YOUR GROUP INSURANCE PLAN BENEFITS

W.B. GUIMARIN & COMPANY, INC.

CLASS 0001

OPTIONAL LIFE, STD, VISION, VOLUNTARY LTD, CRITICAL ILLNESS, ACCIDENT BENEFITS, CANCER BENEFITS

The enclosed certificate is intended to explain the benefits provided by the Plan. It does not constitute the Policy Contract. Your rights and benefits are determined in accordance with the provisions of the Policy, and your insurance is effective only if you are eligible for insurance and remain insured in accordance with its terms.

CERTIFICATE OF COVERAGE

The Guardian
10 Hudson Yards
New York, New York 10001

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

Group Policy No.	Certificate No.	Effective Date
Issued To		

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

The Guardian Life Insurance Company of America

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

CGP-3-R-STK-90-3 B110.0023

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GENERAL PROVISIONS

As used in this booklet:

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

"Covered person" means an *employee* or a dependent insured by this *plan.*

"Employer" means the *employer* who purchased this *plan.*

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

"Plan" means the Guardian *plan* of group insurance purchased by your *employer.*

"You" and "your" mean an *employee* insured by this *plan.*

CGP-3-R-GENPRO-90 B160.0002

Limitation of Authority

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

CGP-3-R-LOA-90 B160.0004

Incontestability

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

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

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

CGP-3-R-INCY-90 B160.0003

Examination and Autopsy

We have the right to have a *doctor* of our choice examine the person for whom a claim is being made under this *plan* as often as reasonably necessary. And we have the right to have an autopsy performed during the period of contestability in the case of death, where allowed by law. All such autopsies must be performed in South Carolina. We'll pay for all such examinations and autopsies.

CGP-3-R-EA-90-SC B160.0031

Accident and Health Claims Provisions

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

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

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

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

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

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

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

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

Limitations of Actions You can't bring a legal action against this *plan* until 60 days from the date you file proof of loss. And you can't bring legal action against this *plan* after six years from the date proof of loss is required to be filed.

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

CGP-3-R-AHC-90-SC B160.0028

An Important Notice About Continuation Rights

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

CGP-3-R-NCC-87 B240.0064

YOUR CONTINUATION RIGHTS

Federal Continuation Rights

Important Notice

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

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

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

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

Conversion

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

If Your Group Health Benefits End

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

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

Extra Continuation for Disabled Qualified Continuees

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

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

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

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

CGP-3-R-COBRA-96-1 B235.0631

If You Die While Insured

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

CGP-3-R-COBRA-96-2 B235.0075

If Your Marriage Ends

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

If a Dependent Child Loses Eligibility

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

Concurrent Continuations

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

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

Special Medicare Rule

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

The Qualified Continuee's Responsibilities

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

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

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

CGP-3-R-COBRA-96-3 B235.0178

Your Employer's Responsibilities

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

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

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

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

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

Your Employer's Liability

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

Election of Continuation

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

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

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

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

Grace in Payment of Premiums

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

When Continuation Ends

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

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

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

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

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

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

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

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

CGP-3-R-COBRA-96-4 B235.0198

Uniformed Services Continuation Rights

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

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

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

CGP-3-R-COBRA-96-4 B235.0195

EMPLOYEE VOLUNTARY CRITICAL ILLNESS INSURANCE

Schedule of Benefits

CGP-3-SI B260.6275

Critical Illness Insurance Amount

Plan A

You may elect amounts of critical illness insurance in increments of $5,000.00, but the amount may not be less than $5,000.00 and may not exceed $50,000.00.

CGP-3-SI B260.1005

Wellness Benefit . . . . . $50.00 each benefit year

CGP-3-SI B260.1020

Reduction of Critical Illness Benefit Amount Based On Age

If you are less than age 65 when your insurance under this plan starts, your benefit amount will be reduced. It will be reduced on the date you reach age 65, by 35% of that amount. Reduced amounts will be rounded to the nearest dollar. But, in no case will such amount be less than $1,000.00.

This reduction also applies to your initial benefit amount if your insurance starts on or after the date you reach age 65 but before the date you reach age 70.

If you are less than age 70 when your insurance under this plan starts, your benefit amount will be reduced. It will be reduced on the date you reach age 70, by 60% of the amount that would otherwise apply to you prior to any reduction. Reduced amounts will be rounded to the nearest dollar. But, in no case will such amount be less than $1,000.00.

This reduction also applies to your initial benefit amount if your insurance starts on or after the date you reach age 70 but before the date you reach age 75.

If you are less than age 75 when your insurance under this plan starts, your benefit amount will be reduced. It will be reduced on the date you reach age 75, by 75% of the amount that would otherwise apply to you prior to any reduction. Reduced amounts will be rounded to the nearest dollar. But, in no case will such amount be less than $1,000.00.

This reduction also applies to your initial benefit amount if your insurance starts on or after the date you reach age 75 but before the date you reaches age 80.

If you are less than age 80 when your insurance under this plan starts, your benefit amount will be reduced. It will be reduced on the date you reach age 80, by 85% of the amount that would otherwise apply to you prior to any reduction. Reduced amounts will be rounded to the nearest dollar. But, in no case will such amount be less than $1,000.00.

This reduction also applies to your initial benefit amount if your insurance starts on or after the date you reach age 80.

CGP-3-SI B260.1024

Critical Illness Benefit Total Amount Payable

300% of the Critical Illness Benefit Amount chosen by you and approved by us, if required by this plan.

CGP-3-SI B260.1026

Critical Illness Benefit Waiting Period

. . . . . 30 days

CGP-3-SI B260.1027

Proof of Insurability Requirements

Proof of insurability requirements apply to your critical illness insurance. This means that you must submit proof to us that you are insurable. We must approve that proof, in writing, before your insurance starts.

We require proof before we will insure you if you enroll for critical illness insurance after the time allowed for enrolling as specified in this plan.

We require proof when you switch from your current plan of critical illness insurance to a plan with a higher benefit amount.

Proof of insurability requirements vary depending upon your age. 'Age' means your attained age in years as of this plan's anniversary date.

Proof of insurability will be required if you are less than age 70 for amounts of critical illness in excess of $5,000. If you are age 70 and over, you will be required to provide proof of insurability for all amounts of critical illness coverage.

CGP-3-SI B260.1080

ELIGIBILITY FOR LIFE COVERAGES

B264.0002

Employee Coverage

Eligible Employees

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

Other Conditions

If you must pay all or part of the cost of employee coverage, we won't insure you until you enroll and agree to make the required payments. If you do this: (a) more than 31 days after you first become eligible; or (b) after you previously had coverage which ended because you failed to make a required payment, we also ask for *proof* that you're insurable. And you won't be covered until we approve that *proof* in writing.

If your active *full-time* service ends before you meet any *proof of insurability* requirements that apply to you, you'll still have to meet those requirements if you're later re-employed.

Part or all of your insurance amounts may be subject to *proof* that you're insurable. The Life Schedule explains if and when we require *proof.* You won't be covered for any amount that requires such *proof* until you give the *proof* to us and we approve it in writing.

CGP-3-EC-90-1.0 B264.0062

When Your Coverage Starts

Employee benefits that don't require *proof* that you are insurable are scheduled to start on your effective date.

Employee benefits that require such *proof* won't start until you send us the *proof* and we approve it in writing. Once we have approved it, the benefits are scheduled to start on the effective date shown in the endorsement section of your application. A copy of the approved application is furnished to you.

But you must be actively at work on a *full-time* basis on the scheduled effective date or dates. And you must have met all of the applicable conditions explained above, and any applicable waiting period. If you are not actively at work on any date part of your insurance is scheduled to start, we will postpone that part of your coverage until the date you return to active *full-time* work.

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

CGP-3-EC-90-2.0 B264.3202

Delayed Effective Date For Employee Optional Life Coverage

With respect to this *plan's* employee optional group term life insurance, if an *employee* is not actively at work on a *full- time* basis on the date his or her coverage is scheduled to start, due to *sickness* or *injury,* we'll postpone coverage for an otherwise covered loss due to that condition. We'll postpone such coverage until he or she completes 10 consecutive days of active *full-time* service without missing a work day due to the same condition.

Coverage for an otherwise covered loss due to all other conditions will start on the date the *employee* returns to active *full-time* service.

CGP-3-DEF-97 B270.0384

When Your Coverage Ends

Your coverage ends on the date your active *full-time* service ends for any reason. Such reasons include disability, death, retirement, layoff, leave of absence and the end of employment.

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

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

Read this booklet carefully if your coverage ends. You may have the right to continue certain group benefits for a limited time. And you may have the right to replace certain group benefits with converted policies.

CGP-3-EC-90-3.0 B264.0013

Your Right To Continue Group Life Insurance During A Family Leave Of Absence

Important Notice

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

Continuation of Coverage

Life insurance may be continued at your employer's option. You must contact your employer to find out if you may continue this insurance.

If Your Group Coverage Would End

Group insurance 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 insurance 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 you return to active work.

- In the case of a leave granted to you to care for a covered servicemember: The end of a total leave period of 26 weeks in one 12 month period. This 26 week total leave period applies to all leaves granted to you under this section for all reasons. If you take an additional leave of absence in a subsequent 12 month period, continued coverage will cease at the end of a total leave period of 12 weeks.
- In any other case: The end of a total leave period of 12 weeks in any 12 month period.
- The date on which your *Employer's Plan* is terminated or you are no longer eligible for coverage under this *Plan.*
- 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.

CGP-3-DEP-90-1.0 B264.0056

Eligible Dependents For Optional Dependent Life Benefits

Your *eligible dependents* are: your legal spouse who is under age 70, and your unmarried dependent children who are 14 or more days old, until they reach age 26 and your unmarried dependent children, from age 26 until they reach age 26, who are enrolled as full-time students at accredited schools.

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

CGP-3-DEP-90-3.0 B264.2634

Adopted Children And Step-Children

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

Dependents Not Eligible

We exclude any dependent who is on active duty in any armed force.

CGP-3-DEP-90-3.0 B264.2593

Proof Of Insurability

We require *proof* that a dependent is insurable, if you enroll a dependent and agree to make the required payments after the end of the *enrollment period.*

A dependent is not insured by any part of this *plan* that requires such *proof* until you give us this *proof,* and we approve it in writing.

If the dependent coverage ends for any reason, including failure to make the required payments, your dependents won't be covered by this *plan* again until you give us new *proof* that they're insurable and we approve that *proof* in writing.

CGP-3-DEP-90-5.0 B200.0659

When Dependent Coverage Starts

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

If you do this on or before your *eligibility date,* the dependent's coverage is scheduled to start on the later of your *eligibility date* and the date you become insured for employee coverage.

If you do this within the *enrollment period,* the coverage is scheduled to start on the later of the date you sign the enrollment form; and the date you become insured for employee coverage.

If you do this after the *enrollment period* ends, your dependent coverage is subject to *proof of insurability* and won't start until we approve that *proof* in writing.

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

A *newly acquired dependent* will be covered for those dependent benefits not subject to *proof of insurability* from the later of the date you notify us and agree to make any additional payments, and the date the *newly acquired dependent* is first eligible.

If *proof of insurability* is required for dependent benefits as explained above, those benefits are scheduled to start, subject to the "Exception" stated below, on the effective date shown in the "Endorsement" section of your application, provided that you send us the *proof* we require and we approve that *proof* in writing. A copy of the approved application is furnished to you.

CGP-3-DEP-90-6.0 B200.0315

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

CGP-3-DEP-90-7.0 B200.0692

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

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

An individual dependent's coverage ends when he stops being an *eligible dependent.* This happens to a child at 12:01 a.m. on the date the child attains this *plan's* age limit, when he marries, or when a step-child is no longer dependent on the employee for support and maintenance. It happens to a spouse when a marriage ends in legal divorce or annulment, and with respect to optional life coverage, it happens at 12:01 a.m. on the date the spouse reaches age 70.

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. And they may have the right to replace certain group benefits with converted policies.

CGP-3-DEP-90-9.0 B200.0792

GROUP TERM LIFE INSURANCE SCHEDULE

CGP-3-R-SCH-90 B265.0002

Employee Optional Contributory Term Life Insurance

CGP-3-R-SCH-90 B265.0055

Optional Life Election

You may choose to be insured under the plan of optional term life insurance shown below. You must notify the employer of your election and pay the required premium.

CGP-3-R-SCH-90 B265.0799

Your Optional Term Life Insurance Amount

Plan A

You may elect amounts of optional term life insurance in increments of $25,000.00, but your amount may not be less than $25,000.00 and may not exceed $250,000.00.

CGP-3-R-SCH-90 B265.0063

Reduction of Optional Life Insurance Amount Based on Age

If an employee is less than age 65 when his or her insurance under this plan starts, his or her insurance amount is reduced, on the date he or she reaches age 65, by 35% of the amount which otherwise applies to his or her classification and/or option. But in no case will such reduced amount be less than $1,000.00.

The preceding reduction also applies to an employee's initial insurance amount if his or her insurance starts after he or she reaches age 65 but before he or she reaches age 70.

If an employee is less than age 70 when his or her insurance under this plan starts, the employee's optional life insurance amount is reduced, when he or she reaches age 70, by 50% of the amount which otherwise applies to his or her classification and/or option. But in no case will such reduced amount be less than $1,000.00.

The preceding reduction also applies to an employee's initial insurance amount if his or her insurance starts after he or she reaches age 70.

CGP-3-R-SCH-90 B265.0520

Proof of Insurability Requirements

Proof of insurability requirements apply to your optional term life insurance. Such requirements may apply to your full benefit amount or just part of it. When *proof of insurability* requirements apply, it means you must submit to us *proof* that you're insurable, and we must approve your *proof* in writing before your insurance, or the specified part becomes effective.

We require *proof* as follows:

CGP-3-R-SCH-90 B265.0431

We require *proof* before an *employee* switches from his or her current increment of optional term life insurance to an increment which provides a greater amount of insurance.

CGP-3-R-SCH-90 B265.0732

Employee Optional Contributory Term Life Insurance (Cont.)

We require *proof* before we will insure any *employee* who enrolls for optional term life insurance after the time allowed for enrolling as specified in this *plan.*

CGP-3-R-SCH-90 B265.0435

We require *proof* for amounts of optional term life insurance in excess of $100,000.00.

CGP-3-R-SCH-90 B265.0437

We require *proof* for amounts of optional term life insurance in excess of $10,000.00, if an *employee*'s scheduled optional term life effective date is after he or she reaches age 65.

CGP-3-R-SCH-90 B265.0697

We require *proof* for all amounts of optional term life insurance, if an *employee*'s scheduled optional term life effective date is after he or she reaches age 70.

CGP-3-R-SCH-90 B265.0702

Dependent Optional Term Life Insurance

Dependent Optional Life Election

You may choose the plan of dependent spouse optional term life insurance, and the plan of dependent child optional term life insurance shown below. You must notify the employer of your elections and pay the required premium.

CGP-3-R-SCH-90 B265.0800

Your Optional Dependent Spouse Term Life Insurance Amount

Plan A

An amount equal to 50% of your optional term life insurance amount, to a maximum of $125,000.00.

CGP-3-R-SCH-90 B265.0511

Your Optional Dependent Child Insurance Amount

Plan A

Child's Age At Death	Benefit Amount
At least 14 days but less than 6 months	$500.00
At least 6 months but less than 26 years or at least 26 years but less than 26 years if a full-time student	10% of your optional term life amount to a maximum of $10,000.00.

CGP-3-R-SCH-90 B265.0730

In no event may the insurance amount of a dependent spouse exceed 50% of the insurance amount of an employee.

CGP-3-R-SCH-90 B265.4308

In no event may the insurance amount of a dependent child exceed 10% of the insurance amount of an employee.

CGP-3-R-SCH-90 B265.0777

Proof of Insurability Requirements

Proof of insurability requirements apply to your dependent optional term life insurance. Such requirements may apply to the full benefits amount or just part of them. When proof of insurability requirements apply, it means you must submit to us proof that a dependent is insurable, and we must approve the proof in writing before the insurance, or the specified part becomes effective.

We require proof as follows:

CGP-3-R-SCH-90 B265.0536

We require proof before we will insure any spouse who is enrolled for dependent optional term life insurance after the time allowed for enrolling as specified in this plan.

CGP-3-R-SCH-90 B265.0540

We require proof for any increase in the amount of dependent optional term life insurance with respect to a dependent spouse.

CGP-3-R-SCH-90 B265.0863

We require proof for any amount of dependent optional term life insurance in excess of $ 10,000.00 with respect to your dependent spouse.

CGP-3-R-SCH-90 B265.0542

We require proof for any amount of dependent optional term life insurance in excess of $5,000.00 with respect to your dependent spouse, if your dependent spouse’s scheduled dependent optional term life effective date is after he or she reaches age 65.

CGP-3-R-SCH-90 B265.0864

We require proof before we will insure any child who is enrolled for dependent optional term life insurance after the time allowed for enrolling as specified in this plan.

CGP-3-R-SCH-90 B265.0549

We require proof for any increase in the amount of dependent optional term life insurance with respect to a dependent child.

CGP-3-R-SCH-90 B265.0867

Your Optional Group Term Life Insurance

Life Benefit Subject to the limitations and exclusions below, if you die while insured for this benefit, we'll pay your beneficiary the amount shown in the schedule for the plan of benefits you have elected. Your life benefit may be subject to reductions based on your age. These reductions are also shown in the schedule. Your benefit amount, a portion thereof, or increases in such amount may not become effective until you submit *proof of insurability* to us, and we approve it in writing. These requirements are also shown in the schedule.

Proof of Death Subject to all of the terms of this *plan,* we'll pay this insurance as soon as we receive written proof of death which is acceptable to us. This should be sent to us as soon as possible.

Suicide Exclusion We pay no benefits if your death is due to suicide, if such death occurs within two years from your employee optional group term life insurance effective date under this *plan.* Also, we pay no increased benefit amount if your death is due to suicide, if such death occurs within two years from the effective date of the increase.

Seatbelt and Airbag Benefits If you die as a direct result of an automobile accident while properly wearing a seatbelt, we will increase your benefit amount by $10,000.00. And if you die as a direct result of an automobile accident while both properly wearing a seatbelt, and sitting in a seat equipped with an airbag, we'll increase your benefit amount by an additional $5,000.00, for a total increase of $15,000.00.

Your Beneficiary You decide who gets this insurance if you die. You should have named your beneficiary on your enrollment form. You can change your beneficiary at any time by giving your employer written notice, unless you've assigned this insurance. But the change won't take effect until your employer gives you written confirmation of the change.

If you named more than one person, but didn't tell us what their shares should be, they'll share equally. If someone you named dies before you do, his or her share will be divided equally by the beneficiaries still alive, unless you've told us otherwise.

If there is no beneficiary when you die, we'll pay the insurance to one of the following: (a) your estate; (b) your spouse; (c) your parents; (d) your children; or (e) your brothers and sisters.

Assigning Your Life Insurance If you assign this insurance, you permanently transfer all your rights under this insurance to the assignee. Only one of the following can be an assignee: (a) your spouse; (b) one of your parents or grandparents; (c) one of your children or grandchildren; (d) one of your brothers or sisters; or (e) the trustee(s) of a trust set up for the benefit of one or more of these relatives.

We will recognize an assignee as the owner of the rights assigned only if: (a) the assignment is in writing and signed by you; and (b) a signed or certified copy of the written assignment has been received and approved by us.

We will not be responsible for legal, tax or other effects of any assignment, or for any benefits we pay under this *plan* before we receive and approve any assignment.

We suggest you speak to a lawyer before you make any assignment. If you decide you want to assign this insurance, write to us for details.

Payment to a Minor or Incompetent

If your beneficiary is a minor or incompetent, we have the option of paying this insurance in monthly installments. We would pay them to the person who cares for and supports your beneficiary.

Payment of Funeral or Last Illness Expense

We have the option of paying up to $2,000.00 of this insurance to any person who incurs expenses for your funeral or last illness.

Settlement Option

If you or your beneficiary asks us, we'll pay all or part of this insurance in installments. Any request must be made to us in writing. The amounts of the installments and how they would be paid depend on what we offer at the time the request is made.

CGP-3-R-EOPT-96 B273.0373

Portability Privilege

Applicability

This provision applies only to this *plan's* employee and dependent Optional group term life insurance. It does not apply to supplemental life insurance, if any is included in this *plan.* And it does not apply to Accidental Death and Dismemberment Insurance.

Important Restriction

You may not elect a portable certificate of coverage unless you have been covered by this group *plan,* or the one it replaced, for employee Optional group term life insurance for at least three consecutive months prior to the date your coverage under this *plan* ends.

Portability Of Optional Group Term Life Insurance

You may elect to continue all or part of your employee Optional group term life insurance and dependent Optional group term life insurance, by choosing a portable certificate of coverage, subject to the following terms.

You may port your coverage if coverage under this *plan* ends because you: (a) have terminated employment; or (b) stop being a member of an eligible class of employees.

You may not port your coverage or coverage for any of your dependents, if you: (a) have reached your 70th birthday on the day coverage under this *plan* ends; or (b) are eligible for this *plan's* Optional Group Term Life Insurance Extended Life Benefit.

You may not port your coverage or coverage for any of your dependents if coverage under this plan ends due to: (a) failure to pay any required premium; or (b) the end of this group *plan.*

You may port: (a) the full amount(s) of your Optional term life insurance as of the day your coverage under this *plan* ends, or (b) 50% of such amount, if such amount under this *plan* is at least $50,000.00.

You may port: (a) the full amount(s) of your dependent Optional term life insurance as of the day your coverage under this *plan* ends; or (b) 50% of such amount(s), if: (i) your dependent spouse amount under this *plan* is at least $20,000.00; and (ii) your dependent child amount under this *plan* is at least $4,000.00. However, if you port the full amount of your insurance, any dependent amount(s) ported must be a full amount. And, if you elect to port 50% of your insurance, any dependent amount(s) ported must be 50% of such amount(s).

You may port: (a) your insurance only; (b) your insurance and insurance of your covered spouse; (c) your insurance and the insurance of all of your covered dependents; or (d) if you are a single parent, your insurance and the insurance of all of your covered dependent children. No other combinations will be allowed.

To be eligible to port, a dependent must be insured as of the day your coverage under this *plan* ends.

If You Die While Insured

If you die while insured for dependent Optional term life insurance, your spouse may port the insurance of your dependents as described above. But, your spouse and dependents must be insured on the date of death. No dependents will be allowed to port if: (a) there is no surviving spouse; or (b) your surviving spouse has reached his or her 70th birthday on the day you die.

The Portable Certificate Of Coverage

You or your surviving spouse can port to a portable certificate of coverage. The certificate provides group term insurance. It does not provide any: (a) accidental death and dismemberment benefits: (b) income replacement benefits; or (c) extended life benefits or waiver of premium privileges. The benefits provided by the portable certificate of coverage may not be the same as the benefits of this group *plan.*

The premium for the portable certificate of coverage will be based on: (a) your and/or your dependent's rate class under this plan; and (b) your or your surviving spouse's age bracket as shown in the Optional Life Portability Coverage Premium Notice.

How To Port

To get a portable certificate of coverage, you or your surviving spouse must: (a) apply to us in writing; and (b) pay the required premium. You have 31 days from the date your coverage under this *plan* ends to do this. We won't ask for proof that you are insurable.

Defined Term

As used in this provision, the term "port" means to choose a portable certificate of coverage which provides group term life insurance.

CGP-3-R-LP-00 B273.0732

Information About Conversion and Portability

No covered person is allowed to convert his or her coverage, and elect a portable certificate of coverage at the same time. If a situation arises in which a covered person would be eligible to both convert and port, he or she may only exercise one of these privileges. A covered person may never be insured under both a converted policy and a portable certificate of coverage at the same time. The covered person should read his or her plan, as well as any related materials carefully before making an election.

CGP-3-R-LPN-95 B270.0326

THE FOLLOWING PROVISION APPLIES TO YOUR OPTIONAL GROUP TERM LIFE INSURANCE:

B275.0077

Converting This Group Term Life Insurance

If Employment or Eligibility Ends

Your group life insurance ends if: (a) your employment ends; or (b) you stop being a member of an eligible class of employees. If either happens, you can convert your group life insurance to an individual life insurance policy. Conversion choices are based on your disability status.

If you are not disabled, as defined in the section labeled "Extended Life Benefit With Waiver of Premium", you can convert to a permanent life insurance policy. You can convert the amount for which you were covered under this plan, less any group life benefits you become eligible for in the 31 days after this insurance ends.

If you: (a) are disabled, as defined in the section labeled "Extended Life Benefit With Waiver of Premium"; and (b) have not yet been approved for the Extended Life Benefit, you can convert to: (a) a permanent life insurance policy; or (b) an interim term insurance policy, as explained in the section labeled "Interim Term Insurance". You can convert the full amount for which you were covered under this plan.

If you are later approved for the Extended Life Benefit, then the converted policy, if any, is cancelled as of our approval date.

If The Group Plan Ends or Group Life Insurance Is Dropped

Your group life insurance also ends if: (a) this group plan ends; or (b) life insurance is dropped from the group plan for all employees or for your class. If either happens, you may be eligible to convert as explained below. Conversion choices are based on your disability status.

If you: (a) are not disabled, as defined in the section labeled "Extended Life Benefit With Waiver of Premium", when this coverage ends; and (b) you have been insured by a Guardian group life plan for at least five years, you can convert to a permanent life insurance policy. But, the amount you can convert is limited to the lesser of: (a) $10,000.00; or (b) the amount of your insurance under this plan, less any group life benefits you become eligible for in the 31 days after this insurance ends.

If you: (a) are disabled, as defined in the section labeled "Extended Life Benefit With Waiver of Premium"; and (b) have not yet been approved for the Extended Life Benefit, you can convert to: (a) a permanent life insurance policy; or (b) an interim term insurance policy. You can convert the full amount for which you were covered under this plan.

If you are later approved for the Extended Life Benefit, then the converted policy, if any, is cancelled as of our approval date.

The Converted Policy

The premium for the converted policy will be based on your age on the converted policy's effective date. The converted policy will start at the end of the period allowed for conversion. The converted policy does not include disability or dismemberment benefits.

Interim Term Insurance

If you: (a) are disabled, as defined in the section labeled "Extended Life Benefit With Waiver of Premium" and (b) have not yet been approved for the Extended Life Benefit, you have the option to convert your coverage to an individual term life insurance policy. The individual term policy requires lower premiums than an individual permanent insurance policy.

This Interim term policy is available for only one year from the date you become disabled. During this year, if you are approved for the Extended Life Benefit, the interim term insurance is cancelled, as of our approval date. If, after one year, you have not been approved for the Extended Life Benefit, you must convert to an individual permanent life insurance policy, or coverage will end. Premiums for the individual permanent life insurance policy will be based on your age as of the date you convert from the interim term insurance policy.

How and When to Convert

To get a converted policy, you must apply to us in writing and pay the required premium. You have 31 days after your group life insurance ends to do this. We won't ask for proof that you are insurable.

Death During the Conversion Period

If you die in the 31 days allowed for conversion, we'll pay your beneficiary the amount you could have converted. We'll pay whether or not you applied for conversion.

Important Notice

If your eligibility ends or group life insurance is dropped, the Guardian will give you written notice of this conversion right. We'll mail the notice to your last address, as supplied by the employer.

The notice will be given within 15 days after the group insurance ends. If it's not, you will have 15 days from the date it is given to apply for the converted policy and pay the required premium. In no event will the time allowed to convert extend more than 60 days from the date your group life insurance ends.

CGP-3-R-LCONV-99-SC B275.0215

Your Accelerated Life Benefit

IMPORTANT NOTICE: USE OF THE BENEFIT PROVIDED BY THIS SECTION MAY HAVE TAX IMPLICATIONS AND MAY AFFECT GOVERNMENT BENEFITS OR CREDITORS. YOU SHOULD CONSULT WITH YOUR TAX OR FINANCIAL ADVISOR BEFORE APPLYING FOR THIS BENEFIT.

PLEASE NOTE: THE AMOUNT OF GROUP TERM LIFE INSURANCE IS PERMANENTLY REDUCED BY THE GROSS AMOUNT OF THE ACCELERATED LIFE BENEFIT PAID TO YOU.

Accelerated Life Benefit

If you have a medical condition that is expected to result in your death within 6 months, you may apply for an Accelerated Life Benefit. An Accelerated Life Benefit is a payment of part of your group term life insurance made to you before you die.

We subtract the gross amount paid to you as an Accelerated Life Benefit from the amount of your group term life insurance under this plan. The remaining amount of your group term life insurance is permanently reduced by the gross amount paid to you.

By "group term life insurance" we mean any Employee Optional Group Term Life Insurance for which you are insured under this plan. "Group term life insurance" does not mean Accidental Death and Dismemberment Benefits, any insurance provided under this plan for covered persons other than you or any scheduled increase in the amount of any Employee Group Term Life Insurance that is due within the 6 month period after the date you apply for the Accelerated Life Benefit.

By "gross amount" we mean the amount of an Accelerated Life Benefit elected by you, before the discount and the processing fee are subtracted.

For the purposes of this provision, "terminal condition" means a medical condition that is expected to result in your death within 6 months.

You may use the Accelerated Life Benefit in any way you choose. But you may receive only one Accelerated Life Benefit during your lifetime. If you live longer than 6 months, or if you recover from the condition, the benefit does not have to be repaid. But the amount of this benefit is not restored to your remaining group term life insurance. And you may not receive another Accelerated Life Benefit if you have a relapse or develop another terminal condition.

Maximum Benefit Amount

The amount of the Accelerated Life Benefit for which you may apply is based on the amount of group term life insurance for which you are insured on the day before you apply for the benefit. The minimum benefit amount is the lesser of: (a) $10,000.00; or (b) 50% of the inforce amount. The maximum benefit amount is the lesser of: (a) $100,000.00; or (b) 50% of the inforce amount.

Discount

The amount for which you apply is discounted to the present value in 6 months from the date the benefit is paid, based on the maximum adjustable policy loan interest rate permitted in the state in which your employer is located.

A detailed statement of the method of computing the amount of the Accelerated Life Benefit is filed with each state insurance department. This statement is available from The Guardian upon request.

Processing Fee

A fee of up to $150.00 may also be required for the administrative cost of evaluating and processing your Accelerated Life Benefit. This fee is deducted from the amount of the Accelerated Life Benefit paid to you.

Payment of An Accelerated Life Benefit

If we approve your application for an Accelerated Life Benefit, we pay the amount you have elected, less the discount and the processing fee. We pay the benefit to you in one lump sum. And what we pay is subject to all of the other terms of this plan.

How And When To Apply

To receive the Accelerated Life Benefit, you must send us written proof from a licensed doctor who is operating within the scope of his or her license that your medical condition is expected to result in your death within 6 months of the date of the written medical proof. We must approve such proof in writing before the Accelerated Life Benefit will be paid.

We can have you examined by a doctor of our choice to verify the terminal condition. We'll pay the cost of such examination. We will not pay the Accelerated Life Benefit if our doctor does not verify the terminal condition.

If we approve you to receive an Accelerated Life Benefit, we give you a statement which shows: (a) the amount of the maximum Accelerated Life Benefit for which you are eligible; and (b) the amount by which your group term life insurance will be reduced if you elect to receive the maximum Accelerated Life Benefit; and (c) the amount of the processing fee.

Even if you are receiving an Extended Life Benefit under this plan, you can still apply for an Accelerated Life Benefit. However, once you convert your group term life insurance, the terms of the converted life policy will apply. Any amount to which you could otherwise convert is permanently reduced by the gross amount of the Accelerated Life Benefit paid to you.

Please read "Your Remaining Group Term Life Insurance" provision for restrictions that may apply.

If You Have Assigned Your Group Term Life Insurance

If you have already assigned your group term life insurance, according to the terms of this plan, you can't apply for an Accelerated Life Benefit.

CGP-3-R-EALB-95 B275.0027

If You Are Incompetent

If you are determined to be legally incompetent, the person the court appoints to handle your legal affairs may apply for the Accelerated Life Benefit for you.

Your Remaining Group Term Life Insurance

The remaining amount of group term life insurance for which you are covered after receiving an Accelerated Life Benefit payment is subject to any increases or cutbacks that would otherwise apply to your insurance. Applicable cutbacks are applied to the amount of group term life insurance for which you are insured on the day before you apply for the Accelerated Life Benefit.

The premium cost of your remaining coverage is based on the amount of group term life insurance for which you are insured on the day before you apply for the Accelerated Life Benefit.

You may be required to provide proof of insurability for increased amounts. If you are, we must approve that proof in writing before you are covered for the new amount.

The total amount of group term life insurance your beneficiary would Otherwise receive upon your death is reduced by the gross amount of the Accelerated Life Benefit paid to you.

If you die after electing the Accelerated Life Benefit, but before we send the benefit to you, your beneficiary will receive the amount of the group term life insurance for which you are insured on the day before you apply for the Accelerated Life Benefit.

Restrictions We will not pay an Accelerated Life Benefit to you if you:

- are required by law to use the payment to meet the claims of creditors, whether or not you are in bankruptcy; or
- are required by court order to pay all or part of the benefit to another person; or
- are required by a government agency to use the payment to apply for, to receive or to maintain a governmental benefit or entitlement; or
- lose your coverage under the group plan for any reason after you elect the Accelerated Life Benefit but before we pay such benefit to you.

Your Extended Life Benefit With Waiver Of Premium

Important Notice This section applies to your optional life benefit. But, it does not apply to your accidental death and dismemberment benefits; nor to any of your dependent's insurance under this group plan. In order to continue dependent optional life insurance, you must convert your dependent coverage. To convert dependent coverage you must choose an individual permanent policy.

If You Are Disabled You are disabled if you meet the definition of total disability, as stated below. If you meet the requirements in the "How and When to Apply" provision, we'll extend your optional life insurance under this section without payment of premiums from you or the employer.

Total Disability or Totally Disabled means, due to sickness or injury, you are:

(a) not able to perform any work for wages or profit; and

(b) you are receiving regular doctor's care appropriate to the cause of disability.

How And When To Apply To apply for this extension, you must submit satisfactory written medical proof of your total disability. You must provide this proof within one year of the onset of that disability. Any claim filed after one year from the onset of total disability will be denied. We will deny the claim unless we receive written proof that: (a) you lacked the legal capacity to file the claim; or (b) it was not reasonably possible for you to file the claim.

Also, in order to be eligible for this extension, you must:

(a) become totally disabled before you reach age 60 and while insured by the group plan; and

(b) remain totally disabled for 09 continuous months.

You may apply for this benefit immediately upon the onset of disability.

Continued Eligibility For Extended Life Benefit

We may require periodic written proof that you remain totally disabled to maintain this extension. This written proof of your: (a) continued disability; and (b) and doctor's care must be provided to us within 30 days of the date we make each such request.

We can require that you take part in a medical assessment, with a medical specialist of our choice. During the first two years of this extension, we may require this as often as we feel is reasonably necessary. But after two years, we can't have you examined more than once a year.

Until You've Been Approved For This Extended Life Benefit

Your life insurance under the group plan may end after you've become totally disabled, but before we've approved you for this extension. During this time period, you may either:

(a) continue group premium payments, including any portion which would have been paid by the employer, until you are approved or declined for this extension; or

(b) convert to an individual permanent or term policy. Please read the section labeled "Converting This Group Term Life Insurance" for details on how to convert.

However, you must convert if: (i) this group plan terminates; and (ii) you are totally disabled and eligible, but not yet approved, for this extended benefit. You must remain insured under such policy until you are approved by us for the extended benefit.

Converting does not stop you from claiming your rights under this section. But if you convert and we later approve you for this extended benefit, we'll cancel the converted policy as of our approval date. Once you are approved for this extended benefit, your group term life coverage will be reinstated. This will be done at no further cost to you or the employer.

When This Extension Begins

Once approved by us, your extended benefit will be effective on the later of:

(a) 09 continuous months from the date active full-time service ends due to total disability; or

(b) the date we approve you for this benefit.

Your Extended Life Benefit With Waiver Of Premium (Cont.)

When This Extension Ends

Your extension will end on the earliest of:

(a) the date you are no longer disabled;

(b) the date we ask you to be examined by our doctor, and you refuse;

(c) the date you do not give us the proof of disability we require;

(d) the date you are no longer receiving regular doctor's care appropriate to the cause of disability; or

(e) the day before the date you reach age 65.

If the extension ends, and you are not insured by the group plan again as an active full-time employee, you can convert as if your employment just ended. Read the section labeled "Converting This Group Term Life Insurance".

If You Die While Covered By This Extension

If you die while covered by this extension we'll pay your beneficiary the amount for which you were covered as of your last day of active full-time work, subject to all reductions which would have applied had you stayed an active employee.

Proof Of Death

We'll pay as soon as we receive

(a) written proof of your death, that is acceptable to us; and

(b) medical proof that you were continuously disabled until your death. This must be sent within one year of your death.

CGP-3-R-LW-TD-99-2 B275.0059

LifeAssist

If you are eligible for this plan's Optional Life Extended Life Benefit you may also be eligible for the LifeAssist benefit.

When And How The LifeAssist Benefit Begins

You become eligible for LifeAssist benefits when all of the following conditions are met:

(a) you are eligible for this plan's Optional Life Extended Life Benefit; and

(b) you are functionally disabled, as defined below; and

(c) you have been insured under this Optional Life plan for at least 12 consecutive months, prior to the start of your disability.

Functional Disability or Functionally Disabled means, due to sickness or injury, you are:

(a) not able to perform 2 or more activities of daily living on a routine basis, without help; or

(b) cognitively impaired and need verbal cueing to protect yourself or others; and

you are:

(c) receiving regular doctor's care appropriate to the cause of disability; and

(d) not working for wage or profit.

Activities of Daily Living means:

(1) Bathing: the ability to wash in a tub or shower; or by taking a sponge bath; and to towel dry, with or without adaptive equipment or adaptive devices.

(2) Dressing: the ability to put on and take off all clothes; and those medically necessary braces or prosthetic limbs usually worn; and also to fasten or unfasten them.

(3) Toileting: the ability to get to and from and on and off the toilet; to maintain personal hygiene; and to care for clothes.

(4) Transferring: the ability to move in and out of a chair or bed with or without equipment such as: canes; walkers; crutches; grab bars; or any other support devices.

(5) Continence: the ability to control bowel and bladder function; or, in the event of incontinence, the ability to maintain personal hygiene.

(6) Eating: the ability to get food into the body by any means once it has been prepared and made available.

Cognitively impaired means a decline or loss in intellectual aptitude. Such loss may result from: (a) injury; (b) sickness; (c) Alzheimer's disease; or (d) similar forms of senility or irreversible dementia. It must be supported by clinical proof and standardized tests that precisely measure decline in the areas of: (i) short term memory; (ii) orientation to time, place and person; (iii) deductive or abstract reasoning; and (iv) judgement as it relates to awareness of safety.

Payment Of Benefits

We pay this benefit monthly, in arrears. We pay benefits to you if you are legally competent. If you are not, we pay benefits to the legal representative of your estate.

What We Pay

Subject to all the terms of this plan, the monthly LifeAssist benefit is equal to 1% of your Optional Life Extended Life Benefit, to a monthly maximum of $2,000.00.

Payments are made based on a 30 day month. You may be eligible for the LifeAssist benefit for only part of a month. In such case, we compute the benefit payable as 1/30th of the monthly benefit times the number of days you are eligible for this benefit.

While you are approved for the Optional Life Extended Life Benefit, if your insurance coverage is reduced under the extension, the amount of the LifeAssist benefit is reduced accordingly.

Continued Eligibility For The LifeAssist Benefit

We may require periodic written proof that you remain functionally disabled. This written proof of your continued disability and regular doctor's care must be provided to us within 30 days of the date we make each such request.

We can require that you take part in a medical assessment, with a medical professional of our choice, as often as we feel is reasonably necessary.

When The LifeAssist Benefit Ends

We stop paying this benefit on the earliest of the following dates:

(a) the date you are no longer functionally disabled;

(b) the date you are no longer eligible for this Optional Life plan's Extended Life Benefit;

(c) the date we ask you to take part in a medical assessment and you refuse;

(d) the date you do not give us proof of disability that we require;

(e) the date you are no longer receiving regular doctor's care appropriate to the disability; and

(f) the date the lifetime maximum LifeAssist benefit is reached.

The lifetime maximum LifeAssist benefit payments to be made to you by this plan are 100 months of benefit payments.

CGP-3-R-LSUPP-99 B275.0351

Your Dependent Spouse and Child Optional Term Life Insurance

The Benefit

Subject to the limitations and exclusions shown below, if one of your dependents dies while insured for this benefit, we pay the amount shown in the schedule for the plan you have elected. We pay this in a lump sum when we receive written proof of death which is acceptable to us. Send the proof to us as soon as soon as possible.

We pay you, if you're living. If you're not, and the dependent was your child, we pay your spouse. If your spouse is not living, we pay the child's living brothers and sisters in equal shares. If there are none, we pay the child's estate. If the dependent was your spouse, we pay your spouse's estate.

Suicide Exclusion

We pay no benefits if the dependent's death is due to suicide, if such death occurs within two years from the effective date of the dependent's optional term life insurance under this *plan.* Also, we pay no increased benefit amount if the dependent's death is due to suicide, if such death occurs within two years from the effective date of the increase.

Your Dependent Spouse and Child Optional Term Life Insurance (Cont.)

Seatbelt and Airbag Benefits

If a dependent dies as a direct result of an automobile accident while properly wearing a seatbelt, we will increase the benefit amount by $5,000.00. And if a dependent dies as a direct result of an automobile accident while both properly wearing a seatbelt, and sitting in a seat equipped with an airbag, we'll increase the benefit amount by an additional $2,500.00, for a total increase of $7,500.00.

Payment to a Minor or Incompetent

If the beneficiary is a minor or not competent, we have the right to pay in monthly installments. We would pay the person who cares for and supports the beneficiary. We completely discharge our liability for any amounts paid this way.

CGP-3-R-DOPT-96 B293.0132

Converting This Dependent Term Life Insurance

If Your Group Life Insurance Ends or You Stop Being Eligible

Dependent term life insurance ends for all of your dependents when your group life insurance ends. Your insurance ends when: (a) your active full-time employment ends; (b) you stop being a member of a class of employees eligible for employee group life insurance; (c) your group life insurance is extended under the Extended Life Benefit provision; or (d) you die.

Dependent term life insurance also ends when you stop being a member of a class of employees eligible for dependent term life insurance.

If one of the above happens, each dependent who was insured may convert all or part of his insurance.

If This Plan Ends or Life Insurance is Dropped

Dependent term life insurance also ends for all of your dependents when this plan ends. And it ends if either employee or dependent term life insurance is dropped from this plan for all employees or for your class.

If one of the above happens, and your dependents have been insured by a Guardian group life plan for at least five years, they can convert. But we limit the amount each dependent can convert to the lesser of: (a) $2,000.00; and (b) the amount of his insurance under this plan less any group life benefits he becomes eligible for in the 31 days after this insurance ends.

If a Dependent Stops Being Eligible

A dependent's term life insurance ends when he stops being an eligible dependent. This happens to a child when he reaches the limiting age shown in the schedule or when he marries. And it happens to a spouse when a marriage ends in legal divorce or annulment. If a dependent stops being eligible, that dependent can convert all or part of his insurance.

The Converted Policy

The dependent can convert to one of the individual life insurance policies we normally issue. That policy can't include disability benefits. And it can't be a term policy.

The premium for the converted policy will be based on: (a) the dependent's risk and rate class under this plan; and (b) the dependent's age when the converted policy takes effect. The converted policy takes effect at the end of the period allowed for conversion.

Ask your employer or write to us for details.

How and When to Convert

To get a converted policy, the dependent must apply to us in writing and pay the required premium. He has 31 days after his group insurance ends to do this. We won't ask for proof that he's insurable.

If the dependent is a minor or not competent, the person who cares for and supports the dependent may apply for him.

Death During the Conversion Period

If a dependent dies in the 31 days allowed for conversion, we pay the amount he could have converted, as stated above. We do this whether or not he applied for conversion.

CGP-3-R-DEPL B295.0009

ELIGIBILITY FOR DISABILITY COVERAGE

B329.0002

Employee Coverage

Eligible Employees

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

Other Conditions

If you must pay all or part of the cost of employee coverage, we won't insure you until you enroll and agree to make the required payments. If you do this: (a) more than 31 days after you first become eligible; or (b) after you previously had coverage which ended because you failed to make a required payment, we also ask for *proof* that you're insurable. And you won't be covered until we approve that *proof* in writing.

If your active *full-time* service ends before you meet any *proof of insurability* requirements that apply to you, you'll still have to meet those requirements if you're later re-employed.

Part or all of your insurance amounts may be subject to *proof* that you're insurable. Other parts of this coverage explain if and when we require *proof.* You won't be covered for any amount that requires such *proof* until you give the *proof* to us and we approve it in writing.

CGP-3-EC-90-1.0 B329.0039

When Your Coverage Starts

Employee benefits that don't require *proof* that you are insurable are scheduled to start on your effective date.

Employee benefits that require such *proof* won't start until you send us the *proof* and we approve it in writing. Once we have approved it, the benefits are scheduled to start on the effective date shown in the endorsement section of your application. A copy of the approved application is furnished to you.

But you must be actively at work on a *full-time* basis on the scheduled effective date or dates. And you must have met all of the applicable conditions explained above, and any applicable waiting period. If you are not actively at work on any date part of your insurance is scheduled to start, we will postpone that part of your coverage until the date you return to active *full-time* work.

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

CGP-3-EC-90-2.0 B264.3202

Delayed Effective Date For Disability Coverage

With respect to this *plan's* disability insurance, if an *employee* is not actively at work on a *full-time* basis on the date his or her coverage is scheduled to start, due to *sickness* or *injury,* we'll postpone coverage for an otherwise covered loss due to that condition. We'll postpone such coverage until he or she completes 10 consecutive days of active *full-time* service without missing a work day due to the same condition.

Coverage for an otherwise covered loss due to all other conditions will start on the date the *employee* returns to active *full-time* service.

CGP-3-DEF-97 B329.0103

When Your Coverage Ends

Your short term disability coverage ends on the date your active *full-time* service ends for any reason.

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

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

If you are disabled, as defined by this *plan* when your active *full-time* service ends, coverage remains inforce while you are continuously disabled, subject to all the terms of this plan.

CGP-3-EC-90-3.0 B329.0142

When Your Coverage Ends

Your long term disability coverage ends on the date your active *full-time* service ends for any reason.

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

It ends on the date you are no longer working in the United States, unless you are on a temporary assignment: (1) not exceeding one year in a country or region that is not under a travel warning issued by the US Department of State; or (2) for which was have agreed, in writing, to provide coverage.

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

However, if you are disabled, as defined by this *plan* when your active *full-time* service ends, coverage remains in force during: (a) the elimination period, subject to premium payment, if (i) the disability is not excluded under the *plan;* and (ii) benefits are not excluded due to application of this *plan's* pre-existing condition provision; and (b) the period for which benefits are payable under this *plan.*

CGP-3-EC-90-3.0 B329.0175

Your Right To Continue Group Short and Long Term Disability During A Family Leave Of Absence

Important Notice

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

Continuation of Short Term And Long Term Disability Coverage

Your Short Term Disability and Long term Disability coverage may be continued at your employer's option. You must contact your employer to find out if you may continue this coverage.

If Your Group Coverage Would End

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

When Continuation Ends

Coverage may continue until the earliest of the following:

- The date you return to active work.
- In the case of a leave granted to you to care for a covered servicemember: The end of a total leave period of 26 weeks in one 12 month period. This 26 week total leave period applies to all leaves granted to you under this section for all reasons. If you take an additional leave of absence in a subsequent 12 month period, continued coverage will cease at the end of a total leave period of 12 weeks.
- In any other case: The end of a total leave period of 12 weeks in any 12 month period.
- The date on which your *Employer's Plan* is terminated or you are no longer eligible for coverage under this *Plan.*
- 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.

SHORT TERM DISABILITY HIGHLIGHTS

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

CGP-3-STD05-HL B335.0587

Elimination Period

For disability due to injury . . . . . 14 days

For disability due to sickness . . . . . 14 days

CGP-3-STD05-HL B335.0588

Maximum Payment Period

For disability due to injury . . . . . 26 weeks

For disability due to sickness . . . . . 26 weeks

Payments for a pre-existing condition will be limited to a maximum of 2 weeks.

CGP-3-STD05-HL B335.0590

Benefit Percent 60%

CGP-3-STD05-HL B335.0592

Maximum Weekly Benefit $500.00

CGP-3-STD05-HL B335.0598

SHORT TERM DISABILITY INCOME INSURANCE

This insurance replaces part of your income if you become disabled due to sickness or injury.

We decide: (a) if you are eligible for this insurance; (b) if you meet the requirements for benefits to be paid; and (c) what benefits are to be paid by this plan. We also interpret how this plan is to be administered. What we pay and the terms for payment are explained below.

All terms in *italics* are defined terms with special meanings. Their definitions are shown at the end of this section. Other terms are defined where they are used.

Claim Provisions

Your Duties If you become *disabled* due to *sickness* or *injury* while insured by this *plan,* you must:

(a) Give notice of claim as soon as possible after the date of your *injury* or the start of your *sickness.* Prompt notice will permit us to start disability management services.

(b) Give a complete account of the details of your *sickness* or *injury.* This will include: (i) the cause of your *disability,* if known; (ii) a description of your *sickness* or the accident that caused your *injury;* and (iii) a list of all *doctors,* hospitals, or other facilities where you have been treated for the cause of your *disability.*

(c) Allow release of medical and/or income data needed to assess your claim.

(d) Give periodic medical updates as required by this *plan.*

(e) Take part in any medical, financial or vocational assessment as required by this *plan.*

(f) Apply for other income benefits to which you may be entitled.

(g) Promptly report to us the receipt or denial of such other income benefits. And, appeal any denials to the extent possible.

(h) Promptly report to us changes in your personal status. This includes: (i) change of address or phone number; (ii) changes in how your *disability* affects your daily living; and (iii) changes in your level of social, volunteer or business activities.

(i) If we overpay benefits, promptly report and repay any amount overpaid.

(j) If you are working while *disabled,* promptly report to us the amount of your income from such work.

(k) Give us proof of your earnings for the period prior to your *disability* and while you are *disabled.*

The term "disability management services" means medical and vocational analyses and services. The goal of these services is to maximize your potential to return to gainful work. Gainful work means work for which you are, or may become, qualified by: (a) training; (b) education; or (c) experience. Such work must also be consistent with the level of your *insured earnings.*

Notice You must give written notice of your intent to file a claim under this *plan* as described in this certificate's "Accident and Health Claims Provisions."

You will need to provide the information listed below:

(a) Your full name, address, phone number, social security number, and group plan number.

(b) Your last day at work, number of hours worked, and your *own job.*

(c) Your employer contact and phone number.

(d) The nature of your *disability,* and whether or not it is work-related.

(e) Your *doctor's* name, address, and phone number.

For details, you can contact the *plan sponsor* or call Guardian at 1-800-268-2525.

Proof Of Loss You can obtain a claim form to file proof of loss from the *plan sponsor.* This form requires data from you, the *plan sponsor,* and the *doctor(s)* treating you for your *sickness* or *injury.* Proof of loss must be given to us within the time stated in this certificate's "Accident and Health Claims Provisions." If you do not receive a claim form within 15 days, you should send us written proof of loss without waiting for the form.

We require the items listed below as proof of loss:

(a) Proof of the limits on your ability to perform your *own job,* starting on the date you first became *disabled.* This proof is required from all *doctors* who have treated you for the cause of your *disability.*

(b) Proof that you have applied for all other sources of income to which you may be entitled, that may affect your payment from this *plan.*

(c) Proof of receipt of other income that may affect your payment from this *plan.*

(d) Your signed authorization for release of medical and/or financial data by the sources of such data.

Proof of loss and other claim data should be submitted to:

The Guardian Life Insurance Company of America
Group Short Term Disability Claims Department
P.O. Box 26160
Lehigh Valley, PA 18002-6160

How Payments Start

To start getting payments from this *plan,* you must meet all of the conditions listed below:

(a) You must: (i) become *disabled* while insured by this *plan;* and (ii) remain *disabled* for this *plan's elimination period.*

(b) You must be: (i) under a *doctor's regular care* for the cause of your *disability,* starting from the date you were first *disabled;* and (ii) receiving medical care appropriate to the cause of your *disability* and any other *sickness* or *injury* which exists during your *disability.*

(c) You must send us written proof of: (i) your *disability;* (ii) your weekly earnings prior to the start of your *disability;* and (iii) any earnings from work while you are *disabled.*

Proof of earnings may consist of: (1) copies of your U.S. Individual Income Tax Returns; (2) a statement from a certified public accountant; or (3) any other records we agree to accept.

Waiver Of Premium

Premiums for this insurance are waived while you are entitled to receive a payment from this *plan.*

To Continue Receiving Payments

To continue to receive payments from this *plan,* you must give us current proof of loss when we request it.

You must give proof that satisfies us as to the items listed below:

(a) your continued *disability;*

(b) continued *regular care* by a *doctor* that is appropriate for the cause of your *disability* and any other *sickness* or *injury* which exists during your *disability;*

(c) earnings from work while you are *disabled;* and

(d) any other income that you are entitled to receive.

You must also give us current signed authorizations for release of medical and financial data when we request it.

You must give us such items within 90 days of the date we make each such request. If you do not, we have the right to suspend or stop your payments under this *plan.*

Right To Request Medical, Financial Or Vocational Assessment

We may ask you to take part in a medical, financial or vocational assessment as often as we feel is reasonably necessary. We will pay for all such assessments. If you do not take part in the assessment, we have the right to stop or suspend your payments under this *plan.*

Payment Of Benefits

We pay benefits to you if you are legally competent. If you are not, we pay benefits to the legal representative of your estate.

We pay benefits twice each month on a pro rata basis after the period for which they are payable.

Benefits to which you are entitled may remain unpaid at your death. Such benefits may be paid at our discretion to: (a) your estate; or (b) your spouse, parents, children, or brothers and sisters.

When Payments End

Your benefits from this *plan* will end on the earliest of the dates shown below:

(a) The date you are no longer *disabled.*

(b) The date you earn, or are able to earn, the maximum earnings allowed while *disabled* under this *plan.*

(c) The date you are able to perform the major duties of your *own job* on a full-time basis with reasonable accommodation that an employer is willing to provide.

(d) The date you no longer reside in the United States.

(e) The date you die.

(f) The end of the *maximum payment period.*

(g) The date you fail to give us required current proof of loss. This includes taking part in any medical, financial or vocational assessment we may require.

(h) The date you are no longer under the *regular care* of a *doctor.*

(i) The date you become eligible for any other group short term disability income plan.

The term "reasonable accommodation" means any modification or adjustment to: (i) a job; (ii) an employment practice; (iii) a work process; or (iv) the work place. The modification or adjustment must make it possible for a *disabled* person to: (1) reach the same level of performance as a similarly situated non-disabled person; or (2) enjoy equal benefits and privileges of employment as are available to a similarly situated non-disabled person. The modification or adjustment must not place an undue hardship on the employer.

CGP-3-STD2K-3.0 B335.0014

Maximum Payment Period

The *maximum payment period* is the longest time that benefits are paid by this *plan* for your *disability.*

For *disability* due to *injury* the *maximum payment period* is 26 weeks.

For *disability* due to *sickness,* the *maximum payment period* is 26 weeks.

Payments for a pre-existing condition will be limited to a maximum of 2 weeks.

If This Plan Ends

This insurance ends when the group plan ends. It also ends when this insurance is dropped from the group plan for all insureds, or for your class. If you are *disabled* when this insurance ends, we will treat you as if your insurance did not end. But, your benefit will be based on all of the terms of this *plan.*

CGP-3-STD2K-3.1 B335.0016

Your benefit is determined by the plan of benefits and your *insured earnings* in effect on the date your *disability* starts.

Any changes to this *plan* that take place while you are *disabled* will not affect how we determine your benefit. This is also true for any changes that take place during a period of *active work* that occurs between an initial period of *disability* and a *recurring disability.*

Determining Your Weekly Benefit

Your *weekly benefit* is determined as shown below.

(a) Multiply your *insured earnings* by 60%. Round this amount to the nearest dollar.

(b) If the amount determined above is less than this *plan's maximum weekly benefit,* that amount is your *gross weekly benefit.*

If the amount determined above is equal to or more than this *plan's maximum weekly benefit,* your *gross weekly benefit* is equal to the *maximum weekly benefit.*

(c) From your *gross weekly benefit,* subtract the amount of any income listed in "Income We Integrate With" that you receive or are entitled to receive. The result is your *weekly benefit.*

The amount of your *gross weekly benefit* may be limited if the *plan sponsor* has not updated the amount of your *insured earnings* on the most recent reporting date prior to the start of your *disability.*

See the "Redetermination" section of this *plan* for details.

CGP-3-STD2K-4.0 B335.0018

Redetermination

As of each January 1st , we use your then current *insured earnings* to set rates and to project benefit amounts and limits under this *plan.* However, you must be *actively-at-work* on a full-time basis on that date. If you are not, we do not do this until the date you return to *active work* on a full-time basis. But, changes in earnings will not apply to a *recurring disability.*

CGP-3-STD2K-4.1 B335.0024

Income We Integrate With

You may receive, or be entitled to receive, income shown in the list below. We will integrate your *gross weekly benefit* with such income to determine your *weekly benefit* from this *plan.*

- Commissions received, due to be received, or paid after *disability* benefits start. This includes vested and nonvested renewal commissions.
- Disability benefits from any mandated benefit act or law. This includes all temporary disability or state disability benefits required by law.
- Disability benefits from all group plans of: (1) the *plan sponsor;* or (2) your *employer.* This includes payments made by a group life insurance plan due to your *disability.* This does not include payments made from a group life insurance plan's: (a) accelerated death benefit; or (b) like provision that allows payment of such plan's proceeds due to terminal illness.
- Disability benefits from any other group plan.

- Benefits as shown below from: (1) the United States Social Security Act; (2) the Railroad Retirement Act; or (3) any other like U.S. or Canadian plan or act.

  (a) All disability benefits for which: (i) you are qualified; and (ii) your spouse and children are qualified due to your *disability;*

  (b) All unreduced retirement benefits for which: (i) you are qualified; and (ii) your spouse and children are qualified due to your qualification; and

  (c) all reduced retirement benefits paid to: (i) you; and (ii) your spouse and children due to your receipt of such benefits.

  We will integrate your *gross weekly benefit* with such benefits to which your spouse and children are entitled due to your receipt of or qualification for disability benefits. We do this without regard to: (a) your marital status; (b) where you live; (c) where your spouse lives; (d) where your child lives; or (e) any custody arrangements made on behalf of your child.

- *Retirement plan retirement benefits* funded for your benefit by: (1) the *plan sponsor;* or (2) your *employer.*

- *Retirement plan disability benefits.*

- *Retirement benefits* or *retirement plan disability benefits,* due to your *disability,* from any *government plan* other than those shown above.

- Disability benefits from any: (1) *no-fault motor vehicle* coverage; (2) motor vehicle financial responsibility act; or (3) like law.

- Benefits from: (1) a Workers' Compensation law; (2) an occupational disease law; or (3) any other act or law of like intent. This includes: (a) the Jones' Act; (b) the Longshoreman's and Harbor Workers' Compensation Act; or (c) any Maritime doctrine of Maintenance, Wages or Cure.

- Payment from your *employer* as part of a termination agreement.

We integrate your *gross weekly benefit* with income shown above that you are entitled to receive without regard to the reason you are entitled to receive it.

Our right to reduce your benefit by such income shall not be negated by a transfer of claim liability to a third party. Payment by such third party by law, settlement, judgement, waiver or otherwise shall not negate our right.

Lump Sum Payments Of Other Income

Income with which we integrate may be paid in a lump sum. In this case, we take the equivalent weekly rate stated in the award into account when we determine your *weekly benefit.* If no weekly rate is given, we divide the lump sum payment by the number of calendar days in the period for which it was awarded. This will determine the daily rate. Then, multiply the daily rate by seven. The result is the prorated weekly rate.

To Determine Your Benefit (Cont.)

Cost Of Living Freeze

You may receive a cost of living increase in other income with which we integrate. In this case, we do not further reduce your *weekly benefit* by the amount of such increase.

Application For Other Income

You must apply for other income benefits to which you may be entitled. If these benefits are denied, you must appeal until: (a) all possible appeals have been made; or (b) we notify you that no further appeals are required.

If we feel you are entitled to receive such income benefits, we will estimate the amount due to you and your spouse and children. We will take this estimated amount into account when we determine your *weekly benefit.* But, we will not take this estimated amount into account if you sign our reimbursement agreement. In this agreement you promise: (a) to apply for any benefits for which you may be eligible; (b) to appeal any denial of such benefits until all possible appeals have been made; and (c) to repay any amount we overpaid due to an award of such benefits.

If we do reduce your *gross weekly benefit* by an estimated amount, we will adjust your *weekly benefit* when we receive written proof: (a) of the amount awarded; or (b) that the other income benefits have been denied; and no further appeals are possible. If we underpaid you, we pay the full amount of the underpayment in a lump sum.

We will assist you in applying for other income benefits.

CGP-3-STD2K-4.3 B335.0027

Partial Week Payment

You may be disabled for only part of a week. In this case, we compute your payment as 1/7th of the benefit to which you would be entitled for the week times the number of days you are disabled.

Overpayment Recovery

If we overpaid you, you must repay us in full. We have the right to reduce your payment or apply any benefits payable, including the minimum payment, toward recovery of the overpayment.

CGP-3-STD2K-4.4 B335.0074

If You Work While Disabled

Income Earned During Disability

Subject to the other terms of this *plan, income earned during disability* is treated as shown below while this *plan* pays benefits.

We reduce your *weekly benefit* by 50% of your *income earned during disability.*

CGP-3-STD2K-5.0 B335.0032

Maximum Income Earned During Disability

This *plan* limits the amount of income you may earn, or may be able to earn, and still be considered *disabled.*

If your *income earned during disability* is more than 80% of your *insured earnings,* payments from this *plan* will end. Payments from this *plan* will also end if you are able to earn more than that limit.

CGP-3-STD2K-5.1 B335.0033

Recurring Disability

Your benefits from this *plan* will end because you cease to be *disabled.* In this case, a later *disability* may be treated as a *recurring disability.* The terms listed below must be met:

(a) You return to *active work* right after your benefits end;

(b) Your *disability* recurs less than two weeks after you were last entitled to benefits;

(c) Your later *disability* is due to the same cause of, or a cause related to the cause of, your earlier *disability;*

(d) This *plan* does not end during your return to *active work;*

(e) You do not become covered under any other group short term disability plan during the time you return to *active work;*

(f) During the time you return to *active work,* you stay insured by this *plan* and premium payments are made on your behalf; and

(g) Your benefits do not end because you have used up the *maximum payment period.*

Any changes in benefit or the *plan* which take place during your return to *active work,* will not apply to the *recurring disability.*

If the later *disability* is a *recurring disability,* you will not need to complete a new *elimination period* before becoming entitled to benefits. Your claim for *recurring disability* will be subject to the same terms of the *plan* as your earlier *disability.*

CGP-3-STD2K-6.0 B335.0034

Pre-Existing Conditions

A pre-existing condition is a *sickness* or *injury,* including all related conditions and complications, for which, in the look back period, you:

(a) receive advice or treatment from a *doctor;*

(b) take prescribed drugs; or

(c) receive other medical care or treatment, including consultation with a *doctor.*

You may have been prescribed drugs by a *doctor* for a condition to be taken during the look back period. In that case, such condition or a related condition will be considered pre-existing.

The "look back period" is the three months before the latest of: (a) the effective date of your insurance under this *plan;* (b) the effective date of a change that increases the benefits payable by this *plan;* and (c) the effective date of a change in your benefit election that increases the benefit payable by this *plan.*

A pregnancy that exists on the date your insurance under this *plan* starts is also a pre-existing condition.

For any *disability* due to a pre-existing condition, we limit the *maximum payment period* to 2 weeks; unless the *disability* starts after the date you are insured under this *plan* for 12 months in a row.

You may become *disabled* due to a pre-existing condition after: (a) a change which provides for an increase in the benefits payable by this *plan;* or (b) a change in your benefit election which increases the benefit payable by this *plan.* In this case, your benefit will be limited to the amount that would have been payable had the change not taken place. This limit does not apply if your *disability* starts after the change has been in force for 12 months in a row.

We do not cover any *disability* that starts before your insurance under this *plan.*

CGP-3-STD2K-8.0 B335.0240

Prior Coverage Credit

If this *plan* replaces a similar short term disability plan the *plan sponsor* had with another insurer, the pre-existing condition provision may not apply to you. This *plan* must start within 62 days after the old plan ends.

We credit any time used to meet the old plan's pre-existing condition provision toward meeting this *plan's* pre-existing condition provision. If the old plan did not have a pre-existing condition provision, we credit any time you were covered under the old plan toward meeting this *plan's* pre-existing condition provision. We do this if: (a) you were covered under the old plan when it ended; and (b) you are *actively-at-work* and enroll for insurance on the effective date of this *plan.*

But, we limit the *maximum weekly benefit* under this *plan* if: (a) it is more than the old plan's maximum; (b) you become *disabled* due to a pre-existing condition; and (c) this *plan* pays benefits for such *disability* because we credit time as explained above. In this case, we limit the *maximum weekly benefit* to an amount equal to the old plan's maximum.

We deduct all payments made by the old plan under an extension provision.

Also, you may have been covered under a group disability insurance plan or an employer-provided disability plan prior to your enrollment in this *plan.* When this happens, we may credit any time you were covered under the prior plan toward meeting this *plan's* pre-existing condition provision. To determine if a condition is pre-existing, we go back to the date your coverage under the prior plan started. We do this if: (a) the prior plan was substantially similar to this *plan;* (b) your active full-time service with the *employer* starts within 30 days of the date your coverage under the prior plan ended; and (c) you enroll in this plan within 31 days of the date you first become eligible under this *plan.* If the *plan sponsor* has included an eligibility waiting period in the *plan,* you must still meet it before becoming insured under this *plan.*

CGP-3-STD2K-8.1-SC B335.0277

Not Covered

Exclusions This *plan* does not pay benefits for *disability* caused by, or related to:

(a) declared or undeclared war, act of war, or armed aggression;

(b) service in the armed forces, National Guard, or military reserves of any state or country;

(c) your taking part in a riot or civil disorder;

(d) your commission of, or attempt to commit a crime;

(e) your being engaged in an illegal occupation; or

(f) intentional self-inflicted injuries.

We do not cover any period of *disability* caused directly or indirectly by: (i) job related or on the job *injury;* or (ii) conditions for which benefits are payable by Workers' Compensation or like laws.

We do not pay benefits for any period of *disability:*

(1) during which you are not receiving regular care by a *doctor;*

(2) during which you are not receiving medical care appropriate to the cause of your *disability* and any other *sickness* or *injury* which exists during your *disability;*

(3) which starts before you are insured by this *plan;* or

(4) during which your loss of earnings is not solely due to your *disability.*

CGP-3-STD2K-9.0-PA B335.0241

Definitions

Active Work, Actively-At-Work Or Actively Working You are able to perform and are performing all of the regular duties of your work for your *employer,* on a full-time basis at: (a) one of your *employer's* usual places of business; (b) some place where your *employer's* business requires you to travel; or (c) any other place you and your *employer* have agreed on for your work.

CGP-3-STD2K-10.0 B335.0045

Disability Or Disabled These terms mean you have physical, mental or emotional limits caused by a current *sickness* or *injury.* And, due to these limits, you are not able to perform, on a full-time basis, the major duties of your *own job.*

You are not *disabled* if you earn, or are able to earn, more than this *plan's* maximum allowed *income earned during disability.*

You may be required, on average, to work more than 40 hours per week. In this case, you are not *disabled* if you are able to perform the major duties of your *own job* for 40 hours per week.

Loss of a professional or occupational license will not, in itself, constitute *disability.*

CGP-3-STD2K-10.2 B335.0048

Doctor Any medical practitioner we are required by law to recognize. He or she must: (a) be properly licensed or certified by the laws of the state where he or she practices; and (b) provide services that are within the lawful scope of his or her practice. We do not recognize you, or your spouse, child, parent, sibling, or business associate, as a *doctor* with respect to your claim for this *plan's* benefits.

Elimination Period The period of time you must be *disabled,* due to a covered *disability,* before this *plan's* benefits are payable.

Any days during which you return to *active work* will not count toward the *elimination period.* The *elimination period* will be extended by one day for each day of *active work.* If you become eligible under any other group short term disability plan while you are at *active work,* you will not be entitled to benefits from this *plan.*

Employer The business entity that employs you and is: (a) the *plan sponsor;* or (b) associated with the *plan sponsor.*

CGP-3-STD2K-10.3 B335.0050

Government Plan Any of the following: (1) the United States Social Security Act; (2) the Railroad Retirement Act; (3) the Canadian Pension Plan; or (4) any other plan provided under the laws of a state, province or any other political subdivision. It also includes: (a) any public employee retirement plan; or (b) any plan provided in place of the above named plan or acts. It does not include: (i) any Workers' Compensation Act or similar law; (ii) the Jones' Act; (iii) the Longshoreman's and Harbor Workers' Compensation Act; or (iv) the Maritime Doctrine of Maintenance, Wages, or Cure.

Gross Weekly Benefit This *plan's weekly benefit* before it is integrated with other income and earnings.

Income Earned During Disability The weekly income you earn from working while *disabled.* It includes any income you earn while *disabled* but which is returned to your *employer,* partnership, or any other similar business arrangement to cover any business or overhead expenses.

Injury A bodily *injury* due to an accident that occurs, independent of all other causes, while you are insured by this *plan.* We will cover a *disability* caused by an *injury* when the *disability* starts within 90 days of the date of such *injury.*

CGP-3-STD2K-10.4 B335.0051

Insured Earnings Only your earnings from the *employer* will be included as *insured earnings.*

The full amount of your *insured earnings* is used to calculate benefit amounts and limits under this *plan.* We base all calculations on the amount of your *insured earnings* as reported by the *plan sponsor* on the most current reporting date prior to the start of your *disability.* See the "Redetermination" section of this *plan.*

Insured earnings includes your contributions deposited into a cash or deferred compensation plan, or salary reduction plan, qualified under IRC Section 401(k), 403(b) or 457. Earnings based on excluded income and *employer* contributions deposited into such 401(k), 403(b) or 457 plan are excluded.

For all covered persons, *insured earnings* means your rate of weekly earnings, excluding bonuses, commissions, expense accounts and any other extra compensation, as reported by the *plan sponsor.* If you are paid hourly, we calculate weekly earnings based on actual hours worked or billed in the eight weeks before the start of your *disability.* We do not include pay for hours worked or billed over 40 per week.

CGP-3-STD2K-10.5 B335.0057

Maximum Payment Period The longest time that benefits are paid by this *plan.*

No-Fault Motor Vehicle Coverage A motor vehicle plan that pays disability or medical benefits no matter who was at fault in an accident.

Own Job Your job for the *employer.* We use the job description provided by the *plan sponsor* to determine the duties and requirements of your *own job.*

Plan Sponsor The employer, association, union, trustee, or other group to which this *plan* is issued.

Recurring Disability A later *disability* that: (a) is related to an earlier *disability* for which this *plan* paid benefits; and (b) meets the conditions described in "Recurring Disability."

Regular Care You are being treated by, or in consultation with, a *doctor* at a frequency that is consistent with your condition. The requirement for *regular care* does not apply if you have reached your maximum point of recovery yet are still *disabled* under the terms of this *plan.*

CGP-3-STD2K-10.6 B335.0060

Retirement Plan A defined benefit or defined contribution plan funded wholly or in part by the *employer's* deposits for your benefit. The term does not include: (a) profit sharing plans; (b) thrift plans; (c) non-qualified deferred compensation plans: (d) individual retirement accounts; (e) tax sheltered annuities; or (f) stock ownership plans.

Retirement Plan **"retirement benefits"** are lump sum or periodic payments at normal or early retirement. Some *retirement plans* make payments for disability(as defined by those plans) that start before normal retirement age. When such payments reduce the amount that would have been paid at normal retirement age, they are *retirement benefits.* When such payments do not reduce the normal retirement amount, they are **"disability benefits."**

Sickness An illness or disease. Pregnancy is treated as a *sickness* under this *plan.*

We, Us, And Guardian The Guardian Life Insurance Company of America.

Weekly Benefit This *plan's gross weekly benefit* reduced by other income.

If you are working while *disabled,* your *weekly benefit* will be further reduced based on the amount of your *income earned during disability.* See "If You Work While Disabled."

You The person insured by this *plan.*

LONG TERM DISABILITY HIGHLIGHTS

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

CGP-3-LTD2K-HL B380.1513

Plan A

Own Occupation Period

The first 24 months of benefit payments from this plan.

CGP-3-LTD2K-HL B380.1578

Elimination Period

For disability due to injury . . . . . 180 days

For disability due to sickness . . . . . 180 days

CGP-3-LTD2K-HL B380.1526

Maximum Payment Period

See the following table:

Age when disability starts	Maximum payment period
Under age 60	To age 65
Age 60	5.00 years
Age 61	4.00 years
Age 62	3.50 years
Age 63	3.00 years
Age 64	2.50 years
Age 65	2.00 years
Age 66	1.75 years
Age 67	1.50 years
Age 68	1.25 years
Age 69 or older	1.00 year

CGP-3-LTD2K-HL B380.1531

Benefit Percent 60%

CGP-3-LTD2K-HL B380.1534

Maximum Monthly Benefit

60% of your *insured earnings,* rounded to the nearest $1.00, if not already a multiple thereof, limited to a maximum of $5,000.00.

NOTE: We integrate your *gross monthly benefit* with certain other income you may receive. Read all the terms of this *plan* to see what income we integrate with, and how.

CGP-3-LTD2K-HL B380.2600

LONG TERM DISABILITY INCOME INSURANCE

This insurance replaces part of your income if you become disabled due to sickness or injury.

We decide: (a) if you are eligible for this insurance; (b) if you meet the requirements for benefits to be paid; and (c) what benefits are to be paid by this plan. We also interpret how this plan is to be administered. What we pay and the terms for payment are explained below.

All terms in *italics* are defined terms with special meanings. Their definitions are shown at the end of this section. Other terms are defined where they are used.

Claim Provisions

Your Duties If you become *disabled* due to *sickness* or *injury* while insured by this *plan,* you must:

(a) Give notice of claim as soon as possible after the date of your *injury* or the start of your *sickness.* Prompt notice will permit us to start case management. See the "Rehabilitation and Case Management" section of this *plan* for details.

(b) Give a complete account of the details of your *sickness* or *injury.* This will include: (i) the cause of your *disability,* if known; (ii) a description of your *sickness* or the accident that caused your *injury;* and (iii) a list of all *doctors,* hospitals, or other facilities where you have been treated for the cause of your *disability.*

(c) Allow release of medical and/or income data needed to assess your claim.

(d) Give periodic medical updates as required by this *plan.*

(e) Take part in any medical, financial or vocational assessment as required by this *plan.*

(f) Apply for other income benefits to which you may be entitled.

(g) Promptly report to us the receipt or denial of such other income benefits. And, appeal any denials to the extent possible.

(h) Promptly report to us changes in your personal status. This includes: (i) change of address or phone number; (ii) changes in how your *disability* affects your daily living; and (iii) changes in your level of social, volunteer or business activities.

(i) If we overpay benefits, promptly report and repay any amount overpaid.

(j) If you are working while *disabled,* promptly report to us the amount of your income from such work.

(k) Give us proof of your earnings for the period prior to your *disability* and while you are *disabled.*

Notice You must send us written notice of your intent to file a claim under this *plan* as described in this certificate's "Accident and Health Claims Provisions." Notice must include:

(a) your full name; phone number; social security number, and group number;

(b) the date of your last day worked; the number of hours you worked; and your job title;

(c) your *employer* contact and phone number;

(d) a statement of the nature of your *disability;* and whether or not it is work-related;

(e) your *doctor's* name, address and phone number.

For details, you can call Guardian at 1-800-538-4583.

Proof Of Loss When we receive your notice, we will provide you with a claim form for filing proof of loss. This form requires data from you, the *plan sponsor,* and the *doctor(s)* treating you for your *sickness* or *injury.* Proof of loss must be given to us within the time stated in this certificate's "Accident and Health Claims Provisions." If you do not receive a claim form within 15 days of the date you sent your notice, you should send us written proof of loss without waiting for the form.

We require the items listed below as proof of loss:

(a) During the *elimination period* and the *own occupation* period, medical evidence in support of the limits on your ability to perform your *own occupation,* starting on the date you first became *disabled.* This proof is required from all *doctors* who have treated you for the cause of your *disability.*

After the *own occupation* period, medical evidence in support of the limits on your ability to perform any *gainful work.*

(b) Proof that you have applied for all other sources of income to which you may be entitled, that may affect your payment from this *plan.*

(c) Proof of receipt of other income that may affect your payment from this *plan.*

(d) Your signed authorization for release of medical and/or financial data by the sources of such data.

Proof of loss and other claim data should be submitted to:

The Guardian Life Insurance Company of America
Group Long Term Disability Claims Department
P.O. Box 26025
Lehigh Valley, PA 18002-6025

How Payments Start

To start getting payments from this *plan,* you must meet all of the conditions listed below:

(a) You must (i) become *disabled* while insured by this *plan;* and (ii) remain *disabled* for this *plan's elimination period.*

(b) You must be: (i) under a *doctor's regular care* for the cause of your *disability,* starting from the date you were first *disabled;* and (ii) receiving medical care appropriate to the cause of your *disability* and any other *sickness* or *injury* which exists during your *disability.*

(c) You must send us written documentation of: (i) medical evidence in support of the limits causing your *disability;* (ii) your monthly earnings prior to the start of your *disability;* and (iii) any earnings from work while you are *disabled.*

Proof of earnings may consist of: (1) copies of your U.S. Individual Income Tax Returns; (2) a statement from a certified public accountant; or (3) any other records we agree to accept.

Waiver Of Premium

Premiums for this insurance are waived while you are entitled to receive a payment from this *plan.*

To Continue Receiving Payments

To continue to receive payments from this *plan,* you must give us current proof of loss when we request it.

You must give proof that satisfies us as to the items listed below:

(a) medical evidence in support of the limits causing your continued *disability;*

(b) continued *regular care* by a *doctor* that is appropriate for the cause of your *disability* and any other *sickness* or *injury* which exists during your *disability;*

(c) earnings from work while you are *disabled;* and

(d) any other income that you are entitled to receive.

You must also give us current signed authorizations for release of medical and financial data when we request it.

You must permit such assessments and give us such items within 90 days of the date we make each such request. If you do not, we have the right to suspend or stop your payments under this *plan.*

Right To Request Medical, Financial Or Vocational Assessment

We may ask you to take part in a medical, financial or vocational assessment as often as we feel is reasonably necessary. We will pay for all such assessments. If you do not take part in the assessment, we have the right to stop or suspend your payments under this *plan.*

Payment Of Benefits

We pay benefits to you if you are legally competent. If you are not, we pay benefits to the legal representative of your estate.

We pay benefits once each month at the end of the period for which they are payable.

Benefits to which you are entitled may remain unpaid at your death. Such benefits may be paid at our discretion to: (a) your estate; or (b) your spouse, parents, children, or brothers and sisters.

CGP-3-LTD2K-2.1 B380.0015

When Benefits End

When Payments End

Your benefits from this *plan* will end on the earliest of the dates shown below:

(a) The date you are no longer *disabled.*

(b) The date you earn, or are able to earn, the maximum earnings allowed while *disabled* under this *plan.*

(c) The date you are able to perform the major duties of your *own occupation* on a full-time basis with reasonable accommodation that an employer is willing to provide.

(d) After the *own occupation* period, the date you are able to perform the major duties of any *gainful work* on a full-time basis with reasonable accommodation that an employer is willing to provide.

(e) The date you no longer reside in the United States.

(f) The date you die.

(g) The end of the *maximum payment period.*

(h) The date you fail to give us required current proof of loss. This includes taking part in any medical, financial or vocational assessment we may require.

(i) The date you are no longer under the *regular care* of a *doctor.*

(j) The date payments end in accord with a *rehabilitation agreement.*

(k) The date you refuse to take part in a *rehabilitation program.*

The term "reasonable accommodation" means any modification or adjustment to: (i) a job; (ii) an employment practice; (iii) a work process; or (iv) the work place. The modification or adjustment must make it possible for a *disabled* person to: (1) reach the same level of performance as a similarly situated non-disabled person; or (2) enjoy equal benefits and privileges of employment as are available to a similarly situated non-disabled person. The modification or adjustment must not place an undue hardship on the employer.

CGP-3-LTD2K-3.0 B380.0019

Plan ID A

Maximum Payment Period

The *maximum payment period* is the longest time that benefits are paid by this *plan* for your *disability.* It is determined by the table shown below.

But, it may be less than that shown due to the nature of your *disability.* See "Special Limitations."

Age when disability starts	Maximum payment period
Under age 60	To age 65
Age 60	5.00 years
Age 61	4.00 years
Age 62	3.50 years
Age 63	3.00 years
Age 64	2.50 years
Age 65	2.00 years
Age 66	1.75 years
Age 67	1.50 years
Age 68	1.25 years
Age 69 or older	1.00 year

CGP-3-LTD2K-3.1 B380.2068

Special Limitations

We limit the *maximum payment period,* if you are *disabled* due to a condition listed below.

The *maximum payment period* for all such periods of *disability* is 24 months. This is a combined maximum for all such conditions and all periods of *disability.*

We limit the *maximum payment period* for *disabilities* caused or contributed to by the following conditions:

- *Mental or emotional conditions*
- Drug or alcohol abuse
- Musculoskeletal and connective tissue disorders including, but not limited to:
  - Sprains or strains of joints and muscles
  - Soft tissue conditions
  - Repetitive motion syndromes or injuries
  - Fibromyalgia
- Chronic fatigue conditions including, but not limited to:
  - Chronic fatigue syndrome
  - Chronic fatigue immunodeficiency syndrome
  - Epstein-barr syndrome
- Chemical and environmental sensitivities
- Headache

- Chronic pain, myofascial pain
- Gastro-esophageal reflux disorder
- Irritable bowel syndrome
- Vestibular dysfunction, vertigo, dizziness

This limitation will not apply to *disabilities* caused or contributed to by the following conditions:

- Schizophrenia
- Dementia
- Organic brain syndromes
- Amnesia syndromes
- Organic delusional or hallucinogenic syndromes
- Arthritis
- Ruptured intervertebral discs
- Spinal fractures
- Osteopathies
- Spinal tumors, malignancy or vascular malformations
- Radiculopathies, documented by EMG
- Spondylolisthesis, Grade II or higher
- Myelopathies
- Demyelinating diseases
- Traumatic spinal cord necrosis

No benefits will be paid for *disability* due to a *mental or emotional condition* or drug or alcohol abuse if you are not receiving treatment for the cause of the *disability* from a provider, or in a facility that is: (a) licensed by the state to provide treatment for such condition; and (b) accredited or approved by the Joint Commission on the Accreditation of Health Care Facilities or Medicare.

If payments under this *plan* would end due to the limits in this section, we may extend such payments, as shown below. But, you must meet all of the following conditions: (a) you must be *disabled* due to a condition named above; (b) you must be an inpatient in a qualified institution because of your *disability;* and (c) you must have been treated as an inpatient for at least 14 days in a row. In such case, we extend payments until the earliest of: (i) 90 days from the date of your discharge; (ii) the end of this *plan's maximum payment period;* or (iii) the date your *disability* ends.

The term "qualified institution" means a legally operated hospital or other public or private facility licensed to provide inpatient medical care and treatment for the cause of your *disability.*

If This Plan Ends

This insurance ends when the group plan ends. It also ends when this insurance is dropped from the group plan for all insureds, or for your class. If you are *disabled* when this insurance ends, we will treat you as if your insurance did not end. But, your benefit will be based on all of the terms of this *plan.*

CGP-3-LTD2K01-3.2 B380.0430

To Determine Your Benefit

Plan A

Your benefit is determined by the plan of benefits and your *insured earnings* in effect on the date your *disability* starts.

Any changes to this *plan* that take place while you are *disabled* will not affect how we determine your benefit. This is also true for any changes that take place during a period of *active work* that occurs between an initial period of *disability* and a *recurring disability.*

Determining Your Monthly Benefit

Your *monthly benefit* is determined as shown below.

(a) Multiply your *insured earnings* by 60%. Round this amount to the nearest dollar.

(b) If the amount determined above is less than this *plan's maximum monthly benefit,* that amount is your *gross monthly benefit.*

If the amount determined above is equal to or more than this *plan's maximum monthly benefit,* your *gross monthly benefit* is equal to the *maximum monthly benefit.*

(c) From your *gross monthly benefit,* subtract the amount of any income listed in "Income We Integrate With" that you receive or are entitled to receive. The result is your *monthly benefit.*

The amount of your *gross monthly benefit* may be limited if:

(a) you have not provided any proof of insurability required by this *plan;*

(b) we have not given you written approval of such proof; or

(c) the *plan sponsor* has not updated the amount of your *insured earnings* to reflect your then current *insured earnings* on the most recent reporting date prior to the start of your *disability.*

See the "Redetermination" and "Proof of Insurability" section of this *plan* for details.

CGP-3-LTD2K-4.0 B380.1956

Redetermination

This plan redetermines *insured earnings* for each covered person on January 1st . Each January 1st , the *plan sponsor* must report current *insured earnings* for all covered persons under the *plan.* Changes to a covered person's *insured earnings* are subject to any proof of insurability requirements of this *plan.* As of this *plan's* redetermination date, we use a covered person's *insured earnings* on record with us to: (a) set rates; (b) project benefit amounts and limits; and (c) calculate premium payable under this *plan.* However, the covered person must be *actively-at-work* on a full-time basis on that date. If he or she is not, we do not do this until the date he or she returns to *active work* on a full-time basis. But, changes in earnings will not apply to a *recurring disability.*

CGP-3-LTD2K01-4.2 B380.0436

Income We Integrate With

You may receive, or be entitled to receive, income shown in the list below. We will integrate your *gross monthly benefit* with such income to determine your *monthly benefit* from this *plan.*

- Commissions received, due to be received, or paid after *disability* benefits start. This includes vested and nonvested renewal commissions.
- Disability benefits from any mandated benefit act or law. This includes all temporary disability or state disability benefits required by law.
- Disability benefits from all group plans of: (1) the *plan sponsor;* or (2) your *employer.* This includes payments made by a group life insurance plan due to your *disability.* This does not include payments made from a group life insurance plan's: (a) accelerated death benefit; or (b) like provision that allows payment of such plan's proceeds due to terminal illness.
- Disability benefits from any other group plan.
- Income from a sick leave or salary continuance plan. This applies whether such plan is sponsored on a formal or informal basis. This includes lump sum or recurrent payments of accrued sick leave benefits.
- Benefits as shown below from: (1) the United States Social Security Act; (2) the Railroad Retirement Act; or (3) any other like U.S. or Canadian plan or act.

  (a) All disability benefits for which: (i) you are qualified; and (ii) your spouse and children are qualified due to your *disability;*

  (b) All unreduced retirement benefits for which: (i) you are qualified; and (ii) your spouse and children are qualified due to your qualification; and

  (c) all reduced retirement benefits paid to: (i) you; and (ii) your spouse and children due to your receipt of such benefits.

We will integrate your *gross monthly benefit* with such benefits to which your spouse and children are entitled due to your receipt of, or qualification for, disability benefits. We do this without regard to: (a) your marital status; (b) where you live; (c) where your spouse lives; (d) where your child lives; or (e) any custody arrangements made on behalf of your child.

- *Retirement plan retirement benefits* funded for your benefit by: (1) the *plan sponsor;* or (2) your *employer.*
- *Retirement plan disability benefits.*
- *Retirement benefits* or *retirement plan disability benefits,* due to your *disability,* from any *government plan* other than those shown above.
- Benefits from: (1) a Workers' Compensation law; (2) an occupational disease law; or (3) any other act or law of like intent. This includes: (a) the Jones' Act; (b) the Longshoreman's and Harbor Workers' Compensation Act; or (c) any Maritime doctrine of Maintenance, Wages or Cure.
- Payment from your *employer* as part of a termination agreement.

We integrate your *gross monthly benefit* with income shown above that you are entitled to receive without regard to the reason you are entitled to receive it.

Our right to reduce your benefit by such income shall not be negated by a transfer of claim liability to a third party. Payment by such third party by law, settlement, judgement, waiver or otherwise shall not negate our right.

CGP-3-LTD2K-4.3 B380.0629

Lump Sum Payments Of Other Income

Income with which we integrate may be paid in a lump sum. In this case, we take the equivalent monthly rate stated in the award into account when we determine your *monthly benefit.* If no monthly rate is given, we pro-rate the lump sum over the lesser of: (a) 60 months; or (b) the *maximum payment period.*

Cost Of Living Freeze

You may receive a cost of living increase in other income with which we integrate. In this case, we do not further reduce your *monthly benefit* by the amount of such increase.

Application For Other Income

You must apply for other income benefits to which you may be entitled. If these benefits are denied, you must appeal until: (a) all possible appeals have been made; or (b) we notify you that no further appeals are required.

If we feel you are entitled to receive such income benefits, we will estimate the amount due to you and your spouse and children. We will take this estimated amount into account when we determine your *monthly benefit.* But, we will not take this estimated amount into account if you sign our reimbursement agreement. In this agreement you promise: (a) to apply for any benefits for which you may be eligible; (b) to appeal any denial of such benefits until all possible appeals have been made; and (c) to repay any amount we overpaid due to an award of such benefits.

If we do reduce your *gross monthly benefit* by an estimated amount, we will adjust your *monthly benefit* when we receive written proof: (a) of the amount awarded; or (b) that the other income benefits have been denied; and no further appeals are possible. If we underpaid you, we pay the full amount of the underpayment in a lump sum.

We will assist you in applying for other income benefits.

CGP-3-LTD2K-4.4 B380.0062

Minimum Payment The minimum monthly payment for *disability* under this *plan* is $50.00.

Partial Month Payment You may be *disabled* for only part of a month. In this case, we compute your payment as 1/30th of the benefit to which you would be entitled for the full month times the number of days you are *disabled.* Payment will not be made for more than 30 days in any month.

Overpayment Recovery If we overpaid you, you must repay us in full. We have the right to reduce your payment or apply any benefits payable, including the minimum payment, toward recovery of the overpayment.

CGP-3-LTD2K-4.5 B380.0064

If You Work While Disabled

Income Earned During Disability Subject to the other terms of this *plan,* if you are working to your *maximum capacity,* income earned during disability is treated as shown below while this *plan* pays benefits. In all cases, your *insured earnings* are adjusted each year by an indexing factor. See the "Indexing" section of this *plan* for how this is done.

1. For each of the first 12 months after you return to work, add your *gross monthly benefit* and your *income earned during disability.*
   (a) If the sum is not more than 100% of your *insured earnings,* we do not reduce your *monthly benefit* for that month.
   (b) If the sum is more than 100% of your *insured earnings,* we reduce your *monthly benefit* for that month by the amount over 100% of your *insured earnings.*
2. For each month after 12 months of work while *disabled:*
   (a) If your *income earned during disability* is less than 20% of your *insured earnings,* we do not reduce your *monthly benefit* for that month.
   (b) If your *income earned during disability* is 20% or more of your *insured earnings,* we reduce your *monthly benefit* for that month by 50% of your *income earned during disability.*

CGP-3-LTD2K01-5.0 B380.0442

Part-Time Earnings Capacity If you are able to work *part-time* while *disabled,* but you are not working to your *maximum capacity,* we adjust the *monthly benefit* as follows.

During the *own occupation* period, we reduce your *monthly benefit* by 50% of the income you would currently be able to earn, if working to your *maximum capacity,* in your *own occupation.* After the *own occupation* period, we reduce your *monthly benefit* by 50% of the income you would currently be able to earn, if working to your *maximum capacity,* in any *gainful occupation.*

Maximum Income Earned During Disability

This *plan* limits the amount of income you may earn, or may be able to earn, and still be considered *disabled.*

If your *income earned during disability* is more than the limit shown below, payments from this *plan* will end. Payments from this *plan* will also end if you are able to earn more than the limit shown below.

(a) During the *own occupation* period, the limit is 80% of your *insured earnings.*

(b) After the *own occupation* period, the limit is 60% of your *insured earnings.*

In all cases, your *insured earnings* are adjusted each year by an indexing factor. See the "Indexing" section of this *plan* for how this is done.

CGP-3-LTD2K01-5.1 B380.0518

Indexing

If you return to work while *disabled,* we adjust your *insured earnings* each year. We do this by means of an indexing factor. This factor increases the amount of income you may earn and still be considered *disabled.* This adjustment does not increase your *gross monthly benefit, monthly benefit,* or any other benefit under this *plan.*

We make the first indexing adjustment after you: (a) have returned to work; and (b) have received 12 monthly payments in a row from this *plan.*

To make the first adjustment, we multiply your *insured earnings* by the indexing factor for that year. To make adjustments in each later year, we multiply the amount of your last indexed *insured earnings* by the indexing factor for the current year.

The indexing factor is the lesser of: (a) 10%; or (b) one-half of the percentage change in the *CPI-W* for the prior calendar year.

CGP-3-LTD2K-5.2 B380.0073

Recurring Disability

Your benefits from this *plan* will end because you cease to be *disabled.* In this case, a later *disability* may be treated as a *recurring disability.* The terms listed below must be met:

(a) You return to *active work* right after your benefits end;

(b) Your *disability* recurs less than six months after you were last entitled to benefits;

(c) Your later *disability* is due to the same cause of, or a cause related to the cause of, your earlier *disability;*

(d) This *plan* does not end during your return to *active work;*

(e) You do not become covered under any other similar group income replacement plan during the time you return to *active work;* and

(f) During the time you return to *active work,* you stay insured by this *plan* and premium payments are made on your behalf.

(g) Your benefits do not end because you have used up the *maximum payment period.*

Any changes in benefit or the *plan* which take place during your return to *active work,* will not apply to the *recurring disability.*

If the later *disability* is a *recurring disability,* you will not need to complete a new *elimination period* before becoming entitled to benefits. Your claim for *recurring disability* will be subject to the same terms of the *plan* as your earlier *disability.*

CGP-3-LTD2K-6.0 B380.0075

Income Recovery Benefit

This *plan* may pay an Income Recovery Benefit, if *monthly benefits* cease because you are no longer *disabled.*

When And How The Income Recovery Benefit Starts

To be eligible for the Income Recovery Benefit, you must be:

(a) able to perform the major duties of your *own occupation;* and

(b) working in your *own occupation* the same number of hours as you did prior to *disability;* and

(c) unable to earn this *plan's* maximum allowable *income earned during disability,* due to the *sickness* or *injury* which caused the prior *disability.*

What We Pay

We pay this benefit monthly, in arrears. We determine the amount we pay in two steps. In step one, we compute the following: (a) your *gross monthly benefit* as of the last month you were *disabled* under the terms of this *plan;* less (b) any other income this *plan* integrates with that you are entitled to receive. In step two we make a current earnings adjustment. We add: (a) your *gross monthly benefit* as of the last month you were *disabled* under the terms of this *plan;* and (b) your current monthly earnings. If such sum exceeds 100% of your *insured earnings,* we pay the amount in step one less the excess over 100%. If such sum does not exceed 100%, we pay the amount in step one.

When The Income Recovery Benefit Ends

We stop paying this benefit on the earliest of:

(a) the date you are able to earn this *plan's* maximum allowable *income earned during disability;*

(b) the date you become *disabled;*

(c) the date you stop working;

(d) the date 12 consecutive months after the first Income Recovery Benefit is paid; or

(e) the end of the *maximum payment period.*

We will not pay more than 12 monthly Income Recovery Benefit payments following any one period of *disability,* including any *recurrent disability.*

CGP-3-LTD2K01-7.5 B380.0452

Services Available

Social Security Assistance

We may feel you are qualified for Social Security disability benefits. If so, we may offer to help you apply for them. If such benefits are under review by Social Security, we may also offer to help you keep them.

We may offer to help:

(a) Fill out your application for such benefits, and any related forms;

(b) Find suitable legal counsel; and

(c) Give medical and vocational data needed to file your claim.

You must apply for all income benefits for which you may be eligible, whether or not you use our help. Using our help does not cancel your duties shown in the "Application for Other Income" section of this *plan.*

Rehabilitation And Case Management

Case management starts when we are notified of your *disability.*

We will review your *disability* to see if certain services are likely to help you return to *gainful work.* If needed, we may ask for more medical or vocational information.

When our review is complete, we may offer you a *rehabilitation program.* We have the right to suspend or end your *monthly benefit* if you do not accept it.

The *rehabilitation program* will start when a written *rehabilitation agreement* is signed by: (1) you; (2) us; and (3) your *employer,* if needed. The program may include, but is not limited to:

(a) vocational assessment of your work potential;

(b) coordination and transition planning with an employer for your return to work;

(c) consulting with your *doctor* on your return to work and need for accommodations;

(d) training in job seeking skills and resume preparation;

(e) retraining;

(f) child care expense aid; and

(g) aid in worksite alteration made to comply with the Americans with Disabilities Act. This includes a one-time payment of up to $2,500.00.

We have the right to determine which services are appropriate.

If you accept the *rehabilitation agreement,* we will pay an enhanced benefit. The enhanced benefit will be 110% of the *monthly benefit* that would otherwise be paid. This enhanced benefit will be payable as of the first *monthly benefit* after the *rehabilitation program* starts.

We stop paying the enhanced benefit on the earliest of:

(a) The date your benefits from this *plan* end,

(b) The date you violate the terms of the *rehabilitation agreement;*

(c) The date you end the *rehabilitation program;* and

(d) The date the *rehabilitation agreement* ends.

If you end a *rehabilitation program* without our consent, you must repay any enhanced benefits paid.

CGP-3-LTD2K-8.0 B380.0089

Pre-Existing Conditions

Pre-Existing Conditions

A pre-existing condition is a *sickness* or *injury,* including all related conditions and complications, for which, in the look back period, you:

(a) receive advice or treatment from a *doctor;*

(b) take prescribed drugs; or

(c) receive other medical care or treatment, including consultation with a *doctor.*

You may have been prescribed drugs by a *doctor* for a condition to be taken during the look back period. In that case, such condition or a related condition will be considered pre-existing.

The "look back period" is the twelve months before the latest of: (a) the effective date of your insurance under this *plan;* (b) the effective date of a change that increases the benefits payable by this *plan;* and (c) the effective date of a change in your benefit election that increases the benefit payable by this *plan.*

A pregnancy that exists on the date your insurance under this *plan* starts is also a pre-existing condition.

No benefits are payable for *disability* due to a pre-existing condition; unless the *disability* starts after the date you are insured under this *plan* for 12 months in a row.

You may become *disabled* due to a pre-existing condition after: (a) a change which provides for an increase in the benefits payable by this *plan;* or (b) a change in your benefit election which increases the benefit payable by this *plan.* In this case, your benefit will be limited to the amount that would have been payable had the change not taken place. This limit does not apply if your *disability* starts after the change has been in force for 12 months in a row.

We do not cover any *disability* that starts before your insurance under this *plan.*

CGP-3-LTD2K-9.0 B380.0561

Prior Coverage Credit

If this *plan* replaces a similar income replacement plan the *plan sponsor* had with another insurer, the pre-existing condition provision may not apply to you. This *plan* must start within 62 days after the old plan ends.

We credit any time used to meet the old plan's pre-existing condition provision toward meeting this *plan's* pre-existing condition provision. If the old plan did not have a pre-existing condition provision, we credit any time you were covered under the old plan toward meeting this *plan's* pre-existing condition provision. We do this if: (a) you were covered under the old plan when it ended; and (b) you are *actively-at-work* and enroll for insurance on the effective date of this *plan.*

But, we limit the *maximum monthly benefit* under this *plan* if: (a) it is more than the old plan's maximum; (b) you become *disabled* due to a pre-existing condition; and (c) this *plan* pays benefits for such *disability* because we credit time as explained above. In this case, we limit the *maximum monthly benefit* to an amount equal to the old plan's maximum.

We deduct all payments made by the old plan under an extension provision.

Also, you may have been covered under a group disability insurance plan or an employer-provided disability plan prior to your enrollment in this *plan.* When this happens, we may credit any time you were covered under the prior plan toward meeting this *plan's* pre-existing condition provision. To determine if a condition is pre-existing, we go back to the date your coverage under the prior plan started. We do this if: (a) the prior plan was substantially similar to this *plan;* (b) your active full-time service with the *employer* starts within 30 days of the date your coverage under the prior plan ended; and (c) you enroll in this *plan* within 31 days of the date you first become eligible under this *plan.* If the *plan sponsor* has included an eligibility waiting period in the *plan,* you must still meet it before becoming insured under this *plan.*

CGP-3-LTD2K-9.1-SC B380.0631

Not Covered

Exclusions

This *plan* does not pay benefits for *disability* caused by, or related to:

(a) declared or undeclared war, act of war, or armed aggression;

(b) service in the armed forces, National Guard, or military reserves of any state or country;

(c) your taking part in a riot or civil disorder;

(d) your commission of, or attempt to commit a crime;

(e) your being engaged in an illegal occupation; or

(f) intentional self-inflicted injuries.

We do not pay any benefits for any period of *disability:*

(1) during which you are not receiving regular care by a *doctor;*

(2) during which you are not receiving medical care appropriate to the cause of your *disability* and any other *sickness* or *injury* which exists during your *disability;*

(3) which starts before you are insured by this *plan;* or

(4) during which your loss of earnings is not solely due to your *disability.*

CGP-3-LTD2K-10.0-PA B380.0534

Definitions

Active Work, Actively-At-Work Or Actively Working You are able to perform and are performing all of the regular duties of your work for your *employer,* on a full-time basis at: (a) one of your *employer's* usual places of business; (b) some place where your *employer's* business requires you to travel; or (c) any other place you and your *employer* have agreed on for your work.

CGP-3-LTD2K-12.0 B380.0098

CPI-W That part of the United States Department of Labor Consumer Price Index that measures the relative value of the cost of a typical urban wage earner's purchase of certain goods and services. The change in cost is expressed as a percentage of the cost of those goods and services in a base period. When we compute the change in *CPI-W,* we use the value of the *CPI-W* published in December of that year and the value published in December of the prior year. If the Department of Labor stops publishing the *CPI-W,* we have the right to use some other similar standard.

CGP-3-LTD2K-12.2 B380.0100

Disability Or Disabled These terms mean you have physical, mental or emotional limits caused by a current *sickness* or *injury.* And, due to these limits, you are not able to perform the major duties of your *own occupation* or any *gainful work* as shown below:

(1) During the *elimination period* and the *own occupation* period, you are not able to perform, on a full-time basis, the major duties of your *own occupation.*

(2) After the end of the *own occupation* period, you are not able to perform, on a full-time basis, the major duties of any *gainful work.*

You are not *disabled* if you earn, or are able to earn, more than this *plan's* maximum allowed *income earned during disability.*

You may be required, on average, to work more than 40 hours per week. In this case, you are not *disabled* if you are able to work for 40 hours per week.

Loss of a professional or occupational license will not, in itself, constitute *disability.*

CGP-3-LTD2K-12.3 B380.0102

Doctor Any medical practitioner we are required by law to recognize. He or she must: (a) be properly licensed or certified by the laws of the state where he or she practices; and (b) provide services that are within the lawful scope of his or her practice. We do not recognize you, or your spouse, child, parent, sibling, or business associate, as a *doctor* with respect to your claim for this *plan's* benefits.

Elimination Period The period of time you must be *disabled,* due to a covered *disability,* before this *plan's* benefits are payable.

Any days during which you return to *active work* will not count toward the *elimination period.* The *elimination period* will be extended by one day for each day of *active work.* If you become eligible under any other similar group income replacement plan while you are at *active work,* you will not be entitled to benefits from this *plan.*

Employer The business entity that employs you and is: (a) the *plan sponsor;* or (b) associated with the *plan sponsor.*

CGP-3-LTD2K-12.10 B380.0112

Gainful Occupation or Gainful Work Work for which you are, or may become, qualified by: (a) training; (b) education; or (c) experience. When you are able to perform such work on a full-time basis, you can be expected to earn at least 60% of your indexed *insured earnings,* within 12 months of returning to work.

Government Plan Any of the following: (1) the United States Social Security Act; (2) the Railroad Retirement Act; (3) the Canadian Pension Plan; or (4) any other plan provided under the laws of a state, province or any other political subdivision. It also includes: (a) any public employee retirement plan; or (b) any plan provided in place of the above named plan or acts. It does not include: (i) any Workers' Compensation Act or similar law; (ii) the Jones' Act; (iii) the Longshoreman's and Harbor Workers' Compensation Act; or (iv) the Maritime Doctrine of Maintenance, Wages, or Cure.

Gross Monthly Benefit This *plan's monthly benefit* before it is reduced by other income and earnings.

Income Earned During Disability The monthly income you earn from working while *disabled.* It includes any income you earn while *disabled* but which is returned to your *employer,* partnership, or any other similar business arrangement to cover any business or overhead expenses.

Injury A bodily *injury* due to an accident that occurs, independent of all other causes, while you are insured by this *plan.* We will cover a *disability* caused by an *injury* when the *disability* starts within 90 days of the date of such *injury.*

CGP-3-LTD2K01-12.11 B380.0458

Insured Earnings Only your earnings from the *employer* will be included as *insured earnings.*

We calculate benefit amounts and limits based on the amount of your *insured earnings* on record with us as of the Redetermination date immediately prior to the start of your *disability.* See the "Redetermination" section of this *plan.*

Insured earnings includes your contributions deposited into a cash or deferred compensation plan, or salary reduction plan, qualified under IRC Section 401(k), 403(b) or 457. Earnings based on excluded income and *employer* contributions deposited into such 401(k), 403(b) or 457 plan are excluded.

For all covered persons, *insured earnings* means your rate of monthly earnings, excluding bonuses, commissions, expense accounts, and any other extra compensation, as reported by the *plan sponsor.* We do not include pay for hours worked or billed over 40 per week. Such earnings are multiplied by 4.333.

CGP-3-LTD2K01-12.12 B380.2124

Maximum Capacity During the *own occupation* period, the fullest extent of work you are able to do in your *own occupation.* After the *own occupation* period, the fullest extent of work you are able to do in any *gainful occupation.* We decide the fullest extent of work you are able to do based on objective data provided by: (a) your treating *doctor;* (b) impartial medical or vocational exams; (c) peer review specialists; (d) functional capacities exams; and (e) other medical and vocational specialists whose area of expertise is appropriate to your *disability.*

Maximum Payment Period The longest time that benefits are paid by this *plan.*

Mental Or Emotional Conditions Include, but are not limited to: (a) neurosis; (b) psychoneurosis; (c) psychosis; (d) psychopathy; and (e) any other mental or emotional disorder.

Monthly Benefit This *plan's gross monthly benefit* reduced by other income. If you are working while *disabled,* your *monthly benefit* will be further reduced based on the amount of your *income earned during disability.* See the "If You Work While Disabled" provision of this *plan* for how this is done.

CGP-3-LTD2K01-12.13 B380.0489

No-Fault Motor Vehicle Coverage A motor vehicle plan that pays disability or medical benefits no matter who was at fault in an accident.

Own Occupation Your occupation as done in the general labor market in the national economy. To determine the duties and requirements of your *own occupation,* we use: (a) the job description provided by the *plan sponsor;* and (b) the duties and requirements of that occupation as shown in the most recent version of the Dictionary of Occupational Titles. That document is published by the Department of Labor. If the Department stops publishing that document, we have the right to use some other similar standard.

Part-Time The ability to work and earn between 40% and 80% of *insured earnings* during the *own occupation* period and between 40% and 60% of *insured earnings* after the *own occupation* period.

Plan Sponsor The employer, association, union, trustee, or other group to which this *plan* is issued.

Recurring Disability A later *disability* that: (a) is related to an earlier *disability* for which this *plan* paid benefits; and (b) meets the conditions described in "Recurring Disability."

Regular Care A person is being treated by, or in consultation with, a *doctor* at a frequency that is consistent with his or her condition. The requirement for *regular care* does not apply if he or she has reached his or her maximum point of recovery yet is still disabled under the terms of this *plan.*

CGP-3-LTD2K01-12.14 B380.0522

Rehabilitation Agreement A formal agreement between; (a) you; (b) us; and (c) your *employer,* if needed. It outlines the *rehabilitation program* in which you agree to take part.

Rehabilitation Program A program of work or job-related training for you that we approve in writing. Its aim is to restore your wage earning abilities.

Retirement Plan A defined benefit or defined contribution plan funded wholly or in part by the *employer's* deposits for your benefit. The term does not include: (a) profit sharing plans; (b) thrift plans; (c) non-qualified deferred compensation plans: (d) individual retirement accounts; (e) tax sheltered annuities; or (f) stock ownership plans.

Retirement Plan **"retirement benefits"** are lump sum or periodic payments at normal or early retirement. Some *retirement plans* make payments for disability (as defined by those plans) that start before normal retirement age. When such payments reduce the amount that would have been paid at normal retirement age, they are *retirement benefits.* When such payments do not reduce the normal retirement amount, they are **"disability benefits."**

Sickness An illness or disease. Pregnancy is treated as a *sickness* under this *plan.*

We, Us, And Guardian The Guardian Life Insurance Company of America.

You The person insured by this *plan.*

CGP-3-LTD2K-12.15 B380.0135

ELIGIBILITY FOR CRITICAL ILLNESS INSURANCE

Employee Coverage

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

Other Condition If you must pay all or part of the cost of *employee* coverage, we won't insure you until you enroll and agree to make the required payments. If you do this: (a) more than 31 days after you first become eligible; or (b) after you previously had coverage which ended because you failed to make a required payment, we also ask for *proof* that you're insurable. And you won't be covered until we approve that *proof* in writing.

If your active *full-time* service ends before you meet any *proof of insurability* requirements that apply to you, you'll still have to meet those requirements if you're later re-employed.

Part or all of your insurance amounts may be subject to *proof* that you're insurable. Other parts of this coverage explain if and when we require *proof.* You won't be covered for any amount that requires such *proof* until you give the proof to us and we approve it in writing.

CGP-3-EC-90-1.0 B473.0020

When Your Coverage Starts *Employee* benefits that don't require *proof* that you are insurable are scheduled to start on your effective date.

Employee benefits that require such *proof* won't start until you send us the *proof* and we approve it in writing. Once we have approved it, the benefits are scheduled to start on the effective date shown in the endorsement section of your application. A copy of the approved application is furnished to you.

But you must be actively at work on a *full-time* basis on the scheduled effective date or dates. And you must have met all of the applicable conditions explained above, and any applicable waiting period. If you are not actively at work on any date part of your insurance is scheduled to start, we will postpone that part of your coverage until the date you return to active *full-time* work.

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

CGP-3-EC-90-2.0 B264.3202

When Your Coverage Ends

Your coverage ends on the date your active full-time service ends for any reason. Such reasons include disability, death, retirement, layoff, leave of absence and the end of employment. It also ends on the date you stop being a member of a class of employees eligible for insurance under this plan, or when this plan ends for all employees. And it ends when this plan is changed so that benefits for the class of employees to which you belong ends. If you are required to pay all or part of the cost of this coverage and you fail to do so, your coverage ends. It ends on the last day of the period for which you made the required payments, unless coverage ends earlier for other reasons.

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

Group Critical Illness Insurance Coverage During a Family Leave of Absence

This section may not apply to an employer's plan. You must contact your employer to find out if:

- the employer must allow for a leave of absence under Federal law, in which case;
- the section applies to you.

Group Critical Illness Insurance may normally end for you because you cease work due to an approved leave of absence. But, you may continue your coverage if the leave of absence has been granted: (a) to allow *you* to care for a seriously injured or ill spouse, child, or parent; (b) after the birth or adoption of a child; (c) due to *your* own serious health condition; or (d) because of any serious injury or illness arising out of the fact that your spouse, child, parent, or next of kin, who is a covered servicemember, 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. You will be required to pay the same share of the premium as you paid before the leave of absence.

Group Critical Illness Insurance may continue until the earliest of the following:

- The date you return to active work.
- In the case of a leave granted to you to care for a covered servicemember: The end of a total leave period of 26 weeks in one 12 month period. This 26 week total leave period applies to all leaves granted to you under this section for all reasons. If you take an additional leave of absence in a subsequent 12 month period, continued coverage will cease at the end of a total leave period of 12 weeks.
- In any other case: The end of a total leave period of 12 weeks in any 12 month period.
- The date on which your *Employer's Plan* is terminated or you are no longer eligible for coverage under this *Plan.*
- 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.

CRITICAL ILLNESS INSURANCE

Important Notice **This is *critical illness* insurance. It provides a limited specified benefit. It is a supplement to, and not a substitute for, medical coverage. Please read this *plan* carefully to fully understand what it covers, limits, and excludes.**

Subject to all of this *plan's* terms and the Total Amount Payable provision, this *plan* will pay the benefits described below if a *covered person* is *diagnosed* with a listed *critical illness,* both after the date he or she becomes insured by this *plan* and after the end of the *benefit waiting period.* This plan pays no benefits for any other conditions, procedures or illnesses.

This *plan* deems each *critical illness* to occur on the date described in this *plan's* Special Proof Requirements For Each Critical Illness section.

All terms in *italics* are defined terms with special meanings. See the "Definitions" section of this *plan.* Other terms with special meanings are defined where they are used.

CGP-3-CIP-IC-07 B475.0122

THE CRITICAL ILLNESS BENEFIT

The Choices

You may choose any of the plans of employee *critical illness* insurance available to your class. These *plans* are shown in the schedule.

But, you may only choose to be insured under one *plan* for yourself at a time. You must notify your employer of your choices and pay the required premium.

You may change your choices at any time, subject to any of this *plan's proof of insurability* requirements. You must notify your employer of any change. The change will take effect on the next premium due date that coincides with or next follows the later of, the date: (a) we approve your *proof of insurability* in writing, if required; or (b) you notify your employer of the change.

Delayed Effective Date

You may not be actively at work due to *sickness* or *injury* on the date specified above. In that case, we will postpone the change to a higher employee benefit amount for a covered loss due to that *sickness* or *injury* until you complete ten days in a row without missing a work day due to that *sickness* or *injury* in which you are: (a) actively at work; (b) working your regular number of hours; and (c) fully capable of performing the major duties of your regular occupation. The change to a higher employee benefit amount for an otherwise covered loss for any other condition will become effective on the date you are: (i) actively at work; (ii) working your regular number of hours; and (iii) fully capable of performing the major duties of your regular occupation.

This *plan* will pay a benefit based on the benefit amount for which a person is insured. The benefit will be subject to all of the terms of this *plan.*

The *critical illness* must occur: (a) while the person is insured by this *plan:* and (b) after the date he or she completes the benefit waiting period. The benefit waiting period is shown in the "Limitations" section. This plan deems each critical illness to occur on the date shown for it in the "Special Proof Requirements For Each Critical Illness" section. This plan pays a benefit only if the Critical Illness diagnosis is made during the lifetime of the insured.

This plan pays a different level of benefits for the first ever occurrence and the second ever occurrence of a critical illness. The levels are shown in the table below.

Voluntary Critical Illness	% of Benefit Amount For First Ever Occurrence	% of Benefit Amount For Second Ever Occurrence
Category 1 Cancer	100%	50%
Category 2 Cancer	25%	0%
Coronary Artery Bypass Graft (CABG)	25%	0%
Heart Attack	100%	50%
Kidney Failure	100%	50%
Major Organ Transplant	100%	50%
Stroke	100%	50%

(1) This plan does not pay benefits for any procedures, conditions, or illnesses that are not listed above.

(2) This *plan* does not pay benefits for a *second ever occurrence;* unless the *covered person* has not exhibited symptoms or received care or treatment for that *critical illness* for at least 12 months in a row prior to the second ever occurrence. For purposes of this provision, care or treatment does not include: (a) preventive medications in the absence of disease; and (b) routine scheduled follow-up visits to a doctor.

(3) This *plan* does not pay benefits for a *second ever occurrence* of: (a) *category 2 cancer;* or (b) *coronary artery bypass graft (CABG).*

(4) This plan does not pay benefits for a first ever occurrence of a critical illness that starts less than 03 months from the date of the first ever occurrence of a different critical illness for which we paid benefits.

(5) This plan does not pay benefits for a third or later occurrence.

Wellness Benefit

This *plan* will pay a benefit if a covered employee has one of the following wellness tests or procedures performed.

What this *plan* pays is shown in the schedule. This *plan* pays this benefit regardless of the results of the test or procedure.

The benefit this *plan* pays does not count toward the Critical Illness Total Amount Payable.

Well tests or procedures are limited to:

- Blood test for triglycerides
- Bone marrow testing
- Breast ultrasound
- CA 15-3 (blood test for breast cancer)
- CA125 (blood test for ovarian cancer)
- CEA (blood test for colon cancer)
- Chest x-ray
- Colonoscopy
- Completion of a smoking cessation program
- Completion of a weight reduction program
- Fasting blood glucose test
- Flexible sigmoidoscopy
- Hemoccult stool analysis
- Mammography

- Pap smear
- PSA (blood test for prostate cancer)
- Serum cholesterol test to determine level of HDL and LDL
- Serum Protein Electrophoresis (blood test for myeloma)
- Stress test on a bicycle or treadmill
- Thermography
- ThinPrep pap test
- Virtual colonoscopy

The employee must submit proof of the cost incurred for the test or procedure.

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Limitations

Total Amount Payable This *plan* limits what it pays for each *covered person* for all *critical illnesses* in his or her lifetime to the Total Amount Payable. The Total Amount Payable is shown in the schedule.

Age Reduction Your benefit amount will be reduced when you reach certain ages. These reductions are shown in the schedule.

Proof Of Insurability The *covered person's* benefit amount, a part of it, or increases in it may not become effective until you submit *proof of insurability* to us. This *plan* must approve such *proof* in writing. These requirements are shown in the schedule.

Benefit Waiting Period This *plan* has a benefit waiting period. It is shown in the schedule. This period starts on the date the person is first insured by this *plan.* We do not pay benefits for a *critical illness:* (a) that occurs during the benefit waiting period; or (b) for which the *covered person* exhibits symptoms during the benefit waiting period.

If this plan replaces a similar plan the employer had with some other insurer, the benefit waiting period under this plan will be waived for any *covered person* who was covered under the employer's old plan on the day before this plan starts, and is covered by this plan on the day it starts.

Pre-Existing Conditions A pre-existing condition is a *sickness* or *injury,* whether diagnosed or misdiagnosed, for which in the 3 months before a person becomes insured by this *plan* he or she: (a) sought medical advice, treatment or care; (b) exhibited symptoms of any medical or physical conditions; (c) underwent diagnostic procedures; (d) took prescription drugs; or (e) received other medical care or treatment, including consultation with a doctor.

This plan will not pay benefits for a *critical illness* that is caused by, or results from, a pre-existing condition if the *critical illness* occurs during the first 12 months that the person is insured by this plan.

If This Plan Replaces Another Plan

This plan may be replacing a similar plan that your employer had with some other insurer. In that case, the pre-existing condition limitation will not apply to any *covered person* who: (a) was covered on the day before this plan started under the employer's old plan; (b) has met the requirements of any pre-existing condition or limitation of the old plan; and (c) in the case of the employee, is actively at work on a full-time basis on the effective date of this plan.

If the covered person: (a) was covered under the old plan when it ended; (b) enrolls for insurance under this plan on or before this plan's effective date; and (c) is actively working on the effective date of this plan; but (d) has not fulfilled the requirements of any pre-existing condition provision of the old plan; this plan will credit any time used to meet the old plan's pre-existing condition provision toward meeting this plan's pre-existing condition provision.

But, this plan limits a *covered persons* benefit under this plan if: (a) it is more than the *critical illness* benefit for which he or she was insured under the old plan; (b) the illness is due to a pre-existing condition; and (c) this plan pays benefits because this *plan* credits time as explained above. In this case, this *plan* limits the benefit to the amount the *covered person* would have been entitled to under the old plan.

This *plan* deducts all payments made by the old plan under an extension provision.

CGP-3-CIP-CI-4-07 B475.0266

This *plan* will not pay benefits for any *critical illness:*

(1) caused by, contributed to by, or resulting from a *covered person:*

(a) participating in a felony, riot or insurrection;

(b) intentionally causing a self-inflicted *injury;*

(c) committing or attempting to commit suicide while sane or insane;

(d) that is caused by the *covered person's* voluntary use of any poison, chemical, prescription or non-prescription drug or controlled substance unless: (i) it was prescribed for him or her by a doctor, and (ii) it was used as prescribed. In the case of a non- prescription drug, this *plan* does not pay for any critical illness resulting from or contributed to by the *covered person's* use in a manner inconsistent with package instructions. A controlled substance is anything called a controlled substance in Title II of the Comprehensive Drug Abuse Prevention and Control Act of 1970, as amended from time to time;

(e) engaging in any illegal activity; or

(f) serving in the armed forces or any auxiliary unit of the armed forces of any country.

(2) arising from war or act of war, even if war is not declared.

(3) for which *diagnosis* is made outside the United States, unless the *diagnosis* is confirmed in the United States. In that case, the *critical illness* will be deemed to occur on the date the *diagnosis* was made outside the United States.

(4) that is caused by, contributed to by, or results from a *covered person's* involvement in an incident where he or she is legally intoxicated at the time of the incident. This includes, but is not limited to, his or her operation of a motor vehicle. "Legally intoxicated" means that the *covered person's* alcohol level met or exceeded the level that creates a legal presumption of intoxication under the laws of the jurisdiction in which the incident occurred.

(5) *first ever occurrence* that occurs less than 12 months after the *first ever occurrence* of a different *critical illness* for which this plan paid benefits.

(6) that does not have its *first ever occurrence* or *second ever occurrence* while the person is covered by this *plan.*

(7) unless it is *diagnosed* while the *covered person* is alive.

(8) for which proof is submitted by a *doctor* who is the: (a) *covered person;* or (b) his or her spouse, child, parent, sibling or business associate.

This *plan* will not pay benefits for any *diagnosis* of *category 1 cancer* for:

(1) any benign tumor, dysplasia, intraepithelial neoplasia or pre-malignant growth;

(2) any papillary tumor of the bladder classified as Ta under *TNM classification;*

(3) any tumor of the prostate classified as T1N0M0 under *TNM classification;*

(4) any papillary tumor of the thyroid that is classified as T1N0M0 or less under *TNM classification* and is one centimeter or less in diameter, unless there is metastasis;

(5) any tumor in the presence of human immuno-deficiency virus;

(6) any non-melanoma skin cancer, unless there is metastasis;

(7) any malignant tumor classified as less than T1N0M0 under *TNM classification;*

(8) Chronic Lymphocytic Leukemia (CLL), less than Stage III, as defined by RAI classification; or

(9) any condition that is *category 2 cancer.*

This *plan* will not pay benefits for any *diagnosis* of *category 2 cancer* for:

(1) any benign tumor, dysplasia, intraepithelial neoplasia or pre-malignant growth;

(2) any papillary tumor of the bladder classified as Ta under *TNM classification;*

(3) any tumor of the prostate classified as T1N0M0 under *TNM classification;*

(4) any papillary tumor of the thyroid that is classified as T1N0M0 or less under *TNM classification* and is one centimeter or less in diameter, unless there is metastasis;

(5) any tumor in the presence of human immuno-deficiency virus;

(6) any non-melanoma skin cancer; or

(7) any melanoma in situ classified as TisN0M0 under *TNM classification.*

This *plan* will not pay benefits for any coronary artery bypass graft (CABG) performed outside of the United States.

This *plan* will not pay benefits for a *major organ transplant:*

(1) involving organs other than:

  (a) bone marrow solely for treatment of cancer or bone marrow failure; or

  (b) an entire kidney, liver, heart, lung, or pancreas;

(2) involving transplants of parts of organs, tissues or cells;

(3) involving organs transplanted from the same covered person;

(4) performed outside the United States;

(5) involving organs received from non-human donors;

(6) involving implantation of mechanical devices or mechanical organs;

(7) involving stem cell generated transplants (other than for a bone marrow transplant);

(8) involving islet cell transplants; or

(9) involving bone marrow transplanted from the same *covered person.*

Special Proof Requirements For Each Critical Illness

Category 1 Cancer Or Category 2 Cancer

Diagnosis of *category 1 cancer* or *category 2 cancer* must be based on microscopic (histologic) exam of: (a) fixed tissues; or (b) preparations of blood or bone marrow. Such exam must be documented in a written report by a *doctor* who is *board certified* in pathology.

Category 1 cancer or *category 2 cancer* will be deemed to occur on the date the *diagnosis* is made.

Coronary Artery Bypass Graft (CABG)

Proof of *coronary artery bypass graft (CABG)* requires submission of medical records. These records must show that it:

(1) was determined to be *medically necessary* by a *doctor* who is a *board certified* cardiologist;

(2) was supported by pre-operative angiographic evidence; and

(3) has been done on the *covered person.*

The *CABG* will be deemed to occur on the date it is done.

Heart Attack

Proof of *heart attack* requires submission of medical records. The *heart attack* will be deemed to occur on the date it is *diagnosed* by a *doctor* who is a *board certified* cardiologist.

Kidney Failure

Proof of *kidney failure* requires submission of medical records. The *kidney failure* will be deemed to occur on the earlier of the date: (a) renal or peritoneal dialysis is started; or (b) renal transplant is done.

Major Organ Transplant

Proof of a *major organ transplant* requires submission of medical records. These records must show that it:

(1) was determined to be *medically necessary* by a *doctor* who is *board certified* in a medical specialty that is appropriate to the organ involved; and

(2) has been done on the *covered person.*

The *major organ transplant* will be deemed to start on the date it is done.

Stroke *Diagnosis* of *stroke* must be:

(1) confirmed in writing by a doctor who is board certified in neurology; and

(2) be based on medical records. These records must show objective evidence of significant neurological impairment.

Such impairment must be documented by meeting all of the following criteria:

(a) clinical evidence of infarction of brain tissue, or intracranial or subarachnoid hemorrhage;

(b) clear evidence on a CT, MRI or similar imaging techniques that a stroke has occurred; and

(c) permanent neurologic deficit measured three months or more after the event that results in a score of two or higher on the Modified Rankin Scale for stroke outcome.

The *stroke* will be deemed to occur on the date of the event.

We reserve the right to accept diagnostic markers other than those outlined above. In all cases, diagnostic markers will be determined according to generally accepted medical standards supported by nationally recognized authorities in the health care field including the American Medical Association (AMA); The AMA Board of Medical specialties; the food and Drug Administration; the Centers for Disease Control; the National Cancer Institutes of Health; the Department of Health and Human Services; and any other agency of similar repute.

DEFINITIONS

Benefit Year This term means each period of 12 months in a row which starts on January 1 and ends on December 31.

Board Certified This term means a *doctor* who has been certified in the appropriate medical specialty by a member board of the American Board of Medical Specialties.

Category 1 Cancer As used in this *plan,* this term means a malignant tumor which has: (a) uncontrolled growth of malignant cells; and (b) invaded normal tissue. It must be positively *diagnosed* with histopathological confirmation.

The term does not include the tumors listed below:

(1) Chronic lymphocytic leukemia that has not progressed to at least: (a) Rai stage II; or (b) Binet Stage B.

(2) All tumors that are histologically described as: (a) premalignant; (b) noninvasive; (c) carcinoma in situ (including cervical dysplasia: CIN-1; CIN-2; and CIN-3); (d) borderline malignant; or (e) low malignant potential.

(3) All skin cancers; unless: (a) there is evidence of metastasis; or (b) the tumor is a malignant melanoma of greater than 1.0 mm maximum thickness (regardless of Clark level or ulceration) as determined by histological examination using the Breslow method.

(4) Prostate cancer; unless histologically classified as: (a) Gleason score 7 or greater; or (b) *TNM classification* T2N0M0 or greater.

(5) Papillary carcinoma of the thyroid that is: (a) 1 cm or less in diameter; and (b) limited to the thyroid.

(6) Noninvasive papillary cancer of the bladder histologically described as *TNM classification* TaN0M0 or lower.

Category 2 Cancer As used in this *plan,* this term means a malignant neoplasm of epithelial origin that is confined to the basement membrane. Carcinoma in situ must be *diagnosed* with histopathological confirmation.

The term does not mean: (a) premalignant lesions of the skin; (b) carcinoma in situ of the skin; and (c) melanoma in situ.

Coronary Artery Bypass Graft (CABG) As used in this *plan,* this term means major surgery which requires median sternotomy (division of the breast bone) to correct narrowing or blockage of one or more coronary arteries with bypass grafts.

The term does not mean procedures that do not require median sternotomy. These include, but are not limited to: (a) minimally invasive, endoscopic, and "keyhole" heart surgery; (b) balloon and laser angioplasty; (c) stent procedures; and (d) atherectomy.

Covered Person This term means an employee covered by this *plan.*

Critical Illness As used in this *plan,* this term means: (a) *category 1 cancer;* (b) *category 2 cancer;* (c) *coronary artery bypass Graft (CABG);* (d) *heart attack;* (e) *kidney failure;* (f) *major organ transplant;* and (g) *stroke.*

Diagnosis This term means the establishment of a *critical illness* by a *doctor* through the use of clinical and/or lab findings, as described in this plan's "Special Proof Requirements For Each Critical Illness" section.

Doctor This term means any medical practitioner we are required by law to recognize. He or she must: (a) be properly licensed or certified by the laws of the state where he or she practices; and (b) provide services that are within the lawful scope of his or her practice.

First Ever Occurrence This term means:

(1) With respect to *category 1 cancer, category 2 cancer, heart attack, kidney failure,* or *stroke,* the first time ever in a *covered person's* lifetime that: (a) he or she experiences such *critical illness;* and (b) he or she is *diagnosed* with such *critical illness.*

(2) With respect to *coronary artery bypass graft (CABG),* the first time ever in a covered person's lifetime that he or she undergoes such procedure.

(3) With respect to major organ transplant, the first time ever in a covered person's lifetime that he or she undergoes a major organ transplant.

Second Ever Occurrence This term means:

(1) With respect to category 1 cancer, category 2 cancer, heart attack, kidney failure, or stroke, the second time in a covered person's lifetime that: (a) he or she experiences such critical illness; and (b) he or she is diagnosed with such critical illness.

(2) With respect to coronary artery bypass graft (CABG), the second time in a covered person's lifetime that he or she undergoes such procedure.

(3) With respect to major organ transplant, the second time in a covered person's lifetime that he or she undergoes a major organ transplant.

Heart Attack As used in this plan, this term means death of heart muscle due to inadequate blood supply. All of the following criteria for acute myocardial infarction must be satisfied: (a) typical clinical symptoms such as central chest pain; (b) diagnostic increase of specific cardiac markers; and (c) new electrocardiographic changes of infarction.

Injury This term means: (a) all damage to a covered person's body due to an accident; and (b) all complications arising from that damage.

Kidney Failure As used in this plan, this term means chronic irreversible failure of both kidneys to function, as a result of which either regular renal or peritoneal dialysis is started, or renal transplant is performed.

Major Organ Transplant As used in this plan, this term means: (a) human to human organ transplant from a donor to the covered person of bone marrow solely for treatment of cancer or bone marrow failure; or (b) transplant of an entire liver, heart, lung, or pancreas. Kidney transplant is covered under the Kidney Failure provision.

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Medically Necessary This term means health services and supplies that are all of the following:

(1) medically appropriate;

(2) needed to diagnose or treat a sickness or injury;

(3) consistent in type, frequency, and length of treatment with scientifically based guidelines of national medical research or health care coverage organizations or government agencies;

(4) needed for reasons other than comfort or convenience of the covered person or doctor;

(5) of proven medical value; and

(6) done with the appropriate level of service or supply needed to provide safe and adequate care.

Plan This term means the Guardian group Critical Illness Insurance plan purchased by the employer.

Proof or Proof Of Insurability These terms mean an application for insurance which shows that a person is insurable.

Sickness This term means any illness or disease suffered by a covered person.

Stroke As used in this plan, this term means death of brain tissue due to an acute cerebrovascular event. All of the following criteria must be satisfied: (a) clinical evidence of infarction of brain tissue, or intracranial or subarachnoid hemorrhage; (b) clear evidence on a CT, MRI or similar imaging techniques that a stroke has occurred; and (c) permanent neurologic deficit measured three months or more after the event that results in a score of two or higher on the Modified Rankin Scale for stroke outcome.

The term does not mean symptoms due to: (a) transient ischemic attack; (b) migraine; (c) hypoxia; (d) traumatic injury to brain tissue or blood vessels; and (e) vascular disease affecting the eye, optic nerve or vestibular functions.

TNM Classification This term means the classification standards for cancer developed by the American Joint Committee on Cancer.

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

You and Your These terms mean you, the employee who enrolled for this Critical Illness Insurance plan.

CGP-3-CIP-DEF-3-07 B475.0445

ELIGIBILITY FOR ACCIDENT INSURANCE

Employee Coverage

Eligible Employees

To be eligible for *employee* coverage *you* must be an active *full-time employee.* and *you* must belong to a class of *employees* covered by this *plan.*

Other Conditions

If *you* must pay all or part of the cost of *employee* coverage, *we* won't insure *you* until *you* enroll and agree to make the required payments.

CGP-3-EC-90-1.0 B476.1228

When Your Coverage Starts

Employee benefits are scheduled to start on your effective date. But you must be actively at work on a *full-time* basis on the scheduled effective date. And you must have met all of the applicable conditions explained above, and any applicable waiting period. If you are not actively at work on any date part of your insurance is scheduled to start, we will postpone that part of your coverage until the date you return to active *full-time* work.

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

CGP-3-EC-90-2.0 B476.3878

When Your Coverage Ends

Your coverage ends on the date *your* active *full-time* service ends for Any reason. Such reasons include disability, death, retirement, layoff, leave of absence and the end of employment.

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

Your coverage ends on the date *you* are no longer working in the United States or working outside the United States for a United States based *employer* in a country or region approved by *us.*

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

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

Group Accident Insurance Coverage During a Family Leave of Absence

This section may not apply to an employer's *plan. You* must contact *your* employer to find out if:

- the employer must allow for a leave of absence under Federal law, in which case;
- the section applies to *you.*

Group Accident Insurance may normally end for *you* because *you* cease work due to an approved leave of absence. But, *you* may continue *your* coverage if the leave of absence has been granted: (a) to allow the *you* to care for a seriously injured or ill spouse, child, or parent; (b) after the birth or adoption of a child; (c) due to *your* own serious health condition; or (d) because of any serious injury or illness arising out of the fact that *your* spouse, child, parent, or next of kin, who is a covered service member, 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. *You* will be required to pay the same share of the premium as *you* paid before the leave of absence.

Group Accident Insurance may continue until the earliest of the following:

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

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

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

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

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

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

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

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

CGP-3-DEP-90-1.0 B473.0009

Eligible Dependents For Dependent Accident Coverage

Your eligible dependents are: (1) *your* legal spouse; And (2) *your* unmarried dependent children from birth until they reach age 26.

CGP-3-DEP-90-2.0 B476.1242

Adopted Children And Step-Children

Your "unmarried dependent children" include: (a) *your* legally adopted children; and (b) if they depend on *you* for most of their support and maintenance, *your* step-children.

We treat a child as legally adopted from the time the child is placed in *your* home for the purpose of adoption. *We* treat such a child this way whether or not a final adoption order is ever issued.

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. Upon notice of entry into service, pro rata unearned premiums will be refunded.

A child may be an eligible dependent of more than one *employee* who is insured under this *plan.* In that case, the child may be insured for dependent accident benefits by only one *employee* at a time.

CGP-3-DEP-90-3.0 B476.1244

Handicapped Children

You may have an unmarried child with a mental or physical handicap, or developmental disability, who can't support himself or herself. Subject to all of the terms of this section and the *plan,* such a child may stay eligible for dependent benefits past this *plan'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 condition started before he reached this *plan's* age limit; (b) he or she became insured for dependent accident benefits before he or she reached the age limit, and stayed continuously insured until he or she reached such limit; and (c) he or she depends on *you* for most of his or her support and maintenance.

But, for the child to stay eligible, *you* must send us written *proof* that the child is handicapped and depends on *you* for most of his or her support and maintenance. *You* have 31 days from the date he or she 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 *your* coverage does.

CGP-3-DEP-90-4.0 B476.1246

When Dependent Coverage Starts

In order for *your* dependent coverage to start, *you* must: (a) already be insured for *employee* coverage; or (b) enroll for *employee* and dependent coverage at the same time.

Subject to all of the terms of this *plan,* the date *your* dependent coverage is scheduled to start depends on when *you* elect to enroll *your* initial dependents and agree to make the required payments.

If *you* do this on or before *your* eligibility date, the dependent coverage is scheduled to start on the later of: (a) *your* eligibility date; and (b) the date *you* become insured for *employee* coverage.

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

Once *you* have dependent child coverage for *your* initial dependent child(ren), any *newly acquired dependent* children will be covered as of the date they are eligible.

CGP-3-DEP-90-6.0 B476.1247

Exception *We* will postpone the effective date of a dependent's, other than a newborn child's, coverage if, on that date, he or she is: (1) confined to a hospital or other health care facility; (2) home confined; or (3) unable to perform two or more activities of daily living. In that case, *we* will postpone the effective date of his or her coverage until the day after the date: (a) of his or her discharge from such facility; (b) his or her home confinement ends; or (c) he or she is no longer requires assistance with two or more activities of daily living. If a dependent was covered under a prior plan at transfer, this language will not apply to the amount of coverage that was in force with the prior plan.

CGP-3-DEP-90-7.0 B476.1248

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

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

An individual dependent's coverage ends when he or she stops being an eligible dependent. This happens to a child: (a) at 12:01 A.M. Standard Time at the child's place of residence on the date the child attains this *plan's* age limit; (b) when the child marries; or (c) when a step-child is no longer dependent on *you* for most of his or her support and maintenance. This happens to a spouse when a marriage ends in legal divorce or annulment.

CGP-3-DEP-90-7.0 B476.1250

Schedule of Benefits

Employee And Dependent Accident Coverage

For limitations regarding the number of benefit payments per covered accident please refer to the BENEFIT section.

Benefits	
Accident Emergency Room Treatment	$175.00
Accident Follow-Up Visit - Doctor	$50.00 up to 6 treatments
Accidental Death	Employee: $25,000.00 Spouse: $12,500.00 Child: $5,000.00
Accidental Death Common Carrier	200% of the Accidental Death benefit
Accidental Death Common Disaster	200% of the spouse's Accidental Death benefit
Accidental Dismemberment	Limit for all losses due to same accident: $25,000.00
	Loss of a hand, foot or sight: 50% of Accidental Death benefit
	Multiple Losses of hand, foot or sight: For more than one covered loss due to the same Accident, we will pay 100% of the Accidental Death benefit
	Loss of thumb and index finger of same hand or Loss of four fingers of same hand: 25% of Accidental Death benefit
	Loss of all toes of same foot: 25% of Accidental Death benefit
Accidental Death Seatbelt & Airbag benefit	Seatbelt: $10,000.00 Seatbelt & Airbag: $15,000.00
Air Ambulance	$1,000.00
Ambulance	$150.00
Appliance	$125.00
Blood/Plasma/ Platelets	$300.00

Burn	2nd Degree 18 to 35 square inches: $1,000.00 over 35: $3,000.00 3rd degree 9 to 18 square inches: $2,000.00 18 to 35 square inches: $4,000.00 over 35: $12,000.00
Burn - Skin Graft	50% of burn benefit
Catastrophic Loss	Quadriplegia: 100% of Accidental Death Loss of speech and Hearing (both ears): 100% of Accidental Death Loss of cognitive function: 100% of Accidental Death Hemiplegia: 50% of Accidental Death Paraplegia: 50% of Accidental Death
Child Organized Sport	Additional 20% of payable benefits
Chiropractic Visits	$25.00 per visit
Coma	$10,000.00
Concussions	$75.00
Dislocations	Closed/Open
Hip	$2,200.00/$4,400.00
Knee	$1,100.00/$2,200.00
Shoulder	$330.00/$660.00
Collar bone (sternoclavicular)	$550.00/$1,100.00
Collar bone (acromioclavicular and separation)	$110.00/$220.00
Ankle or foot	$880.00/$1,760.00
Lower jaw	$330.00/$660.00
Wrist or elbow	$330.00/$660.00
Toe or finger	$110.00/$220.00
Bones of the hand	$330.00/$660.00
Diagnostic Exam (Major)	$150.00
Emergency Dental Work	Crown: $300.00 Extraction: $75.00
Epidural Anesthesia Pain Management	$100.00
Eye Injury	$300.00
Family Care	$20.00 per day
Fracture	Closed/Open
Skull (depressed)	$2,750.00/$5,500.00

Skull (non-depressed)	$1,100.00/$2,200.00
Hip, Thigh (femur)	$1,650.00/$3,300.00
Vertebrae, body of (excluding vertebrae processes)	$825.00/$1,650.00
Pelvis	$825.00/$1,650.00
Leg	$825.00/$1,650.00
Bones of the face or nose	$385.00/$770.00
Upper jaw, maxilla	$385.00/$770.00
Upper arm (humerous)	$385.00/$770.00
Lower jaw, mandible	$330.00/$660.00
Shoulder blade	$330.00/$660.00
Vertebral process	$330.00/$660.00
Forearm	$330.00/$660.00
Kneecap	$330.00/$660.00
Foot (except toes)	$330.00/$660.00
Ankle	$330.00/$660.00
Rib	$275.00/$550.00
Coccyx	$220.00/$440.00
Finger, toe	$110.00/$220.00
Hospital Admission	$1,000.00
Hospital Confinement	$225.00 per day
Hospital ICU Admission	$2,000.00
Hospital ICU Confinement	$450.00 per day
Initial Physician's office/Urgent care facility treatment	$75.00
Knee Cartilage	$500.00
Joint Replacement	Hip: $2,500.00 Knee: $1,250.00 Shoulder: $1,250.00
Laceration	No sutures required: $25.00 Lacerations less than 5 cm: $50.00 Lacerations at least 5 cm but less than 15 cm: $200.00 Lacerations at least 15 cm or more: $400.00
Lodging	$125.00 per day
Occupational or Physical Therapy	$25.00 per day
Prosthetic Device/Artificial Limb	1: $500.00 2 or more: $1,000.00

Reasonable Accommodation to Home or Vehicle	$2,500.00
Rehabilitation Unit Confinement	$150.00 per day
Ruptured Disc With Surgical Repair	$500.00
Surgery	Cranial, open-abdominal or thoracic: $1,250.00 Hernia $150.00
Surgery - Exploratory or Arthroscopic	$250.00
Tendon/Ligament/Rotator Cuff	1: $500.00 2 or more: $1,000.00
Transportation	$500.00
Wellness Benefit	$50.00 per year
X - Ray	$30.00

ACCIDENT COVERAGE

Subject to all of this *plan's* terms, this *plan* will pay the benefits described below if a *covered person* sustains an injury or incurs a loss as a result of a covered accident which occurs on or after the date he or she becomes insured by this *plan.* This *plan* pays no benefits other than what is specifically listed below.

All terms in italics are defined terms with special meanings. See the "Definitions" section of this plan. Other terms with special meanings are defined where they are used.

CGP-3-AC-IC-12 B476.0002

Benefits

Accident Emergency Room Treatment

We pay the amount shown in the Schedule of Insurance if a *covered person* is examined or treated by a doctor in a *hospital emergency room* for the initial treatment of injuries sustained in a *covered accident* within 72 hours after the *covered accident.* This benefit is payable once per *covered person* per *covered accident. We* will not pay the Accident Emergency Room Treatment benefit and the Initial Doctor's Office/Urgent Care Facility benefit for the same *covered accident.*

Accident Follow-Up Visit

We pay the amount shown in the Schedule of Insurance if a *covered person* requires additional follow up treatments (not including occupational, speech or *physical therapy* or chiropractic treatment) after initial *emergency room* treatment or *doctor's* office/*urgent care facility* treatment. *We* pay up to 6 treatments per *covered person* per *covered accident.* Treatment must begin within 60 days of a *covered accident* and be completed within 365 days.

Accidental Death

We pay the amount shown in the Schedule of Insurance if a *covered person* sustains an *injury* in a *covered accident* that causes his or her death. The *injury* must cause his or her death within 90 days of the *covered accident.* If *we* pay this benefit, *we* will not pay the Accidental Death Common Carrier benefit.

Accidental Death Common Carrier

We pay the amount shown in the Schedule of Insurance if a *covered person's accidental death* is due to a *covered accident* which occurs while the *covered person* is riding as a fare-paying passenger in a public conveyance. If *we* pay this benefit, *we* will not pay the Accidental Death benefit.

Accidental Death Common Disaster

We pay the increased amount shown in the Schedule of Insurance if both *you* and *your* insured spouse die in a *covered accident* or in separate *covered accidents* within the same 24 hour period. The benefit increase applies to *your* insured spouse's benefit.

Accidental Dismemberment

We pay the amount shown in the Schedule of Insurance if a listed loss is sustained by a *covered person* due to injuries caused by a *covered accident.*

- "Loss of a hand" means the hand is completely severed at or above the wrist.

- "Loss of a foot" means the foot is completely severed at or above the ankle.
- "Loss of sight" means total and permanent loss of sight.
- "Loss of thumb and index finger of same hand" or "Loss of four fingers of same hand" means complete severance at the metacarpophalangeal joints of the same hand. This benefit is not payable if benefits have been paid for "Loss of hand".
- "Loss of all toes of same foot" means complete severance at the metatarsalphalangeal joint. This benefit is not payable if benefits have been paid for "Loss of foot".

We will not pay more than $25,000.00 for all losses due to the same *covered accident.*

Accidental Death Seatbelt and Airbag benefit

We pay the seatbelt amount shown in the Schedule of Insurance if a *covered person* dies due to injuries sustained in a *covered accident* while properly wearing a seatbelt. *We* will pay the Seatbelt and Airbag amount shown in the Schedule of Insurance if a *covered person* dies as a direct result of an automobile *accident* while both properly wearing a seatbelt, and sitting in a seat equipped with an airbag. *We* will not pay both the Seatbelt and Seatbelt and Airbag benefit for the same *covered accident.*

Air Ambulance

We pay the amount shown on the Schedule of Insurance if a *covered person* is transported by air ambulance to or from a *hospital* or between medical facilities for treatment of injuries sustained as the result of a *covered accident* within 48 hours of a *covered accident.* This benefit is payable once per *covered person* per *covered accident.*

Ambulance

We pay the amount shown on the Schedule of Insurance if a licensed ambulance company transports a *covered person* by ground to or from a *hospital* or between medical facilities for treatment of injuries sustained as a result of a *covered accident* within 90 days of *covered accident.* This benefit is payable once per *covered person* per *covered accident.*

Appliance

We pay the amount shown on the Schedule of Insurance if a covered person uses an *appliance* prescribed by a *doctor* as necessary due to an *injury* sustained as a result of a *covered accident.* An *appliance* includes wheelchairs, leg or back braces, crutches, walkers, walking boot that extends above the ankle, and brace for the neck. Use of the *appliance* must begin within 90 days of *covered accident.* This benefit is payable once per *covered person* per *covered accident.*

Blood/Plasma/ Platelets

We pay the amount shown in the Schedule of Insurance if as the result of a *covered accident* a *covered person* receives a transfusion, administration, cross matching, typing and processing of blood/plasma/platelets within 90 days of the *covered accident.* This benefit is payable once per *covered person* per *covered accident.*

Burn *We* pay the amount shown in the Schedule of Insurance if a *covered person* receives burns as a result of a *covered accident* and is treated by a *doctor* within 72 hours of the *covered accident.* If a *covered person* meets more than one of the burn classifications, *we* pay the higher amount. This benefit is payable once per *covered person* per *covered accident.*

Burn - Skin Graft *We* pay the amount shown in the Schedule of Insurance when medically necessary grafting of the skin is received by a *covered person* for a burn that was payable under the Burn benefit. This benefit is payable once per *covered person* per *covered accident.*

Catastrophic Loss *We* pay the amount shown in the Schedule of Insurance if a *covered person* suffers a catastrophic loss within 365 days of a *covered accident* due to injuries sustained in a *covered accident.* This benefit is payable once per *covered person* per *covered accident.* If a Catastrophic Loss benefit is paid, an Accidental Dismemberment benefit will not be paid for the same or attached body part.

Child Organized Sport *We* pay the additional amount shown on the Schedule of Insurance if the *covered accident* occurred while an *employee's* covered dependent child is participating in an *organized sport.* The child must be insured by this plan on the date the *accident* occurred. The covered child must be 18 years of age or younger.

Chiropractic visits *We* pay the amount shown in the Schedule of Insurance if as the result of a *covered accident* a *covered person* suffers a structural imbalance and receives *chiropractic care services* by a chiropractor in a chiropractor's office. Treatment must begin within 60 days after a *covered accident* and be completed within 180 days of the *covered accident. We* will pay for up to 6 visits per *covered person* per *covered accident* but no more than 12 visits per calendar year.

Coma *We* pay the amount shown in the Schedule of Insurance if as the result of a *covered accident* a *covered person* is in a *coma* lasting at least 7 consecutive days characterized by the absence of eye opening, verbal response, and motor response. The condition must require intubation for respiratory assistance, be diagnosed or treated by a *doctor* within 90 days of the *covered accident.* This benefit is not payable for a medically induced *coma.*

Concussions *We* pay the amount shown in the Schedule of Insurance if a *covered person* sustains a concussion as the result of a *covered accident* and is diagnosed within 72 hours of the *covered accident.* This benefit is payable once per *covered person* per *covered accident.*

Dislocations *We* pay the amount shown in the Schedule of Insurance if a *covered person* is injured and suffers a *dislocation* as the result of a *covered accident.* A *dislocation* must be diagnosed by a *doctor* within 90 days of the *covered accident.* The *dislocation* must be corrected by open (surgical) or closed (non-surgical) reduction.

For multiple *dislocations* due to the same *covered accident,we* will pay no more than two times the benefit amount for the joint involved with the highest benefit amount.

For partial *dislocations, we* will pay 25% of the benefit shown in the Schedule of Insurance for a closed reduction.

Diagnostic Exam (Major)

We pay the amount shown in the Schedule of Insurance if a *covered person* receives one of the following imaging studies due to a *covered accident* Computerized Tomography (CT scan), computerized axial tomography (CAT), magnetic resonance imaging (MRI or electroencephalography (EEG). The imaging study must be prescribed by a *doctor* and performed in a *doctor's* office or in a *hospital* on an *inpatient* or *outpatient* basis. This benefit is payable once per *covered person* per *covered accident.*

Emergency Dental Work

We pay the amount shown in the Schedule of Insurance if a *covered person* suffers a broken tooth as the result of a *covered accident* and it is repaired by a *dentist* with a dental crown and/or dental extraction. The dental services must begin within 60 days of the *covered accident.* One dental crown and one dental extraction is payable per *covered person* per *accident.*

Epidural Anesthesia Pain Management

We pay the amount shown in the Schedule of Insurance if a *covered person* is prescribed and receives an epidural administered for pain management for injuries received as a result of a *covered accident.* The epidural must be administered in a *hospital* or *doctor's* office and is payable twice per covered person per *accident.* This benefit is not payable for an epidural administered during a surgical procedure.

Eye Injury

We pay the amount shown in the Schedule of Insurance if a *covered person* is injured as the result of a *covered accident* and suffers an eye *injury.* They eye *injury* must require surgery or the removal of a foreign object by a *doctor* within 90 days of a *covered accident.* This benefit is payable once per *covered person* per *covered accident.*

Family Care

We pay the amount shown in the Schedule of Insurance if a *covered person* is injured as the result of a *covered accident* and is confined in a *hospital,* ICU or *alternate care* or *rehabilitative facility* and an *employee* has a child or children attending a *child care center.* The benefit is payable for each child attending a *child care center* while the *covered person* is confined. The child attending the *child care center* does not need to be insured under this Policy for Accident coverage but must meet the eligibility requirements found in the Dependent Eligibility section. This benefit is payable for up to 30 days within 365 days of the *covered accident.* This benefit is payable once per child per *covered accident.*

Fracture (Bone) *We* pay the amount shown in the Schedule of Insurance if a *covered person* suffers a *fracture* as a result of a *covered accident* and it is diagnosed within 90 days of the *covered accident.* The *fracture* must require open (surgical) or closed (non-surgical) reduction by a *doctor.* This benefit is payable for up to two *fractures* per *covered person* per *covered accident.* If there are more than two *fractures, we* will pay the highest two benefit amounts per *covered person* per *covered accident. We* pay 25% of the amount shown in the Schedule of Insurance for the closed reduction of a bone with a chip *fracture* that was a result of a *covered accident.*

CGP-3-AC-BEN-12 B476.0005

Hospital Admission *We* pay the amount shown in the Schedule of Insurance if a *covered person* is admitted to a *hospital* within 180 days of a *covered accident* as a result of injuries sustained in a *covered accident.* This benefit is payable once per *covered person* per *covered accident.* This benefit is not payable for *emergency room* treatment, *outpatient treatment,* or a *hospital* stay less than 20 hours in an observation unit. *We* will not pay the Hospital Admission and Hospital Intensive Care Unit Admission benefits for the same *covered accident.*

Hospital Confinement *We* pay the amount shown in the Schedule of Insurance if a *covered person* is confined to a *hospital* within 180 days of a *covered accident* as a result of injuries sustained in a *covered accident.* This benefit is payable up to 365 days per *covered accident.* This benefit is not payable for a *hospital* stay less than 20 hours. *We* pay either the Hospital Confinement or the Hospital Intensive Care Unit Confinement benefits for each day.

Hospital Intensive Care Unit Admission *We* pay the amount shown in the Schedule of Insurance if a *covered person* is admitted directly to a *hospital intensive care unit* within 30 days of a *covered accident* as a result of injuries sustained in a *covered accident.* This benefit is payable once per *covered person* per *covered accident.* This benefit is not payable for *emergency room* treatment, *outpatient treatment,* or a *hospital* stay less than 20 hours in an observation unit. *We* will not pay the Hospital Admission and the Hospital Intensive Care Unit Admission benefits for the same *covered accident.*

Hospital Intensive Care Unit Confinement *We* pay the amount shown in the Schedule of Insurance if a *covered person* is confined to a *hospital intensive care unit* within 30 days of a *covered accident* as a result of injuries sustained in a *covered accident.* This benefit is payable up to 15 days per *covered accident.* This benefit is not payable for a *hospital intensive care unit* stay less than 20 hours. *We* pay either the Hospital Confinement or the Hospital Intensive Care Unit Confinement for each day.

Initial Doctor's Office/Urgent Care Facility Treatment *We* pay the amount shown in the Schedule of Insurance if a covered person is examined or treated by a *doctor* in a *doctor's* office or *urgent care facility* for the initial treatment of a *covered accident* within 30 days after the *covered accident.* This benefit is payable once per *covered person* per *covered accident. We* will not pay the Accident Emergency Room Treatment benefit and the Initial Doctor's Office/Urgent Care Facility Treatment benefit for the same *covered accident.*

Knee Cartilage *We* pay the amount shown in the Schedule of Insurance if a *covered person* tears, ruptures or severs knee cartilage (meniscus) as the result of a *covered accident* and requires surgical repair. The *injury* must be treated by a *doctor* within 60 days after the *covered accident* and repaired through surgery within 365 days.

Joint Replacement *We* pay the amount shown in the Schedule of Insurance if due to an *injury* sustained in a *covered accident* a *covered person* requires a hip, knee, or shoulder joint replacement. The joint replacement must be performed by a *doctor* within 90 days of a *covered accident* and is payable once per *covered person* per *covered accident.*

Laceration *We* pay the amount shown in the Schedule of Insurance if a *covered person* sustains a laceration as a result of a *covered accident* and it is repaired by a *doctor* within 72 hours of the *covered accident.* The amount *we* pay will be based on the total length of all lacerations received in any one covered accident which require repair. This benefit is payable once per *covered person* per *covered accident* for a laceration with no sutures and once per *covered person* per *covered accident* for a laceration which required sutures.

Lodging *We* pay the amount shown in the Schedule of Insurance for a *companion's* hotel/motel stay during the period of time a *covered person* is confined to the *hospital* as the result of a *covered accident.* This benefit is payable up to 30 days per *covered person* per *covered accident* and is only payable while the insured is confined to the *hospital.* The *hospital* must be more than 50 miles from the residence of the covered person.

Occupational or Physical Therapy *We* pay the amount shown in the Schedule of Insurance if a *covered person* requires occupational or *physical therapy* due to injuries sustained in a *covered accident.* Treatment must begin within 60 days of the *covered accident,* be completed within 6 months, and be performed by a licensed *occupational* or *physical therapist.* This benefit is payable up to 10 treatments per *covered person* per *covered accident.*

Prosthetic Device/Artificial Limb *We* pay the amount shown in the Schedule of Insurance if due to injuries sustained in a *covered accident* a *covered person* receives one or more prosthetic devices/artificial limbs as prescribed by a *doctor* for functional use due to the loss of a hand, foot or sight of an eye. The device or limb must be prescribed within 365 days of the *covered accident* and is payable once per *covered person* per *covered accident.* This benefit is not payable for hearing aids, dental aids (including false teeth), eyeglasses, or cosmetic prostheses such as hair wigs.

Reasonable Accommodation to Home or Vehicle *We* pay the amount shown in the Schedule of Insurance for a required modification made to a *covered person's* place of residence or vehicle if the *covered person* suffers an Accidental Dismemberment or Catastrophic Loss due to a *covered accident.* The modification must be made within two years of the *covered accident* and is payable once per *covered person* per *covered accident.*

Rehabilitation Unit Confinement

We pay the amount shown in the Schedule of Insurance if a *covered person* is confined to rehabilitation unit due to injuries sustained in a *covered accident.* This benefit is payable up to 15 days per *covered person* per *covered accident* but cannot exceed 30 days per calendar year. *We* will not pay the Rehabilitation Unit Confinement and the Hospital Confinement benefits for the same day.

Ruptured Disc With Surgical Repair

We pay the amount shown in the Schedule of Insurance if a *covered person* receives a ruptured disc in his spine as a result of injuries sustained in a *covered accident.* The *injury* must be treated by a *doctor* within 60 days of the *covered accident* and surgically repaired within 365 days of the *covered accident.* This benefit is payable once per *covered person* per *covered accident.*

Surgery (cranial, open-abdominal, thoracic, hernia)

We pay the amount shown in the Schedule of Insurance if a *covered person* undergoes cranial, open-abdominal, thoracic, or hernia surgery due injuries sustained to a *covered accident.* Cranial, open-abdominal, and thoracic surgery must be performed within 72 hours of the *covered accident.* Hernia surgery must be diagnosed within 30 days of *covered accident* and surgery must be performed within 60 days. If more than one surgery is performed, *we* pay the benefit with the highest dollar amount. This benefit is payable once per *covered person* per *covered accident.*

Surgery (Exploratory and Arthroscopic)

We pay the amount shown in the Schedule of Insurance if a *covered person* undergoes exploratory or arthroscopic surgery as a result of injuries sustained in a *covered accident* and the surgery takes place within 60 days of the *covered accident.* This benefit is payable once per *covered person* per *covered accident.* Hernia repair is not covered under this benefit. This benefit is not payable if the Surgery or Tendon/Ligament/Rotator Cuff benefits are payable for the same surgery.

Tendon/Ligament/ Rotator Cuff

We pay the amount shown in the Schedule of Insurance if a *covered person* receives a torn, ruptured or severed tendon, ligament, or rotator cuff as the result of injuries sustained in a *covered accident.* The *injury* must be treated within 60 days of the *covered accident* and repaired through surgery within 365 days of the *covered accident.* This benefit is payable once per *covered person* per *covered accident.*

Transportation

We pay the amount shown in the Schedule of Insurance if a *covered person* must travel more than 50 miles one way to receive special treatment at a *hospital* or free standing treatment facility due to a *covered accident.* The treatment must be prescribed by a *doctor* and not available locally. This benefit is payable up to three times per *covered person* per *covered accident* and is not payable if transportation is provided by *ambulance* or *air ambulance.*

Wellness Benefit

We pay the amount shown in the Schedule of Insurance for one wellness benefit per calendar year per covered person if such person has a wellness test performed while coverage is in force. Wellness tests are

- Abdominal aortic aneurysm ultrasonography

- Blood test for triglycerides
- Bone marrow testing
- Bone density screening
- Breast ultrasound
- CA 15-3 (blood test for breast cancer)
- CA125 (blood test for ovarian cancer)
- Carotid ultrasound
- CEA (blood test for colon cancer)
- Chest x-ray
- Colonoscopy
- Completion of a smoking cessation program
- Completion of a weight reduction program
- Double contrast barium enema
- EKG
- Fasting blood glucose test
- Flexible sigmoidoscopy
- Hemoccult stool analysis
- Immunizations
- Mammography
- Pap smear
- PSA (blood test for prostate cancer)
- Routine/annual physicals
- Serum cholesterol test to determine level of HDL and LDL
- Serum Protein Electrophoresis (blood test for myeloma)
- Skin cancer biopsy
- Stress test on a bicycle or treadmill
- Thermography
- ThinPrep pap test
- Virtual colonoscopy.

X - Ray *We* pay the amount shown in the Schedule of Insurance if a *covered person* receives an x-ray as the result of injuries sustained in a *covered accident.* The test must be prescribed by a *doctor* and performed in a *doctor's* office or a *hospital* on an *inpatient* or *outpatient* basis and performed within 90 days of the *covered accident.* This benefit is payable once per *covered person* per *covered accident.*

Payment of Benefits For covered loss of life, *we* pay *your* beneficiary described below.

For all other covered losses, *we* pay *you,* if *you* are living. If not, *we* pay *your* beneficiary described below.

We pay all benefits in a lump sum, as soon as *we* receive proof of loss which is acceptable to *us.* This should be sent to *us* as soon as possible.

The Beneficiary *You* decide who gets this benefit if *you* die. *You* should have named a beneficiary on *your* enrollment form. *Your* beneficiary designation should be maintained by *your employer. You* can change *your* beneficiary at any time by giving *us* written notice, unless *you* have assigned this insurance. But the change will not take effect until the *employer* gives *you* written confirmation of the change.

If *you* named more than one person, but didn't tell *us* what their shares should be, they will share equally. If someone *you* named dies before *you,* that person's share will be divided equally by the beneficiaries still alive, unless *you* have specified otherwise.

If there is no beneficiary when *you* die, we will pay this benefit to one of the following: (a) *your* estate; (b) *your* spouse; (c) *your* parents; (d) *your* children; or (e) *your* brothers and sisters.

CGP-3-AC-BEN-12 B476.0010

Exclusions

This *plan* will not pay benefits for any injury caused by or related to, directly or indirectly:

- Sickness, disease, mental infirmity or medical or surgical treatment.
- Voluntary use of any poison, chemical, prescription or non-prescription drug or controlled substance unless: (1) it was prescribed for a *covered person* by a *doctor,* and (2) it was used as prescribed. In the case of a non-prescription drug, this *plan* does not pay for any *accident* resulting from or contributed to by use in a manner inconsistent with package instructions. "Controlled substance" means anything called a controlled substance in Title II of the Comprehensive Drug Abuse Prevention and Control Act of 1970, as amended from time to time.
- The *covered person* being legally intoxicated.
- Declared or undeclared war, act of war, or armed aggression.
- Service in the armed forces, National Guard, or military reserves of any state or country.

- Taking part in a riot or civil disorder.
- Commission of, or attempt to commit a felony.
- Treatment rendered or *hospital confinement* outside the United States or Canada.
- Intentionally self inflicted injury, while sane or insane.
- Suicide or attempted suicide, while sane or insane.
- Travel or flight in any kind of aircraft, including any aircraft owned by or for the *employer* except as a fare-paying passenger on a common carrier.
- Participation in any kind of sporting activity for compensation or profit, including coaching or officiating.
- Riding in or driving any motor-driven vehicle in a race, stunt show or speed test.
- Participation in hang gliding, bungee jumping, sailgliding, parasailing, parakiting ballooning, parachuting, or skydiving.
- Job related or on the job injuries.
- An accident that occurred before the *covered person* is covered by this *plan.*
- Injuries to a dependent child received during birth.

CGP-3-AC-EXC-12 B476.0013

PORTABILITY PRIVILEGE

Note This section does not apply to residents of Kansas, Maine, or South Dakota.

Definition As used in this provision, the terms "port" and "to port" mean to choose a portable certificate of coverage which provides *accident* coverage.

Portability Conditions Portability is subject to all of the conditions described below.

- *You* may port *your* coverage or coverage for any of *your* dependents if coverage under this *plan* ends because *you:* (1) have terminated employment; (2) stop being a member of an eligible class of *employees;* or (3) this *plan* ends.
- *You* may not Port *your* coverage or coverage for any of *your* dependents if: (1) coverage under this *plan* ends due to *your* failure to pay any required Premium; or (2) *you* have reached age 70 on or before *your* coverage under this *plan* ends.

Portability Options *You* may port: (1) *your* coverage only; (2) *your* coverage and the coverage of *your* covered spouse; (3) *your* coverage and the coverage of all of *your* covered dependents; or (4) if *you* are a single parent, *your* coverage and the coverage of all of *your* covered dependent children. No other combinations will be allowed.

A dependent must be covered as of the date *your* coverage under this *plan* ends in order to be eligible to port.

If *you* die while covered for dependent *accident* coverage, *your* spouse may port the dependent *accident* coverage as described above. *Your* spouse and dependent children must be covered under this *plan* on the date of your death. But this option is not available if (1) there is no surviving spouse; or (2) the surviving spouse has reached age 70 on the date *you* die.

The Portable Certificate of Coverage The portable certificate of coverage provides group *accident* coverage. The benefits provided by the portable certificate of coverage are the same as the benefits provided by this *plan.*

The premium for the portable certificate of coverage will be based on: (1) *your* rate class under this *plan;* and (2) *your* or *your* surviving spouse's age bracket as shown in the Accident Portability Coverage Premium Notice.

How to Port *You* or *your* surviving spouse must: (1) apply to *us* in writing; and (2) pay the required premium. *You* or *your* surviving spouse must do this within 31 days from the date *your* coverage under this *plan* ends.

We will not ask for *proof* that *you* or *your* surviving spouse are in good health.

DEFINITIONS

Accident This term means an event or occurrence that was not reasonably foreseeable, or that could not have been reasonably expected or anticipated. The term *accident* does not include a *sickness.*

Accidental Death This term means death caused by an *accident* independent of *sickness,* bodily infirmity, or any other cause and which is not excluded under the Limitations and Exclusions section.

Alternate Care Facility This term means a facility that is licensed according to state and/or local laws to provide skilled care, intermediate care, intermingled care, custodial care, or rehabilitative care as an alternative to care at a *hospital.*

Child Care Center This term means a program of child care which: (1) is provided in a facility that is licensed as a day care center or is operated by a licensed day care provider; and (2) charges a fee for the care of children. The term does not include child care provided by a: (a) parent; (b) stepparent; (c) grandparent; (d) sibling; (e) aunt; or (f) uncle.

Chiropractic Care Services This term means spinal manipulation by a licensed chiropractor to correct a structural imbalance caused by a *covered accident.* This does not include services for massage therapy or treatment of chronic conditions or other injuries not related to structural imbalance.

Covered Accident This term means an *accident* that:

- Occurs while *your* coverage or *your* dependent's coverage under this policy is in effect.
- Results in a bodily *injury* and
- Is not otherwise excluded under the terms of this policy.

Common Carrier This term means any land, air or water conveyance operated under a license to transport passengers for hire.

Covered Person This term means an *employee* or dependent insured by this *plan.*

Coma This term means a state of complete mental unresponsiveness, due to *injury,* with no evidence of appropriate responses to stimulation, as diagnosed by a *doctor.*

Companion This term means a spouse, domestic partner, civil union partner, sibling, child, parent, grandparent, or any primary care giver.

Dentist This term means a licensed *doctor* of dentistry, operating within the scope of his or her license, in the state in which he or she is licensed.

Dislocation This term means a completely separated joint due to an *injury.* A partial *dislocation* means the joint is misaligned but not completely dislocated, as diagnosed by a *doctor.*

Doctor This term means any medical practitioner We are required by law to recognize. He or she must: (1) be properly licensed or certified by the laws of the state where he or she practices; and (2) provide services that are within the lawful scope of his or her practice.

Emergency Room This term means a department of the *hospital* that is designated for emergency care of accidental injuries. This area must be staffed and equipped to handle trauma, be supervised and provide treatment by *doctors,* and provide care seven days per week, 24 hours per day.

Epidural Anesthesia This term means a form of regional anesthesia involving injection of drugs through a catheter placed into the epidural space. The epidural must be administered due to a *covered accident,* and does not include treatment for childbirth or diseases.

Fracture This term means a broken bone that can be determined by a diagnostic exam. A chip *fracture* is a *fracture* in which a piece of the bone is broken off near a joint at a place where a ligament is usually attached.

Hospital This term means a short-term, acute care general facility, which:

(1) is primarily engaged in providing, by or under the continuous supervision of *doctors,* to *inpatients,* diagnostic services and therapeutic services for diagnosis, treatment and care of sick or injured persons;

(2) has organized departments of medicine and major surgery;

(3) has a requirement that every patient must be under the care of a *doctor* or *dentist;*

(4) provides 24 hour nursing service by or under the supervision of a registered professional nurse(R.N.);

(5) is duly licensed by the agency responsible for licensing such *hospitals;* and

(6) is not, other than incidentally: (a) a place of rest; (b) a place primarily for the treatment of tuberculosis; (c) a place for the aged; (d) a place for drug addicts or alcoholics; or (e) a place for convalescent, custodial, educational or rehabilitative care.

Hospital Intensive Care Unit This term means a designated area of a *hospital* that

(1) provides the highest quality of medical care and is restricted to patients who are critically ill or injured and who require intensive comprehensive observation and care;

(2) is separate and apart from the surgical recovery room and from rooms, beds, wards, and units customarily used for patient confinement

(3) is permanently equipped with special lifesaving equipment for the care of the critically ill or injured;

(4) is under continuous observation by a specially trained nursing staff assigned exclusively to the intensive care unit on a 24 hour basis and is assigned a *doctor* on a full-time basis.

Hospital Confinement This term means admission to a *hospital* as an *inpatient* for at least 24 consecutive hours by a *doctor* for an *injury.*

Injury This term means unintentional physical damage or harm caused directly by an *accident* and not due to *sickness,* disease or any other causes. The *injury* must occur while you or your covered dependent are insured under this *plan.*

Inpatient This term means a patient who is admitted to a *hospital* for an *injury.*

Occupational Therapy This term means the treatment of a physically disabled person by means of constructive activities designed and adapted to promote the restoration of the *covered person's* ability to satisfactorily accomplish the ordinary tasks of daily living and those tasks required by the *covered person's* particular occupational role. Occupational therapy does not include diversional, recreational, vocational therapies(i.e. hobbies, arts and crafts).

Occupational Therapist This term means a person, other than you or a family member, who: 1) possesses the designation "Occupational Therapists Registerd(OTR)", 2) is licensed by the state to practice *occupational therapy,* 3) performs services which are allowed by his licenses; and 4) performs services for which benefits are provided by this *plan.*

Organized Sport This term means a sport activity that is governed by an organization and requires formal registration to participate. Proof of registration will be required at claim time.

Outpatient Treatment This term means medical services that a *covered person* receives when not confined as an *inpatient* in a *hospital.*

Physical Therapy This term means treatment by physical means, hydrotherapy, heat, or similar modalities, physical agents, bio-mechanical and neuro-physiological principles and devices. Such therapy is given to relieve pain, restore function, and to prevent disability following *injury* or loss of a body part.

Physical Therapist This term means a person, other than you or a family member, who: 1) is licensed by the state to practice *physical therapy;* 2) performs services which are allowed by his or her license; 3) performs services for which benefits are provided by this Policy and 4) practices according to the code of ethics of the American Physical Therapy Association.

Rehabilitative Unit This term means an appropriately licensed facility or separate section of a *hospital* that provides rehabilitation care services on an *inpatient* basis and is designated, staffed and equipped to provide restorative services under the supervision of a trained and experienced rehabilitation *doctor.* A rehabilitation unit is not: a nursing home; an extended care facility; a skilled nursing facility; a rest home or home for the aged; a hospice care facility; a place for alcoholics or drug addicts; or an assisted living facility.

Sickness This term means a disease, illness or other condition not related to *injury* including diseases or infections except when the due to an accidental cut or wound.

Urgent Care Facility This term means a health care facility that is organizationally separate from a *hospital* and whose primary purpose is the offering and provision of immediate, short term medical care, without appointment, for urgent care.

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

You or Your These terms mean the insured *employee.*

CGP-3-AC-DEF-12 B476.0022

ELIGIBILITY FOR CANCER INSURANCE

Employee Coverage

Eligible Employees

To be eligible for *employee* coverage *you* must be an active *full-time employee.* and *you* must belong to a class of *employees* covered by this *plan.*

Other Conditions

If *you* must pay all or part of the cost of *employee* coverage, *we* won't insure *you* until *you* enroll and agree to make the required payments.

We require that *you* answer insurability questions. The answers to these questions will determine whether or not *you* will be covered by this *plan.*

We require that *you* answer insurability questions again to change to a richer plan of benefits, if offered by *your employer.* The answers to these questions will determine whether or not *you* will be covered for the richer benefits.

CGP-3-EC-90-1.0 B477.0054

When Your Coverage Starts

Employee benefits are scheduled to start on your effective date. But you must be actively at work on a *full-time* basis on the scheduled effective date. And you must have met all of the applicable conditions explained above, and any applicable waiting period. If you are not actively at work on any date part of your insurance is scheduled to start, we will postpone that part of your coverage until the date you return to active *full-time* work.

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

CGP-3-EC-90-2.0 B476.3878

When Your Coverage Ends

Your coverage ends on the date *your* active *full-time* service ends for Any reason. Such reasons include disability, death, retirement, layoff, leave of absence and the end of employment.

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

Your coverage ends on the date *you* are no longer working in the United States or working outside the United States for a United States based *employer* in a country or region approved by *us.*

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

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

Group Cancer Insurance Coverage During a Family Leave of Absence

This section may not apply to an employer's *plan. You* must contact *your* employer to find out if:

- the employer must allow for a leave of absence under Federal law, in which case;
- the section applies to *you.*

Group Cancer Insurance may normally end for *you* because *you* cease work due to an approved leave of absence. But, *you* may continue *your* coverage if the leave of absence has been granted: (a) to allow the *you* to care for a seriously injured or ill spouse, child, or parent; (b) after the birth or adoption of a child; (c) due to *your* own serious health condition; or (d) because of any serious injury or illness arising out of the fact that *your* spouse, child, parent, or next of kin, who is a covered service member, 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. *You* will be required to pay the same share of the premium as *you* paid before the leave of absence.

Group Cancer Insurance may continue until the earliest of the following:

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

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

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

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

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

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

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

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

CGP-3-DEP-90-1.0 B473.0009

Eligible Dependents For Dependent Cancer Coverage

Your eligible dependents are: (1) *your* legal spouse; And (2) *your* unmarried dependent children from birth until they reach age 26.

CGP-3-DEP-90-2.0 B477.0070

Adopted Children And Step-Children

Your "unmarried dependent children" include: (a) *your* legally adopted children; and (b) if they depend on *you* for most of their support and maintenance, *your* step-children.

We treat a child as legally adopted from the time the child is placed in *your* home for the purpose of adoption. *We* treat such a child this way whether or not a final adoption order is ever issued.

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. Upon notice of entry into service, pro rata unearned premiums will be refunded.

A child may be an eligible dependent of more than one *employee* who is insured under this *plan.* In that case, the child may be insured for dependent cancer benefits by only one *employee* at a time.

CGP-3-DEP-90-3.0 B477.0071

Handicapped Children

You may have an unmarried child with a mental or physical handicap, or developmental disability, who can't support himself or herself. Subject to all of the terms of this section and the *plan,* such a child may stay eligible for dependent benefits past this *plan'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 condition started before he reached this *plan's* age limit; (b) he or she became insured for dependent cancer benefits before he or she reached the age limit, and stayed continuously insured until he or she reached such limit; and (c) he or she depends on *you* for most of his or her support and maintenance.

But, for the child to stay eligible, *you* must send us written *proof* that the child is handicapped and depends on *you* for most of his or her support and maintenance. *You* have 31 days from the date he or she 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 *your* coverage does.

CGP-3-DEP-90-4.0 B477.0073

Proof of Insurability

We require that *you* answer insurability questions with respect to *your* dependents. The answers to these questions will determine whether or not *your* dependents will be covered by this *plan.*

CGP-3-DEP-90-5.0 B477.0075

When Dependent Coverage Starts

In order for *your* dependent coverage to start, *you* must: (a) already be insured for *employee* coverage; or (b) enroll for *employee* and dependent coverage at the same time.

Subject to all of the terms of this *plan,* the date *your* dependent coverage is scheduled to start depends on when *you* elect to enroll *your* initial dependents and agree to make the required payments.

If *you* do this on or before *your* eligibility date, the dependent coverage is scheduled to start on the later of: (a) *your* eligibility date; and (b) the date *you* become insured for *employee* coverage.

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

Once *you* have dependent child coverage for *your* initial dependent child(ren), any *newly acquired dependent* children will be covered as of the date they are eligible.

CGP-3-DEP-90-6.0 B477.0074

Exception

We will postpone the effective date of a dependent's, other than a newborn child's, coverage if, on that date, he or she is: (1) confined to a hospital or other health care facility; (2) home confined; or (3) unable to perform two or more activities of daily living. In that case, *we* will postpone the effective date of his or her coverage until the day after the date: (a) of his or her discharge from such facility; (b) his or her home confinement ends; or (c) he or she is no longer requires assistance with two or more activities of daily living. If a dependent was covered under a prior plan at transfer, this language will not apply to the amount of coverage that was in force with the prior plan.

CGP-3-DEP-90-7.0 B477.0076

When Dependent Coverage Ends

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

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

An individual dependent's coverage ends when he or she stops being an eligible dependent. This happens to a child: (a) at 12:01 A.M. Standard Time at the child s place of residence on the date the child attains this *plan s* age limit; (b) when the child marries; or (c) when a step-child is no longer dependent on *you* for most of his or her support and maintenance. This happens to a spouse when a marriage ends in legal divorce or annulment.

CGP-3-DEP-90-9.0 B477.0078

SCHEDULE OF INSURANCE

Cancer Benefit

Air Ambulance:	$1,500.00 per trip. Limited to 2 one-way trips per *hospital confinement.*
Ambulance:	$200.00 per trip. Limited to 2 one-way trips per *hospital confinement.*
Anesthesia:	25% of surgery benefit.
Anti-Nausea Medication:	$50.00 per day up to $150.00 per month.
Attending Doctor:	$25.00 per day. Limited to 75 visits per *hospital confinement.*
Blood, Plasma and Platelets:	$100.00 per day. Limited to $5,000.00 in 12 months.
Bone Marrow and Stem Cells:	$7,500.00 for *bone marrow transplant.* $1,500.00 for *stem cell transplant.* 50% for second transplant. Limited to two of each in a covered person's lifetime $1,000.00 if a covered person donates bone marrow, limited to one benefit in a covered person's lifetime.
Experimental Treatment:	$100.00 per day. Limited to $1,000.00 per month.
Extended Care Facility/Skilled Nursing Care:	$100.00 per day. Limited to 90 days per *benefit year.*
Government or Charity Hospital:	$300.00 per day in lieu of other benefits provided by this *plan.*
Home Health Care:	$50.00 per visit. Limited to 30 visits per *benefit year.*
Hormone Therapy	$25.00 per treatment. Limited to 12 per benefit year.
Hospice:	$50.00 per day. Limited to 100 days per lifetime.
Hospital Confinement:	$300.00 for first 30 days per *period of hospital confinement.* $600.00 for 31st day and thereafter per *period of hospital confinement.*
Immunotherapy:	$500.00 per month. $2,500.00 per lifetime.
Intensive Care Unit Confinement:	$400.00 for first 30 days per confinement. $600.00 for 31st day and thereafter confinement.

Inpatient Special Nursing:	$100.00 per day. Limited to 30 days per *benefit year.*
Medical Imaging:	$100.00 per image. Limited to 2 images per *benefit year.*
Outpatient and Family Member Lodging:	$75.00 per day. Limited to 90 days per *benefit year.*
Outpatient or Ambulatory Surgical Center:	$250.00 per day. Limited to 3 days per procedure.
Physical or Speech Therapy:	$25.00 per visit. Limited to 4 visits per month. Limited to $400.00 per lifetime.
Surgically Implanted Prosthetic Devices:	$2,000.00 per device. Limited to $4,000.00 per lifetime.
Non-Surgically Implanted Prosthetic Devices:	$200.00 per device. Limited to $400.00 per lifetime.
Radiation Therapy and Chemotherapy:	$4,000.00 per *benefit year.*
Injected cytoxic meds	$300.00 per week.
Pump dispensed cytoxic meds (first prescription then per week for refills)	$300.00 per week.
Oral cytoxic meds	$150.00 per prescription up to $450.00 per month.
Cytoxic meds administration by any other method	$300.00 per week.
External radiation therapy	$400.00 per week.
Insertion of interstitial or intracavity admin of radioisotopes or radium	$450.00 per week.
Oral of I.V. radiation	$400.00 per week.
Reconstructive Surgery:	
Breast TRAM flap	$2,000.00
Breast reconstruction	$500.00
Breast symmetry	$250.00
Facial reconstruction	$500.00
Second Surgical Opinion:	$200 Limited to one per surgical procedure.
Skin Cancer:	
Biopsy only	$100.00
Reconstructive surgery following excision of a skin cancer	$250.00
Excision of a skin cancer with no flap or graft	$375.00
Excision of a skin cancer with flap or graft	$600.00
Surgical Benefits:	

Surgery	Surgical Benefit
Abdomen - Cholecystectomy	$575.00
Abdomen - Exploratory laparotomy	$435.00
Abdomen - Paracentesis	$110.00
Bladder - (TUR) transurethral resection bladder tumors	$435.00
Bladder - Cystectomy (complete)	$1,485.00
Bladder - Cystectomy (partial)	$740.00
Bladder - Cystectomy (with ureteroileal conduit)	$2,970.00
Bladder - Cystoscopy	$110.00
Brain - Burr holes not followed by surgery	$575.00
Brain - Excision brain tumor	$2,885.00
Brain - Exploratory craniotomy	$1,235.00
Brain - Ventriculoperitoneal shunt	$575.00
Brain - Hemispherectomy	$4,125.00
Breast - lumpectomy	$285.00
Breast - mastectomy partial	$435.00
Breast - mastectomy radical	$860.00
Breast - mastectomy simple	$575.00
Chest - Bronchoscopy	$245.00
Chest - Lobectomy	$1,235.00
Chest - Mediastinoscopy	$245.00
Chest - Pneumonectomy	$1,730.00
Chest - Thoracentesis	$110.00
Chest - Thoracostomy	$245.00
Chest - Thoracotomy	$575.00
Chest - Wedge resection	$990.00
Esophagus - Esophagogastrectomy	$1,235.00
Esophagus - Esophagoscopy	$225.00
Esophagus - Resection of esophagus	$1,650.00
Eye - Enucleation	$410.00
Eye - P32 uptake	$200.00
Female Reproductive - Abdominal hysterectomy/uterus only	$740.00
Female Reproductive - Colposcopy	$140.00
Female Reproductive - D&C	$140.00

Female Reproductive - Oophorectomy	$435.00
Female Reproductive - Uterus, tubes & ovaries	$1,440.00
Female Reproductive - Uterus, tubes & ovaries with exenteration	$4,125.00
Female Reproductive - Vaginal hysterectomy/uterus only	$435.00
Intestines - Abdominal-perineal resection	$2,060.00
Intestines - Colectomy	$740.00
Intestines - Colonoscopy (does not include virtual or CT Colonography)	$225.00
Intestines - Colostomy/or revision of	$285.00
Intestines - ERCP	$285.00
Intestines - Excesional on rectum for biopsy	$225.00
Intestines - Ileostomy	$285.00
Intestines - Proctosigmoidoscopy	$110.00
Intestines - Resection of small intestine	$1,730.00
Intestines - Sigmoidoscopy	$110.00
Kidney - Nephrectomy (radical)	$2,970.00
Kidney - Nephrectomy (simple)	$1,730.00
Liver - Resection of liver	$2,060.00
Lymphatic - Axillary node dissection	$575.00
Lymphatic - Excision of lymph nodes	$140.00
Lymphatic - Lymphadenectomy (bilaterial)	$740.00
Lymphatic - Lymphadenectomy (unilateral)	$575.00
Lymphatic - Splenectomy	$575.00
Mandible - Mandibulectomy	$1,155.00
Misc - Bone marrow aspiration	$110.00
Misc - Pathological hip fracture (chemo)	$720.00
Misc - Venous-Catheters/venous port (chemo)	$110.00
Misc - Peripherally inserted central catheter (PICC)	$110.00
Misc - Pathological fracture (chemo)	$330.00
Mouth - Glossectomy	$575.00
Mouth - Hemiglossectomy	$285.00
Mouth - Resection of palate	$575.00
Mouth - Tonsil/Mucous membranes	$435.00
Pancreas - Jejunostomy	$740.00

Pancreas - Pancreatectomy	$1,730.00
Pancrease - Whipple procedure	$2,970.00
Penis - amputation, complete	$575.00
Penis - amputation, partial	$285.00
Penis - amputation, radical	$740.00
Prostate - (TUR) transurethral resection prostate	$435.00
Prostate - Cystoscopy	$110.00
Prostate - Radical Prostatectomy	$1,155.00
Radium Implants - Insertion	$825.00
Radium Implants - Removal	$410.00
Salivary glands - Parotidectomy	$575.00
Salivary glands - Radical neck dissection	$1,485.00
Spine - Cordotomy	$435.00
Spine - Laminectomy	$740.00
Stomach - Gastrectomy (complete)	$1,155.00
Stomach - Gastrectomy (partial)	$740.00
Stomach - Gastrojejunostomy	$740.00
Stomach - Gastroscopy	$245.00
Testis - Orchiectomy (bilateral)	$395.00
Testis - Orchiectomy (unilateral)	$285.00
Throat - Laryngectomy (w/out neck dissection)	$740.00
Throat - Laryngectomy (with neck dissection)	$1,485.00
Throat - Laryngoscopy	$245.00
Throat - Tracheostomy	$245.00
Thyroid - Thyroidectomy (partial: one lobe)	$435.00
Thyroid - Thyroidectomy (total: both lobes)	$575.00
Vulva - Vulvectomy (partial)	$435.00
Vulva - Vulvectomy (radical)	$1,155.00
Transportation/Companion Transportation:	$0.50 per mile. Limited to $1,000 per round trip.

CANCER COVERAGE

Important Notice: **This is *Cancer* coverage. It provides a limited specified benefit. It is a supplement to, and not a substitute for, medical coverage. Please read this *plan* carefully to fully understand what it covers, limits, and excludes.**

Subject to all of this *plan's* terms, this *plan* will pay the benefits described below if a *covered person* is *diagnosed* with *cancer* after the date he or she becomes insured by this *plan.* This *plan* pays no benefits other than what is specifically listed below.

All services or treatment must be received by the covered person within 120 days of the date his or coverage under this *plan* ends.

All terms in italics are defined terms with special meanings. See the "Definitions" section of this plan. Other terms with special meanings are defined where they are used.

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Benefits

Air Ambulance *We* will pay the amount shown in the schedule of insurance if a licensed professional air ambulance is used to transport a *covered person* to a *hospital* where a *covered person* is confined as an *inpatient* for internal *cancer* treatment. *We* limit what *we* pay to two one-way trips per *period of hospital confinement.*

Ambulance *We* will pay the amount shown in the schedule of insurance if a licensed professional ambulance is used to transport a *covered person* to a *hospital* where a *covered person* is confined as an *inpatient* for *internal cancer* treatment. *We* limit what *we* pay to two one-way trips per *period of hospital confinement.*

Anesthesia If general anesthesia is provided to a *covered person* in connection with a surgical procedure covered under the Surgical Benefits section, *we* will pay 25% of the amount shown in the schedule of insurance for the surgical procedure.

Anti-Nausea Medication *We* will pay the amount shown in the schedule of insurance if a *doctor* prescribes a *covered person* drugs to control nausea related to chemotherapy or radiation for *internal cancer* treatments. *We* limit what *we* pay each month to the amount shown in the schedule of insurance.

Attending Doctor *We* will pay the amount shown in the schedule of insurance if a *covered person* is visited by a *doctor* for the treatment of *internal cancer* while confined in a *hospital* . *We* don't pay for visits by the operating surgeon. *We* limit what *we* pay per *period of hospital confinement* to the number of days shown in the schedule of insurance.

Blood, Plasma and Platelets

We will pay the amount shown in the schedule of insurance for each day a *covered person* receives blood, plasma and/or platelets for the treatment of *internal cancer. We* pay whether the blood, plasma and/or platelets is received as an *inpatient* in a *hospital* or as an outpatient in a *doctor's* office, *hospital* or *ambulatory surgical center.* We don't pay for blood, plasma and/or platelets for any other reason, including replacement of blood during surgery. And *we* limit what *we* pay in the 12 months which starts on the date of the first treatment to the amount shown in the schedule of insurance.

Bone Marrow and Stem Cells

We will pay the amount shown in the schedule of insurance if a *covered person* receives a *bone marrow transplant* or *stem cell transplant* to treat *internal cancer.*

Experimental Treatment

We pay the amount shown in the schedule of insurance if a *doctor* prescribes experimental treatment for a *covered person* for the purpose of destroying or changing abnormal tissue, and the treatment is administered by medical personnel in a *doctor's* office, *clinic* or *hospital.* All treatment must be *NCI-listed* as viable experimental treatment for *internal cancer.*

We will not pay benefits under this provision for laboratory tests, *immunotherapy,* diagnostic x-rays, and therapeutic devices or other procedures related to the treatments. *We* will not pay benefits under this provision for the same day the radiation and chemotherapy benefit is payable. However if a *covered person* is eligible for both the experimental treatment benefit and the radiation and chemotherapy benefit on the same day, then *we* will pay the higher benefit.

Extended Care Facility/Skilled Nursing Care

If *we* pay benefits under this *plan's hospital* confinement section for a *covered person,* and such *covered person* subsequently is confined to an *extended care* or *skilled nursing facility* for the treatment of *internal cancer, we* will pay the amount in the schedule of insurance. The *extended care* or *skilled nursing facility* confinement must start within 30 days of the end of the *hospital* confinement. *We* limit what *we* pay each *benefit year* to the number of days shown in the schedule of insurance.

Government or Charity Hospital

In lieu of all the other benefits provided by this *plan, we* will pay the amount shown in the schedule of insurance per day when a *covered person* is confined to: (a) a *hospital* operated by or for the U.S. Government (including the Veteran's Administration); or (b) a *hospital* that does not charge for its services (charity). The confinement must be for the treatment of *internal cancer.*

Home Health Care

We pay the amount shown in the schedule of insurance if a *covered person* receives home health care or health support services for the treatment of *internal cancer. We* limit what *we* pay each *benefit year* to the limit shown in the schedule of insurance.

However, these services must start within seven days of release from a *hospital.* And the *covered person's doctor* must certify that the *covered person* would need to be *hospital* confined if home health care was not available.

We will pay benefits under this section only if the home health care or health support services providers are licensed or certified and as qualified as caregivers providing comparable services at a *hospital* or other appropriate medical facility. This benefit will not be paid for any day a benefit is paid under the *hospice* section. If a *covered person* is eligible for both a benefit under the home health care and *hospice* sections on the same day, *we* will pay the higher amount.

Hormone Therapy If a *doctor* prescribes, and a *covered person* receives hormone therapy as a treatment for *internal cancer, we* will pay the amount shown in the schedule of insurance. *We* limit what *we* pay to the number of treatments shown in the schedule of insurance each *benefit year.*

Hospice We pay the amount shown in the schedule of insurance per day if a covered person receives hospice care. We limit what we pay to the number of days shown in the schedule of insurance during the covered person's lifetime.

We require that the covered person's doctor certify in writing that the covered person is terminally ill as a result of internal cancer, with a life expectancy of less than six months.

This benefit is not payable on the same day the extended care facility, home health care or hospital confinement benefit is payable. However, if a covered person is eligible for the extended care facility, home health care, hospice or hospital confinement benefit on the same day, we will pay the highest benefit.

Hospital Confinement We will pay the amount shown in the schedule of insurance for each day during a period of hospital confinement in which a covered person is confined in a hospital for the treatment of internal cancer.

Intensive Care Unit Confinement We will pay the amount shown in the schedule of insurance if a covered person is confined in a hospital's intensive care unit for the treatment of internal cancer. We don't pay for intensive care unit confinement and hospital confinement on the same day.

Immunotherapy If a doctor prescribes immunotherapy for a covered person as treatment for internal cancer, we will pay the amount shown in the schedule of insurance each month. And we limit what we pay in a covered person's lifetime to the amount shown in the schedule of insurance.

We will not pay benefits under this provision for the same treatment under this plan's radiation or chemotherapy provision or the experimental treatment provision. However, if a covered person is eligible for the immunotherapy, radiation therapy or chemotherapy and the experimental treatment benefit on the same day, then we will pay the highest benefit.

Inpatient Special Nursing While a covered person is an inpatient being treated for internal cancer, we pay the amount shown in the schedule of insurance each day for inpatient special nursing if a covered person requires full-time nursing care. Full-time means at least 8 hours of attendance in a 24 hour period. We limit what we pay each benefit year to the number of days shown in the schedule of insurance.

Nursing care must be ordered by a doctor for the treatment of internal cancer, and must be provided by a licensed registered graduate nurse or licensed practical or vocational nurse. Care can't be provided by a family member.

Medical Imaging

We will pay the amount shown in the schedule of insurance if a covered person receives a medical imaging procedure related to a diagnosed internal cancer. We limit what we pay each benefit year to the number of images shown in the schedule of insurance.

Outpatient and Family Member Lodging

We pay the amount in the schedule of insurance per day for lodging as described below. We limit what we pay for lodging to the number of days shown in the schedule of insurance.

We pay a daily lodging benefit when a covered person stay in a hotel, motel or other commercial accommodation in conjunction with receiving treatment of internal cancer. Such treatment must be ordered by a doctor and must not be able to be obtained locally. Lodging must occur more than 50 miles from the covered person's home.

We pay a daily lodging benefit for one adult family member who stays in a hotel, motel or other commercial accommodation in order to be near the covered person while confined in a hospital for internal cancer treatment. The hospital must be at least 50 miles from the covered person's home.

We don't pay for any day that a stay begins more than 24 hours prior to treatment or more than 24 hours after treatment.

Outpatient or Ambulatory Surgical Center

We will pay the amount shown in the schedule of insurance when a covered person uses an outpatient or ambulatory surgical center for a surgical procedure covered under this plan's surgical benefits section. We limit what we pay to three days per surgical procedure.

Physical or Speech Therapy

We will pay the amount shown in the schedule of insurance for physical or speech therapy provided to a covered person for restoration of normal body function following treatment of internal cancer. Such therapy must be provided by a licensed or certified physical or speech therapist.

We limit what we pay combined for physical and speech therapy to the number of visits per month shown in the schedule of insurance. We limit what we pay for physical and speech therapy combined to the lifetime limit shown in the schedule of insurance.

Prosthetic Devices

We will pay the amount shown in the schedule of insurance for prosthetic devices provided to a covered person as a direct result of treatment of internal cancer. There are separate amounts shown in the schedule of insurance for surgically implanted prosthetic devices and non-surgically implanted prosthetic devices. We limit what we pay for prosthetic devices in a covered person's lifetime to the amounts shown in the schedule of insurance.

Surgically implanted prosthetic devices must be the direct result or consequence of the surgical treatment of internal cancer.

The prosthetic device coverage does not include coverage for a Breast Transverse Rectus Abdominis Myocutaneous (TRAM) Flap procedure as listed under the Reconstructive Surgery benefit.

Radiation Therapy or Chemotherapy

We will pay the amounts shown in the schedule of insurance if a covered person receives radiation therapy or chemotherapy as internal cancer treatment for the purpose of changing or destroying abnormal tissue. Such therapy must be administered by medical personnel in a hospital, doctor's office or clinic. Benefits will be paid only for days on which treatment is performed.

Benefits will not be paid for office visits, laboratory tests, diagnostic x-rays, treatment planning, simulation, treatment devices, dosimetry, radiation physics, teletherapy or other treatments related to radiation therapy or chemotherapy treatments. Hormone therapy and immunotherapy is not covered under this provision.

Radiation therapy and chemotherapy treatments must be approved for the treatment of cancer by the United States Food and Drug Administration.

Reconstructive Surgery

We will pay the amount shown in the schedule of insurance if a covered person has reconstructive surgery performed related to the treatment of internal cancer. We pay only for the following procedures: (a) Breast symmetry (modification of the non-cancerous breast performed within 5 years of reconstructing the cancerous breast); (b) Breast reconstruction; (c) Facial reconstruction; and (d) Breast transverse rectus abdominis myocutaneous (TRAM) flap.

Also, we will pay 25% of the reconstructive surgery amounts shown in the schedule of insurance for general anesthesia used during these procedures.

Second Surgical Opinion

If a doctor has diagnosed a covered person with internal cancer requiring surgery and a covered person obtains a second surgical opinion, we will pay the amount shown in the schedule of insurance. However, the second surgical opinion must be from a different doctor than the one who recommended the surgery. We limit what we pay to one benefit per surgical procedure.

Skin Cancer

We will pay the amount shown in the schedule of insurance if a doctor performs any of the following procedures for the purpose of treating diagnosed skin cancer in a covered person: (a) biopsy; (b) reconstructive surgery following previous excision of skin cancer; (c) excision of skin cancer without flap or graft; or (d) excision of skin cancer with flap or graft.

The amount shown in the schedule of insurance includes the amount payable for anesthesia services.

Surgical Benefits

We pay the amount shown in the schedule of insurance if a doctor performs one of the procedures shown in the of insurance for the purpose of treating internal cancer diagnosed in a covered person. The schedule of insurance for surgical procedures does not apply to surgery for skin cancer, which will be covered only under the skin cancer section.And the schedule of insurance for surgical procedures does not apply to reconstructive surgery, which is covered only under the reconstructive surgery section.

If more than one surgical procedure is performed through the same incision, benefits will be paid for only one procedure based upon the highest eligible benefit.

Transportation/ Companion Transportation

We pay the amount shown in the schedule of insurance for transportation and companion transportation as follows.

We pay a transportation benefit upon completion of a round trip to transport a covered person to a hospital or clinic for the purpose of internal cancer treatment. However the hospital or clinic must be at least 50 miles from the covered person's home. And transportation cannot be by the use of an ambulance or air ambulance.

If commercial travel (coach-class plane, train or bus) is necessary, we will pay for one additional person to accompany the covered person. If treatment is for a covered dependent child, we will pay for up to two adults to accompany the covered dependent child

DEFINITIONS

Ambulatory Surgical Center This term means a facility in which outpatient surgery is done. It must meet all of the requirements shown below:

- have a medical staff of *doctors,* nurses, and licensed anesthesiologist;
- maintain at least two operating rooms; and one recovery room;
- maintain diagnostic lab and x-ray facilities;
- be staffed and equipped to give emergency care;
- have a blood supply;
- maintain medical records;
- have agreements with *hospitals* for immediate acceptance of patients who need *inpatient* confinement; and
- be licensed in accord with the laws of the appropriate legally authorized agency. A facility is not an *ambulatory surgical center* if it is part of a *hospital.*

Benefit Year This term means each period of 12 months in a row which starts on starts on January 1st and ends on December 31st.

Board Certified This term means a *doctor* who has been certified in the appropriate medical specialty by a member board of the American Board of Medical Specialties.

Bone Marrow Transplant This term means a procedure in which a patient's bone marrow is replaced with cellular elements to reconstitute the bone marrow. It may be preceded by chemotherapy, radiotherapy, or other treatments which cause residual bone marrow to be destroyed. The collection of stem cells or other peripheral blood cells and their reinfusion is not a *bone marrow transplant.*

Cancer This term means *you* have been *diagnosed* with a disease manifested by the presence of a malignant tumor characterized by the uncontrolled growth and spread of malignant cells in any part of the body. This includes leukemia, Hodgkin's disease, lymphoma, sarcoma, malignant tumors and melanoma. *Cancer* includes carcinomas in- situ (in the natural or normal place, confined to the site of origin, without having invaded neighboring tissue). Pre-malignant conditions or conditions with malignant potential, such as myelodyplastic and myeloproliferative disorders, carcinoid, leukoplakia, hyperplasia, actinic keratosis, polycythemia, and nonmalignant melanoma, moles or similar diseases or lesions will not be considered *cancer.*

Clinic This term means an institution, building or part of a building where outpatients receive treatment for Diagnoses.

Covered Person This term means *you,* if *you* are covered under this *plan* and *your* covered dependents.

Diagnosed or Diagnosis These terms mean the establishment of *cancer* by a *doctor* through the use of clinical and/or lab findings. Diagnosis of *cancer* must be based on microscopic (histologic) exam of: (a) fixed tissues; or (b) preparations of blood or bone marrow. Such exam must be documented in a written report by a *doctor* who is *board certified* in pathology. If, however, in the opinion of the attending *doctor,* a pathological diagnosis is medically inappropriate, a clinical diagnosis of *cancer* will be accepted.

Doctor This term means any practitioner of the healing arts that: (a) is properly licensed or certified by the laws of the state in which he or she practices; and (b) provides services that are within the lawful scope of his or license.

Extended Care Facility or Skilled Nursing Facility This term means a facility which mainly provides full-time *inpatient* skilled nursing care for sick or injured people who do not need to be in a *hospital.* This *plan* recognizes such a place if it carries out its stated purpose under all relevant state and local laws, and it is: (a) accredited for its stated purpose by the Joint Commission of Healthcare Organizations; or (b) approved for its stated purpose by Medicare. In some places an extended care facility is called: (a) a rehabilitation facility; or (b) a skilled nursing facility; or (c) a sub-acute facility.

Family Member This term means *your* spouse, brother or sister (including stepbrother or stepsister), children (including stepchildren), parents (including stepparents), grandchildren, father or mother-in-law, and spouses, if applicable, of any of these.

Hospice This term means a licensed facility or program which provides a coordinated set of services at home or in a facility for persons who are certified by a *doctor* as terminally ill.

Hospital This term means a short-term, acute care general facility, which:

(1) is primarily engaged in providing, by or under the continuous supervision of *doctors,* to *inpatients,* diagnostic services and therapeutic services for diagnosis, treatment and care of sick or injured persons;

(2) has organized departments of medicine and major surgery;

(3) has a requirement that every patient must be under the care of a *doctor* or *dentist;*

(4) provides 24 hour nursing service by or under the supervision of a registered professional nurse (R.N.);

(5) is duly licensed by the agency responsible for licensing such *hospitals;* and

(6) is not, other than incidentally: (a) a place of rest; (b) a place primarily for the treatment of tuberculosis; (c) a place for the aged; (d) a place for drug addicts or alcoholics; or (e) a place for convalescent, custodial, educational or rehabilitative care.

Immunotherapy This term means treatments intended to improve the immune system by providing antibodies, colony stimulating factors, or immunoglobulins for the purpose of treating *cancer.*

Inpatient This term means: (a) a *covered person* who is physically confined as a registered bed patient in a *hospital* or other recognized health care facility; or (b) the confinement itself.

Intensive Care Unit This term means a *hospital* area of special care, which at the time of admission is separate and apart from the surgical recovery room, other rooms, beds or wards normally used for patient confinement. In addition, the unit must provide the following: (a) 24 hour continuous nursing care attended by nurses assigned to the unit on a full-time basis; (b) direction and/or supervision by a full time doctor director or a standing "intensive care" committee of the medical staff; and (c) special medical apparatus used to treat the critically ill.

Internal Cancer This term means a *cancer* contained within the body. *Internal cancers* do not include skin *cancer* except for melanomas classified as Clark's level III and higher or a Breslow level greater than or equal to 1.5mm.

NCI-Listed This term means a *cancer* treatment protocol that is listed in the National Cancer Institute's (NCI) Physician Data Query (PDQ). The PDQ is an on-line database that contains *cancer* information summaries, listings of clinical trials, and directories of *doctors* and organization involved in *cancer* care.

Palliative Care This term means treatment or services designed to reduce the severity of a condition or symptoms without curing the underlying disease.

Period of Hospital Confinement This term means *hospital* confinement for a continuous and uninterrupted period of time while under the regular care and attendance of a *doctor.* A new period of *hospital* confinement will begin if a new *hospital* confinement occurs 30 or more days after the end of the previous *hospital* confinement or if the *hospital* confinement results from a completely independent cause from the previous *hospital* confinement.

Plan This term means the group *cancer* coverage described in the *plan* and this certificate.

Pre-Existing Condition A pre-existing condition is a *cancer,* whether diagnosed or misdiagnosed, for which in the 3 months before a person becomes covered by this *plan,* he or she: (1) received advice or treatment from a *doctor;* (2) underwent diagnostic procedures; (3) was prescribed or took prescription drugs; or (4) received other medical care or treatment, including consultation with a *doctor.*

Proof or Proof Of Insurability These terms mean an application for coverage showing that a person is insurable.

Stem Cell Transplant This term means the delivery of autologous or allogeneic stem cells to a person who has received chemotherapy or radiology to treat *internal cancer.* This definition does not include allogeneic or autogeneic bone marrow collection and infusion of bone marrow under general anesthesia.

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

You or Your These terms mean the insured *employee.*

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Limitations

Proof Of Insurability The *covered person's* coverage may not become effective until he or she submits *proof of insurability* to *us.* These requirements are shown in the schedule of insurance.

Pre-Existing Conditions A *pre-existing condition* is a *cancer,* whether *diagnosed* or misdiagnosed, for which in the 3 months before a person becomes covered by this *plan,* he or she: (1) received advice or treatment from a *doctor;* (2) underwent diagnostic procedures; (3) was prescribed or took prescription drugs; or (4) received other medical care or treatment, including consultation with a *doctor.* This *plan* will not pay benefits for *cancer* that is caused by, or results from, a *pre-existing condition* if the *cancer* occurs during the first 12 months that a *covered person* is covered by this *plan.*

If This Plan Replaces Another Plan This *plan* may be replacing a similar plan that the *employer* had with some other insurer. In that case, the *pre-existing condition* limitation will not apply to any *covered person* who: (1) was covered under the *employer's* old plan on the day before this *plan* started; and (2) has met the requirements of any *pre-existing conditions* limitation of the old plan; and (3) you are *actively at work on a full-time* basis on the effective date of this *plan.*

If the *covered person:* (1) was covered under the old plan when it ended; (2) enrolls for insurance under this *plan* on or before this *plan's* effective date; and (3) is actively working on the effective date of this *plan;* but(4) has not fulfilled the requirements of any pre-existing condition provision of the old plan; this *plan* will credit any time used to meet the old plan's pre-existing condition provision toward meeting this *plan's* pre-existing condition provision.

But, this *plan* limits a *covered person's* benefit under this *plan* if: (1) the *cancer* is a *pre-existing condition;* and (2) this *plan* pays benefit because this *plan* credits time as explained above. In this case, this *plan* limits the benefit to the amount the *covered person* would have been entitled to under the old plan.

This *plan* deducts all payments made by the old plan under an extension provision.

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Exclusions

This *plan* will not pay benefits for:

- Services or treatment not included in the Schedule of Insurance.
- Services or treatment provided by a *family member.*
- Services or treatment rendered outside the United States or Canada.
- Treatment of any *cancer* diagnosed solely outside of the United States or Canada.
- Services or treatment provided primarily for cosmetic purposes.
- Services or treatment for premalignant conditions.
- Services or treatment for conditions with malignant potential.
- Services or treatment for non-cancer *sicknesses.*
- *Cancer* caused by, contributed to by, or resulting from: (1) participating in a felony, riot or insurrection; (2) intentionally causing a self- inflicted injury; (3) committing or attempting to commit suicide while sane or insane; (4) a *covered person's* mental or emotional disorder, alcoholism or drug addiction; (5) engaging in any illegal activity; or (6) serving in the armed forces or any auxiliary unit of the armed forces of any country.
- *Cancer* arising from war or act of war, even if war is not declared.

CGP-3-CAN-EXC-12 B477.0030

Waiver of Premium

If, while covered by this *plan,* an *employee* becomes disabled due to *cancer* that is diagnosed after the *employee's* effective date, and such *employee* remains disabled for 90 days, *we* will waive the premium due after such 90 days for as long as the *employee* remains disabled.

To be considered disabled the *employee* must: (1) be unable to work at any job for which he or she is qualified by education, training or experience; and (2) not be working at any job for pay or benefits; and (3) be under the care of a *doctor* for the treatment of *cancer.*

CGP-3-CAN-WP-12 B477.0031

PORTABILITY

Note This section does not apply to residents of Kansas, Maine, or South Dakota.

Definition As used in this provision, the terms "port" and "to port" mean to choose a portable certificate of coverage which provides group *cancer* coverage.

Portability Conditions Portability is subject to all of the conditions described below.

- *You* may port *your* coverage or coverage for any of *your* dependents if coverage under this *plan* ends because *you:* (a) have terminated employment; (2) stop being a member of an eligible class of employees; or (3) this *plan* ends.
- *You* may not Port *your* coverage or coverage for any of *your* dependents if(1) coverage under this *plan* ends due to *your* failure to pay any required premium; or (2) you have reached age 70 on or before *your* coverage under this *plan* ends.

Portability Options *You* may port: (1) *your* coverage only; (2) *your* coverage and the coverage of *your* covered spouse; (3)*your* coverage and the coverage of all of *your* covered dependents; or (4) if *you* are a single parent, *your* coverage and the coverage of all of *your* covered dependent children. No other combinations will be allowed.

A dependent must be covered as of the date *your* coverage under this *plan* ends in order to be eligible to port.

If *you* die while covered for dependent *cancer* coverage, *your* spouse may port *your* dependent Cancer coverage as described above. *your* spouse and dependent children must be covered under this *plan* on the date of *your* death. But this option is not available if(1) there is no surviving spouse; or (2) the surviving spouse has reached age 70 on the date *you* die.

The Portable Certificate of Coverage The portable certificate of coverage provides group *cancer* coverage. The benefits provided by the portable certificate of coverage are the same as the benefits provided by this *plan.*

The premium for the portable certificate of coverage will be based on: *your* rate class under this *plan;* and (2)*you* or *your* surviving spouse's age bracket as shown in the Cancer Portability Coverage Premium Notice.

How to Port *You* or *your* surviving spouse must: (1) apply to us in writing; and (2) pay the required premium. *You* or *your* surviving spouse must do this within 31 days from the date Your coverage under this *plan* ends.

We will not ask for *proof* that *you* or *your* surviving spouse are in good health.

CERTIFICATE AMENDMENT

The certificate is amended to add the following:

Initial Diagnosis Benefit

We pay a one-time benefit when *you* are diagnosed for the first time as having *internal cancer,* other than carcinomas in-situ. The first *diagnosis* must occur while *you* are covered by this *plan.*

The benefit is $2,500.00 for *you,* $2,500.00 for *your* spouse and $2,500.00 for *your* child.*We* pay this benefit once per *covered person in a covered person's* lifetime.

We don't pay this benefit for a *diagnosis* of skin cancer.

We don't pay the benefit if the *diagnosis* occurred prior to the *covered person's* effective date under this *plan.*

We don't pay this benefit for a recurrence, extension or metastatic spread of an *internal cancer* that was *diagnosed* : (a) prior to a *covered person's* effective date under this *plan;* or (b) during this *plan's benefit waiting period.*

We don't pay this benefit if the diagnosis was made solely outside of the United States or Canada.

Benefit Waiting Period: This plan has a *benefit waiting period.* It is 30 days. This period starts on the date a *covered person* is first covered by this *plan. We* do not pay an initial *diagnosis* benefit for *cancer* that is *diagnosed* during the *benefit waiting period.*

If this *plan* replaces a similar plan the *employer* had with some other insurer, the *benefit waiting period* under this *plan* will be waived if for any *covered person* who was covered under the *employer's* old plan on the day before this *plan* starts and is covered by this *plan* on the day it starts.

As used in this rider, *benefit waiting period* means the period of time a *covered person* must be covered under this *plan* before we pay an Initial Diagnosis Benefit.

As used in this rider, carcinomas in-situ means *cancer* that is confined to the site of origin, without having invaded neighboring tissue.

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

The Guardian Life Insurance Company of America

Stuart J Shaw

Vice President, Risk Mgt. & Chief Actuary

CGP-3-A-CAN-IDB-12 B477.0036

ELIGIBILITY FOR VISION CARE EXPENSE COVERAGE

B505.0152

Employee Vision Care Expense Coverage

Eligible Employees

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

Other Conditions

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

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

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

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

CGP-3-EC-90-1.0 B505.0060

When Your Coverage Starts

Your coverage under this *plan* is scheduled to start on your effective date. But you must be actively at work on a *full-time* basis on that date. And you must have met all of the applicable conditions explained above, and any applicable waiting period. If you are not actively at work on that date, we will postpone your coverage until the date you return to active *full-time* work.

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

CGP-3-EC-90-2.0 B505.1681

When Your Coverage Ends

Your coverage under this *plan* ends on the date your active *full-time* service ends for any reason. Such reasons include disability, death, retirement, layoff, leave of absence and the end of employment.

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

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

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

CGP-3-EC-90-3.0 B505.0088

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

Important Notice

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

If Your Group Coverage Would End

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

When Continuation Ends

Coverage may continue until the earliest of the following:

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

Definitions

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

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

- **Contingency Operation:** This term means a military operation that: (a) is designated by the Secretary of Defense as an operation in which members of the armed forces are or may become involved in military actions, operations, or hostilities against an enemy of the United States or against an opposing military force; or (b) results in the call or order to, or retention on, active duty of members of the uniformed services under any provision of law during a war or during a national emergency declared by the President or Congress.
- **Covered Servicemember:** This term means a member of the Armed Forces, including a member of the National Guard or Reserves, who for a serious injury or illness: (a) is undergoing medical treatment, recuperation, or therapy; (b) is otherwise in outpatient status; or (c) is otherwise on the temporary disability retired list.
- **Next Of Kin:** This term means the nearest blood relative of the *employee.*
- **Outpatient Status:** This term means, with respect to a covered servicemember, that he or she is assigned to: (a) a military medical treatment facility as an outpatient; or (b) a unit established for the purpose of providing command and control of members of the Armed Forces receiving medical care as outpatients.
- **Serious Injury Or Illness:** This term means, in the case of a covered servicemember, an injury or illness incurred by him or her in line of duty on active duty in the Armed Forces that may render him or her medically unfit to perform the duties of his or her office, grade, rank, or rating.

CGP-3-EC-90-3.0 B449.0727

Dependent Vision Care Expense Coverage

CGP-3-DEP-90-1.0 B505.0099

Eligible Dependents For Dependent Vision Care Benefits

Your *eligible dependents* are: (a) your legal spouse; (b) your unmarried dependent children who are under age 26; and (c) your unmarried dependent children from age 26 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.* You 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.*

CGP-3-DEP-90-2.0 B505.0782

Adopted Children And Step-Children

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

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

CGP-3-DEP-90-3.0 B505.0112

Handicapped Children

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

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

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

The child's coverage ends when yours does.

CGP-3-DEP-90-4.0 B505.0119

When Dependent Coverage Starts

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

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

If you do this after the *enrollment period* ends, you can't enroll your *initial dependents* until the next vision open enrollment period.

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

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

CGP-3-DEP-90-6.0 B505.0130

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

CGP-3-DEP-90-7.0 B505.0132

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

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

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

CGP-3-DEP-90-8.0 B505.0153

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

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

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

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

An individual dependent's coverage ends when he stops being an *eligible dependent.* This happens to a child at 12:01 a.m. on the date the child attains this *plan's* age limit, when he marries, or when a step-child is no longer dependent on the *employee* for support and maintenance. It happens to a spouse 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 vision care benefits for a limited time.

CGP-3-DEP-90-9.0 B505.0139

VISION CARE HIGHLIGHTS

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

PPO Copayments

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

Non-PPO Cash Deductibles

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

CGP-3-VSN-96-BEN3 B505.0519

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

CGP-3-VSN-96-BEN3 B505.0516

VISION CARE BENEFITS

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

CGP-3-DAVIS-05-VIS B505.0466

This Plan's Vision Care Preferred Provider Organization

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

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

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

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

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

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

Choice of Preferred Providers

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

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

It is not necessary to submit a claim for services or supplies from a *preferred provider.*

Non-Preferred Providers

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

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

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

CGP-3-DAVIS-05-PPOA B505.0468

Appeals Process

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

Grievance Process

Registering a Complaint or Grievance

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

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

Davis Vision defines a "grievance" as a complaint that may or may not require specific corrective action and is made:

1. via the telephone;
2. in writing to Davis Vision;
3. via the Davis Vision website.

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

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

Verbal Grievances and Telephone Communication

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

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

Written Grievances

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

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

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

Appeal Level 1 Upon receipt of a concern or grievance by a Davis Vision associate, the *covered person* is contacted by telephone, or in writing, within five (5) business days to confirm that the concern or grievance was received and is being investigated. Every attempt is made to contact the *covered person* or his or her designated representative. Contact may include but is not limited to telephone contact, e-mail or U.S. Mail. A designated Davis Vision associate reviews the appeal with the *covered person* and may request additional information. Details of the complaint are documented in the *covered person's* file. The *covered person* is given the Associate's name, phone number, department and the estimated time needed to perform the research. The *covered person* is informed of their right to have a representative, including their provider, present during the review of the concern and final outcome of the investigation. The *covered person* is informed of their right to appeal to an external review organization at any time during the grievance procedure or as required by state statute.

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

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

CGP-3-DAVIS-05-APP-2 B505.0470

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

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

The decision of the Quality Assurance/Patient Advocate Department shall be final and binding unless appealed by the *covered person* to Davis Vision within fifteen (15) business days of the date of notice of the decision.

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

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

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

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

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

External Grievance Procedure

External Review A *covered person,* as required by state statute, has the right to request an impartial review of concerns that resulted in a denial of coverage. A *covered person* who has exhausted the internal appeals process may appeal the final decision if the denial for services was not deemed medically necessary or the requested service was deemed Investigational or Experimental.

An external review organization will refer the case for review by a neutral, independent practitioner experienced in vision care. Davis Vision will provide all requested documentation to the external review organization. The external review organizations will have up to thirty (30) days, or as required by state statute, to make their determination.

External Review Process

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

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

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

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

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

CGP-3-DAVIS-05-APP-2 B505.0471

How This Plan Works

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

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

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

CGP-3-DAVIS-05-HPW B505.0472

Copays

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

CGP-3-DAVIS-05-COP B505.0474

How We Cover Vision Examinations

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

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

A vision examination includes:

- case history - chief complaint, eye and vision history, medical history;
- entrance distance acuities;
- external ocular evaluation including slit lamp examination;
- internal ocular examination;
- tonometry;
- distance refraction - objective and subjective;
- binocular coordination and ocular motility evaluation;
- evaluation of papillary function;
- biomicroscopy;
- gross visual fields;
- assessment and plan;
- advice to a Covered Person on matters pertaining to vision care;
- form completion - school, motor vehicle, etc.

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

CGP-3-DAVIS-05-VE B505.0802

How We Cover Vision Materials

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

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

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

CGP-3-DAVIS-05-VM B505.0805

How We Cover Standard Lenses

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

- $48.00 for single vision lenses;
- $67.00 for bifocal lenses;
- $86.00 for trifocal lenses; and
- $126.00 for *lenticular lenses.*

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

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

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

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

- standard progressive addition lenses - $50
- premium progressives (Varilux, Kodak, Seiko, Rodenstock) - $90
- photochromatic lenses - single vision or multifocal - $20
- scratch resistant coating - single vision or multifocal - $20
- ultra violet coating - $12
- blended invisible bifocal lenses - $20
- intermediate Lenses - $30
- plastic photosensitive lenses - $65
- polarized lenses - $75
- hi-Index lenses - $55
- supershield (scratchguard) coating - $20
- glare resistant treatment (multi layer hydrophobic) - $35
- premium glare resistant treatment - $48

How We Cover Elective Contact Lenses

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

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

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

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

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

- If a *preferred provider* offers Davis' elective contact lenses collection (the formulary), we cover any elective contact lenses selected from the formulary in full in excess of a $20.00 copay.
- We cover non-formulary elective contact lenses in full to the retail elective contact lenses allowance of $120.00. The copay is waived.
- If a covered person receives a vision examination from a *preferred provider,* he or she will receive a discount on the cost of a pair of non-formulary elective contact lenses, including evaluation and fitting, from the same *preferred provider*.*

  The discount is an amount equal to 15% of the *preferred provider's* usual and customary fee in excess of the copay and retail elective contact lenses allowance.

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

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

CGP-3-DAVIS-05-ECL B505.0833

How We Cover Necessary Contact Lenses

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

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

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

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

CGP-3-DAVIS-05-NCL B505.0489

How We Cover Frames

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

If the frames are purchased from a *non-preferred provider,* we pay benefits in excess of a $20.00 copay up to $48.00.

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

- If a *preferred provider* offers Davis' Tower designer frame collection (the Tower), we cover any Fashion or Designer Collection frame selected from the Tower in excess of a $20.00 copay. We cover any Premier Collection frame selected from the Tower in full in excess of a $45.00 copay.
- We cover a non-Tower frame in excess of a $20.00 copay up to the retail frame allowance of $120.00.
- If a *covered person* receives a vision examination from a *preferred provider,* he or she will receive a discount on the cost of purchasing a pair of non-Tower frames from the same *preferred provider*.*

  The discount is an amount equal to 20% of the *preferred provider's* usual and customary fee in excess of the copay and retail frame allowance.

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

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

CGP-3-DAVIS-05-FRM B505.0853

Exclusions

- We won't pay for *orthoptics* or vision training and any associated supplemental training.
- We won't pay for medical or surgical treatment of the eyes.
- We won't pay for any eye examination or corrective eyewear required by an *employer* as a condition of employment.
- We won't pay for *plano lenses* (lenses with less than a +/-.38 diopter power).
- We won't pay for two sets of glasses in lieu of bifocals.

- We won't pay for replacement of lenses and frames furnished under this *Plan* which are lost or broken, except at normal intervals when services are otherwise available.
- We won't pay for necessary contact lenses prescribed for a *covered person* affected with *keratoconus* for which prior notification was not sent to Davis Vision.
- We won't pay for lens cosmetic extras that are not specifically listed in this *Plan* as covered.

CGP-3-DAVIS-05-EXC B505.0492

CERTIFICATE AMENDMENT

Effective on the first policy anniversary on or after January 1, 2011 the certificate is amended as follows:

The Life Insurance eligibility provisions applicable to dependent coverage are changed so that a dependent child means your child under age 26. The dependent eligibility provisions are further modified so that marital status, residency and financial dependency requirements do not apply to your dependent child.

But your child who is no longer eligible for coverage under the policy due to the policy's prior dependent age limitations, may be eligible to enroll for coverage under the policy subject to all the terms and conditions below.

To be eligible for such coverage under the policy, your child (i) must be less than 26 years of age; (ii) must not be eligible for similar coverage through an employer sponsored policy; other than the policy of the parent and (iii) must make a written election for such coverage as a dependent:

(a) During the special open enrollment period which starts 30 days prior to the Policy's first Policy Anniversary on or after January 1, 2011, if he or she enrolls during this special open enrollment period his or her coverage is scheduled to start on the Policy Anniversary Date.

(b) After the open enrollment period, if he or she enrolls within 30 days of his or her eligibility date his or her coverage is scheduled to start on the date his or her enrollment form is signed and dated. If he or she does this more than 30 days after the Policy Anniversary Date he or she is considered a late enrollee and is subject to this coverage's limitations for late enrollee. Such coverage will start on the date set forth in the Policy's eligibility provisions. To the extent the policy provides coverage with respect to a dependent child age 26 or older such provisions will continue to apply.

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

The Guardian Life Insurance Company of America

Stuart J Shaw

Vice President, Risk Mgt. & Chief Actuary

CGP-1-A B531.0018

CERTIFICATE AMENDMENT

The certificate is amended as follows:

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

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

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

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

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

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

The Guardian Life Insurance Company of America

Stuart J Shaw

Vice President, Risk Mgt. & Chief Actuary

CGP-A-1 B505.1291

CERTIFICATE AMENDMENT

This rider amends this Plan to provide additional services as described below.

ADDITIONAL SERVICES

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

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

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

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

- Comprehensive Employee Assistance Program (EAP) Services e.g. WorkLife Services.
- Estate Planning Services.

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

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

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

The Guardian Life Insurance Company of America

Raymond Marra, Senior Vice President, Group and Worksite Markets

B531.0619

CGP-3-A-VAP-14

GLOSSARY

This Glossary defines the italicized terms appearing in your booklet.

CGP-3-GLOSS-90 B900.0118

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

CGP-3-GLOSS-90 B750.0781

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

CGP-3-GLOSS-90 B750.0782

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

CGP-3-GLOSS-90 B750.0783

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

CGP-3-GLOSS-90 B750.0784

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

CGP-3-GLOSS-90 B750.0785

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

CGP-3-GLOSS-90 B900.0003

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

CGP-3-GLOSS-90 B750.0015

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.

CGP-3-GLOSS-90 B750.0006

Employer means W.B. GUIMARIN & COMPANY, INC. .

CGP-3-GLOSS-90 B900.0051

Enrollment Period with respect to dependent coverage, means the 31 day period which starts on the date that you first become eligible for dependent coverage.

CGP-3-GLOSS-90 B900.0004

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

CGP-3-GLOSS-90 B750.0229

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

CGP-3-GLOSS-90 B900.0006

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

CGP-3-GLOSS-90 B750.0786

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

CGP-3-GLOSS-90 B750.0787

Newly Acquired Dependent means an *eligible dependent* you acquire after you already have coverage in force for *initial dependents.*

CGP-3-GLOSS-90 B900.0008

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

CGP-3-GLOSS-90 B750.0788

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

CGP-3-GLOSS-90 B750.0789

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

CGP-3-GLOSS-90 B750.0790

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

CGP-3-GLOSS-90 B750.0791

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

CGP-3-GLOSS-90 B900.0039

Plan means the Davis Vision plan of vision care services described herein.

CGP-3-GLOSS-90 B750.0792

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

CGP-3-GLOSS-90 B750.0793

Preferred Provider with respect to vision care insurance means an optometrist, ophthalmologist or optician or other licensed and qualified vision care provider who has entered into a contract with Davis Vision to provide vision care services and/or vision care materials on behalf of *covered persons* of the *plan.*

CGP-3-GLOSS-90 B750.0794

Proof or Proof of Insurability means an application for insurance showing that a person is insurable.

CGP-3-GLOSS-90 B900.0010

Standard Lenses means regular glass or plastic lenses. See "Exclusions" for what we limit or exclude.

CGP-3-GLOSS-90 B750.0795

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

CGP-3-GLOSS-90 B750.0796

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

CGP-3-GLOSS-90 B750.0797

The following notice applies if your plan is governed by the Employee Retirement Income Security Act of 1974 and its amendments. This notice is not part of the Guardian plan of insurance or any employer funded benefits, not insured by Guardian.

STATEMENT OF ERISA RIGHTS

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

Receive Information About Your Plan and Benefits

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

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

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

Continue Group Health Plan Coverage

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

Prudent Actions By Plan Fiduciaries

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

Enforcement Of Your Rights

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

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

Assistance with Questions

If you have questions about the plan, you should contact the plan administrator. If you have questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the plan administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor listed in your telephone directory or the Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

Qualified Medical Child Support Order

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

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

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

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

If you have questions about this statement, see the plan administrator.

B800.0094

The Guardian's Responsibilities

B800.0048

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.

B800.0055

The Guardian is located at 10 Hudson Yards, New York, New York 10001.

B800.0049

If you seek benefits under the plan you should complete, execute and submit a claim form. Claim forms and instructions for filing claims may be obtained from the Plan Administrator.

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

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

Definitions

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

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

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

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

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

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

Timing For Initial Benefit Determination

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Adverse Benefit Determination

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

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

Appeal of Adverse Benefit Determinations

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

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

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

- the opportunity to submit written comments, documents, records and other information relating to the claim;

- 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.

B800.0076

Termination of This Group Plan

Your *employer* may terminate this group *plan* at any time by giving us 31 days advance written notice. This *plan* will also end if your *employer* fails to pay a premium due by the end of this grace period.

We may have the option to terminate this *plan* if the number of people insured falls below a certain level.

When this *plan* ends, you may be eligible to continue or convert your insurance coverage. Your rights upon termination of the *plan* are explained in this booklet.

B800.0007

If you seek benefits under the plan you should complete, execute and submit a claim form. Claim forms and instructions for filing claims may be obtained from the Plan Administrator.

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

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

Definitions

"Adverse Benefit 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.

"Group Health Benefits" means any accident, cancer, critical illness, or specified disease coverages which are a part of this plan.

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.

Claims. Guardian will provide a benefit determination not later than 30 days after receipt of a 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.

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.

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.

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:

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

B752.0052

Termination of This Group Plan

Your *employer* may terminate this group *plan* at any time by giving us 31 days advance written notice. This *plan* will also end if your *employer* fails to pay a premium due by the end of this grace period.

We may have the option to terminate this *plan* if the number of people insured falls below a certain level.

When this *plan* ends, you may be eligible to continue your insurance coverage. Your rights upon termination of the *plan* are explained in this booklet.

B800.0086

STATEMENT OF ERISA RIGHTS

The Guardian Life Insurance Company of America
10 Hudson Yards
New York, New York 10001
(212) 598-8000

Your group term life insurance benefits may be covered by the Employee Retirement Income Security Act of 1974 (ERISA). If so, you are entitled to certain rights and protections under ERISA.

ERISA provides that all plan participants shall be entitled to:

Receive Information about Your Plan and Benefits

- 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.
- 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.
- 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.

Prudent Actions by Plan Fiduciaries

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

Enforcement of Your Rights

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

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

Assistance with Questions

If you have questions about the plan, you should contact the plan administrator. If you have questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the plan administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor listed in your telephone directory or the Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

Life Insurance Claims Procedure

If you seek benefits under the plan you should complete, execute and submit a claim form. Claim forms and instructions for filing claims may be obtained from the Guardian Life Insurance Company of America (hereinafter referenced as Guardian.)

Guardian is the Claims Fiduciary with discretionary authority to interpret and construe the terms of the Policy, the Certificate, the Schedule of Benefits, and any riders, or other documents or forms that may be attached to the Certificate or the Policy, and any other plan documents. Guardian has discretionary authority to determine eligibility for benefits and coverage under those documents. Guardian has the right to secure independent professional healthcare advice and to require such other evidence as needed to decide your claim.

In addition to the basic claim procedure explained in your certificate, Guardian will also observe the procedures listed below. These procedures are the minimum requirements for benefit claims procedures of employee benefit plans covered by Title 1 of 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.

Timing for Initial Benefit Determination of Life Insurance Claims

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.

Guardian will provide a benefit determination not later than 90 days from the date of receipt of a claim. This period may be extended by up to 90 days if Guardian determines that an extension is necessary due to special circumstances, and so notifies the claimant before the end of the initial 90-day period. Such notification will include the reason for the special circumstances requiring the extension and a date by which the determination l is expected to be made.

A notification of an extension to the time period in which a benefit determination will be made will include an explanation of the standards upon which entitlement to a benefit is based, any unresolved issues that prevent a decision of the claim, and the additional information needed to resolve those issues.

Adverse Benefit Determination of Life Insurance Claims

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

- The specific reason(s) for the adverse determination;
- References to the specific provisions in the Policy, Certificate, plan or other documents, on which the determination is based;
- A description of any additional material or information needed to perfect the claim, and an explanation of why such material or information is necessary;
- A description of the plan's claim review procedures which a claimant may follow to have a claim for benefits reviewed and the time limits applicable to such procedures; and
- A description of the plan's review procedures and the time limits applicable to such procedures, including a statement of the claimant's right to bring a civil action under ERISA Section 502(a) following an adverse benefit determination.

B752.0186

Appeals of Adverse Determinations of Life Insurance Claims

If a claim is wholly or partially denied, you will have up to 60 days to make an appeal. 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 relevant 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.

Guardian will notify the claimant of its decision not later than 60 days after receipt of the request for review of the adverse determination. This period may be extended by an additional period of up to 60 days if Guardian determines that special circumstances require an extension of the time period for processing and so notifies the claimant before the end of the initial 60-day period.

A notification with respect to an extension will indicate the special circumstances requiring an extension of the time period for review, and the date by which the final determination will be made.

In the event Guardian denies the appeal of an adverse benefit determination, it will:

- Provide the specific reason or reasons why the appeal was denied;
- Refer to the specific provisions in the Policy, Certificate, plan, or other documents on which the benefit determination is based;
- Provide a statement that the claimant is entitled to receive, upon request and free of charge, reasonably access to, and copies of all documents, records, and other information relevant to the claimant's claim for benefits; and
- Provide a statement describing any voluntary appeal procedures offered by the Plan, the claimant's right to obtain information about such procedures, and a statement that the claimant's right to bring an action under ERISA section 502(a).

Waiver of Premium

If you apply for an extension of life insurance benefits due to Total Disability under the Waiver of Premium benefit under this plan, these claim procedures will apply to such request:

Timing For Initial Benefit Determination for Waiver of Premium

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

Guardian will make a determination of whether the claimant meets the plan's standard for total disability not later than 45 days from the date of receipt of a claim. This period may be extended by up to 30 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 45-day period. Such notification will include the reason for the extension and a date by which the determination will be made. If prior to the end of the 30-day period Guardian determines that an additional extension is necessary due to matters beyond the control of the plan, and so notifies the claimant, the time period for making a benefit determination may be extended for up to an additional period of up to 30 days. Such notification will include the special circumstances requiring the extension and a date by which the final determination will be made.

A notification of an extension to the time period in which a benefit determination will be made will include an explanation of the standards upon which entitlement to a benefit is based, any unresolved issues that prevent a decision of the claim, and the additional information needed to resolve those issues.

If Guardian extends the time period for making a benefit determination due to a claimant's failure to submit the 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.

Adverse Benefit Determination

If a claim for an extension of benefits is denied, Guardian will provide a notice that will set forth:

- The specific reason(s) for the adverse determination;
- References to the specific provisions in the Policy, Certificate, plan or other documents, on which the determination is based;
- A description of any additional material or information needed to perfect the claim, and an explanation of why such material or information is necessary;
- A description of the plan's claim review procedures which a claimant may follow to have a claim for benefits reviewed and the time limits applicable to such procedures;
- A description of the plan's review procedures and the time limits applicable to such procedures, including a statement of the claimant's right to bring a civil action under ERISA Section 502(a) following an adverse benefit determination; and
- In the case of 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.

B997.0365

Appeals of Adverse Determinations for Waiver of Premium

If a claim for Waiver of Premium is denied, the claimant will have up to 180 days to make an appeal. 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 relevant 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 not later than 45 days after receipt of the request for review of the adverse determination. This period may be extended by an additional period of up to 45 days if Guardian determines that special circumstances require an extension of the time period for processing and so notifies the claimant before the end of the initial 45-day period.

A notification with respect to an extension will indicate the special circumstances requiring an extension of the time period for review, and the date by which the final determination will be made.

In the event Guardian denies the appeal of an adverse benefit determination, it will:

- Provide the specific reason or reasons why the appeal was denied;
- Refer to the specific provisions in the Policy, Certificate, plan, or other documents on which the benefit determination is based;
- Provide a statement that the claimant is entitled to receive, upon request and free of charge, reasonably access to, and copies of all documents, records, and other information relevant to the claimant's claim for benefits;
- Provide a statement disclosing any internal rule, guideline, protocol or similar criterion relied on in making the adverse benefit determination (or a statement that such information will be provided free of charge upon request); or a statement that no internal rule, guideline, protocol or similar criterion was relied upon in making the adverse benefit determination;
- If applicable, provide an explanation of the basis of disagreement with or not following the views presented by you, of health care professionals who treated you, and vocational professionals who evaluated you;
- If applicable, provide an explanation of the basis for disagreeing with or not following the views of any medical or vocational expert whose advice was obtained on our behalf in connection with the adverse benefit determination, without regard to whether the advice was relied upon in making the determination;
- If applicable, provide an explanation of the basis for disagreeing with or not following a disability determination made by the Social Security Administration that you present to us;
- Provide a statement describing the claimant s right to bring a civil suit under Section 502(a) of the Employee Retirement Income Security Act of 1974 which shall also describe any applicable contractual limitations period that applies the claimant's right to bring such an action, including the calendar date on which the contractual limitations period expires for the claim, and;

- In the event the adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, provide either an explanation of the scientific or clinical judgment for the determination, applying the terms of the plan to the claimant's medical circumstances, or a statement that such explanation will be provided free of charge upon request.

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.

In addition to any legal rights you may have under section 502(a), if you believe that we have violated ERISA's procedural requirements, you may request that we review any claimed violation(s) and we will respond to you within ten days.

B997.0366

STATEMENT OF ERISA RIGHTS

The Guardian Life Insurance Company of America
10 Hudson Yards
New York, New York 10001
(212) 598-8000

Your group Short Term and/or Long Term Disability Income benefits may be covered by the Employee Retirement Income Security Act of 1974 (ERISA). If so, you are entitled to certain rights and protections under ERISA.

ERISA provides that all plan participants shall be entitled to:

Receive Information about Your Plan and Benefits

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

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

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

Prudent Actions by Plan Fiduciaries

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

Enforcement of Your Rights

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

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

Assistance with Questions

If you have questions about the plan, you should contact the plan administrator. If you have questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the plan administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor listed in your telephone directory or the Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

Disability Benefits Claims Procedure

If you seek benefits under the plan you should complete, execute and submit a claim form. Claim forms and instructions for filing claims may be obtained from The Guardian Life Insurance Company of America (hereinafter referenced as Guardian).

Guardian is the Claims Fiduciary with discretionary authority to interpret and construe the terms of the Policy, the Certificate, the Schedule of Benefits, and any riders, or other documents or forms that may be attached to the Certificate or the Policy, and any other plan documents. Guardian has discretionary authority to determine eligibility for benefits and coverage under those documents. Guardian has the right to secure independent professional healthcare advice and to require such other evidence as needed to decide your claim.

In addition to the basic claim procedure explained in your certificate, Guardian will also observe the procedures listed below. These procedures are the minimum requirements for benefit claims procedures of employee benefit plans covered by Title 1 of 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.

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.

Guardian will provide a benefit determination not later than 45 days from the date of receipt of a claim. This period may be extended by up to 30 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 45-day period. Such notification will include the reason for the extension and a date by which the determination will be made. If prior to the end of the 30-day period Guardian determines that an additional extension is necessary due to matters beyond the control of the plan, and so notifies the claimant, the time period for making a benefit determination may be extended for up to an additional period of up to 30 days. Such notification will include the special circumstances requiring the extension and a date by which the final determination will be made.

A notification of an extension to the time period in which a benefit determination will be made will include an explanation of the standards upon which entitlement to a benefit is based, any unresolved issues that prevent a decision of the claim, and the additional information needed to resolve those issues.

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.

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;
- References to the specific provisions in the Policy, Certificate, plan or other documents, on which the determination is based;
- A description of any additional material or information necessary to perfect the claim and an explanation of why such material or information is necessary;
- A description of the plan's claim review procedures which a claimant may follow to have a claim for benefits reviewed and the time limits applicable to such procedures;
- A statement disclosing any internal rule, guideline, protocol or similar criterion relied on in making the adverse benefit determination (or a statement that such information will be provided free of charge upon request); or a statement that no internal rule, guideline, protocol or similar criterion was relied upon in making the adverse benefit determination;
- If applicable, an explanation of the basis of disagreement with or not following the views presented by you, of health care professionals who treated you and vocational professionals who evaluated you;
- If applicable, an explanation of the basis for disagreeing with or not following the views of any medical or vocational expert whose advice was obtained on our behalf in connection with the adverse benefit determination, without regard to whether the advice was relied upon in making the determination;

- If applicable, an explanation of the basis for disagreeing with or not following a disability determination made by the Social Security Administration that you present to us;
- A description of the plan's review procedures and the time limits applicable to such procedures, including a statement of the claimant's right to bring a civil action under ERISA Section 502(a) following an adverse benefit determination on appeal, and;
- 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.

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. 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 relevant 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 not later than 45 days after receipt of the request for review of the adverse determination. This period may be extended by an additional period of up to 45 days if Guardian determines that special circumstances require an extension of the time period for processing and so notifies the claimant before the end of the initial 45-day period.

A notification with respect to an extension will indicate the special circumstances requiring an extension of the time period for review, and the date by which the final determination will be made.

In the event Guardian denies the appeal of an adverse benefit determination, it will:

- Provide the specific reason or reasons why the appeal was denied;
- Refer to the specific provisions in the Policy, Certificate, plan, or other documents on which the benefit determination is based;
- Provide a statement that the claimant is entitled to receive, upon request and free of charge, reasonably access to, and copies of all documents, records, and other information relevant to the claimant's claim for benefits;
- Provide a statement disclosing any internal rule, guideline, protocol or similar criterion relied on in making the adverse benefit determination (or a statement that such information will be provided free of charge upon request); or a statement that no internal rule, guideline, protocol or similar criterion was relied upon in making the adverse benefit determination;
- If applicable, provide an explanation of the basis of disagreement with or not following the views presented by you, of health care professionals who treated you, and vocational professionals who evaluated you;
- If applicable, provide an explanation of the basis for disagreeing with or not following the views of any medical or vocational expert whose advice was obtained on our behalf in connection with the adverse benefit determination, without regard to whether the advice was relied upon in making the determination;
- If applicable, provide an explanation of the basis for disagreeing with or not following a disability determination made by the Social Security Administration that you present to us;
- Provide a statement describing the claimant's right to bring a civil suit under Section 502(a) of the Employee Retirement Income Security Act of 1974 which shall also describe any applicable contractual limitations period that applies the claimant's right to bring such an action, including the calendar date on which the contractual limitations period expires for the claim, and;
- In the event the adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, provide either an explanation of the scientific or clinical judgment for the determination, applying the terms of the plan to the claimant's medical circumstances, or a statement that such explanation will be provided free of charge upon request.

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.

In addition to any legal rights you may have under section 502(a), if you believe that we have violated ERISA's procedural requirements, you may request that we review any claimed violation(s) and we will respond to you within ten days.

B997.0371

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.

Effective: 5/01/2016

This Notice of Privacy Practices describes how Guardian and its subsidiaries may use and disclose your Protected Health Information (PHI) in order to carry out treatment, payment and health care operations and for other purposes permitted or required by law.

Guardian is required by law to maintain the privacy of PHI and to provide you with notice of our legal duties and privacy practices concerning PHI. We are required to abide by the terms of this Notice so long as it remains in effect. We reserve the right to change the terms of this Notice of Privacy Practices as necessary and to make the new Notice effective for all PHI maintained by us. If we make material changes to our privacy practices, copies of revised notices will be made available on request and circulated as required by law. Copies of our current Notice may be obtained by contacting Guardian (using the information supplied below), or on our Web site at: www.guardianlife.com/privacy-policy.

What is Protected Health Information (PHI):

PHI is individually identifiable information (including demographic information) relating to your health, to the health care provided to you or to payment for health care. PHI refers particularly to information acquired or maintained by us as a result of your having health coverage (including medical, dental, vision and long term care coverage).

In What Ways may Guardian Use and Disclose your Protected Health Information (PHI):

Guardian has the right to use or disclose your PHI without your written authorization to assist in your treatment, to facilitate payment and for health care operations purposes. There are certain circumstances where we are required by law to use or disclose your PHI. And there are other purposes, listed below, where we are permitted to use or disclose your PHI without further authorization from you. Please note that examples are provided for illustrative purposes only and are not intended to indicate every use or disclosure that may be made for a particular purpose.

Guardian has the right to use or disclose your PHI for the following purposes :

Treatment.Guardian may use and disclose your PHI to assist your health care providers in your diagnosis and treatment. For example, we may disclose your PHI to providers to supply information about alternative treatments.

Payment.Guardian may use and disclose your PHI in order to pay for the services and resources you may receive. For example, we may disclose your PHI for payment purposes to a health care provider or a health plan. Such purposes may include: ascertaining your range of benefits; certifying that you received treatment; requesting details regarding your treatment to determine if your benefits will cover, or pay for, your treatment.

Health Care Operations.Guardian may use and disclose your PHI to perform health care operations, such as administrative or business functions. For example, we may use your PHI for underwriting and premium rating purposes. However, we will not use or disclose your genetic information for underwriting purposes and are prohibited by law from doing so.

Appointment Reminders.Guardian may use and disclose your PHI to contact you and remind you of appointments.

Health Related Benefits and Services.Guardian may use and disclose PHI to inform you of health related benefits or services that may be of interest to you.

Plan Sponsors.Guardian may use or disclose PHI to the plan sponsor of your group health plan to permit the plan sponsor to perform plan administration functions. For example, a plan may contact us regarding benefits, service or coverage issues. We may also disclose summary health information about the enrollees in your group health plan to the plan sponsor so that the sponsor can obtain premium bids for health insurance coverage, or to decide whether to modify, amend or terminate your group health plan.

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Guardian is required to use or disclose your PHI :

- To you or your personal representative (someone with the legal right to make health care decisions for you);
- To the Secretary of the Department of Health and Human Services, when conducting a compliance investigation, review or enforcement action related to health information privacy or security; and
- Where otherwise required by law.

Guardian is Required to Notify You of any Breaches of Your Unsecured PHI.

Although Guardian takes reasonable, industry-standard measures to protect your PHI, should a breach occur, Guardian is required by law to notify affected individuals. Under federal medical privacy law, a breach means the acquisition, access, use, or disclosure of unsecured PHI in a manner not permitted by law that compromises the security or privacy of the PHI.

Other Uses and Disclosures .

Guardian may also use and disclose your PHI for the following purposes without your authorization:

- We may disclose your PHI to persons involved in your care or payment for care, such as a family member or close personal friend, when you are present and do not object, when you incapacitated, under certain circumstances during an emergency or when otherwise permitted by law.
- We may use or disclose your PHI for public health activities, such as reporting of disease, injury, birth and death, and for public health investigations.
- We may use or disclose your PHI in an emergency, directly to or through a disaster relief entity, to find and tell those close to you of your location or condition
- We may disclose your PHI to the proper authorities if we suspect child abuse or neglect; we may also disclose your PHI if we believe you to be a victim of abuse, neglect, or domestic violence.
- We may disclose your PHI to a government oversight agency authorized by law to conducting audits, investigations, or civil or criminal proceedings.
- We may use or disclose your PHI in the course of a judicial or administrative proceeding (e.g., to respond to a subpoena or discovery request).
- We may disclose your PHI to the proper authorities for law enforcement purposes.

- We may disclose your PHI to coroners, medical examiners, and/or funeral directors consistent with law.
- We may use or disclose your PHI for organ or tissue donation.
- We may use or disclose your PHI for research purposes, but only as permitted by law.
- We may use or disclose PHI to avert a serious threat to health or safety.
- We may use or disclose your PHI if you are a member of the military as required by armed forces services.
- We may use disclose your PHI to comply with workers' compensation and other similar programs.

- We may disclose your PHI to third party business associates that perform services for us, or on our behalf (e.g. vendors).
- We may use and disclose your PHI to federal officials for intelligence and national security activities authorized by law. We also may disclose your PHI to authorized federal officials in order to protect the President, other officials or foreign heads of state, or to conduct investigations authorized by law.
- We may disclose your PHI to correctional institutions or law enforcement officials if you are an inmate or under the custody of a law enforcement official (e.g., for the institution to provide you with health care services, for the safety and security of the institution, and/or to protect your health and safety or the health and safety of other individuals).
- We may use or disclose your PHI to your employer under limited circumstances related primarily to workplace injury or illness or medical surveillance.

We generally will not sell your PHI, or use or disclose PHI about you for marketing purposes without your authorization unless otherwise permitted by law.

Your Rights with Regard to Your Protected Health Information (PHI):

Your Authorization for Other Uses and Disclosures. Other than for the purposes described above, or as otherwise permitted by law, Guardian must obtain your written authorization to use or disclosure your PHI. You have the right to revoke that authorization in writing except to the extent that: (i) we have taken action in reliance upon the authorization prior to your written revocation, or (ii) you were required to give us your authorization as a condition of obtaining coverage, and we have the right, under other law, to contest a claim under the coverage or the coverage itself.

Under federal and state law, certain kinds of PHI will require enhanced privacy protections. These forms of PHI include information pertaining to:

- HIV/AIDS testing, diagnosis or treatment
- Venereal and /or communicable Disease(s)
- Genetic Testing
- Alcohol and drug abuse prevention, treatment and referral
- Psychotherapy notes

We will only disclose these types of delineated information when permitted or required by law or upon your prior written authorization.

Your Right to an Accounting of Disclosures . An 'accounting of disclosures' is a list of certain disclosures we have made, if any, of your PHI. You have the right to receive an accounting of certain disclosures of your PHI that were made by us. This right applies to disclosures for purposes other than those made to carry out treatment, payment and health care operations as described in this notice. It excludes disclosures made to you, or those made for notification purposes.

We ask that you submit your request in writing by completing our form. Your request may state a requested time period not more than six years prior to the date when you make your request. Your request should indicate in what form you want the list (e.g., paper, electronically). Our form for Account of Disclosure requests is available at www.guardianlife.com/privacy-policy.

Your Right to Obtain a Paper Copy of This Notice . You have a right to request a paper copy of this notice even if you have previously agreed to accept this notice electronically. You may obtain a paper copy of this notice by sending a request to the contact information listed at the end of this notice.

Your Right to File a Complaint . If you believe your privacy rights have been violated, you may file a complaint with Guardian or the Secretary of U.S. Department of Health and Human Services. If you wish to file a complaint with Guardian, you may do so using the contact information below. You will not be penalized for filing a complaint.

Please submit any exercise of the Rights designated below to Guardian in writing using the contact information listed below. For some requests, Guardian may charge for reasonable costs associated with complying with your requests; in such a case, we will notify you of the cost involved and provide you the opportunity to modify your request before any costs are incurred.

Your Right to Request Restrictions . You have the right to request a restriction on the PHI we use or disclose about you for treatment, payment or health care operations as described in this notice. You also have the right to request a restriction on the medical information we disclose about you to someone who is involved in your care or the payment for your care.

Guardian is not required to agree to your request; however, if we do agree, we will comply with your request until we receive notice from you that you no longer want the restriction to apply (except as required by law or in emergency situations). Your request must describe in a clear and concise manner: (a) the information you wish restricted; (b) whether you are requesting to limit Guardian's use, disclosure or both; and (c) to whom you want the limits to apply.

Your Right to Request Confidential Communications . You have the right to request that Guardian communicate with you about your PHI be in a particular manner or at a certain location. For example, you may ask that we contact you at work rather than at home. We are required to accommodate all reasonable requests made in writing, when such requests clearly state that your life could be endangered by the disclosure of all or part of your PHI.

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Your Right to Amend Your PHI . If you feel that any PHI about you, which is maintained by Guardian, is inaccurate or incomplete, you have the right to request that such PHI be amended or corrected. Within your written request, you must provide a reason in support of your request. Guardian reserves the right to deny your request if: (i) the PHI was not created by Guardian, unless the person or entity that created the information is no longer available to amend it (ii) if we do not maintain the PHI at issue (iii) if you would not be permitted to inspect and copy the PHI at issue or (iv) if the PHI we maintain about you is accurate and complete. If we deny your request, you may submit a written statement of your disagreement to us, and we will record it with your health information.

Your Right to Access to Your PHI. You have the right to inspect and obtain a copy of your PHI that we maintain in designated record sets. Under certain circumstances, we may deny your request to inspect and copy your PHI. In an instance where you are denied access and have a right to have that determination reviewed, a licensed health care professional chosen by Guardian will review your request and the denial. The person conducting the review will not be the person who denied your request. Guardian promises to comply with the outcome of the review.

How to Contact Us:

If you have any questions about this Notice or need further information about matters covered in this Notice, please call the toll-free number on the back of your Guardian ID card. If you are a broker please call 800-627-4200. All others please contact us at 800-541-7846. You can also write to us with your questions, or to exercise any of your rights, at the address below:

Attention:
Guardian Corporate Privacy Officer
National Operations

Address:
The Guardian Life Insurance Company of America
Group Quality Assurance - Northeast
P.O. Box 981573
El Paso, TX 79998-1573

B998.0055

YOUR BENEFITS INFORMATION - ANYTIME, ANYWHERE

www.GuardianAnytime.com

Insured employees and their dependents can access helpful, secure information about their Guardian benefits(s) online at:

GuardianAnytime.com - 24 hours a day, 7 days a week.

Anytime, anywhere you have an internet connection you will be able to:

- Review your benefits
- Look up coverage amounts
- Check the status of a claim
- Print forms and plan materials
- And so much more!

To register, go to www.GuardianAnytime.com

The Guardian Life Insurance Company of America
10 Hudson Yards
New York, New York 10001

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