à un interprète: si vous avez l’assurance de votre employeur, appelez le numéro de téléphone sur votre carte d’identité; pour tous les autres membres, s’il vous plaît appelez 844-561-5600.

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Se voi o la persona che state aiutando ha domande circa la vostra prestazioni assicurative, reclami, o la copertura, si ha il diritto di richiedere assistenza e informazioni nella propria lingua, senza alcun costo. Per parlare con un interprete: se avete l’assicurazione dal datore di lavoro, chiamare il numero di telefono sulla carta d’identità; per tutti gli altri membri, si prega di chiamare 844-561-5600.

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Se você ou a pessoa que você está ajudando tem dúvidas sobre seus benefícios de seguro, reivindicações, ou cobertura, você tem o direito de obter ajuda e informações na sua língua, sem nenhum custo. Para falar com um intérprete: se você tem seguro de seu empregador, ligue para o número de telefone no seu cartão de identificação; para todos os outros membros, ligue para 844-561-5600.

Este aviso tem informações importantes sobre a sua aplicação ou sua cobertura de seguro. Olhe para as datas-chave neste aviso.

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