Form 5500

Department of the Treasury
Internal Revenue Service

Department of Labor
Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

Annual Return/Report of Employee Benefit Plan

This form is required to be filed for employee benefit plans under sections 104 and 4065 of the Employee Retirement Income Security Act of 1974 (ERISA) and sections 6057(b) and 6058(a) of the Internal Revenue Code (the Code).

▶ **Complete all entries in accordance with the instructions to the Form 5500.**

OMB Nos. 1210-0110
1210-0089

2024

This Form is Open to Public Inspection

Part I Annual Report Identification Information

For calendar plan year 2024 or fiscal plan year beginning 08/01/2024 and ending 07/31/2025

A This return/report is for:
- ☐ a multiemployer plan
- ☐ a multiple-employer plan (Filers checking this box must provide participating employer information in accordance with the form instructions.)
- ☒ a single-employer plan
- ☐ a DFE (specify) ____

B This return/report is:
- ☐ the first return/report
- ☐ the final return/report
- ☐ an amended return/report
- ☐ a short plan year return/report (less than 12 months)

C If the plan is a collectively-bargained plan, check here. . . . . ▶ ☐

D Check box if filing under:
- ☐ Form 5558
- ☐ automatic extension
- ☐ the DFVC program
- ☐ special extension (enter description)

E If this is a retroactively adopted plan permitted by SECURE Act section 201, check here. . . . . ▶ ☐

Part II Basic Plan Information—enter all requested information

1a Name of plan
2 CIRCLE VOLUNTARY CRITICAL ILLNESS

1b Three-digit plan number (PN) ▶ 504

1c Effective date of plan 08/01/2024

2a Plan sponsor's name (employer, if for a single-employer plan)
Mailing address (include room, apt., suite no. and street, or P.O. Box)
City or town, state or province, country, and ZIP or foreign postal code (if foreign, see instructions)
2 CIRCLE INCORPORATED

22560 EPIC DR STE 202
CALIFORNIA, MD 20619-3226

1400 14TH ST N STE1
ARLINGTON, VA 22209

2b Employer Identification Number (EIN) 45-3989137

2c Plan Sponsor's telephone number 240-808-5503

2d Business code (see instructions) 541990

Caution: A penalty for the late or incomplete filing of this return/report will be assessed unless reasonable cause is established.

Under penalties of perjury and other penalties set forth in the instructions, I declare that I have examined this return/report, including accompanying schedules, statements and attachments, as well as the electronic version of this return/report, and to the best of my knowledge and belief, it is true, correct, and complete.

SIGN HERE	Filed with authorized/valid electronic signature.	01/30/2026	NICOLE BELLINGHAUSEN
	Signature of plan administrator	Date	Enter name of individual signing as plan administrator
SIGN HERE			
	Signature of employer/plan sponsor	Date	Enter name of individual signing as employer or plan sponsor
SIGN HERE			
	Signature of DFE	Date	Enter name of individual signing as DFE

3a Plan administrator's name and address [X] Same as Plan Sponsor

3b Administrator's EIN

3c Administrator's telephone number

4 If the name and/or EIN of the plan sponsor or the plan name has changed since the last return/report filed for this plan, enter the plan sponsor's name, EIN, the plan name and the plan number from the last return/report:

a Sponsor's name

c Plan Name

4b EIN

4d PN

5	Total number of participants at the beginning of the plan year	**5**	33
6	Number of participants as of the end of the plan year unless otherwise stated (welfare plans complete only lines **6a(1), 6a(2), 6b, 6c,** and **6d**).		
a(1)	Total number of active participants at the beginning of the plan year	**6a(1)**	33
a(2)	Total number of active participants at the end of the plan year	**6a(2)**	39
b	Retired or separated participants receiving benefits	**6b**	
c	Other retired or separated participants entitled to future benefits	**6c**	
d	Subtotal. Add lines **6a(2)**, **6b**, and **6c**.	**6d**	39
e	Deceased participants whose beneficiaries are receiving or are entitled to receive benefits.	**6e**	
f	Total. Add lines **6d** and **6e**.	**6f**	39
g(1)	Number of participants with account balances as of the beginning of the plan year (only defined contribution plans complete this item)	**6g(1)**	
g(2)	Number of participants with account balances as of the end of the plan year (only defined contribution plans complete this item)	**6g(2)**	
h	Number of participants who terminated employment during the plan year with accrued benefits that were less than 100% vested.	**6h**	
7	Enter the total number of employers obligated to contribute to the plan (only multiemployer plans complete this item)	**7**	

8a If the plan provides pension benefits, enter the applicable pension feature codes from the List of Plan Characteristics Codes in the instructions:

b If the plan provides welfare benefits, enter the applicable welfare feature codes from the List of Plan Characteristics Codes in the instructions:

4Q

9a Plan funding arrangement (check all that apply)

- **(1)** [X] Insurance
- **(2)** [ ] Code section 412(e)(3) insurance contracts
- **(3)** [ ] Trust
- **(4)** [X] General assets of the sponsor

9b Plan benefit arrangement (check all that apply)

- **(1)** [X] Insurance
- **(2)** [ ] Code section 412(e)(3) insurance contracts
- **(3)** [ ] Trust
- **(4)** [X] General assets of the sponsor

10 Check all applicable boxes in 10a and 10b to indicate which schedules are attached, and, where indicated, enter the number attached. (See instructions)

a Pension Schedules

- **(1)** [ ] **R** (Retirement Plan Information)
- **(2)** [ ] **MB** (Multiemployer Defined Benefit Plan and Certain Money Purchase Plan Actuarial Information) - signed by the plan actuary
- **(3)** [ ] **SB** (Single-Employer Defined Benefit Plan Actuarial Information) - signed by the plan actuary
- **(4)** [ ] **DCG** (Individual Plan Information) – Number Attached _____
- **(5)** [ ] **MEP** (Multiple-Employer Retirement Plan Information)

b General Schedules

- **(1)** [ ] **H** (Financial Information)
- **(2)** [ ] **I** (Financial Information – Small Plan)
- **(3)** [X] **A** (Insurance Information) – Number Attached 1
- **(4)** [ ] **C** (Service Provider Information)
- **(5)** [ ] **D** (DFE/Participating Plan Information)
- **(6)** [ ] **G** (Financial Transaction Schedules)

Part III Form M-1 Compliance Information (to be completed by welfare benefit plans)

11a If the plan provides welfare benefits, was the plan subject to the Form M-1 filing requirements during the plan year? (See instructions and 29 CFR 2520.101-2.) ..... ☐ Yes ☒ No

If "Yes" is checked, complete lines 11b and 11c.

11b Is the plan currently in compliance with the Form M-1 filing requirements? (See instructions and 29 CFR 2520.101-2.) ..... ☐ Yes ☐ No

11c Enter the Receipt Confirmation Code for the 2024 Form M-1 annual report. If the plan was not required to file the 2024 Form M-1 annual report, enter the Receipt Confirmation Code for the most recent Form M-1 that was required to be filed under the Form M-1 filing requirements. (Failure to enter a valid Receipt Confirmation Code will subject the Form 5500 filing to rejection as incomplete.)

Receipt Confirmation Code_____

SCHEDULE A (Form 5500)

Department of the Treasury
Internal Revenue Service

Department of Labor
Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

Insurance Information

This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA).

▶ **File as an attachment to Form 5500.**

▶ Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2).

OMB No. 1210-0110

2024

This Form is Open to Public Inspection

For calendar plan year 2024 or fiscal plan year beginning 08/01/2024 and ending 07/31/2025

A Name of plan
2 CIRCLE VOLUNTARY CRITICAL ILLNESS

B Three-digit plan number (PN) ▶ 504

C Plan sponsor's name as shown on line 2a of Form 5500
2 CIRCLE INCORPORATED

D Employer Identification Number (EIN)
45-3989137

Part I Information Concerning Insurance Contract Coverage, Fees, and Commissions

Provide information for each contract on a separate Schedule A. Individual contracts grouped as a unit in Parts II and III can be reported on a single Schedule A.

1 Coverage Information:

(a) Name of insurance carrier
GUARDIAN

(b) EIN	(c) NAIC code	(d) Contract or identification number	(e) Approximate number of persons covered at end of policy or contract year	Policy or contract year	
				(f) From	(g) To
13-5123390	64246	00502570	222	08/01/2024	07/31/2025

2 Insurance fee and commission information. Enter the total fees and total commissions paid. List in line 3 the agents, brokers, and other persons in descending order of the amount paid.

(a) Total amount of commissions paid	(b) Total amount of fees paid
2191	0

3 Persons receiving commissions and fees. (Complete as many entries as needed to report all persons).

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid

FOSTER THOMAS INC
181 HARRY S. TRUMAN PKWY STE110
ANNAPOLIS, MD 21401

(b) Amount of sales and base commissions paid	Fees and other commissions paid		
	(c) Amount	(d) Purpose	(e) Organization code
1328	0		3

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid

DAILYFEASTS INC.
131 TREMONT STREET 3RD FLOOR
BOSTON, MA 02111

(b) Amount of sales and base commissions paid	Fees and other commissions paid		
	(c) Amount	(d) Purpose	(e) Organization code
863	0		3

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid

(b) Amount of sales and base commissions paid	Fees and other commissions paid		**(e)** Organization code
	(c) Amount	**(d)** Purpose	

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid

(b) Amount of sales and base commissions paid	Fees and other commissions paid		**(e)** Organization code
	(c) Amount	**(d)** Purpose	

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid

(b) Amount of sales and base commissions paid	Fees and other commissions paid		**(e)** Organization code
	(c) Amount	**(d)** Purpose	

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid

(b) Amount of sales and base commissions paid	Fees and other commissions paid		**(e)** Organization code
	(c) Amount	**(d)** Purpose	

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid

(b) Amount of sales and base commissions paid	Fees and other commissions paid		**(e)** Organization code
	(c) Amount	**(d)** Purpose	

Part II Investment and Annuity Contract Information

Where individual contracts are provided, the entire group of such individual contracts with each carrier may be treated as a unit for purposes of this report.

4	Current value of plan's interest under this contract in the general account at year end	**4**	
5	Current value of plan's interest under this contract in separate accounts at year end	**5**	

6 Contracts With Allocated Funds:

a State the basis of premium rates ▶

b	Premiums paid to carrier	**6b**	
c	Premiums due but unpaid at the end of the year	**6c**	
d	If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, enter amount.	**6d**	

Specify nature of costs ▶

e Type of contract: (1) ☐ individual policies (2) ☐ group deferred annuity

(3) ☐ other (specify) ▶

f If contract purchased, in whole or in part, to distribute benefits from a terminating plan, check here ▶ ☐

7 Contracts With Unallocated Funds (Do not include portions of these contracts maintained in separate accounts)

a Type of contract: (1) ☐ deposit administration (2) ☐ immediate participation guarantee

(3) ☐ guaranteed investment (4) ☐ other ▶

b	Balance at the end of the previous year			**7b**	
c	Additions: (1) Contributions deposited during the year	**7c(1)**			
	(2) Dividends and credits	**7c(2)**			
	(3) Interest credited during the year	**7c(3)**			
	(4) Transferred from separate account	**7c(4)**			
	(5) Other (specify below)	**7c(5)**			
	▶				
	(6)Total additions			**7c(6)**	
d	Total of balance and additions (add lines **7b** and **7c(6)**).			**7d**	
e	Deductions:				
	(1) Disbursed from fund to pay benefits or purchase annuities during year	**7e(1)**			
	(2) Administration charge made by carrier	**7e(2)**			
	(3) Transferred to separate account	**7e(3)**			
	(4) Other (specify below)	**7e(4)**			
	▶				
	(5) Total deductions			**7e(5)**	
f	Balance at the end of the current year (subtract line **7e(5)** from line **7d**)			**7f**	

Part III Welfare Benefit Contract Information

If more than one contract covers the same group of employees of the same employer(s) or members of the same employee organizations(s), the information may be combined for reporting purposes if such contracts are experience-rated as a unit. Where contracts cover individual employees, the entire group of such individual contracts with each carrier may be treated as a unit for purposes of this report.

8 Benefit and contract type (check all applicable boxes)

- **a** ☐ Health (other than dental or vision)
- **b** ☐ Dental
- **c** ☐ Vision
- **d** ☐ Life insurance
- **e** ☐ Temporary disability (accident and sickness)
- **f** ☐ Long-term disability
- **g** ☐ Supplemental unemployment
- **h** ☐ Prescription drug
- **i** ☐ Stop loss (large deductible)
- **j** ☐ HMO contract
- **k** ☐ PPO contract
- **l** ☐ Indemnity contract
- **m** ☒ Other (specify) ▶ CRITICAL ILLNESS

9 Experience-rated contracts:				
a Premiums: (1) Amount received	**9a(1)**			
(2) Increase (decrease) in amount due but unpaid	**9a(2)**			
(3) Increase (decrease) in unearned premium reserve	**9a(3)**			
(4) Earned (**(1)** + **(2)** - **(3)**)			**9a(4)**	
b Benefit charges (1) Claims paid	**9b(1)**			
(2) Increase (decrease) in claim reserves	**9b(2)**			
(3) Incurred claims (add **(1)** and **(2)**)			**9b(3)**	
(4) Claims charged			**9b(4)**	
c Remainder of premium: (1) Retention charges (on an accrual basis) --				
(A) Commissions	**9c(1)(A)**			
(B) Administrative service or other fees	**9c(1)(B)**			
(C) Other specific acquisition costs	**9c(1)(C)**			
(D) Other expenses	**9c(1)(D)**			
(E) Taxes	**9c(1)(E)**			
(F) Charges for risks or other contingencies	**9c(1)(F)**			
(G) Other retention charges	**9c(1)(G)**			
(H) Total retention			**9c(1)(H)**	
(2) Dividends or retroactive rate refunds. (These amounts were ☐ paid in cash, or ☐ credited.)			**9c(2)**	
d Status of policyholder reserves at end of year: (1) Amount held to provide benefits after retirement			**9d(1)**	
(2) Claim reserves			**9d(2)**	
(3) Other reserves			**9d(3)**	
e Dividends or retroactive rate refunds due. (Do not include amount entered in line **9c(2)**.)			**9e**	
10 Nonexperience-rated contracts:				
a Total premiums or subscription charges paid to carrier			**10a**	13282
b If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, other than reported in Part I, line 2 above, report amount. Specify nature of costs.			**10b**	

Part IV Provision of Information

11 Did the insurance company fail to provide any information necessary to complete Schedule A? ☐ Yes ☒ No

12 If the answer to line 11 is "Yes," specify the information not provided. ▶

2025 Schedule A/5500 Information

From	To
08/01/2024	07/31/2025
Plan Number	**Plan Name**
00502570	2 CIRCLE, INC
Guardian's EIN	**Guardian's NAIC**
13-5123390	64246

Approximate number of employees covered at the end of the plan year

222

Group Insurance coverage(s) included under this plan

Voluntary Critical Illness

Vision (Insured)

Short Term Disability (Insured)

Optional Life

Optional AD&D

Long Term Disability

Life

Dental (Insured)

AD&D

Accident

Commissions

Total commissions

The following figure represents commissions that are to be reported on Schedule A, Line 3, Element (b):

Contract ID	Contract name	Commissions paid
0004B710	FOSTER THOMAS INC	$9,196.35
0009N773	DAILYFEATS INC.	$18,879.56
000T6853	FOSTER THOMAS INC	$18,047.68
Total commissions for plan		**$46,123.59**

0004B710-FOSTER THOMAS INC

181 HARRY S. TRUMAN PKWY SUITE 110 ANNAPOLIS MD 21401

Group insurance coverages	Commissions paid
Accident	2165.49
Optional AD&D	663.18
Optional Life	5039.41
Voluntary Critical Illness	1328.27
Total commissions for contract	**$9,196.35**

0009N773-DAILYFEATS INC.

131 TREMONT STREET 3RD FLOOR BOSTON MA 02111

Group insurance coverages	Commissions paid
AD&D	248.73
Accident	703.78
Dental (Insured)	6912.35
Life	1326.61
Long Term Disability	3042.17
Optional AD&D	331.62
Optional Life	2519.67
Short Term Disability (Insured)	1815.1
Vision (Insured)	1116.16
Voluntary Critical Illness	863.37
Total commissions for contract	**$18,879.56**

000T6853-FOSTER THOMAS INC

181 HARRY S. TRUMAN PKWY SUITE 110 ANNAPOLIS MD 21401

Group insurance coverages	Commissions paid
AD&D	505.35
Dental (Insured)	4962.44
Life	2695.13
Long Term Disability	4809.6
Short Term Disability (Insured)	2777.9
Vision (Insured)	2297.26
Total commissions for contract	**$18,047.68**

Fees

Total fees

The following figure represents fees that are to be reported on Schedule A, Line 3, Element (c) :

Contract ID	Contract name	Amount
000T6853	FOSTER THOMAS INC	$8,783.85
Total Fees Paid	**$8,783.85**	

One time reimbursement

However, the compensation above is not charged to your case in calculating new rates.

Recipient of One Time Reimbursement	Amount Paid
Total Fees Paid	

Group insurance coverages	Gross premium paid
AD&D	$7,106.80
Accident	$10,827.43
Dental (Insured)	$197,495.75
Life	$37,902.87
Long Term Disability	$86,919.25
Optional AD&D	$5,101.49
Optional Life	$38,764.57
Short Term Disability (Insured)	$51,860.08

Vision (Insured)	$31,890.39	
Voluntary Critical Illness	$13,282.69	
Total premium paid		**$481,151.32**
Premium due (unpaid) at the end of the year		**$0.00**

Indirect compensation - Schedule C, Part 1,3, Elements (a & c)

The following figure represents indirect Compensation to be reported on Schedule C, Part 1,3, Elements(a & c)

Contract Identification (a)	Name and Address of Recipient of Indirect Compensation (a)	Amount (c)
Total Indirect Compensation Paid:		

Indirect compensation - Schedule C, Part 1,3, Elements (b, d & e)

The following figure represents indirect Compensation information to be reported on Schedule C, Part 1,3, Elements(b. d & e)

Service Code (b)	Name and Address (d)	Indirect Compensation (e)

YOUR GROUP INSURANCE PLAN BENEFITS

2 CIRCLE, INC

CLASS 0001

AD&D, OPTIONAL LIFE, DENTAL, LTD, LIFE, STD, VISION, CRITICAL ILLNESS, VOLUNTARY AD&D, ACCIDENT 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.

The Guardian Life Insurance Company of America
10 Hudson Yards
New York, New York 10001
(212) 598-8000
www.GuardianAnytime.com

If Your Group Certificate includes any of the following coverages: Guardian Insured: Group Accident, Group Cancer, Group Critical Illness, Group Hospital Indemnity, Group Dental or Group Vision, the following consumer complaint notice is applicable. (Employer Funded Coverages, if any, are excluded from this Rider.)

New Mexico Residents
Consumer Complaint Notice

If You are a resident of New Mexico, Your coverage will be administered in accordance with the minimum applicable standards of New Mexico law. If You have concerns regarding a claim, premium, or other matters relating to this coverage, You may file a complaint with the New Mexico Office of Superintendent of Insurance (OSI) using the complaint form available on the OSI website and found at:

httsp://www.osi.stat.nm.us/ConsumerAssistance/index.aspx

CCN-2019-NM B999.0042

You May not be covered by all options in this Certificate.

This Certificate contains all the benefits and options that are available under the Policy. You are insured only for those benefits and options that you are eligible and enrolled for, and for which the required premium has been paid.

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

Matthew Darula, Head of Product, Strategy and Offerings

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NOTICE

The office in the Administration responsible for receiving and responding to complaints from covered persons about carriers is:

Consumer Complaint Unit

Maryland Insurance Administration

525 St. Paul Place

Baltimore MD 21202

1-800-492-6116 or 410-468-2244

A covered person or a health care provider acting on behalf of a covered person may file a complaint with the Consumer Complaint Unit only after the Company's Internal Appeal Process is exhausted. But a covered person or a health care provider acting on behalf of a covered person may file a complaint with the Consumer Complaint Unit without first filing an appeal with the Company only if the coverage decision involves an urgent medical condition, as defined by regulation adopted by the Commissioner, for which care has not been rendered. "Urgent medical condition" is defined as a condition that satisfies either of the following:

(a) A medical condition, including a physical condition, a mental condition, or a dental condition, where the absence of medical attention within 72 hours could reasonably be expected by an individual, acting on behalf of a carrier, applying the judgment of a prudent layperson who possesses an average knowledge of health and medicine, to result in:

(i) Placing the member's life or health in serious jeopardy;

(ii) The inability of the member to regain maximum function;

(iii) Serious impairment to bodily function;

(iv) Serious dysfunction of any bodily organ or part; or

(v) The member remaining seriously mentally ill with symptoms that cause the member to be a danger to self or others; or

(b) A medical condition, including a physical condition, a mental health condition, or a dental condition, where the absence of medical attention within 72 hours in the opinion of a health care provider with knowledge of the member's medical condition, would subject the member to severe pain that cannot be adequately managed without the care or treatment that is the subject of the coverage decision.

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

All Options

Incontestability

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

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.*

No statement in any application made by a person insured under this *plan* shall be used in contesting the validity of his or her 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 or her lifetime. The application must be signed by the covered person and a copy furnished to the covered person or his or her beneficiary.

Statements

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

Absent fraud, all statements made by an applicant, group policyholder, or insured are considered to be representations and not warranties.

CGP-3-R-INCY-03-MD B160.0119

All Options

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 we feel necessary. And we have the right to have an autopsy performed in the case of death, where allowed by law. We'll pay for all such examinations and autopsies.

CGP-3-R-EA-90 B160.0006

All Options

Accident and Health Claims Provision

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 for 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 three years from the date you are required to file proof of loss, as shown in the "Proof of Loss" provision above.

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.

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

All Options

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

All Options

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.

All Options

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.

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

All Options

ELIGIBILITY FOR DISABILITY COVERAGE

CGP-3-ECOV-09-MD B329.0456

All Options

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 You must:

(a) be legally working in the United States.

(b) be regularly working at least the number of hours in the normal work week set by your *employer* (but not less than 30 hours per week), at:

(i) your *employer's* place of business;

(ii) some place where your *employer's* business requires you to travel; or

(iii) any other place you and your *employer* have agreed upon for performance of occupational duties.

Note: If you are working outside the United States on a temporary assignment and you meet all other conditions of eligibility, you will be covered by this *plan,* provided that: you are on an assignment, not exceeding one year, in a country or region that is not under a travel warning issued by the US Department of State. Coverage may be available when you are: (1) on a longer temporary assignment; or (2) assigned in a region that is under a travel warning; however, coverage must be approved by us in writing.

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

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

CGP-3-ECOV-09-MD B329.0469

All Options

When Your Coverage Starts

Employee benefits that don't require proof that you are insurable are scheduled to start on the effective date shown on the sticker attached to the inside front cover of this booklet.

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 fully capable of performing the major duties of your regular occupation for your *employer* on a full-time basis at 12:01AM Standard Time for your place of residence 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 fully capable of performing the major duties of your regular occupation on any date part of your insurance is scheduled to start we will postpone that part of your coverage. We will postpone that part of your coverage until the date you are so capable and are working your regular number of hours for one full day, with the expectation that you could do so for one full week.

Sometimes, the effective date shown on the sticker or in the endorsement is not a regularly scheduled work day. If the scheduled effective date falls: on a holiday; on a vacation day; on a non-scheduled work day; or during an approved leave of absence, not due to sickness or injury, of 90 days or less; and if you were performing the major duties of your regular occupation and working your regular number of hours on your last regularly scheduled work day, your coverage will start on the scheduled effective date. However, any coverage or part of coverage for which you must elect and pay all or part of the cost, will not start if you are on an approved leave and such coverage or part of coverage was not previously in force for you under a prior plan which this *plan* replaced.

All Options

When Your Short Term Disability Income Coverage Ends

Your short term disability coverage ends on the date your active *full-time* service ends for any reason, except as noted below under "Continuation of Coverage During Disability".

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 we 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.

Continuation of Coverage During Disability

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 the disability is not excluded under the *plan;* and (b) the period for which benefits are payable under the *plan.* However, if no benefits are payable under this *plan* due to application of the *plan's* exclusion for a job related injury or sickness, coverage will remain in force until the earlier of the date: (a) you are terminated from employment with the employer; or (b) you have been disabled for six months.

CGP-3-ECOV-09-MD B329.0518

All Options

When Your Long Term Disability Income 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 we 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 the *plan.*

CGP-3-ECOV-09-MD B329.0499

All Options

An Employee's Right To Continue Group Short and Long Term Disability Income Coverages During a Family Leave of Absence

Continuation of Coverages

Short and Long Term Disability Income coverages may be continued, under a uniform, non-discriminatory policy applicable to all employees.

If Your Group Coverage Would End

Group Short and Long Term Disability Income coverages 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 Short and Long Term Disability Income coverages 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) for the birth or placement for adoption or foster care 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.

All Options

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.

SCHEDULE OF BENEFITS

CGP-3-STD08-HL-MD B340.0776

All Options

Elimination Period

For *disability* due to *injury* . . . . . 7 days

For *disability* due to *sickness* . . . . . 7 days

CGP-3-STD08-HL-MD B340.0778

All Options

Maximum Payment Period

For *disability* due to *injury* . . . . . 13 weeks

For *disability* due to *sickness* . . . . . 13 weeks

CGP-3-STD08-HL-MD B340.0782

All Options

Gross Weekly Benefit

66 2/3% of your *insured earnings,* rounded to the nearest $1.00, if not already a multiple thereof, limited to a maximum of $1,500.00.

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

CGP-3-STD08-HL-MD B340.0785

All Options

Survivor Benefit

4 times the last *weekly benefit* after it is reduced by *disability earnings* you received.

CGP-3-STD08-HL-MD B340.0792

CGP-3-STD08-HL-MD B340.0793

SHORT TERM DISABILITY INCOME INSURANCE

This insurance replaces part of your income if you become *disabled* due to a covered *sickness* or *injury.* What we pay is governed by all the terms of this *plan.*

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.

Benefit Provisions

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 provide proof of loss, as described in this *plan's* Claim Provisions section.

Benefits accrue as of the first day following the end of the *elimination period,* subject to all *plan* terms.

You can satisfy the *elimination period* while working, provided you are *disabled* as defined by this *plan.*

When Payments End

Your benefits from this *plan* will end at 12:01 A.M. standard time at the place you reside, on the earliest of the dates shown below:

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

(b) The date you fail to provide proof of loss as required by this *plan.*

(c) The date you earn in your *own job* the maximum earnings allowed while *disabled* under this *plan.*

(d) The date you are able to perform each and every duty of your *own job* on a full-time basis with *reasonable accommodation.*

(e) The date you have been outside the United States and/or Canada for more than 2 months in a 12 month period.

(f) The date you die.

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

(h) The date no further benefits are payable under any provision in this *plan* that limits the *maximum payment period.*

(i) The date you are no longer receiving *regular and appropriate care* from a *doctor.*

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

All Options

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 13 weeks.

For *disability* due to *sickness,* the *maximum payment period* is 13 weeks.

All Options

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.* See the section entitled "When Your Coverage Ends" under "Eligibility for Disability Coverage".

Recurring Disability

Benefits from this *plan* end if you cease to be *disabled.* But, a later *disability* may be treated as a *recurring disability,* if all of the terms listed below are met:

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

(b) The *disability* must recur less than two weeks after you were last entitled to benefits;

(c) The later *disability* must be due to the same or related cause of your earlier *disability;*

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

(e) During the time you return to *active work,* you must: (i) stay insured by this *plan;* and (ii) premium payments must be made on your behalf; and

(f) Your benefits for the earlier *disability* must not have ended because you have used up the *maximum payment period.*

If the later *disability* is a *recurring disability,* you will not need to complete a new *elimination period.* The *recurring disability* will be subject to all the terms of the *plan* in effect on the date the earlier *disability* began. Benefits for the *recurring disability* will be subject to the remainder of the *maximum payment period* that was not used up for the earlier *disability.*

If all of the terms listed above are not met, the later *disability* will be treated as a new period of *disability.* You will be required to complete a new *elimination period.* The new period of *disability* will be subject to all the terms of the *plan* in effect on the date the new period of *disability* occurs.

All Options

Calculation of Weekly Benefit

Your benefit is governed by the terms of the *plan* in effect on the date *disability* occurs. Any changes to this *plan* that take place: (a) while you are *disabled;* or (b) during a period of *active work* that occurs between an initial period of *disability* and a *recurring disability;* will not affect your benefit.

We calculate your *gross weekly benefit* according to the Schedule of Benefits.

From your *gross weekly benefit,* subtract the amount of any income listed in Other Income Benefits that you receive or are entitled to receive. The result is your *weekly benefit.*

CGP-3-STD08-MD B340.0716

All Options

Redetermination

This *plan* redetermines *insured earnings* for each covered person on August 1st . Each August 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-STD08-MD B340.0718

All Options

Other Income Benefits

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

- Commissions or monies: (1) received; (2) payable but deferred; or (3) paid after *disability* benefits start. This includes: (a) vested and nonvested renewal commissions; (b) bonuses; (c) royalties; (d) profit sharing; and (e) other distributions.
- Disability benefits from any mandated benefit act or law. This includes all temporary disability or state disability benefits required by law. However, this does not include disability benefits from any: (1) no-fault motor vehicle coverage; (2) motor vehicle financial responsibility act; or (3) like law.
- Disability benefits from all group plans of: (1) the *plan sponsor;* or (2) the *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. However, if the group plan was in force prior to this *plan,* and such group plan also deducts for disability benefits from a group plan of: (1) the *plan sponsor* ; or (2) the *employer;* we will not deduct these group disability benefits.

- Disability benefits from any other group plan; but, if the other group plan was in force prior to this *plan* , and the other group plan also deducts for disability benefits from any other group plan, we will not deduct these other group disability 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 which: (i) you receive; and (ii) your spouse and children receive due to your *disability;*

(b) All unreduced retirement benefits which: (i) you receive; and (ii) your spouse and children receive due to your receipt of such benefits; and

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

We do not reduce your *gross weekly benefit* by the retirement benefits described in (b) and (c) above, to the extent that you and your dependents were entitled to receive such income prior to the start of *disability.*

We will reduce your *gross weekly benefit* by benefits referred to in (a), (b) and (c) above, net of attorney fees approved by the Social Security Administration.

We will reduce your *gross weekly benefit* by benefits referred to in (a), (b) and (c) above to which your spouse and children are entitled due to your receipt of 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.

- Income of the type that is included in your *insured earnings* for purposes of determining your *gross weekly benefit* under this *plan.*

- That portion of *retirement plan retirement benefits* which you receive which the *employer* funds.

- That portion of *retirement plan disability benefits* which you receive which the *employer* funds.

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

- Payment or settlement, with or without admission of liability, 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. If you receive a payment net of attorney fees approved by the Workers' Compensation Board or similar authority, we reduce our benefit by the net payment.

- Disability benefits from any third party when your disability is the result of the negligence or intentional tort liability of that third party. Offset for tort recovery will be reduced by a pro rata share of the court costs and legal fees incurred by you in securing such recovery.
- Unemployment compensation benefits.
- Payment from your employer as part of a termination or severance agreement.

All Options

Other Income Not Subject to Deduction

We will not reduce your *gross weekly benefit* by any income you receive or are entitled to receive from the list below.

- Deferred compensation arrangements such as 401(k), 403(b) or 457 plans;
- Profit sharing plans;
- Thrift plans;
- Tax sheltered annuities;
- Stock ownership plans;
- Individual Retirement Accounts (IRA);
- Individual disability income plans;
- Credit disability insurance;
- Non qualified plans of deferred compensation;
- Pension plans for partners;
- Retirement plans of another employer not affiliated with this *plan;*
- Military pension and disability plans;
- Income from a sick leave, salary continuance, or Paid Time Off plan.

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.

Cost of Living Freeze

You may receive an increase in other income with which we integrate. We do not further reduce your *weekly benefit* by the amount of: (a) any increases in social security benefits with which we integrate, or (b) cost of living increases in other income benefits with which we integrate. We do adjust payments if: (i) your *disability earnings* change, or (ii) your income benefits with which we integrate, other than social security benefits, change due to a recalculation of the benefit when updated information is received after the initial benefit is calculated.

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. This paragraph does not apply to benefits from the United States Social Security Act, the Railroad Retirement Act or any other like US or Canadian plan or act.

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.

All Options

Adjustment of Weekly Benefit for Disability Earnings

We adjust the *weekly benefit* for *disability earnings* as follows.

We pay the greater of the amount calculated under Method 1 or Method 2.

Method 1:

We reduce your *weekly benefit* by 50% of your *disability earnings.*

Method 2:

(a) Subtract your *disability earnings* from your *insured earnings.*

(b) Divide the result in (a) above by your *insured earnings.*

(c) Multiply the result in (b) above by your *weekly benefit.* This is the amount we pay.

If your *disability earnings* fluctuate widely from week to week, we may adjust your *weekly benefit* using an average *disability earnings* amount. The average *disability earnings* amount will be computed using your most current week's *disability earnings* and the prior two weeks *disability earnings.*

Maximum Allowable Disability Earnings

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

If your *disability earnings* are more than 80% of your *insured earnings,* payments from this *plan* will end.

All Options

Minimum Payment The minimum weekly payment for *disability* under this *plan* is $25.00.

CGP-3-STD08-MD B340.0730

All Options

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

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

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

(c) you being engaged in an illegal occupation;

(d) your commission of, or attempt to commit a felony, for which you have been convicted;

(e) you being intoxicated. A person is intoxicated when his or her blood alcohol concentration exceeds the statutory limit for driving while intoxicated under the laws of the State of Maryland;

(f) you being under the influence of any narcotic;

(g) intentional self-inflicted injuries; or

(h) job related or on-the-job-injury.

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

(1) during which you are confined to a facility as a result of your conviction of a felony; or

(2) during which you are receiving medical treatment or care outside the United States or Canada unless expressly authorized by us.

CGP-3-STD08-MD B340.1281

All Options

Services

Rehabilitation and Case Management 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.*

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; and

(f) assistance with child care expenses you incur in order to participate in a *rehabilitation program.* (See the Dependent Care Expenses section of this *plan.)*

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 *weekly benefit* that would otherwise be paid. This enhanced benefit will be payable as of the first *weekly 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.

Dependent Care Expenses

While you are participating in a *rehabilitation program,* we will pay a dependent care expense benefit, when all of the following conditions are met:

(a) you incur expense to provide care for a qualified dependent;

(b) the care is provided by a licensed provider other than a family member.

A qualified dependent is: (a) dependent upon you for main support and maintenance; and (b) under the age of fourteen and your: (i) biological child; (ii) lawfully adopted child; (iii) stepchild; or (iv) any other child who is living with you in a regular parent-child relationship.

The dependent care expense benefit will be the lesser of: (a) $100 per week per qualified dependent; not to exceed $300 per week for all qualified dependents combined; and (b) the actual weekly day care expense incurred by you.

We will stop paying the dependent care expense benefit on the earlier of the date you are no longer: (a) incurring dependent care expenses for a qualified dependent; (b) participating in a *rehabilitation program;* or (c) entitled to receive a *weekly benefit* from this *plan.*

All Options

Worksite Modification Benefit

In order to accommodate your *disability,* an employer may incur a cost to modify your worksite. We may reimburse the employer, up to $2,500 for the cost of the worksite modification. We make this payment if we agree that the modification will enable you to: (a) return to work; or (b) remain at work.

CGP-3-STD08-MD B340.0740

All Options

Supplemental Benefits

The Survivor Benefit

We may pay a survivor benefit if you die after you: (a) had been *disabled* for at least five weeks in a row; and (b) were entitled to receive a *weekly benefit* for at least four weeks prior to your death. When we receive proof of your death, we pay your eligible survivor a lump sum benefit.

We pay a benefit equal to 4 times the amount of your last *weekly benefit* for a full week after it is reduced by *disability earnings.* But, we first apply such benefit to reduce any overpayment you may owe us.

If you have no eligible survivor, no survivor benefit is paid.

Your eligible survivor is your spouse, if living.

If your spouse is not living, your eligible survivor is your: (a) unmarried child under age 20; and (b) unmarried child under age 26 who is enrolled as a full-time student at an accredited school. If there is more than one such child when you die, this benefit will be paid to each child in equal shares.

CGP-3-STD08-MD B340.0746

All Options

Claim Provisions

Authority

We have the sole discretionary authority to: (a) interpret the terms of this plan; and (b) determine your eligibility for: (i) coverage; and (ii) benefits under the plan. All such determinations are conclusive and binding, except that they may be modified or reversed by a court or regulatory agency with appropriate jurisdiction.

Notice

You must send us written notice of your intent to file a claim under this plan as described in "Accident and Health Claims Provisions."

For details, you can call Guardian at 1-800-268-2525.

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 the *employer,* you, and the *doctor(s)* treating you for your *sickness* or *injury. Proof of loss must be given to us within the time stated in "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.*

Proof of loss, provided at your expense, consists of the following. Failure to provide this information may delay, suspend, reduce or terminate your benefits.

(a) The date disability began;

(b) Your last day of *active work;*

(c) The cause of *disability;*

(d) The extent of *disability,* including limitations and restrictions preventing you from performing each and every duty of your *own job.*

(e) If your occupation requires that you carry liability or malpractice insurance, any changes to such insurance that become effective on or after the date of *disability;*

(f) Objective medical evidence in support of your limitations and restrictions, beginning with the date *disability* began;

(g) The prognosis of disability;

(h) The name and address of all doctors, hospitals and health care facilities where you have been treated for your disability since the date *disability* began;

(i) Proof that you: (i) are currently; and (ii) have been receiving regular and appropriate care from a doctor, from the date *disability* began;

(j) Proof of *insured earnings,* and, if applicable, *disability earnings;*

(k) Payroll or absence data from the employer for the three months prior to the date *disability* began, or other period we specify;

(l) Proof of application for all other sources of income to which you may be entitled, that may affect your payment from this *plan;* and

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

You must provide objective medical evidence from a *doctor* who is not yourself, your spouse, child, parent, sibling or business associate.

Proof of *insured earnings* and *disability earnings* may consist of: (1) copies of your W-2 forms; (2) payroll records from your employer(s); (3) copies of your U.S. Individual Income Tax Returns; (4) copies of the U.S. income tax returns from any business in which you hold an ownership or shareholder interest; (5) a statement from a certified public accountant; (6) copies of any income records accepted or required by the I.R.S; or (7) any other records we deem necessary.

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. 14331
Lexington, KY 40512

Authorization Required

You must provide us with written, unaltered authorizations to obtain medical, financial, vocational, occupational, and governmental information required to determine our liability under this plan. You must provide us with such authorizations as often as we may require, in order that they remain current. Failure to provide such authorizations may delay, suspend or terminate your benefits.

Right to Request Medical, Financial or Vocational Assessment

We may ask you to take part in a medical, financial, vocational or other assessment that we feel is necessary to determine whether the terms of the *plan* are met. We may require this as often as we feel is reasonably necessary during the pendency of a claim. We will pay for all such assessments. But, if you postpone a scheduled assessment without our approval, you will be responsible for any rescheduling fees. If you do not take part in or cooperate with the assessment, we have the right to stop or suspend your payments under this *plan.*

Ongoing Proof of Loss

To continue to receive payments from this *plan,* you must give us current proof of loss as often as we may reasonably require. Ongoing proof of loss must be provided to us within 90 days of the date we request it. Failure to give such notice within such time will not invalidate or reduce a claim if it was not reasonably possible for you to submit proof within the required time, if proof is furnished as soon as reasonably possible.

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. Benefits are paid in US dollars.

We pay benefits biweekly at the end of the period for which they are payable and any balance remaining unpaid at the termination of the period will be paid as soon as reasonably possible after receipt of proof. The first payment period begins on the day after the *elimination period.*

No benefits are payable for this *plan's elimination period.*

Benefits to which you are entitled may remain unpaid at your death. If any benefit is payable to your estate, or to a minor who is not otherwise competent to give a valid release, we pay the benefit, up to an amount not exceeding $5,000, to any relative by blood or connection by marriage who is considered by us to be entitled to the benefit.

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 full 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.

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.

You are deemed to be in active work on each day of absence while not disabled, provided you were in active work on the last preceding workday before the day of absence.

CGP-3-STD08-MD B340.0743

All Options

Disability or Disabled

These terms mean that, due to *sickness* or *injury,* you are: (a) not able to perform, on a full-time basis, each and every duty of your own job and (b) not able to earn more than this *plan's* maximum allowed *disability earnings.*

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.

Neither: (a) loss of a professional or occupational license; or (b) receipt of or entitlement to Social Security disability benefits; in and of themselves constitute *disability* under this *plan.*

CGP-3-STD08-MD B340.0750

All Options

Disability Earnings

The weekly income you earn from working while *disabled.* It includes salaries, wages, commissions, bonuses and any other compensation earned or accrued while working including pension, profit sharing contributions, sick pay, paid time off, holiday and vacation pay. When you have an ownership interest in the business, *disability earnings* also includes business profits, attributable to you, whether received or not. It includes any income you earn while *disabled* and return to your *employer,* partnership, or any other similar business arrangement to cover any business or overhead expenses. If you have the ability to work on a *part-time* or full-time basis, following the earlier of the date you: (a) have been terminated from employment with the *employer;* (b) have been *disabled* for 3 months in a row; or (c) have been offered a job or workplace modification by the *employer* and you do not return to work; *disability earnings* also includes *maximum capacity earnings.*

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.

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 work earning more than 80% of your *insured earnings* will not count toward the *elimination period.*

We do not require you to complete an *elimination period* if: (a) you were covered under a similar income replacement plan the *plan sponsor* had with another insurer on the day before this *plan* starts; (b) your *disability* would have been a recurring disability under the prior plan had it remained in effect.

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

Gainful Occupation or Gainful Work Work in which you are able to perform each and every duty of any business or occupation for which you are reasonably fitted by: (a) eduction; (b) training; and (c) experience. When you are able to perform such work on a full-time basis, you can be expected to earn at least 80% of your *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 Weekly Benefit This *plan's weekly benefit* before it is integrated with other income and earnings.

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.* If *disability* is due to an accident that occurred before you were insured by this *plan;* or *disability* begins more than 90 days after the date of *injury,* that *disability* will be treated as *disability* due to *sickness.*

All Options

Insured Earnings: Only a covered person's earnings from the *employer* will be included as *insured earnings.*

We calculate benefit amounts and limits based on the amount of the covered person's *insured earnings* as of the Redetermination date immediately prior to the start of his or her *disability.* See the "Redetermination" section of this *plan.*

For Partners and S Corporation Shareholders:

Insured earnings means the sum of the amounts listed below, divided by 52.

(a) His or her compensation as an employee or S Corporation shareholder, as reported on his or her Federal Income Tax Return, Form 1040, for the prior calendar year, less the gross total of unadjusted employee business expenses as included on the corresponding Schedule A-Itemized Deductions;

(b) His or her non-passive income (loss) from trade or business as reported on Schedule E-Part II of his or her Federal Income Tax Return, Form 1040, for the prior calendar year, less any expenses incurred and reported elsewhere on his or her Return; and

(c) His or her contributions during the prior calendar year, deposited into a: (a) cash or deferred compensation plan, or salary reduction plan, qualified under IRC Section: 401(k); 403(b); 457; or similar plan; and (b) elective employee pre-tax deferrals to a Section 125 plan or flexible spending account.

The covered person may not have been a partner or S Corporation shareholder for the entire previous calendar year. In this case, the covered person's earnings are based on the weekly average of the sum of the listed amounts, averaged for the full number of weeks that he or she was a partner or an S Corporation shareholder during such calendar year.

For Sole Proprietors:

Insured earnings means: (a) the average weekly net profit as determined from Schedule C - Part II of the covered person's Federal Income Tax Return, Form 1040, for the prior calendar year; plus (b) the covered person's average weekly contribution during the prior calendar year deposited into a: (i) cash or deferred compensation plan, or salary reduction plan, qualified under IRC Section: 401(k); 403(b); 457; or similar plan; and (ii) a Section 125 plan or flexible spending account. Weekly net profit is calculated as gross income less total expenses. The covered person may not have been a sole proprietor for the previous calendar year. In this case, we calculate average weekly net profit and average weekly contributions using the full number of weeks that he or she was a sole proprietor during such calendar year.

For Covered Persons Who Are Compensated on Less Than a 12 Month Basis:

Insured earnings means the covered person's average rate of weekly earnings determined from his or her annual contract salary. *Insured earnings* also includes the covered person's contributions deposited into a: (a) cash or deferred compensation plan, or salary reduction plan, qualified under IRC Section: 401(k); 403(b); 457; or similar plan; and (b) elective employee pre-tax deferrals to a Section 125 plan or flexible spending account. *Insured earnings* does not include bonuses, commissions, overtime pay, expense accounts, stock options and any other extra compensation. We do not include pay for hours worked or billed over 40 per week. Earnings based on excluded income and *employer* contributions deposited into such 401(k); 403(b); 457; or similar plan are excluded.

For Covered Persons Whose Income Is Reported on a IRS Form 1099:

Insured earnings means the covered person's average rate of weekly earnings as figured from the 1099 form received from the *employer* for the prior calendar year, calculated as (a) minus (b), divided by 52 or the number of weeks the covered person worked for the *employer* during such calendar year, if less than 52.

(a) his or her earned income as reported on the 1099 form.

(b) business expenses, as reported on Schedule C - Part II of his or her Federal Income Tax Return, Form 1040.

Insured earnings also includes the covered person's contributions deposited into a: (a) cash or deferred compensation plan, or salary reduction plan, qualified under IRC Section: 401(k); 403(b); 457; or similar plan; and (b) elective employee pre-tax deferrals to a Section 125 plan or flexible spending account.

Earnings based on excluded income and *employer* contributions deposited into such 401(k); 403(b); 457; or similar plan are excluded.

For All Other Covered Persons:

Insured earnings means a covered person's base weekly salary. *Insured earnings* also includes the covered person's contributions deposited into a: (a) cash or deferred compensation plan, or salary reduction plan, qualified under IRC Section: 401(k); 403(b); 457; or similar plan; and (b) elective employee pre-tax deferrals to a Section 125 plan or flexible spending account. *Insured earnings* does not include bonuses, commissions, overtime pay, expense accounts, stock options and any other extra compensation. We do not include pay for hours worked or billed over 40 per week. Earnings based on excluded income and *employer* contributions deposited into such 401(k); 403(b); 457; or similar plan are excluded.

CGP-3-STD08-MD B340.1206

All Options

Maximum Capacity Earnings The income you could earn if working to the fullest extent you are able to in your *own job.* We decide the fullest extent of work you are able to do based on objective data provided by any or all of the following sources: (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.*

Objective Medical Evidence May include but is not limited to: (a) diagnostic testing; (b) laboratory reports; and (c) medical records of a *doctor's* exam documenting: (i) clinical signs; (ii) presence of symptoms; and (iii) test results consistent with generally accepted medical standards supported by nationally recognized authorities in the health care field.

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.*

CGP-3-STD08-MD B340.0772

All Options

Part-Time The ability to work and earn between 40% and 80% of *insured earnings.*

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

Plan Sponsor The *employer,* to whom this *plan* is issued.

Reasonable Accommodation Any modification or adjustment to: (i) a job; (ii) an employment practice; (iii) a work process; or (iv) the work place; that an employer willingly provides. 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.

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 and Appropriate Care Means, with respect to your: (a) disabling condition; and (b) any other condition which, if left untreated, would adversely affect your disabling condition; you (i) visit a *doctor* as frequently as medically required, according to generally accepted medical standards, to effectively manage these conditions; and (ii) are receiving the most appropriate treatment, according to generally accepted medical standards, designed to achieve maximum medical improvement in these conditions. Treatment must be provided by a *doctor(s)* whose specialty is most appropriate for your: (a) *disability;* and (b) any other conditions which left untreated would adversely affect your disabling condition; according to generally accepted medical standards. Generally accepted medical standards are those 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 Institute; the National Institutes of Health; the Department of Health and Human Services; and any other agency of similar repute.

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; (f) 401(k), 403(b), 457 or similar plans; or (g) 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 *disability earnings.*

CERTIFICATE AMENDMENT

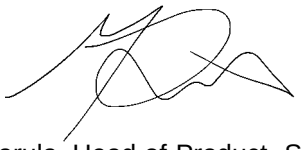
(To be attached to certificates issued to employees)

Effective February 1, 2012 or your first renewal thereafter, this rider amends the Claim Provisions of your certificate by replacing the Authority provision with the following:

Administration: We as a part of our routine operations apply the terms of this plan for making decisions. This includes making a reasonable determination regarding eligibility; receipt of benefits and claims; or explaining our administrative policies; procedures; and processes.

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



Matthew Darula, Head of Product, Strategy and Offerings

CGP-3-A-STD-MD-11 B531.0083

CERTIFICATE AMENDMENT

(To be attached to certificates issued to employees)

The certificate is amended as follows:

1. The Short Term Disability Income Insurance eligibility provisions are modified to provide that:

    a. You are eligible for disability income insurance coverage if you are legally working in the United States or working outside of the United States for a United States based employer in a country or region approved by us.

    b. Any requirements that apply to your working outside of the United States on a temporary assignment are hereby deleted.

    c. Your disability income insurance coverage will end on the date you are no longer working in the United States, or working outside of the United States for a United States based employer in a country or region approved by us.

2. The "When Payments End" section under the Short Term Disability Income Insurance provisions is modified to provide that your benefits will end on the date you have been outside of the United States; and/or Canada; or a country or region approved by us for more than 2 months in a 12 month period.

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

Matthew Darula, Head of Product, Strategy and Offerings

CGP-3-A-STD-11 B341.0008

All Options

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-LTD08-MD B380.2798

All Options

Own Occupation Period

The first 24 months of benefit payments from this plan.

CGP-3-LTD08-MD B380.2799

All Options

Elimination Period

For disability due to injury . . . . . 90 days

For disability due to sickness . . . . . 90 days

CGP-3-LTD08-MD B380.2801

All Options

Maximum Payment Period

See the following table:

Age when disability starts	Maximum payment period
Under age 69	5 years, or to age 70, whichever occurs first
Age 69 or older	1.00 year

CGP-3-LTD08-MD B380.2805

All Options

Maximum Monthly Benefit

66 2/3% of your *insured earnings,* rounded to the nearest $1.00, if not already a multiple thereof, limited to a maximum of $10,000.00.

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-LTD08-MD B380.2811

All Options

Proof Of Insurability

When you become insured under this *plan,* the amount of your first projected *gross monthly benefit* may be in excess of $7,500.00. In this case, you must give us proof that you are insurable for the excess amount. You are not entitled to the excess amount unless we approve that proof in writing.

At times, your projected *gross monthly benefit* may increase due to a change in your monthly earnings or class. If such a change increases your projected *gross monthly benefit* to an amount in excess of $7,500.00, you must give us proof that you are insurable for the excess amount. You are not entitled to the excess amount unless we approve that proof in writing.

After you are first approved for an amount in excess of $7,500.00, your projected *gross monthly benefit* may increase due to changes in your monthly earnings or class. If such changes in any period of 12 months in a row result in a total increase in your projected *gross monthly benefit* of more than 15%, you must give us proof that you are insurable for any increase in excess of 15%. You are not entitled to the increased benefit unless we approve the proof in writing.

Any increase in your *gross monthly benefit* that requires proof of insurability takes effect on the date we approve that proof in writing. However, you must be *actively-at-work* on a full-time basis on that date. If you are not, the increase will take effect on the date you return to *active work* on a full-time basis. But, the increase will not apply to a *recurring disability.*

CGP-3-LTD08-HL-MD B380.3587

All Options

Survivor Benefit

3 times the last gross monthly benefit you received.

CGP-3-LTD08-MD B380.2861

LONG TERM DISABILITY INCOME INSURANCE

This insurance replaces part of your income if you become *disabled* due to a covered *sickness* or *injury.* What we pay is governed by all the terms of this *plan.*

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.

Benefit Provisions

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* and insured for this *plan's elimination period.*

(b) You must provide proof of loss, as described in this *plan's* Claim Provisions section.

Benefits accrue as of the first day following the end of the *elimination period,* subject to all *plan* terms.

You can satisfy the *elimination period* while working, provided you are *disabled* as defined by this *plan.*

Waiver of Premium We waive your premiums for this insurance and for short term disability insurance, if included in the *plan sponsor's* plan of insurance while you are entitled to receive a *monthly benefit* payment from this *plan.*

When Payments End Your benefits from this *plan* will end at 12:01 A.M. standard time at the place you reside, on the earliest of the dates shown below:

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

(b) The date you fail to provide proof of loss as required by this *plan.*

(c) The date you earn in your *own occupation* the maximum earnings allowed while *disabled* under this *plan.*

(d) The date you are able to perform each and every duty of your *own occupation* on a full-time basis with *reasonable accommodation.*

(e) After the *own occupation* period, the date you are able to perform each and every duty of any *gainful work* on a full-time basis with *reasonable accommodation.*

(f) The date you have been outside the United States and/or Canada for more than 2 months in a 12 month period.

(g) The date he or she dies.

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

(i) The date no further benefits are payable under any provision in this *plan* that limits the *maximum payment period.*

(j) The date you are no longer receiving *regular and appropriate care* from a *doctor.*

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

All Options

Maximum Payment Period: The *maximum payment period* is the longest time that benefits are paid by this *plan* for a covered person's *disability.* It is determined by the table shown below.

But, it may be less than that shown due to: (a) the nature of the covered person's *disability;* (b) the date the covered person was first treated for the cause of his or her *disability;* and (c) the length of time the covered person has been insured by this *plan.* See "Disabilities with a Limited Maximum Payment Period" and "Pre-Existing Conditions."

Age When Disability Starts	Maximum Payment Period
Under age 69	5 years, or to age 70, whichever occurs first
Age 69 or older	1.00 year

All Options

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.* See the section entitled "When Your Coverage Ends" under "Eligibility for Disability Coverage".

Recurring Disability Benefits from this *plan* end if you cease to be *disabled.* But, a later *disability* may be treated as a *recurring disability,* if all of the terms listed below are met:

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

(b) The *disability* must recur less than six months after you were last entitled to benefits;

(c) The later *disability* must be due to the same or related cause of your earlier *disability;*

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

(e) During the time you return to *active work,* you must: (i) stay insured by this *plan;* and (ii) premium payments must be made on your behalf; and

(f) Your benefits for the earlier *disability* must not have ended because you have used up the *maximum payment period.*

If the later *disability* is a *recurring disability,* you will not need to complete a new *elimination period.* The *recurring disability* will be subject to all the terms of the *plan* in effect on the date the earlier *disability* began. Benefits for the *recurring disability* will be subject to the remainder of the *maximum payment period* that was not used up for the earlier *disability.*

If all of the terms listed above are not met, the later *disability* will be treated as a new period of *disability.* You will be required to complete a new *elimination period.* The new period of *disability* will be subject to all the terms of the *plan* in effect on the date the new period of *disability* occurs.

All Options

Calculation of Monthly Benefit: Your benefit is governed by the terms of the *plan* in effect on the date *disability* occurs. Any changes to this *plan* that take place: (a) while you are *disabled;* or (b) during a period of *active work* that occurs between an initial period of *disability* and a *recurring disability;* will not affect his or her benefit.

We calculate your *gross monthly benefit* according to the Schedule of Benefits.

This *plan* includes proof of insurability requirements that must be met before: (a) your *gross monthly benefit;* (b) a portion thereof; or (c) increases in such amount; become effective. The Schedule of Benefits explains these requirements.

From your *gross monthly benefit,* subtract the amount of any income listed in Other Income Benefits that you receive or are entitled to receive. The result is his or her *monthly benefit.*

CGP-3-LTD08-MD B383.1192

All Options

Redetermination: This plan redetermines *insured earnings* for each covered person on August 1st .

Each August 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 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-LTD08-MD B383.1194

All Options

Other Income Benefits You may receive, or be entitled to receive, income shown in the list below. We will reduce your *gross monthly benefit* by such other income benefits to determine your *monthly benefit* from this *plan.*

- Commissions or monies: (1) received; (2) payable but deferred; or (3) paid after *disability* benefits start. This includes: (a) vested and nonvested renewal commissions; (b) bonuses; (c) royalties; and (d) other distributions.
- Disability benefits from any mandated benefit act or law. This includes all temporary disability or state disability benefits required by law. However, this does not include disability benefits from any: (1) no-fault motor vehicle coverage; (2) motor vehicle financial responsibility act; or (3) like law.

- Disability benefits from all group plans of: (1) the *plan sponsor;* or (2) the *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. However, if the group plan was in force prior to this *plan,* and such group plan also deducts for disability benefits from a group plan of: (1) the *plan sponsor;* or (2) the *employer;* we will not deduct these group disability benefits.

- Disability benefits from any other group plan; but, if the other group plan was in force prior to this *plan,* and the other group plan also deducts for disability benefits from any other group plan, we will not deduct these other group disability benefits.

- Income from a sick leave, salary continuance or Paid Time Off plan, but only to the extent that such income plus the amount of your *gross monthly benefit* is more than 100% of your *insured earnings.* This applies whether such plan is sponsored on a formal or informal basis. This includes donated, lump sum and recurrent payments of accrued sick leave benefits. But, if you are working while *disabled,* we will account for such income as described in this *plan's* "Adjustment of Monthly Benefit for Disability Earnings".

- 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 which: (i) you receive; and (ii) your spouse and children receive due to your *disability;*

  (b) All unreduced retirement benefits which: (i) you receive; and (ii) your spouse and children receive due to your receipt of such benefits; and

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

  We do not reduce your *gross monthly benefit* by the retirement benefits described in (b) and (c) above, to the extent that you and your dependents were entitled to receive such income prior to the start of *disability.*

  We will reduce your *gross monthly benefit* by benefits referred to in (a), (b) and (c) above, net of attorney fees approved by the Social Security Administration.

  We will reduce your *gross monthly benefit* by benefits referred to in (a), (b) and (c) above to which your spouse and children are entitled due to your receipt of 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.

- Income of the type that is included in your *insured earnings* for purposes of determining your *gross monthly benefit* under this *plan.*

- That portion of *retirement plan retirement benefits* which you receive which the *employer* funds.

- That portion of *retirement plan disability benefits* which you receive which the *employer* funds.
- Retirement benefits or retirement plan disability benefits, due to your disability, from any government plan other than those shown above.
- Payment or settlement, with or without admission of liability, 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. If you receive a payment net of attorney fees approved by the Workers' Compensation Board or similar authority, we reduce our benefit by the net payment.
- Disability benefits from any third party when your disability is the result of the negligence or intentional tort liability of that third party. Offset for tort recovery will be reduced by a pro rata share of the court costs and legal fees incurred by a covered person in securing such recovery.
- Unemployment compensation benefits.
- Payment from your employer as part of a termination or severance agreement.

All Options

Other Income Not Subject to Deduction

We will not reduce your *gross monthly benefit* by any income you receive or are entitled to receive from the list below.

- Deferred compensation arrangements such as 401(k), 403(b) or 457 plans;
- Profit sharing plans;
- Thrift plans;
- Tax sheltered annuities;
- Stock ownership plans;
- Individual Retirement Accounts (IRA);
- Individual disability income plans;
- Credit disability insurance;
- Non qualified plans of deferred compensation;
- Pension plans for partners;
- Retirement plans of another employer not affiliated with this *plan;*
- Military pension and disability plans.

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.* a If no monthly rate is given, we pro-rate the lump sum over the lesser of: (a) 60 months; or (b) the expected remaining number of months for which you would be entitled to benefits from this *plan,* based on the proof of loss submitted to us.

Cost of Living Freeze

You may receive an increase in other income with which we integrate. We do not further reduce your monthly benefit by the amount of: (a) any increases in social security benefits with which we integrate, or (b) cost of living increases in other income benefits with which we integrate. We do adjust payments if: (i) your disability earnings change, or (ii) your income benefits with which we integrate, other than social security benefits, change due to a recalculation of the benefit when updated information is received after the initial benefit is calculated.

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. This paragraph does not apply to benefits form the United States Social Security Act, the Railroad Retirement Act or any other like US or Canadian plan or act.

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.

All Options

Adjustment of Monthly Benefit for Disability Earnings:

We adjust the *monthly benefit* for *disability earnings* as follows.

For each of the first 12 months of payments, following the date you first have *disability earnings,* add your *gross monthly benefit* and your *disability earnings.*

(a) If the sum is not more than 100% of your indexed *insured earnings,* we do not reduce your *monthly benefit.*

(b) If the sum is more than 100% of your indexed *insured earnings,* we reduce your *monthly benefit* by the amount over 100% of your indexed *insured earnings.*

For each month thereafter, we pay the greater of the amount calculated under Method 1 or Method 2.

Method 1:

(a) If your *disability earnings* are less than 20% of your indexed *insured earnings,* we do not reduce your *monthly benefit.*

(b) If your *disability earnings* are 20% or more of your indexed *insured earnings,* we reduce your *monthly benefit* by 50% of your *disability earnings.*

Method 2:

(a) Subtract your *disability earnings* from your indexed *insured earnings.*

(b) Divide the result in (a) above by your indexed *insured earnings.*

(c) Multiply the result in (b) above by your *monthly benefit.* This is the amount we pay.

Maximum Allowable Disability Earnings:

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

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

(b) After this *plan* has paid benefits for 24 months in a row, the limit is 60% of your indexed *insured earnings.*

Indexing: We apply an indexing factor to your *insured earnings* on the date you have received 12 consecutive monthly payments and each anniversary thereafter. 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.*

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 *CPI-W* from the prior December.

Minimum Payment: The minimum monthly payment for *disability* under this *plan* is the larger of: (a) 10% of your *gross monthly benefit;* or (b) $100.00.

Limitations and Exclusions

Disabilities with a Limited Maximum Payment Period

We limit the *maximum payment period,* if you are *disabled* due to: (a) a *mental illness;* (b) *drug addiction;* (c) *alcohol dependence.* However, if you have a coexistent condition, not subject to the limitations in this section, which is *disabling* in and of itself, we will not limit benefits as described below.

The *maximum payment period* for all periods of *disability* due to: (a) a *mental illness;* (b) *drug addiction; or* (c) *alcohol dependence;* is 24 months. This is a combined maximum for all such conditions and all periods of *disability.*

No benefits will be paid for *disability* due to: (a) a *mental illness,* (b) *drug addiction;* or (c) *alcohol dependence;* 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.*

Pre-Existing Conditions

A pre-existing condition is an *injury* or *sickness,* whether diagnosed or misdiagnosed, and any symptoms thereof, for which, in the look back period, you:

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

(b) undergo diagnostic procedures other than routine screening in the absence of symptoms or suspicion of disease process by a *doctor;*

(c) are prescribed or take prescription drugs; or

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

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 pre-existing condition does not include a condition admitted in the application which was not excluded by a signed waiver rider.

No benefits are payable for *disability:* (a) caused by; (b) contributed to by; or (c) resulting from; a pre-existing condition; unless the *disability* starts after the date you are insured under this *plan* for 12 months in a row.

Disability that is: (a) caused by; (b) contributed to by; or (c) resulting from; a pre-existing condition may begin 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. But, 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.*

All Options

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 right after the old plan ends.

The pre-existing condition provision will be waived for any covered person who: (a) is *actively working* on the effective date of this *plan;* and (b) fulfilled the requirements of any pre- existing condition provision of the old plan.

If you: (a) were covered under the old plan when it ended; (b) enroll for insurance under this *plan* on or before this *plan's* effective date; and (c)are *actively working* on the effective date of this *plan;* but (d) have not fulfilled the requirements of any pre-existing condition provision of the old plan; we credit any time used to meet the old plan's pre-existing condition provision toward meeting this *plan's* pre-existing condition provision.

But, we limit your *maximum monthly benefit* under this *plan* if: (a) it is more than the maximum monthly benefit for which you were insured under the old plan; (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 the amount you would have been entitled to under the old plan.

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

All Options

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

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

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

(c) you being engaged in an illegal occupation;

(d) your commission of, or attempt to commit a felony, for which you have been convicted;

(e) you being under the influence of any narcotic; or

(f) intentional self-inflicted injuries.

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

(1) during which you are confined to a facility as a result of your conviction of a felony; or

(2) during which you are receiving medical treatment or care outside the United States or Canada unless expressly authorized by us.

Services

Social Security Assistance: This *plan* requires all *disabled* covered persons to apply for Social Security benefits. (See the "Application for Other Income" section of this *plan.)* If we believe a you to be eligible for such benefits, we may offer to assist you in applying for them. Receiving Social Security benefits will protect your earnings record for retirement and enable you to qualify for Medicare coverage after 24 months.

Services we can provide include:

(a) Help in completing your application for such benefits, and any related forms;

(b) Assistance finding suitable legal counsel; and

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

We may also provide these and other services if your benefits are under review for possible termination by the Social Security Administration.

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: We will review your *disability* to see if certain services are likely to help him or her 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.*

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; and

(f) assistance with family care expenses you incur in order to participate in a *rehabilitation program.* (See the "Dependent Care Expenses" section of this *plan.)*

We have the right to determine which services are appropriate.

If the 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.

Dependent Care Expenses: While you are participating in a *rehabilitation program,* we will pay a dependent care expense benefit, when all of the following conditions are met:

(a) you incur expense to provide care for a qualified dependent;

(b) the care is provided by a licensed provider other than a family member.

A qualified dependent is: (a) dependent upon the covered person for main support and maintenance; and (b) under the age of fourteen and your: (i) biological child; (ii) lawfully adopted child; (iii) stepchild; or (iv) any other child who is living with you in a regular parent-child relationship; or (c) a family member age 14 or over who is physically or mentally incapable of caring for him or herself.

The dependent care expense benefit will be the lesser of: (a) $350 per month per qualified dependent; not to exceed $1,000 per month for all qualified dependents combined; and (b) the actual monthly day care expense incurred by you.

We will stop paying the dependent care expense benefit on the earlier of the date you are no longer: (a) incurring dependent care expenses for a qualified dependent; (b) participating in a *rehabilitation program;* or (c) entitled to receive a *monthly benefit* from this *plan.*

CGP-3-LTD08-MD B383.2107

All Options

Worksite Modification Benefit: In order to accommodate your *disability,* an employer may incur a cost to modify his or her worksite. We may reimburse the employer, up to $2,500 for the cost of the worksite modification. We make this payment if we agree that the modification will enable the covered person to: (a) return to work; or (b) remain at work.

CGP-3-LTD08-MD B383.1238

All Options

Early Intervention Services

This *plan* includes Early Intervention services as part of our disability management program. The intent of these services is to: (a) assist *disabled* persons in reaching better outcomes; and (b) support the *employer's* absence management goals by promoting: stay-at work agendas and return-to work agendas; where possible.

The key to success of an early intervention program is prompt notification of work absences which have the potential to exceed this *plan's elimination period.* With a prompt notification, we are able to more effectively manage the potential claim.

When you are *disabled* from one of the conditions listed below, a long term disability claim form should be completed as soon as possible following the date of *disability.* To facilitate an immediate intervention, the form should be submitted to us within one week of the date your *disability* begins.

- Chronic fatigue conditions, including Epstein-barr syndrome
- *Mental illness*
- Repetitive motion syndromes or injuries
- Fibromyalgia
- Back pain/strain
- Neck pain/strain
- Chronic pain
- Diabetes
- Cardiovascular conditions

Upon receipt of the completed claim form, we will determine whether the claim is appropriate for Early Intervention services. You will be notified of our decision. Examples of services, which we may provide, at our discretion, include, but are not limited to: (a) job accommodation; (b) ergonomic adjustments to workstations; (c) proactive case management consultations with your *doctor* or other providers of medical care.

All Options

The Survivor Benefit

We may pay a survivor benefit if you die after you: (a) had been *disabled* for at least six months in a row ; and (b) were entitled to receive at least one full *monthly benefit.* When we receive proof of your death, we pay your eligible survivor a lump sum benefit.

We pay a benefit equal to 3 times the amount of your last *gross monthly benefit* for a full month after it is reduced by *disability earnings.* but, we first apply such benefit to reduce any overpayment you may owe us.

If you have no eligible survivor, no survivor benefit is paid.

Your eligible survivor is your spouse, if living.

If your spouse is not living, your eligible survivor is your: (a) unmarried child under age 20 ; and (b) unmarried child under age 26 who is enrolled as a full-time student at an accredited school. If there is more than one such child when you die, this benefit will be paid to each child in equal shares.

Accelerated Survivor Benefit

If you have a terminal illness, we may accelerate payment of this *plans'* survivor benefit.

For purposes of the accelerated survivor benefit, a terminal illness means a medical condition that is expected to result in your death within 6 months.

To receive an accelerated survivor benefit, you must: (a) be entitled to receive a *monthly benefit* from this *plan;* (b) request this benefit in writing; and (c) provide written proof of terminal illness from a *doctor.* However, we will not pay an accelerated survivor benefit if there are less than 6 months remaining in the maximum benefit period.

If you elect to receive an accelerated survivor benefit, no survivor benefit is payable upon your death.

CGP-3-LTD08-MD B383.1273

All Options

Income Recovery Benefit

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

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

(a) able to perform each and every duty of your *own occupation;* or

(b) if this *plan* has already paid benefits for the *own occupation* period, able to perform each and every duty of any *gainful occupation;* and

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

(d) unable to earn this *plan's* maximum allowable *disability earnings,* due to the *sickness* or *injury* which caused the prior *disability.*

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 *disability 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.

We stop paying this benefit on the earliest of:

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

(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-LTD08-MD B383.1282

Claim Provisions

Authority We have the sole discretionary authority to: (a) interpret the terms of this *plan;* and (b) determine your eligibility for: (i) coverage; and (ii) benefits under the *plan.* All such determinations are conclusive and binding, except that they may be modified or reversed by a court or regulatory agency with appropriate jurisdiction.

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

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 the *employer,* you, and the *doctor(s)* treating you for your *sickness* or *injury.* Proof of loss must be given to us within the time stated in "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.

Proof of loss, provided at your expense, consists of the following. Failure to provide this information may delay, suspend, reduce or terminate your benefits.

(a) The date *disability* began;

(b) Your last day of *active work;*

(c) The cause of *disability;*

(d) The extent of *disability,* including limitations and restrictions preventing you from performing each and every duty of your *own occupation* and any *gainful occupation;*

(e) If your occupation requires that you carry liability or malpractice insurance, any changes to such insurance that become effective on or after the date of *disability;*

(f) *Objective medical evidence* in support of your limitations and restrictions, beginning with the date *disability* began;

(g) The prognosis of *disability;*

(h) The name and address of all *doctors,* hospitals and health care facilities where you have been treated for your *disability* since the date *disability* began;

(i) Proof that you: (i) are currently; and (ii) have been receiving *regular and appropriate care* from a *doctor,* from the date *disability* began;

(j) Proof of *insured earnings,* and, if applicable, *disability earnings;*

(k) Payroll or absence data from the *employer* for the three months prior to the date *disability* began, or other period we specify;

(l) Proof of application for all other sources of income to which you may be entitled, that may affect your payment from this *plan;* and

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

You must provide *objective medical evidence* from a *doctor* who is not yourself, your spouse, child, parent, sibling or business associate.

Proof of *insured earnings* and *disability earnings* may consist of: (1) copies of your W-2 forms; (2) payroll records from your employer(s); (3) copies of your U.S. Individual Income Tax Returns; (4) copies of the U.S. income tax returns from any business in which you hold an ownership or shareholder interest; (5) a statement from a certified public accountant; (6) copies of any income records accepted or required by the I.R.S; or (7) any other records we deem necessary.

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. 14331
Lexington, KY 40512

Authorization Required

You must provide us with written, unaltered authorizations to obtain medical, financial, vocational, occupational, and governmental information required to determine our liability under this *plan.* You must provide us with such authorizations as often as we may require, in order that they remain current. Failure to provide such authorizations may delay, suspend or terminate your benefits.

Right to Request Medical, Financial or Vocational Assessment

We may ask you to take part in a medical, financial, vocational or other assessment that we feel is necessary to determine whether the terms of the *plan* are met. We may require this as often as we feel is reasonably necessary, during the pendency of a claim. We will pay for all such assessments. But, if you postpone a scheduled assessment without our approval, you will be responsible for any rescheduling fees. If you do not take part in or cooperate with the assessment, we have the right to stop or suspend your payments under this *plan.*

Ongoing Proof of Loss

To continue to receive payments from this *plan,* you must give us current proof of loss as often as we may reasonably require. Ongoing proof of loss must be provided to us within 90 days of the date we request it. Failure to give such notice within such time will not invalidate or reduce a claim if it was not reasonably possible for you to submit proof within the required time, if proof is furnished as soon as reasonably possible.

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. Benefits are paid in US dollars.

We pay benefits once each month at the end of the period for which they are payable, and any balance remaining unpaid at the termination of the period will be paid as soon as reasonably possible after receipt of proof. The first payment period begins on the day after the *elimination period* is completed.

No benefits are payable for this *plan's elimination period.*

Benefits to which you are entitled may remain unpaid at your death. If any benefit is payable to your estate, or to a minor who is not otherwise competent to give a valid release, we pay the benefit, up to an amount not exceeding $5,000, to any relative by blood or connection by marriage who is considered by us to be entitled to the benefit.

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.

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.

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. If the Department of Labor stops publishing the *CPI-W,* we have the right to use some other similar standard.

All Options

Disability or Disabled These terms mean that, due to *sickness* or *injury,* you are:

(1) During the *elimination period* and the *own occupation* period, not able to perform, on a full-time basis, each and every duty of your *own occupation.*

(2) After the end of the *own occupation* period, not able to perform, on a full-time basis, each and every duty of any *gainful work.* You are not *disabled* if you earn more than this *plan's* maximum allowed *disability earnings.*

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.

Neither: (a) loss of a professional or occupational license; or (b) receipt of or entitlement to Social Security disability benefits; in and of themselves constitute *disability* under this *plan.*

All Options

Disability Earnings The monthly income you earn from working while *disabled.* It includes salaries, wages, commissions, bonuses and any other compensation earned or accrued while working including pension, profit sharing contributions, sick pay, paid time off, holiday and vacation pay. When you have an ownership interest in the business, *disability earnings* also includes business profits, attributable to you, whether received or not. It includes any income you earn while *disabled* and return to your *employer,* partnership, or any other similar business arrangement to cover any business or overhead expenses. If you have the ability to work on a *part-time* or full-time basis, following the earlier of the date you: (a) have been terminated from employment with the *employer;* (b) have been *disabled* for 12 months in a row; or (c) have been offered a job or workplace modification by the *employer* and you do not return to work; *disability earnings* also includes *maximum capacity earnings.*

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.

Drug Addiction A style of living characterized by compulsive use and overwhelming involvement with a drug. It may occur in the absence of physical dependence.

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 work earning more than 80% of your *insured earnings* will not count toward the *elimination period.*

We do not require you to complete an elimination period if: (a) you were covered under a similar income replacement plan the plan sponsor had with another insurer on the day before this plan starts; (b) your disability would have been a recurring disability under the prior plan had it remained in effect.

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

Gainful Occupation or Gainful Work Work in which you are able to perform each and every duty of any business or occupation for which you reasonably fitted by: (a) education; (b) training; and (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 integrated with other income and earnings.

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. If disability is due to an accident that occurred before you were insured by this plan; or disability begins more than 90 days after the date of the injury, that disability will be treated as disability due to sickness.

All Options

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

Your *gross monthly benefit* may be limited due to proof of insurability requirements. In this case, only the part of your *insured earnings* that applies to the amount of your limited *gross monthly benefit* is used to calculate premiums due under this *plan.* We calculate benefit amounts and limits based on the amount of your *insured earnings* as of the Redetermination date immediately prior to the start of your *disability.* See the "Redetermination" and "Proof of Insurability" sections of this *plan.*

For Partners and S Corporation Shareholders:

Insured earnings means the sum of the amounts listed below, divided by 12.

(a) Your compensation as an employee or S Corporation shareholder, as reported on your Federal Income Tax Return, Form 1040, for the prior calendar year, less the gross total of unadjusted employee business expenses as included on the corresponding Schedule A-Itemized Deductions;

(b) Your non-passive income (loss) from trade or business as reported on Schedule E-Part II of your Federal Income Tax Return, Form 1040, for the prior calendar year, less any expenses incurred and reported elsewhere on your Return; and

(c) Your contributions during the prior calendar year, deposited into a: (a) cash or deferred compensation plan, or salary reduction plan, qualified under IRC Section: 401(k); 403(b); 457; or similar plan; and (b) elective employee pre-tax deferrals to a Section 125 plan or flexible spending account.

You may not have been a partner or S Corporation shareholder for the entire previous calendar year. In this case, your earnings are based on the monthly average of the sum of the listed amounts, averaged for the full number of months that you were a partner or an S Corporation shareholder during such calendar year.

For Sole Proprietors:

Insured earnings means: (a) the average monthly net profit as determined from Schedule C - Part II of your Federal Income Tax Returns, Form 1040, for the prior calendar year; plus (b) your average monthly contribution during the prior calendar year deposited into a: (i) cash or deferred compensation plan, or salary reduction plan, qualified under IRC Section: 401(k); 403(b); 457; or similar plan; and (ii) a Section 125 plan or flexible spending account. Monthly net profit is calculated as gross income less total expenses. You may not have been a sole proprietor for the previous calendar year. In this case, we calculate average monthly net profit and average monthly contributions using the full number of months that you were a sole proprietor during such calendar year.

For Covered Persons Who Are Compensated on Less Than a 12 Month Basis:

Insured earnings means your average rate of monthly earnings determined from your annual contract salary. Insured earnings also includes your contributions deposited into a: (a) cash or deferred compensation plan, or salary reduction plan, qualified under IRC Section: 401(k); 403(b); 457; or similar plan; and (b) elective employee pre-tax deferrals to a Section 125 plan or flexible spending account. Insured earnings does not include bonuses, commissions, overtime pay, expense accounts, stock options and any other extra compensation. We do not include pay for hours worked or billed over 40 per week. Earnings based on excluded income and employer contributions deposited into such 401(k); 403(b); 457; or similar plan are excluded.

For Covered Persons Whose Income Is Reported on a IRS Form 1099:

Insured earnings means your average rate of monthly earnings as figured from the 1099 form received from the employer for the prior calendar year, calculated as (a) minus (b), divided by 12 or the number of months you worked for the employer during such calendar year, if less than 12.

(a) your earned income as reported on the 1099 form.

(b) business expenses, as reported on Schedule C - Part II of your Federal Income Tax Return, Form 1040. Insured earnings also includes your contributions deposited into a: (a) cash or deferred compensation plan, or salary reduction plan, qualified under IRC Section: 401(k); 403(b); 457; or similar plan; and (b) elective employee pre-tax deferrals to a Section 125 plan or flexible spending account.

Earnings based on excluded income and employer contributions deposited into such 401(k); 403(b); 457; or similar plan are excluded.

For All Other Covered Persons:

Insured earnings means your base monthly salary. Insured earnings also includes your contributions deposited into a: (a) cash or deferred compensation plan, or salary reduction plan, qualified under IRC Section: 401(k); 403(b); 457; or similar plan; and (b) elective employee pre-tax deferrals to a Section 125 plan or flexible spending account. Insured earnings does not include bonuses, commissions, overtime pay, expense accounts, stock options and any other extra compensation. We do not include pay for hours worked or billed over 40 per week. Earnings based on excluded income and employer contributions deposited into such 401(k); 403(b); 457; or similar plan are excluded.

All Options

Maximum Capacity Earnings During the *own occupation* period, the income you could earn if working to the fullest extent you are able to in your *own occupation.* After the own occupation period, the income you could earn if working to the fullest extent you are able to in any *gainful occupation.* We decide the fullest extent of work you are able to do based on objective data provided by any or all of the following sources: (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 Illness Means any mental disorder, regardless of cause, listed in the Diagnostic and Statistical Manual of Mental Disorders (DSM) currently in use by the American Psychiatric Association (APA). If the APA stops publishing the DSM, we have the right to use some other similar standard. A mental illness may be: (a) caused by; (b) contributed to by; or (c) result in; physical, biological or chemical factors or symptoms. For purposes of this plan, mental illness does not include: (a) irreversible dementia caused by Alzheimer's disease, stroke, trauma or viral infection; or (b) any other condition not typically treated by a psychiatrist, clinical psychologist or other qualified mental health practitioner with psychotherapy or psychotropic drugs.

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 *disability earnings.*

Objective Medical Evidence May include but is not limited to: (a) diagnostic testing; (b) laboratory reports; and (c) medical records of a *doctor's* exam documenting: (i) clinical signs; (ii) presence of symptoms; and (iii) test results consistent with generally accepted medical standards supported by nationally recognized authorities in the health care field.

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.*

Own Occupation Employment that involves material duties of the same general character as your regular and ordinary employment with your *employer.* Your *own occupation* is not limited to your own job with the *employer.*

All Options

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 The Guardian group plan purchased by the *employer.*

Plan Sponsor The *employer* to whom this *plan* is issued.

Reasonable Accommodation Any modification or adjustment to: (i) a job; (ii) an employment practice; (iii) a work process; or (iv) the work place; that an employer willingly provides. 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.

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 and Appropriate Care Means, with respect to your: (a) disabling condition; and (b) any other condition which, if left untreated, would adversely affect your disabling condition; you(i) visit a *doctor* as frequently as medically required, according to generally accepted medical standards, to effectively manage these conditions; and (ii) are receiving the most appropriate treatment, according to generally accepted medical standards, designed to achieve maximum medical improvement in these conditions. Treatment must be provided by a *doctor* (s) whose specialty is most appropriate for your: (a) *disability;* and (b) any other conditions which left untreated would adversely affect your disabling condition; according to generally accepted medical standards. Generally accepted medical standards are those 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 Institute; the National Institutes of Health; the Department of Health and Human Services; and any other agency of similar repute.

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; (f) 401(k), 403(b), 457 or similar plans; or (g) 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.

CERTIFICATE AMENDMENT

(To be attached to certificates issued to employees)

Effective February 1, 2012 or your first renewal thereafter, this rider amends the Claim Provisions of your certificate by replacing the Authority provision with the following:

Administration: We as a part of our routine operations apply the terms of this plan for making decisions. This includes making a reasonable determination regarding eligibility; receipt of benefits and claims; or explaining our administrative policies; procedures; and processes.

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

Matthew Darula, Head of Product, Strategy and Offerings

CGP-3-A-LTD-DC-11 B531.0084

CERTIFICATE AMENDMENT

(To be attached to certificates issued to employees)

The certificate is amended as follows:

1. The Long Term Disability Income Insurance eligibility provisions are modified to provide that:

    a. You are eligible for disability income insurance coverage if you are legally working in the United States or working outside of the United States for a United States based employer in a country or region approved by us.

    b. Any requirements that apply to your working outside of the United States on a temporary assignment are hereby deleted.

    c. Your disability income insurance coverage will end on the date you are no longer working in the United States, or working outside of the United States for a United States based employer in a country or region approved by us.

2. The "When Payments End" section under the Long Term Disability Income Insurance provisions is modified to provide that your benefits will end on the date you have been outside of the United States; and/or Canada; or a country or region approved by us for more than 2 months in a 12 month period.

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

Matthew Darula, Head of Product, Strategy and Offerings

All Options

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

All Options

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

All Options

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.

All Options

Dependent Coverage

CGP-3-DEP-90-1.0 B473.0009

All Options

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

All Options

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

All Options

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

All Options

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

All Options

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

All Options

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	$150.00
Accident Follow-Up Visit - Doctor	$25 up to 6 treatments
Accidental Death	Employee: $10,000.00 Spouse: $5,000.00 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: $10,000.00 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	$500.00
Ambulance	$100.00
Appliance	$100.00
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
Coma	$7,500.00
Concussions	$50.00
Dislocations	Closed/Open
Hip	$1,800.00/$3,600.00
Knee	$900.00/$1,800.00
Shoulder	$270.00/$540.00
Collar bone (sternoclavicular)	$450.00/$900.00
Collar bone (acromioclavicular and separation)	$90.00/$180.00
Ankle or foot	$720.00/$1,440.00
Lower jaw	$270.00/$540.00
Wrist or elbow	$270.00/$540.00
Toe or finger	$90.00/$180.00
Bones of the hand	$270.00/$540.00
Diagnostic Exam (Major)	$100.00
Emergency Dental Work	Crown: $200.00 Extraction: $50.00
Epidural Anesthesia Pain Management	$100.00
Eye Injury	$200.00
Family Care	$20.00 per day
Fracture	Closed/Open
Skull (depressed)	$2,250.00/$4,500.00
Skull (non-depressed)	$900.00/$1,800.00

Hip, Thigh (femur)	$1,350.00/$2,700.00
Vertebrae, body of (excluding vertebrae processes)	$675.00/$1,350.00
Pelvis	$675.00/$1,350.00
Leg	$675.00/$1,350.00
Bones of the face or nose	$315.00/$630.00
Upper jaw, maxilla	$315.00/$630.00
Upper arm (humerous)	$315.00/$630.00
Lower jaw, mandible	$270.00/$540.00
Shoulder blade	$270.00/$540.00
Vertebral process	$270.00/$540.00
Forearm	$270.00/$540.00
Kneecap	$270.00/$540.00
Foot (except toes)	$270.00/$540.00
Ankle	$270.00/$540.00
Rib	$225.00/$450.00
Coccyx	$180.00/$360.00
Finger, toe	$90.00/$180.00
Hospital Admission	$750.00
Hospital Confinement	$175.00 per day
Hospital ICU Admission	$1,500.00
Hospital ICU Confinement	$350.00 per day
Initial Physician's office/Urgent care facility treatment	$50.00
Knee Cartilage	$500.00
Joint Replacement	Hip: $1,500.00 Knee: $750.00 Shoulder: $750.00
Laceration	No sutures required: $20.00 Lacerations less than 5 cm: $40.00 Lacerations at least 5 cm but less than 15 cm: $150.00 Lacerations at least 15 cm or more: $300.00
Lodging	$100.00 per day
Occupational or Physical Therapy	$25 per day
Prosthetic Device/Artificial Limb	1: $500.00 2 or more: $1,000.00
Reasonable Accomodation 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:	$1,000.00 Hernia $125.00
Surgery - Exploratory or Arthroscopic		$150.00
Tendon/Ligament/Rotator Cuff		1: $250.00 2 or more: $500.00
Transportation		$400.00
Wellness Benefit		$50.00 per year
X - Ray		$20.00

ACCIDENT COVERAGE

Subject to all of this *plan's* terms, this *plan* will pay the benefits described in the certificate 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 in the certificate.

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-MD B476.3219

All Options

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. 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 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 *injury* must cause *you* and *your* spouse's death within 90 days of the *covered accident.* 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 $10,000.00 for all losses due to the same *covered accident.* The injury must cause his or her death within 90 days fo the *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. The *injury* must cause his or her death within 90 days of the *covered accident. 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 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.

CGP-3-AC-BEN-12-MD B476.3220

All Options

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.

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.* If coverage under this *plan* ends, Emergency Dental Work, resulting from a *covered accident* may extend up to 90 days from the date coverage under this *plan* ends, if the services commenced prior to the termination date.

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.*

All Options

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 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.*

All Options

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.* Proof of loss should be sent within 90 days from the date of the loss.

This should be sent to *us* as soon as possible. Failure to provide proof of loss within the required time will not invalidate for reduce the claim if:

a. The proof is provided as soon as reasonably possible and;

b. Except in the absence of legal capacity of the claimant, not later than 1 year from the time proof is otherwise required.

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-MD B476.3227

All Options

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.
- For an Accidental Death and Dismemberment *injury,* the *covered person's* loss sustained or contracted in consequence of being 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.
- For an Accidental Death and Dismemberment *injury,* the *covered person's* commission of, or attempt to commit a felony, for which they have been convicted.
- 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.
- Injuries to a dependent child received during birth.

CGP-3-AC-EXC-12-MD B476.4091

All Options

Limitations

Pre-Existing Condition

A pre-existing condition is an accident that occurs before a person becomes covered by this *plan.*

Subject to all the terms of each benefit provision, this *plan* will pay benefits for an injury or loss caused by, or resulting from, a pre-existing condition only after the *covered person* has been insured under this *plan* for 12 consecutive months.

A pre-existing condition does not include an accident admitted in the application which was not excluded by a signed waiver rider attached to the contract.

GP-1-AC-LIMIT-12-MD B476.4089

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.

Covered Accident This term means an *accident* that:

- Occurs while *your* coverage or *your* dependent's coverage under this policy is in effect, or meets the terms of the Pre-Existing Conditions limitation as defined under this *plan.*
- 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,* or has met the terms of the Pre-Existing Conditions limitation as defined 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.*

CERTIFICATE AMENDATORY RIDER - Telemed

This Rider amends the Policy as follows and is effective on the Policy Date. If this Rider is added after the Policy Date, the Rider becomes effective on its issue date.

This Rider amends the Certificate by replacing the **Accident Follow-Up Visit - Doctor** provision as shown below.

Accident Follow-Up Visit - Doctor: *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. This follow-up treatment includes *telemedicine services. 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.

This Rider also amends the Certificate with the addition of the following definition:

Telemedicine Services: A medical inquiry with a *doctor* via the use of telecommunication and information technologies (including, but not limited to, audio or video communications) for the *covered person's* evaluation, diagnosis, or treatment as would be practiced in person. This does not include requests for prescription refills, test results or medical records.

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

The Guardian Life Insurance Company of America

Matthew Darula, Head of Product, Strategy and Offerings

B476.4099

All Options

ELIGIBILITY FOR DENTAL COVERAGE

B489.0002

All Options

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 consider you to be a late entrant.

If you initially waived dental coverage under this *plan* because you were covered under another group *plan,* and you now elect to enroll in the dental coverage under this *plan,* the Penalty for Late Entrants provision will not apply to you with regard to dental coverage provided your coverage under the other *plan* ends 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 the dental coverage under this *plan* within 30 days of the date that any of the events described above occur.

CGP-3-EC-90-1.0 B489.0122

All Options

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 the date your insurance is scheduled to start, 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. For example, the scheduled effective date may fall on a holiday, a day of the week when you're not normally at work, during your vacation, or on a day when you'd normally be at work, but are excused for the day by your employer for reasons other than sickness or injury. In such a case, your coverage will start on the scheduled effective 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 B489.0069

All Options

When Your Coverage Ends

Your coverage ends on the date your active *full-time* service ends for any reason, other than disability. Such reasons include 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.

CGP-3-EC-90-3.0 B489.0087

All Options

Dependent Coverage

B200.0271

All Options

Eligible Dependents For Dependent Dental Benefits

Your *eligible dependents* are: (a) your legal spouse; (b) your dependent children who are under age 26.

Your "dependent children" include your grandchildren who are in your legal custody.

CGP-3-DEP-90-2.0 B489.0590

All Options

Adopted Children And Step-Children

Your "dependent children" include your legally adopted children and, 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.

CGP-3-DEP-90-3.0 B489.0463

All Options

Handicapped Children

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

The child will stay eligible as long as he or she stays unmarried and unable to support himself or herself, if: (a) his or her conditions started before he or she reached this coverage's age limit; (b) he or she became insured by this coverage 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. With respect to a grandchild, the grandchild must also remain your dependent and in your court-ordered custody in order to stay eligible.

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 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 B449.0043

All Options

Waiver Of Dental Late Entrants Penalty

If you initially waived dental coverage for your spouse or eligible dependent children under this plan because they were covered under another group plan, and you now elect to enroll them in the dental coverage under this plan, the Penalty for Late Entrants provision will not apply to them with regard to dental coverage provided their coverage under the other plan ends due to one of the following events: (a) termination of 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 your spouse or eligible dependent children in the dental coverage under this plan within 30 days of the date that any of the events described above occur.

In addition, the Penalty for Late Entrants provision for dental coverage will not apply to your spouse or eligible dependent children if: (a) you are under legal obligation to provide dental coverage due to a court-order; and (b) you enroll them in the dental coverage under this plan within 30 days of the issuance of the court-order.

CGP-3-DEP-90-5.0 B200.0749

All Options

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 date you become insured for employee coverage.

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

Once you have dependent coverage for your initial *dependents,* you must notify us when you acquire any new dependents, other than a newborn child, and agree to make any additional payments required for their coverage. See the "Newborn Children" provision to find out when you must notify us of a newborn child.

If you do this within 31 days of the date the newly *acquired dependent* becomes eligible, the dependent's coverage, other than that of a newborn child, will start on the date the dependent first becomes eligible. If you fail to notify us on time, the newly *acquired dependent,* when enrolled, is a late entrant and is subject to any applicable late entrant penalties. The late entrant's coverage is scheduled to start on the date you sign the enrollment form.

CGP-3-DEP-90-6.0 B489.0257

All Options

Exception

If a dependent, other than a newborn child, is confined to a *hospital* or other health care facility 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.

CGP-3-DEP-90-7.0 B200.0694

All Options

Newborn Children

We cover your newborn child for dependent benefits, from the moment of birth if you are already covered for dependent child coverage when the child is born. If the newborn is your first eligible dependent or you are only covered for dependent spouse coverage when the child is born, we cover the child for the first 31 days from the moment of birth. To continue the child's coverage past the 31 days, you must enroll the child and agree to make any required premium payments within 31 days of the date the child is born. If you fail to do this, the child's coverage will end at the end of the 31 days, and once the child is enrolled, the child is a late entrant, is subject to any applicable late entrant penalties, and will be covered as of the date you sign the enrollment form.

We also cover your newborn grandchild for dependent benefits from the moment of birth, if the child is a dependent of and in the court-ordered custody of you.

CGP-3-DEP-90-8.0 B489.0013

All Options

When Dependent Coverage Ends

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

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

Dependent coverage also ends for all of 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 all or 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 or her stops being an *eligible dependent.* This happens to a child, step-child or grandchild at 12:01 a.m. on the date he or she attains this coverage's age limit. A grandchild's coverage also ends when he or she is no longer a dependent of and in the court-ordered custody of you. And a spouse's coverage ends when a marriage ends in legal divorce or annulment.

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

CGP-3-DEP-90-9.0 B489.0597

CERTIFICATE AMENDMENT

This rider amends the "Dependent Coverage" provisions as follows:

An employee's domestic partner, of the same or opposite sex, will be eligible for dental coverage under this plan. Coverage will be provided subject to all the terms of this plan and to the following limitations:

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

- be 18 years of age or older;
- not be related to each other by blood or marriage within four degrees of consanguinity under civil law rule;
- not be married or in a civil union or domestic partnership with another individual;
- have been financially interdependent for at least six consecutive months prior to application in which each individual contributes to some extent to the other individual's maintenance and support with the intention of remaining in the relationship indefinitely. Financial interdependence must be demonstrated by at least one of the following:
    a. joint bank account or credit account;
    b. designation of one of the domestic partners as a primary beneficiary in the other's life insurance policy or retirement plan;
    c. designation of one of the domestic partners as a primary beneficiary in the other's will;
    d. granting each other durable powers of attorney;
    e. granting each other health care powers of attorney;
    f. joint ownership of holding of investments; or
    g. joint ownership or lease of a motor vehicle.
- share a common primary residence. Proof of a common primary residence must be demonstrated by at least one of the following:
    i. common ownership of the primary residence as evidenced by a joint deed or mortgage agreement;
    ii. common leasehold interest in the primary residence;
    iii. a driver's license or state issued identification listing a common address; or
    iv. utility or other household bill with both the name of the insured and the name of the domestic partner appearing.

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

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

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

The domestic partner and his or her covered dependent children will not be eligible for continuation of dental coverage as explained under the "Federal Continuation Rights" section of this plan, unless the employee is also eligible for and elects continuation.

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

Matthew Darula, Head of Product, Strategy and Offerings

CGP-3-A-DMST-MD-08 B489.0263

All Options

DENTAL HIGHLIGHTS

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

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

  For Group I Services . . . . . None
  For Group II and III Services $50.00
  for each covered person

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

  For Group I Services . . . . . None
  For Group II and III Services $50.00
  for each covered person

CGP-3-DENT-HL-90 B497.0070

All Options

- **Payment Rates for Services Furnished by a Preferred Provider:**

  For Group I Services 100%
  For Group II Services 80%
  For Group III Services 50%
  For Group IV Services 50%

- **Payment Rates for Services Not Furnished by a Preferred Provider:**

  For Group I Services 100%
  For Group II Services 50%
  For Group III Services 25%
  For Group IV Services 50%

CGP-3-DENT-HL-90 B497.0089

All Options

- **Benefit Year Payment Limit for Non-Orthodontic Services**

  For Group I, II and III Services . . . . . Up to $1,500.00

- **Lifetime Payment Limit for Orthodontic Treatment**

  For Group IV Services . . . . . Up to $1,000.00

Note: A covered person may be eligible for a rollover of a portion of his or her unused Benefit Year Payment Limit for Non-Orthodontic Services. See "Rollover of Benefit Year Payment Limit for Non-Orthodontic Services" for details.

CGP-3-DENT-HL-90 B497.1432

All Options

DentalGuard Preferred Plus

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

CGP-3-DENT-HL-90 B497.2458

All Options

Group Enrollment Period

A group enrollment period is held each year. The group enrollment period is a time period agreed to by your employer and us. During this period, you may elect to enroll in dental insurance under this *plan.* Coverage starts on the first day of the month that next follows the date of enrollment. You and your *eligible dependents* are not subject to late entrant penalties if you enroll during the group enrollment period.

CGP-3-DENT-HLTS B497.2407

All Options

DENTAL EXPENSE INSURANCE

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

CGP-3-DG2000 B498.0007

All Options

DentalGuard Preferred - This Plan's Dental Preferred Provider Organization

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

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

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

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

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

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

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

CGP-3-DGY2K-PPO B498.0151

Covered Charges

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

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

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

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

We only pay benefits for covered charges incurred by a *covered person* while he or she is insured by this *plan.* A covered charge for a crown, bridge or cast restoration is incurred on the date the tooth is initially prepared. A covered charge for any other *dental prosthesis* is incurred on the date the first master impression is made. A covered charge for root canal treatment is incurred on the date the pulp chamber is opened. A covered charge for *orthodontic treatment* is incurred on the date the *active orthodontic appliance* is first placed. All other covered charges are incurred on the date the services are furnished. If a service is started while a *covered person* is insured, *we'll* only cover charges as explained in "Extended Dental Expense Benefits".

Appeals Process for Adverse Decisions or Grievance Decisions

All grievances regarding dental care service adverse decisions will be handled by Guardian as explained below.

For dental care services under review, the adverse decision will be made by a licensed dentist, or a panel of other appropriate dental care service reviewers with at least one licensed dentist on the panel.

For any dental care service being reviewed by a panel of appropriate health care service reviewers, there will be at least one physician or dentist on the panel who did not render the adverse decision.

Definitions: "Adverse decision" means a utilization review determination by a private review agent or Guardian that:

a. a proposed or delivered dental care service which would otherwise be covered under the covered person's contract is not or was not medically necessary, appropriate, or efficient; and

b. may result in non-coverage of the dental care service.

"Complaint" means a protest filed with the Insurance Commissioner involving an adverse decision or grievance decision concerning a covered person.

"Emergency case" means a case that qualifies for an expedited review because:

a. an adverse decision has been made for dental care services that are proposed but have not been delivered; and

b. the services are necessary to treat a condition or illness that, without immediate medical attention, would

i. seriously jeopardize the life or health of the covered person or his or her ability to regain maximum function; or

ii. cause the covered person to be a danger to himself or herself or to others.

"Filing date" means the earlier of:

a. 5 days after the date of mailing; or

b. the date of receipt.

"Grievance" means a protest filed by a covered person, a covered person's repres or dental care provider with Guardian under its internal grievance process regarding an adverse decision concerning the covered person.

"Grievance decision" means a final determination by Guardian that arises from a grievance filed with Guardian under its internal grievance process regarding an adverse decision concerning the covered person.

"Dental care provider" means:

a. an individual who is licensed under the Health Occupations Article to provide dental care services in the ordinary course of business or practice of a profession and is a treating provider of the covered person; or

b. a hospital, as defined in Section 919-301 of the Health-General Article; and

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

"Dental care service" means a dental care procedure or service rendered by a dental care provider that:

a. provides testing, diagnosis, or treatment of a human disease or dysfunction; or

b. dispenses drugs, medical devices, medical appliances, or medical goods for the treatment of a human disease or dysfunction.

c. provides any other care, service, or treatment of disease or injury, the correction of defects, or the maintenance of the physical and mental well-being of a covered person.

"Representative" means a person who has been authorized by the covered person to file a grievance or a complaint on his or her behalf.

Notice of Adverse Decision

Except in emergency cases as described below, written notice of Guardian's or a private review agent's adverse decision will be sent to the covered person or a covered person's representative and a dental care provider within 5 working days after the adverse decision has been orally communicated to the covered person, a covered person's representative and a dental care provider. Notice of the adverse decision will:

a. state the specific factual bases for the decision, in clear, understandable language;

b. state the specific criteria and standards, including interpretive guidelines, on which the adverse decision was based and will not solely use generalized terms such as "experimental procedure not covered", "cosmetic procedure not covered", "service included under another procedure", or "not medically necessary";

c. include the name, address and telephone number of the Guardian representative who has responsibility for the internal grievance process;

d. include a copy of Guardian's internal grievance process and procedures;

e. state that the covered person, a covered person's representative or a dental care provider has the right to file a complaint with the Insurance Commissioner within 30 working days after receipt of a grievance decision;

f. provide the name, address, phone and fax number for the covered person or a covered person's representative to contact and file a complaint with the Insurance Commissioner;

g. state that a complaint may be filed without first filing a grievance if the covered person, a covered person's representative or a dental care provider can demonstrate a compelling reason to do so as determined by the Insurance Commissioner.

h. provide a disclosure that the Health Advocacy Unit of Maryland's Consumer Protection division is available to assist the covered person or a covered person's representative with mediating and filing a grievance under Guardian's internal grievance process. This Unit may be reached as shown below.

i. provide a disclosure that the Health Advocacy Unit is available to assist the covered person or covered person's representative in filing a complaint with the commissioner. Such statement shall include the name, address, telephone number, facsimile number and electronic mail address of the Health Advocacy Unit. This Unit may be reached as shown below.

Health Education and Advocacy Unit
Consumer Protection Division
Office of the Attorney General
200 St. Paul Place, 16th Floor
Baltimore MD 21202
Phone: 410-528-1840 or toll free 1-877-261-8807
Fax: 410-576-6571
Email: heau@oag.state.md.us

j. provide a disclosure indicating that when filing a complaint with the Commissioner the covered person or covered person's representative will be required to authorize the release of any medical records of the covered person that may be required to be reviewed for the purpose of reaching a decision on the complaint.

All Options

Appeals Process for Adverse Decisions or Grievance Decisions

Adverse Decision Grievance Procedures: The following procedures are available to a covered person or dental care provider:

If a covered person, a covered person's representative or a dental care provider does not agree with an adverse decision, the covered person, a covered person's representative or a dental care provider may submit a grievance under Guardian's Standard Grievance Procedures as explained below.

If qualified, a covered person, a covered person's representative or a dental care provider may submit a grievance under Guardian's Expedited Grievance Procedures as explained below.

Standard Grievance Procedures: The covered person, a covered person's representative or a dental care provider must file a grievance in writing concerning an adverse decision. The grievance must be filed within 180 days of the date of receipt of an adverse decision for services not yet rendered and for retrospective denials.

The covered person or dental care provider may submit any documentation to support a grievance that the parties believe is relevant. However, the grievance should contain sufficient detail to identify the nature of the problem.

The grievance should be sent to:

Kristi Cronkhite, Manager
Group Quality Assurance
Guardian
P.O. Box 981573
El Paso, TX 79998-1573
Phone: 800-541-7846
Fax: 509-468-6399

The written grievance will be referred to a Health or Dental Review Specialist. In resolving the grievance, best efforts are made to obtain all relevant information, including clinical records.

Additional information should be sent to:

Kristi Cronkhite, Manager
Group Quality Assurance
Guardian
P.O. Box 981573
El Paso, TX 79998-1573
Phone: 800-541-7846
Fax: 509-468-6399

A grievance decision will be sent in writing to all parties within forty-five (45) days after the filing date of a grievance concerning services not yet rendered, or within forty-five (45) days after the filing date of the grievance concerning services which have already been rendered.

In cases where a resolution is not possible within 45 days, a letter will be sent to the covered person or covered person's representative explaining the reason for the delay. Written consent will be obtained from the covered person, a covered person's representative or a dental care provider for an extension of not longer than an additional 30 working days.

After oral communication of the decision to the covered person, a covered person's representative or a dental care provider, the Health or Dental Review Specialist will send written notice of the grievance decision to the covered person, a covered person's representative or a dental care provider within five (5) working days after the grievance decision is made. The notice will include:

a. a detailed explanation stated in clear, understandable language of the specific factual bases for the decision, including the specific criteria and standards, including interpretive guidelines, on which the decision was based and will not solely use generalized terms such as "experimental procedure not covered', "cosmetic procedure not covered", "service included under another procedure", or "not medically necessary";

b. a statement advising that the covered person, a covered person's representative or a dental care provider may file a complaint with the Insurance Commissioner within 30 days after receipt of the grievance decision.

c. the Insurance Commissioner may be reached at:

Maryland Insurance Administration
Appeal and Grievance Unit
200 St. Paul Place, Suite 2700
Baltimore MD 21202
Phone: 410-468-2000 or toll free 1-800-492-6116
Fax: 410-468-2270

d. a disclosure that assistance is available through the Health Advocacy Unit of Maryland's Consumer Protection Division if the covered person or covered person's representative wish to dispute the decision of the plan.

Expedited Grievance Procedure:

The covered person, a covered person's representative or a dental care provider may file a grievance in writing or orally upon receipt of an adverse decision in an emergency case.

The grievance should be sent to the Guardian representative who is responsible for Guardian's internal grievance procedures:

a. by telephone or sent by facsimile to the numbers provided in the notice of adverse decision; and

b. must include a telephone number where the covered Person, a covered person's representative or a dental care provider may be reached.

The grievance will be referred to a Health or Dental Review Specialist. In resolving the grievance, best efforts will be made to obtain all relevant information, including clinical records.

Guardian will orally communicate the grievance decision to the covered person, a covered person's representative or a dental care provider within 24 hours of receipt of the grievance.

Within 1 day after oral communication has been made, written notice of the adverse decision or grievance decision will be sent to the covered person, a covered person's representative or a dental care provider. The notice will include:

a. the specific factual bases for the decision, stated in detail in clear, understandable language.

b. the specific criteria and standards, including interpretive guidelines, on which the adverse decision or grievance decision was based and may not solely use generalized terms such as "experimental procedure not covered", "cosmetic procedure not covered", "service included under another procedure", or "not medically necessary".

c. the name, address and telephone number of the Guardian representative who has responsibility for the internal grievance process.

d. a statement advising that the covered person, a covered person's representative or a dental care provider may file a complaint with the Insurance Commissioner if a grievance decision was not received within 24 hours after filing the grievance pursuant to Guardian's internal grievance process.

e. the address and phone and facsimile numbers where the Insurance Commissioner may be reached.

f. a disclosure that assistance is available through the Health Advocacy Unit of Maryland's Consumer Protection Division if the covered person or a covered person's representative wish to dispute the decision of the plan.

Insurance Commissioner Complaints: A covered person, a covered person's representative or a dental care provider may file a complaint directly with the Insurance Commissioner within 4 months of receipt of a grievance decision. A complaint may also be filed:

a. prior to completion of the grievance process if the complaint demonstrates that a delay in medical treatment could result in:

   i. loss of life;

   ii. serious impairment to a bodily function;

   iii. serious dysfunction of a bodily organ.

   iv. the covered person remaining seriously ill with symptoms that cause him or her to be a danger to himself or herself or others.

b. if the covered person, a covered person's representative or a dental care provider does not receive a grievance decision:

   i. on or before the 45th day after the filing date of a grievance concerning services not yet rendered, or;

   ii. on or before the 45th day after the filing date of a grievance concerning services which have already been rendered.

   iii. for emergency cases, within 24 hours after filing the grievance.

c. if Guardian waives the requirement that the internal process be exhausted before filing a complaint with the Commissioner.

d. if Guardian fails to comply with any of the requirements of Guardian's internal grievance process as described in these provisions.

The Commissioner may be reached at:

Maryland Insurance Administration
Appeal and Grievance Unit
200 St. Paul Place, Suite 2700
Baltimore MD 21202-2272
Phone: 410-468-2000 or toll free: 1-800-492-6116
Fax: 410-468-2270

The Insurance Commissioner will inform Guardian of receipt of a complaint within 5 working days after the complaint is filed.

The Insurance Commissioner will notify all parties in writing of the final decision regarding the complaint.

Regarding such final decision:

- Guardian may not request a hearing, but may file a petition for judicial review; and
- A covered person or covered person's representative may file a petition for judicial review, and unless prohibited by federal law, may request a hearing.

CGP-3-GRV-MD-1-11 B497.2467

All Options

Alternate Treatment

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

Proof Of Claim

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

CGP-3-DGY2K-AT B498.0002

All Options

Pre-Treatment Review

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

A treatment plan should always be sent to us before orthodontic treatment starts.

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

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

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

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

CGP-3-DGY2K-PTR B498.0003

All Options

Benefits From Other Sources

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

CGP-3-DGY2K-OS B498.0005

The Benefit Provision - Qualifying For Benefits

Penalty For Late Entrants

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

- All Group II Services.

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

- All Group III Services; and
- All Group IV Services.

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

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

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

CGP-3-DGY2K-LE-MD B498.1998

All Options

How We Pay Benefits For Group I, II And III Non-Orthodontic Services

There is no deductible for Group I services. *We* pay for Group I covered charges at the applicable *payment rate.*

A *benefit year* deductible of $50.00 applies to Group II and III services provided by a *preferred provider.* A *benefit year* deductible of $50.00 applies to Group II and III services provided by a *non-preferred provider.* Each *covered person* must have covered charges from these service groups which exceed each applicable deductible before *we* pay him or her any benefits for such charges. These charges must be incurred while the *covered person* is insured.

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

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

CGP-3-DGY2K-BP B498.0177

All Options

All covered charges must be incurred while insured. And we limit what we pay each benefit year to $1,500.00.

CGP-3-DGY2K-BP B498.0192

All Options

The Benefit Provision - Qualifying For Benefits

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

CGP-3-DG-ROLL-04-2.1 B498.2041

All Options

Rollover of Benefit Year Payment Limit for Group I, II and III Non-Orthodontic Services

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

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

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

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

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

- *Rollover Threshold* $700.00
- *Reward* $350.00
- *Bank Maximum* $1,250.00

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

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

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

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

Definitions of terms used in this provision:

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

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

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

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

CGP-3-DG-ROLL-04-2 B498.9149

All Options

How We Pay Benefits For Group IV Orthodontic Services

This *plan* provides benefits for Group IV orthodontic services only for covered dependent children who are less than 19 years old when the *active orthodontic appliance* is first placed.

We pay for Group IV covered charges at the applicable *payment rate.* There may be different *payment rates* which apply to covered charges for services from a *preferred provider* and a *non-preferred provider.*

Using the *covered person's* original treatment *plan, we* calculate the total benefit *we* will pay. *We* divide the benefit into equal payments, which *we* will spread out over the shorter of: (a) the proposed length of treatment; or (b) two years.

We make the initial payment when the *active orthodontic appliance* is first placed. *We* make further payments at the end of each subsequent three month period, upon receipt of verification of ongoing treatment. But, treatment must continue and the *covered person* must remain covered by this *plan. We* limit what *we* pay for orthodontic services to the lifetime payment of $1,000.00. What *we* pay is based on all of the terms of this *plan.*

We don't pay for orthodontic charges incurred by a *covered person* prior to being covered by this *plan. We* limit what *we* pay for *orthodontic treatment* started prior to a *covered person* being covered by this *plan* to charges determined to be incurred by the *covered person* while covered by this *plan.* Based on the original treatment *plan, we* determine the portion of charges incurred by the *covered person* prior to being covered by this *plan,* and deduct them from the total charges. What *we* pay is based on the remaining charges. *We* limit what *we* consider of the proposed treatment *plan* to the shorter of the proposed length of treatment, or two years from the date the *orthodontic treatment* started.

The benefits *we* pay for *orthodontic treatment* won't be charged against a *covered person's benefit year* payment limits that apply to all other services.

The negotiated discounted fees for orthodontics performed by a *preferred provider* include: (a) treatment *plan* and records, including initial, interim and final records; (b) orthodontic retention, including any and all necessary fixed and removable *appliances* and related visits; and (c) limited, interceptive and comprehensive *orthodontic treatment,* with associated: (i) fabrication and insertion of any and all fixed *appliances;* and (ii) periodic visits.

There is a separate negotiated discounted fee for *orthodontic treatment* which extends beyond 24 consecutive months.

The negotiated discounted fee for orthodontics performed by a *preferred provider* does not include: (a) any incremental charges for orthodontic *appliances* made with clear, ceramic, white lingual brackets or other optional material; (b) procedures, *appliances* or devices to correct harmful habits; (c) retreatment of orthodontic cases, or changes in *orthodontic treatment* necessitated by any kind of accident; (d) replacement or repair of orthodontic *appliances* damaged due to the neglect of the patient; (e) orthognathic surgery and associated incremental charges; (f) extractions performed solely to facilitate *orthodontic treatment;* and (g) *orthodontic treatment* started before the member was eligible for orthodontic benefits under this *plan.*

Whether or not a charge is based on a discounted fee, it will be counted toward a *covered person's* orthodontic lifetime payment limit under this *plan.*

All Options

Non-Orthodontic Family Deductible Limit

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

CGP-3-DGY2K-FL B498.0073

All Options

Payment Rates

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

- Benefits for Group I Services performed by a *preferred provider* 100%
- Benefits for Group I Services performed by a *non-preferred provider* 100%
- Benefits for Group II Services performed by a *preferred provider* 80%
- Benefits for Group II Services performed by a *non-preferred provider* 50%
- Benefits for Group III Services performed by a *preferred provider* 50%
- Benefits for Group III Services performed by a *non-preferred provider* 25%
- Benefits for Group IV Services performed by a *preferred provider* 50%
- Benefits for Group IV Services performed by a *non-preferred provider* 50%

CGP-3-DGY2K-PR B498.0080

All Options

After This Insurance Ends

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

We pay benefits for *orthodontic treatment* to the end of the month in which the *covered person's* insurance ends.

CGP-3-DGY2K-END-MD-02 B498.1597

All Options

Extended Dental Expense Benefits

If a *covered person's* insurance ends, we extend dental expense benefits for that *covered person* under this *plan* as explained below.

We only extend benefits for covered charges for dental procedures, if the procedure: (a) is begun before the *covered person's* insurance ends; and (b) requires two or more visits on separate days to a *dentist's* office.

With respect to *non-orthodontic* procedures, benefits will be paid until the earlier of: (a) when all work is completed; or (b) 90 days after the date the *covered person's* insurance ends.

With respect to *orthodontic* procedures, benefits will be paid for work which is: (a) performed within 60 days of the date the *covered person's* insurance ends, if the orthodontist has agreed to or is receiving monthly payments for his services at the time coverage ends; or (b) performed by the end of the quarter in progress or within 60 days of the date the *covered person's* insurance ends, whichever is longer, if the orthodontist has agreed to accept or is receiving payments on a quarterly basis.

We don't grant an extension if the *covered person's* insurance ended because he failed to make required payments.

CGP-3-DGY2K-EXT-MD B498.1600

All Options

Special Limitations

Teeth Lost, Extracted Or Missing Before A *Covered Person* Becomes Covered By This *Plan*

A *covered person* may have one or more congenitally missing teeth or may have had one or more teeth lost or extracted before he or she became covered by this *plan.* For the first twelve months that a *covered person* is covered by this *plan,* we won't pay for a *dental prosthesis* which replaces such teeth unless the *dental prosthesis* also replaces one or more eligible natural teeth lost or extracted after the *covered person* became covered by this *plan.*

CGP-3-DGY2K-TL-MD B498.1601

All Options

If This Plan Replaces The Prior Plan

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

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

All Options

Exclusions

We will not pay for:

- Any service or supply which is not specifically listed in this *plan's* List of Covered Dental Services.
- Any procedure performed in conjunction with, as part of, or related to a procedure which is not covered by this *plan.*
- Educational services, including, but not limited to, oral hygiene instruction, plaque control, tobacco counseling or diet instruction.
- Precision attachments and the replacement of part of a precision attachment, magnetic retention or overdenture attachments.
- Overdentures and related services, including root canal therapy on teeth supporting an overdenture.
- Any restoration, procedure, *appliance* or *prosthetic device* used solely to: (1) alter vertical dimension; (2) restore or maintain occlusion, except to the extent that this *plan* covers *orthodontic treatment;* (3) treat a condition necessitated by attrition or abrasion; or (4) splint or stabilize teeth for periodontal reasons.
- The use of general anesthesia, intramuscular sedation, intravenous sedation, non-intravenous sedation or inhalation sedation, including but not limited to nitrous oxide, except when administered in conjunction with covered periodontal surgery, surgical extractions, the surgical removal of impacted teeth, apicoectomies, root amputations and services listed under the "Other Oral Surgical Procedures" section of this *plan.*

- The use of local anesthetic.
- Cephalometric radiographs, oral/facial images, including traditional photographs and images obtained by intraoral camera, except when performed as part of the *orthodontic treatment* plan and records for a covered course of *orthodontic treatment.*
- Replacement of a lost, missing or stolen *appliance* or *dental prosthesis* or the fabrication of a spare *appliance* or *dental prosthesis.*
- Prescription medication.
- Desensitizing medicaments and desensitizing resins for cervical and/or root surface.
- Duplication of radiographs, the completion of claim forms, OSHA or other infection control charges.
- Pulp vitality tests or caries susceptibility tests.
- Bite registration or bite analysis.
- Gingival curettage.
- The localized delivery of chemotherapeutic agents.
- Tooth transplants.
- Maxillofacial prosthetics that repair or replace facial and skeletal anomalies, maxillofacial surgery, orthognathic surgery or any oral surgery requiring the setting of a fracture or dislocation.
- Temporary or provisional *dental prosthesis* or *appliances* except interim partial dentures/stayplates to replace anterior teeth extracted while insured under this *plan.*
- Any service furnished solely for cosmetic reasons. This includes, but is not limited to: (1) characterization and personalization of a *dental prosthesis;* (2) facings on a *dental prosthesis* for any teeth posterior to the second bicuspid; (3) bleaching of discolored teeth; and (4) odontoplasty.
- Replacing an existing *appliance* or *dental prosthesis* with a like or unlike *appliance* or *dental prosthesis;* unless (1) it is at least 5 years old and is no longer usable; or (2) it is damaged while in the *covered person's* mouth in an *injury* suffered while insured, and can't be made serviceable.
- A fixed bridge replacing the extracted portion of a hemisected tooth or the placement of more than one unit of crown and/or bridge per tooth.
- The replacement of extracted or missing third molars/wisdom teeth.
- Treatment of congenital or developmental malformations, or the replacement of congenitally missing teeth.
- Any endodontic, periodontal, crown or bridge abutment procedure or *appliance* performed for a tooth or teeth with a guarded, questionable or poor prognosis.

- Any procedure or treatment method which does not meet professionally recognized standards of dental practice or which is considered to be experimental in nature.
- Any procedure, *appliance, dental prosthesis,* modality or surgical procedure intended to treat or diagnose disturbances of the temporomandibular joint (TMJ).
- Treatment needed due to: (1) an on-the-job or job-related *injury;* or (2) a condition for which benefits are payable by Worker's Compensation or similar laws.
- Treatment for which no charge is made. This usually means treatment furnished by: (1) the *covered person's* employer, labor union or similar group, in its dental or medical department or clinic; (2) a facility owned or run by any governmental body; and (3) any public program, except Medicaid, paid for or sponsored by any governmental body. If a charge is made and we are legally required to pay it, we will pay it.
- Evaluations and consultations for non-covered services; detailed and extensive oral evaluations covered under a group medical plan.
- The repair of an orthodontic appliance.
- The replacement of a lost or broken orthodontic retainer.
- Any service provided as a result of a prohibited referral, as determined by Section 1-302 of the Health Occupations Article.

CGP-3-DGY2K-EXCH-MD-01 B498.2365

All Options

List of Covered Dental Services

The services covered by this *plan* are named in this list. Each service on this list has been placed in one of four groups. A separate payment rate applies to each group. Group I is made up of preventive services. Group II is made up of basic services. Group III is made up of major services. Group IV is made up of orthodontic services.

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

CGP-3-DNTL-90-13 B490.0048

All Options

Group I - Preventive Dental Services
(Non-Orthodontic)

Prophylaxis And Fluorides

Prophylaxis - limited to a total of 2 prophylaxis or periodontal maintenance procedures (considered under "Periodontal Services") in a calendar year. Allowance includes scaling and polishing procedures to remove coronal plaque, calculus, and stains. "Also see Basic Periodontal Services."

- Adult prophylaxis covered age 12 and older.

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

Fluoride treatment, topical application - limited to *covered persons* under age 19 and limited to 2 treatment(s) in a calendar year.

Office Visits, Evaluations And Examination

Office visits, oral evaluations, examinations or limited problem focused re-evaluations - limited to a total of 2 in a calendar year.

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

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

CGP-3-DNTL-90-14 B498.9014

All Options

Radiographs

Allowance includes evaluation and diagnosis. Also see BASIC DENTAL SERVICES, Radiographs.

- Bitewing films - limited to either a maximum of 4 bitewing films or a set (7-8 films) of vertical bitewings, in one visit, once in a calendar year.

CGP-3-DNTL-90-14 B498.8738

All Options

Dental Sealants

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

CGP-3-DNTL-90-14 B498.0166

Group II - Basic Dental Services
(Non-Orthodontic)

Diagnostic Services Allowance includes examination and diagnosis.

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

Diagnostic Services: Allowance includes examination and diagnosis.

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

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

Adjunctive pre-diagnostic test that aids in detection of mucosal abnormalities including premalignant and malignant lesions, not to include cytology or biopsy procedures - limited to one test in any 24 consecutive month period for covered persons age 40 and older.

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

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

Resin restorations - limited to *anterior teeth* only. Coverage for resins on *posterior teeth* is limited to the corresponding amalgam benefit. Allowance includes light curing, acid etching, adhesives, including resin bonding agents and local anesthetic.

Silicate cement, per restoration
Composite resin

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

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

All Options

Crown And Prosthodontic Restorative Services

Also see the "Major Restorative Services" section.

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

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

Inlay or onlay
Crown
Bridge

Adding teeth to partial dentures to replace extracted natural teeth

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

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

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

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

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

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

CGP-3-DNTL-90-15 B498.1122

All Options

Periodontal Services

Periodontal maintenance procedure - limited to 4 periodontal maintenance procedure(s) in a calendar year, to a maximum of 4 total prophylaxis and periodontal maintenance cleanings. Allowance includes periodontal pocket charting, scaling and polishing. (Also see Prophylaxis under "Preventive Services")

CGP-3-DNTL-90-15.0 B498.8806

All Options

Space Maintainers

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

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

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

Fixed And Removable Appliances

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

CGP-3-1- B498.0236

All Options

Radiographs

Allowance includes evaluation and diagnosis. Also see PREVENTIVE DENTAL SERVICES, Radiographs
Full mouth, complete series or panoramic radiograph - Either, but not both, of the following procedures, limited to one in any 36 consecutive month period.

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

Other diagnostic radiographs:

- Intraoral periapical or occlusal films - single films

CGP-3-DNTL-90-15.0 B498.2043

All Options

Non-Surgical Extractions

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

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

CGP-3-DNTL-90-15.0 B498.0204

All Options

Other Services

Injectable antibiotics needed solely for treatment of a dental condition.

CGP-3-DNTL-90-15 B498.0224

Group III - Major Dental Services
(Non-Orthodontic)

Major Restorative Services

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

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

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

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

Implant supported prosthetics - Allowance includes the treatment plan and local anesthetic, when done in conjunction with a covered surgical placement of an implant, on the same tooth.
- Abutment supported crown
- Implant supported crown
- Abutment supported retainer for fixed partial denture
- Implant supported retainer for fixed partial denture
- Implant/abutment supported removable denture for completely edentulous arch
- Implant/abutment supported removable denture for partially edentulous arch
- Implant/abutment supported fixed denture for completely edentulous arch
- Implant/abutment supported fixed denture for partially edentulous arch
- Dental implant supported connecting bar
- Prefabricated abutment
- Custom abutment

Implant services - Allowance includes the treatment plan, local anesthetic and post-surgical care. Limited to the replacement of permanent teeth only. The number of implants we cover is limited to the number of teeth extracted while insured under this plan.

Surgical placement of implant body, endosteal implant
Surgical placement, eposteal implant
Surgical placement transosteal implant

Other Implant services

Bone replacement graft for ridge preservation, per site, when done in conjunction with a covered surgical placement of an implant in the same site, limited to once per tooth, per lifetime
Radiographic/surgical implant index - limited to once per arch in any 24 month period
Repair implant supported prosthesis
Repair implant abutment
Implant removal

All Options

Prosthodontic Services

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

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

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

Bridge Pontics
Resin with metal
Porcelain
Porcelain with metal
Full cast metal

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

Complete or Immediate dentures, upper or lower

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

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

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

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

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

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

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

Simple stress breakers, per unit

All Options

Endodontic Services

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

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

Vital pulpotomy, only when root canal therapy is not the definitive treatment

Gross pulpal debridement

Pulpal therapy, limited to primary teeth only coinsurance

Root Canal Treatment
- Root canal therapy
- Root canal retreatment, limited to once per tooth, per lifetime
- Treatment of root canal obstruction, no-surgical access
- Incomplete endodontic therapy, inoperable or fractured tooth
- Internal root repair of perforation defects

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

All Options

Periodontal Services

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

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

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

Periodontal Surgery

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

The following treatment is limited to a total of one of the following, once per tooth in any 12 consecutive months.
- Gingivectomy, per tooth (less than 3 teeth)
- Crown lengthening - hard tissue

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

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

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

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

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

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

Periodontal surgery related

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

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

All Options

Surgical Extractions

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

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

Other Oral Surgical Procedures

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

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

CGP-3-DNTL-90-16 B498.1125

All Options

General Anesthesia

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

CGP-3-DNTL-90-16 B498.0225

All Options

Group IV - Orthodontic Services

Orthodontic Services

Any covered Group I, II or III service in connection with *orthodontic treatment.*

Transseptal fiberotomy

Surgical exposure of impacted or unerupted teeth in connection with *orthodontic treatment* - Allowance includes treatment and final radiographs, local anesthetics and post-surgical care.

Treatment *plan* and records, including initial, interim and final records.

Limited *orthodontic treatment,* Interceptive *orthodontic treatment* or Comprehensive *orthodontic treatment,* including fabrication and insertion of any and all fixed *appliances* and periodic visits.

Orthodontic retention, including any and all necessary fixed and removable *appliances* and related visits - limited to initial *appliance(s)* only.

CGP-3-DNTL-90-8 B498.0071

All Options

ELIGIBILITY FOR VISION CARE EXPENSE COVERAGE

B505.0152

All Options

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 July 1st to July 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

All Options

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. For example, the scheduled effective date may fall on a holiday, a day of the week when you're not normally at work, during your vacation, or on a day when you'd normally be at work, but are excused for the day by your *employer* for reasons other than sickness or injury. In such a case, your coverage will start on the scheduled effective 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 B505.1679

All Options

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

All Options

Dependent Vision Care Expense Coverage

CGP-3-DEP-90-1.0 B505.0099

All Options

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 they reach age 26, who are enrolled as full-time students at accredited schools.

An unmarried dependent child who is enrolled as a student less than full-time may be an *eligible dependent* if he or she: (a) is enrolled less than full-time as a result of a documented disability that prevents the student from maintaining a full-time course load; and (b) is maintaining a course load of at least 7 credit hours per semester. You must provide verification of the disability from: (a) a disability services professional employed by the institution of higher education that the student attends; or (b) a health care provider with special expertise in and knowledge of the disability.

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.*

Your "unmarried dependent children" include:

(1) your grandchildren who are in your court-ordered custody.

(2) your legally adopted children. We treat a child as legally adopted from the earlier of: (a) the date of a judicial decree of adoption; or (b) the assumption of custody. We treat such a child this way whether or not a final adoption order is ever issued.

(3) minors in your custody as a result of a guardianship, other than a temporary guardianship of less than 12 months duration, granted by court or testamentary appointment. We treat a child as a dependent as of the date of the court order or testamentary appointment.

In any case, the children must reside with you and depend on you for most of their support and maintenance.

CGP-3-DEP-10-2.0-MD B505.1450

All Options

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 earlier of: (a) the date of a judicial decree of adoption; or (b) the assumption of custody. 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.

Dependent Vision Enrollment Requirement

An employee may add his or her "legal spouse" to this plan at any time if:

(1) The "legal spouse" losses coverage under another group health insurance contract or policy because of involuntary termination of the spouse's employment other than for cause; and

(2) The employee notifies us of the termination of the spouse's coverage within 6 months of the event.

An employee may add his or her "unmarried dependent children" at any time if:

(1) The "unmarried dependent children" were previously covered under the policy or contract of the employee's legal spouse; and

(2) The employee's legal spouse has died.

CGP-3-DEP-10-3.0-MD B505.1451

All Options

Incapacitated Children

You may have an unmarried child or grandchild or a person under guardianship with a mental or physical incapacity, or developmental disability, who can't support himself or herself. Subject to all of the terms of this coverage and the plan, such a child may stay eligible for dependent benefits past this coverage's age limit.

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

- The grandchild must remain your dependent and in your court-ordered custody; and
- A person under guardianship must remain your dependent and in your court-ordered custody as a result of a guardianship, other than a temporary guardianship of less than 12 months duration, granted by court or testamentary appointment.

But, for the child to stay eligible, you must send us written proof that the child is incapacitated and depends on you for most of his or her 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.

All Options

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.

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

If an employee who is eligible for dependent coverage is required under a QMCSO to provide health insurance coverage for a child:

(1) *We* shall allow the insuring parent to enroll in dependent coverage and include the child in that coverage regardless of enrollment period restrictions.

(2) If the insuring parent is enrolled in health insurance coverage but does not include the child in the enrollment, *we* shall:

(i) allow the non-insuring parent, child support enforcement agency, or Department of Health and Mental Hygiene to apply for enrollment on behalf of the child.

(ii) include the child in the coverage regardless of enrollment period restrictions.

(3) *We* may not terminate health insurance coverage for the child unless written evidence is provided to us that:

(i) the order is no longer in effect.

(ii) the child has been or will be enrolled under other reasonable health insurance coverage that will take effect on or before the effective date of the termination.

(iii) the employer has eliminated dependent coverage for all of its employees.

(iv) the employer no longer employs the insuring parent, except that if the parent is eligible for and elects to exercise the provisions of the federal Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), coverage shall be provided for the child consistent with the employer's plan for postemployment health insurance coverage for dependents.

If the employee's health insurance plan requires that the employee be enrolled in order for the child to be enrolled and the employee is not currently enrolled, *we* shall enroll both the employee and the child, without regard to enrollment period restrictions, within 20 business days after receipt of a medical support notice from an employer.

If a child is eligible for enrollment, *we* shall complete the enrollment without regard to enrollment period restrictions, within 20 business days after receipt of a medical support notice from an employer.

CGP-3-DEP-10-4.1-MD B505.1453

All Options

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,* 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 within 31 days of your *eligibility date,* date, your dependent coverage is scheduled to start on 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 B505.0714

All Options

Exception If a dependent is confined to a hospital or other health care facility on the date his or her dependent benefits would otherwise start, we will postpone the effective date of such benefits until the day after his or her discharge from such facility.

This does not apply to a newborn child or a child covered under a Qualified Medical Child Support Order.

CGP-3-DEP-10-7.0-MD B505.1454

All Options

Newborn Children We cover your newborn child for dependent vision care benefits, from the moment of his or her birth.

Your "newborn child" includes:

(1) your newly born or newly adopted dependent grandchild who is in your court-ordered custody, from the moment of birth or the date of adoption of the grandchild.

(2) your newly born or newly legally adopted dependent child. We treat a child as legally adopted from the earlier of: (a) the date of a judicial decree of adoption; or (b) the assumption of custody. We treat such a child this way whether or not a final adoption order is ever issued.

(3) a minor in your custody as a result of a guardianship, granted by court or testamentary appointment. We treat a child as a dependent as of the date of the court order or testamentary appointment.

In any case, the child must reside with you and depend on you for most of his or her support and maintenance.

CGP-3-DEP-10-8.0-MD B505.1464

All Options

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, step-child or grandchild at 12:01 a.m. on the date he attains this *plan's* age limit or when he marries. A step-child's coverage also ends when he is no longer dependent on the *employee* for support and maintenance. A grandchild's coverage also ends when he is no longer a dependent of and in the court-ordered custody of the *employee.* And a spouse's coverage ends 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 B505.0140

CERTIFICATE AMENDMENT

This rider amends the "Dependent Coverage" provisions as follows:

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

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

- be 18 years of age or older;
- not be related to each other by blood or marriage within four degrees of consanguinity under civil law rule;
- not be married or in a civil union or domestic partnership with another individual;
- have been financially interdependent for at least six consecutive months prior to application in which each individual contributes to some extent to the other individual's maintenance and support with the intention of remaining in the relationship indefinitely. Financial interdependence must be demonstrated by at least one of the following:
    a. joint bank account or credit account;
    b. designation of one of the domestic partners as a primary beneficiary in the other's life insurance policy or retirement plan;
    c. designation of one of the domestic partners as a primary beneficiary in the other's will;
    d. granting each other durable powers of attorney;
    e. granting each other health care powers of attorney;
    f. joint ownership of holding of investments; or
    g. joint ownership or lease of a motor vehicle.
- share a common primary residence. Proof of a common primary residence must be demonstrated by at least one of the following:
    i. common ownership of the primary residence as evidenced by a joint deed or mortgage agreement;
    ii. common leasehold interest in the primary residence;
    iii. a driver's license or state issued identification listing a common address; or
    iv. utility or other household bill with both the name of the insured and the name of the domestic partner appearing.

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

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

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

The domestic partner and his or her covered dependent children will not be eligible for continuation of vision coverage as explained under the "Federal Continuation Rights" section of this plan, unless the employee is also eligible for and elects continuation.

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

Matthew Darula, Head of Product, Strategy and Offerings

CGP-3-A-DMST-MD-08 B505.0720

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	$10.00
	Standard Frames	$25.00
	Standard Lenses	$25.00
	Necessary Contact Lenses	$25.00
Non-PPO Cash Deductibles	Examinations	$10.00
	Standard Frames	$25.00
	Standard Single Vision Lenses	$25.00
	Standard Bifocal Lenses	$25.00
	Standard Trifocal Lenses	$25.00
	Lenticular Lenses	$25.00
	Necessary Contact Lenses	$25.00
Payment Rates	For Other Covered Charges	100%

CGP-3-VSN-96-BEN3 B505.0231

VISION CARE BENEFITS

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

CGP-3-VSN-96-VIS B505.0233

All Options

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

Vision Service Plan

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

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

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

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

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

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

Choice of Preferred Providers

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

Replacement of Preferred Provider

If a *Preferred Provider* terminates his or her relationship with VSP for any reason, and the *Covered Person* has already started treatment with or ordered glasses or contact lenses from such provider, VSP will be responsible for furnishing vision services to *Covered Persons* either through that provider as if the provider had not terminated; or through another VSP *Preferred Provider* until such treatment is completed or such glasses or contact lenses are received. The *Covered Person's* benefits will be provided at the *Preferred Provider* levels.

Pre-Authorization of Preferred Provider Services

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

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

CGP-3-VSN-96-PPOA-MD B505.0235

All Options

Pre-Treatment Review for Necessary Contact Lenses

Subject to prior approval by VSP Consultants, we will pay benefits for Necessary Contact Lenses provided to a *Covered Person.* A *Covered Person's* doctor must request approval for Necessary Contact Lenses from VSP.

When VSP Consultants receive the request and all required information, they will evaluate the necessity of the Necessary Contact Lenses within 2 business days. If additional information is needed to make a determination, VSP will notify the doctor within 3 calendar days after the initial request. VSP will notify the *Covered Person's* doctor, by phone, of the outcome of the review. They will confirm the outcome of the review in writing. If the review confirms the necessity of the Necessary Contact Lenses, we pay benefits for the Necessary Contact Lenses, subject to all of the terms of this *plan.* If the review does not confirm the medical necessity of the Necessary Contact Lenses, VSP will notify the *Covered Person* and his or her doctor, in writing, within 5 working days after the oral communication. In this case, we pay no benefits for the Necessary Contact Lenses, subject to the *Covered Person's* right to appeal the decision as described in the "Grievance Process". If the *Covered Person's* doctor believes that the adverse determination warrants an immediate reconsideration, VSP Consultants may provide the *Covered Person's* doctor the opportunity to speak with the physician that rendered the determination, by telephone on an expedited basis, within a period of time not to exceed 24 hours of the *Covered Person's* doctor seeking the reconsideration.

No benefits will be paid for Necessary Contact Lenses if prior approval is not received from VSP. We will not retroactively deny approval of pre-authorized services.

CGP-3-VSN-96-PTR2-MD B505.0237

Appeals Process for Adverse Decisions or Grievance Decisions

Definitions

"Adverse decision" means a utilization review determination by a private review agent or Guardian that:

a) a proposed or delivered vision care service which would otherwise be covered under the *covered person's* contract is not or was not medically necessary, appropriate, or efficient; and

b) may result in non-coverage of the vision care service.

"Complaint" means a protest filed with the Insurance Commissioner involving an adverse decision or grievance decision concerning a *covered person.*

"Emergency case" means a case that qualifies for an expedited review because:

a) an adverse decision has been made for vision care services that are proposed but have not been delivered; and

b) the services are necessary to treat a condition or illness that, without immediate medical attention, would seriously jeopardize the life or health of the *covered person* or his or her ability to regain maximum function.

"Filing date" means the earlier of:

a) 5 days after the date of mailing; or

b) the date of receipt.

"Grievance" means a protest filed by a *covered person* or vision care provider with Guardian under its internal grievance process regarding an adverse decision concerning the *covered person.*

"Grievance decision" means a final determination by Guardian that arises from a grievance filed with Guardian under its internal grievance process regarding an adverse decision concerning the *covered person.*

"Vision care provider" means:

a) an individual who is licensed under the Health Occupations Article to provide vision care services in the ordinary course of business or practice of a profession and is a treating provider of the *covered person;* or

b) a hospital, as defined in 919-301 of the Health-General Article; and

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

"Vision care service" means a vision or medical care procedure or service rendered by a vision care provider that:

a) provides testing, diagnosis, or treatment of a human disease or dysfunction; or

b) dispenses drugs, medical devices, medical appliances, or medical goods for the treatment of a human disease or dysfunction.

Notice of Adverse Decision

Except in emergency cases as described below, written notice of Guardian's or a private review agent's adverse decision will be sent to the *covered person* and vision care provider within 5 working days after the adverse decision has been orally communicated to the *covered person* and vision care provider.

Notice of the adverse decision will:

- state the specific factual bases for the decision, in clear, understandable language;
- state the specific criteria and standards, including interpretive guidelines, on which the adverse decision was based and will not solely use generalized terms such as "experimental procedure not covered", "cosmetic procedure not covered", "service included under another procedure", or "not medically necessary";
- include the name, address and telephone number of the Guardian representative who has responsibility for the internal grievance process;

For Vision Claims

Vision Service Plan, Inc.
Attn: Precious James
3333 Quality Drive
Rancho Cordova, CA 95670
1-877-814-8970 or 1-800-877-7195
Fax: 1-916-851-5131

- include a copy of Guardian's internal grievance process and procedures;
- state that the *covered person* or vision care provider has the right to file a complaint with the Insurance Commissioner 30 working days after receipt of a grievance decision;
- provide the name, address, phone and fax number for the *covered person* to contact and file a complaint with the Insurance Commissioner;
- state that a complaint may be filed without first filing a grievance if the *covered person* or vision care provider can demonstrate a compelling reason to do so as determined by the Insurance Commissioner.
- provide a disclosure that the Health Advocacy Unit of Maryland's Consumer Protection division is available to assist the *covered person* with both mediating and filing a grievance under Guardian's internal grievance process. This Unit may be reached at:

Health Education and Advocacy Unit
Consumer Protection Division
Office of the Attorney General
200 St. Paul Place, 16th Floor
Baltimore MD 21202
Phone: 410-528-1840 or toll free 1-877-261-8807
Fax: 410-576-6571
Email: heau@oag.state.md.us

Adverse Decision Grievance Procedures

The following procedures are available to a *covered person* or vision care provider:

If a *covered person* or vision care provider does not agree with an adverse decision, the *covered person* or vision care provider may submit a grievance under Guardian's Standard Grievance Procedures as explained below.

If qualified, a *covered person* or vision care provider may submit a grievance under Guardian's Expedited Grievance Procedures as explained below.

CGP-3-VSN-96-GRV-MD-2 B505.0238

All Options

Standard Grievance Procedures

The *covered person* or vision care provider must file a grievance in writing concerning an adverse decision. For retrospective denials, the grievance must be filed within 180 days of the date of receipt of an adverse decision.

The *covered person* or vision care provider may submit any documentation to support a grievance that the parties believe is relevant. However, the grievance should contain sufficient detail to identify the nature of the problem.

The grievance should be sent to:

For Vision Claims

Vision Service Plan, Inc.
Attn: Precious James
3333 Quality Drive
Rancho Cordova, CA 95670
1-877-814-8970 or 1-800-877-7195
Fax: 1-916-851-5131

The written grievance will be referred to a Vision Review Specialist. In resolving the grievance, best efforts are made to obtain all relevant information, including clinical records.

If required, the *covered person* or vision care provider will be notified within five (5) working days of the filing date that review of the grievance may not proceed unless certain additional information is provided. Guardian will assist the *covered person* or vision care provider in gathering the necessary information without further delay.

Additional information should be sent to:

For Vision Claims

Vision Service Plan, Inc.
Attn: Precious James
3333 Quality Drive
Rancho Cordova, CA 95670
1-877-814-8970 or 1-800-877-7195
Fax: 1-916-851-5131

A grievance decision will be sent in writing to all parties within thirty (30) working days after the filing date of a grievance concerning services not yet rendered, or within forty-five (45) working days after the filing date of the grievance concerning services which have already been rendered.

In cases where a resolution is not possible within 30 or 45 working days, a letter will be sent to the *covered person* explaining the reason for the delay. Written consent will be obtained from the *covered person* or vision care provider for an extension of not longer than an additional 30 working days.

After oral communication of the decision to the *covered person* or vision care provider, the Vision Review Specialist will send written notice of the grievance decision to the *covered person* or vision care provider within five (5) working days after the grievance decision is made. The notice will include:

a) a detailed explanation stated in clear, understandable language of the specific factual bases for the decision, including the specific criteria and standards, including interpretive guidelines, on which the decision was based and will not solely use generalized terms such as "experimental procedure not covered", "cosmetic procedure not covered", "service included under another procedure", or "not medically necessary";

b) a statement advising that the *covered person* or vision care provider may file a complaint with the Insurance Commissioner within 30 working days after receipt of the grievance decision.

c) the Insurance Commissioner may be reached at:

Maryland Insurance Administration
Appeal and Grievance Unit
525 St. Paul Place
Baltimore MD 21202-2272
Phone: 410-468-2000 or toll free 1-800-492-6116
Fax: 410-468-2270

d) a disclosure that assistance is available through the Health Advocacy Unit of Maryland's Consumer Protection Division if the *covered person* wishes to dispute the decision of the *plan.*

Expedited Grievance Procedure

The *covered person* or vision care provider may file a grievance in writing or orally upon receipt of an adverse decision in an emergency case.

The grievance should be sent to:

For Vision Claims
Vision Service Plan, Inc.
Attn: Precious James
3333 Quality Drive
Rancho Cordova, CA 95670
1-877-814-8970 or 1-800-877-7195
Fax: 1-916-851-5131

and must include a telephone number where the *covered person* or vision care provider may be reached.

The grievance will be referred to a Vision Review Specialist. In resolving the grievance, best efforts will be made to obtain all relevant information, including clinical records.

Guardian will orally communicate the grievance decision to the *covered person* or vision care provider within 24 hours of receipt of the grievance.

Within 1 day after oral communication has been made, written notice of the adverse decision or grievance decision will be sent to the *covered person* or vision care provider. The notice will include:

a) the specific factual bases for the decision, stated in detail in clear, understandable language.

b) the specific criteria and standards, including interpretive guidelines, on which the adverse decision or grievance decision was based and may not solely use generalized terms such as "experimental procedure not covered", "cosmetic procedure not covered", "service included under another procedure", or "not medically necessary".

c) the name, address and telephone number of the Guardian representative who has responsibility for the internal grievance process.

d) a statement advising that the *covered person* or vision care provider may file a complaint with the Insurance Commissioner if a grievance decision was not received within 24 hours after filing the grievance pursuant to Guardian's internal grievance process.

e) the address and phone and facsimile numbers where the Insurance Commissioner may be reached.

f) a disclosure that assistance is available through the Health Advocacy Unit of Maryland's Consumer Protection Division if the *covered person* wishes to dispute the decision of the *plan.*

Insurance Commissioner Complaints

A *covered person* or a vision care provider: may file a complaint directly with the Insurance Commissioner within 30 working days of receipt of a grievance decision. A complaint may also be filed:

- Prior to completion of the grievance process if the complaint demonstrates that a delay in medical treatment could result in:

  a) loss of life;

  b) serious impairment to a bodily function;

  c) serious dysfunction of a bodily organ.

- If the *covered person* or vision care provider does not receive a grievance decision:

  a) on or before the 30th working day after the filing date of a grievance concerning services not yet rendered, or;

  b) on or before the 45th working day after the filing date of a grievance concerning services which have already been rendered.

The Commissioner may be reached at:

Maryland Insurance Administration
Appeal and Grievance Unit
525 St. Paul Place
Baltimore MD 21202-2272
Phone: 410-468-2000 or toll free 1-800-492-6116
Fax: 410-468-2270

The Insurance Commissioner will inform Guardian of receipt of a complaint within 5 working days after the complaint is filed.

The Insurance Commissioner will notify all parties in writing of the final decision regarding the complaint.

All Options

How This Plan Works

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

Services or Supplies From a Preferred Provider

If a *covered person* uses the services of a *preferred provider,* the *preferred provider* must receive approval from VSP prior to providing the *covered person* with any service or supply. See the "Pre-Authorization of Preferred Provider Services" section of this *plan* for specific requirements.

Copayments The *covered person* must pay a *copayment* when he or she receives services from a *preferred provider.* We pay benefits for the covered charges a *covered person* incurs in excess of the *copayment.* This *plan's copayments* are as follows:

For each vision examination from a *preferred provider* $10.00

For each pair of *standard frames* and/or
standard lenses from a *preferred provider* $25.00

For Necessary Contact Lenses from a *preferred provider* $25.00

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

Services or Supplies From a Preferred Provider (Cont.)

Payment Rates Once a *covered person* has paid any applicable *copayment,* we pay benefits for covered charges under this *plan* as follows. What we pay is subject to all of the terms of this *plan.*

For covered charges 100%

CGP-3-VSN-96-BEN1 B505.1521

All Options

Services or Supplies From a Non-Preferred Provider

If a *Covered Person* uses the services of a *Non-Preferred Provider,* the *Covered Person* must submit the itemized bill to VSP for claims payment. All claims must be sent to VSP within 180 days of the date services are completed or supplies are received. Failure to furnish proof of loss within the time required does not invalidate or reduce a claim if it was not reasonably possible to submit the proof within the required time, if the proof is furnished as soon as possible and, except in the absence of legal capacity of the claimant, not later than 1 year from the time proof is otherwise required. The benefits we pay are subject to all of the terms of this *Plan.*

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

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

For each pair of *Standard Frames* from a *Non-Preferred Provider* . . . $25.00

For each pair of *Standard Lenses* from a *Non-Preferred Provider*

Single vision lenses $25.00

Bifocal lenses $25.00

Trifocal lenses $25.00

Lenticular lenses $25.00

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

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

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

For Covered Charges 100%

CGP-3-VSN-MD-BEN2 B505.0244

Covered Charges

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

Covered Services and Supplies

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

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

Vision Examinations

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

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

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

And if a *Covered Person* uses a *Non-Preferred Provider,* we limit what we pay for the vision examination to $65.00.

Standard Lenses

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

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

- $50.00 for each pair of single vision lenses

- $75.00 for each pair of bifocal lenses
- $100.00 for each pair of trifocal lenses and
- $126.00 for each pair of *lenticular lenses.*

CGP-3-VSN-05-SL-MD B505.0525

All Options

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

CGP-3-VSN-05-SL-MD B505.0529

All Options

Standard Frames

We cover charges for standard frames.

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

If a covered person uses a non-preferred provider, we limit what we pay for each set of standard frames to $75.00.

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

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

CGP-3-VSN-05-SF B505.1261

All Options

Necessary Contact Lenses

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

(a) following cataract surgery;

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

(c) for certain conditions of *anisometropia;* or

(d) for *keratoconus.*

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

If a *covered person* receives Necessary Contact Lenses from a *preferred provider,* we pay 100% of covered charges. If he or she receives Necessary Contact Lenses from a *non-preferred provider,* we limit what we pay to $210.00 in any 12 month period.

CGP-3-VSN-96-LIST7 B505.0028

All Options

Elective Contact Lenses

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

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

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

CGP-3-VSN-05-ECL B505.0427

All Options

Special Limitations

If This VSP Plan Replaces Another VSP Plan

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

CGP-3-VSN-MD-SL1 B505.0250

All Options

Extended Vision Care Expense Benefits

If a *Covered Person's* insurance ends, we extend vision care expense benefits for that *Covered Person* under this *Plan* as explained below.

If a *Covered Person* has ordered glasses or contact lenses before the date coverage terminates, we will continue to provide benefits for the glasses or contact lenses if the *Covered Person* receives the glasses or contact lenses within 30 days after the date of the order. And what we pay is based on all of the terms of this *plan.*

We don't grant an extension if the *Covered Person's* insurance ended because he or she failed to make required payments or because he or she has committed fraud or material misrepresentation.

This section does not apply if any coverage provided by a succeeding vision care plan:

a. is provided at a cost to the *Covered Person* that is less than or equal to the cost to the *Covered Person* of the Extended Vision Care Expense benefits; and

b. does not result in an interruption of benefits.

CGP-3-VSN-96-EXT-MD B505.0251

All Options

Exclusions

- We wont pay for *orthoptics* or vision training and any associated supplemental testing.
- We won't pay for any service other than routine eye examinations and corrective lenses.
- We won't pay for any eye examination or corrective eyewear required by an *employer* as a condition of employment.

CGP-3-VSN-96-EXC1-MD B505.0252

All Options

- We won't pay for *plano lenses* (lenses with less than a +/- .38 diopter power).
- We won't pay for two pairs 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 *blended lenses.*
- We won't pay for *oversized lenses.*
- We won't pay for *photochromic lenses* and *tinted lenses,* except for Pink #1 and Pink #2.
- We won't pay for progressive multifocal lenses.
- We won't pay for the coating of the lens or lenses.
- We won't pay for a frame that costs more than the *Plan* allowance.
- We won't pay for cosmetic lenses.
- We won't pay for optional cosmetic processes.
- We won't pay for UV (ultraviolet) protected lenses.

CGP-3-VSN-96-EXC2 B505.0253

All Options

Charges not covered due to this provision are not considered covered vision services and cannot be used to satisfy this *plan's copayments* or *deductibles,* if any.

CGP-3-VSN-96-EXC17 B505.0037

The Guardian Life Insurance Company of America
10 Hudson Yards, New York, NY 10001

Certificate amendatory rider

This Rider amends the Certificate as follows and is effective on the certificate effective date. If this rider is added after the certificate effective date, the rider becomes effective on its issue date.

The **Appeals Process for Adverse Decisions or Grievance Decisions** provision is replaced with the following:

All grievances regarding dental care service adverse decisions will be handled by Guardian as explained below.

For dental care services under review, the adverse decision will be made by a licensed dentist, or a panel of other appropriate dental care service reviewers with at least one licensed Dentist on the panel.

For any dental care service being reviewed by a panel of appropriate dental care service reviewers, there will be at least one physician or dentist on the panel who did not render the adverse decision.

If a private review agent fails to make a determination within the time limits required under this section, the request shall be deemed approved.

Definitions:

"Adverse decision" means a utilization review determination by Guardian's private review agent that:

- a proposed or delivered dental care service which would otherwise be covered under the Covered Person's contract is not or was not medically necessary, appropriate, or efficient; and
- may result in non-coverage of the dental care service.

"Adverse decision" includes a utilization review determination based on a prior authorization or step therapy requirement.

"Compelling Reason" means that the potential delay in receipt of a dental care service until after the Covered Person or dental care provider exhausts the internal grievance process and obtains a final decision under the grievance process could result in loss of life, serious impairment to a bodily function, serious dysfunction of a bodily organ, the Covered Person remaining seriously mentally ill or using intoxicating substances with symptoms that cause the Covered Person to be in danger to self or others, or the Covered Person continues to experience severe withdrawal symptoms.

"Complaint" means a protest filed with the Insurance Commissioner involving an adverse decision or grievance decision concerning a Covered Person.

"Emergency case" means a case that qualifies for an expedited review because:

- an adverse decision has been made for dental care services that are proposed but have not been delivered; and

- the services are necessary to treat a condition or illness that, without immediate medical attention, would:
  - seriously jeopardize the life or health of the Covered Person or his or her ability to regain maximum function;
  - cause the Covered Person to be a danger to himself or herself or to others; or
  - cause the Covered Person to continue using intoxicating substances in an imminently dangerous manner.

"Filing date" means the earlier of:

- 5 days after the date of mailing; or
- the date of receipt.

"Grievance" means a protest filed by a Covered Person, a Covered Person's representative or dental care provider with Guardian under its internal grievance process regarding an adverse decision concerning the Covered Person.

"Grievance decision" means a final determination by Guardian that arises from a grievance filed with Guardian under its internal grievance process regarding an adverse decision concerning the Covered Person.

"Dental care provider" means:

- an individual who is licensed under the Health Occupations Article to provide dental care services in the ordinary course of business or practice of a profession and is a treating provider of the Covered Person; or
- a hospital, as defined in Section 19-301 of the Health-General Article; and
- for purposes of this provision, is acting on behalf of the Covered Person.

"Dental care service" means a dental care procedure or service rendered by a dental care provider that:

- provides testing, diagnosis, or treatment of a human disease or dysfunction; or
- dispenses drugs, medical devices, medical appliances, or medical goods for the treatment of a human disease or dysfunction; or
- provides any other care, service, or treatment of disease or injury, the correction of defects, or the maintenance of the physical and mental well-being of a Covered Person.

"Representative" means a person who has been authorized by the Covered Person to file a grievance or a complaint on his or her behalf.

B531.1148

All Options

Notice of Adverse Decision

Except in emergency cases as described below, notice of Guardian's private review agent's adverse decision will be verbally communicated via the telephone to the Covered Person or a Covered Person's representative and a dental care provider, or with affirmative assent of the Covered Person, Covered Person's representative or dental care provider, by text, facsimile, E-mail, an online portal or other expedited means. Written notice will be sent to the Covered Person, or a Covered Person's representative and a dental care provider within 5 working days after the adverse decision has been orally communicated.

Notice of the adverse decision will:

- state in detail in clear, understandable language the specific factual bases for the decision and the reasoning used to determine that the health care service is not medically necessary and did not meet the Guardian's criteria and standards used in conducting the utilization review;
- provide the specific reference, language, or requirements from the criteria and standards, including any interpretive guidelines on which the decision was based, and may not solely use:
    a. generalized terms such as "experimental procedure not covered", "cosmetic procedure not covered", "service included under another procedure", or "not medically necessary"; or
    b. language directing the member to review the additional coverage criteria in the Covered Person's policy or plan documents;
- include the name, clinical specialty, title, address and telephone number of the Guardian representative who has responsibility for the internal grievance process and the dentist who is required to make all adverse decisions;
- include the dedicated phone number for Adverse Decisions: Phone: 800-927-1402;
- include a copy of Guardian's internal grievance process and procedures;
- state that the Covered Person, a Covered Person's representative or dental care provider has the right to file a complaint with the Insurance Commissioner within 4 months after receipt of a grievance decision;
- state that a complaint may be filed without first filing a grievance if the Covered Person, a Covered Person's representative or a dental care provider can demonstrate a Compelling Reason to do so as determined by the Insurance Commissioner;

- The Commissioners address is:

  Maryland Insurance Administration
  Appeal and Grievance Unit
  200 St. Paul Place, Suite 2700
  Baltimore MD 21202-2272
  Phone: 410-468-2000 or toll free 1-800-492-6116
  Fax: 410-468-2270;

- provide a statement that the Health Advocacy Unit of Maryland's Consumer Protection division is available to assist the Covered Person or Covered Person's representative with mediating and filing a grievance under Guardian's internal grievance process. This Unit may be reached as shown below:

  Health Education and Advocacy Unit
  Consumer Protection Division
  Office of the Attorney General
  200 St. Paul Place, 16th Floor
  Baltimore MD 21202
  Phone: 410-528-1840 or toll free 1-877-261-8807
  Fax: 410-576-6571
  Email: heau@oag.state.md.us

- provide a statement indicating that when filing a complaint with the Commissioner the Covered Person or Covered Person's representative will be required to authorize the release of any medical records of the Covered Person that may be required to be reviewed for the purpose of reaching a decision on the complaint;
- Provide a statement that Guardian will be responsible for a violation of these requirements regardless of the delegation made with respect to the grievance decision.

Adverse Decision Procedures

The following procedures are available to a Covered Person, the Covered Person's representative or dental care provider:

If a Covered Person, the insured person's representative or a dental care provider does not agree with an adverse decision, the Covered Person, a Covered Person's representative or a dental care provider may submit a grievance under Guardian's Standard Grievance Procedures as explained below.

If qualified, a Covered Person, a Covered Person's representative or dental care provider may submit a grievance under Guardian's Expedited Grievance Procedures as explained below.

Standard Grievance Procedures

The Covered Person, a Covered Person's representative or a dental care provider must file a grievance in writing concerning an adverse decision. The grievance must be filed within 180 days of the date of receipt of an adverse decision for retrospective denials.

The Covered Person or dental care provider may submit any documentation to support a grievance that the parties believe is relevant. However, the grievance should contain sufficient detail to identify the nature of the problem.

The grievance should be sent to:

The Guardian Life Insurance Company of America
Attention: Chris Williams, Manager
Dental Claims Services, Quality & Compliance
PO Box 2457
Spokane WA 99210-2457
Phone: 800-541-7846
Fax: 509-468-6399

The written grievance will be referred to a Health or Dental Review Specialist. In resolving the grievance, best efforts are made to obtain all relevant information, including clinical records.

Additional information should be sent to:

The Guardian Life Insurance Company of America
Attention: Chris Williams, Manager
Dental Claims Services, Quality & Compliance
PO Box 2457
Spokane WA 99210-2457
Phone: 800-541-7846
Fax: 509-468-6399

The Health Advocacy Unit is available to assist the Covered Person or Covered Person's representative in filing a grievance under Our internal grievance process. Such statement shall include the name, address, telephone number, facsimile number and electronic mail address of the Health Advocacy Unit. This Unit may be reached as shown below:

Health Education and Advocacy Unit
Consumer Protection Division
Office of the Attorney General
200 St. Paul Place, 16th Floor
Baltimore MD 21202
Phone: 410-528-1840 or toll free 1-877-261-8807
Fax: 410-576-6571
Email: heau@oag.state.md.us

A grievance decision will be sent in writing to all parties within thirty (30) working days after the filing date of a grievance concerning services not yet rendered, or within thirty (30) working days after the filing date of the grievance concerning services which have already been rendered unless: (1) the grievance involves an emergency case, (2) You or Your representative, or a dental care provider filing a grievance on Your behalf agrees in writing to an extension for a period of no longer than 30 working days, or (3) the grievance involves a retrospective denial, a grievance decision will be sent in writing to all parties within forty-five (45) working days after the date on which the grievance is filed when the grievance involves a retrospective denial.

B531.1149

If within 5 working days after a Covered Person, the Covered Person's representative, or a dental care provider, files a grievance with the Guardian, We find We do not have sufficient information to complete the internal grievance process, Guardian will, after confirming through a complete review of any information already submitted by the dental care provider:

- notify the Covered Person, the Covered Person's representative, or the dental care provider that the Guardian cannot proceed with reviewing the grievance unless additional information is provided; and request the specific information, including any lab or diagnostic test or other clinical information that must be submitted to complete the internal grievance process;
- provide the specific reference language, or requirements from the criteria and standards used by Guardian to support the need for additional information;
- assist the Covered Person, the Covered Person's representative, or the dental care provider in gathering the necessary information without further delay.

Notice of Grievance Decision

For nonemergency decisions an oral communication of the decision will be made to the Covered Person, a Covered Person's representative or a dental care provider. The Dental Review Specialist will also send written notice of the grievance decision to the Covered Person, a Covered Person's representative or a dental care provider within five (5) working days after the grievance decision is made.

Notice of the grievance decision will include:

- a detailed explanation stated in clear, understandable language of the specific factual bases for the decision and the reasoning used to determine that the health care service is not medically necessary and did not meet Guardian's criteria and standards used in conducting the utilization review. Generalized terms such as "experimental procedure not covered", "cosmetic procedure not covered", "service included under another procedure", or "not medically necessary" will not be used;
- the specific reference, language, or requirements for the criteria and standards, including any interpretive guidelines, on which the decision was based;
- the name, clinical specialty, title, address and telephone number of the Guardian representative who has responsibility for Guardian's internal grievance process and the dentist who is required to make all adverse decisions;
- include the dedicated phone number for Grievance Decisions: Phone: 800-927- 1402;
- a statement advising that the Covered Person, a Covered Person's representative or dental care provider may file a complaint with the Insurance Commissioner within 4 months after receipt of the grievance decision;

- the Insurance Commissioner may be reached at:

  Maryland Insurance Administration
  Appeal and Grievance Unit
  200 St. Paul Place, Suite 2700
  Baltimore MD 21202-2272
  Phone: 410-468-2000 or toll free 1-800-492-6116
  Fax: 410-468-2270;

- a statement that the Health Advocacy Unit of Maryland's Consumer Protection Division is available to assist the Covered Person or Covered Person's representative with filing a complaint with the Commissioner;

  The Health Advocacy Unit may be reached as shown below:

  Health Education and Advocacy Unit
  Consumer Protection Division
  Office of the Attorney General
  200 St. Paul Place, 16th Floor
  Baltimore MD 21202
  Phone: 410-528-1840 or toll free 1-877-261-8807
  Fax: 410-576-6571
  Email: heau@oag.state.md.us;

- provide a statement indicating that when filing a complaint with the Commissioner the Covered Person or Covered Person's representative will be required to authorize the release of any medical records of the Covered Person that may be required to be reviewed for the purpose of reaching a decision on the complaint;

- a statement that Guardian will be responsible for a violation of these requirements regardless of the delegation made with respect to the grievance decision.

Expedited Grievance Procedures - Emergency Case

The Covered Person, a Covered Person's representative or a dental care provider may file a grievance in writing or orally upon receipt of an adverse decision in an emergency case.

The grievance should be sent to the Guardian representative who is responsible for Guardian's internal grievance procedures:

- by telephone or sent by facsimile to the numbers provided in the notice of adverse decision; and

- must include a telephone number where the Covered Person, a Covered Person's representative or a dental care provider may be reached. The grievance will be referred to a Dental Review Specialist. In resolving the grievance, best efforts will be made to obtain all relevant information, including clinical records. Guardian will orally communicate the grievance decision to the Covered Person, a Covered Person's representative or a dental care provider within 24 hours of receipt of the grievance.

Within 1 day after oral communication has been made, written notice of the adverse or grievance decisions as described above will be sent to the Covered Person, a Covered Person's representative or a dental care provider.

B531.1150

All Options

Insurance Commissioner Complaints:

A Covered Person, a Covered Person's representative or a dental care provider may file a complaint directly with the Insurance Commissioner within 4 months of receipt of a grievance decision. A complaint may also be filed:

- prior to completion of the grievance process if the complaint demonstrates that a delay in dental treatment could result in:
- loss of life;
    - serious impairment to a bodily function;
    - serious dysfunction of a bodily organ.
    - the Covered Person remaining seriously ill with symptoms that cause him or her to be a danger to himself or herself or others;
- if the Covered Person, a Covered Person's representative or dental care provider does not receive a grievance decision:
    - on or before the 30th day after the filing date of a grievance concerning services not yet rendered, or;
    - on or before the 30th day after the filing date of a grievance concerning services which have already been rendered;
    - for emergency cases, within 24 hours after filing the grievance;
- if Guardian waives the requirement that the internal process be exhausted before filing a complaint with the Commissioner;
- if Guardian fails to comply with any of the requirements of Guardian's internal grievance process as described in these provisions.
- if the Covered Person, a Covered Person's representative or dental care provider provide sufficient information and supporting documentation in the complaint that demonstrates a compelling reason to do so.

The complaint should be mailed to:

Maryland Insurance Administration
Appeal and Grievance Unit
200 St. Paul Place, Suite 2700
Baltimore MD 21202-2272
Phone: 410-468-2000 or toll free: 1-800-4962-6116; TTY Phone: 1-800-735-2258
Fax: 410-468-2270

The Insurance Commissioner will inform Guardian of receipt of a complaint within 5 working days after the complaint is filed.

The Insurance Commissioner will notify all parties in writing of the final decision regarding the complaint.

Regarding such final decision:

- Guardian may not request a hearing, but may file a petition for judicial review; and
- A Covered Person or representative may file a petition for judicial review, and unless prohibited by federal law, may request a hearing.

This rider is part of the member guide. There aren't any changes to the member guide, except for what's stated in this rider.

The Guardian Life Insurance Company of America

Matthew Darula, Head of Product, Strategy and Offerings

B531.1151

GC-DENGRIEVE-24-MD

CERTIFICATE AMENDMENT

This rider amends this *plan's* Dental Expense Insurance provisions to provide that the difference between the payment rates for *non-preferred providers* and *preferred providers* will not exceed 20 percentage points, and the allowed amount paid to *non-preferred providers* for a dental service covered by the *plan* will not be less than the allowed amount paid to a similarly licensed *preferred provider* for the same dental service in the same region.

As used herein, "Allowed Amount" means the dollar amount that *we* determine is the value of the dental service provided by a provider before any cost sharing amounts are applied.

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

Matthew Darula, Head of Product, Strategy and Offerings

CGP-3-A-PNP-13MD B531.0173

CERTIFICATE AMENDMENT

This rider replaces this plan's Coordination of Benefits provisions as shown below:

COORDINATION OF BENEITS

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

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

Definitions

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

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

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

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

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

(4) If a person is covered by two or more plans that provide benefits or services on the basis of negotiated fees, an amount in excess of the highest negotiated fees for a specific benefit is **not** an allowable expense. If a person is covered by one plan that computes its benefits or services on the basis of reasonable and customary charges and another plan that provides its benefits or services on the basis of negotiated fees, the primary plan's payment arrangements will be the allowable expense for all plans. However, if the provider has contracted with the secondary plan to provide the benefit or service for a specific negotiated fee or payment amount that is different than the primary plan's payment arrangement and if the provider's contract permits, the negotiated fee or payment shall be the allowable expense used by the secondary plan to determine its benefit.

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

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

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

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

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

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

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

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

This term does not include: (a) individual or family insurance; (b) closed panel or other individual coverage, except for group-type coverage; (c) school accident type coverage; (d) benefits for non-medical components of group long-term care policies; (e) individually underwritten and issued, guaranteed renewable specified disease or intensive care policies that do not provide benefits on an expense-incurred basis; or (f) Medicare, Medicare supplement policies, Medicaid, and coverage under other governmental plans, unless permitted by law.

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

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

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

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

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

All Options

Order Of Benefit Determination

The primary plan pays or provides its benefits as if the secondary plan or plans did not exist. Coverage that is obtained by virtue of membership in a group and designed to supplement a part of a basic package of benefits may provide that the supplementary coverage will be excess to any other parts of the plan provided by the contract holder.

A plan may consider the benefits paid or provided by another plan to determine its benefits only when it is secondary to that other plan. If a person is covered by more than one secondary plan, the rules explained below decide the order in which secondary plan benefits are determined in relation to each other. A plan that does not contain a coordination of benefits provision is always primary. When all plans have coordination of benefits provisions, the rules to determine the order of payment are listed below. The first of the rules that applies is the rule to use.

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

Child Covered Under More Than One Plan

The order of benefit determination when a child is covered by more than one plan is:

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

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

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

(4) If a dependent child is covered by a plan designed to supplement a part of a basic package of benefits, the supplementary coverage will be excess to any other parts of the plan provided by the contractholder.

Active Or Inactive Employee

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

Continuation Coverage

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

Length Of Coverage The plan that covered the person longer is primary and the plan that covered the person for the shorter period of time is secondary. To determine the length of time a person has been covered under a plan, two successive plans will be treated as one plan if the Covered Person was eligible under the second plan within 24 hours after coverage under the first plan ended. The start of a new plan does not include a change: (a) in the amount or scope of a plan's benefits, (b) in the entity that pays, provides or administers the plan's benefits, or (c) from one type of plan to another, such as, from a single employer plan to a multiple employer plan.

The person's length of time covered under a plan is measured from the person's first date of coverage under that plan. If that date is not readily available for a group plan, the date the person first became a member of the group shall be used as the date from which to determine the length of time the person's coverage under the present plan has been in force.

If the preceding rules do not determine the order of benefits, the plan that covered the Covered Person for the longer period of time is the primary plan and the plan that covered the Covered Person for the shorter period of time is the secondary plan.

CERTIFICATE AMENDMENT

Amendment Effective: January 1, 2015 or your first renewal following thereafter. This rider amends the Dental Benefits provisions of your certificate as follows:

Continuity of Care - Maryland Members

If You are transitioning Your Dental Coverage from another carrier, the Maryland Medical Assistance Program or the Maryland Children's Health Program (respectively referred to as "Relinquishing Carrier"), We, as the Receiving Carrier, will coordinate dental services in progress under the Relinquishing Carrier's plan ("Coordinated Dental Treatment Plan") as follows, provided that the dental services outlined in Your Coordinated Dental Treatment Plan are covered under Your Plan:

- If the covered dental services that form Your Coordinated Dental Treatment Plan require utilization review under this Plan, We will accept the Relinquishing Carrier's written pre-authorization.

  Such pre-authorization will remain in effect under this Plan for a period of 90 days from the effective date of Your Dental Coverage under this Plan or until Your Coordinated Dental Treatment Plan has concluded, whichever is less (the "Coordinated Treatment Period").

- Upon the expiration of the Coordinated Treatment Period, We reserve the right to perform utilization review of any future dental services that are covered under this Plan.

- During the Coordinated Treatment Period, You may continue to receive covered dental services that are part of Your Coordinated Dental Treatment Plan from a non-participating provider if the services were started by and rendered by such non-participating provider and were in progress as of Your effective date under this Plan. During your Coordinated Treatment Period, Your coinsurance for services received from a non-participating provider as part of Your Coordinated Dental Treatment Plan will not exceed Your coinsurance for the same covered dental services had they been received from a participating provider. You may continue to receive services for the following conditions: acute conditions; serious chronic conditions; and any other condition on which the non-participating provider and We reach agreement. Such services will be provided for the lesser of the course of treatment or 90 days.

This provision is subject to all other terms and conditions of coverage, including but limited to deductibles, limits and exclusions and/or annual maximums.

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

Matthew Darula, Head of Product, Strategy and Offerings

CGP-3-A-COC-AMEND B531.0181

CERTIFICATE AMENDMENT

Effective on the latter of (i) the original effective date of the Policy; or (ii) the effective date of any applicable amendment requested by the Policyholder and approved by the Insurance Company, this rider amends the Dental Expense Insurance provisions of the Group Policy as follows:

The Alternate Treatment provision is changed to read as follows when titanium or high noble metal (gold) is used in a *dental prosthesis.*

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

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

The Guardian Life Insurance Company of America

Matthew Darula, Head of Product, Strategy and Offerings

CGP-3-A-DGOPT-10 B531.0029

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 incapacitated 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 an incapacitated 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

Matthew Darula, Head of Product, Strategy and Offerings

CGP-3-A-DEP-V-11 B531.0043

All Options

The Guardian Life Insurance Company of America
10 Hudson Yards, New York, NY 10001

CERTIFICATE AMENDATORY RIDER

This Rider amends the Certificate as follows and is effective on 10/1/2023.

The Appeals Process for Adverse Decisions or Grievance Decisions provision is replaced with the following:

Appeals Process for Adverse Decisions or Grievance Decisions

All grievances regarding vision care service adverse decisions will be handled by Guardian as explained below.

For vision care services under review, the adverse decision will be made by a licensed provider, or a panel of other appropriate vision care service reviewers with at least one licensed Provider on the panel.

For any vision care service being reviewed by a panel of appropriate vision care service reviewers, there will be at least one physician or provider on the panel who did not render the adverse decision.

Definitions:

"Adverse decision" means a utilization review determination by a private review agent or Guardian that:

- a proposed or delivered vision care service which would otherwise be covered under the Covered Person's contract is not or was not medically necessary, appropriate, or efficient; and
- may result in non-coverage of the vision care service.

"Compelling Reason" means that the potential delay in receipt of a vision care service until after the Covered Person or vision care provider exhausts the internal grievance process and obtains a final decision under the grievance process could result in loss of life, serious impairment to a bodily function, serious dysfunction of a bodily organ, the Covered Person remaining seriously mentally ill or using intoxicating substances with symptoms that cause the Covered Person to be in danger to self or others, or the Covered Person continues to experience severe withdrawal symptoms.

"Complaint" means a protest filed with the Insurance Commissioner involving an adverse decision or grievance decision concerning a Covered Person.

"Emergency case" means a case that qualifies for an expedited review because:

- an adverse decision has been made for vision care services that are proposed but have not been delivered; and

- the services are necessary to treat a condition or illness that, without immediate medical attention, would:
  - seriously jeopardize the life or health of the Covered Person or his or her ability to regain maximum function;
  - cause the Covered Person to be a danger to himself or herself or to others; or
  - cause the Covered Person to continue using intoxicating substances in an imminently dangerous manner.

"Filing date" means the earlier of:

- 5 days after the date of mailing; or
- the date of receipt.

"Grievance" means a protest filed by a Covered Person, a Covered Person's representative or vision care provider with Guardian under its internal grievance process regarding an adverse decision concerning the Covered Person.

"Grievance decision" means a final determination by Guardian that arises from a grievance filed with Guardian under its internal grievance process regarding an adverse decision concerning the Covered Person.

"Vision care provider" means:

- an individual who is licensed under the Health Occupations Article to provide vision care services in the ordinary course of business or practice of a profession and is a treating provider of the Covered Person; or
- a hospital, as defined in 19-301 of the Health-General Article; and
- for purposes of this provision, is acting on behalf of the Covered Person.

"Vision care service" means a vision care procedure or service rendered by a vision care provider that:

- provides testing, diagnosis, or treatment of a human disease or dysfunction; or
- dispenses drugs, medical devices, medical appliances, or medical goods for the treatment of a human disease or dysfunction; or
- provides any other care, service, or treatment of disease or injury, the correction of defects, or the maintenance of the physical and mental well-being of a Covered Person.

"Representative" means a person who has been authorized by the Covered Person to file a grievance or a complaint on his or her behalf.

All Options

Notice of Adverse Decision

Except in emergency cases as described below, notice of Guardian's or a private review agent's adverse decision will be verbally communicated via the telephone to the covered person or a covered person's representative and a vision care provider, or with affirmative assent of the Covered Person, Covered Person's representative or vision care provider, by text, facsimile, E-mail, an online portal or other expedited means. Written notice will be sent to the covered person, or a covered person's representative and a vision care provider within 5 working days after the adverse decision has been orally communicated.

Notice of the adverse decision will:

- state the specific factual bases for the decision, in clear, understandable language;
- state the specific criteria and standards, including interpretive guidelines, on which the adverse decision was based and will not solely use generalized terms such as "experimental procedure not covered", "cosmetic procedure not covered", "service included under another procedure", or "not medically necessary";
- include the name, address and telephone number of the Guardian representative who has responsibility for the internal grievance process;
- include a copy of Guardian's internal grievance process and procedures;
- state that the Covered Person, a Covered Person's representative or vision care provider has the right to file a complaint with the Insurance Commissioner within 4 months after receipt of a grievance decision;
- provide the name, address, phone and fax number for the Covered Person or Covered Person's representative to contact and file a complaint with the Insurance Commissioner
- state that a complaint may be filed without first filing a grievance if the Covered Person, a Covered Person's representative or a vision care provider can demonstrate a Compelling Reason to do so as determined by the Insurance Commissioner.
- provide a disclosure that the Health Advocacy Unit of Maryland's Consumer Protection division is available to assist the Covered Person or Covered Person's representative with mediating and filing a grievance under Guardian's internal grievance process. This Unit may be reached as shown below.
- provide a disclosure that the Health Advocacy Unit is available to assist the Covered Person or Covered Person's representative in filing a complaint with the commissioner. Such statement shall include the name, address, telephone number, facsimile number and electronic mail address of the Health Advocacy Unit. This Unit may be reached as shown below:

Health Education and Advocacy Unit
Consumer Protection Division
Office of the Attorney General
200 St. Paul Place, 16th Floor
Baltimore MD 21202
Phone: 410-528-1840 or toll free 1-877-261-8807
Fax: 410-576-6571
Email: heau@oag.state.md.us

- provide a disclosure indicating that when filing a complaint with the Commissioner the Covered Person or Covered Person's representative will be required to authorize the release of any medical records of the Covered Person that may be required to be reviewed for the purpose of reaching a decision on the complaint.

Adverse Decision Grievance Procedures

The following procedures are available to a Covered Person, the Covered Person's representative or vision care provider:

If a Covered Person, the insured person's representative or a vision care provider does not agree with an adverse decision, the Covered Person, a Covered Person's representative or a vision care provider may submit a grievance under Guardian's Standard Grievance Procedures as explained below.

If qualified, a Covered Person, a Covered Person's representative or vision care provider may submit a grievance under Guardian's Expedited Grievance Procedures as explained below.

Standard Grievance Procedures

The Covered Person, a Covered Person's representative or a vision care provider must file a grievance in writing concerning an adverse decision. The grievance must be filed within 180 days of the date of receipt of an adverse decision for retrospective denials.

The Covered Person or vision care provider may submit any documentation to support a grievance that the parties believe is relevant. However, the grievance should contain sufficient detail to identify the nature of the problem.

The grievance should be sent to:

Vision Service Plan (VSP)
Attention: Appeals & Grievances Department
P.O. Box 38300
Phoenix, Arizona 85069-8300
844-557-2646

The written grievance will be referred to a Health or Vision Review Specialist. In resolving the grievance, best efforts are made to obtain all relevant information, including clinical records.

Additional information should be sent to:

Vision Service Plan (VSP)
Attention: Appeals & Grievances Department
P.O. Box 38300
Phoenix, Arizona 85069-8300
844-557-2646

The Health Advocacy Unit is available to assist the Covered Person or Covered Person's representative in filing a grievance under Our internal grievance process. Such statement shall include the name, address, telephone number, facsimile number and electronic mail address of the Health Advocacy Unit. This Unit may be reached as shown below:

Health Education and Advocacy Unit
Consumer Protection Division
Office of the Attorney General
200 St. Paul Place, 16th Floor
Baltimore MD 21202
Phone: 410-528-1840 or toll free 1-877-261-8807
Fax: 410-576-6571
Email: heau@oag.state.md.us

A grievance decision will be sent in writing to all parties within thirty (30) working days after the filing date of a grievance concerning services not yet rendered, or within thirty (30) working days after the filing date of the grievance concerning services which have already been rendered unless: (1) the grievance involves an emergency case, (2) You or Your representative, or a vision care provider filing a grievance on Your behalf agrees in writing to an extension for a period of no longer than 30 working days, or (3) the grievance involves a retrospective denial, a grievance decision will be sent in writing to all parties within forty-five (45) working days after the date on which the grievance is filed when the grievance involves a retrospective denial.

B531.1056

All Options

Notice of Grievance Decision

After oral communication of the decision to the Covered Person, a Covered Person's representative or a vision care provider, the Vision Review Specialist will send written notice of the grievance decision to the Covered Person, a Covered Person's representative or a vision care provider within five (5) working days after the grievance decision is made.

Notice of the grievance decision will include:

- a detailed explanation stated in clear, understandable language of the specific factual bases for the decision, including the specific criteria and standards, including interpretive guidelines, on which the decision was based and will not solely use generalized terms such as "experimental procedure not covered', "cosmetic procedure not covered", "service included under another procedure", or "not medically necessary";
- the name, address and telephone number of the Guardian representative who has responsibility for the internal grievance process;
- a statement advising that the Covered Person, a Covered Person's representative or vision care provider may file a complaint with the Insurance Commissioner within 4 months after receipt of the grievance decision;
- the Insurance Commissioner may be reached at:

  Maryland Insurance Administration
  Appeal and Grievance Unit
  200 St. Paul Place, Suite 2700
  Baltimore MD 21202-2272
  Phone: 410-468-2000 or toll free 1-800-492-6116
  Fax: 410-468-2270;

- a disclosure that assistance is available through the Health Advocacy Unit of Maryland's Consumer Protection Division if the Covered Person or Covered Person's representative wish to file a complaint with the Commissioner. Such statement shall include the name, address, telephone number, facsimile number and electronic mail address of the Health Advocacy Unit;
- The Health Advocacy Unit may be reached as shown below:

  Health Education and Advocacy Unit
  Consumer Protection Division
  Office of the Attorney General
  200 St. Paul Place, 16th Floor
  Baltimore MD 21202
  Phone: 410-528-1840 or toll free 1-877-261-8807
  Fax: 410-576-6571
  Email: heau@oag.state.md.us;

- a statement that Guardian will be responsible for a violation of these requirements regardless of the delegation made with respect to the grievance decision.

If within 5 working days after a Covered Person, the Covered Person's representative, or a vision care provider, who has filed a grievance on behalf of a Covered Person, files a grievance with the Guardian, and if Guardian does not have sufficient information to complete its internal grievance process, Guardian shall:

- notify the Covered Person, the Covered Person's representative, or the vision care provider that the Guardian cannot proceed with reviewing the grievance unless additional information is provided; and
- assist the Covered Person, the Covered Person's representative, or the vision care provider in gathering the necessary information without further delay.

Expedited Grievance Procedures - Emergency Case

The Covered Person, a Covered Person's representative or a vision care provider may file a grievance in writing or orally upon receipt of an adverse decision in an emergency case.

The grievance should be sent to the Guardian representative who is Responsible for Guardian's internal grievance procedures:

- by telephone or sent by facsimile to the numbers provided in the notice of adverse decision; and
- must include a telephone number where the Covered Person, a Covered Person's representative or a vision care provider may be reached. The grievance will be referred to a Vision Review Specialist. In resolving the grievance, best efforts will be made to obtain all relevant information, including clinical records. Guardian will orally communicate the grievance decision to the Covered Person, a Covered Person's representative or a vision care provider within 24 hours of receipt of the grievance.

Within 1 day after oral communication has been made, written notice of the adverse decision or grievance decision will be sent to the Covered Person, a Covered Person's representative or a vision care provider.

Notice of the adverse decision will:

- state the specific factual bases for the decision, in clear, understandable language;
- state the specific criteria and standards, including interpretive guidelines, on which the adverse decision was based and will not solely use generalized terms such as "experimental procedure not covered", "cosmetic procedure not covered", "service included under another procedure", or "not medically necessary";
- include the name, address and telephone number of the Guardian representative who has responsibility for the internal grievance process;
- include a copy of Guardian's internal grievance process and procedures;
- state that the Covered Person, a Covered Person's representative or vision care provider has the right to file a complaint with the Insurance Commissioner within 4 months after receipt of a grievance decision;
- provide the name, address, phone and fax number for the Covered Person or Covered Person's representative to contact and file a complaint with the Insurance Commissioner
- state that a complaint may be filed without first filing a grievance if the Covered Person, a Covered Person's representative or a vision care provider can demonstrate a Compelling Reason to do so as determined by the Insurance Commissioner.
- provide a disclosure that the Health Advocacy Unit of Maryland's Consumer Protection division is available to assist the Covered Person or Covered Person's representative with mediating and filing a grievance under Guardian's internal grievance process. This Unit may be reached as shown below.
- provide a disclosure that the Health Advocacy Unit is available to assist the Covered Person or Covered Person's representative in filing a complaint with the commissioner. Such statement shall include the name, address, telephone number, facsimile number and electronic mail address of the Health Advocacy Unit. This Unit may be reached as shown below:

  Health Education and Advocacy Unit
  Consumer Protection Division
  Office of the Attorney General
  200 St. Paul Place, 16th Floor
  Baltimore MD 21202
  Phone: 410-528-1840 or toll free 1-877-261-8807
  Fax: 410-576-6571
  Email: heau@oag.state.md.us

- provide a disclosure indicating that when filing a complaint with the Commissioner the Covered Person or Covered Person's representative will be required to authorize the release of any medical records of the Covered Person that may be required to be reviewed for the purpose of reaching a decision on the complaint.

All Options

Notice of the grievance decision will include:

- a detailed explanation stated in clear, understandable Language of the specific factual bases for the decision, including the Specific criteria and standards, including interpretive guidelines, on which the decision was based and will not solely use generalized terms such as "experimental procedure not covered', "cosmetic procedure not covered", "service included under another procedure", or "not medically necessary";
- the name, address and telephone number of the Guardian representative who has responsibility for the internal grievance process;
- a statement advising that the Covered Person, a Covered Person's representative or vision care provider may file a complaint with the Insurance Commissioner within 4 months after receipt of the grievance decision;
- the Insurance Commissioner may be reached at:

  Maryland Insurance Administration
  Appeal and Grievance Unit
  200 St. Paul Place, Suite 2700
  Baltimore MD 21202-2272
  Phone: 410-468-2000 or toll free 1-800-492-6116
  Fax: 410-468-2270;

- a disclosure that assistance is available through the Health Advocacy Unit of Maryland's Consumer Protection Division if the Covered Person or Covered Person's representative wish to file a complaint with Commissioner. Such statement shall include the name, address, telephone number, facsimile number and electronic mail address of the Health Advocacy Unit;
- The Health Advocacy Unit may be reached as shown below:

  Health Education and Advocacy Unit
  Consumer Protection Division
  Office of the Attorney General
  200 St. Paul Place, 16th Floor
  Baltimore MD 21202
  Phone: 410-528-1840 or toll free 1-877-261-8807
  Fax: 410-576-6571
  Email: heau@oag.state.md.us;

- a statement that Guardian will be responsible for a violation of these requirements regardless of the delegation made with respect to the grievance decision.

After a Covered Person, the Covered Person's representative, or a vision care provider, who has filed a grievance on behalf of a Covered Person, files a grievance with the Guardian, and if Guardian does not have sufficient information to complete its internal grievance process, Guardian shall:

- immediately notify the Covered Person, the Covered Person's representative, or the vision care provider that it cannot proceed with reviewing the grievance unless additional information is provided; and
- assist the Covered Person, the Covered Person's representative, or the vision care provider in gathering the necessary information without further delay.

Insurance Commissioner Complaints:

A Covered Person, a Covered Person's representative or a vision care provider may file a complaint directly with the Insurance Commissioner within 4 months of receipt of a grievance decision. A complaint may also be filed:

- prior to completion of the grievance process if the complaint demonstrates that a delay in vision treatment could result in:
  - loss of life;
  - serious impairment to a bodily function;
  - serious dysfunction of a bodily organ.
  - the Covered Person remaining seriously ill with symptoms that cause him or her to be a danger to himself or herself or others.
- if the Covered Person, a Covered Person's representative or vision care provider does not receive a grievance decision:
  - on or before the 30th day after the filing date of a grievance concerning services not yet rendered, or;
  - on or before the 30th day after the filing date of a grievance concerning services which have already been rendered.
  - for emergency cases, within 24 hours after filing the grievance.
- if Guardian waives the requirement that the internal process be exhausted before filing a complaint with the Commissioner.
- if Guardian fails to comply with any of the requirements of Guardian's internal grievance process as described in these provisions.

  Maryland Insurance Administration
  Appeal and Grievance Unit
  200 St. Paul Place, Suite 2700
  Baltimore MD 21202-2272
  Phone: 410-468-2000 or toll free: 1-800-4962-6116; TTY Phone: 1-800-735-2258
  Fax: 410-468-2270

- if the Covered Person, a Covered Person's representative or vision care provider provide sufficient information and supporting documentation in the complaint that demonstrates a compelling reason to do so.

The Insurance Commissioner will inform Guardian of receipt of a complaint within 5 working days after the complaint is filed.

The Insurance Commissioner will notify all parties in writing of the final decision regarding the complaint.

Regarding such final decision:

- Guardian may not request a hearing, but may file a petition for judicial review; and
- A Covered Person or representative may file a petition for judicial review, and unless prohibited by federal law, may request a hearing.

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

The Guardian Life Insurance Company of America

Matthew Darula, Head of Product, Strategy and Offerings

B531.1058

GC-A-VISGRIEVE-23-MD

COORDINATION OF BENEFITS

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

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

Definitions

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

This term does not include: (a) individual or family insurance; (b) closed panel or other individual coverage, except for group-type coverage; (c) amounts of group or group-type hospital indemnity benefits of $200.00 or less per day; (d) school accident type coverage; (e) benefits for non-medical components of group long-term care policies; (f) individually underwritten and issued, guaranteed renewable specified disease or intensive care policies that do not provide benefits on an expense-incurred basis; or (g) Medicare, Medicare supplement policies, Medicaid, and coverage under other governmental plans, unless permitted by law.

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

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

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

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

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

All Options

Order Of Benefit Determination

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

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

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

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

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

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

Child Covered Under More Than One Plan

The order of benefit determination when a child is covered by more than one plan is:

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

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

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

Active Or Inactive Employee

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

Continuation Coverage

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

Length Of Coverage

The plan that covered the person longer is primary.

Other

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

Effect On The Benefits Of This Plan

When This Plan Is Primary

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

When This Plan Is Secondary

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

Closed Panel Plans

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

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

Right To Receive And Release Needed Information

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

Facility Of Payment

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

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

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

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

CGP-3-R-COB-05 B555.0264

CERTIFICATE AMENDMENT

Group Policy No.: as shown in the Certificate of Coverage to which this Certificate Amendment is attached.

Amendment Effective: August 1, 2014

Notwithstanding any provision in the certificate to the contrary, your certificate is amended so that any coverage which provides reimbursement for any service which is within the lawful scope of practice of a duly licensed certified social worker who meets the qualifications set forth below, shall provide such benefits when such services are performed by such social worker, provided the Covered Person was referred to the social worker by a doctor of medicine. For the purposes of this amendment, a social worker qualified for reimbursement must have at least two years or 3,000 hours of post-masters clinical social work practice in a clinical program as established by the Maryland Board of Social Work examiners.

All terms and conditions of your certificate, not specifically changed herein, remain in full force and effect.

The Guardian Life Insurance Company of America

Matthew Darula, Head of Product, Strategy and Offerings

CGP-3-A-SW-MD B590.9015

All Options

GLOSSARY

This Glossary defines the italicized terms appearing in your booklet.

CGP-3-GLOSS-90 B900.0118

All Options

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

CGP-3-VSN-96-DEF1 B750.0457

All Options

Active Orthodontic means an *appliance,* like a fixed or removable appliance, braces or a functional orthotic used for orthodontic treatment to move teeth or reposition the jaw.

CGP-3-GLOSS-90 B750.0663

All Options

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

CGP-3-GLOSS-90 B750.0664

All Options

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

CGP-3-GLOSS-90 B750.0665

All Options

Benefit Period with respect to Vision Care Insurance, means the time period beginning when a covered service is received and extending to the date on which, according to the time limitations contained in this *plan,* the covered service is again available to a *covered person.*

CGP-3-VSN-96-DEF3 B750.0458

All Options

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

CGP-3-GLOSS-90 B750.0666

All Options

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

CGP-3-VSN-96-DEF3 B750.0459

All Options

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

CGP-3-VSN-96-DEF3 B750.0460

All Options

Copayment with respect to Vision Care Insurance, means a charge, expressed as a fixed dollar amount, required to be paid by or on behalf of a *covered person* to a *preferred provider* at the time covered vision services are received.

CGP-3-VSN-96-DEF3 B750.0461

All Options

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

CGP-3-GLOSS-90 B750.0667

All Options

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

CGP-3-GLOSS-90 B750.0668

All Options

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

CGP-3-GLOSS-90 B750.0669

All Options

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-VSN-96-DEF3 B750.0462

All Options

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

CGP-3-VSN-96-DEF3 B750.0484

All Options

Deductible with respect to Vision Care Insurance, means any amount which a *covered person* must pay before he or she is reimbursed for covered services provided by a *non-preferred provider.*

CGP-3-VSN-96-DEF3 B750.0483

All Options

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

CGP-3-GLOSS-90 B750.0670

All Options

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

CGP-3-GLOSS-90 B750.0671

All Options

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

All Options

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

CGP-3-GLOSS-90 B750.0015

All Options

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

CGP-3-GLOSS-90 B750.0672

All Options

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

CGP-3-GLOSS-90 B750.0006

All Options

Employer means 2 CIRCLE, INC .

CGP-3-GLOSS-90 B900.0051

All Options

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

All Options

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

CGP-3-GLOSS-90 B750.0229

All Options

Incurred, Or Incurred Date with respect to Vision Care Insurance, means the placing of an order for lenses, frames or contact lenses, or the date on which such an order was placed.

CGP-3-VSN-96-DEF3 B750.0466

All Options

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

All Options

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

CGP-3-GLOSS-90 B750.0673

All Options

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

CGP-3-VSN-96-DEF11 B750.0467

All Options

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

CGP-3-VSN-96-DEF11 B750.0485

All Options

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

All Options

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

CGP-3-GLOSS-90 B750.0674

All Options

Non-Preferred Provider with respect to Vision Care Insurance, means any optometrist, optician, ophthalmologist, or other licensed and qualified vision care provider who has not contracted with the *plan* to provide vision care services and/or vision care materials to *covered persons* of the *plan.*

CGP-3-VSN-96-DEF14 B750.0487

All Options

Orthodontic Treatment means the movement of one or more teeth by the use of *active appliances.* it includes: (a) treatment plan and records, including initial, interim and final records; (b) periodic visits, limited orthodontic treatment, interceptive orthodontic treatment and comprehensive orthodontic treatment, including fabrication and insertion of any and all fixed appliances; (c) orthodontic retention, including any and all necessary fixed and removable appliances and related visits.

CGP-3-GLOSS-90 B750.0675

All Options

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

CGP-3-VSN-96-DEF16 B750.0472

All Options

Oversize lenses mean larger than a *standard lens* blank, to accommodate prescriptions.

CGP-3-VSN-96-DEF17 B750.0489

All Options

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

CGP-3-GLOSS-90 B750.0676

All Options

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

CGP-3-GLOSS-90 B750.0677

All Options

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

CGP-3-VSN-96-DEF17 B750.0490

All Options

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

CGP-3-GLOSS-90 B750.0679

All Options

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

CGP-3-GLOSS-90 B750.0678

All Options

Plan Benefits with respect to Vision Care Insurance, mean the vision care services and vision care materials which a *covered person* is entitled to receive by virtue of coverage under this *plan.*

CGP-3-VSN-96-DEF17 B750.0492

All Options

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

CGP-3-VSN-96-DEF17 B750.0491

All Options

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

CGP-3-GLOSS-90 B750.0680

All Options

Preferred Provider with respect to Vision Care Insurance, means an optometrist, ophthalmologist or optician or other licensed and qualified vision care provider who has contracted with the *plan* to provide vision care services and/or vision care materials on behalf of *covered persons* of the *plan.*

CGP-3-VSN-96-DEF14 B750.0488

All Options

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

CGP-3-GLOSS-90 B750.0681

All Options

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

CGP-3-GLOSS-90 B750.0682

All Options

Proof or Proof of Insurability means an application for insurance showing that a person is insurable.

CGP-3-GLOSS-90 B900.0010

All Options

Standard Frames mean frames valued up to the limit published by VSP which is given to *preferred providers.*

CGP-3-VSN-96-DEF17 B750.0478

All Options

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

CGP-3-VSN-96-DEF17 B750.0479

All Options

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

CGP-3-VSN-96-DEF17 B750.0480

All Options

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-VSN-96-DEF17 B750.0481

All Options

Visually Necessary Or Appropriate means medically or visually necessary for the restoration or maintenance of a *covered person's* visual acuity and health and for which there is no less expensive professionally acceptable alternatives.

CGP-3-VSN-96-DEF17 B750.0482

All Options

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

CGP-3-GLOSS-90 B750.0683

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

All Options

The Guardian's Responsibilities

B800.0048

All Options

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

B800.0053

All Options

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

B800.0055

All Options

The Guardian is located at 10 Hudson Yards, New York, New York 10001.

B800.0049

Group Health 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 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

Group Health 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 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

All Options

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 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 reasonable 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 reasonable 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.

B752.0205

All Options

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.

B752.0145

All Options

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.

B998.0051

All Options

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.

B998.0052

All Options

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.

B998.0053

All Options

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

You May not be covered by all options in this Certificate.

This Certificate contains all the benefits and options that are available under the Policy. You are insured only for those benefits and options that you are eligible and enrolled for, and for which the required premium has been paid.

CERTIFICATE OF COVERAGE

The Guardian Life Insurance Company of America
10 Hudson Yards
New York, New York 10001
(212) 598-8000

The Group Term Life Insurance described in this Certificate is attached to the group Policy effective August 1, 2014. This Certificate replaces any Certificate previously issued under this Policy or under any other plan providing similar or identical benefits issued to the Policyholder by Guardian.

GROUP TERM LIFE INSURANCE

Guardian certifies that the Employee to whom this Certificate is issued is eligible for the coverage, and in the amount, described herein. In order to be eligible for coverage, the Employee must: (a) satisfy all of this Policy's eligibility and Effective Date requirements; (b) be listed in Our and/or the Policyholder's records as a validly covered Employee under the Policy; (c) satisfy any necessary Proof of Insurability requirements; and (d) all required premium payments have been made by or on behalf of the Employee.

The Employee and/or his or her Dependents are not covered by any part of this Policy for which he or she has waived coverage. Such a waiver of coverage is shown in Our and/or the Policyholder's records.

Policyholder: 2 CIRCLE, INC
Group Policy Number: 00502570

The Guardian Life Insurance Company of America

Matthew Darula, Head of Product, Strategy and Offerings

B400.3114

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GENERAL PROVISIONS

Applicable Benefits

This Certificate may include multiple benefit options and types of benefits. You will only be covered for benefits if:

- They were previously selected in an acceptable manner and mode, such as an enrollment form or other required form; and
- We have received any required premium.

If Proof of Insurability is required, You will not be covered unless You satisfy the Proof of Insurability requirements stated in the Certificate and Schedule of Benefits.

Limitation Of Authority

Only the President, a Vice President or a Secretary of Guardian, has the authority to act for Us in a written and signed statement to:

- Determine whether any contract, Policy or Certificate is to be issued;
- Waive or alter any contract or Policy provisions, or any of Our requirements;
- Bind Us by any statement or promise relating to the contract issued or to be issued; or
- Accept any information or representation which is not in a signed application.

Agents and brokers do not have the authority to change the contract or Policy or waive any of its provisions.

Incontestability

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

Any statement made by You may not be used to contest validity of Your insurance unless such insurance has been in force for less than two years during Your lifetime, and the statement is in writing and signed by You.

No statement in any application, made by You, or any dependent, will be used to contest the validity of Your insurance or to deny a claim for a loss incurred, or for a disability which starts, after such insurance has been in force for two years during Your lifetime.

If this Certificate replaces a plan Your Employer had with another insurer, We may rescind this Certificate based on misrepresentations or omissions made by Your Employer or You in a signed application for up to two years from the Effective Date of the Policy.

In the event Your insurance is rescinded, We will refund premiums paid for the periods such insurance is void. The premium paid by You will be sent to Your last known address on file with Your Employer or Us.

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 the Certificate as often as We feel is reasonably necessary. We also have the right to have an autopsy performed in the case of death where allowed by law. We will pay for all such examinations and autopsies.

Overpayment Recovery

If We overpay benefits, all such benefits must be repaid in full. We have the right to reduce the benefit or reduce any other benefits payable under this Certificate, toward recovery of any overpayment.

B400.5920

ELIGIBILITY FOR GROUP TERM LIFE COVERAGE - EMPLOYEE COVERAGE

Conditions Of Eligibility

Subject to the conditions of eligibility set forth below, and to all of the other conditions of this Certificate, You are eligible for Group Term Life coverage if You are:

- In an eligible class of Employees;
- An active Full time Employee;
- Legally working in the United States and/or Canada or working outside of the United States for a United States based Employer in a country or region approved by Us; and
- Working at least the minimum number of hours of an Employee in Your eligible class at:
  - The Employer's place of business;
  - Some place where the Employer's business requires You to travel; or
  - Any other place You and the Employer have agreed upon for the performance of your occupational duties.

You are **not** eligible for Group Term Life coverage if You are:

- A temporary or seasonal Employee.

Enrollment Requirement If You must pay all or part of the cost of Your coverage, We will not cover You until You enroll and agree to make the required payments.

Proof Of Insurability Part or all of Your insurance amounts may be subject to proof that You are insurable. The Schedule of Benefits explains if and when We require Proof of Insurability. You will not be covered for any amount that requires such Proof of Insurability until You provide such proof to Us and We approve it in writing.

The Waiting Period If You are in an eligible class, You are eligible for Group Term Life insurance under this Certificate after You complete the service waiting period, if any, established by the Employer.

Multiple Employment If You work for both the Employer and a covered associated company, or for more than one covered associated company, We will treat You as if only one firm employs You. You will not have multiple life insurance coverage under this Certificate. But, if this Certificate uses the amount of Your Insured Earnings to set the rates, determine class, figure insurance amounts, or for any other reason, such Insured Earnings will be figured as the sum of Your Insured Earnings from all covered Employers.

When Coverage Starts

For coverage to start, You must be fully capable of performing the major duties of Your regular occupation for the Employer and working the minimum required number of hours of an Employee in Your eligible class at 12:01 A.M. Standard Time for Your place of residence on Your scheduled Eligibility Date. And, for coverage to start, You must satisfy all of the Conditions of Eligibility described above, and the conditions shown below which apply to You. If You are not fully capable of performing the major duties of Your regular occupation on Your scheduled Eligibility Date, We will postpone the start of Your coverage until You are so capable and working the minimum required number of hours of an Employee in Your eligible class for one full day, with the capacity to do so for one full week.

Whether You must pay all or part of the cost of Your coverage, You must elect to enroll and agree to make the required payments before Your coverage starts. If You do this on or before Your Eligibility Date, Your coverage is scheduled to start on Your Eligibility Date. If You do this within 31 days after Your Eligibility Date, Your coverage is scheduled to start on Your Eligibility Date. If You elect to enroll and agree to make the required payments more than 31 days after Your Eligibility Date, Your coverage will not start until You send Us Proof Of Insurability. Once We approve such Proof Of Insurability, Your coverage will start on the date we approve such coverage.

B400.3129

All Options

Exception to When Coverage Starts

Sometimes a scheduled Eligibility Date is not a regularly scheduled work day. If the scheduled Eligibility Date falls on:

- A holiday;
- A vacation day;
- A non-scheduled work day;
- A day during an approved leave of absence not due to Sickness or Injury, of 90 days or less; or
- A day during a period of absence that is less than 7 days in duration;

and if:

- You are fully capable of performing the major duties of Your regular occupation for Your Employer for the minimum number of hours of an Employee in Your eligible class at 12:01 AM Standard Time for Your place of residence on the scheduled Eligibility Date; and

- You were performing the major duties of Your regular occupation and working the minimum number of hours of an Employee in Your eligible class on Your last regularly scheduled work day;

Your coverage will start on the scheduled Eligibility Date. However, any coverage or part of coverage for which You must elect and pay all or part of the cost, will not start if You are on an approved leave, layoff or absence and such coverage or part of coverage was not previously in force for You under a prior plan which this Certificate replaced.

Any part of Your coverage which is subject to Proof Of Insurability will not start unless You send such proof to Us, and We approve it in writing. Once We have approved it, that part of Your coverage is scheduled to start on Your approved Eligibility Date.

B400.3131

All Options

Delayed Eligibility Date For Employee Voluntary Term Life Insurance

If due to sickness or injury, You are not Actively at Work and working the minimum required number of hours of an Employee in Your eligible class, on the date Your Voluntary Term Life coverage is scheduled to start, We will postpone coverage for an otherwise covered loss for any condition that prevents you from meeting the Actively at Work requirement. We will postpone such coverage until You:

- Complete one full day of Active Work, working the minimum number of hours of an Employee in Your eligible class, with the capacity to do so for one full week; and,
- Do not miss a day of work due to the same condition.

Coverage for an otherwise covered loss due to all other conditions will start on the date You:

- Return to Active Work working the minimum number of hours of an Employee in Your eligible class and;
- Are performing the regular duties of your occupation.

B400.3132

All Options

When Coverage Ends

Your coverage will end on the first of the following dates:

- The date Your Active Work ends for any reason, except as noted below under Coverage During Leave of Absence. Such reasons include:
  - Disability;
  - Death;
  - Retirement;
  - Layoff;

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- Leave of absence;
- The end of employment; and
- Expiration of the employment contract.

- The date You stop being an eligible Employee under this Certificate.
- The date You are no longer working in the United States and/or Canada, or no longer working outside the United States for a United States based Employer in a country or region approved by Us. Any incidental business or personal travel outside of the United States and/or Canada, or outside of a country or region approved by Us, is covered. Such travel will be considered incidental if it is for a period not to exceed 30 consecutive days.
- The date the group Certificate ends, or is discontinued for a class of Employees to which You belong.
- The last day of the period for which required payments are made for You.

You may have the right to continue certain group benefits for a limited time after Your coverage would otherwise end. And, You may have the right to replace certain group benefits with converted policies. The Employer will notify you of any conversion options available.

B400.3135

CONTINUATION OF COVERAGE

Coverage During Disability

If Your Active Work ends because You are Totally Disabled, You and Your Employer may agree to continue Your insurance for the amount of basic and voluntary term life insurance for which You are insured on Your last day of Active Work, subject to continued payment of all required premiums, until the earlier of:

- The date you are no longer Totally Disabled, as defined by this Certificate;
- 12 months; from the date Your Total Disability began;
- The date you are approved for any Waiver of Premium Benefit for which you are eligible; or
- The date of Your 99th birthday.

We may require written Proof of Loss that You remain Totally Disabled and are receiving regular Doctor's care to maintain this benefit. This Proof of Loss must be given to Us within 30 days of the date We request it. Your eligibility for benefits will be governed by all the terms of this Certificate.

Coverage During Temporary Layoff

If Your Active Work ends because You are temporarily laid off, You and Your Employer may agree to continue Your insurance, subject to continued payment of all required premium, until the earlier of:

- The end of the temporary layoff; or
- The end of the month in which You are laid off plus 1 months.
- The end of the time period covered under a severance agreement not to exceed 1 months.

If You die or become Disabled under this Certificate while Your coverage is being continued during a temporary layoff, Your eligibility for benefits will be governed by all the terms of this Certificate.

Coverage During Temporary Leave of Absence

If Your Active Work ends because You go on a leave of absence that has been approved by Your Employer, You and Your Employer may agree to continue Your insurance, subject to continued payment of all required premiums, until the earlier of:

- The end of the Employer approved leave of absence; or

- The end of the month in which Your leave begins plus 1 months.

If You become Disabled under this Certificate while Your coverage is being continued during a leave of absence, Your eligibility for benefits will be governed by all the terms of this Certificate.

B400.3138

All Options

ELIGIBILITY FOR GROUP TERM LIFE COVERAGE DEPENDENT COVERAGE

B400.3143

All Options

Eligible Dependents For Dependent Voluntary Term Life Insurance

Your eligible dependents are Your:

- Spouse who is under age 70; and
- dependent children from 14 days old; and dependent children who are enrolled as full-time students at accredited schools, from age 26, until they reach age 26.

B400.3169

All Options

Adopted Children And Step-Children

Your dependent children include Your legally adopted children and Your step-children. However, to qualify as a dependent, each person must depend on You for at least 50% of their support and maintenance. 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.

B400.3200

All Options

Dependents Not Eligible

We exclude:

- A dependent who is on Active Duty in any armed force.

B400.3201

All Options

Continuing Coverage For Dependent Children Past the Limiting Age

If You have a child or children who:

- Is/are incapable of independent living by reason of a mental, physical, or developmental disability; and
- Is/are primarily dependent upon You for support and maintenance,

Then, the child or children may remain eligible for dependent benefits past the age limit provided all the conditions shown below are satisfied.

Each such child:

- Must have a mental, physical, or developmental disability that began before he or she reached the dependent age limit;
- Became covered by this Certificate, or the prior carrier's group life policy that it replaced, before he or she reached the dependent age limit, and remained continuously covered until he or she reached the age limit;
- Remains:
  - Incapable of independent living; and
  - Dependent upon You for most of his or her support and maintenance; and

You must send Us written proof, and we must approve such proof, of the child's disability and dependence within 31 days from the date he or she reaches the dependent age limit. After the two year period following the child's attainment of the age limit, We can ask for periodic proof that the child's condition continues, but We cannot ask for this proof more than once a year.

Irrespective of this provision, any coverage provided under this section ends when Your coverage ends.

B400.3202

All Options

Proof Of Insurability

Part or all of Your dependent insurance amounts may be subject to proof that they are insurable. The Schedule of Benefits explains if and when We require Proof of Insurability. Your dependents will not be covered for any amount that requires Proof of Insurability until You provide that proof to Us and We approve that proof in writing.

B400.3203

All Options

When Dependent Coverage Starts

In order for Your dependent coverage to start, You must already be covered for Employee coverage, or enroll for Employee and dependent coverage at the same time.

Subject to the Exception shown below and to all of the other terms of this Certificate, the date Your dependent coverage starts depends on when You elect to enroll Your Initial Dependents and agree to make any required payments.

Initial Dependents

If You enroll Your Initial Dependents on or before Your Eligibility Date, the dependents' coverage begins on the later of Your Eligibility Date and the date You become covered for Employee coverage.

If You enroll Your Initial Dependents within the Enrollment Period, their coverage begins on the later of Your Eligibility Date and the date You become covered for Employee coverage.

If You do not enroll Your Initial Dependents when they are first eligible, and enroll those Initial Dependents after the Enrollment Period ends, You must supply Proof Of Insurability and coverage will not start until We approve that proof in writing.

If an Initial Dependent becomes eligible after this Certificate's Effective Date, his or her coverage will start on the date We approve him or her for coverage.

If Dependent Proof of Insurability is required

Subject to the Exception shown below, if Proof Of Insurability is required for dependent benefits, You must send Us the proof We require, and We must approve that proof in writing. Those benefits will then begin on the approved Eligibility Date.

If You must pay part of the cost of dependent coverage, We will not cover You for such coverage until You enroll each of Your dependents, agree to make the required payments, submit Proof Of Insurability and We approve that proof in writing.

Newly Acquired Dependents

If You do not pay any part of the cost of dependent coverage, a Newly Acquired Dependent is covered from the date he or she first becomes eligible.

If You must pay part of the cost of dependent coverage, and are already enrolled for dependent child coverage for Your Initial Dependent children, any Newly Acquired Dependent children will be covered as of the date he or she is first eligible.

However, if You were previously eligible to enroll for dependent child coverage and waived coverage or failed to enroll, We will not cover any of Your dependent children until You submit Proof of Insurability and we approve that proof in writing and you make any additional required payments.

B400.3204

All Options

Exception We will postpone the Eligibility Date of a dependent's, other than a newborn child's, coverage if, on that date, he or she is unable to perform two or more Activities of Daily Living (ADLs).

In that case, We will postpone the Eligibility Date of his or her coverage until the day after the date he or she 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.

B400.3206

All Options

When Dependent Coverage Ends

Dependent coverage ends for all of Your dependents when:

- Your Employee coverage ends;
- You stop being a member of a class of Employees eligible for such coverage;
- This Certificate ends; or
- Dependent coverage is discontinued from this Certificate for all Employees or for Your 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 or she stops being an eligible dependent. For dependent children the coverage ends at 12:01 A.M. Standard Time for Your place of residence on the date the child attains this Certificate's age limit, or when a step-child is no longer dependent on You for at least 50% of their support and maintenance, or for Your disabled child who has reached the age limit, when he or she is no longer eligible under the Continuing Coverage for Dependent Children Past the Limiting Age provision.

Coverage ends for a Spouse when a marriage is lawfully terminated, and with respect to Voluntary life coverage, it happens at 12:01 A.M. on the date the Spouse reaches age 70.

Read this Certificate 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.

B400.3210

EMPLOYEE TERM LIFE INSURANCE

B400.3211

All Options

Basic Term Life Insurance

If You die while covered for Group Term Life insurance, We will pay Your beneficiary the amount shown in the Schedule Of Benefits.

Payment Of Benefits

We will pay this insurance as soon as We receive written Proof of Loss as shown in the Claims Provisions section of this Certificate.

The Beneficiary

You decide who receives this benefit when You die. The name of the beneficiary appears in the enrollment or similar form unless changed by You. Your beneficiary designation should be provided in a means acceptable by Us.

You can change Your beneficiary at any time by providing written notice; unless You have assigned this insurance. But, the change will not take effect until We or the Employer records the change.

We will not be liable for any amounts paid before receiving notice of a beneficiary change.

If You named more than one person as a primary beneficiary, but You do not specify what shares each such primary beneficiary is entitled to receive, We will divide the benefits equally among all such named primary beneficiaries who survive You. If someone You named as a primary beneficiary dies before You, that person's share will be divided equally by the primary beneficiaries still alive; unless You have specified otherwise.

If You have named a contingent beneficiary or contingent beneficiaries, We will pay Your contingent beneficiary or contingent beneficiaries, if no primary beneficiary survives You. If there is more than one contingent beneficiary who is eligible for benefits, We will divide the benefits equally among all such named contingent beneficiaries who survive You; unless You have specified otherwise.

If there is no primary or contingent beneficiary or beneficiaries eligible for benefits when You die, We will pay this benefit as follows:

- To Your Spouse;
- If Your Spouse does not survive You, then to Your children who survive You in equal shares;
- If no Spouse or children survive You, then to Your parents who survive You in equal shares;
- If no Spouse, children, or parents survive You, then to Your brothers and sisters in equal shares;

- If none of the above parties survive You, then to Your executors or administrators of Your estate.

Assigning This Life Insurance

If You assign this insurance, You permanently transfer all Your rights under this insurance to the assignee.

We will recognize an assignee as the owner of the rights assigned only if:

- The assignment is in writing and signed by You; and
- A signed or certified copy of the written assignment has been received and approved by Us in writing.

Unless otherwise specified by You, the assignment shall take effect on the date the notice of assignment is signed by You, subject to any payments made or actions taken by Us prior to receipt of the notice.

We are not responsible for any legal, tax, or other effects of any assignment, or for any benefits We pay under this Certificate before We receive and approve any assignment.

We suggest You speak to Your lawyer before You make any assignment.

Payment Of Funeral Expenses

We have the option of paying up to $500 of this benefit to any person who incurred expenses for Your funeral.

Repatriation Benefit

We will pay an extra sum for covered loss of life which occurs at least 75 miles from Your home. In that case, We will reimburse up to $5,000 to any person who incurred expenses to prepare and transport Your body to a mortuary chosen by You or an authorized agent. The total repatriation benefit payable under Your life and AD&D contracts will not exceed $5,000.

B400.5922

All Options

Voluntary Term Life Insurance

Subject to the limitations and exclusions shown below, if You die while covered for this Group Term Life insurance, We will pay Your beneficiary the amount shown in the Schedule Of Benefits for the plan of voluntary term life insurance You have elected. The voluntary term life insurance amount may be subject to reductions. These reductions are also shown in the Schedule Of Benefits. Your voluntary term life insurance amount, a part of it, 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 Of Benefits.

Payment Of Benefits

Subject to all of the terms of this Certificate, We will pay this insurance as soon as We receive written Proof of Loss as shown in the Claims Provisions section of this Certificate.

B400.3213

All Options

Suicide Exclusion We pay no voluntary term life insurance benefits if Your death is due to suicide, and if such death occurs within 2 years from Your voluntary term life insurance effective date under this Certificate. And, We pay no increased voluntary term life insurance benefit amount if Your death is due to suicide, and if such death occurs within 2 years from the effective date of the increase.

If this Certificate replaces another voluntary Group Term Life insurance plan Your Employer had with another insurer, You will be given credit for the amount of time covered under the prior plan's Suicide Exclusion if:

- You were covered under the prior plan when it ended;
- You Enrolled for voluntary Group Term Life insurance under this Certificate on or before this Certificate's effective date; and
- You are Actively At Work on the effective date of this Certificate.

If You satisfy these conditions We will credit any time covered under the prior term life plan toward meeting this Certificate's 2 year Suicide Exclusion requirement.

However, We limit Your voluntary term life insurance benefit under this Certificate if it is more than the benefit for which You were insured under the prior term life plan. In this case, We limit the benefit to the amount You would have been entitled to under the prior term life plan.

The Beneficiary You decide who receives this benefit when You die. The name of the beneficiary appears in the enrollment or similar form unless changed by You. Your beneficiary designation should be provided in a means acceptable by Us.

You can change Your beneficiary at any time by providing written notice; unless You have assigned this insurance. But, the change will not take effect until We or the Employer records the change.

We will not be liable for any amounts paid before receiving notice of a beneficiary change.

If You named more than one person as a primary beneficiary, but You do not specify what shares each such primary beneficiary is entitled to receive, We will divide the benefits equally among all such named primary beneficiaries who survive You. If someone You named as a primary beneficiary dies before You, that person's share will be divided equally by the primary beneficiaries still alive; unless You have specified otherwise.

If You have named a contingent beneficiary or contingent beneficiaries, We will pay Your contingent beneficiary or contingent beneficiaries, if no primary beneficiary survives You. If there is more than one contingent beneficiary who is eligible for benefits, We will divide the benefits equally among all such named contingent beneficiaries who survive You; unless You have specified otherwise.

If there is no primary or contingent beneficiary or beneficiaries eligible for benefits when You die, We will pay this benefit as follows:

- To Your Spouse;

- If Your Spouse does not survive You, then to Your children who survive You in equal shares;
- If no Spouse or children survive You, then to Your parents who survive You in equal shares;
- If no Spouse, children, or parents survive You, then to Your brothers and sisters in equal shares;
- If none of the above parties survive You, then to Your executors or administrators of Your estate.

Assigning This 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:

- Your Spouse;
- One of Your parents or grandparents;
- One of Your children or grandchildren;
- One of Your brothers or sisters; or
- 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:

- The assignment is in writing and signed by You; and
- A signed or certified copy of the written assignment has been received and approved by Us in writing.

We are not responsible for any legal, tax, or other effects of any assignment, or for any benefits We pay under this Certificate before We receive and approve any assignment.

We suggest You speak to Your lawyer before You make any assignment.

Payment Of Funeral Expenses

We have the option of paying up to $500 of this benefit to any person who incurred expenses for Your funeral.

Repatriation Benefit

We will pay an extra sum for covered loss of life which occurs at least 75 miles from Your home. In that case, We reimburse up to $5,000 to any person who incurred expenses to prepare and transport Your body to a mortuary chosen by You or an authorized agent. The total repatriation benefit payable under Your life and AD&D contracts will not exceed $5,000.

B400.5923

CONVERTING THIS EMPLOYEE BASIC AND VOLUNTARY TERM LIFE INSURANCE

If Employment Or Eligibility Ends

Your group life insurance ends on the date:

- Your active Full-Time employment ends; or
- You stop being a member of an eligible class.

If Your group life insurance ends, Your Employer is responsible for providing You Notice of Your Right to Convert.

If You are not Totally Disabled, You can apply to convert Your Employee group basic and voluntary life insurance to a permanent life insurance policy.

You can apply to convert up to the full amount of basic and voluntary life insurance for which You were insured under this Certificate on the date Your insurance ended, less any group life insurance for which You become eligible in the 31 days after Your insurance under this Certificate ends.

If This Certificate Ends Or Group Life Insurance Is Discontinued

Your group life insurance also ends:

- If this Certificate ends; or
- Life insurance is discontinued from this Certificate for all Employees or for Your class.

If Your group life insurance ends for either of these reasons, You may apply to convert Your Employee group basic and voluntary life insurance to a Converted Policy.

You can apply to convert to a permanent life insurance policy, if

- You are not Totally Disabled; and
- You have been insured by a Guardian group life insurance plan or a group plan it replaces for at least five consecutive years.

However, the amount of life insurance that You can convert in either scenario is limited to the lesser of:

- $10,000.00, or
- The amount of Your basic and voluntary life insurance under this Certificate, less any group life insurance for which You become eligible in the 31 days after Your insurance under this Certificate ends.

If You Are Totally Disabled

Your group life insurance ends on the date:

- Your active Full-Time employment ends;
- You stop being a member of an eligible class;
- This Certificate ends; or

- Life insurance is discontinued from this Certificate for all Employees or for Your class;

and

- You are Totally Disabled; and
- You are eligible for Waiver of Premium Benefits pursuant to the Waiver of Premium Benefit Rider, but You have not yet been approved for the Waiver of Premium of Benefit,

You can apply to convert Your group term life insurance to:

- A permanent life insurance policy; or
- Interim term life insurance coverage.

You can apply to convert up to the full amount of basic and voluntary life insurance for which You are insured under this Certificate on the date Your insurance ends, less any group life insurance for which You become eligible in the 31 days after Your insurance under this Certificate ends.

However, if You have coverage under this Certificate's Exception to When Employee Coverage Starts, You may not convert if You are eligible or could become eligible under the prior plan's waiver of premium provision.

If You have converted and are later approved for this Certificate's Waiver of Premium Benefit, the Converted Policy will be cancelled as of the date You are approved for the Waiver of Premium Benefit. In this instance, Your coverage under this Certificate will continue subject to its terms, provided You remain eligible for the Waiver of Premium Benefit.

Interim Term Life Insurance

You may choose to apply to convert to interim term life insurance coverage if:

- You are Totally Disabled; and
- You may be eligible for Waiver of Premium Benefits based upon Your age, but You have not yet been approved for the Waiver of Premium Benefit.

If interim term life insurance coverage is issued to You, it can remain in force for up to one year from the date the interim term life insurance coverage goes into force and effect.

If You are approved for this Certificate's basic and voluntary Waiver of Premium Benefit during this year, the interim term life insurance coverage will be cancelled as of the date that You are approved for the Waiver of Premium Benefit. In this instance, Your coverage under this Certificate will continue subject to its terms, provided You remain eligible for the Waiver of Premium Benefit. If You have not been approved for this Certificate's basic and voluntary Waiver of Premium Benefit, the interim term life insurance coverage will end exactly one year from the first day said coverage goes into force and effect, and Your life insurance will be converted to a permanent life insurance policy. Premiums for the permanent life insurance policy will be based on Your age as of the date You convert from the interim term life insurance coverage.

If You are Totally Disabled, but You are not eligible for the Waiver of Premium Benefit based on Your age, You can apply to convert to a permanent life insurance policy.

How and When to Convert

To obtain a Converted Policy, We must receive a written application fully completed by You, and all required premiums within the Conversion Period. Your Employer is responsible for providing You with Notice of Your Right to Convert within 15 days of the date Your group life insurance ends. We will not ask for proof that You are insurable. In order to obtain a Converted Policy, You must satisfy all conditions required to convert within the Conversion Period.

Coverage will begin under the Converted Policy when We receive:

- A written application fully completed by You; and
- All required premiums during the Conversion Period.

Death During The Conversion Period

We will pay a death benefit equal to the amount of life insurance that could have been converted if:

- You die within the Conversion Period; and
- But for Your death, You would have been entitled to purchase a Converted Policy; and
- We receive Proof of Loss.

Any benefit payable under the group Certificate will be paid to the beneficiary You designate under the group Certificate. However, if the Converted Policy has already taken effect, any benefit payable under the Converted Policy will be paid to the beneficiary You designated for the individual life insurance on the application for conversion. Under no circumstances will a benefit be paid under both the group Certificate and the Converted Policy.

B400.8808

All Options

Portability And Conversion

If You choose to convert, this Certificate's portability privilege will not be available. In the event that a person would be eligible to both convert and to port, only one of these privileges may be chosen. Coverage under both a Conversion Policy and a portable certificate of coverage at the same time is not permitted. You should read the entire Certificate, as well as any related materials carefully before making a choice.

B400.3234

DEPENDENT TERM LIFE INSURANCE

B400.3235

All Options

Voluntary Term Life Insurance

A Subject to the limitations and exclusions shown below, If Your dependent dies while insured for this benefit, We will pay You the amount shown in the Schedule Of Benefits. If You are not living when Your dependent dies, We will pay this benefit as follows:

If the dependent was Your Spouse, We will pay this benefit to the Spouse's estate. If there is no established estate, We will pay this benefit in equal shares to the first eligible party or parties in the following order:

- To Your Spouse's children in equal shares;
- If no children survive him or her, then to his or her parents in equal shares;
- If no children, or parents survive him or her, then to then to his or her brothers and sisters in equal shares;
- If none of the above parties survive Your Spouse, then to the executors or administrators of Your estate.

If the dependent was Your child, we will pay this benefit in equal shares to the first eligible party or parties in the following order:

- Your child's custodial parent(s);
- If no custodial parent survives him or her, then to Your parents;
- If no custodial parent or Your parents survive him or her, then to Your child's estate;
- If none of the above parties survive him or her and no estate exists, then to the executors or administrators of Your estate;
- If none of the above parties survive him or her, and no estates exist, then to Your child's siblings.

We have the option of paying up to $500 of this benefit to any person who incurred expenses for your dependent's funeral.

Payment Of Benefits

Subject to all of the terms of this Certificate, We will pay this insurance as soon as We receive written Proof of Loss which is acceptable to Us. This should be sent to Us as soon as possible. We will pay this benefit in a lump sum.

B400.3238

All Options

The Choices: You may elect coverage of any of the plans of dependent Spouse voluntary term life insurance and any of the plans of dependent child voluntary term life insurance offered by the Employer. These plans are shown in the Schedule Of Benefits. But, You can only be covered for one Spouse plan and one child plan at a time. You must notify the Employer of Your election and pay the required premium.

You may switch to another Spouse and child plan during the dependent voluntary life enrollment period shown in the Schedule Of Benefits. Subject to any of this Certificate's Proof Of Insurability requirements, You will be covered for the new plan as of the transfer date shown in the Schedule of Benefits. You must notify the Employer of any desired switch.

B400.3242

All Options

Suicide Exclusion We pay no voluntary term life insurance benefits if Your dependent's death is due to suicide, if such death occurs within 2 years from his or her voluntary term life insurance effective date under this Certificate. And, We pay no increased voluntary term life insurance benefit amount if Your dependent's death is due to suicide, if such death occurs within 2 years from the effective date of the increase.

If this Certificate replaces another voluntary term life insurance plan Your Employer had with another insurer, your dependent may be given credit for the amount of time covered. If your dependent was:

- Covered under the prior plan when it ended;
- Enrolled for insurance under this Certificate on or before this Certificate's effective date; and
- You were actively working on the effective date of this Certificate;

We credit any time covered under the prior plan toward meeting this Certificate's 2 year Suicide Exclusion requirement.

However, We limit Your dependent voluntary term life insurance benefit under this Certificate if it is more than the benefit for which Your dependents were insured under the prior plan. In this case, We limit the benefit to the amount Your dependents would have been entitled to under the prior plan.

B400.3246

CONVERTING THIS DEPENDENT TERM LIFE INSURANCE

If A Dependent's Life Insurance Ends

Dependent term life insurance ends for all of Your dependents when Your group life insurance eligibility ends. Your group life insurance eligibility ends if:

- Your active Full-Time employment ends;
- You stop being a member of an eligible class; or
- Your group life insurance is continued under the Waiver of Premium Benefit provision; or
- 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 Dependent Life Insurance ends for any of the above reasons any dependent who was insured under this Certificate may apply to convert all or part of the amount for which he or she was insured on the day before insurance ended. Your Employer is responsible for notifying You or Your dependents of any conversion options available.

Your dependent may apply to convert up to the full amount of voluntary life insurance for which he or she was insured under this Certificate on the date his or her insurance ended to a permanent life insurance policy.

If This Certificate Ends Or Group Life Insurance Is Discontinued

Dependent term life insurance also ends for all of Your dependents:

- If this Certificate ends; or
- Dependent life insurance is discontinued from this Certificate for all Employees or for Your class.

If Dependent term life insurance ends for either of these reasons, and any of Your dependents have been insured by a Guardian Group plan, or a group plan it replaces, for at least five consecutive years, each such dependent may apply to convert to a permanent life insurance policy.

However the amount that he or she can convert in either scenario is limited to the lesser of:

- $10,000.00; or
- The amount of Your dependent's life insurance under this Certificate, less any group life insurance for which Your dependent becomes eligible in the 31 days after dependent life insurance under this Certificate ends.

If A Dependent Stops Being Eligible

A dependent's term life insurance ends when he or she stops being an eligible dependent. A Spouse is no longer an eligible dependent when:

- A marriage is lawfully terminated; or

- He or she reaches age 70.

A child is no longer an eligible dependent when he or she:

- Reaches the limiting age.

If a dependent stops being eligible, he or she may convert all or part of the amount for which he or she was insured on the day before insurance ended to a permanent life insurance policy.

B400.8815

All Options

How And When to Convert

To obtain a Converted Policy, We must receive a written application fully completed by You or Your dependent, and all required premiums within the Conversion Period. Your Employer is responsible for providing You and Your dependents with written Notice of Your Right to Convert within 15 days of the date Your group life insurance ends. You will have 31 days after Your dependent group voluntary life insurance ends to convert. We will not ask for proof that he or she is insurable. If the dependent is a minor or incompetent, the person who cares for and supports the dependent may apply for him or her.

Death During The Conversion Period

We will pay a death benefit equal to the amount of dependent life insurance that could have been converted if:

- Your dependent dies within the Conversion Period; and
- But for his or her death, Your dependent would have been entitled to purchase a Converted Policy; and
- We receive Proof of Loss.

Any benefit payable under the group Certificate will be paid to you. However, if the Converted Policy has already taken effect, any benefit payable under the Converted Policy will be paid to the beneficiary You or Your dependent designated for the individual life insurance on the application for conversion. Under no circumstances will a benefit be paid under both the group Certificate and the Converted Policy.

B400.3501

CLAIM PROVISIONS

Your right to make a claim for Group Term Life insurance benefits provided by this Certificate is governed as follows:

Authority We have discretionary authority to:

- Interpret the terms of this Certificate; and
- Determine Your eligibility for coverage and benefits under this Certificate.

All such determinations are conclusive and binding, except that they may be modified or reversed by a court or regulatory agency with appropriate jurisdiction.

Notice Written notice of intent to file a claim under this Certificate must be sent to Us within 20 days of the date of the loss. This Notice should include the name of the insured and the Policy number. If the claim is being made for any other Covered Person, his or her name should also be shown. For details, You can call Us at 1-800-525-4542.

Claim Forms We will furnish forms for filing proof of death within 15 days of receipt of Notice. If we do not furnish the forms on time, We will accept a written Notice and adequate proof of death that is the basis of the claim as Proof of Loss.

Proof of Loss You must send written Proof of Loss to Our designated office within 90 days of the loss.

Late Notice and Proof of Loss We will not void or reduce Your claim if we do not receive Notice and Proof of Loss within the required time. In that case, Notice and Proof of Loss must be sent as soon as reasonably possible.

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

The Guardian Life Insurance Company of America
Group Life Claims Department
P.O. Box 14334
Lexington, KY 40512

Payment of Benefits We will pay the Group Term Life insurance benefit as soon as We receive written Proof of Loss.

If the benefit is not paid within 30 days, interest will be paid on the proceeds beginning on the 31st day until the time benefits are paid. If the benefit is not paid within 180 days, interest will be paid on the proceeds from the date of receipt of written Proof of Loss until the time benefits are paid. Interest will be computed daily at the rate of interest currently payable on individual life policy dividends left on deposit. Such amount shall be added to the life insurance benefit amount.

Legal Actions No legal action against Guardian related to this Certificate may be brought until 60 days from the date Proof of Loss has been given as shown above. No legal action may be brought against Guardian related to claims for benefits under this Certificate after three years from the date of the final benefit determination.

B400.5924

All Options

DEFINITIONS

This section defines certain terms appearing in this Certificate.

B400.3503

All Options

Active Work or Actively At Work These terms mean You are able to perform, and are performing, all of the regular duties of Your work for the Employer, on a Full-Time basis at:

- One of the Employer's usual places of business;
- Some place where the Employer's business requires You to travel; or
- Any other place You and the Employer have agreed on for Your work.

B400.3504

All Options

Activities Of Daily Living This term means the ability to independently perform the following, with or without equipment or adaptive devices:

- **Bathing:** wash in a tub or shower; or take a sponge bath; and towel dry.
- **Dressing:** put on and take off all clothes; and those medically necessary braces or prosthetic limbs usually worn; and fasten or unfasten them.
- **Toileting:** get to and from and on and off the toilet; to maintain personal hygiene; and care for clothes.
- **Transferring:** move in and out of a chair or bed.
- **Continence:** control bowel and bladder function; or, in the event of incontinence, maintain personal hygiene.
- **Eating:** get food into the body by any means once it has been prepared and made available.

B400.3505

All Options

Certificate This term means this Certificate of Coverage, including any riders and enrollment forms that may be attached to this Certificate.

B400.3506

All Options

Conversion Period This term means the consecutive 31 day period beginning on the date Your Employee and dependent group basic and voluntary life insurance ends.

B400.3512

All Options

Converted Policy This term means a policy which provides individual life insurance, on an interim term or permanent basis, resulting from the option to convert provided in the Policy. The Converted Policy will not provide any:

- Benefits for accidental death;
- Waiver of Premium Benefits; or
- Other supplemental benefits.

The benefits provided by the Converted Policy may not be the same as the benefits provided by this Certificate.

The premium for the Converted Policy will be based on

- Your risk and rate class under this Certificate; and
- Your age on the date the Converted Policy goes into effect.

B400.3513

All Options

Covered Person This term means the Employee and dependents who are insured by this Certificate.

B400.3514

All Options

Disabled This term means the Covered Person is:

- Not able to perform any work for wage or profit; and
- Receiving Regular and Appropriate Care for the cause of Disability.

B400.3516

All Options

Doctor Any medical practitioner We are required by law to recognize. He or she must:

- Be properly licensed or certified by the laws of the state where he or she practices; and
- Provide services that are within the lawful scope of his or her practice.

B400.3517

All Options

Effective Date This term means the date the Certificate goes into force and effect as stated on the cover page of the Certificate of Coverage, or any change to the Certificate as requested by the Policyholder and approved by Us and in force and effect as stated on the cover page of the Certificate of Coverage.

B400.3518

All Options

Eligibility Date This term means the earliest date a Covered Person is eligible for coverage under this Certificate, and he or she has satisfied all requirements for coverage to begin, as required by this Certificate.

- For Employee coverage, this term means the earliest date You are eligible for coverage under this Certificate.
- For an Employee in Active Work who has completed any waiting period required by the Employer as of the Effective Date of this Certificate, the Eligibility Date means the Effective Date of this Certificate.
- For an Employee in Active Work as of the Effective Date of this Certificate who has not completed any waiting period required by the Employer, the Eligibility Date will be the date following the completion of the required waiting period.
- For an Employee hired on or after the Effective Date of this Certificate, the Eligibility Date will be the later of the Employee's date of hire or the first date after the end of any waiting period required by the Employer.

If this plan requires Employees to elect coverage under this Certificate, the Eligibility Date will be the later of:

- The Employee's date of hire;
- The first date after any waiting period required by the Employer; or
- The approval by Us in writing of any coverage for which You were required to provide Proof of Insurability.

For dependent coverage, this term means the earliest date on which:

- You have Initial Dependents; and
- Are eligible for dependent coverage.

B400.3519

All Options

Employee This term means a person who works for the Employer at the Employer's place of business and whose income is reported to the United States Internal Revenue Service, and/or a state, for tax purposes. Partners and proprietors will also be treated as employees if the Conditions of Eligibility requirements are met.

B400.3521

All Options

Employer This term means 2 CIRCLE, INC .

B400.3522

All Options

Enrollment Period This term means the 31 day period which starts on the date the Covered Person first becomes eligible for coverage.

B400.3523

All Options

Full-Time This term means You are not a part time Employee as defined by Your Employer and the average number of hours You worked for the 6 months prior to the last full day worked was at least 30 hours per week at:

- Your Employer's place of business;
- Some place where the Employer's business requires You to travel; or
- Any other place You and Your Employer have agreed upon for the performance of occupational duties.

B400.3525

All Options

Initial Dependents This term 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.

B400.3526

All Options

Newly Acquired Dependent This term means an eligible dependent You acquire after You already have coverage in force for Initial Dependents.

B400.3538

All Options

Notice of Right to Convert This term means the written notice presented to You by the Employer, delivered to Your last known address.

B400.3539

All Options

Policy or Plan This term means the Group Term Life insurance coverage described in the Policy and this Certificate.

B400.3541

All Options

Proof Of Insurability This term means the completion of an evidence of insurability requirement as defined in the Schedule of Benefits.

B400.3542

All Options

Proof of Loss This term means the documents that are deemed acceptable for purposes of substantiating a claim. Acceptable Proof of Loss includes:

- An original certified finalized death certificate;
- The beneficiary designation in effect at the time of death;
- Enrollment information documenting that the insured was properly enrolled for the amount of coverage claimed;
- A fully completed claim form; and
- Any additional information deemed necessary during the course of Our claim investigation. This may include, but is not limited to, an autopsy report, investigative reports, toxicology reports and medical records.

B400.3543

All Options

Reasonable Accommodation This term means any modification or adjustment that the Employer willingly provides to:

- A job;
- An employment practice;
- A work process; or
- The work place.

The modification or adjustment must make it possible for a Disabled person to:

- Reach the same level of performance as a similarly situated non-disabled person; or
- 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.

B400.3545

All Options

Regular and Appropriate Care This term means, with respect to Your disabling condition(s) and any other condition(s) which, if left untreated, would adversely affect Your disabling condition, You:

- Visit a Doctor as frequently as medically required, according to generally accepted medical standards, to effectively manage these conditions; and
- Are receiving the most appropriate treatment, according to generally accepted medical standards, designed to achieve maximum medical improvement in these conditions.

Treatment must be provided by a Doctor or Doctors whose specialty is most appropriate according to generally accepted medical standards for Your:

- Disability; and
- Any other conditions which left untreated would adversely affect Your disabling condition.

Generally accepted medical standards are those 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 Institute;
- The National Institutes of Health;
- The Department of Health and Human Services; and
- Any other agency of similar repute.

B400.3546

All Options

Spouse This term means the person to whom You are legally married, or Your domestic partner, civil union partner or equivalent, as recognized and allowed by federal law, or state law in Your state of residence or the state in which the marriage or Your domestic partnership, civil union, or equivalent, was recorded.

B401.1733

All Options

Total Disability and Totally Disabled This term means that, due to sickness or injury, the Covered Person is:

- Not able to perform any work for wages or profit; and
- Receiving Regular and Appropriate Care for the cause of disability.

B400.3548

All Options

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

B400.3550

All Options

You or Your These terms mean the insured Employee.

B400.3551

All Options

GROUP TERM LIFE SCHEDULE OF BENEFITS

B400.4199

All Options

Employee Basic Term Life Insurance Schedule

B400.4200

All Options

Basic Term Life Insurance Amount

Insurance Amount $100,000.00

B400.4213

All Options

Reduction of Basic Life Insurance Amount Based on Age

If You are less than age 65 when Your insurance under this Policy starts, Your insurance amount is reduced at 12:01 A.M Standard Time for Your place of residence on the date You reach age 65, by 35% of the amount which otherwise applies to Your classification. But in no case will such reduced amount be less than $1,000.00. This reduction also applies to Your initial insurance amount if Your insurance starts after You reach age 65 but before You reach age 70.

If You are less than age 70 when Your insurance under this Policy starts, Your basic life insurance amount is reduced at 12:01 A.M Standard Time for Your place of residence on the date You reach age 70, by 50% of the amount which otherwise applies to Your classification. But in no case will such reduced amount be less than $1,000.00. This reduction also applies to Your initial insurance amount if Your insurance starts after You reach age 70.

With respect to any of the reductions described above, the reduced insurance amount is in place of the amount which otherwise applies to Your classification.

B400.4361

All Options

Limitations For Future Entrants

But, regardless of any of the above reductions, we limit Your initial insurance amount as shown below if Your insurance under this Policy starts both:

(a) after this Policy's effective date; and

(b) after you reach age 70.

The limited amount is in place of the amount which otherwise applies to Your classification.

If you give Us Proof Of Insurability, and We approve it in writing, Your insurance amount will be 50% of the amount which otherwise applies to Your classification. But in no event will this reduced amount be less than $10,000.00.

If you do not give Us Proof Of Insurability or We do not approve Your Proof, Your insurance amount will be $10,000.00.

B400.4369

All Options

Proof of Insurability

Depending on the coverage selected, or as otherwise required in this Certificate, You, Your Spouse and/or Dependents may be required to supply proof that the person applying for coverage is insurable for the amount and type of coverage selected. This requirement is called Proof of Insurability. For purposes of this section, any person applying for coverage requiring Proof of Insurability is referred to as "Applicant."

To determine if the Applicant is required to submit Proof of Insurability for the type and amount of coverage sought, please see below.

Any applicant required to submit Proof of Insurability is required to complete and submit to Us an Enrollment/Change form. We may also require the completion of additional forms so that We may determine whether the Applicant is insurable, according to Our underwriting standards for the amount and type of coverage applied for. To determine if the Applicant is insurable, We may also need to obtain and review the Applicant’s

- Health and medical history;
- Prescription history;
- Records relating to treatment, diagnostic testing, hospitalization, and
- Records pertaining to Applicant’s driving and motor vehicle history.

No coverage requiring Proof of Insurability will become effective unless and until it is approved by Us in writing. Our receipt of any premiums associated with coverage requiring Proof of Insurability does not waive or modify any requirement that must be satisfied for coverage to begin, including but not limited to the requirement that the Applicant submit Proof of Insurability. In the event that any premiums are overpaid, Our only obligation is to return the amount of overpaid premiums.

The Policyholder, or its designee, must give Us complete and accurate information so that we may determine:

- Who is insured;
- The type and amount of coverage for which someone is insured; and
- Any other information required so that Guardian may meet its obligations under the Policy.

Proof Of Insurability Requirements

Proof Of Insurability requirements apply to Basic Term Life Insurance. Such requirements may apply to the full insurance amount, or just part of it, as outlined below. When Proof Of Insurability requirements apply, it means You must submit to Us Proof that You are insurable, and We must approve the Proof in writing before the insurance, or the specified part becomes effective.

We require Proof of Insurability as follows:

If You:

- Do not meet this Policy's enrollment requirement within 30 days after You first become eligible; or
- Enroll after You previously had coverage which ended because You failed to make a required payment,

We will require that You provide Proof Of Insurability. And, You will not be covered until We approve that proof in writing.

If Your Active Full-Time Work ends before You meet any Proof Of Insurability requirements that apply You will still have to meet those requirements if You are later re-employed by the Employer or an associated company.

B400.4376

All Options

Employee Voluntary Term Life Insurance Schedule

B400.4492

All Options

Initial Election

You may choose to be insured under the plan of Voluntary Term Life Insurance shown below. You must notify the Employer of Your election and pay the required premium.

B400.4493

All Options

Changing Election

You may switch to another plan of Voluntary Term Life Insurance during the Voluntary life enrollment period. Each year, the Voluntary life enrollment period starts on July 1st and ends on July 31st. You must notify the Employer of any desired switch. We may require Proof Of Insurability before You become insured under the new plan of benefits. See below For details. If We do not require Proof, You will become insured under the new plan of benefits as of the August 1st which coincides with or next follows the end of the Voluntary life enrollment period.

B400.4495

All Options

Voluntary Term Life Insurance Amount

Plan A

You may elect amounts of voluntary term life insurance in increments of $10,000.00, but the amount may not be less than $10,000.00 and may not exceed $300,000.00.

B400.4510

All Options

Annual Election

After You first enroll for Employee Voluntary Term Life Insurance, You may choose to increase Your amount of Voluntary Term Life Insurance by an amount not to exceed an increase of $50,000 as shown above. This option is available once annually during the Voluntary life enrollment period described above. Proof Of Insurability will not be required unless the insurance amount exceeds the amount of Voluntary Term Life Insurance for which Proof Of Insurability is required as shown below.

If Proof Of Insurability is required and has been submitted and approved by Us, Proof of Insurability for additional increases will be required on the second anniversary of the date we approve such coverage.

If Proof Of Insurability is required and has been declined, You will not be eligible for additional annual increases without submitting Proof Of Insurability for them, and then if such increases are approved by Us in writing.

B400.4698

All Options

Family Status Change

You may request a change to your Voluntary Term Life Insurance coverage if you have experienced a Family Status Change.

A Family Status Change includes one or more of the following:

- Marriage or divorce;
- Death of a Spouse or child;
- Birth or adoption of a child;
- Your Spouse’s termination of employment or a change in Your Spouse’s employment that results in the loss of group coverage.

The term "marriage" may also refer to civil unions and domestic partnerships, as recognized by the jurisdiction in which You reside.

If a change in Family Status occurs, You may request an increase to Your Voluntary Term Life Insurance amount or the addition of Employee voluntary term life for which You were not previously insured. You may also request an increase or the addition of dependent Spouse or dependent child Voluntary Term Life Insurance for your living eligible dependents. You must provide proof of the Family Status Change and request the change to Your Voluntary Term Life Insurance in writing within 31 days after the date of the Family Status Change as described below.

Proof Of Insurability is not required for the change to Voluntary Term Life Insurance due to Family Status Change as long as the change to Your Voluntary Term Life Insurance does not exceed the Proof of Insurability requirements as shown in the Schedule of Benefits. Refer to When Coverage Begins and When Dependent Coverage Begins in the Eligibility section of Your Certificate for information regarding when this coverage is effective.

B400.3558

All Options

Reduction of Voluntary Life Insurance Amount Based on Age

If You are less than age 65 when Your insurance under this Policy starts, Your insurance amount is reduced at 12:01 A. M. Standard Time for your place of residence on the date You reach age 65, by 35% of the amount which otherwise applies to Your classification. But in no case will such reduced amount be less than $1,000.00. The reduced amount is in place of the amount which otherwise applies to Your classification. This reduction also applies to Your initial insurance amount if Your insurance starts after You reach age 65, but before You reach age 70.

If You are less than age 70 when Your insurance under this Policy starts, Your insurance amount is reduced at 12:01 A. M. Standard Time for your place of residence on the date You reach age 70, by 60% of the amount which otherwise applies to Your classification. But in no case will such reduced amount be less than $1,000.00. The reduced amount is in place of the amount which otherwise applies to Your classification. This reduction also applies to Your initial insurance amount if Your insurance starts after You reach age 70.

B400.4734

All Options

Proof Of Insurability Requirements

Depending on the coverage selected, or as otherwise required in this Certificate, You may be required to supply proof that the person applying for coverage is insurable for the amount and type of coverage selected. This requirement is called Proof of Insurability. For purposes of this section, any person applying for coverage requiring Proof of Insurability is referred to as "Applicant."

To determine if the coverage requires an applicant to submit Proof of Insurability, please see below.

Any applicant required to submit Proof of Insurability is required to complete and submit to Us an Enrollment/Change form. We may also require the completion of additional forms so that We may determine whether the Applicant is insurable, according to Our underwriting standards for the amount and type of coverage applied for. To determine if the Applicant is insurable, We may also need to obtain and review the Applicants:

- Health and medical history;
- Prescription history;
- Records relating to treatment, diagnostic testing, hospitalization; and
- Records pertaining to an Applicants driving and motor vehicle history.

No coverage requiring Proof of Insurability will become effective unless and until it is approved by Us in writing. Our receipt of any premiums associated with coverage requiring Proof of Insurability does not waive or modify any condition that must be satisfied for coverage to begin, including but not limited to the requirement that the applicant submit Proof of Insurability. In the event that any premiums are overpaid, Our only obligation is to return the amount of overpaid premiums.

The Policyholder, or its designee, must give Us complete and accurate information so that we may determine:

- Who is insured;
- The type and amount of coverage for which someone is insured; and

Any other information required so that Guardian may meet its obligations under the Policy.

Proof Of Insurability Requirements

Proof of Insurability requirements apply to Voluntary Term Life Insurance. Such requirements may apply to the full insurance amount, or just part of it, as outlined below. When Proof of Insurability requirements apply, it means You must submit to Us Proof that You are insurable, and We must approve the Proof of Insurability in writing before the insurance, or the specified amount of insurance becomes effective.

We require Proof of Insurability as follows:

B400.4903

All Options

Except as provided for annual election, We require Proof of Insurability before You switch from Your current increment of Voluntary Term Life Insurance to an increment which provides a greater amount of insurance.

B400.5270

All Options

We require Proof of Insurability before We will insure You if You enroll for Voluntary Term Life Insurance after the time allowed for enrolling as specified in this Policy.

B400.4906

All Options

We require Proof of Insurability for amounts of Voluntary Term Life Insurance which exceed $100,000.00.

B400.4912

All Options

We require Proof for amounts of Voluntary Term Life Insurance which exceed of $50,000.00, if Your scheduled Voluntary term life effective date is after You reach age 65.

B400.4915

All Options

We require Proof for amounts of Voluntary Term Life Insurance which exceed of $10,000.00, if Your scheduled Voluntary term life effective date is after You reach age 70.

B400.4915

All Options

Dependent Voluntary Term Life Insurance Schedule

B400.5473

All Options

Initial Election You may choose the plan of dependent Spouse Voluntary Term Life Insurance and the plan of dependent child Voluntary life insurance shown below. You must notify the Employer of Your election and pay the required premium.

B400.5476

All Options

Voluntary Dependent Spouse Term Life Insurance Amount

Plan A

An amount equal to 50% of Your voluntary term life insurance amount, to a maximum of $150,000.00.

B400.5553

All Options

Voluntary Dependent Child Insurance Amount

Plan A

Child's Age At Death	Insurance Amount (expressed as a % of Your voluntary life insurance amount)
At least 14 days but less than 26 years; less than 26 years if a full-time student	10% to a maximum of $10,000.00

B400.6721

All Options

In no event may the insurance amount of a dependent Spouse exceed 50% of Your insurance amount.

B400.6652

All Options

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

B400.6653

All Options

Reduction of Dependent Voluntary Life Insurance Amount Based on Age

An employee's dependent benefits are reduced in the same manner as his or her employee benefits. The dependent reductions are based on the employee's age.

B400.5474

All Options

Proof Of Insurability Requirements

Depending on the coverage selected, or as otherwise required in this Certificate, Your Spouse and Dependent Children may be required to supply proof that the person applying for coverage is insurable for the amount and type of coverage selected. This requirement is called Proof of Insurability. For purposes of this section, any person apply for coverage requiring Proof of Insurability is referred to as "Applicant."

To determine if the Applicant is required to submit Proof of Insurability for the type and amount of coverage sought, please see below.

Any applicant required to submit Proof of Insurability is required to complete and submit to Us an Enrollment/Change form. We may also require the completion of additional forms so that we may determine whether the Applicant is insurable according to our underwriting standards for the amount and type of coverage applied for. To determine if the Applicant is insurable, We may also need to obtain and review the Applicant's:

- Health and medical history;
- Prescription history;

- Records relating to treatment, diagnostic testing, hospitalization; and
- Records pertaining to the Applicant's driving and motor vehicle history.

No coverage requiring Proof of Insurability will become effective unless and until it is approved by Us in writing. Our receipt of any premiums associated with coverage requiring Proof of Insurability does not waive or modify any requirement that must be satisfied for coverage to begin, including but not limited to the requirement that the Applicant provide Proof of Insurability. In the event that any premiums are overpaid, Our only obligation is to return the amount of overpaid premiums.

The Policyholder, or its designee, must give Us complete and accurate information so that We may determine:

- Who is insured;
- The type and amount of coverage for which someone is insured; and
- Any other information required so that Guardian may meet its obligations under the Policy.

We require Proof of Insurability as follows:

B400.6014

All Options

We require Proof Of Insurability that a dependent is insurable if You:

- Enroll a dependent, submit the dependent's signed health statement, and agree to make the required payments after the end of the Enrollment Period;
- In the case of a Newly Acquired Dependent, other than the first newborn child, have other eligible dependents who You have not elected to enroll; or
- In the case of a Newly Acquired Dependent, have other eligible dependents whose coverage previously ended because You failed to make the required contributions, or otherwise chose to end such coverage.

B400.6018

All Options

A dependent is not covered by any part of this Policy that requires such proof until You give Us this proof and We approve it in writing.

If Your dependent coverage ends for any reason, including failure to make the required payments, Your dependents will not be covered by this Policy again until You give Us new proof that they are insurable and We approve that proof in writing.

B400.6019

All Options

We require Proof of Insurability before We will insure any dependent Spouse who is enrolled for dependent Spouse Voluntary Term Life Insurance after the time allowed for enrolling as specified in this Policy.

B400.6048

All Options

We require Proof of Insurability for any increase in the amount of dependent Voluntary Term Life Insurance with respect to a dependent Spouse.

B400.6049

All Options

We require Proof of Insurability for any amount of dependent Voluntary Term Life Insurance in excess of $25,000.00 with respect to a dependent Spouse.

B400.6051

All Options

We require Proof of Insurability for any amount of dependent Voluntary Term Life Insurance In excess of $10,000.00 with respect to a dependent Spouse, if the dependent Spouse's scheduled dependent Voluntary term life effective date is after he or she reaches age 65.

B400.6050

All Options

We require Proof of Insurability before We will insure any dependent child who is enrolled for dependent child Voluntary Term Life Insurance after the time allowed for enrolling as specified in this Policy.

B400.6060

All Options

We require Proof of Insurability for any increase in the amount of dependent Voluntary Term Life Insurance with respect to a dependent child.

B400.6061

All Options

Changes to Insurance

B400.6066

All Options

Changes In Insurance Amounts

If You are not Actively At Work on a Full-Time basis, any change in Your amount of coverage will not become effective prior to the date You return to Active Work on a Full-Time basis.

B400.6069

Changes In Insurance Classification

If Your classification changes, insurance will not be changed to the new amount until the first day on which You are:

- Actively At Work on a Full-Time basis; and
- Make a contribution, if required, for the new classification.

If a contribution is required for the new classification for which a larger amount of insurance is provided, You must make the required contribution for the new amount within 31 days of the change. If You do not make the required contribution within 31 days of the change or within 31 days of becoming Actively At Work on a Full-Time basis, if You are not Actively At Work on a Full-Time basis, when Your classification changes, no increase will be allowed due to such change or any later change. In that case, in order to become insured for the larger amount, You must:

- Make the required contribution for the new amount; and
- Furnish Proof Of Insurability to Us, which We approve in writing.

If the insurance amount was previously reduced because of age or retirement, it will be retained at the reduced amount.

B400.6072

SUPPLEMENTAL RIDER - Accelerated Life Benefit

This Rider is effective as of the effective date of the Employee's Certificate. If this Rider is added to an inforce Certificate, the Rider becomes effective on its issue date. This Rider amends the Certificate by the addition of the following:

Note: This benefit is not available for retirees.

Employee Accelerated Basic and Voluntary Life Benefit

IMPORTANT NOTICE: USE OF THIS BENEFIT MAY HAVE TAX IMPLICATIONS. IT MAY ALSO AFFECT GOVERNMENT BENEFITS OR CLAIMS OF CREDITORS. YOU SHOULD CONSULT YOUR TAX OR FINANCIAL ADVISOR BEFORE YOU APPLY FOR THIS BENEFIT.

THE AMOUNT OF YOUR GROUP TERM LIFE INSURANCE IS PERMANENTLY REDUCED BY THE GROSS AMOUNT OF THE ACCELERATED LIFE BENEFIT.

Accelerated Life Benefit

You may be eligible for an Accelerated Life Benefit if you meet the following conditions:

- You have a Terminal Condition;
- You supply the required written proof of Your Terminal Condition (see "How To Apply");
- You apply for this benefit in writing while living and before You attain age 60. If You are unable to request this benefit yourself, Your legal representative may request it on Your behalf.

This benefit is a payment of part of Your Group Term Life Insurance made to You before death. You may use this benefit in any way You choose, subject to the restrictions stated below.

If You qualify for the Accelerated Life Benefit, We will subtract the Gross Amount paid to You as an Accelerated Life Benefit from the amount of Your Group Term Life Insurance under the Certificate. The remaining amount of Group Term Life Insurance is permanently reduced by the Gross Amount of this benefit.

You may only receive one Employee Accelerated Life Benefit during Your lifetime. This benefit does not have to be repaid, even if You:

- Live longer than 6 months from the date We receive Your application for this benefit; or
- Recover from the Terminal Condition.

However, the amount of this benefit will not be restored to Your remaining Group Term Life Insurance. And, You may not receive another Accelerated Life Benefit under any circumstances and even if You:

- Have a relapse; or

- You are subsequently diagnosed as having another Terminal Condition.

Benefit Amount For The Accelerated Life Benefit

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 subject to the following minimum and maximum amounts.

The minimum benefit amount is the lesser of: (1) $10,000.00; or (2) 50% of Your amount of Group Term Life Insurance.

The maximum benefit amount is the lesser of: (1) $250,000.00; or (2) 50% of Your amount of Group Term Life Insurance.

Discount

The amount of the Accelerated Life Benefit which is available to You is discounted to the present value in 6 months from the date this benefit is paid. The discount is based on the maximum adjustable policy loan interest rate permitted in the state in which the group policy is delivered.

A detailed statement of the method of computing the amount of the Accelerated Life Benefit is available from Us on request.

Payment Of The Accelerated Life Benefit

If We approve Your application for this benefit, We pay the amount You have elected, less the present value discount. We pay this benefit to You in one lump sum. This payment is subject to all of the other terms of the Certificate.

How To Apply

You must send Us written proof from a Doctor who is operating within the scope of his or her license that You have a Terminal Condition. We must approve such proof in writing before this benefit is paid.

We may have You examined by a Doctor of Our choice to determine whether the Terminal Condition exists. We will pay the cost of such exam.

If We approve Your application to receive this benefit, We will provide You with a statement along with Your benefit payment which shows:

- The amount of the Accelerated Life Benefit You requested;
- The amount of the present value discount;
- The amount of Your Accelerated Life Benefit check; and
- The remaining amount of Your Basic and Voluntary Life Insurance coverage.

Even if You have been approved for a waiver of premium benefit under this Certificate, You may still apply for an Accelerated Life Benefit. But, if 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 Your Accelerated Life Benefit.

If You Are Legally Incompetent

If You are not legally competent, Your lawful guardian, conservator, legal representative, or any person or fiduciary with the lawful authority to act on Your behalf or handle Your affairs may apply for the Accelerated Life Benefit on Your behalf.

Your Remaining Group Term Life Insurance

The remaining amount of Your Group Term Life Insurance after You receive an Accelerated Life Benefit payment is subject to any increases or reductions that would otherwise apply to Your insurance. Applicable reductions are applied to the amount of Group Term Life Insurance for which You were insured on the day before the date You applied for the Accelerated Life Benefit.

If Your Life Benefit is scheduled to reduce within 6 months of the date You apply for the Accelerated Life Benefit, any applicable reduction will also be applied to Your Accelerated Benefit amount.

The premium cost of Your remaining insurance is based on the amount of Group Term Life Insurance for which You were insured on the day before the date You applied for the Accelerated Life Benefit.

The total amount of Group Term Life Insurance Your beneficiary would otherwise receive on Your death is reduced by the Gross Amount of the Accelerated Life Benefit.

If You die after applying, and were eligible, for the Accelerated Life Benefit, but before We send You the benefit, Your beneficiary will receive the full amount of Group Term Life Insurance for which You were insured on the day before the date You applied for the Accelerated Life Benefit.

Restrictions

We will not pay an Accelerated Life Benefit if:

- Your coverage under the Certificate ends for any reason after You apply for the Accelerated Life Benefit, but before We pay such benefit;
- You are required by law to use the proceeds of the Group Term Life Insurance from the Certificate to meet the claims of creditors, whether or not You are in bankruptcy;
- You are required by court order to pay all or part of the proceeds of the Group Term Life Insurance from the Certificate to another person; or
- You are required by a government agency to use the payment to apply for, receive or maintain a governmental benefit or entitlement.

Definitions

This section defines certain terms appearing in this Rider. Additional terms, not listed here, are defined in the Certificate.

- **Doctor:** Any medical practitioner We are required by law to recognize. He or she must:
  - Be properly licensed or certified by the laws of the state where he or she practices; and
  - Provide services that are within the lawful scope of his or her practice.
- **Gross Amount:** This term means the amount of the Accelerated Life Benefit elected by You before subtraction of the discount.
- **Group Term Life Insurance:** This term means the amount of Employee Basic and Voluntary Group Term Life Insurance for which You are insured under the Certificate. The term does not include any:

- Accidental death benefits; or
- Scheduled increase in the amount of Employee Basic and Voluntary group term life insurance that is due within the 6 month period after the date You apply for the Accelerated Life Benefit.

- **Terminal Condition:** This term means a medical condition that is expected to result in death within 6 months from the date You apply for the Accelerated Life Benefit.

The Guardian Life Insurance Company of America

Matthew Darula, Head of Product, Strategy and Offerings

B400.5929

GC-R-ALB-15-MD

SUPPLEMENTAL RIDER - Seatbelt and Airbag Benefit

This Rider is effective as of the effective date of the Employee's Certificate. If this Rider is added to an inforce Certificate, the Rider becomes effective on its issue date. This Rider amends the Certificate by the addition of the following:

Terms not specifically defined within this Rider are defined in the Certificate.

Employee Basic and Voluntary Term Life Insurance and Dependent Voluntary Term Life Insurance Seatbelt and Airbag Benefit

This rider applies to Your Basic and Voluntary term life insurance and dependent Voluntary term life insurance.

Seatbelt And Airbag Benefits

If You die as a direct result of an automobile accident while properly wearing a seatbelt, We will increase Your term life benefit amount by $10,000. 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 will increase Your term life benefit amount by an additional $5,000, for a total increase of $15,000.

Proof that You were properly wearing a seatbelt must be provided. A law enforcement official investigating the accident must certify that the seatbelt was properly fastened and that the automobile in which the deceased was traveling was equipped with airbags. A copy of such certification must be submitted to Us with the claim for benefits.

If We cannot determine that You were wearing a seatbelt at the time of the Accident, We will increase Your term life benefit amount by $1,000.

If We determine that a seatbelt was not worn at the time of the automobile accident directly resulting in Your death, or if the required official report is not provided, no Seatbelt or Airbag benefit will be paid.

The total amount payable for the Seatbelt and Airbag Benefit under Your Basic and Voluntary term life insurance and Basic and Voluntary Accidental Death and Dismemberment insurance may not exceed $30,000.

Exclusions

This Policy does not pay a Seatbelt or Airbag Benefit for loss of life caused by, or related to an accident occurring:

- While You are the driver in an automobile Accident, if Your driver's license has been suspended or revoked or if You are unlicensed;
- While You are legally intoxicated; or
- While You are voluntarily using a controlled substance, unless:
  - It was prescribed for You by a doctor; and
  - It was used as prescribed.

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.

- While You were intentionally or voluntarily inhaling or ingesting a gas, chemical, solvent, poison or other substances not intended for internal consumption;
- During Your commission of, or attempt to commit a felony as defined per the laws in the jurisdiction in which the felony was committed or attempted, or as defined under federal law if the offense charged was a federal offense;
- During Your participation in any sport for compensation or profit; or
- During Your racing an automobile in an organized event or street race.

Dependent Seatbelt and Airbag Benefit

Seatbelt And Airbag Benefits

If Your dependent dies as a direct result of an automobile accident while properly wearing a seatbelt, We will increase his or her Voluntary term life benefit amount by $5,000. And, if Your 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 will increase his or her Voluntary term life benefit amount by an additional $2,500, for a total increase of $7,500.

You are responsible for providing proof that Your dependent was properly wearing a seatbelt. A law enforcement official investigating the Accident must certify that the seatbelt was properly fastened and that the automobile in which the deceased was traveling was equipped with airbags. A copy of such certification must be submitted to Us with the claim for benefits.

If We cannot determine that Your dependent was wearing a seatbelt at the time of the automobile accident directly resulting in his or her death, We will increase Your dependent term life benefit amount by $1,000.

If We determine that a seatbelt was not worn at the time of the automobile accident directly resulting in Your dependent's death, or if the required official report is not provided, no Seatbelt or Airbag Benefit will be paid.

The total amount payable for the Seatbelt and Airbag Benefit under Your Dependent Voluntary term life insurance and Dependent Voluntary Accidental Death and Dismemberment insurance may not exceed $15,000.

Exclusions

This Policy does not pay a Seatbelt or Airbag Benefit for loss of life caused by, or related to an accident occurring:

- While Your dependent is the driver in an automobile Accident, if his or her driver's license is suspended or revoked or if the driver is unlicensed;
- While Your dependent is legally intoxicated; or
- While Your dependent is voluntarily using a controlled substance, unless:
  - It was prescribed for the dependent by a doctor; and
  - It was used as prescribed.

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.

- While Your dependent intentionally or voluntarily inhales or ingests a gas, chemical, solvent, poison or other substances not intended for internal consumption;
- During Your dependent's commission of, or attempt to commit a felony as defined per the laws in the jurisdiction in which the felony was committed or attempted, or as defined under federal law if the offense charged was a federal offense;
- During Your dependent's participation in any sport for compensation or profit; or
- During Your dependent's racing an automobile in an organized event or street race.

The Guardian Life Insurance Company of America

Matthew Darula, Head of Product, Strategy and Offerings

B400.7271

SUPPLEMENTAL RIDER - Waiver of Premium Benefit

This Rider is effective as of the effective date of the Employee's Certificate. If this Rider is added to an inforce Certificate, the Rider becomes effective on its issue date. This Rider amends the Certificate by the addition of the following:

Employee Basic and Voluntary Term Life Insurance
Waiver Of Premium Benefit

Important Notice This rider applies to Your Basic and Voluntary term life insurance. It does not apply to any of Your dependent life insurance under the Certificate. To continue dependent life insurance, You must convert Your dependent coverage. See "Converting This Dependent Term Life Insurance" for details.

If You Are Disabled If You are Totally Disabled, and meet the requirements in "How And When To Apply," We will extend Your Basic and Voluntary life insurance without payment of premiums from You or the Employer in an amount equal to the amount of Basic and Voluntary life insurance for which You are insured on Your last day of Active Work.

How And When To Apply To apply for this benefit, You must submit, while living, written medical proof of Your Total Disability satisfactory to Us within one year of the start of that disability. Any claim filed after one year from the start of Total Disability will be denied, unless We receive written proof that:

- You lacked the legal capacity to file the claim; or
- It was not reasonably possible for You to file the claim within the required period of time.

To be approved for this benefit, You must:

- Become Totally Disabled before You reach age 60 and while insured by the Certificate; and
- Remain Totally Disabled for at least 9 months in a row.

You should apply for this benefit immediately at the start of Your Total Disability.

Continued Proof For Waiver of Premium Benefit We may require written proof that You remain Totally Disabled and receive regular Doctor's care to maintain this benefit, or written Proof that You have reached Your maximum point of recovery and still remain Totally Disabled. This proof must be given to Us within 30 days of the date We request it.

We can also require that You take part in a medical assessment by a medical professional of Our choice as often as We feel is reasonably necessary during the first 2 years We have waived Your life insurance premiums pursuant to the Rider. After 2 years, We cannot have You examined more than once a year.

Until You Have Been Approved For This Benefit

If Your life insurance under the Certificate ends after You have become Totally Disabled and applied for Waiver of Premium Benefits, but before We have approved You for this benefit, You may:

- Continue to pay your group premium payments, including any part which would have been paid by the Employer, until You are approved or declined for this benefit; or
- Apply to convert to an individual permanent or term life insurance policy.

Please read "Converting This Employee Basic and Voluntary Term Life Insurance" for details on how to convert.

Converting Your life insurance does not stop You from claiming Your rights under this section. But, if You apply to convert and obtain a policy, and We later approve You for this benefit, We will cancel the converted policy on the date We approve You for this Benefit. See "Converting This Employee Basic and Voluntary Term Life Insurance" for details on how We do this. Once You are approved for this benefit, Your insurance under the Certificate will be reinstated at no further cost to You or the Employer.

If You are declined for the Waiver of Premium benefit, You will have the option to apply to convert to an individual permanent or term life insurance policy. If You do not convert within 31 days of the date You are declined for the Waiver of Premium benefit, and You have not returned to Active Work, Your coverage will end.

If the Certificate terminates before You are approved

If this group Certificate terminates and You are Totally Disabled and eligible, but not yet approved, for this Waiver of Premium benefit, You must apply to convert to an individual permanent or term policy, and remain insured under such policy until You are approved by Us for the Waiver of Premium benefit.

When This Waiver Begins

Once approved by Us, Your Waiver of Premium benefit will be effective on the date following the day You have been Totally Disabled for 9 months in a row.

When This Waiver Ends

Your Waiver of Premium benefit will end on the earliest of:

- The date You are no longer Totally Disabled;
- The date We ask You to be examined by Our Doctor, and You refuse;
- The date You do not give Us the proof of Total Disability We require;
- the date you have been out of the United States and/or Canada or a country or region approved by Us for more than 2 months in a 12 month period;
- The date You are no longer receiving regular Doctor’s care appropriate to the cause of Your claimed Total Disability;
- The day before the date You reach age 65.

If Your Waiver of Premium Benefit ends and You do not return to Active Work, You will have the option to convert the Employee Basic and Voluntary life insurance that was in effect on the date the Waiver of Premium Benefit ends.

Please read "Converting This Employee Basic and Voluntary Term Life Insurance" for details on how to convert.

If You Die While Covered By This Waiver of Premium Benefit

If You die while covered for this benefit, We will pay Your beneficiary the amount of Basic and Voluntary life insurance for which You were insured as of Your last day of Active Full-Time Work. This payment is subject to all the terms of the Certificate and all reductions which would have applied had You remained an Active at Work Employee.

If You Die Prior to Approval for This Waiver of Premium Benefit

If You die prior to being approved for the Waiver of Premium Benefit and within 12 months of the onset date of Total Disability 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 provided You:

- Were Totally Disabled, as defined by this Rider, through the date of death,
- Became Totally Disabled prior to age 60; and
- Became Totally Disabled while insured; and
- We received the required premiums for this coverage.

Proof Of Death

We will pay the term life insurance benefit as soon as We receive:

- Written proof of Your death; and
- Medical proof that You were continuously Totally Disabled until Your death.

This proof must be sent to Us within one year of Your date of death.

B400.5978

All Options

Definitions

This section defines certain terms appearing in this Rider. Additional terms, not listed here, are defined in the Certificate.

Reasonable Accommodation: This term means any modification or adjustment that the Employer willingly provides to:

- A job;
- An employment practice;
- A work process; or
- The work place.

The modification or adjustment must make it possible for a Disabled person to:

- Reach the same level of performance as a similarly situated non-disabled person; or
- Enjoy equal benefits and privileges of employment as are available to a similarly situated non-disabled person.

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The modification or adjustment must not place an undue hardship on the Employer.

Regular and Appropriate Care: This term means, with respect to Your disabling condition(s) and any other condition(s) which, if left untreated, would adversely affect Your disabling condition, You:

- Visit a Doctor as frequently as medically required, according to generally accepted medical standards, to effectively manage these conditions; and
- Are receiving the most appropriate treatment, according to generally accepted medical standards, designed to achieve maximum medical improvement in these conditions.

Treatment must be provided by a Doctor or Doctors whose specialty is most appropriate according to generally accepted medical standards for Your:

- Disability; and
- Any other conditions which left untreated would adversely affect Your disabling condition.

Generally accepted medical standards are those 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 Institute;
- The National Institutes of Health;
- The Department of Health and Human Services; and
- Any other agency of similar repute.

"Total Disability" and **"Totally Disabled":** This term means that, due to sickness or injury, You are:

- Not able to perform any work for wages or profit; and
- Receiving Regular and Appropriate Care for the cause of Your Total Disability.

This Rider is a 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

Matthew Darula, Head of Product, Strategy and Offerings

B400.6210

GC-R-WOP-15-MD

SUPPLEMENTAL RIDER - Portability Privilege

This Rider is effective as of the effective date of the Employee's Certificate. If this Rider is added to an inforce Certificate, the Rider becomes effective on its issue date. This Rider amends the Certificate by the addition of the following:

PORTABILITY PRIVILEGE

This rider applies only to Your Employee Basic term life insurance.

Portability Conditions

Portability is subject to all of the conditions described below.

- You may Port if Your coverage under the Certificate if coverage ends because:
  - You are no longer employed by the Employer; or
  - You are no longer a member of an eligible class of Employees
- You may **not** Port unless You have been covered by the Certificate, or the plan it replaced, for Employee Basic term life insurance for at least three months in a row prior to the date Your coverage under the Certificate ends.
- You may **not** Port if You have reached age 70 on the date coverage under the Certificate ends.
- You may **not** Port if You are eligible for the Certificate's Waiver of Premium Benefit.
- You may **not** Port if coverage under the Certificate ends due to:
  - Failure to pay any required premium; or
  - Termination of the Certificate
- In order to Port, You must provide Proof Of Insurability.

Portability Options

You may Port the full amount of Your Basic term life insurance in force as of the date Your coverage under the Certificate ends. If You do not wish to Port the full amount, You may choose to Port 50% of such amount, if such amount under the Certificate is at least $50,000 and does not exceed $1,000,000.

The Portable Certificate Of Coverage

If You Port, You will obtain a new Certificate of coverage, which will be issued under the Portable group policy and will describe the benefits provided. The Portable group policy has been established specifically for, and limited to, providing portability coverage for Employees whose coverage ends under an Employer's plan. The benefits provided by the Portable certificate of coverage may not be the same as the benefits provided by the Certificate provided by your Employer. The group term life insurance provided by the Portable Certificate of coverage will not provide any of the following benefits or types of coverage:

- Accidental death or dismemberment;
- Income replacement;
- Or Waiver of Premium benefits.

The premium for the Portable certificate of coverage will be based on:

- the covered person's rate class under the Ported Policy; and
- Your age bracket as shown in the Life Portability Coverage Premium Notice.

The Portable Certificate of Coverage ends at age 70.

How To Port You must:

- Apply to Us in writing; and
- Pay the required premium.

You must do this within 31 days from the date Your coverage under the Certificate ends. In order to Port Your Basic term life insurance, We require Proof of Insurability.

Portability And Conversion If You choose to Port, the Certificate's conversion privilege will not be available. In the event that a person would be eligible to both convert and to Port, only one of these privileges may be chosen. Coverage under both a converted policy and a Portable certificate of coverage at the same time is not permitted. You should read the entire Certificate, as well as any related materials carefully before making a choice.

Definitions

This section defines certain terms appearing in this Rider. Additional terms, not listed here, are defined in the Certificate.

- **Port or "To Port":**these terms mean to choose a Portable certificate of coverage which provides group term life insurance.

This rider is a 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

Matthew Darula, Head of Product, Strategy and Offerings

B400.3877

GC-R-LIFPORT-15

SUPPLEMENTAL RIDER - Portability Privilege

This Rider is effective as of the effective date of the Employee's Certificate. If this Rider is added to an inforce Certificate, the Rider becomes effective on its issue date. This Rider amends the Certificate by the addition of the following:

PORTABILITY PRIVILEGE

This rider applies only to Your Employee and dependent Voluntary term life insurance.

Portability Conditions

Portability is subject to all of the conditions described below.

- You may Port if Your coverage under the Certificate if coverage ends because:
  - You are no longer employed by the Employer; or
  - You are no longer a member of an eligible class of Employees
- You may **not** Port unless You have been covered by the Certificate, or the plan it replaced, for Employee Voluntary term life insurance for at least three months in a row prior to the date Your coverage under the Certificate ends.
- You may **not** Port if You have reached age 70 on the date coverage under the Certificate ends.
- You may **not** Port if You are eligible for the Certificate's Waiver of Premium Benefit.
- You may **not** Port if coverage under the Certificate ends due to:
  - Failure to pay any required premium; or
  - Termination of the Certificate

Portability Options

You may Port the full amount of Your Voluntary term life insurance in force as of the date Your coverage under the Certificate ends. If You do not wish to Port the full amount, You may choose to Port 50% of such amount, if such amount under the Certificate is at least $50,000 and does not exceed $1,000,000.

You may Port the full amount of Your dependent's Voluntary term life insurance in force as of the date Your coverage under the Certificate ends. If You do not wish to Port the full amount, You may choose to Port 50% of such amount if:

- Your dependent Spouse amount under the Certificate is at least $10,000; and
- Your dependent child amount under the Certificate is at least $2,000.

You may Port:

- Your insurance only;
- Your insurance and insurance of Your covered Spouse; or
- Your insurance and the insurance of all of Your covered dependents.

If You Port the full amount of Your insurance and You choose to Port Your dependent's insurance, You must Port the full amount of Your dependent's insurance. If You Port 50% of Your insurance and You choose to Port Your dependent's insurance, You must Port 50% of Your dependent's insurance.

A dependent must be insured as of the date Your coverage under the Certificate ends in order to be eligible for Portability.

If You die while insured for dependent Voluntary term life insurance, Your Spouse may Port Your dependent Voluntary term life insurance as described above. Your Spouse and dependent children must be insured under the Certificate on the date of Your death. But, this option is not available if:

- There is no surviving Spouse; or
- Your surviving Spouse has reached age 70 on the date of Your death.

The Portable Certificate Of Coverage

If You Port, You will obtain a new Certificate of coverage, which will be issued under the Portable group policy and will describe the benefits provided. The Portable group policy has been established specifically for, and limited to, providing portability coverage for Employees and their dependents whose coverage ends under an Employer's plan. The benefits provided by the Portable certificate of coverage may not be the same as the benefits provided by the Certificate provided by your Employer. The group term life insurance provided by the Portable Certificate of coverage will not provide any of the following benefits or types of coverage:

- Accidental death or dismemberment;
- Income replacement;
- Or Waiver of Premium benefits.

The premium for the Portable certificate of coverage will be based on:

- the covered person's rate class under the Ported Policy; and
- Your or Your surviving Spouse's age bracket as shown in the Life Portability Coverage Premium Notice.

The Portable Certificate of Coverage ends at age 70.

How To Port

You or Your surviving Spouse must:

- Apply to Us in writing; and
- Pay the required premium.

You or Your surviving Spouse must do this within 31 days from the date Your coverage under the Certificate ends. In order to port Your Voluntary term life insurance, We will not ask for proof that You or Your surviving Spouse is insurable.

Portability And Conversion

If You or Your surviving Spouse choose to Port, the Certificate's conversion privilege will not be available. In the event that a person would be eligible to both convert and to Port, only one of these privileges may be chosen. Coverage under both a converted policy and a Portable certificate of coverage at the same time is not permitted. You or Your surviving Spouse should read the entire Certificate, as well as any related materials carefully before making a choice.

Definitions

This section defines certain terms appearing in this Rider. Additional terms, not listed here, are defined in the Certificate.

- **Port or "To Port":**these terms mean to choose a Portable certificate of coverage which provides group term life insurance.

This rider is a 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

Matthew Darula, Head of Product, Strategy and Offerings

B400.3884

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 reasonable 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 reasonable 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.

B997.0260

All Options

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.

B997.0261

All Options

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.

B997.0262

CERTIFICATE OF COVERAGE

The Guardian Life Insurance Company of America
10 Hudson Yards
New York, New York 10001
(212) 598-8000

The Group Accidental Death and Dismemberment Coverage described in this Certificate is attached to the group Policy effective August 1, 2014. This Certificate replaces any Certificate previously issued under this Policy or under any other plan providing similar or identical benefits issued to the Policyholder by Guardian.

GROUP ACCIDENTAL DEATH AND DISMEMBERMENT COVERAGE

Guardian certifies that the Employee to whom this Certificate is issued is eligible for the coverage, and in the amount, described herein. In order to be eligible for coverage, the Employee must: (a) satisfy all of this Policy's eligibility and Effective Date requirements; (b) be listed in Our and/or the Policyholder's records as a validly covered Employee under the Policy; (c) satisfy any necessary Proof of Insurability requirements; and all required premium payments have been made by or on behalf of the Employee.

The Employee and/or his or her Dependents are not covered by any part of this Policy for which he or she has waived coverage. Such a waiver of coverage is shown in Our and/or the Policyholder's records.

Policyholder: 2 CIRCLE, INC
Group Policy Number: 00502570

The Guardian Life Insurance Company of America

Matthew Darula, Head of Product, Strategy and Offerings

B400.6089

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GENERAL PROVISIONS

Applicable Benefits

This Certificate may include multiple benefit options and types of benefits. You will only be covered for benefits if:

- They were previously selected in an acceptable manner and mode, such as an enrollment form or other required form; and
- We have received any required premium.

Limitation Of Authority

Only the President, a Vice President or a Secretary of Guardian, has the authority to act for Us in a written and signed statement to:

- Determine whether any contract, Policy or Certificate is to be issued;
- Waive or alter any contract or Policy provisions, or any of Our requirements;
- Bind Us by any statement or promise relating to the contract issued or to be issued; or
- Accept any information or representation which is not in a signed application.

Agents and brokers do not have the authority to change the contract or Policy or waive any of its provisions.

Incontestability

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

No statement in any application, made by You, or any dependent, will be used to contest the validity of Your insurance or to deny a claim for a loss incurred, or for a disability which starts, after such insurance has been in force for two years during Your lifetime.

If this Certificate replaces a plan Your Employer had with another insurer, We may rescind this Certificate based on misrepresentations or omissions made by Your Employer or You in a signed application for this Policy for up to two years from the Effective Date of this Policy.

In the event Your insurance is rescinded, We will refund premiums paid for the periods such insurance is void. The premium paid by You will be sent to Your last known address on file with Your Employer or Us.

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 the Certificate as often as We feel necessary. We also have the right to have an autopsy performed in the case of death where allowed by law. We will pay for all such examinations and autopsies.

New Entrants

From time to time, We may add new eligible Employees desiring insurance to the group or class of insurance issued under the Policy. Eligibility for benefits will be governed by all the terms of this Certificate.

Overpayment Recovery

If We overpay benefits, all such benefits must be repaid in full. We have the right to reduce the benefit, or reduce any other benefits payable under this Certificate, toward recovery of any overpayment.

B400.6213

ELIGIBILITY FOR ACCIDENTAL DEATH AND DISMEMBERMENT COVERAGE EMPLOYEE COVERAGE

Conditions Of Eligibility

Subject to the conditions of eligibility set forth below, and to all of the other conditions of this Certificate, You are eligible for Accidental Death and Dismemberment coverage if You are

- In an eligible class of Employees;
- Are an active Full time Employee;
- Legally working in the United States and/or Canada or working outside of the United States for a United States based Employer in a country or region approved by Us;

  and

- Working at least the minimum number of hours of an Employee in Your eligible class at:
  - The Employer's place of business;
  - Some place where the Employer's business requires You to travel; or
  - Any other place You and the Employer have agreed upon for the performance of your occupational duties.

You are **not** eligible for Accidental Death and Dismemberment coverage if You are

- A temporary or seasonal Employee.

The Waiting Period If You are in an eligible class, You are eligible for Accidental Death and Dismemberment coverage under this Certificate after You complete the service waiting period, if any, established by the Employer and as stated in the Schedule of Benefits.

Multiple Employment If You work for both the Employer and a covered associated company, or for more than one covered associated company, We will treat You as if only one firm employs You. You will not have multiple Accidental Death and Dismemberment Coverage under this Certificate. But, if this Certificate uses the amount of Your Insured Earnings to set the rates, determine class, figure insurance amounts, or for any other reason, such Insured Earnings will be figured as the sum of Your Insured Earnings from all covered Employers.

B400.6098

When Coverage Starts

For coverage to start, You must be fully capable of performing the major duties of Your regular occupation for the Employer and working the minimum required number of hours of an Employee in Your eligible class at 12:01 A.M. Standard Time for Your place of residence on Your scheduled Eligibility Date. And, for coverage to start, You must satisfy all of the Conditions of Eligibility described above, and the conditions shown below which apply to You. If You are not fully capable of performing the major duties of Your regular occupation on Your scheduled Eligibility Date, We will postpone the start of Your coverage until You are so capable and working the minimum required number of hours of an Employee in Your eligible class for one full day, with the capacity to do so for one full week.

Whether You must pay all or part of the cost of Your coverage, You must elect to enroll and agree to make the required payments before Your coverage will start. If You do this on or before Your Eligibility Date, Your coverage is scheduled to start on Your Eligibility Date. If You do this within 31 days after Your Eligibility Date, Your coverage is scheduled to start on Your Eligibility Date. If You elect to enroll and agree to make the required payments more than 31 days after Your Eligibility Date, Your coverage will not start until You send Us Proof Of Insurability. Once We approve such Proof Of Insurability, Your coverage will start on the date we approve such coverage.

B400.6103

All Options

Exception to When Coverage Starts

Sometimes a scheduled Eligibility Date is not a regularly scheduled work day. If the scheduled Eligibility Date falls on:

- A holiday;
- A vacation day;
- A non-scheduled work day;
- A day during an approved leave of absence not due to sickness or injury, of 90 days or less; or
- A day during a period of absence that is less than 7 days in duration;

and if:

- You are fully capable of performing the major duties of Your regular occupation for Your Employer for the minimum number of hours of an Employee in Your eligible class at 12:01 AM Standard Time for Your place of residence on the scheduled Eligibility Date ; and
- You were performing the major duties of Your regular occupation and working the minimum number of hours of an Employee in Your eligible class on Your last regularly scheduled work day;

Your coverage will start on the scheduled Eligibility Date. However, in no event will any coverage or part of coverage for which You must elect and pay all or part of the cost, start if You are on an approved leave, layoff or absence and such coverage or part of coverage was not previously in force for You under a prior plan which this Certificate replaced.

B400.6106

All Options

Delayed Eligibility Date For Employee Voluntary Accidental Death and Dismemberment Insurance

If due to sickness or injury, You are not Actively At Work and working the minimum number of hours of an Employee in Your eligible class on the date Your Voluntary Accidental Death and Dismemberment coverage is scheduled to start, We will postpone coverage for an otherwise Covered Loss for any condition(s) that prevent you from meeting the Actively at Work requirement. We will postpone such coverage until You:

- Complete one full day of Active Work, working the minimum number of hours of an Employee in Your eligible class, with the capacity to do so for one full week; and,
- Do not miss a day of work due to the same condition.

Coverage for an otherwise Covered Loss due to all other conditions will start on the date You:

- Return to Active Work working the minimum number of hours of an Employee in Your eligible class and;
- Are performing the regular duties of your occupation.

B400.6107

All Options

When Coverage Ends

Your coverage will end on the first of the following dates:

- The date Your Active Work ends for any reason, except as noted below under Coverage During Leave of Absence. Such reasons include:
  - Disability;
  - Death;
  - Retirement;

- Layoff;
- Leave of absence;
- The end of employment; and
- Expiration of the employment contract.

- The date You stop being an eligible Employee under this Certificate.
- The date You are no longer working in the United States and/or Canada, or no longer working outside the United States for a United States based Employer in a country or region approved by Us. Any incidental business or personal travel outside of the United States and/or Canada, or outside of a country or region approved by Us, is covered. Such travel will be considered incidental if it is for a period not to exceed 30 consecutive days.
- The date the group Certificate ends, or is discontinued for a class of Employees to which You belong.
- The last day of the period for which required payments are made for You.

You may have the right to continue certain group benefits for a limited time after Your coverage would otherwise end. Contact Your Employer regarding any continuation options available.

Extension Of Benefits

We will provide covered benefits, in accordance with the Certificate in effect at the time the Covered Persons coverage terminates, for a covered loss that occurs after the date coverage terminates if: (1) an accident occurs while the Covered Person is covered; and (2) the loss occurs within 90 days after the accident.

B400.6216

CONTINUATION OF COVERAGE

Coverage During Disability

If Your Active Work ends because You are Totally Disabled, You and Your Employer may agree to continue Your insurance, subject to continued payment of all required premiums, until the earlier of:

- The date you are no longer Totally Disabled, as defined by this Certificate;
- 12 months; from the date Your Total Disability began;
- The date you are approved for any Waiver of Premium Benefit for which you are eligible; or
- The date of Your 99th birthday.

We may require written Proof of Loss that You remain Totally Disabled and receiving regular Doctor's care to maintain this benefit. We will pay this benefit in accordance with the Proof of Loss section of the Claims Provision.

Your eligibility for benefits will be governed by all the terms of this Certificate.

Coverage During Temporary Layoff

If Your Active Work ends because You are temporarily laid off, You and Your Employer may agree to continue Your insurance, subject to continued payment of all required premium, until the earlier of:

- The end of the temporary layoff; or
- The end of the month in which You are laid off plus 1 months following the date the temporary layoff begins.
- The end of the time period covered under a severance agreement not to exceed 1 months.

If You die or become Disabled under this Certificate while Your coverage is being continued during a temporary layoff, Your eligibility for benefits will be governed by all the terms of this Certificate.

Coverage During Temporary Leave of Absence

If Your Active Work ends because You go on a leave of absence that has been approved by Your Employer, You and Your Employer may agree to continue Your insurance, subject to continued payment of all required premiums, until the earlier of:

- The end of the Employer approved leave of absence; or

- The end of the month in which Your leave begins plus 1 months following the date the approved leave of absence begins.

If You become disabled under this Certificate while Your coverage is being continued during a leave of absence, Your eligibility for benefits will be governed by all the terms of this Certificate.

B400.6217

GC-ADD-15-MD

All Options

DEPENDENT COVERAGE

B400.6116

All Options

Eligible Dependents For Dependent Voluntary Accidental Death and Dismemberment Insurance

Your eligible dependents are Your:

- Spouse who is under age 70; and
- dependent children who are 14 or more days old; until they reach age 26.

B400.6118

All Options

Adopted Children And Step-Children

Your dependent children include Your legally adopted children and Your step-children. However, to qualify as a dependent, each person must depend on You for at least 50% of their support and maintenance. 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.

B400.6127

All Options

Dependents Not Eligible

We exclude:

- A dependent who is on Active Duty in any armed force.

B400.6128

All Options

Continuing Coverage For Dependent Children Past the Limiting Age

If You have a child or children who:

- Is/are incapable of independent living by reason of a mental or physical, or developmental disability; and
- Is/are primarily dependent upon You for support and maintenance;

Then, the child or children may remain eligible for dependent benefits past the age limit provided all the conditions shown below are satisfied.

Each such child:

- Must have a mental, physical, or developmental disability that began before he or she reached the dependent age limit;
- Became covered by this Certificate, or the prior carrier s group accidental death and dismemberment plan that it replaced, before he or she reached the dependent age limit, and remained continuously covered until he or she reached the age limit;
- and remains:
  - Incapable of independent living; and
  - Dependent upon You for most of his or her support and maintenance; and

You send Us written proof, and we approve such proof, of the child's disability and dependence within 31 days from the date he or she reaches the dependent age limit. After the two year period following the child's attainment of the age limit, We can ask for periodic proof that the child's condition continues, but We cannot ask for this proof more than once a year.

Irrespective of this provision, any coverage provided under this section ends when Your coverage ends.

B400.6129

All Options

When Dependent Coverage Starts

In order for Your dependent coverage to start, You must already be covered for Employee coverage, or enroll for Employee and dependent coverage at the same time.

Subject to the Exception shown below and to all of the other terms of this Certificate, the date Your dependent coverage starts depends on when You elect to enroll Your Initial Dependents and agree to make any required payments.

Initial Dependents

If You enroll Your Initial Dependents on or before Your Eligibility Date, the dependents' coverage begins on the later of Your Eligibility Date and the date You become covered for Employee coverage.

If You enroll Your Initial Dependents within the Enrollment Period, their coverage begins on the later of Your Eligibility Date and the date You become covered for Employee coverage.

If You do not enroll Your Initial Dependents when they are first eligible, and enroll those Initial Dependents after the Enrollment Period ends, You must supply Proof Of Insurability and coverage will not start until We approve that proof in writing.

If an Initial Dependent becomes eligible after this Certificate's Effective Date, his or her coverage will start on the date We approve him or her for coverage.

If Dependent Proof of Insurability is required

Subject to the Exception shown below, if Proof Of Insurability is required for dependent benefits, You must send Us the proof We require, and We must approve that proof in writing. Those benefits will then begin on the approved Eligibility Date.

If You must pay part of the cost of dependent coverage, We will not cover You for such coverage until You enroll each of Your dependents, agree to make the required payments, submit Proof Of Insurability and We approve that proof in writing.

Newly Acquired Dependents

If You do not pay any part of the cost of dependent coverage, a Newly Acquired Dependent is covered from the date he or she first becomes eligible.

If You must pay part of the cost of dependent coverage, and are already enrolled for dependent child coverage for Your Initial Dependent children, any Newly Acquired Dependent children will be covered as of the date he or she is first eligible.

However, if You were previously eligible to enroll for dependent child coverage and waived coverage or failed to enroll, We will not cover any of Your dependent children until You submit Proof of Insurability and we approve that proof in writing and you make any additional required payments.

B400.6130

All Options

Exception

We will postpone the Eligibility Date of a dependent's, other than a newborn child's, coverage if, on that date, he or she is Unable to perform two or more Activities of Daily Living (ADLs).

In that case, We will postpone the Eligibility Date of his or her coverage until the day after the date he or she 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.

B400.6131

When Dependent Coverage Ends

Dependent coverage ends for all of Your dependents when:

- Your Employee coverage ends;
- You stop being a member of a class of Employees eligible for such coverage;
- This Certificate ends, or
- Dependent coverage is discontinued from this Certificate for all Employees or for Your 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 or she stops being an eligible dependent. For dependent children the coverage ends at 12:01 A.M. Standard Time for Your place of residence on the date the child attains this Certificate's age limit, or when a step-child is no longer dependent on You for at least 50% of their support and maintenance, or for Your disabled child who has reached the age limit, when he or she is no longer eligible under the Continuing Coverage for Dependent Children Past the Limiting Age provision.

Coverage ends for a Spouse when a marriage is lawfully terminated, and with respect to Voluntary Accidental Death and Dismemberment coverage, it happens at 12:01 A.M. on the date the Spouse reaches age 70 .

Read this Certificate 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.

B400.6132

EMPLOYEE ACCIDENTAL DEATH AND DISMEMBERMENT (AD&D) INSURANCE

B400.6134

All Options

Basic Accidental Death and Dismemberment Insurance And Catastrophic Loss Benefits

B400.6136

We will pay the benefits described below if You suffer an irreversible loss due to an Accident and the Accident occurs while You are insured by this Certificate. The loss also must:

- Be a direct result of the Accident;
- Be independent of all other causes; and
- Occur within 365 days of the date of the Accident.

Payment Of Benefits We will pay this insurance within 30 days of receiving written Proof of Loss as shown in the Claims Provisions section of this Certificate.

Payment Of Benefits For Covered Loss of life, We pay the beneficiary of Your Accidental Death and Dismemberment Insurance under the Employer's Policy with Us.

For all other Covered Losses, We pay You if You are living. If You are not living, We pay the beneficiary of Your Term Life coverage under the Employer's Plan with Us.

Subject to all the terms of this Certificate, We pay all benefits in a lump sum within 30 days of receiving written proof of Covered Loss and proof of claim which is acceptable to Us. This should be sent to Us as soon as possible.

The Beneficiary You decide who receives this benefit when You die. Your beneficiary designation should be provided in a means acceptable by Us.

You can change Your beneficiary at any time by providing written notice. But, the change will not take effect until We or the Employer records the change.

We will not be liable for any amounts paid before receiving notice of a beneficiary change.

In no event may a beneficiary be changed by a Power of Attorney.

If You named more than one person as a primary beneficiary, but You do not specify what shares each such primary beneficiary is entitled to receive, We will divide the benefits equally among all such named primary beneficiaries who survive You. If someone You named as a primary beneficiary dies before You, that person's share will be divided equally by the primary beneficiaries still alive; unless You have specified otherwise.

If You have named a contingent beneficiary or contingent beneficiaries, We will pay Your contingent beneficiary or contingent beneficiaries, if no primary beneficiary survives You. If there is more than one contingent beneficiary who is eligible for benefits, We will divide the benefits equally among all such named contingent beneficiaries who survive You; unless You have specified otherwise.

If there is no primary or contingent beneficiary or beneficiaries eligible for benefits when You die, We will pay this benefit as follows:

- To Your Spouse;
- If Your Spouse does not survive You, then to Your children who survive You in equal shares;
- If no Spouse or children survive You, then to Your parents who survive You in equal shares;
- If no Spouse, children, or parents survive You, then to then to Your brothers and sisters in equal shares;
- If none of the above parties survive You, then to Your executors or administrators of Your estate.

Payment Of Funeral Expenses We have the option of paying up to $500 of this benefit to any person who incurred expenses for Your funeral.

B400.6218

All Options

Covered Losses Benefits will be paid only for losses listed in the Table of Covered Losses shown below. Your insurance amount is shown in the Accidental Death and Dismemberment Schedule Of Benefits.

B400.6147

All Options

ACCIDENTAL DEATH AND DISMEMBERMENT

Table Of Covered Losses

Covered Loss	Benefit
Loss of life	100% of Your AD&D insurance amount.
Disappearance	100% of Your AD&D insurance amount.
Loss of a hand	50% of Your AD&D insurance amount. No benefit will be paid if benefits have been paid for "loss of one arm".

Loss of a foot	50% of Your AD&D insurance amount. No benefit will be paid if benefits have been paid for "loss of one leg".
Loss of sight in one eye	50% of Your AD&D insurance amount.
Loss of thumb and index finger of same hand	25% of Your AD&D insurance amount. No benefit will be paid if benefits have been paid for "Loss of a hand" or "loss of one arm".
Loss of four fingers of same hand	25% of Your AD&D insurance amount. No benefit will be paid if benefits have been paid for "Loss of a hand" or "loss of one arm".
Loss of all toes of same foot	25% of Your AD&D insurance amount. No benefit will be paid if benefits have been paid for "Loss of a foot" or "loss of one leg".
Loss of the great toe (hallux)	15% of Your AD&D insurance amount. No benefit will be paid if benefits have been paid for "Loss of a foot" or "loss of one leg".

CATASTROPHIC LOSS BENEFITS

Loss of speech and hearing	100% of Your AD&D insurance amount.
Loss of speech or hearing	50% of Your AD&D insurance amount.
Quadriplegia	100% of Your AD&D insurance amount. No benefit will be paid if benefits have been paid for "Loss of a foot" or "loss of one leg".
Paraplegia	75% of Your AD&D insurance amount.
Hemiplegia	50% of Your AD&D insurance amount.

Uniplegia	25% of Your AD&D insurance amount
Loss of cognitive function	100% of Your AD&D insurance amount.
Comatose state, in excess of one month	100% of Your AD&D insurance amount.
Loss of one arm or leg	75% of Your AD&D insurance amount.
Third degree burns covering 75% or more of the body	75% of Your AD&D insurance amount
Third degree burns covering 50% or more but less than 75% of the body	50% of Your AD&D insurance amount

B400.6144

All Options

As used here:

- "Loss of cognitive function" means a significant decline or loss in intellectual aptitude. Such loss must result from an Accidental injury. And, it must be supported by clinical proof or standardized tests that precisely measure decline in the areas of:
  - Short term memory;
  - Orientation to time, place and person;
  - Deductive or abstract reasoning; and
  - Judgement as it relates to awareness of safety.
- "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 hearing" means that hearing in both ears is lost entirely.
- "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.
- "Loss of all toes of same foot" means complete severance at the metatarsalphalangeal joint.
- "Loss of the great toe (hallux)" means complete severance at the metatarsalphalangeal joint.
- "Loss of one arm" means the arm is completely severed at or above the elbow.

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- "Loss of one leg" means the leg is completely severed at or above the knee.
- "Loss of speech" means that speech is lost entirely.
- "Hemiplegia" means total paralysis of upper and lower limbs, unilaterally.
- "Paraplegia" means total paralysis of both lower limbs.
- "Quadriplegia" means total paralysis of upper and lower limbs, bilaterally.
- "Uniplegia" means paralysis of one arm or one leg

B400.6150

All Options

Multiple Losses For more than one Covered Loss due to the same Accident, We will pay up to 100% of Your Accidental Death and Dismemberment Insurance amount. We will not pay more than 100% of Your Accidental Death and Dismemberment Insurance amount for all losses due to the same Accident, except as shown under the Common Carrier Benefit, Seatbelt And Airbag Benefits and Repatriation Benefit.

B400.6151

All Options

Exclusions Conditions that are not considered Covered Losses and that are not covered under the terms of this Certificate can be found in the definition of "Accident". Please refer to the Definitions section of this Certificate.

B400.6153

All Options

Repatriation Benefit We pay an extra sum for Covered Loss of life due to an Accident which occurs at least 75 miles from Your home. In that case, We pay up to $5,000 for costs to prepare and transport Your body to a mortuary chosen by You or an authorized agent. In the event that a Repatriation Benefit is paid under Your Group Term Life Insurance Certificate, no additional benefit will be paid under this Accidental Death and Dismemberment Certificate.

B400.6155

All Options

Exposure If You suffer a Covered Loss shown in the Table of Covered Losses due to an Accidental bodily injury caused by being unavoidably exposed to the elements, We will pay the amount which otherwise applies to the loss. If Covered Loss benefits are deemed payable under Exposure, the Covered Loss benefit is only paid once, not in addition to the Exposure payments.

B400.6156

All Options

Disappearance You will have a presumed Covered Loss due to an Accident if:

- You are riding in a public conveyance that is involved in an Accident;
- As a result of the Accident, the public conveyance is wrecked, sinks, is stranded or disappears;
- Your body is not found within 365 days of the day the Accident; and
- The Accident occurs while You are covered by this Certificate.

If Covered Loss benefits are deemed payable under Disappearance, the Covered Loss benefit is only paid once, not in addition to the Disappearance payments.

B400.6157

All Options

Helmet Benefit If You die as a result of a Motorcycle Accident while properly wearing a Helmet and You are the driver and hold a valid driver's license with a Motorcycle endorsement and We determine an Accidental Death and Dismemberment benefit is payable, We will increase Your benefit by the lesser of:

- 50% of the benefit amount; or
- $25,000.

We must receive satisfactory evidence that the Employee's death resulted from a Motorcycle Accident, and that the Employee was wearing a Helmet at the time of the Accident. A copy of the police report is required.

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

Helmet: This term means a protective head covering made of a hard material to resist impact and that conforms to the Department Of Transportation helmet certification.

Motorcycle: This term means a motor vehicle licensed for use on public highways which requires a Motorcycle endorsement on a driver's license to operate the vehicle.

B400.6158

All Options

Workplace Assault If You suffer a Covered Loss due to an Accidental bodily injury caused directly by a Felonious Act of Violence and We determine that an Accidental Death and Dismemberment Benefit is payable, We will pay a Workplace Assault benefit subject to all the terms below:

- A benefit is payable under the Certificate's Employee Basic Accidental Death and Dismemberment and Catastrophic Loss Benefit due to a Covered Loss;

- The Felonious Act of Violence must occur while You are working for Your Employer, at Your Employer's usual place of business, at an alternative work site at the direction of Your Employer, including Your home or a location to which the job requires You to travel;
- The loss did not occur while You were committing a felonious act; and
- The Felonious Act of Violence was not committed by members of Your family or household.

What We Pay: Subject to all the terms of this Certificate, the Workplace Assault Benefit pays the lesser of: (a) 10% of the benefit amount; or (b) $25,000.

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

- **A Felonious Act of Violence:** This term includes but is not limited to robbery, theft, hijacking, assault and battery, sniping, murder or civil disturbance. The Workplace Assault benefit is subject to all the exclusions under the Accidental Death and Dismemberment benefit, including act of war language.

B400.6162

All Options

Rehabilitation Benefit

If You suffer a Covered Loss other than loss of life due to an Accidental bodily injury and We determine an Accidental Death and Dismemberment Benefit is payable, We will pay a Rehabilitation Benefit subject to all of the terms below:

- A benefit is payable under this Certificate's Employee Basic Accidental Death and Dismemberment and Catastrophic Loss Benefit due to a Covered Loss other than loss of life;
- You require rehabilitative training, for which there is an Incurred Expense, due to Your Accidental bodily injury;
- You are trained for another occupation because You cannot perform Your occupation due to the Accidental bodily injury; and
- The expense is incurred within one year of the date of the Accident.

What We Pay: Subject to all the terms of this Certificate, the Rehabilitation Benefit pays the lesser of:

- The expense incurred for rehabilitative training; or
- 5% of the benefit amount payable for the Covered Loss; or
- $2,500.

We pay this benefit within 30 days of receiving written proof of incurred expense for training. We will pay this benefit in accordance with the Proof of Loss section of the Claims Provision.

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

Incurred Expense: This term means the actual cost of the

- Training; and
- Materials needed for the training.

B400.6220

All Options

Adaptive Home & Vehicle Benefit

If You suffer a Covered Loss other than loss of life due to an Accidental bodily injury and We determine that an Accidental Death and Dismemberment Benefit is payable, We will pay an Adaptive Home and Vehicle Benefit subject to all of the terms below:

- A benefit is payable under this Certificate's Employee Basic Accidental Death and Dismemberment and Catastrophic Loss Benefit due to a Covered Loss other than loss of life; and
- The home alteration must be:
  - Made to Your principal residence;
  - Made by a licensed contractor that is not You, Your Spouse, child, parent, sibling or business associate; and
  - Reasonable based on Your residual capabilities; and
- The vehicle modification must be:
  - Made to Your Private Automobile; and
  - Carried out by a licensed technician that is not You, Your Spouse, child, parent, sibling or business associate; and
  - Approved by the Motor Vehicle Department; and
- The expense is incurred within one year of the date of the Accident.

What We Pay: Subject to all the terms of this Policy, the Adaptive Home and Vehicle Benefit pays the lesser of:

- 5% of the Insurance Amount; or
- $2,500; or
- The actual one-time cost.

We pay this benefit within 30 days of receiving written proof of incurred expense for the alteration or modification. We will pay this benefit in accordance with the Proof of Loss section of the Claims Provision.

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

Incurred Expense: This term means the actual cost (materials and labor) of the alteration and modification.

Private Automobile: This term means a four-wheeled, private passenger car, station wagon, pick-up truck, van or jeep-type automobile which is not being used as a public conveyance.

B400.6302

All Options

Spousal Education And Retraining Benefit

If You suffer a Specified Loss due to an Accidental bodily injury, We will pay a Spousal Education and Retraining Benefit subject to all of the terms shown below.

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

- **Hemiplegia:** This term means total paralysis of upper and lower limbs, unilaterally.
- **Institute Of Higher Learning:** This term includes, but is not limited to:
  - Universities;
  - Colleges;
  - Trade schools; and
  - Professional schools.

  It does not include graduate level programs.
- **Loss Of Cognitive Function:** This term means a significant decline or loss in intellectual aptitude. Such loss must result from an Accidental injury. And, it must be supported by clinical proof or standardized tests that precisely measure decline in the areas of:
  - Short term memory;
  - Orientation to time, place and person;
  - Deductive or abstract reasoning; and
  - Judgment as it relates to awareness of safety.
- **Net Tuition Expense:** This term means Tuition Expense less any scholarships or grants to which the Spouse is entitled.
- **Paraplegia:** This term means total paralysis of both lower limbs.
- **Quadriplegia:** This term means total paralysis of upper and lower limbs, bilaterally.

- **Specified Loss:** This term means:
  - Loss of life;
  - A comatose state which lasts for a period in excess of one month;
  - Spinal cord injury which results in Hemiplegia, Paraplegia or Quadriplegia; or
  - Severe head injury which results in Loss of Cognitive Function.
- **Tuition Expense:** This term means charges incurred for courses or lab fees. It does not include:
  - Cost of books;
  - Cost of other related course materials;
  - Student activity fees; or
  - Room and board.

When And How The Spousal Education And Retraining Benefit Begins

We will pay a Spousal Education and Retraining Benefit when all of the conditions shown below are met:

- A benefit is payable under this Certificate's Basic Accidental Death and Dismemberment Insurance and Catastrophic Loss Insurance due to a Specified Loss;
- You and Your Spouse share the same place of residence on the date of the Accidental injury which results in the Specified Loss; and
- We receive proof of Your enrollment in an Institute Of Higher Learning. You must:
  - Be enrolled on the date of the Accidental injury which results in the Specified Loss; or
  - Enroll within 12 months of that date.

What We Pay

Subject to all the terms of this Policy, this benefit per academic term will be equal to the lesser of:

- Your Net Tuition Expense for the term;
- 5% of the Basic Accidental Death and Dismemberment Insurance benefit and Catastrophic Loss Insurance Benefit paid as a result of the Specified Loss; and
- $2,500 And, this benefit is subject to a lifetime maximum of $20,000.

We pay this benefit to the person who has primary responsibility for these expenses within 30 days of written proof of loss.

This benefit is paid per academic term. The maximum number of benefit payments is based on whether You are enrolled in a part-time or full-time course of study. For full-time study, the maximum number of benefit payments is eight. For part-time study, the maximum number of benefit payments is four.

Continued Eligibility For The Spousal Education And Retraining Benefit

We require periodic proof of Your continued enrollment in an Institute Of Higher Learning. And, You must maintain a grade point average of at least 2.0 on a 4.0 scale, or its equivalent. We also require proof, per academic term of:

- Your Tuition Expenses; and
- Any scholarships and grants to which You are entitled.

When The Spousal Education And Retraining Benefit Ends

This benefit ends on the earliest of the dates shown below:

- The date You are no longer enrolled in an Institute Of Higher Learning;
- The date You fail to maintain a minimum grade point average as shown above;
- The date You fail to furnish any required proof as shown above;
- The date the lifetime maximum benefit is paid; and
- The date the maximum number of benefit payments have been made.

If you die as a result of an Accidental bodily injury and the Spousal Education and Retraining benefit is in effect on the date You die and there is no qualified dependent Spouse who could qualify for this benefit, we will pay a one time benefit of $500 to the beneficiary in one sum.

B400.6222

All Options

Dependent Child Education Benefit

If You suffer a Specified Loss due to an Accidental bodily injury, We will pay a Dependent Child Education Benefit on behalf of a Qualified Dependent Child subject to all of the terms shown below.

Definitions

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

- **Hemiplegia:** This term means total paralysis of upper and lower limbs, unilaterally.
- **Institute Of Higher Learning:** This term includes, but is not limited to:
  - Universities;
  - Colleges;
  - Trade schools; and
  - Professional schools.

It does not include graduate level programs

- **Loss Of Cognitive Function:** This term means a significant decline or loss in intellectual aptitude. Such loss must result from an Accidental injury. And, it must be supported by clinical proof or standardized tests that precisely measure decline in the areas of: (1) short term memory; (2) orientation to time, place and person; (3) deductive or abstract reasoning; and (4) judgement as it relates to awareness of safety.
- **Net Tuition Expense:** This term means Tuition Expense less any scholarships or grants to which the dependent child is entitled.
- **Paraplegia:** This term means total paralysis of both lower limbs.
- **Quadriplegia:** This term means total paralysis of upper and lower limbs, bilaterally.
- **Qualified Dependent Child:** This term means a child who is:
  - Your biological child, lawfully adopted child, stepchild, or any other child who is living with You in a regular parent-child relationship; and
  - Dependent on You for his or her chief support and maintenance.
- **Specified Loss:** This term means:
  - Loss of life;
  - A comatose state which lasts for a period in excess of one month;
  - Spinal cord injury which results in Hemiplegia, Paraplegia or Quadriplegia; or
  - Severe head injury which results in Loss of Cognitive Function.
- **Tuition Expense:** This term means charges incurred for courses or lab fees. It does not include:
  - Cost of books;
  - Cost of other related course materials;
  - Student activity fees; or
  - Room and board.

When And How The Dependent Child Education Benefit Begins

We will pay a dependent child education benefit when all of the conditions shown below are met:

- A benefit is payable under this Certificate's Basic Accidental Death and Dismemberment and Catastrophic Loss Insurance due to a Specified Loss;
- On the date of the Accidental injury which results in the Specified Loss, the Qualified Dependent Child must be 22 years of age or younger; and
- We receive proof of the Qualified Dependent Child's enrollment in an Institute Of Higher Learning. He or she must be a full-time student, as defined by the institute. And, he or she must:

- Be enrolled on the date of the Accidental injury which results in the Specified Loss; or
- Be in the 12th grade and enroll within 12 months of that date.

What We Pay

Subject to all the terms of this Policy, this benefit per academic term will be equal to the lesser of:

- The Qualified Dependent Child's Net Tuition Expense for the term;
- 5% of the Basic Accidental Death and Dismemberment Benefit and Catastrophic Loss Insurance Benefit paid as a result of the Specified Loss; and
- $2,500 And, this benefit is subject to a lifetime maximum of $20,000.

We pay this benefit to the person who has primary responsibility for these expenses within 30 days of proof of loss.

This benefit is paid per academic term. The maximum number of benefit payments is eight.

Continued Eligibility For The Dependent Child Education Benefit

We require periodic proof that a child remains a Qualified Dependent Child as shown above. We also require proof, per academic term of:

- His or her Tuition Expenses; and
- Any scholarships and grants to which he or she is entitled.

When The Dependent Child Education Benefit Ends

This benefit ends on the earliest of the dates shown below:

- The date the child is no longer a Qualified Dependent Child as shown above;
- The date the child is no longer enrolled in an Institute Of Higher Learning;
- The date the child fails to furnish any required proof as shown above;
- The date the lifetime maximum benefit is paid; and
- The date the maximum number of benefit payments have been made.
- The end of a period of six years from the date the first child education benefit payment is made.

If you die as a result of an Accidental bodily injury and the Dependent Child Education benefit is in effect on the date You die and there is no Qualified Dependent Child who could qualify for this benefit, we will pay a one time benefit of $500 to the beneficiary in one sum.

B400.6224

Day Care Expense Benefit

If You suffer a Specified Loss due to an Accidental bodily injury, We will pay a Day Care Expense Benefit subject to all of the terms shown below.

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

- **Hemiplegia:** This term means total paralysis of upper and lower limbs, unilaterally.
- **Loss Of Cognitive Function:** This term means a significant decline or loss in intellectual aptitude. Such loss must result from an Accidental injury. And, it must be supported by clinical proof or standardized tests that precisely measure decline in the areas of:
  - Short term memory;
  - Orientation to time, place and person;
  - Deductive or abstract reasoning; and
  - Judgement as it relates to awareness of safety.
- **Paraplegia:** This term means total paralysis of both lower limbs.
- **Quadriplegia:** This term means total paralysis of upper and lower limbs, bilaterally.
- **Qualified Day Care Program:** This term means a program of child care which:
  - Is provided in a facility that is licensed as a day care center or is operated by a licensed day care provider; and
  - Charges a fee for the care of children.

  The term does not include child care provided by a:
  - Parent;
  - Stepparent;
  - Grandparent;
  - Sibling;
  - Aunt; or
  - Uncle.
- **Qualified Dependent Child:** This term means a child who is:
  - Your biological child, lawfully adopted child, stepchild, or any other child who is living with You in a regular parent-child relationship; and
  - Dependent on You for his or her chief support and maintenance.

- **Specified Loss:** This term means:
  - Loss of life
  - A comatose state which lasts for a period in excess of one month;
  - Spinal cord injury which results in Hemiplegia, Paraplegia or Quadriplegia; or
  - Or severe head injury which results in Loss of Cognitive Function.

When And How The Day Care Expense Benefit Begins

We will pay a day care expense benefit when all of the conditions shown below are met:

- A benefit is payable under this Certificate's Basic Accidental Death and Dismemberment and Catastrophic Loss due to a Specified Loss;
- On the date of the Accidental injury which results in the Specified Loss, the Qualified Dependent Child must be under the age of seven of age or younger; and
- We receive proof of the Qualified Dependent Child's enrollment in a Qualified Day Care Program. His or her enrollment must start within 12 months of the date of the Accidental injury which results in the Specified Loss.

What We Pay

Subject to all the terms of this Policy, this benefit will be equal to the lesser of:

- $10,000 per year; and
- The actual yearly day care expenses for all of Your Qualified Dependent Children.

If this benefit is payable as both an Employee Accidental Death and Dismemberment Benefit and a Dependent Accidental Death and Dismemberment Benefit under this Certificate, the total benefit paid will not exceed the yearly day care expenses for all of Your Qualified Dependent Children.

We pay this benefit to the person who has primary responsibility for these expenses within 30 days of written proof of loss.

Continued Eligibility For The Day Care Expense Benefit

We require periodic proof:

- That a child remains enrolled in a Qualified Day Care Program; and
- Of the child's day care expenses.

When The Day Care Expense Benefit Ends

This benefit ends on the earliest of the dates shown below:

- The date the child is no longer a Qualified Dependent Child as shown above;
- The date the child is no longer enrolled in a Qualified Day Care Program;

- The date We do not receive any required proof as shown above; and
- The end of a period of four years from the date the first day care expense benefit was paid.

If you die as a result of an Accidental bodily injury and the Day Care Expense benefit is in effect on the date You die and there is no Qualified Dependent Child who could qualify for this benefit, we will pay a one time benefit of $500 to the beneficiary in one sum.

B400.6226

All Options

Voluntary Accidental Death and Dismemberment Insurance

B400.6139

We will pay the benefits described below if You suffer an irreversible loss due to an Accident and the Accident occurs while You are insured by this Certificate. The loss also must:

- Be a direct result of the Accident;
- Be independent of all other causes; and
- Occur within 365 days of the date of the Accident.

Payment Of Benefits We will pay this insurance within 30 days of receiving written Proof of Loss as shown in the Claims Provisions section of this Certificate.

Payment Of Benefits For Covered Loss of life, We pay the beneficiary of Your Voluntary Accidental Death and Dismemberment Insurance under the Employer's Policy with Us.

For all other Covered Losses, We pay You if You are living. If You are not living, We pay the beneficiary of Your Voluntary Term Life coverage under the Employer's Plan with Us.

Subject to all the terms of this Certificate, We pay all benefits in a lump sum within 30 days of receiving written proof of Covered Loss and proof of claim which is acceptable to Us. This should be sent to Us as soon as possible.

The Beneficiary You decide who receives this benefit when You die. Your beneficiary designation should be provided in a means acceptable by Us.

You can change Your beneficiary at any time by providing written notice. But, the change will not take effect until We or the Employer records the change.

We will not be liable for any amounts paid before receiving notice of a beneficiary change.

In no event may a beneficiary be changed by a Power of Attorney.

If You named more than one person as a primary beneficiary, but You do not specify what shares each such primary beneficiary is entitled to receive, We will divide the benefits equally among all such named primary beneficiaries who survive You. If someone You named as a primary beneficiary dies before You, that person's share will be divided equally by the primary beneficiaries still alive; unless You have specified otherwise.

If You have named a contingent beneficiary or contingent beneficiaries, We will pay Your contingent beneficiary or contingent beneficiaries, if no primary beneficiary survives You. If there is more than one contingent beneficiary who is eligible for benefits, We will divide the benefits equally among all such named contingent beneficiaries who survive You; unless You have specified otherwise.

If there is no primary or contingent beneficiary or beneficiaries eligible for benefits when You die, We will pay this benefit as follows:

- To Your Spouse;
- If Your Spouse does not survive You, then to Your children who survive You in equal shares;
- If no Spouse or children survive You, then to Your parents who survive You in equal shares;
- If no Spouse, children, or parents survive You, then to then to Your brothers and sisters in equal shares;
- If none of the above parties survive You, then to Your executors or administrators of Your estate.

Payment Of Funeral Expenses We have the option of paying up to $500 of this benefit to any person who incurred expenses for Your funeral.

B400.6389

All Options

Covered Losses Benefits will be paid only for losses listed in the Table of Covered Losses shown below. Your insurance amount is shown in the Accidental Death and Dismemberment Schedule Of Benefits.

B400.6147

All Options

ACCIDENTAL DEATH AND DISMEMBERMENT

Table Of Covered Losses

Covered Loss	Benefit
Loss of life	100% of Your Voluntary AD&D insurance amount.

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Disappearance	100% of Your Voluntary AD&D insurance amount.
Loss of a hand	50% of Your Voluntary AD&D insurance amount. No benefit will be paid if benefits have been paid for "loss of one arm".
Loss of a foot	50% of Your Voluntary AD&D insurance amount. No benefit will be paid if benefits have been paid for "loss of one leg".
Loss of sight in one eye	50% of Your Voluntary AD&D insurance amount.
Loss of thumb and index finger of same hand	25% of Your Voluntary AD&D insurance amount. No benefit will be paid if benefits have been paid for "Loss of a hand" or "loss of one arm".
Loss of four fingers of same hand	25% of Your Voluntary AD&D insurance amount. No benefit will be paid if benefits have been paid for "Loss of a hand" or "loss of one arm".
Loss of all toes of same foot	25% of Your Voluntary AD&D insurance amount. No benefit will be paid if benefits have been paid for "Loss of a foot" or "loss of one leg".
Loss of the great toe (hallux)	15% of Your Voluntary AD&D insurance amount. No benefit will be paid if benefits have been paid for "Loss of a foot" or "loss of one leg".

B400.6145

All Options

As used here:

- "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.

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- "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.
- "Loss of all toes of same foot" means complete severance at the metatarsalphalangeal joint.
- "Loss of the great toe (hallux)" means complete severance at the metatarsalphalangeal joint.

B400.6149

All Options

Multiple Losses For more than one Covered Loss due to the same Accident, We will pay up to 100% of Your Voluntary Accidental Death and Dismemberment Insurance amount. We will not pay more than 100% of Your Voluntary Accidental Death and Dismemberment Insurance amount for all losses due to the same Accident, except as shown under the Common Carrier Benefit, Seatbelt And Airbag Benefits and Repatriation Benefit.

B400.6152

All Options

Exclusions Conditions that are not considered Covered Losses and that are not covered under the terms of this Certificate can be found in the definition of "Accident". Please refer to the Definitions section of this Certificate.

B400.6153

All Options

Repatriation Benefit We pay an extra sum for Covered Loss of life due to an Accident which occurs at least 75 miles from Your home. In that case, We pay up to $5,000 for costs to prepare and transport Your body to a mortuary chosen by You or an authorized agent. In the event that a Repatriation Benefit is paid under Your Group Term Life Insurance Certificate, no additional benefit will be paid under this Accidental Death and Dismemberment Certificate.

B400.6155

All Options

Exposure If You suffer a Covered Loss shown in the Table of Covered Losses due to an Accidental bodily injury caused by being unavoidably exposed to the elements, We will pay the amount which otherwise applies to the loss. If Covered Loss benefits are deemed payable under Exposure, the Covered Loss benefit is only paid once, not in addition to the Exposure payments.

B400.6156

All Options

Disappearance You will have a presumed Covered Loss due to an Accident if:

- You are riding in a public conveyance that is involved in an Accident;

- As a result of the Accident, the public conveyance is wrecked, sinks, is stranded or disappears;
- Your body is not found within 365 days of the day the Accident; and
- The Accident occurs while You are covered by this Certificate.

If Covered Loss benefits are deemed payable under Disappearance, the Covered Loss benefit is only paid once, not in addition to the Disappearance payments.

B400.6157

All Options

DEPENDENT ACCIDENTAL DEATH AND DISMEMBERMENT (AD&D) INSURANCE

B400.6177

All Options

Dependent Voluntary Accidental Death and Dismemberment Insurance

B400.6178

All Options

We will pay the benefits described below within 30 days of receiving written proof of loss if a covered dependent suffers an irreversible loss due to an Accident that occurs while he or she is insured under this Certificate. The loss must: (1) be a direct result of the Accident; (2) be independent of all other causes; and (3) occur within 365 days of the date of the Accident.

B400.6227

All Options

Payment Of Benefits

For all Covered Losses, We pay You, if You are living. If You are not living, We will pay this benefit as follows:

If the dependent was Your Spouse, We will pay this benefit in equal shares to the first eligible party or parties in the following order:

- To Your Spouses estate;
- To Your Spouses children in equal shares;
- If no children survive him or her, then to his or her parents in equal shares;
- If no children, or parents survive him or her, then to then to his or her brothers and sisters in equal shares;
- If none of the above parties survive Your Spouse, then to the executors or administrators of Your estate.

If the dependent was Your child, we will pay this benefit in equal shares to the first eligible party or parties in the following order:

- Your childs custodial parent(s);
- If no custodial parent survives him or her, then to Your parents;
- If no custodial parent or Your parents survive him or her, then to Your childs estate;

- If none of the above parties survive him or her and no estate exists, then to the executors or administrators of Your estate;
- If none of the above parties survive him or her, and no estates exist, then to Your childs siblings.

Payment of Funeral Expenses We have the option of paying up to $500 of this benefit to any person who incurred expenses for your dependents funeral.

B400.6184

All Options

ACCIDENTAL DEATH AND DISMEMBERMENT

Covered Losses Benefits will be paid only for losses listed in the Table of Covered Losses shown below. Your covered dependent's insurance amount is shown in the Accidental Death and Dismemberment Schedule Of Benefits.

Table Of Covered Losses

Covered Loss	Benefit
Loss of life	100% of the Voluntary AD&D insurance amount.
Disappearance	100% of the Voluntary AD&D insurance amount.
Loss of a hand	50% of the Voluntary AD&D insurance amount. No benefit will be paid if benefits have been paid for "loss of one arm".
Loss of a foot	50% of the Voluntary AD&D insurance amount. No benefit will be paid if benefits have been paid for "loss of one leg".

Loss of sight in one eye	50% of the Voluntary AD&D insurance amount.
Loss of thumb and index finger of same hand	25% of the Voluntary AD&D insurance amount. No benefit will be paid if benefits have been paid for "Loss of a hand" or "loss of one arm".
Loss of four fingers of same hand	25% of the Voluntary AD&D insurance amount. No benefit will be paid if benefits have been paid for "Loss of a hand" or "loss of one arm".
Loss of all toes of same foot	25% of the Voluntary AD&D insurance amount. No benefit will be paid if benefits have been paid for "Loss of a foot" or "loss of one leg".
Loss of the great toe (hallux)	15% of the Voluntary AD&D insurance amount. No benefit will be paid if benefits have been paid for "Loss of a foot" or "loss of one leg".

B400.6185

All Options

As used here:

- "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 all toes of same foot means complete severance at the metatarsalphalangeal joint.
- Loss of the great toe (hallux) means complete severance at the metatarsalphalangeal joint.
- "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.
- Loss of all toes of same foot means complete severance at the metatarsalphalangeal joint.

B400.6187

All Options

Multiple Losses For more than one Covered Loss due to the same Accident, We will pay up to 100% of the covered dependent's Voluntary Accidental Death and Dismemberment Insurance amount. We will not pay more than 100% of his or her Voluntary Accidental Death and Dismemberment Insurance amount for all losses due to the same Accident, except as shown under the Common Carrier Benefit, Seatbelt And Airbag Benefits and Repatriation Benefit.

B400.6189

All Options

Repatriation Benefit We pay an extra sum for Covered Loss of life due to an Accident which occurs at least 75 miles from the covered dependent's home. In that case, We pay up to $5,000 for costs to prepare and transport his or her body to a mortuary chosen by You.

B400.7168

All Options

Exposure If the covered dependent suffers a Covered Loss shown in the Table of Covered Losses due to an Accidental bodily injury caused by being unavoidably exposed to the elements, We will pay the amount which otherwise applies to the loss.

If Covered Loss benefits are deemed payable under Exposure, the Covered Loss benefit is only paid once, not in addition to the Exposure payment.

B400.7169

All Options

Disappearance The covered dependent will have a presumed Accidental bodily injury due to an Accident if:

- The covered dependent is riding in a public conveyance that is involved in an Accident;
- As a result of the Accident, the public conveyance is wrecked, sinks, is stranded or disappears;
- The covered dependent's body is not found within 365 days of the day the Accident; and
- The Accident occurs while the covered dependent is covered by this policy.

If Covered Loss benefits are deemed payable under Disappearance, the Covered Loss benefit is only paid once, not in addition to the Disappearance payment.

B400.7170

CLAIM PROVISIONS

Your right to make a claim for Group Accidental Death and Dismemberment Insurance Benefits provided by this Certificate is governed as follows:

Authority We have discretionary authority to:

- Interpret the terms of this Certificate; and
- Determine Your eligibility for coverage and benefits under this Certificate.

All such determinations are conclusive and binding, except that they may be modified or reversed by a court or regulatory agency with appropriate jurisdiction.

Notice Written notice of intent to file a claim under this Certificate must be sent to Us within 20 days of the date of the loss. This Notice should include the name of the insured and the Policy number. If the claim is being made for any other Covered Person, his or her name should also be shown. For details, You can call Us at 1-800-525-4542.

Claim Forms We will furnish forms for filing proof of death within 15 days of receipt of Notice. If we do not furnish the forms on time, We will accept a written Notice and adequate proof of death that is the basis of the claim as Proof of Loss.

Proof of Loss You must send written Proof of Loss to Our designated office within 90 days of the loss. Failure to furnish written Proof of Loss within that time does not invalidate or reduce a claim if it was not reasonably possible to submit proof within the required time, if proof is furnished as soon as reasonably possible and, except in the absence of legal capacity of the claimant, not later than 1 year from the time proof is otherwise required.

Late Notice and Proof of Loss We will not void or reduce Your claim if we do not receive Notice and Proof of Loss within the required time. In that case, Notice and Proof of Loss must be sent as soon as reasonably possible, but, except in the absence of legal capacity, not later than one year from the time proof is otherwise required.

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

The Guardian Life Insurance Company of America
Group Life Claims Department
P.O. Box 14334
Lexington, KY 40512

Payment of Benefits We will pay the Group Accidental Death & Dismemberment Insurance Benefit not more than 30 days from the time We receive written Proof of Loss.

Legal Actions No legal action against Guardian related to this Certificate may be brought until 60 days from the date Proof of Loss has been given as shown above. No legal action may be brought against Guardian related to claims for benefits under this Certificate after three years from the date of the final benefit determination.

B400.6233

GC-ADD-15-MD

All Options

DEFINITIONS

This section defines certain terms appearing in Your Certificate.

B400.7183

All Options

Accident This term means an event or occurrence, resulting in bodily injury or death, independent of all other causes, while a Covered Person is insured by this Certificate. Accident does not include:

- Willful self-injury, suicide, or attempted suicide while sane or insane;
- Sickness, disease, mental infirmity, or result of any medical or surgical treatment;
- Infection, except pyogenic infections or infection sustained due to terrorist attacks, which result from a bodily injury or bacterial infections which result from the unintentional ingestion of contaminated substances;
- An injury the Covered Person suffers while taking part in the commission of or attempt to commit a felony, as defined per the laws in the jurisdiction in which the felony was committed or attempted, or as defined under federal law if the offense charged was a federal offense;
- Injury suffered while travelling on any type of aircraft if the Covered Person is an instructor or crew member; or has any duties at all on that aircraft;
- Injury suffered in declared or undeclared war or act of war or armed aggression;
- Injury suffered while the Covered Person is a member of any armed force;
- Injury suffered while the Covered Person is intoxicated as defined by the laws of the jurisdiction in which the accident took place; or
- Injury suffered while the Covered Person is voluntarily using a narcotic, unless:
  - It was prescribed for the Covered Person by a doctor; and
  - It was used as prescribed.

B400.6234

All Options

Active Work or Actively At Work

These terms mean You are able to perform, and are performing, all of the regular duties of Your work for the Employer at:

- One of the Employer's usual places of business;
- Some place where the Employer's business requires You to travel; or
- Any other place You and the Employer have agreed on for Your work.

B400.7186

All Options

Activities Of Daily Living

This term means the ability to independently perform the following, with or without equipment or adaptive devices:

- **Bathing:** wash in a tub or shower; or take a sponge bath; and towel dry.
- **Dressing:** put on and take off all clothes; and those medically necessary braces or prosthetic limbs usually worn; and fasten or unfasten them.
- **Toileting:** get to and from and on and off the toilet; to maintain personal hygiene; and care for clothes.
- **Transferring:** move in and out of a chair or bed.
- **Continence:** control bowel and bladder function; or, in the event of incontinence, maintain personal hygiene.
- **Eating:** get food into the body by any means once it has been prepared and made available.

B400.7187

All Options

Certificate

This term means this Certificate of Coverage, including any riders and enrollment forms that may be attached to this Certificate.

B400.7188

All Options

Covered Loss

This term means loss due to an Accident while a Covered Person is insured by this Certificate and as outlined in the Table of Covered Losses.

B400.7189

All Options

Covered Person

This term means the Employee and dependents who are insured by this Certificate.

B400.7190

All Options

Effective Date The date the Certificate goes into force and effect as stated on the cover page of the Certificate of Coverage, or any change to the Certificate as requested by the Policyholder and approved by Us and in force and effect as stated on the cover page of the Certificate of Coverage.

B400.7192

All Options

Eligibility Date This term means the earliest date a Covered Person is eligible for coverage under this Certificate, and he or she has satisfied all requirements for coverage to begin, as required by this Certificate.

- For Employee coverage, this term means the earliestdate You are eligible for coverage under this Certificate.
- For an Employee in Active Work who had completed any waiting period required by the Employer as of the Effective Date of this Certificate, the Eligibility Date means the Effective Date of this Certificate.
- For an Employee in Active Work as of the Effective Date of this Certificate who has not completed any waiting period required by the Employer , the Eligibility Date will be the first date following the completion of the required waiting period.
- For an Employee hired on or after the Effective Date of this Certificate, the Eligibility Date will be the later of the Employee's date of hire, or the first date following the completion of any waiting period required by the Employer.

If this plan requires Employees to elect coverage under this Certificate, the Eligibility date will be the later of:

- The Employee's date of hire;
- The first date following the completion of any waiting period required by the Employer; or
- The approval by Us in writing of any coverage for which You were required to provide Proof of Insurability.

For dependent coverage, this term means the earliest date on which:

- You have Initial Dependents; and
- Are eligible for dependent coverage.

B400.7193

All Options

Employee This term means a person who works for the Employer at the Employer's place of business and whose income is reported to the United States Internal Revenue Service, and/or a state, for tax purposes. Partners and proprietors will also be treated as Employees if the eligibility requirements are met.

B400.7195

GC-ADD-15-MD

All Options

Employer This term means 2 CIRCLE, INC .

B400.7196

All Options

Enrollment Period This term means the 31 day period which starts on the date You first become eligible for coverage.

B400.7197

All Options

Full-Time This term means You are not a part time Employee as defined by Your Employer and the average number of hours You worked for the six months prior to the last full day worked was at least 30 hours per week at:

- Your Employer's place of business;
- Some place where the Employer's business requires You to travel; or
- Any other place You and Your Employer have agreed upon for the performance of occupational duties.

B401.3005

All Options

Initial Dependents This term 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.

B400.7199

All Options

Month or Months or Monthly These terms mean a consecutive 30 day period.

B400.7220

All Options

Newly Acquired Dependent This term means an eligible dependent You acquire after You already have coverage in force for Initial Dependents.

B400.7221

All Options

Policy or Plan This term means the Group Accidental Death and Dismemberment Coverage described in the Policy and in this Certificate.

B400.7223

All Options

Proof Of Insurability This terms means the completion of an evidence of insurability form, acceptable to Us, which shows that a person is insurable.

B400.7224

All Options

Proof of Loss This term means the documents that are deemed acceptable for purposes of substantiating a life claim. Acceptable Proof of Loss includes:

- An original certified finalized death certificate;
- The beneficiary designation in effect at the time of death;
- Enrollment information documenting that the insured was properly enrolled for the amount of coverage claimed;
- A fully completed claim form; and
- Any additional information deemed necessary during the course of Our claim investigation. This may include, but is not limited to, an autopsy report, investigative reports, toxicology reports and medical records.

B400.7225

All Options

Third degree Burn This term means a burn involving the full thickness of skin including the tissue beneath the skin; burns in which both the epidermis and dermis are destroyed with damage extending into underlying tissues.

B400.7227

All Options

Spouse This term means the person to whom You are legally married, or Your domestic partner, civil union partner or equivalent, as recognized and allowed by federal law, or state law in Your state of residence or the state in which the marriage, or domestic partnership, civil union or equivalent, was recorded.

B401.1736

All Options

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

B400.7229

All Options

You or Your These terms mean the insured Employee.

B400.7230

All Options

GROUP ACCIDENTAL DEATH AND DISMEMBERMENT SCHEDULE OF BENEFITS

B400.7846

All Options

Employee Basic Accidental Death And Dismemberment (AD&D) Insurance Schedule

B400.7859

All Options

Basic AD&D Insurance Amount

The Insurance Amount is $100,000.00

B400.7860

All Options

Reduction of Basic AD&D Insurance Amount Based on Age

If You are less than age 65 when Your insurance under this Policy starts, Your insurance amount will be reduced at 12:01 A.M. Standard Time for Your place of residence on the date You reach age 65, by 35% of the amount which otherwise applies to Your classification. But in no case will such reduced amount be less than $1,000.00. This reduction also applies to Your initial insurance amount if Your insurance starts after You reach age 65, but before You reach age 70.

If You are less than age 70 when Your insurance under this Policy starts, Your insurance amount will be reduced at 12:01 A.M. Standard Time for Your place of residence on the date You reach age 70, by 50% of the amount which otherwise applies to Your classification. But in no case will such reduced amount be less than $1,000.00. This reduction also applies to Your initial insurance amount if Your insurance starts after You reach age 70.

The reduced amount is in place of the amount which otherwise applies to Your classification.

B400.7899

All Options

Limitations For Future Entrants

But, regardless of any of the above reductions, we limit Your initial insurance amount as shown below if Your insurance under this Policy starts both:

(a) after this Policy's effective date; and

(b) after you reach age 70.

The limited amount is in place of the amount which otherwise applies to Your classification.

If you give Us Proof Of Insurability, and We approve it in writing, Your insurance amount will be 50% of the amount which otherwise applies to Your classification. But in no event will this reduced amount be less than $10,000.00.

If you do not give Us Proof Of Insurability or We do not approve Your Proof, Your insurance amount will be $10,000.00.

B400.7974

All Options

Proof of Insurability

Depending on the coverage selected, or as otherwise required in this Certificate, You, Your Spouse and/or Dependents may be required to supply proof that the person applying for coverage is insurable for the amount and type of coverage selected. This requirement is called Proof of Insurability. For purposes of this section, any person applying for coverage requiring Proof of Insurability is referred to as "Applicant."

To determine if the Applicant is required to submit Proof of Insurability for the type and amount of coverage sought, please see below.

Any applicant required to submit Proof of Insurability is required to complete and submit to Us an Enrollment/Change form. We may also require the completion of additional forms so that We may determine whether the Applicant is insurable, according to Our underwriting standards for the amount and type of coverage applied for. To determine if the Applicant is insurable, We may also need to obtain and review the Applicant's health and medical history; prescription history; records relating to treatment, diagnostic testing, hospitalization and the like; and records pertaining to Applicant's driving and motor vehicle history.

No coverage requiring Proof of Insurability will become effective unless and until it is approved by Us in writing. Our receipt of any premiums associated with coverage requiring Proof of Insurability does not waive or modify any requirement that must be satisfied for coverage to begin, including but not limited to the requirement that the Applicant submit Proof of Insurability. In the event that any premiums are overpaid, Our only obligation is to return the amount of overpaid premiums.

The Policyholder, or its designee, must give Us complete and accurate information so that we may determine:

- Who is insured;
- The type and amount of coverage for which someone is insured; and
- Any other information required so that Guardian may meet its obligations under the Policy.

Proof Of Insurability Requirements

Proof Of Insurability requirements apply to Basic Accidental Death and Dismemberment Insurance. Such requirements may apply to the full insurance amount, or just part of it, as outlined below. When Proof Of Insurability requirements apply, it means You must submit to Us Proof that You are insurable, and We must approve the Proof in writing before the insurance, or the specified part becomes effective.

We require Proof of Insurability as follows:

If You:

- Do not meet this Policy's enrollment requirement within 30 days after You first become eligible; or
- Enroll after You previously had coverage which ended because You failed to make a required payment,

We will require that You provide Proof Of Insurability. And, You will not be covered until We approve that proof in writing.

If Your Active Full-Time Work ends before You meet any Proof Of Insurability requirements that apply You will still have to meet those requirements if You are later re-employed by the Employer or an associated company.

B400.8032

All Options

Employee Voluntary Accidental Death And Dismemberment (AD&D) Insurance Schedule

B400.8097

All Options

Initial Election

You will be insured under one of the plans of Voluntary Accidental Death and Dismemberment Insurance which is equal to 100% of the Voluntary Term Life amount not to exceed $300,000.00. You may only be insured under one plan at a time. You must notify the Employer of your election and pay the required premium.

B400.8100

All Options

Changing Election

You may switch to another benefit any time the Voluntary Term Life amount is changed. You must notify the Employer of the switch and the amount must be 100% of the Voluntary Term Life amount.

B400.8104

All Options

Voluntary AD&D Insurance Amount

Plan A

You may elect amounts of Voluntary Accidental Death and Dismemberment Insurance in increments of $10,000.00, but your amount may not be less than $10,000.00 and may not exceed $300,000.00.

B400.8127

All Options

Annual Election

After You first enroll for Employee Voluntary Accidental Death and Dismemberment Insurance, You may choose to increase Your amount of Voluntary Accidental Death and Dismemberment Insurance by an amount not to exceed an increase of $50,000 as shown above. This option is available during the Voluntary Accidental Death and Dismemberment enrollment period described above. Proof Of Insurability will not be required unless the insurance amount exceeds the amount of Voluntary Accidental Death and Dismemberment Insurance for which Proof Of Insurability is required as shown below.

If Proof Of Insurability is required and has been submitted and approved by Us, Proof of Insurability for additional increases will be required on the second anniversary of the date we approve such coverage.

If Proof Of Insurability is required and has been declined, You will not be eligible for additional annual increases without submitting Proof Of Insurability for them, and then if such increases are approved by Us in writing.

B400.9092

All Options

Family Status Change

You may request a change to your Voluntary Accidental Death and Dismemberment Insurance coverage if you have experienced a Family Status Change.

A Family Status Change includes one or more of the following:

- Marriage or divorce;
- Death of a Spouse or child;
- Birth or adoption of a child;

- Your Spouse's termination of employment or a change in Your Spouse's employment that results in the loss of group coverage.

The term "marriage" may also refer to civil unions and domestic partnerships, as recognized by the jurisdiction in which You reside.

If a change in Family Status occurs, You may request an increase to Your Voluntary Accidental Death and Dismemberment Insurance amount or the addition of Employee Voluntary Accidental Death and Dismemberment Insurance for which You were not previously insured. You may also request an increase or the addition of dependent Spouse or dependent child Voluntary Accidental Death and Dismemberment Insurance for your living eligible dependents. You must provide proof of the Family Status Change and request the change to Your Voluntary Accidental Death and Dismemberment Insurance in writing within 31 days after the date of the Family Status Change as described below.

B400.9096

All Options

Reduction of Voluntary AD&D Insurance Amount Based on Age

If You are less than age 65 when Your insurance under this Plan starts, Your insurance amount is reduced at 12:01 A.M. Standard Time for Your place of residence on the date You reach age 65, by 35% of the amount which otherwise applies to Your classification. But in no case will such reduced amount be less than $1,000.00. This reduction also applies to Your initial insurance amount if Your insurance starts after You reach age 65, but before You reach age 70.

If You are less than age 70 when Your insurance under this Plan starts, Your insurance amount is reduced at 12:01 A.M. Standard Time for Your place of residence on the date You reach age 70, by 60% of the amount which otherwise applies to Your classification. But in no case will such reduced amount be less than $1,000.00. This reduction also applies to Your initial insurance amount if Your insurance starts after You reach age 70.

The reduced amount is in place of the amount which otherwise applies to Your classification.

B400.9128

All Options

Proof of Insurability

Depending on the coverage selected, or as otherwise required in this Certificate, You, Your Spouse and/or Dependents may be required to supply proof that the person applying for coverage is insurable for the amount and type of coverage selected. This requirement is called Proof of Insurability. For purposes of this section, any person applying for coverage requiring Proof of Insurability is referred to as "Applicant."

To determine if the Applicant is required to submit Proof of Insurability for the type and amount of coverage sought, please see below.

Any applicant required to submit Proof of Insurability is required to complete and submit to Us an Enrollment/Change form. We may also require the completion of additional forms so that We may determine whether the Applicant is insurable, according to Our underwriting standards for the amount and type of coverage applied for. To determine if the Applicant is insurable, We may also need to obtain and review the Applicant's health and medical history; prescription history; records relating to treatment, diagnostic testing, hospitalization and the like; and records pertaining to Applicant's driving and motor vehicle history.

No coverage requiring Proof of Insurability will become effective unless and until it is approved by Us in writing. Our receipt of any premiums associated with coverage requiring Proof of Insurability does not waive or modify any requirement that must be satisfied for coverage to begin, including but not limited to the requirement that the Applicant submit Proof of Insurability. In the event that any premiums are overpaid, Our only obligation is to return the amount of overpaid premiums.

The Policyholder, or its designee, must give Us complete and accurate information so that we may determine:

- Who is insured;
- The type and amount of coverage for which someone is insured; and
- Any other information required so that Guardian may meet its obligations under the Policy.

Proof Of Insurability Requirements

Proof Of Insurability requirements apply to Voluntary Accidental Death and Dismemberment Insurance. Such requirements may apply to the full insurance amount, or just part of it, as outlined below. When Proof Of Insurability requirements apply, it means You must submit to Us Proof that You are insurable, and We must approve the Proof in writing before the insurance, or the specified part becomes effective.

We require Proof of Insurability as follows:

B400.9141

All Options

Except as provided for annual election, We require Proof of Insurability before You switch from Your current increment of Voluntary Accidental Death and Dismemberment Insurance to an increment which provides a greater amount of insurance.

B400.9179

All Options

We require Proof of Insurability before We will insure You if You enroll for Voluntary Accidental Death and Dismemberment Insurance after the time allowed for enrolling as specified in this Certificate.

B400.9184

All Options

We require Proof of Insurability for all amounts of Voluntary Accidental Death and Dismemberment Insurance which exceed $100,000.00.

B400.9188

All Options

We require Proof of Insurability for all amounts of Voluntary Accidental Death and Dismemberment Insurance which exceed $50,000.00, if Your scheduled Voluntary Accidental Death and Dismemberment Insurance effective date is after You reach age 65.

B400.9191

All Options

We require Proof of Insurability for all amounts of Voluntary Accidental Death and Dismemberment Insurance which exceed $10,000.00, if Your scheduled Voluntary Accidental Death and Dismemberment Insurance effective date is after You reach age 70.

B400.9191

All Options

Dependent Voluntary Accidental Death and Dismemberment Schedule

B400.9308

All Options

Initial Election You may choose the plan of dependent Spouse Voluntary Accidental Death and Dismemberment Insurance and the plan of dependent child Voluntary Accidental Death and Dismemberment Insurance shown below. You must notify the Employer of Your election and pay the required premium.

B400.9309

All Options

Voluntary Dependent Spouse Insurance Amount

Plan A

An amount equal to 50% of Your Voluntary Accidental Death and Dismemberment Insurance amount, to a maximum of $150,000.00.

B400.9319

All Options

Voluntary Dependent Child Insurance Amount

Plan A

Child's Age At Death	Insurance Amount (expressed as a % of Your voluntary AD&D insurance amount)
At least 14 days but less than 26 years	10% to a maximum of $10,000.00

B400.9359

All Options

In no event may the insurance amount of a dependent Spouse exceed 50% of Your insurance amount.

B401.2814

All Options

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

B401.2813

All Options

Reduction of Dependent Voluntary Accidental Death and Dismemberment Insurance Amount based on Age

Your dependent benefits are reduced in the same manner as Your benefits. The dependent reductions are based on Your age.

B400.9363

All Options

Proof Of Insurability Requirements

Depending on the coverage selected, or as otherwise required in this Certificate, Your Spouse and Dependent Children may be required to supply proof that the person applying for coverage is insurable for the amount and type of coverage selected. This requirement is called Proof of Insurability. For purposes of this section, any person apply for coverage requiring Proof of Insurability is referred to as "Applicant."

To determine if the Applicant is required to submit Proof of Insurability for the type and amount of coverage sought, please see below.

Any applicant required to submit Proof of Insurability is required to complete and submit to Us an Enrollment/Change form. We may also require the completion of additional forms so that we may determine whether the Applicant is insurable according to our underwriting standards for the amount and type of coverage applied for. To determine if the Applicant is insurable, We may also need to obtain and review the Applicant's:

- Health and medical history;

- Prescription history;
- Records relating to treatment, diagnostic testing, hospitalization; and
- Records pertaining to the Applicant's driving and motor vehicle history.

No coverage requiring Proof of Insurability will become effective unless and until it is approved by Us in writing. Our receipt of any premiums associated with coverage requiring Proof of Insurability does not waive or modify any requirement that must be satisfied for coverage to begin, including but not limited to the requirement that the Applicant provide Proof of Insurability. In the event that any premiums are overpaid, Our only obligation is to return the amount of overpaid premiums.

The Policyholder, or its designee, must give Us complete and accurate information so that We may determine:

- Who is insured;
- The type and amount of coverage for which someone is insured; and
- Any other information required so that Guardian may meet its obligations under the Policy.

We require Proof of Insurability as follows:

B400.9364

All Options

We require Proof Of Insurability that a dependent is insurable if You:

- Enroll a dependent, submit the dependent's signed health statement, and agree to make the required payments after the end of the Enrollment Period;
- In the case of a Newly Acquired Dependent, other than the first newborn child, have other eligible dependents who You have not elected to enroll; or
- In the case of a Newly Acquired Dependent, have other eligible dependents whose coverage previously ended because You failed to make the required contributions, or otherwise chose to end such coverage.

B400.9367

All Options

A dependent is not covered by any part of this Policy that requires such proof until You give Us this proof and We approve it in writing.

If Your dependent coverage ends for any reason, including failure to make the required payments, Your dependents will not be covered by this Policy again until You give Us new proof that they are insurable and We approve that proof in writing.

B400.9368

All Options

We require Proof of Insurability before We will insure any dependent Spouse who is enrolled for dependent Spouse Voluntary Accidental Death and Dismemberment Insurance after the time allowed for enrolling as specified in this Policy.

B400.9373

All Options

We require Proof of Insurability for any increase in the amount of dependent Voluntary Accidental Death and Dismemberment Insurance with respect to a dependent Spouse.

B400.9374

All Options

We require Proof of Insurability for any amount of dependent Voluntary Accidental Death and Dismemberment Insurance in excess of $25,000.00 with respect to a dependent Spouse.

B400.9376

All Options

We require Proof of Insurability for any amount of dependent Voluntary Accidental Death and Dismemberment Insurance In excess of $10,000.00 with respect to a dependent Spouse, if the dependent Spouse's scheduled dependent Voluntary Accidental Death and Dismemberment effective date is after he or she reaches age 65.

B400.9375

All Options

We require Proof of Insurability before We will insure any dependent child who is enrolled for dependent child Voluntary Accidental Death and Dismemberment Insurance after the time allowed for enrolling as specified in this Policy.

B400.9481

All Options

We require Proof of Insurability for any increase in the amount of dependent Voluntary Accidental Death and Dismemberment Insurance with respect to a dependent child.

B400.9482

All Options

Changes to Insurance

B400.9564

All Options

Changes In Insurance Amounts

If You are not Actively At Work on a Full-Time basis, any change in Your amount of coverage or the amount of coverage on a covered dependent will not become effective prior to the date You return to Active Work on a Full-Time basis.

B400.9568

All Options

Changes In Insurance Classification

If Your classification changes, insurance will not be changed to the new amount until the first day on which You are:

- Actively At Work on a Full-Time basis; and
- Make a contribution, if required, for the new classification.

If a contribution is required for the new classification for which a larger amount of insurance is provided, You must make the required contribution for the new amount within 31 days of the change. If You do not make the required contribution within 31 days of the change or within 31 days of becoming Actively At Work on a Full-Time basis, if You are not Actively At Work on a Full-Time basis, when Your classification changes, no increase will be allowed due to such change or any later change. In that case, in order to become insured for the larger amount, You must:

- Make the required contribution for the new amount; and
- Furnish Proof Of Insurability to Us, which We approve in writing.

If the insurance amount was previously reduced because of age or retirement, it will be retained at the reduced amount.

B400.9570

CERTIFICATE RIDER - Seatbelt and Airbag Benefit

This Rider is effective as of the effective date of the Employee's Certificate. If this Rider is added to an inforce Certificate, the Rider becomes effective on its issue date. This Rider amends the Certificate by the addition of the following:

Terms not specifically defined within this Rider are defined in the Certificate.

Employee Basic and Voluntary
Accidental Death and Dismemberment Insurance
and Dependent Voluntary Accidental Death
and Dismemberment Insurance
Seatbelt and Airbag Benefit

This rider applies to Your Basic and Voluntary Accidental Death and Dismemberment Insurance and dependent Voluntary Accidental Death and Dismemberment Insurance.

Seatbelt And Airbag Benefits

If You die as a direct result of an automobile Accident while properly wearing a seatbelt, We will increase Your Accidental Death and Dismemberment Benefit amount by $10,000. 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 will increase Your Accidental Death and Dismemberment Benefit amount by an additional $5,000, for a total increase of $15,000.

Proof that You were properly wearing a seatbelt must be provided. A law enforcement official investigating the Accident must certify that the seatbelt was properly fastened and that the automobile in which the deceased was traveling was equipped with airbags. A copy of such certification must be submitted to Us with the claim for benefits.

If We cannot determine that You were wearing a seatbelt at the time of the Accident, We will increase Your Accidental Death and Dismemberment Benefit amount by $1,000.

If We determine that a seatbelt was not worn at the time of the automobile Accident directly resulting in Your death, or if the required official report is not provided, no Seatbelt or Airbag Benefit will be paid.

The total amount payable for the Seatbelt and Airbag Benefit under Your Basic and Voluntary Accidental Death and Dismemberment Insurance and Basic and Voluntary Group Term Life Insurance and may not exceed $30,000.

Exclusions

This Certificate Rider does not pay a Seatbelt or Airbag Benefit for loss of life caused by, or related to an Accident occurring:

- While You are intoxicated as defined by the laws of the jurisdiction in which the accident took place;
- While You are voluntarily using a narcotic, unless:

- It was prescribed for You by a Doctor; and
- It was used as prescribed.

- During Your commission of, or attempt to commit a felony as defined per the laws in the jurisdiction in which the felony was committed or attempted, or as defined under federal law if the offense charged was a federal offense;
- During Your participation in any sport for compensation or profit; or
- During Your racing an automobile in an organized event or street race.

Dependent Seatbelt and Airbag Benefit

Seatbelt And Airbag Benefits

If Your dependent dies as a direct result of an automobile Accident while properly wearing a seatbelt, We will increase his or her Voluntary Accidental Death and Dismemberment Benefit amount by $5,000. And, if Your 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 will increase his or her Voluntary Accidental Death and Dismemberment Benefit amount by an additional $2,500, for a total increase of $7,500.

You are responsible for providing proof that Your dependent was properly wearing a seatbelt. A law enforcement official investigating the Accident must certify that the seatbelt was properly fastened and that the automobile in which the deceased was traveling was equipped with airbags. A copy of such certification must be submitted to Us with the claim for benefits.

If We cannot determine that Your dependent was wearing a seatbelt at the time of the automobile Accident directly resulting in his or her death, We will increase Your dependent Accidental Death and Dismemberment Benefit amount by $1,000.

If We determine that a seatbelt was not worn at the time of the automobile Accident directly resulting in Your dependent's death, or if the required official report is not provided, no Seatbelt or Airbag Benefit will be paid.

The total amount payable for the Seatbelt and Airbag Benefit under Your dependent Voluntary Accidental Death and Dismemberment Insurance and Voluntary Group Term Life Insurance may not exceed $15,000 for each covered dependent.

Exclusions

This Policy does not pay a Seatbelt or Airbag Benefit for loss of life caused by, or related to an Accident occurring:

- While Your dependent is intoxicated as defined by the laws of the jurisdiction in which the accident took place;
- While Your dependent is voluntarily using a narcotic, unless:
  - It was prescribed for the dependent by a doctor; and
  - It was used as prescribed.

- During Your dependent's commission of, or attempt to commit a felony as defined per the laws in the jurisdiction in which the felony was committed or attempted, or as defined under federal law if the offense charged was a federal offense;
- During Your dependent's participation in any sport for compensation or profit;
- During Your dependent's racing an automobile in an organized event or street race.

The Guardian Life Insurance Company of America

Matthew Darula, Head of Product, Strategy and Offerings

B400.6246

GC-R-ADD-SBA-15-MD

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 accidental death and dismemberment 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.

Accidental Death and Dismemberment 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 reasonable 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 reasonable 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 Accidental Death and Dismemberment 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 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 Accidental Death and Dismemberment 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;
- 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;
- 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.

B997.0263

Appeals of Adverse Determinations of Accidental Death and Dismemberment 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.

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 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;

- 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.

Waiver of Premium

If you apply for an extension of accidental death and dismemberment 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 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 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 on 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 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; 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.

B997.0264

All Options

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.

B997.0265

You May not be covered by all options in this Certificate.

This Certificate contains all the benefits and options that are available under the Policy. You are insured only for those benefits and options that you are eligible and enrolled for, and for which the required premium has been paid.

CERTIFICATE OF COVERAGE

The Guardian
10 Hudson Yards
New York, New York 10001

The group Critical Illness coverage described in this Certificate Is attached to the group Policy effective August 1, 2018. This Certificate replaces any Certificate previously issued under this Plan or under any other plan providing similar or identical benefits issued to the planholder by Guardian.

Important Notice: This is a limited plan of Critical Illness insurance. It is a supplement to health insurance. It is not a substitute for hospital or medical expense insurance, a health maintenance organization (HMO) contract, or major medical expense insurance. Please read this Plan carefully to fully understand what it covers, limits, and excludes.

GROUP CRITICAL ILLNESS COVERAGE

Guardian certifies that the Employee to whom this Certificate is issued is entitled to the benefits described herein. However, the Employee must: (a) satisfy all of this Plan's eligibility and effective date requirements; (b) be listed in Our and/or the Policyholder's records as a validly covered Employee under this Plan; and (c) all required premium payments must have been made by or on behalf of the Employee.

The Employee and/or his or her Dependents are not covered by any part of this Plan for which he or she has waived coverage. Such a waiver of coverage is shown in Our and/or the Policyholder's records.

Policyholder: 2 CIRCLE, INC

Group Policy Number: 00502570

Matthew Darula, Head of Product, Strategy and Offerings

B005.0138

GC-CI-14-MD

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All Options

DEFINITIONS

This section defines certain terms appearing in Your Certificate.

B040.0004

All Options

Active Work or Actively At Work: These terms mean Your performance of all the duties that pertain to Your work at the place: (1) where it is normally done; or (2) where it is required to be done by Your Employer.

B040.0882

All Options

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.

B005.0010

All Options

Covered Dependent Child: This term means Your eligible dependent child covered under this Plan.

B005.0011

All Options

Covered Person: This term means You, if You are covered under this Plan and Your covered dependents.

B005.0012

All Options

Critical Illness: This term means any of the conditions shown in the Covered Critical Illnesses section of this Plan.

B005.0013

All Options

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 the Covered Critical Illnesses section of this Plan.

B005.0042

All Options

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.

B005.0014

All Options

Domestic Partner: This term means an opposite or same sex partner who has met all of the following requirements for at least 12 months: (1) resides with the Covered Person; (2) shares financial assets and obligations with the Covered Person; (3) is not related by blood to the Covered Person to a degree of closeness that would prohibit a legal marriage; (4) is at least the age of consent in the state in which they reside; and (5) neither the Covered Person or Domestic Partner is married to anyone else, nor has any other Domestic Partner. The Company requires proof of the Domestic Partner relationship in the form of a signed and completed Affidavit of Domestic Partnership.

B005.0015

All Options

Eligibility Date: For Employee coverage, this term means the earliest date You are eligible for coverage under this Plan. For dependent coverage, this term means the earliest date on which: (1) You have Initial Dependents; and (2) are eligible for dependent coverage.

B005.0016

All Options

Employee: This term means a person who works for the Employer and whose income is reported for tax purposes using a W-2 form.

B005.0018

All Options

Employer: This term means 2 CIRCLE, INC .

B005.0019

All Options

Enrollment Period: This term means the 31 day period which starts on the date You first become eligible for dependent coverage.

B005.0020

All Options

Full-Time: This term means You regularly work at least the number of hours in the normal work week set by the Employer (but not less than 30 hours per week), at: (1) Your Employer's place of business; (2) some place where the Employer's business requires You to travel; or (3) any other place You and Your Employer have agreed upon for the performance of occupational duties.

B005.0021

All Options

Initial Dependents: This term means 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.

B005.0023

All Options

Injury: This term means: (1) all damage to a Covered Person's body due to an accident; and (2) all complications arising from that damage.

B005.0024

All Options

Medically Necessary This term means health services, treatments 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.

The treating provider is the authority who determines whether treatments, services or supplies are medically necessary.

B022.0005

All Options

Newly Acquired Dependent: This term means an eligible dependent You acquire after You already have coverage in force for Initial Dependents.

B005.0026

All Options

Plan: This term means the group Critical Illness coverage plan described in the Policy and this Certificate.

B005.0028

All Options

Proof of Insurability: This term means the completion of an evidence of insurability form, acceptable to Us, showing that a person is insurable.

B005.0029

All Options

Sickness: This term means any illness or disease suffered by a Covered Person.

B005.0030

All Options

Spouse: This term means Your lawful spouse, which shall include the marriage between opposite or same-sex partners. This term shall also include registered Domestic Partners.

B022.0006

All Options

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

Your or Your: These terms mean the insured Employee.

B005.0032

All Options

GENERAL PROVISIONS

B005.0033

All Options

Applicable Benefits

This Certificate may include multiple benefit options and types of benefits. In the event that the Certificate includes such multiple benefit options and types of benefits, each Covered Person will only be covered for those applicable benefits that (1) were previously selected in a manner and mode acceptable to Guardian such as an enrollment form and (2) for which applicable premium has been received by Guardian.

B005.0034

All Options

Limitation of Authority

No person, except by a writing signed by the President, a Vice President or a Secretary of Guardian, has the authority to act for Us to: (1) determine whether any contract, Policy or certificate is to be issued; (2) waive or alter any provisions of any contract or Policy, or any of Our requirements; (3) bind Us by any statement or promise relating to any contract, Policy or certificate issued or to be issued; or (4) accept any information or representation which is not in a signed application.

B005.0035

All Options

Incontestability

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

No statement in any application from Us, except a fraudulent statement, made by a Covered Person will be used to contest the validity of his or her insurance or to deny a claim for a loss incurred after such insurance has been in force for two years during his or her lifetime.

If the Policy replaces a plan your Employer had with another insurer, we may rescind the Plan based on misrepresentations made by the Employer or an Employee in a signed application from Us for up to two years from the effective date of the Plan.

In the event Your insurance is rescinded due to a fraudulent statement made in Your application We will refund premiums paid for the periods such insurance is void. The premium paid by You will be sent to Your last known address on file with Your Employer or Us.

B022.0007

All Options

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 the Plan as often as We feel necessary. We also have the right to have an autopsy performed in the case of death where allowed by law. We will pay for all such examinations and autopsies.

B005.0038

All Options

Critical Illness Claims Provisions

Your right to make a claim for Critical Illness benefits provided by the Policy is governed as shown below.

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 the Policy number. If the claim is being made for any other Covered Person, his or her name should also be shown. Failure to provide Notice within the specified time frame does not reduce or invalidate a claim if it was not reasonably possible to give such Notice and the Notice was provided as soon as reasonably possible.

Claim Forms

We will furnish You with forms for filing proof of loss within 15 days of receipt of notice. If We do not furnish the forms on time, We will accept a written description and adequate proof 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.

Proof Of Loss

You must send written proof to Our designated office within 90 days after the date of the loss.

Late Notice Of Proof

We will not void or reduce Your claim if You cannot send Us notice and proof of loss within the required time. In that case, You must send Us notice and proof as soon as reasonably possible. Failure to furnish proof of loss within the time required does not invalidate or reduce a claim if it was not reasonably possible to submit proof within the required time, if proof is furnished as soon as reasonably possible and, except in the absence of legal capacity of the claimant, not later than 1 year from the time proof is otherwise required.

Payment Of Benefits

We will pay Critical Illness benefits as soon as we receive written proof of loss.

Unless otherwise required by law or regulation, We pay all Critical Illness benefits to You if you are living. If You are not living, We have the right to pay all Critical Illness benefits to one of the following: (1) Your estate; (2) Your spouse; (3) Your parents; (4) Your children; or (5) Your brothers and sisters. For any benefit payable to the estate, or to an individual who is a minor or otherwise not competent to give a valid release, We may pay the benefit, up to an amount not exceeding $5,000, to any relative by blood or connection by marriage to You, who is considered to be equitably entitled to the benefit.

Legal Actions

No legal action against this Plan shall be brought until 60 days from the date proof of loss has been given as shown above. No legal action shall be brought against this Plan after three years from the date written proof of loss is required to be given.

Workers' Compensation

The Critical Illness benefits provided by this Plan are not in place of and do not affect requirements for coverage by Workers' Compensation.

B022.0009

ELIGIBILITY FOR CRITICAL ILLNESS - EMPLOYEE COVERAGE

Eligible Employees

Subject to the conditions of eligibility set forth below, and to all of the other conditions of the Plan, You are eligible if You are in an eligible class of Employees and are an active Full-Time Employee.

If You are a partner or proprietor, We will treat You like an Employee if You meet the Plan's conditions of eligibility.

Conditions of Eligibility

You are eligible for Critical Illness coverage if You are;

- Legally working in the United States, or working outside of the United States for a United States based employer in a country or region approved by Us; and
- Regularly working at least the number of hours in the normal work week set by the Employer (but not less than 30 hours per week) at: (1) the Employer's place of business; (2) some place where the Employer's business requires You to travel; or (3) any other place You and the Employer have agreed upon for the performance of occupational duties.

You are **not** eligible for Critical Illness coverage if You are a temporary or seasonal Employee.

Enrollment Requirement: If You must pay all or part of the cost of Your coverage, We will not cover You until You enroll and agree to make the required payments.

Proof of Insurability: If You: (1) do not meet this Plan's enrollment requirement within 31 days after You first become eligible; or (2) enroll after You previously had coverage which ended because You failed to make a required payment, We will ask for Proof of Insurability. And, You will not be covered until We approve that Proof of Insurability in writing.

Part or all of Your insurance amounts may be subject to Proof of Insurability. The Schedule of Benefits explains if and when We require Proof of Insurability. You will not be covered for any amount that requires such Proof of Insurability until You give the Proof of Insurability to Us and We approve that Proof of Insurability in writing.

If Your active Full-Time service ends before You meet any Proof of Insurability requirements that apply You will still have to meet those requirements if You are later re-employed by the Employer or an associated company.

B005.0043

All Options

The Waiting Period If You are in an eligible class, You are eligible for Critical Illness coverage under this Plan after You complete the service waiting period, if any, established by the Employer.

B005.0045

All Options

Multiple Employment If You work for both the Employer and a covered associated company, or for more than one covered associated company, We will treat You as if only one firm employs You. You will not have multiple Critical Illness coverages under this plan. But, if this Plan uses the amount of Your earnings to set the rates, determine class, figure coverage amounts, or for any other reason, such earnings will be figured as the sum of Your earnings from all covered Employers.

B005.0046

All Options

When Employee Coverage Starts

Your eligibility date is the date You have met all of the conditions of eligibility.

Whether You must pay all or part of the cost of Your coverage, You must elect to enroll and agree to make the required payments before Your coverage will start. If You do this on or before Your Eligibility Date, Your coverage is scheduled to start on Your Eligibility Date. If You do this within 31 days after Your Eligibility Date, Your coverage is scheduled to start on Your Eligibility Date. If You elect to enroll and agree to make the required payments more than 31 days after Your Eligibility Date, Your coverage will not be scheduled to start until You send Us Proof of Insurability. Once We have approved such Proof of Insurability, Your coverage is scheduled to start on the effective date shown in the endorsement section of Your evidence of insurability form.

Any part of Your coverage which is subject to Proof of Insurability will not start unless You send such Proof of Insurability to Us, and We approve it in writing. Once We have approved it, that part of Your coverage is scheduled to start on the effective date shown in the endorsement section of Your evidence of insurability form. If Your active service ends before You meet any Proof of Insurability requirements that apply You will still have to meet those requirements if You are later re-employed by the Employer or an associated company.

On the date all or part of Your coverage is scheduled to start, You must be: (1) Actively At Work; (2) fully capable of performing the major duties of Your regular occupation; and (3) working Your regular number of hours. In that case, Your coverage will start at 12:01 A.M. Standard Time for Your place of residence on that date. In any other case, We will postpone the start of Your coverage until the date You: (a) return to Active Work; (b) are working Your regular number of hours; and (c) are fully capable of performing the major duties of Your regular occupation. Sometimes, a scheduled effective date is not a regularly scheduled work day. If the scheduled effective date falls: on a holiday; on a vacation day; on a non-scheduled work day; during a layoff of less than 180 days in duration; during an approved leave of absence not due to sickness or injury, of 90 days or less; or on a day during a period of absence that is less than 7 days in duration; and if: (a) You were fully capable of performing the major duties of Your regular occupation for the Employer on a full-time basis at 12:01 AM Standard Time for Your place of residence on the scheduled effective date; and (b) You were performing the major duties of Your regular occupation and working Your regular number of hours on Your last regularly scheduled work day; Your coverage will start on the scheduled effective date.

Delayed Effective Date For Voluntary Critical Illness Coverage: If You are not Actively At Work on the date Your Voluntary Critical Illness coverage is scheduled to start due to Sickness or Injury, We will postpone coverage for an otherwise covered loss due to that Sickness or Injury. We will postpone such coverage until You complete ten days in a row without missing a work day due to that Sickness or Injury in which You are: (1) Actively At Work; (2) fully capable of performing the major duties of Your regular occupation; and (3) working Your regular number of hours. Coverage for an otherwise covered loss due to all other conditions will start on the date You are: (a) Actively At Work; (b) fully capable of performing the major duties of Your regular occupation; and (c) working Your regular number of hours.

Exception to When Employee Coverage Starts: If You are not capable of performing the major duties of Your regular occupation for Your Employer on a full-time basis on the date Your coverage is scheduled to start, You will be insured for Critical Illness insurance if:

1. You were insured under the prior insurer's group critical illness policy at the time of the transfer;
2. You are a member of an eligible class; and
3. premiums for You were paid up to date; and
4. You are not receiving or eligible to receive benefits under the prior insurer's group critical illness policy.

Any Critical Illness benefit payable will be the lesser of:

1. the Critical Illness benefit payable under the Group Policy; or
2. the critical illness benefit payable under the prior insurer's group critical illness policy had it remained in force.

The Critical Illness benefit payable will be reduced by any amount paid by the prior insurer's group critical illness policy.

All other provisions under this Policy will apply under the Exception to When Employee Coverage Starts.

You will remain insured under this provision until the first to occur of:

1. the date You are fully capable of performing the major duties of Your regular occupation for Your Employer on a full-time basis;
2. the date insurance terminates for one of the reasons stated in When Employee Coverage Ends;
3. the last day of a period of 12 consecutive months which begins on the Policy effective date; or
4. the last day You would have been covered under the prior insurer's group critical illness policy, had the prior plan not terminated.

B005.0078

All Options

When Employee Coverage Ends

Your coverage will end on the first of the following dates:

- The date in which Your active service ends for any reason. Your active service ends when You are no longer: (1) Actively At Work; and (2) working Your regular number of hours.
- The date You stop being an eligible Employee under this Plan.
- The date You are no longer working in the United States or working outside of the United States for a United States based Employer in a country or region approved by Us.
- The date the group Plan ends, or is discontinued for a class of Employees to which You belong.
- The last day of the period for which required payments are made for You.

B005.0050

All Options

Your Right to Continue Critical Illness Coverage During a Family Leave of Absence

Important Notice: This section may not apply to Your Employer's Plan. You must contact Your Employer to find out if he or she must allow for a family leave of absence under federal law. If he or she must allow for such leave, this section applies.

If Your Coverage Would End: Your Critical Illness coverage would normally end because You cease work due to an approved leave of absence. But, You may continue Your coverage if the leave has been granted: (1) to allow You to care for a seriously injured or ill spouse, child or parent; (2) after the birth or adoption of a child; (3) due to Your own serious health condition; or (4) because of a 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. To continue Your coverage, You will be required to pay the same share of the premium as You paid before the leave of absence.

When Continuation Ends: Continued coverage will end on 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 service member, the end of a total leave period of 26 weeks in one 12 month period. This 26 weeks 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 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: (1) 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 (2) results in the call or order to, or retention on, active duty of members of the uniformed services under any provision of law or during a national emergency declared by the President or Congress.
- **Covered Service Member:** 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 is: (1) undergoing medical treatment, recuperation or therapy; (2) otherwise in Outpatient Status; or (3) otherwise on the temporary disability retired list.
- **Next Of Kin:** This term means Your nearest blood relative.

- **Outpatient Status:** This term means, in the case of a covered service member, that he or she is assigned to: (1) a military medical treatment facility as an outpatient; or (2) 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 Service Member, 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: (1) office; (2) grade; (3) rank; or (4) rating.

B005.0062

All Options

ELIGIBILITY FOR CRITICAL ILLNESS COVERAGE - DEPENDENT COVERAGE

B005.0063

All Options

Eligible Dependents for Dependent Critical Illness Coverage

B005.0064

All Options

Eligible Dependents for Voluntary Dependent Critical Illness

Your eligible dependents are Your spouse and unmarried dependent children from birth until they reach age 26.

B005.0080

All Options

Adopted Children and Step-Children

Your "unmarried dependent children" include Your legally adopted children, and Your step-children. But, Your step-children must depend on You for most of their support and maintenance. 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.

B005.0065

All Options

Dependents Not Eligible

We exclude any dependent who is on active duty in any armed force. And, We exclude any dependent who is covered by this Plan as an Employee.

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 Critical Illness benefits by only one Employee at a time.

B005.0066

All Options

Handicapped Children

You may have an unmarried child who is: (a) incapable of self-sustaining employment by reason of a mental or physical handicap or developmental disability; and (b) chiefly dependent upon You for support and maintenance. In that case such a child may remain eligible for dependent benefits past the age limit subject to the conditions shown below.

- His or her condition started before he or she reached the age limit.
- He or she became covered for dependent Critical Illness benefits before he or she reached the age limit and is chiefly dependent for support on the Employee at the time of reaching the age limit, and is incapable of self-support because of mental or physical incapacity that started before the child, grandchild, or individual under guardianship attained the age limit.
- He or she stays unmarried and remains chiefly dependent on You for for support.
- You send Us written proof, and We approve such proof, of the child's disability and dependence within 31 days from the date he or she reaches the age limit. After the two year period following the child's attainment of the age limit, We can ask for periodic proof that the child's condition continues, but We cannot ask for this proof more than once a year. The child's coverage ends when Your coverage ends.

B022.0014

All Options

Proof of Insurability

We require Proof of Insurability that a dependent is insurable if You: (1) enroll a dependent who was previously declined or would have been considered a late enrollee under a group critical illness coverage plan providing dependent coverage which this Plan replaced; (2) enroll a dependent and agree to make the required payments after the end of the Enrollment Period.

A dependent is not covered by any part of this Plan that requires such Proof of Insurability until You give Us this Proof of Insurability and We approve it in writing.

If Your dependent coverage ends for any reason, including failure to make the required payments, Your dependent will not be covered by this Plan again until You give Us new Proof of Insurability that they are insurable and We approve that Proof of Insurability in writing.

B005.0069

All Options

When Dependent Coverage Starts

In order for Your dependent coverage to start, You must already be covered for Employee coverage, or enroll for Employee and dependent coverage at the same time.

Subject to the Exception below and to all of the other 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 covered for Employee coverage.

If You do this within the Enrollment Period, the coverage is scheduled to start on the date You become covered for Employee coverage.

If You do this after the Enrollment Period ends, Your dependent coverage is subject to Proof of Insurability and will not start until We approve that Proof of Insurability in writing.

Once You have dependent child coverage for Your Initial Dependent child(ren) any Newly Acquired Dependent children will be covered as of the date he or she is first eligible.

If Proof of Insurability is required for dependent benefits as explained above, those benefits will not be scheduled to start until You give Us Proof of Insurability that the dependent is insurable. Once We have approved that Proof of Insurability, those benefits will be scheduled to start on the effective date shown in the endorsement section of Your application.

B005.0070

All Options

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 or home confined. 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 or his or her home confinement ends. 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.

B022.0079

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 Your class.

If You are required to pay all or 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.

Your dependent's coverage ends when he or she stops being an eligible dependent. This happens to a child at 12:01 A.M. on the date the child attains this Plan's age limit, when he or she marries, or when a step-child is no longer dependent on You for support and maintenance. It happens to a spouse: (1) when a marriage ends in legal divorce or annulment; and (2) at 12:01 A.M. on the date the spouse reaches the limiting age, if applicable.

B005.0075

All Options

CRITICAL ILLNESS COVERAGE

This Certificate includes the Schedule of Benefits form. Your class and benefit options are shown in the Schedule of Benefits that applies to You.

Subject to all of this Plan's terms, We will pay the benefits described below if a Covered Person is Diagnosed with a listed Critical Illness on or after the date he or she becomes covered by this Plan.

This Plan pays no Critical Illness benefits for any condition other than those listed below in Covered Critical Illnesses.

B005.0083

All Options

Critical Illness Benefits

This Plan will pay a benefit based on the benefit amount for which a Covered Person is covered. The benefit will be subject to all of the terms of this Plan.

This Plan only pays benefits for the occurrence of the Critical Illnesses listed and defined in the Covered Critical Illnesses section below.

Each Critical Illness must occur while the Covered Person is covered by this Plan. This Plan deems each Critical Illness to occur on the date described for each Critical Illness in the Covered Critical Illnesses section below.

Where one Critical Illness is caused by or contributes to another Critical Illness, only one benefit is payable. We will pay the greater of the benefits payable. If the amount payable for each Critical Illness is the same, You may choose which benefit to receive.

This Plan may pay a different level of benefits for the First Occurrence and the Recurrence of a Critical Illness. For some Critical Illnesses We pay no benefits for a Recurrence. The benefit levels are shown in the Schedule of Benefits.

By First Occurrence We mean the first time a Covered Person is Diagnosed with a Critical Illness while insured by this Plan. By Recurrence, We mean the second time a Covered Person is diagnosed with the same Critical Illness while insured by this Plan. We pay no benefits for occurrences beyond the second time.

B005.0084

All Options

Covered Critical Illnesses

B005.0086

All Options

Cancer Related Conditions

B005.0087

All Options

Benign Brain Tumor

We pay a benefit if a Covered Person is Diagnosed with a Benign Brain Tumor, which means a non-cancerous brain tumor confirmed by the examination of tissue (biopsy or surgical excision) or specific neuroradiological examination. The tumor must result in persistent neurological deficits, including but not limited to:

- loss of vision;
- loss of hearing; or
- balance disruption

We do not consider the following to be Benign Brain Tumors:

- tumors of the skull;
- pituitary adenomas; and
- germanomas.

We deem a Benign Brain Tumor to occur on the date a Doctor of appropriate specialty makes a Diagnosis.

B005.0088

All Options

Carcinoma in Situ

We pay a benefit if a Covered Person is Diagnosed with Carcinoma In Situ, which means early forms of cancer that have not invaded surrounding tissue. Any malignant tumor classified as less than T1NOMO under TNM classification is considered Carcinoma in Situ. Carcinomas in Situ can include early forms of many common cancers such as breast and prostate cancer.

We do not pay a benefit under this provision for:

- Pre-malignant growths or lesions, such as dysplasia or Intraepithelial neoplasia;
- Any benign tumor or polyp;
- Carcinoma in Situ of the skin

Diagnosis of Carcinoma in Situ 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 histopathological confirmation is not advisable, Diagnosis may be based on the confirmation of the attending Doctor's Diagnosis by a consulting Doctor not associated in practice with the attending Doctor.

We deem Invasive Cancer to occur on the date a Doctor of appropriate specialty makes a Diagnosis.

We deem Carcinoma in Situ to occur on the date a Doctor of appropriate specialty makes a Diagnosis.

"TNM classification" means the classification standards for cancer developed by the American Joint Committee on Cancer.

B022.0016

All Options

Invasive Cancer We pay a benefit if a Covered Person is Diagnosed with Invasive Cancer, which means a malignant tumor which is characterized by the uncontrolled growth and spread of malignant cells and the invasion of neighboring tissue.

Invasive Cancer also includes leukemia and lymphoma.

Invasive Cancer must be supported by pathological diagnosis.

We do not pay a benefit under this provision for:

- Pre-malignant growths or lesions, such as dysplasia or intraepithelial neoplasia;
- Any benign tumor or polyp;
- Any condition that is Carcinoma in Situ.
- Any skin cancer, including carcinoma in situ of the skin, unless there is metastasis.

Diagnosis of Invasive 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 histopathological confirmation is not advisable, Diagnosis may be based on the confirmation of the attending Doctor's Diagnosis by a consulting Doctor not associated in practice with the attending Doctor.

We deem Invasive Cancer to occur on the date a Doctor of appropriate specialty makes a Diagnosis.

B022.0017

All Options

Vascular Conditions

B005.0123

All Options

Arteriosclerosis We pay a benefit if a Covered Person is diagnosed with Arteriosclerosis, which means blockage of a coronary artery of sufficient severity to require one or more coronary artery bypass graft(s).

Diagnosis must include demonstrated need for intervention.

We deem Arteriosclerosis to occur on the date a Doctor of appropriate specialty makes a Diagnosis of Arteriosclerosis of sufficient severity to warrant one or more coronary artery bypass graft(s).

B005.0092

All Options

Heart Attack We pay a benefit if a Covered Person is Diagnosed with a Heart Attack, which means death of heart muscle due to inadequate blood supply. Symptoms of cardiac ischemia must be present, as well as two or more of the following criteria for acute myocardial infarction:

(1) typical clinical symptoms such as central chest pain;

(2) diagnostic increase of specific cardiac markers;

(3) new electrocardiographic changes indicative of new ischemia (new ST-T changes or new left bundle branch block (LBBB);

(4) development of pathological Q waves in the ECG; or

(5) imaging evidence of new loss of viable myocardium or new regional wall motion abnormality.

Sudden Cardiac Arrest is not a Heart Attack.

Proof of Heart Attack requires submission of medical records. We deem a heart attack to occur on the date a Doctor of appropriate specialty makes a Diagnosis. A Heart Attack that results in death or is Diagnosed after death will be covered under this provision.

We don’t pay a benefit for a Heart Attack that occurs during a medical procedure, including, but not limited to, surgery.

B005.0093

All Options

Heart Failure We pay a benefit if a Covered Person is Diagnosed with Heart Failure. By Heart Failure We mean the irreversible failure of the heart, which requires a human to human heart, heart/lung or heart combined with any other organ transplant determined to be Medically Necessary by a Doctor of the appropriate specialty.

We deem Heart Failure to occur on the date the Covered Person is accepted onto the transplant waiting list of a recognized transplant program in the United States. We pay the benefit whether or not the transplant is ever performed. If the Covered Person is too ill for a transplant, but otherwise meets the criteria for being on the waiting list of a recognized transplant program, the waiting list requirement will be waived. In this instance We deem Heart Failure to occur on the date a Doctor of appropriate specialty deems the Covered Person is too ill for a transplant, but otherwise meets the criteria for being on a waiting list of a recognized transplant program in the United States.

B005.0094

All Options

Stroke We pay a benefit if a Covered Person is diagnosed with a Stroke, which means death of brain tissue due to an acute cerebrovascular event. All of the following criteria must be satisfied: (1) clinical evidence of infarction of brain tissue, or intracranial or subarachnoid hemorrhage; (2) clear evidence on a CT, MRI or similar imaging techniques that a stroke has occurred; and (3) permanent neurologic deficit measured 30 days or more after the event that results in functional impairment rated at 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.

Diagnosis of Stroke must be:

(1) confirmed in writing by a Doctor of the appropriate specialty; and

(2) 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 30 days or more after the event that results in a score of two or higher on the Modified Rankin Scale for stroke outcome.

We deem the Stroke to occur on the date of the event. In the event of death, an autopsy confirmation and/or death certificate identifying Stroke as the cause of death will be accepted.

B005.0095

Neurological Conditions

B005.0096

All Options

Alzheimer's Disease

We pay a benefit if a Covered Person is Diagnosed with Alzheimer's Disease, which means a progressive degenerative disease of the brain that is Diagnosed by a Board Certified psychiatrist or Board Certified neurologist as Alzheimer's Disease. The Diagnosis must be supported by medical evidence that the Covered Person exhibits the loss of intellectual capacity resulting in impairment of memory and judgment as documented and demonstrated by cognitive testing and supported by neuroradiological tests (e.g., CT Scan, MRI, PET of the brain). This impairment must result in a significant reduction in mental and social functioning.

In addition to memory impairment (impaired ability to learn new information or to recall previously learned information), one or more of the following cognitive disturbances must be present:

- aphasia (language disturbance);
- apraxia (impaired ability to carry out motor activities despite intact motor function);
- angosia (failure to recognize or identify objects despite intact sensory function); and
- disturbance in executive functioning (i.e. planning, organizing, sequencing, abstracting).

No other dementing organic brain disorders or psychiatric illnesses are included in this definition.

Diagnosis must be based on clinical and/or diagnostic findings as supported by the Covered Person's medical records. We deem Alzheimer's Disease to occur on the date a Doctor of appropriate specialty makes a Diagnosis. The Diagnosis must occur while the Covered Person is insured under this Plan.

Diagnosis must be based on clinical and/or diagnostic findings as supported by the Covered Person's medical records. We deem Alzheimer's Disease to occur on the date a Doctor of appropriate specialty makes a Diagnosis. The Diagnosis must occur while the Covered Person is insured under this Plan.

B022.0018

All Options

Amyotrophic Lateral Sclerosis (also known as ALS or Lou Gehrig's Disease

We pay a benefit if a Covered Person is Diagnosed with Amyotrophic Lateral Sclerosis (ALS), which means motor neuron disease, marked by muscular weakness and atrophy with spasticity and hyperreflexia due to a loss of motor neurons of the spinal cord, medulla and cortex.

We deem ALS to occur on the date a Doctor of appropriate specialty makes a Diagnosis.

B005.0098

All Options

Huntington's Disease

We pay a benefit if a Covered Person is Diagnosed with Huntington's Disease, which is a neurodegenerative genetic disorder that affects muscle coordination and leads to cognitive decline and psychiatric problems.

Diagnosis must document symptoms and verify the presence of the gene via genetic testing. We don't pay a benefit for the presence of the Huntington's Disease gene in absence of symptoms.

Symptoms include

- Personality changes, mood swings and depression;
- Forgetfulness and impaired judgment;
- Unsteady gait and involuntary movements;
- Slurred speech and difficulty in swallowing.

We deem Huntington's Disease to occur on the date a Doctor of appropriate specialty makes a Diagnosis.

The Diagnosis must occur while the Covered Person is insured under this Plan.

B005.0099

All Options

Multiple Sclerosis (MS)

We pay a benefit if a Covered Person is diagnosed with Multiple Sclerosis (MS), which means demonstrated neurological deficits that have been present for 6 months or more. Diagnosis must be made on the basis of:

(1) neurological examination demonstrating functional impairments;

(2) imaging studies of the brain or spine demonstrating lesions consistent with MS; and

(3) analysis of cerebrospinal fluid consistent with the diagnosis, or when contraindicated, confirmation of the Doctor's Diagnosis by a consulting Doctor not associated with the Doctor who made the initial Diagnosis.

We deem MS to occur on the date a Doctor of appropriate specialty makes a Diagnosis. Diagnosis must occur while the Covered Person is insured under this Plan.

B022.0019

All Options

Advanced Parkinson's Disease

We pay a benefit if a Covered Person is Diagnosed with Advanced Parkinson's Disease, which means Parkinson's Disease that has progressed to Stage 4, as Diagnosed by a Board Certified, or board-eligible, neurologist based on abnormal findings from neurological examination, cognitive testing, and results of imaging studies.

We deem Advanced Parkinson's Disease to occur on the date a Doctor of appropriate specialty makes a Diagnosis that the person has progressed to Stage 4. The Diagnosis must occur while the Covered Person is covered under this Plan.

B005.0101

All Options

Childhood Conditions

B005.0102

All Options

Cerebral Palsy

We pay a benefit if a Covered Dependent Child is Diagnosed with Cerebral Palsy, which means a group of disorders of the development of movement and posture causing activity limitation that are attributed to progressive disturbances that occurred in the developing fetal or infant brain. The motor disorders of cerebral palsy are often accompanied by disturbances of sensation, cognition, communication, perception and/or behavior and/or a seizure disorder. Other similar conditions such as degenerative nerve disorders, genetic diseases, muscle diseases, metabolic disorders, nervous system tumors, coagulation disorders, or other injuries or disorders which delay early development, but can be outgrown, are not included in this definition.

We deem Cerebral Palsy to occur on the first date after live birth where a Doctor of appropriate specialty makes a Diagnosis.

B005.0103

All Options

Cleft Lip or Palate We pay a benefit if a Covered Dependent Child is Diagnosed with Cleft Lip or Cleft Palate. A Cleft Lip appears as a narrow opening or gap in the skin of the upper lip that extends all the way to the base of the nose. A Cleft Palate is an opening between the roof of the mouth and the nasal cavity, including clefts that occur on one side of the mouth or both sides.

We pay a benefit for either a Cleft Lip or Cleft Palate, but not both.

We deem Cleft Lip or Cleft Palate to occur on the first date after live birth where a Doctor of appropriate specialty makes a definite clinical Diagnosis of a cleft lip or palate.

B005.0104

All Options

Clubfoot We pay a benefit if a Covered Dependent Child is Diagnosed with Clubfoot, which means a congenital deformity of the foot.

We pay the benefit only once even if Clubfoot is present in both of the child's feet.

We deem Clubfoot to occur on the first day after live birth where a Doctor of appropriate specialty makes a definite Diagnosis of Clubfoot.

B005.0105

All Options

Cystic Fibrosis We pay a benefit if a Covered Dependent Child is Diagnosed with Cystic Fibrosis, which means chronic lung disease and pancreatic insufficiency. The Diagnosis of Cystic Fibrosis made via sweat test is based upon sweat chloride concentrations greater than 60 mmol/L.

We deem Cystic Fibrosis to occur on the first date after live birth where Cystic Fibrosis has been definitively Diagnosed by a Doctor of appropriate specialty via sweat test.

B005.0106

All Options

Down Syndrome We pay a benefit if a Covered Dependent Child is Diagnosed with Down Syndrome, which means a Diagnosis of Down Syndrome through study of the 21st chromosome. Down Syndrome includes:

- Trisomy - an individual has three instead of two number 21 chromosomes;

- Translocation - an extra part of the 21st chromosome is attached to another chromosome;
- Mosaicism - the individual has an extra 21st chromosome in only some of the cells but not all of them. The other cells have the usual pair of 21st chromosomes.

We deem Down Syndrome to occur on the first date after live birth where a Doctor of appropriate specialty completes a chromosome test that positively reveals Down Syndrome.

B005.0107

All Options

Muscular Dystrophy We pay a benefit if a Covered Dependent Child is Diagnosed with Muscular Dystrophy, which means a hereditary condition that is marked by progressive weakening and wasting of muscles. The Covered Dependent Child must have well defined neurological abnormalities, confirmed by electromyography and muscle biopsy.

We deem Muscular Dystrophy to occur on the first date after live birth where a Doctor of appropriate specialty makes a Diagnosis.

B005.0108

All Options

Spina Bifida We pay a benefit if a Covered Dependent Child is Diagnosed with Spina Bifida, which means either of the following types of Spina Bifida:

(1) Meningocele - the protective coatings (meninges) come through the open part of the spine like a sac that is pushed out. Cerebrospinal fluid is in the sac and there is usually no nerve damage.

(2) Myelomeningocele - This occurs when the meninges (protective covering of the spinal cord) and spinal nerves come through the open part of the spine.

We pay no benefits for spina bifida occulta.

We deem Spina Bifida to occur on the first date after live birth where a Doctor of appropriate specialty makes a Diagnosis

B005.0109

All Options

Type 1 Diabetes We pay a benefit if a Covered Dependent Child is Diagnosed with Type 1 Diabetes, which means the child has a total insulin deficiency and a continuous dependence on exogenous insulin for survival. Dependence on insulin must persist for a continuous period of at least 3 months.

We deem Type 1 Diabetes to occur on the date a Doctor of appropriate specialty makes a Diagnosis.

B005.0110

All Options

Other Critical Illnesses

B005.0111

All Options

Addison's Disease We pay a benefit if a Covered Person is Diagnosed with Addison's disease, which means an endocrine or hormonal disorder resulting in the adrenal glands not producing sufficient cortisol.

Diagnosis must be made by laboratory tests designed to show insufficient levels of cortisol.

We deem Addison's Disease to occur on the date a Doctor of appropriate specialty makes a Diagnosis.

B005.0112

All Options

Coma We pay a benefit if a Covered Person is Diagnosed with a Coma, which means a state of complete mental unresponsiveness with no evidence of appropriate responses to stimulation, lasting for a period of 7 or more consecutive days and characterized by the absence of eye opening, verbal response and motor response. The condition must require intubation for respiratory assistance. This benefit is not payable for a medically induced Coma.

We deem a Coma to occur on the date a Doctor of appropriate specialty makes a Diagnosis.

B005.0113

All Options

Kidney Failure We pay a benefit if a Covered Person is Diagnosed with Kidney Failure, which means chronic irreversible failure of both kidneys to function, as a result of which either weekly or bi-weekly renal or peritoneal dialysis is started, or renal transplant is performed.

Proof of Kidney Failure requires submission of medical records. Diagnosis of Kidney Failure will be deemed to occur on the earlier of the date: (a) renal or peritoneal dialysis is started; or (b) the date the Covered Person is accepted onto the kidney transplant waiting list of a recognized transplant program in the United States. If the Covered Person is too ill for a transplant, but otherwise meets the criteria for being on the waiting list of a recognized transplant program, the waiting list requirement will be waived. In this instance We deem Kidney Failure to occur on the date a Doctor of appropriate specialty deems the Covered Person is too ill for a transplant, but otherwise meets the criteria for being on a waiting list of a recognized transplant program in the United States.

B005.0114

All Options

Loss of Hearing We pay a benefit if a Covered Person is Diagnosed with Loss of Hearing, which means clinically-proven irreversible loss of hearing in both ears, with an auditory threshold of more than 90 decibels, as a result of illness or injury that has continued without interruption for at least 6 consecutive months after Diagnosis.

No benefit will be paid if, in general medical opinion, surgery, a hearing aid, device, or implant could result in the partial or total restoration of hearing.

The Diagnosis must be made by physical examination by an licensed audiologist.

A Covered Dependent Child must be at least 3 years old on the date of Diagnosis in order to receive a benefit. However, if a Covered Dependent Child is Diagnosed prior to age 3, We will pay a benefit if the initial Diagnosis occurred while insured by this Plan, and the Diagnosis is confirmed on or after the child reaches age 3 and remains insured by this Plan.

We deem Loss of Hearing to occur on the date on which a licensed audiologist physically examines the Covered Person and certifies that the Covered Person meets the definition above.

B005.0115

All Options

Loss of Sight We pay a benefit if a Covered Person is diagnosed with Loss of Sight, based on best corrected visual acuity of 20/400 or less or visual field of 20 degrees or less in the better eye. No benefit will be paid if, in general medical opinion, surgery, device, or implant could result in the partial or total restoration of sight.

A Covered Dependent Child must be at least 3 years old on the date of Diagnosis in order to receive a benefit. However, if a Covered Dependent Child is Diagnosed prior to age 3, We will pay a benefit if the initial diagnosis occurred while insured by this Plan, and the Diagnosis is confirmed on or after the child reaches age 3 and remains insured by this Plan.

We deem Loss of Sight to occur on the date on which a licensed ophthalmologist physically examines the Covered Person and certifies that the Covered Person has best corrected visual acuity of 20/400 or less or visual field of 20 degrees or less in the better eye.

B005.0116

All Options

Loss of Speech We pay a benefit if a Covered Person is Diagnosed with Loss of Speech, which means the clinically proven total, permanent and irreversible loss of the ability to speak as a result of Illness or injury that has continued without interruption for a period of at least 6 consecutive months.

No benefit will be payable if, in general medical opinion, surgery, a device or implant could result in the partial or total restoration of speech.

The Diagnosis must be made by physical examination by a speech pathologist.

A Covered Dependent Child must be at least 3 years old on the date of Diagnosis in order to receive a benefit. However, if a Covered Dependent Child is Diagnosed prior to age 3, We will pay a benefit if the initial diagnosis occurred while insured by this Plan, and the Diagnosis is confirmed on or after the child reaches age 3 and remains insured by this Plan.

We deem Loss of Speech to occur on the date on which a Doctor of appropriate specialty physically examines the Covered Person and certifies that the Covered Person meets the definition above.

B005.0117

All Options

Major Organ Failure

We pay a benefit if a Covered Person is Diagnosed with Major Organ Failure. By Major Organ Failure We mean the irreversible failure of both lungs, liver, pancreas, or bone marrow, which requires a human to human transplant determined to be Medically Necessary by a Doctor of the appropriate specialty.

We deem Major Organ Failure to occur on the date the Covered Person is accepted onto the transplant waiting list of a recognized transplant program in the United States. We pay the benefit whether or not the transplant is ever performed. If the Covered Person is too ill for a transplant, but otherwise meets the criteria for being on the waiting list of a recognized transplant program, the waiting list requirement will be waived. In this instance We deem Major Organ Failure to occur on the date a Doctor of appropriate specialty deems the Covered Person is too ill for a transplant, but otherwise meets the criteria for being on a waiting list of a recognized transplant program in the United States.

We don’t pay a benefit under both this provision and the Heart Failure provision at the same time.

We pay no benefits for autologous bone marrow transplants.

B005.0118

All Options

Permanent Paralysis

We pay a benefit if a Covered Person is Diagnosed with Permanent Paralysis, which means a complete and irreversible condition marked by loss of muscle function in any combination of arms and legs. Permanent Paralysis must be the direct result of a Sickness or Injury, other than a Stroke.

We pay 100% of the benefit amount for the Permanent Paralysis of two or more limbs. We pay 50% of the benefit amount for the Permanent Paralysis of one limb.

We deem Permanent Paralysis to occur on the date a Doctor of appropriate specialty makes a Diagnosis.

B005.0119

All Options

Severe Burns We pay a benefit if a Covered Person is Diagnosed with Severe Burns, which means full-thickness or third-degree burn, as determined by a Doctor covering at least 25% of the body. A full-thickness or third-degree burn is the destruction of the skin through the entire thickness or depth of the dermis and possibly into underlying tissues, with loss of fluid and sometimes shock, by means of exposure to fire, heat, caustics, electricity or radiation.

We deem Severe Burns to occur on the date of the Injury.

B005.0120

All Options

Limitations

B005.0124

All Options

Age Reduction The Covered Person's benefit amount will be reduced when You reach certain ages. These reductions are shown in the Schedule of Benefits. The dependent's benefit amount will be reduced on a pro rata basis when Your benefit amount is reduced.

B005.0126

All Options

Proof Of Insurability The Covered Person's benefit amount, part of it, or increases in it, may not become effective until he or she submits Proof of Insurability to Us. We must approve such Proof of Insurability in writing. These requirements are shown in the Schedule of Benefits.

B005.0127

All Options

Pre-Existing Conditions A pre-existing condition is a Injury or Sickness, whether diagnosed or misdiagnosed, and any symptoms of it, for which in the 3 months before a person becomes covered by this Plan he or she: (1) receives advice or treatment from a Doctor; (2) undergoes diagnostic procedures, other than routine screening in the absence of symptoms or suspicion of disease process by a Doctor; (3) is prescribed or has taken prescription drugs; or (4) receives 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 the person is covered by this Plan.

This Plan also limits the Covered Person's benefits under this Plan if a Critical Illness that is caused by, or results from, a Pre-Existing Condition occurs 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 increased 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 the Critical Illness occurs after the Covered Person completes at least one full day of active work after the change has been in force for 12 months in a row.

B005.0137

All Options

If This Plan Replaces Another Plan

This Plan may be replacing a similar plan that the Employer had with some other carrier. 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 Condition or limitation of the old plan; and (3) in Your case, are Actively At Work on a Full-Time basis on the effective date of this 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, if the Covered Person: (1) was covered under the old plan when it ended; (2) enrolls for coverage 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.

But, this Plan limits a Covered Person's benefit under this Plan if: (1) it is more than the Critical Illness benefit for which he or she was covered under the old plan; (2) the illness is due to a Pre-Existing Condition; and (3) 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 to which he or she would have been entitled under the old plan.

This Plan deducts all payments made by the old plan under an extension provision.

B005.0130

All Options

Exclusions

1) This Plan will not pay benefits for any Critical Illness:

- That is not listed as a Critical Illness in the section entitled Covered Critical Illnesses.
- Caused by, contributed to by, or resulting from: (1) intentionally causing a self-inflicted Injury; (2) committing or attempting to commit suicide while sane or insane; or (3) serving in the armed forces or any auxiliary unit of the armed forces of any country.
- Arising from war or act of war, even if war is not declared.
- 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.
- That is Diagnosed while the person is not covered by this Plan.
- For which the only proof of Diagnosis is made by a Doctor who is the Covered Person, his or her spouse, child, parent, sibling or business associate.

- For which Diagnosis is made while the Covered Person is not alive, unless otherwise specified under Covered Critical Illnesses.

2) This Plan will not pay benefits for the First Occurrence of a Critical Illness if it occurs less than 3 months after the First Occurrence of a related Critical Illness for which this Plan paid benefits. By related we mean either: (a) both Critical Illnesses are contained within the Cancer Related Conditions category; or (b) both Critical Illnesses are contained within the Vascular Conditions category; or (c) both Critical Illnesses are contained within the Childhood Conditions category.

3) This Plan will not pay benefits for a Recurrence of a Critical Illness 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 Recurrence. For purposes of this exclusion, care or treatment does not include: (1) preventive medications in the absence of disease; and (2) routine scheduled follow-up visits to a Doctor.

4) This Plan will not pay benefits for more than one Recurrence of any Critical Illness.

B022.0025

All Options

SCHEDULE OF BENEFITS

CRITICAL ILLNESS COVERAGE

Effective on the latter of (i) the original effective date of the Policy; or (ii) the effective date of any applicable amendment requested by the Policyholder and approved by the Insurance Company, this Schedule of Benefits is attached to the Certificate. This Schedule of Benefits replaces any previously issued Schedule of Benefits.

B005.0141

All Options

Initial Election When You first become eligible for this Plan You may choose to become covered for one of the plans described below and pay the required premium.

You may request to switch to another plan at any time. But, We will require Proof of Insurability before You switch to another plan which provides greater benefits. You must notify the Employer of any desired switch and pay the required premium.

B005.0237

All Options

Benefit Levels	Critical Illness	% of Benefit Amount for First Occurrence	% of Benefit Amount for Recurrence
All Options			
Cancer Related Conditions:			
All Options			
	Benign Brain Tumor	75%	Not Covered
All Options			
	Carcinoma in Situ	30%	Not Covered
All Options			
	Invasive Cancer	100%	50%
All Options			
Vascular Conditions:			
All Options			
	Arteriosclerosis	30%	Not Covered

All Options			
	Heart Attack	100%	50%
All Options			
	Heart Failure	100%	50%
All Options			
	Stroke	100%	50%
All Options			
Neurological Conditions:			
All Options			
	Alzheimer's Disease for Covered Person	50%	Not Covered
All Options			
	ALS (Lou Gehrigs's Disease)	100%	Not Covered
All Options			
	Huntington's Disease	30%	Not Covered
All Options			
	Multiple Sclerosis	30%	Not Covered
All Options			
	Advanced Parkinson's Disease	100%	Not Covered
All Options			
Childhood Conditions: **(applies only to covered dependent children)**			
All Options			
	Cerebral Palsy	100%	Not Covered
All Options			
	Cleft lip/cleft palate	100%	Not Covered
All Options			
	Club Foot	100%	Not Covered

All Options			
	Cystic Fibrosis	100%	Not Covered
All Options			
	Down's Syndrome	100%	Not Covered
All Options			
	Muscular Dystrophy	100%	Not Covered
All Options			
	Spina Bifida	100%	Not Covered
All Options			
	Type 1 Diabetes	100%	Not Covered
All Options			
Other Conditions:			
All Options			
	Addison's Disease	30%	Not Covered
All Options			
	Coma	100%	Not Covered
All Options			
	Kidney Failure	100%	50%
All Options			
	Loss of Hearing	100%	Not Covered
All Options			
	Loss of Sight	100%	Not Covered
All Options			
	Loss of Speech	100%	Not Covered
All Options			
	Major Organ Failure	100%	50%
All Options			
	Permanent Paralysis	100% for 2 or more limbs; 50% for 1 limb	Not Covered
All Options			
	Severe Burns	100%	Not Covered

All Options

EMPLOYEE VOLUNTARY CRITICAL ILLNESS COVERAGE

All Options

Critical Illness Benefit Amount

Plan A $5,000.00

B005.0316

All Options

Critical Illness Benefit Amount

Plan B $10,000.00

B005.0314

All Options

Reduction of Critical Illness Benefit Amount Based On Age

If You are less than age 70 when Your coverage under this Plan starts, Your benefit amount will be reduced. It will be reduced on the date you reach age 70, by 50% 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 coverage starts on or after the date You reach age 70.

B005.0318

All Options

Proof of Insurability Requirements

Proof of Insurability requirements may apply to this coverage. Such requirements may apply to the full benefit amount, or just part of it. When Proof of Insurability requirements apply, it means You must submit to Us, Proof of Insurability, and We must approve the Proof of Insurability in writing before the coverage, or the specified part becomes effective.

We require Proof of Insurability as follows:

We require Proof of Insurability before We will cover You if You enroll for Critical Illness coverage after the time allowed for enrolling as specified in this Plan.

We require Proof of Insurability when You switch from Your current plan of Critical Illness coverage to a plan with a higher benefit amount.

Proof of Insurability requirements vary depending on Your age. If You are less than age 70, You must provide Proof of Insurability for amounts of Critical Illness coverage in excess of $10,000.00.

If You are age 70 or over, You must provide Proof of Insurability for all amounts of Critical Illness coverage.

B005.0321

All Options

DEPENDENT VOLUNTARY CRITICAL ILLNESS COVERAGE

All Options

Dependent Spouse Critical Illness Benefit Amount

$5,000.00 not to exceed 50% of Your Critical Illness Benefit Amount.

B005.0403

All Options

Dependent Child Critical Illness Benefit Amount

$2,500.00 not to exceed 25% of Your Critical Illness Benefit Amount.

B005.0427

All Options

Reduction of Critical Illness Benefit Amount Based On Employee's Age

Your dependent's Critical Illness Benefit Amount is reduced in the same manner as Your Critical Illness Benefit Amount.

B005.0442

All Options

Dependent Spouse Proof of Insurability Requirements

Proof of Insurability requirements may apply to this coverage. Such requirements may apply to the full benefit amount, or just part of it. When Proof of Insurability requirements apply, it means You must submit to Us, Proof of Insurability for Your dependent spouse, and We must approve the Proof of Insurability in writing before the coverage, or the specified part becomes effective.

We require Proof of Insurability as follows:

We require Proof of Insurability before We will cover Your spouse if You enroll him or her for Critical Illness coverage after the time allowed for enrolling as specified in this Plan.

We require Proof of Insurability for Your spouse when You switch from Your current plan of dependent spouse Critical Illness coverage to a plan with a higher benefit amount.

Proof of Insurability requirements vary depending on Your spouse's age. If Your spouse is less than age 70, You must provide Proof of Insurability for Your spouse for amounts of dependent spouse Critical Illness coverage in excess of $5,000.00.

If Your spouse is age 70 or over, You must provide Proof of Insurability for Your spouse for all amounts of dependent spouse Critical Illness coverage.

B005.0445

Changes To Coverage

Changes in Coverage Amounts

If You are not Actively At Work on a Full-Time basis, any change in Your amount of coverage or the amount of coverage on a covered dependent will not become effective prior to the date You return to Active Work on a Full-Time basis.

Changes in Insurance Classification

If Your classification changes, coverage will not be changed to the new amount until the first day on which You are: (1) Actively At Work on a Full-Time basis; and (2) make a contribution, if required, for the new classification.

If a contribution is required for the new classification for which a larger amount of coverage is provided, You must make the required contribution for the new amount within 31 days of the change. If You do not make the required contribution within 31 days of the change or within 31 days of becoming Actively At Work on a Full-Time basis, if You are not Actively At Work on a Full-Time basis, when Your classification changes, no increase will be allowed due to such change or any later change. In that case, in order to become covered for the larger amount, You must: (1) make the required contribution for the new amount; and (2) furnish Proof of Insurability to Us, which We approve in writing.

If the coverage amount was previously reduced because of age or retirement, it will be retained at the reduced amount.

B005.0450

CERTIFICATE RIDER - Portability Privilege

Effective on the latter of (i) the original effective date of the Policy; or (ii) the effective date of any applicable amendment requested by the Policyholder and approved by the Insurance Company, this rider amends this Plan by the addition of the following:

PORTABILITY PRIVILEGE

Definition: As used in this provision, the terms "port" and "to port" mean to choose a portable certificate of coverage which provides group Critical Illness coverage.

Portability Conditions: Portability is subject to all of the Conditions described below.

- You may port if Your coverage under this Plan ends because: (1) You have terminated employment; (2) You stop being a member of an eligible class of Employees; or (3) this Plan ends.
- You may **not** port Your coverage if You have reached Your 70th birthday on the date coverage under this Plan ends.
- You may **not** port coverage for any of Your dependents if he or she has reached his or her 70th birthday on the date coverage under this Plan ends.
- You may **not** port if coverage under this Plan ends due to Your failure to pay any required premium.

Portability Options: You may port Your Critical Illness coverage, subject to any benefit amount reductions based on age, less the amount of any Critical Illness benefits paid by this Plan.

You may port Your dependent's Critical Illness coverage, subject to any benefit amount reductions based on Your age, less the amount of any Critical Illness benefits paid by this Plan.

You may port: (1) Your coverage only; (2) Your coverage and 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 for portability.

If You die while covered for dependent Critical Illness coverage, Your Spouse may port Your dependent Critical Illness 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) Your surviving Spouse has reached his or her 70th birthday on the date of Your death.

The Portable Certificate of Coverage: The portable certificate of coverage provides group Critical Illness. The benefits provided by the portable certificate of coverage are the same as the benefits provided by this Plan. The portable certificate provides seamless coverage. Benefit limits, maximums and timeframes do not reset when someone becomes covered under the portable certificate. The premium for the portable certificate of coverage will be based on: (1) the Covered Person's rate class under this Plan; and (2) Your surviving Spouse's age bracket as shown in the Critical Illness 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.

This rider is a 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

Matthew Darula, Head of Product, Strategy and Offerings

B005.0240

GC-R-CI-PORT-14

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.

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.

B800.0093

Group Health 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 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, specified disease or hospital indemnity 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.

B055.0061

All Options

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

YOUR BENEFITS INFORMATION - ANYTIME, ANYWHERE

www.guardianlife.com

You can access helpful, secure information about your Guardian benefits online 24 hours a day, 7 days a week.

Anytime, anywhere you have internet access, you'll be able to:

- Review your benefits
- Look up coverage amounts
- Check the status of your claim
- Print forms and plan materials
- And so much more!

To register, go to **www.guardianlife.com**

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