YOUR GROUP INSURANCE PLAN BENEFITS

LOCKMANN KRANE INTERNATIONAL INC
CLASS 0001
AD&D, DENTAL, LTD, LIFE, STD, VISION

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

The Guardian certifies that the employee named on the attached application is entitled to the benefits described in this certificate, as of the effective date shown in the endorsement on the attached application, provided he or she satisfies all of this plan's eligibility and effective date requirements.

The name of the Employer to whom the group plan has been issued, the number of the group plan, and the number of this certificate appear also in the endorsement on the attached application.

This certificate supersedes and replaces any and all certificates and certificate riders and amendments issued to the employee previously under any group plans and riders issued by The Guardian providing the types of benefits described in this certificate.

The Guardian Life Insurance Company of America

Michael Prestileo, Senior Vice President

CGP-3-CC B110.0041

TABLE OF CONTENTS

COMPLAINT NOTICE 1

GENERAL PROVISIONS
Limitation of Authority 3
Incontestability 4
Examination and Autopsy 4
Accident and Health Claims Provisions 4

YOUR CONTINUATION RIGHTS
Important Notice 6
A Totally Disabled Employee's Right to
Continue Group Life Benefits 6
Dependent Spouse Continuation Rights 7
Dependent Child Continuation Rights 10

ELIGIBILITY FOR LIFE AND DISMEMBERMENT COVERAGES
Employee Coverage 13
An Employee's Right To Continue Group Life and AD&D
Insurance During a Family Leave Of Absence 15

GROUP TERM LIFE INSURANCE SCHEDULE
Employee Basic Term Life Insurance 18
Employee Basic Accidental Death
and Dismemberment Insurance (AD&D) 19

LIFE INSURANCE
Your Group Term Life Insurance 22
Converting This Group Term Life Insurance 23
Your Extended Life Benefit With Waiver Of Premium 25
LifeAssist 27
Your Basic Accidental Death And Dismemberment
With Catastrophic Loss Benefits 29

ELIGIBILITY FOR DISABILITY COVERAGE
Employee Coverage 37
An Employee's Right To Continue Group Short and Long Term
Disability Income Insurance During A Family Leave Of Absence 39

SHORT TERM DISABILITY HIGHLIGHTS 42

SHORT TERM DISABILITY INCOME INSURANCE
Benefit Provisions 43
Services 50
Claim Provisions 51
Definitions 53

LONG TERM DISABILITY HIGHLIGHTS 60

LONG TERM DISABILITY INCOME INSURANCE
Benefit Provisions 62
Limitations and Exclusions 70
Services 74
Claim Provisions 78
Definitions 81

TABLE OF CONTENTS (CONT.)

ELIGIBILITY FOR DENTAL COVERAGE
Employee Coverage 88
Dependent Coverage 89

DENTAL HIGHLIGHTS 93

DENTAL EXPENSE INSURANCE
DentalGuard Preferred - This Plan's Dental Preferred Provider Organization 95
Covered Charges 96
Alternate Treatment 97
Proof Of Claim 97
Pre-Treatment Review 97
Benefits From Other Sources 98
The Benefit Provision - Qualifying For Benefits 98
Rollover of Benefit Year Payment Limit for Group I, II and III Non-Orthodontic Services 100
After This Insurance Ends 102
Plus Services Program 102
Special Limitations 103
Exclusions 104
List of Covered Dental Services 106
Group I - Preventive Dental Services 107
Group II - Basic Dental Services 108
Group III - Major Dental Services 114

ELIGIBILITY FOR VISION CARE EXPENSE COVERAGE
Employee Vision Care Expense Coverage 117
Dependent Vision Care Expense Coverage 118

VISION CARE HIGHLIGHTS 122

VISION CARE BENEFITS
This Plan's Vision Care Preferred Provider Organization 123
Appeals Process 124
Grievance Process 124
Internal Grievance Procedure 126
External Grievance Procedure 127
How This Plan Works 129
Exclusions 133

CERTIFICATE AMENDMENT 134
ADDITIONAL SERVICES 135

COORDINATION OF BENEFITS
Definitions 136
Order Of Benefit Determination 138
Effect On The Benefits Of This Plan 140
Right To Receive And Release Needed Information 140
Facility Of Payment 140
Right Of Recovery 140

TABLE OF CONTENTS (CONT.)

WORKER'S COMPENSATION **141**

CERTIFICATE AMENDMENT **142**

GLOSSARY **143**

STATEMENT OF ERISA RIGHTS

The Guardian's Responsibilities 154
Group Health Benefits Claims Procedure 155
Termination of This Group Plan 159

All Options

COMPLAINT NOTICE

This notice is to advise you that should any complaints arise regarding this insurance you may contact the following:

The Guardian Sales Office
Small Group Sales
95 Highland Avenue
Bethlehem, Pennsylvania 18017
Telephone: (800) 356-5808
Fax: (800) 562-4859

*****

Illinois Department of Insurance
Consumer Division or Public Services Section
Springfield, Illinois 62767

CGP-3-ILDISC B120.0007

All Options

WARNING, LIMITED BENEFITS WILL BE PAID WHEN NON-PREFERRED PROVIDERS ARE USED

You should be aware that when you elect to utilize the services of a non-preferred provider for a covered treatment in non-emergency situations, benefit payments to such non-preferred provider are not based upon the amount billed. The basis of your benefit payment will be determined according to your plan's reasonable and customary charge (which is determined by comparing charges for similar services adjusted to the geographical area where the services are performed), or other method as defined by the plan. YOU CAN EXPECT TO PAY MORE THAN THE PAYMENT RATE DEFINED IN THE PLAN AFTER THE PLAN HAS PAID ITS REQUIRED PORTION. Non-preferred providers may bill for any amount up to the billed charge after the plan has paid its portion of the bill. Preferred providers have agreed to accept discounted payments for services with no additional billing other than payment rate and deductible amounts. You may obtain further information about the participating status of professional providers and information on out- of-pocket expenses by calling the toll free telephone number on your identification card.

CGP-3-PPODI-IL-02 B120.0060

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

All Options

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.

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

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

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

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 Provisions

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

Notice You must send us written notice of an *injury* or *sickness* for which a claim is being made within 20 days of the date the *injury* occurs or the *sickness* starts. This notice should include your name and *plan* number. If the claim is being made 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 file proof of loss.

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

YOUR CONTINUATION RIGHTS

Important Notice

This section applies to an employee's group term life benefits. These benefits are referred to as "group life benefits."

This section does not apply to accidental death and dismemberment benefits.

A Totally Disabled Employee's Right to Continue Group Life Benefits

If an Employee is Totally Disabled

If an employee's group life benefits end while the employee is totally disabled, he may continue such benefits for a limited period of time subject to the payment of premiums. In this section, an employee is totally disabled if:

(a) he is not able to perform any work for wage or profit due to a sickness or an injury; and

(b) he becomes so disabled while insured by this group plan.

This continuation will end on the later of:

(a) six months, starting on the date the total disability began; or

(b) for employees who meet our standard for total disability under the extended life benefits section of this plan, the end of the waiting period which applies to the permanent disability provision under that section.

The monthly premium the employee must pay to continue his group life benefits will be the amount which he would have been required to pay had he stayed insured by this group plan on a regular basis. He must make this payment to his employer at the times and in the manner specified by his employer. If the employee fails to pay his amount on time, he waives his right to continue his group life benefits.

If the employer fails, after timely receipt of any required employee payment, to pay us on behalf of such employee, thereby causing the employee's group life benefits to end, then the employer will become liable for the employee's group life benefits to the same extent as, and in place of, us.

When the Continued Group Life Benefits End

An employee's continued group life benefits end on the first of the following:

(a) the end of the applicable continuation period;

(b) the end of the period for which the last total monthly premium payment was made to us;

(c) the date the group plan ends or is amended to end benefits for the class of employees to which the employee belonged;

(d) the date the employee is no longer totally disabled; or

(e) the date the employee is approved by us in writing for coverage under any permanent disability provision of the extended life benefits section of this plan.

Conversion Rights and Extended Life Benefits

Any applicable conversion rights will still be in effect when the continuation period ends. Continuing his group life benefits under this section does not stop an employee from claiming his rights under the extended life benefits section of this plan.

All Options

Dependent Spouse Continuation Rights

Important Notice

This section applies only to any hospital, surgical, medical, major medical, prescription drug, and dental expense coverages as that are provided by this plan. In this section, these coverages are referred to as "group health benefits."

This section does not apply to coverages which provide benefits for loss of life or loss of income due to disability. These coverages, if provided, cannot be continued under this section.

Any continuation of group health benefits under this section will be subject to all of the terms and conditions of this plan.

If An Employee's Marriage Ends Or If An Employee Dies While Covered

If an employee's marriage ends by legal divorce or annulment, or if an employee dies while covered, his or her then covered spouse may continue this plan's group health benefits subject to all the terms and conditions below and to the timely payment of premiums. Such group health benefits may cover the employee's former spouse and those of the employee's dependent children whose group health benefits would otherwise end.

If An Employee Retires While Covered

If an employee retires while covered, his or her then covered spouse who is age 55 or older at that time may continue this plan's group health benefits subject to all the terms and conditions below and to the timely payment of premiums. Such group health benefits may cover the retired employee's spouse and those of the retired employee's dependent children whose group health benefits would otherwise end.

How And When To Continue The Group Health Benefits

To continue the group health benefits, the employee's former spouse or retired employee's spouse must: (a) be covered for group health benefits under this plan at the time the marriage ends or the employee dies or retires; (b) in the case of a retired employee's spouse, be age 55 or older at the time the employee retires; (c) give written notice to Guardian or the employer of the end of the marriage or the death or retirement of the employee within 30 days after such event occurs; and (d) elect to continue the group health benefits and pay the first monthly premium as described below.

If the employee's former spouse or retired employee's spouse fails to elect to continue group health benefits, and/or fails to pay the first monthly premium, within 30 days after the date he or she receives the notice described below, group health benefits will end, and he or she waives the right to continue group health benefits under this plan.

The Employer's Responsibility

The employer must give written notice to Guardian within 15 days of the date of receipt of written notice from the employee's spouse of the end of the marriage or the death or retirement of the employee. The employer's notice must include the former spouse's or retired employee's spouse's place of residence. The employer must also send, at the same time, a copy of such notice to the employee's former spouse or retired employee's spouse at the employee's former spouse's or retired employee's spouse's place of residence.

Guardian's Responsibility

Within 30 days after the date of receipt of written notice from the employer, employee's former spouse or retired employee's spouse of the end of the marriage or the death or retirement of the employee, Guardian will notify the employee's former spouse or retired employee's spouse of his or her right to continue group health benefits for him or her and those of the employee's or retired employee's dependent children whose group health benefits would otherwise end.

Guardian's notice will be sent by certified mail, return receipt requested to the former spouse's or retired employee's spouse's place of residence. This notice will include: (a) a form for electing to continue group health benefits; (b) the amount of periodic premiums to be charged to continue group health benefits, and the method and place of payment; and (c) instructions for returning the election form within 30 days after the date it is received.

If Guardian fails to give notice as required above, all premiums for continued group health benefits will be waived from the date notice was required until the date notice is sent. Except as stated below, group health benefits will continue under the terms and conditions of this plan from the date notice was required until the date notice is sent. This will not apply where the group health benefits that exist at the time the notice was to be sent are ended for all employees or the class of employees to which the employee, deceased employee, or retired employee belongs.

Premiums

The monthly premium for continued group health benefits will be computed as follows:

1. With respect to a former spouse who has not reached the age of 55 at the time continued group health benefits start: (a) an amount, if any, that would be charged an employee if the former spouse were a current employee of the employer; plus (b) an amount, if any, that the employer would contribute toward the premium if the former spouse were a current employee.

2. With respect to a retired employee's spouse or former spouse who has reached the age of 55 at the time continued group health benefits start:

(a) For each month during the first two years of continued group health benefits: (i) an amount, if any, that would be charged an employee if the retired employee's spouse or the former spouse were a current employee of the employer; plus (ii) an amount, if any, that the employer would contribute toward the premium if the retired employee's spouse or the former spouse were a current employee.

(b) Starting two years after continued group health benefits start: (i) an amount, if any, that would be charged an employee if the retired employee's spouse or the former spouse were a current employee of the employer; plus (ii) an amount, if any, that the employer would contribute toward the premium if the retired employee's spouse or the former spouse were a current employee; plus (iii) an additional amount, not to exceed 20% of the total of the amounts determined by (i) and (ii), for costs of administration.

When Continued Group Health Benefits End

Continued group health benefits end for each covered person on the first to occur of the following:

1. With respect to a former spouse who has not reached the age of 55 at the time continued group health benefits start: (a) the end of the period for which the last premium payment was made; (b) the date the person becomes covered for similar benefits under another group plan; (c) the date the former spouse remarries; (d) with respect to each person, the date such person's coverage would cease if the employee and former spouse were still married to each other, but group health benefits will not be modified or ended during the first 120 days in a row after the employee's death or end of the marriage unless the group health benefits under this plan are modified or ended for all employees or the class of employees to which the employee belongs; and (e) the end of two years from the date the person's continued group health benefits began.

2. With respect to a retired employee's spouse or the former spouse who has reached the age of 55 at the time continued group health benefits start: (a) the end of the period for which the last premium payment was made; (b) the date the person becomes covered for similar benefits under another group plan; (c) the date the former spouse remarries; (d) with respect to each covered person, the date such person's coverage would cease, except due to the employee's retirement, if the employee and former spouse were still married to each other, but group health benefits will not be modified or ended during the first 120 days in a row after the employee's death or retirement or end of the marriage unless the group health benefits under this plan are modified or ended for all employees or the class of employees to which the employee belongs; and (e) the date the person reaches the qualifying age or otherwise becomes eligible for Medicare.

The Right To Convert

When a person's continued group health benefits end, conversion rights to which he or she may be entitled will be available according to all the terms and conditions of this plan.

CGP-3-R-DSC-IL-04 B240.0253

All Options

Dependent Child Continuation Rights

Important Notice

This section applies to any hospital, surgical, medical, major medical, prescription drug, and dental expense coverages that are provided by this plan. In this section, these coverages are referred to as "group health benefits."

This section does not apply to coverages which provide benefits for loss of life or loss of income due to disability. These coverages, if provided, cannot be continued under this section.

Any continuation of group health benefits under this section will be subject to all of the terms and conditions of this plan.

If An Employee Dies While Covered

If an employee dies while covered, his or her then covered dependent child, or a responsible adult acting on behalf of the child, may continue this plan's group health benefits subject to all the terms and conditions below and to the timely payment of premiums. Such group health benefits may cover the child whose group health benefits would otherwise end. This continuation is not available if the child's group health benefits are being continued as provided in the Dependent Spouse Continuation section.

If A Dependent Child Reaches This Plan's Limiting Age

If an employee's dependent child reaches this plan's limiting age, he or she may continue this plan's group health benefits subject to all the terms and conditions below and to the timely payment of premiums. Such group health benefits may cover the child whose group health benefits would otherwise end.

How And When To Continue The Group Health Benefits

To continue the group health benefits, the employee's dependent child must be covered for group health benefits under this plan at the time the employee dies or the child reaches this plan's limiting age. The child, or a responsible adult acting on behalf of the child in the case of the employee's death, must: (a) give written notice to Guardian or the employer of the death of the employee or the child reaching the limiting age within 30 days after such event occurs; and (b) elect to continue the group health benefits and pay the first monthly premium as described below.

If the child, or a responsible adult acting on behalf of the child in the case of the employee's death, fails to elect to continue group health benefits, and/or fails to pay the first monthly premium, within 30 days after the date he or she receives the notice described below, group health benefits will end, and he or she waives the right to continue group health benefits under this plan.

The Employer's Responsibility

The employer must give written notice to Guardian within 15 days of the date of receipt of written notice from the child, or a responsible adult acting on behalf of the child in the case of the employee's death, of the death of the employee or the child reaching the limiting age. The employer's notice must include the child's place of residence. The employer must also send, at the same time, a copy of such notice to the child, or the responsible adult acting on behalf of the child in the case of the employee's death, at the child's place of residence.

Guardian's Responsibility

Within 30 days after the date of receipt of written notice from the employer, child, or a responsible adult acting on behalf of the child in the case of the employee's death of the death of the employee or the child reaching the limiting age, Guardian will notify the child, or the responsible adult acting on behalf of the child of his or her right to continue group health benefits for the child whose group health benefits would otherwise end.

Guardian's notice will be sent by certified mail, return receipt requested to the child's place of residence. This notice will include: (a) a form for electing to continue group health benefits; (b) the amount of periodic premiums to be charged to continue group health benefits, and the method and place of payment; and (c) instructions for returning the election form within 30 days after the date it is received.

If Guardian fails to give notice as required above, all premiums for continued group health benefits will be waived from the date notice was required until the date notice is sent. Except as stated below, group health benefits will continue under the terms and conditions of this plan from the date notice was required until the date notice is sent. This will not apply where the group health benefits that exist at the time the notice was to be sent are ended for all employees or the class of employees to which the employee or deceased employee belongs.

Premiums

The monthly premium for continued group health benefits will be computed as follows: (a) an amount, if any, that would be charged an employee if the child were a current employee of the employer; plus (b) an amount, if any, that the employer would contribute toward the premium if the child were a current employee.

When Continued Group Health Benefits End

Continued group health benefits end for the covered child on the first to occur of the following:

(a) the end of the period for which the last premium payment was made;

(b) the date the child becomes covered for similar benefits under another group plan;

(c) the date the child's coverage would cease if he or she was still an eligible dependent of the employee; and

(d) the end of two years from the date the child's continued group health benefits began.

The Right To Convert

When a child's continued group health benefits end, conversion rights to which he or she may be entitled will be available according to all the terms and conditions of this plan.

CGP-3-R-DCC-IL-04 B240.0254

All Options

ELIGIBILITY FOR LIFE AND DISMEMBERMENT COVERAGES

B264.0003

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.

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

CGP-3-EC-90-1.0 B264.0969

All Options

When Your Coverage Starts

Your coverage under this *plan* is scheduled to start on the effective date shown in the endorsement section of your application. If you become eligible after this *plan's* effective date, your insurance will start on the date we approve you for insurance.

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 that date. 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 that date we will postpone your coverage. We will postpone 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 in your application 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

Exception to When Your Coverage Starts

If you are not capable of performing the major duties of your regular occupation for the employer on a full-time basis on the date your coverage is scheduled to start, you will be insured for Life insurance if:

1. you were insured under the prior insurer's group Life policy at the time of the transfer;
2. you were a member of an eligible class under the prior carrier's group life policy and are eligible under this plan;
3. your premiums for the employee were paid up to date;
4. your premiums are not currently being waived under the Extended Life Benefit provision, or you were not eligible, under the terms of the prior insurer's group Life policy, to have premiums waived under the Extended Life Benefit provisions; and
5. you are not receiving or eligible to receive benefits under the prior carriers group Life policy.

Any Life benefit payable will be the lesser of:

1. the Life benefit payable under the Group Policy; or
2. the Life benefit payable under the prior insurer's group Life policy had it remained in force.

The Life benefit payable will be reduced by any amount paid by the prior insurer's group life policy.

An employee covered under the Exception to When Your Coverage Starts will not be eligible for (1) Extended Life Benefit provision under this Policy; or (2) Accidental Death and Dismemberment coverage, if any, until such a time that you are Actively At Work as defined by this policy.

All other provisions under this Policy, including Accelerated Life Benefit, Conversion and Dependent coverage, if any, will apply under the Exception to Your 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 occupation for the employer on a Full-Time basis; 2) the date insurance terminates for one of the reasons stated in When Your Coverage Ends; 3) the last day of a period of 12 consecutive months which begins on the Policy effective date; 4) the date you become eligible for the Extended Life Benefit provision under the prior insurer's group Life policy; or 5) the last day the you would have been covered under the prior insurer's group Life policy, had the prior plan not been terminated.

CGP-3-EC-90-2.0 B264.3167

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.

It ends on the date you have been outside the United States for six months in any twelve month period.

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

CGP-3-EC-90-3.0 B264.0914

An Employee's Right To Continue Group Life and AD&D Insurance During a Family Leave Of Absence

All Options

Important Notice

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

Continuation of Coverages

Life and accidental death and dismemberment coverages may be continued, under a uniform, non-discriminatory policy applicable to all employees. You must contact your *employer* to find out if you may continue these coverages.

If Your Group Insurance Would End

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

When Continuation Ends

Coverage may continue until the earliest of the following:

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

Definitions

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

- **Active Duty:** This term means duty under a call or order to active duty in the Armed Forces of the United States.
- **Contingency Operation:** This term means a military operation that: (a) is designated by the Secretary of Defense as an operation in which members of the armed forces are or may become involved in military actions, operations, or hostilities against an enemy of the United States or against an opposing military force; or (b) results in the call or order to, or retention on, active duty of members of the uniformed services under any provision of law during a war or during a national emergency declared by the President or Congress.
- **Covered Servicemember:** This term means a member of the Armed Forces, including a member of the National Guard or Reserves, who for a serious injury or illness: (a), is undergoing medical treatment, recuperation, or therapy; (b) is otherwise in outpatient status; or (c) is otherwise on the temporary disability retired list.

- **Next Of Kin:** This term means the nearest blood relative of the *employee.*
- **Outpatient Status:** This term means, with respect to a covered servicemember, that he or she is assigned to: (a) a military medical treatment facility as an outpatient; or (b) a unit established for the purpose of providing command and control of members of the Armed Forces receiving medical care as outpatients.
- **Serious Injury Or Illness:** This term means, in the case of a covered servicemember, an injury or illness incurred by him or her in line of duty on active duty in the Armed Forces that may render him or her medically unfit to perform the duties of his or her office, grade, rank, or rating.

All Options

GROUP TERM LIFE INSURANCE SCHEDULE

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

All Options

Employee Basic Term Life Insurance

CGP-3-R-SCH-90 B265.0003

All Options

Your Basic Term Life Insurance Amount

An amount equal to 100% of your annual earnings, rounded to the next higher $1,000.00, if not already a multiple thereof, to a maximum of $125,000.00.

CGP-3-R-SCH-90 B265.0008

All Options

Redetermination

Subject to any of the plan's proof of insurability requirements, your basic life insurance amount will be redetermined each October 1st , to an amount in accordance with the parameters enumerated above, on the basis of your then current annual earnings. If you are not actively at work on a full-time basis on that date, your insurance amount will be redetermined on the date you return to active full-time service. However, if your benefits were previously reduced because of an age or retirement reduction, your benefit will not be redetermined due to your change in earnings.

CGP-3-R-SCH-90 B265.0013

All Options

Earnings Definition

Annual earnings means your annual rate of earnings excluding bonuses, commissions, expense accounts, overtime pay and any other extra compensation. We do not include pay for hours worked or billed over 40 per week.

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

Annual earnings is calculated using the earnings components described above applicable as of the most current redetermination date on which your employer has provided earnings data to us. Proof of earnings will be required. Proof may consist of: (1) copies of your U.S. Individual Income Tax Returns; (2) a statement from a certified public accountant; or (3) any other records we agree to accept.

CGP-3-R-SCH-90 B265.1217

All Options

Reduction of Basic Life Insurance Amount Based on Age

If an employee is less than age 65 when his or her insurance under this plan starts, his or her insurance amount is reduced, on the date he or she reaches age 65, by 50% of the amount which otherwise applies to his or her classification and/or option. But in no case will such reduced amount be less than $1,000.00.

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

CGP-3-R-SCH-90 B265.0482

All Options

Proof of Insurability Requirements

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

We require proof as follows:

CGP-3-R-SCH-90 B265.0022

All Options

We require proof for any amount of basic term life insurance.

CGP-3-R-SCH-90 B265.0027

All Options

Employee Basic Accidental Death and Dismemberment Insurance (AD&D)

CGP-3-R-SCH-90 B265.0029

All Options

Your Basic AD&D Insurance Amount

An amount equal to 100% of your annual earnings, rounded to the next higher $1,000.00, if not already a multiple thereof, to a maximum of $125,000.00.

CGP-3-R-SCH-90 B265.0035

All Options

Spousal Education and Retraining Benefit

Lifetime Maximum Benefit
$20,000

Maximum Number Of Benefit Payments
Full-Time Post Secondary Education 8
Part-Time Post Secondary Education 4

CGP-3-R-SCH-90 B265.0847

All Options

Dependent Child Education Benefit

Lifetime Maximum Benefit
$20,000.00 per eligible dependent

Maximum Number Of Benefit Payments
8 per lifetime per eligible dependent

Maximum Benefit Period
6 years from the date the first education benefit is made; per eligible dependent.

CGP-3-R-SCH-90 B265.0848

All Options

Redetermination
Subject to any of the plan's proof of insurability requirements, your basic AD&D insurance amount will be redetermined each October 1st , to an amount in accordance with the parameters enumerated above, on the basis of your then current annual earnings. If you are not actively at work on a full-time basis on that date, your insurance amount will be redetermined on the date you return to active full-time service. However, if your benefits were previously reduced because of an age or retirement reduction, your benefit will not be redetermined due to your change in earnings.

CGP-3-R-SCH-90 B265.0039

All Options

Earnings Definition

Annual earnings means your annual rate of earnings excluding bonuses, commissions, expense accounts, overtime pay and any other extra compensation. We do not include pay for hours worked or billed over 40 per week.

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

Annual earnings is calculated using the earnings components described above applicable as of the most current redetermination date on which your employer has provided earnings data to us. Proof of earnings will be required. Proof may consist of: (1) copies of your U.S. Individual Income Tax Returns; (2) a statement from a certified public accountant; or (3) any other records we agree to accept.

CGP-3-R-SCH-90 B265.1217

All Options

Reduction of Basic AD&D Amount Based on Age

If an employee is less than age 65 when his or her insurance under this plan starts, his or her insurance amount is reduced, on the date he or she reaches age 65, by 50% of the amount which otherwise applies to his or her classification and/or option. But in no case will such reduced amount be less than $1,000.00.

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

CGP-3-R-SCH-90 B265.0493

All Options

Proof of Insurability Requirements

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

We require proof as follows:

CGP-3-R-SCH-90 B265.0048

All Options

We require proof for any amount of basic AD&D insurance.

LIFE INSURANCE

B270.0070

All Options

Your Group Term Life Insurance

Basic Life Benefit If you die while insured for this benefit, we'll pay your beneficiary the amount shown in the schedule.

Proof of Death We'll pay this insurance as soon as we receive written proof of death. This should be sent to us as soon as possible.

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

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

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

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

We suggest you speak to your lawyer before you make any assignment. If you decide you want to assign this insurance, ask your *employer* for details or write to us.

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

Payment of Funeral or Last Illness Expenses

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

Settlement Option

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

CGP-3-R-LB-90 B270.0174

All Options

THE FOLLOWING PROVISION APPLIES TO YOUR BASIC TERM LIFE INSURANCE:

B275.0076

All Options

Converting This Group Term Life Insurance

If Employment or Eligibility Ends

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

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

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

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

If The Group Plan Ends or Group Life Insurance Is Dropped

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

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

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

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

The Converted Policy

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

Interim Term Insurance

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

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

How and When to Convert

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

Death During the Conversion Period

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

Notice of Conversion Right

If you are entitled to obtain a converted policy under this section, full compliance with this provision for Notice of Conversion Right will be satisfied by written notice: (a) given to you by the employer; (b) mailed to you by the employer at your last known address; or (c) mailed to you by us at your last known address that is supplied to us by the employer.

This notice should be given at least 15 days before the end of the 31 day period allowed for conversion as described in "How and When to Convert." If the notice is not given at least 15 days before the end of such period, you will have an additional period of 15 days from the date notice is given to apply for the converted policy and pay the required premium. But, in no event shall the additional period extend more than 60 days beyond the 31 day period allowed for conversion as described above.

CGP-3-R-LCONV-99-AL B275.0226

All Options

Your Extended Life Benefit With Waiver Of Premium

Important Notice

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

If You Are Disabled

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

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

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

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

How And When To Apply

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

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

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

(b) remain totally disabled for 09 continuous months.

You are encouraged to apply for this benefit immediately upon the onset of disability.

Continued Eligibility For Extended Life Benefit

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

We can require that you take part in a medical assessment, with a medical professional of our choice, as often as we feel is reasonably necessary during the first two years we've extended your life benefits. But after two years, we can't have you examined more than once a year.

Until You've Been Approved For This Extended Life Benefit

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

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

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

However, if this group plan terminates, and you are totally disabled and eligible, but not yet approved, for this extended benefit, you must convert to an individual permanent or term policy, and remain insured under such policy until you are approved by us for the extended benefit.

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

When This Extension Begins

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

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

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

When This Extension Ends

Your extension will end on the earliest of:

(a) the date you are no longer disabled;

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

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

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

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

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

If You Die While Covered By This Extension

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

Proof Of Death

We'll pay as soon as we receive

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

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

LifeAssist

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

When And How The LifeAssist Benefit Begins

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

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

(b) you are functionally disabled, as defined below.

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

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

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

you are:

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

(d) not working for wage or profit.

Activities of Daily Living means:

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

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

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

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

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

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

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

Payment Of Benefits

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

What We Pay

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

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

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

Continued Eligibility For The LifeAssist Benefit

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

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

When The LifeAssist Benefit Ends

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

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

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

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

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

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

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

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

CGP-3-R-LSUPP-99 B275.0350

All Options

Your Basic Accidental Death And Dismemberment With Catastrophic Loss Benefits

The Benefit

We'll pay the benefits described below if you suffer an irreversible covered loss due to an accident that occurs while you are insured. The loss must be a direct result of the accident, independent of disease or bodily infirmity. And, it must occur within 365 days of the date of the accident.

Covered Losses

Benefits will be paid only for losses identified in the following table. The Insurance Amount is shown in the Schedule.

ACCIDENTAL DEATH AND DISMEMBERMENT

Covered Loss	Benefit
Loss of Life	100% of Insurance Amount
Loss of a hand	50% of Insurance Amount
Loss of a foot	50% of Insurance Amount
Loss of sight in one eye	50% of Insurance Amount
Loss of thumb and index finger of same hand	25% of Insurance Amount

CATASTROPHIC LOSS BENEFITS

Covered Loss	Benefit
Quadriplegia (total paralysis of upper and lower limbs, bilaterally)	100% of Insurance Amount
Loss of speech and hearing (both ears)	100% of Insurance Amount
Loss of cognitive function	100% of Insurance Amount
Comatose state, in excess of one month	100% of Insurance Amount
Hemiplegia (total paralysis of upper and lower limbs, unilaterally)	50% of Insurance Amount
Paraplegia (total paralysis of both lower limbs)	50% of Insurance Amount
Loss of speech or hearing (both ears)	50% of Insurance Amount

For covered multiple losses due to the same accident, we will pay 100% of the Insurance Amount. We won't pay more than 100% of the Insurance Amount for all losses due to the same accident, except under the Common Carrier, Seatbelt and Airbag Benefit, and Repatriation Benefit provisions.

Loss of:

(a) cognitive function means a significant decline or loss in intellectual aptitude. Such loss must result from an accidental injury. It must be supported by clinical proof or standardized tests that precisely measure decline in the areas of: (i) short term memory; (ii) orientation to time, place and person; (iii) deductive or abstract reasoning; and (iv) judgement as it relates to awareness of safety.

(b) a hand or foot means it is completely cut off at or above the wrist or ankle.

(c) sight means the total and permanent loss of sight.

(d) speech or hearing means that speech or hearing is lost entirely.

Payment Of Benefits

For covered loss of life, we pay the beneficiary of your basic group term life insurance.

For all other covered losses, we pay you, if you are living. If not, we pay the beneficiary of your basic group term life insurance.

We pay all benefits in a lump sum, as soon as we receive proof of loss which is acceptable to us. This should be sent to us as soon as possible.

CGP-3-R-ADCL1-05-IL B310.1006

All Options

Seatbelt And Airbag Benefits

If you die as a direct result of a motor vehicle accident while properly wearing a seatbelt, we will increase your benefit by $10,000.00. And if you die as a direct result of a motor vehicle accident while both: (a) properly wearing a seatbelt; and (b) sitting in a seat equipped with an airbag; we'll increase your benefit by another $5,000.00, for a total increase of $15,000.00. This benefit will be applied after the Common Carrier provision.

Common Carrier

If your loss is due to an accident which occurs while you are riding in a public conveyance, we increase the benefit payable. We pay two times the amount which otherwise applies to such loss. But, you must have been a fare-paying passenger.

Repatriation Benefit

For covered loss of life due to an accident which occurs at least 75 miles from your home, we pay an extra sum. We pay up to $5,000.00 for costs to prepare and transport your body to a mortuary chosen by you or an authorized agent.

Exclusions

We won't pay for any loss caused:

- by willful self-injury, suicide, or attempted suicide;
- by sickness, disease, mental infirmity, medical or surgical treatment;
- by your taking part in a riot or other civil disorder; or in the commission of or attempt to commit a felony;
- by travel on any type of aircraft if you are an instructor or crew member; or have any duties at all on that aircraft;
- by declared or undeclared war or act of war or armed aggression;
- while you are a member of any armed force;

- while you are a driver in a motor vehicle accident, if you do not hold a current and valid driver's license;
- by your legal intoxication; this includes, but is not limited to, your operation of a motor vehicle; or
- by your voluntary use of a controlled substance, unless: (1) it was prescribed for you by a doctor; and (2) 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.

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 the terms below.

When And How The Spousal Education And Retraining Benefit Begins

We will pay a spousal education and retraining benefit when all of the following conditions are met:

(a) a benefit is payable under this plan's Employee Basic Accidental Death and Dismemberment with Catastrophic Loss (ADDCL) Benefit, due to a specified loss; and

(b) on the date of the accidental injury which results in the specified loss, you and your spouse share the same place of residence;

(c) we receive proof of the spouse's enrollment in an institute of higher learning. The spouse must: (i) be enrolled on the date of the accidental injury which results in the specified loss; or (ii) enroll within 12 months of this date.

Specified Loss means: (1) death; (2) a comatose state which lasts for a period in excess of one month; (3) spinal cord injury, resulting in: (a) quadriplegia; (b) paraplegia; or (c) hemiplegia; or (4) severe head injury resulting in loss of cognitive function. Loss of cognitive function means a significant decline or loss in intellectual aptitude. It must be supported by clinical proof or standardized tests that precisely measure decline in the areas of: (i) short term memory; (ii) orientation to time, place and person; (iii) deductive or abstract reasoning; and (iv) judgement as it relates to awareness of safety.

Institute of Higher Learning includes, but is not limited to: (a) universities; (b) colleges; (c) trade schools; and (d) professional schools. It does not include graduate level programs.

What We Pay

Subject to all the terms of this plan, the Spousal Education and Retraining Benefit per academic term is equal to the lesser of: (i) the spouse's net tuition expense for the term; (ii) 5% of the Employee Basic ADDCL Benefit paid as a result of the specified loss; and (iii) $2,500.00.

Tuition Expense means charges incurred for courses or lab fees. It does not include: (a) cost of books; (b) other related course materials; (c) student activity fees; or (d) room and board.

Net Tuition Expense means tuition expense less any scholarships or grants to which the spouse is entitled.

We pay this benefit to the person who has primary responsibility for these expenses.

This benefit is paid per academic term. Benefit duration is based on whether the spouse is enrolled in a part-time or full-time course of study. See the Employee Basic Accidental Death and Dismemberment Insurance Schedule.

Continued Eligibility For The Spousal Education And Retraining Benefit

We require periodic proof of the spouse's continued enrollment in an institute of higher learning. The spouse must maintain a grade point average of at least 2.0 on a 4.0 scale, or the equivalent. We also require proof, per academic term, of: (a) the spouse's tuition expenses; and (b) any scholarships and grants the spouse is entitled to.

When The Spousal Education And Retraining Benefit Ends

The spousal education and retraining benefit ends on the earliest of the following dates:

(a) the date the spouse is no longer enrolled in an institute of higher learning;

(b) the date the spouse fails to maintain a minimum grade point average as required above;

(c) the date the spouse fails to furnish proof as required above;

(d) the date the lifetime maximum benefit amount, shown in the schedule, is reached; and

(e) the date the maximum number of benefit payments, shown in the schedule, is reached.

All Options

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 the terms below.

Eligibility For The Day Care Expense Benefit

This plan provides a day care expense benefit when all of the following conditions are met:

(a) a benefit is payable under this plan's Employee Basic Accidental Death and Dismemberment with Catastrophic Loss Benefit (ADDCL), due to a specified loss; and

(b) we receive proof of a qualified dependent's enrollment in a qualified day care program. Such enrollment must commence within 12 months of the date of the specified loss.

Specified Loss means: (1) death; (2) a comatose state which lasts for a period in excess of one month; (3) spinal cord injury, resulting in: (a) quadriplegia; (b) paraplegia; or (c) hemiplegia; or (4) severe head injury resulting in loss of cognitive function. Loss of cognitive function means a significant decline or loss in intellectual aptitude. It must be supported by clinical proof or standardized tests that precisely measure decline in the areas of: (i) short term memory; (ii) orientation to time, place and person; (iii) deductive or abstract reasoning; and (iv) judgement as it relates to awareness of safety.

Qualified Dependent: For purposes of the Day Care Expense Benefit a qualified dependent is: (a) 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; (b) dependent upon you for main support and maintenance; and (c) under the age of seven on the date of the accidental injury which results in the specified loss.

Qualified Day Care Program: means a program of child care which: (i) is provided in a facility that is licensed as a day care center; or (ii) is operated by a licensed day care provider; and (iii) charges a fee for the care of children. A qualified day care program does not include child care provided by a parent, step-parent, grandparent, sibling, aunt or uncle.

What We Pay

Subject to all the terms of this plan, the Day Care Expense Benefit is equal to the lesser of: (i) $10,000 annually; or (ii) the actual annual day care expenses for all of your qualified dependents.

We pay this benefit quarterly, in arrears, upon receipt of proof of qualified day care expenses. Proof should be submitted within 30 days following the end of each calendar year quarter.

Payment will be made to the person who has primary responsibility for these expenses.

Continued Eligibility For The Day Care Expense Benefit

We require periodic proof that a qualified dependent remains enrolled in a qualified day care program. We require periodic proof of the qualified dependent's day care expenses.

When The Day Care Expense Benefit Ends

This plan's Day Care Expense Benefits end on the earliest of the following dates:

(a) the date the dependent is no longer qualified, as defined above;

(b) the date the dependent is no longer enrolled in a qualified day care program;

(c) the date we do not receive proof of qualified day care expenses, as required by this plan; and

(d) four years from the date the first day care expense benefit is paid.

DEPENDENT CHILD EDUCATION BENEFIT

If you suffer a specified loss due to an accidental bodily injury, we will pay an education benefit on behalf of a qualified dependent, subject to all the terms below.

When And How The Dependent Child Education Benefit Begins

We will pay a Dependent Child Education Benefit when all of the following conditions are met:

(a) A benefit is payable under this plan's Employee Basic Accidental Death and Dismemberment with Catastrophic Loss Benefit (ADDCL), due to a specified loss;

(b) We receive proof of a qualified dependent's enrollment in an institute of higher learning. The dependent must be a full-time student, as defined by the institute.

Specified Loss means: (1) death; (2) a comatose state which lasts for a period in excess of one month; (3) spinal cord injury which results in: (a) quadriplegia; (b) paraplegia; or (c) hemiplegia; or (4) severe head injury which results in loss of cognitive function. Loss of cognitive function means a significant decline or loss in intellectual aptitude. It must be supported by clinical proof or standardized tests that precisely measure decline in the areas of: (i) short term memory; (ii) orientation to time, place and person; (iii) deductive or abstract reasoning; and (iv) judgement as it relates to awareness of safety.

Qualified Dependent: To be qualified for the Dependent Child Education Benefit, a dependent must meet the following conditions. The dependent must be: (a) 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; (b) unmarried; and (c) dependent upon you for main support and maintenance. On the date of the accidental injury which results in the specified loss, the dependent must be: (a) 22 years of age or younger; and (b) enrolled as a full-time student in an institute of higher learning; or (c) in the 12th grade, and enroll as a full-time student in an institute of higher learning within 12 months of this date. The dependent must maintain a grade point average of at least 2.0 on a 4.0 scale, or the equivalent.

Institute of Higher Learning includes, but is not limited to: (a) universities; (b) colleges; (c) trade schools; and (d) professional schools. It does not include graduate level programs.

What We Pay

Subject to all the terms of this plan, the Dependent Child Education Benefit per academic term is equal to the lesser of: (i) the qualified dependent's net tuition expense for the term; (ii) 5% of the Basic ADDCL Benefit paid as a result of the specified loss; or (iii) $2,500.00.

Tuition Expense means charges incurred for credit courses or lab fees. It does not include: (a) cost of books; (b) other related course materials; (c) student activity fees; or (d) room and board.

Net Tuition Expense means tuition expense less any scholarships or grants to which the dependent is entitled.

We pay this benefit per academic term for each qualified dependent.

We pay this benefit to the person who has primary responsibility for these expenses.

Continued Eligibility For Dependent Education Benefit

We require periodic proof that a dependent remains a qualified dependent, as defined above. We also require proof, per academic term, of: (a) the qualified dependent's tuition expenses; and (b) any scholarships and grants the dependent is entitled to.

When The Dependent Child Education Benefit Ends

A qualified dependent's Dependent Child Education Benefit ends on the earliest of the following dates:

(a) the date the dependent child is no longer a qualified dependent, as defined above;

(b) the date the dependent fails to furnish proof as required above;

(c) the date the lifetime maximum benefit amount, shown in the schedule, is reached;

(d) the date the maximum number of benefit payments, shown in the schedule, is reached; and

(e) the date the maximum benefit period, shown in the schedule, is reached.

ELIGIBILITY FOR DISABILITY COVERAGE

B329.0002

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 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.

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

CGP-3-EC-90-1.0 B329.0383

All Options

When Your Coverage Starts

Your coverage under this *plan* is scheduled to start on the effective date shown in the endorsement section of your application. If you become eligible after this *plan's* effective date, your insurance will start on the date we approve you for insurance.

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 that date. 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 that date we will postpone your coverage. We will postpone 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 in your application 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 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 have been outside the United States for six months in any twelve month period.

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-EC-90-3.0 B329.0452

All Options

When Your Coverage Ends

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

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

It ends on the date you have been outside the United States for six months in any twelve month period.

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-EC-90-3.0 B329.0435

All Options

An Employee's Right To Continue Group Short and Long Term Disability Income Insurance During A Family Leave Of Absence

Important Notice

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

An Employee's Right To Continue Group Short and Long Term Disability Income Insurance During A Family Leave Of Absence (Cont.)

Continuation of Disability Coverage

Short Term Disability and Long Term Disability income coverage may be continued, under a uniform, non-discriminatory policy applicable to all employees. You must contact your *employer* to find out if you may continue this coverage.

If Your Group Insurance Would End

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

When Continuation Ends

Coverage may continue until the earliest of the following:

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

Definitions

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

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

- **Covered Servicemember:** This term means a member of the Armed Forces, including a member of the National Guard or Reserves, who for a serious injury or illness: (a), is undergoing medical treatment, recuperation, or therapy; (b) is otherwise in outpatient status; or (c) is otherwise on the temporary disability retired list.
- **Next Of Kin:** This term means the nearest blood relative of the *employee.*
- **Outpatient Status:** This term means, with respect to a covered servicemember, that he or she is assigned to: (a) a military medical treatment facility as an outpatient; or (b) a unit established for the purpose of providing command and control of members of the Armed Forces receiving medical care as outpatients.
- **Serious Injury Or Illness:** This term means, in the case of a covered servicemember, an injury or illness incurred by him or her in line of duty on active duty in the Armed Forces that may render him or her medically unfit to perform the duties of his or her office, grade, rank, or rating.

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-STD07-HL B340.0086

All Options

Elimination Period

For *disability* due to *injury* . . . . . none

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

CGP-3-STD07-HL B340.0088

All Options

Maximum Payment Period

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

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

CGP-3-STD07-HL B340.0092

All Options

Gross Weekly Benefit

60% 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-STD07-HL B340.0094

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 may not satisfy this *plan's elimination period* while working.

When Payments End

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

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

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

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

(d) The date you are able to perform the major duties 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 he or she dies.

(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 26 weeks.

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

CGP-3-STD07-2.0 B340.0011

All Options

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

(f) 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

(g) Your benefits 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.

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.

CGP-3-STD07-3.0 B340.0012

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

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-STD07-4.0 B340.0013

All Options

Redetermination

This *plan* redetermines *insured earnings* for each covered person on October 1st . Each October 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-STD07-4.1 B340.0042

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.
- 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.

- 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 for which: (i) you are entitled; and (ii) your spouse and children are entitled due to your disability;

  (b) All unreduced retirement benefits for which: (i) you are entitled; and (ii) your spouse and children are entitled due to your entitlement; 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 the gross weekly benefit by marginal increases in such income you and your dependents were entitled to receive after disability begins.

  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, or entitlement for, disability benefits. We do this without regard to: (a) your marital status; (b) where you live; (c) where your spouse lives; (d) where your child lives; or (e) any custody arrangements made on behalf of your child.

- 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 the employer funds.

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

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

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

- 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.
- Unemployment compensation benefits.
- Payment from your *employer* as part of a termination or severance agreement.

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

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

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

Application for Other Income

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

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

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

We will assist you in applying for other income benefits.

All Options

Adjustment of Weekly Benefit for Disability Earnings

This *plan* will not pay benefits if you work during the *elimination period.* 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, or may be able to earn, and still be considered *disabled.*

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

All Options

Exclusions

This *plan* does not pay benefits for *disability* caused by:

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

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

(c) you taking part in a riot or insurrection;

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

(e) your voluntary use of any poison, chemical, prescription or non-prescription drug or controlled substance unless: (a) it was prescribed for you by a *doctor;* and (b) it was used as prescribed. In the case of a non-prescription drug, we do not pay for any loss resulting from your use in a manner inconsistent with package instructions. A controlled substance is anything called a controlled substance in Title II of the Comprehensive Drug Abuse Prevention and Control Act of 1970, as amended from time to time;

(f) intentional self-inflicted injuries; or

(g) 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 crime;

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

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

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

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.

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

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.*

CGP-3-STD07-8.0 B340.1361

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-STD07-8.1 B340.0058

All Options

Claim Provisions

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 the major duties 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. 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 30 days of the date we request it.

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 on a biweekly basis at the end of the period for which they are payable.

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

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

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.

CGP-3-STD07-11.0-IL B340.1498

All Options

Definitions

Active Work, Actively-At-Work or Actively Working

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

CGP-3-STD07-12.0 B340.0062

All Options

Disability or Disabled

These terms mean that a current *sickness* or *injury* causes physical or mental impairment to such a degree that you are: (a) not able to perform, on a full-time basis, the major duties of your *own job* and (b) not able to earn more than this plan's maximum allowed *disability earnings.*

You are not *disabled* if you perform any work for wage or profit during the *elimination period.*

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-STD07-12.2 B340.0063

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 20% of your *insured earnings* will not count toward the *elimination period.* If you are or become eligible under any other similar group income replacement plan while you are working during the *elimination period,* you will not be entitled to benefits from this *plan.*

If you return to work earning more than 20% of your *insured earnings* for more than 7 days during the *elimination period,* you must start a new *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 for which you are, or may become, qualified by: (a) training; (b) education; or (c) experience. When you are able to perform such work on a full-time basis, you can be expected to earn at least 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 disease or bodily infirmity, while this *plan* is in force. We will consider a *disability* to be caused by an *injury* when the *disability* starts within 90 days of the date of such *injury.*

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.

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.*

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

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.

All Options

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

Plan Sponsor The *employer,* association, union, trustee, or other group to which 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. The modification or adjustment must not place an undue hardship on the *employer.*

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.*

All Options

LONG TERM DISABILITY HIGHLIGHTS

SCHEDULE OF BENEFITS

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-LTD07-HL B380.2868

All Options

Own Occupation Period

The first 24 months of benefit payments from this plan.

CGP-3-LTD07-HL B380.2630

All Options

Elimination Period

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

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

CGP-3-LTD07-HL B380.2632

All Options

Maximum Payment Period

See the following table:

For a disability starting before the *employee* reaches age 60, the *maximum payment period* will last until the Social Security Normal Retirement Age as shown in the following table:

Employee's Year of Birth	Social Security Normal Retirement Age
Before 1938	65
1938	65 and 2 months
1939	65 and 4 months
1940	65 and 6 months
1941	65 and 8 months
1942	65 and 10 months
1943-1954	66
1955	66 and 2 months
1956	66 and 4 months
1957	66 and 6 months
1958	66 and 8 months
1959	66 and 10 months
After 1959	67

For a disability starting on or after the employee reaches age 60, the maximum payment period will be determined according to the following table:

Age When Disability Starts	Maximum Payment Period
Age 60	5.00 years
Age 61	4.00 years
Age 62	3.50 years
Age 63	3.00 years
Age 64	2.50 years
Age 65	2.00 years
Age 66	1.75 years
Age 67	1.50 years
Age 68	1.25 years
Age 69 or older	1.00 year

But if an employee whose disability starts after age 60 reaches the end of the maximum payment from this table before he reaches the Social Security Normal Retirement Age, we will extend his maximum payment period until he reaches Social Security Normal Retirement Age.

CGP-3-LTD07-HL B380.2634

All Options

Maximum Monthly Benefit

60% of your *insured earnings,* rounded to the nearest $1.00, if not already a multiple thereof, limited to a maximum of $6,000.00.

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-LTD07-HL B380.2648

All Options

Survivor Benefit

3 times the last monthly benefit after it is reduced by *disability earnings* you received.

CGP-3-LTD07-HL B380.2736

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* 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 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, or are able to earn, the maximum earnings allowed while *disabled* under this *plan.*

(d) The date you are able to perform the major duties 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 the major duties 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."

For a *disability* starting before the employee reaches age 60, the *maximum payment period* will last until the Social Security Normal Retirement Age as shown in the following table:

Employee's Year of Birth	Social Security Normal Retirement Age
Before 1938	65
1938	65 and 2 months
1939	65 and 4 months
1940	65 and 6 months
1941	65 and 8 months
1942	65 and 10 months
1943-1954	66
1955	66 and 2 months
1956	66 and 4 months
1957	66 and 6 months
1958	66 and 8 months
1959	66 and 10 months
After 1959	67

For a *disability* starting on or after the employee reaches age 60, the *maximum payment period* will be determined according to the following table:

Age When Disability Starts	Maximum Payment Period
Age 60	5.00 years
Age 61	4.00 years
Age 62	3.50 years
Age 63	3.00 years
Age 64	2.50 years

Age 65	2.00 years
Age 66	1.75 years
Age 67	1.50 years
Age 68	1.25 years
Age 69 or older	1.00 year

But if an employee whose *disability* starts after age 60 reaches the end of the maximum payment from this table before he or she reaches the Social Security Normal Retirement Age, we will extend the *maximum payment period* until he or she reaches Social Security Normal Retirement Age.

CGP-3-LTD07-2.0 B383.0244

All Options

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

(f) 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

(g) Your benefits 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.

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.

CGP-3-LTD07-3.0 B383.0183

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 your benefit.

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

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 your *monthly benefit.*

CGP-3-LTD07-4.0 B383.0184

All Options

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

Each October 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-LTD07-4.1 B383.0187

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.
- 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.

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

  (b) All unreduced retirement benefits for which: (i) you are entitled; and (ii) your spouse and children are entitled due to your entitlement; 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 the *gross monthly benefit* by marginal increases in such income you and your dependents were entitled to receive after *disability* begins.

  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, or entitlement for, disability benefits. We do this without regard to: (a) your marital status; (b) where you live; (c) where your spouse lives; (d) where your child lives; or (e) any custody arrangements made on behalf of your child.

- 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 the *employer* funds.

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

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

- Disability benefits from any: (1) *no-fault motor vehicle* coverage; (2) motor vehicle financial responsibility act; or (3) like law.
- 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.
- Unemployment compensation benefits.
- Payment from your *employer* as part of a termination or severance agreement.

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

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

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

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

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

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

We will assist you in applying for other income benefits.

CGP-3-LTD07-4.3 B383.0198

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.

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

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

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

(a) During the *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.*

CGP-3-LTD07-5.0 B383.0284

All Options

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 $100.00.

CGP-3-LTD07-5.1 B383.0206

All Options

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 or alcohol abuse; or (c) a specific condition listed below. 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 or alcohol abuse; or (c) a specific condition listed below is 24 months. This is a combined maximum for all such conditions and all periods of *disability.*

The specific conditions subject to a limited maximum payment period include the following:

- Musculoskeletal and connective tissue disorders including, but not limited to:
  - Sprains or strains of joints and muscles
  - Soft tissue conditions
  - Repetitive motion syndromes or injuries
  - Fibromyalgia
- Chronic fatigue conditions including, but not limited to:
  - Chronic fatigue syndrome
  - Chronic fatigue immunodeficiency syndrome
  - Epstein-barr syndrome
- Chemical and environmental sensitivities
- Headache
- Chronic pain, Myofascial pain
- Gastro-esophageal reflux disorder
- Irritable bowel syndrome
- Vestibular dysfunction, vertigo, dizziness

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

- Arthritis
- Ruptured intervertebral discs
- Spinal fractures
- Osteopathies
- Spinal tumors, malignancy or vascular malformations
- Radiculopathies, documented by EMG
- Spondylolisthesis, Grade II or higher
- Myelopathies
- Demyelinating diseases
- Traumatic spinal cord necrosis

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

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

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

CGP-3-LTD07-6.0 B383.0212

All Options

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.*

No benefits are payable for *disability* : (a) caused by or (b) resulting from; a pre-existing condition; unless the *disability* starts after you complete at least one full day of *active work* after the date you are insured under this *plan* for 12 months in a row.

Disability that is: (a) caused by or (b) 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 you complete at least one full day of *active work* after the change has been in force for 12 months in a row.

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

CGP-3-LTD07-6.1-IL B383.0547

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:

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

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

(c) you taking part in a riot or insurrection;

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

(e) your voluntary use of any poison, chemical, prescription or non-prescription drug or controlled substance unless: (a) it was prescribed for you by a *doctor;* and (b) it was used as prescribed. In the case of a non-prescription drug, we do not pay for any loss resulting from your use in a manner inconsistent with package instructions. A controlled substance is anything called a controlled substance in Title II of the Comprehensive Drug Abuse Prevention and Control Act of 1970, as amended from time to time; 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 crime;

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

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

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

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.

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

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-LTD07-8.0 B383.2098

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-LTD07-8.1 B383.0222

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 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.

CGP-3-LTD07-8.2 B383.0223

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 *monthly benefit* 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.

For purposes of this benefit, spouse includes a partner to a civil union when that union is in accordance with Illinois law. We treat the civil union partner as a spouse in marriage, and the civil union as a marriage. Such unions also include same-sex relationships from other jurisdictions that provide substantially all of the rights and benefits of marriage.

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 the major duties of your *own occupation;* or

(b) if this *plan* has already paid benefits for the *own occupation* period, able to perform the major duties 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.*

All Options

Claim Provisions

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 the major duties 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

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. 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 30 days of the date we request it.

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.

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

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

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.

Disability or Disabled These terms mean that a current *sickness* or *injury* causes physical or mental impairment to such a degree that you are:

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

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

You are not *disabled* if you earn, or are able to earn, more than this *plan's* maximum allowed *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, 1 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.

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.* If you are or become eligible under any other similar group income replacement plan while you are working during the *elimination period,* you will not be entitled to benefits from this *plan.*

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 for which you are, or may become, qualified by: (a) training; (b) education; or (c) experience. When you are able to perform such work on a full-time basis, you can be expected to earn at least 60% of your indexed *insured earnings* as much as your gross monthly benefit, 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 disease or bodily infirmity, while this *plan* is in force. We will consider a *disability* to be caused by an *injury* when the *disability* starts within 90 days of the date of such *injury.*

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 or (b) 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.*

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

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 Occupation Means the occupation: (a) you are routinely performing immediately prior to disability; (b) which is your primary source of income prior to disability; and (c) for which you are insured under this plan. Occupation includes any employment, trade or profession that are related in terms of similar: (i) tasks; (ii) functions; (ii) skills; (iv) abilities; (v) knowledge; (vi) training; and (vii) experience; required by employers from those engaged in a particular occupation in the general labor market in the national economy. Occupation is not specific to a certain employer or a certain location.

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 Sponsor The *employer,* association, union, trustee, or other group to which 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. The modification or adjustment must not place an undue hardship on the employer.

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.

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. 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 B489.0070

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 your (a) legal spouse; (b) unmarried dependent children who are under age 26; and (c) unmarried dependent children who are under age 30, if the children (i) are Illinois residents, (ii) served as members of the active or reserve components of any of the branches of the Armed Forces of the United States; and (iii) have received a release or discharge other than a dishonorable discharge.

Legal spouse includes a partner to a civil union when that union is in accordance with Illinois law. We treat the civil union partner as a spouse in marriage, and the civil union as a marriage. Such unions also include same-sex relationships from other jurisdictions that provide substantially all of the rights and benefits of marriage.

CGP-3-DEP-90-2.0 B489.0447

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 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 B264.0007

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 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.

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 B449.0042

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

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

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

If you do this after the *enrollment period* for an *initial dependent* spouse, that spouse is a late entrant and is subject to any applicable late entrant penalties. The spouse's coverage is scheduled to start on the date you sign the enrollment form.

If you do this after the *enrollment period* for an *initial dependent* child, that child may not be enrolled until the next yearly dental dependent enrollment period. And, that child will be subject to any applicable late entrant penalties.

Once you have dependent coverage for your *initial dependents,* you must notify us when you acquire new dependents and agree to make any additional payments required for their coverage. If you do this within 31 days of the date a dependent is acquired, that dependent's coverage will start on the date the dependent first becomes eligible.

If you fail to notify us on time after having acquired a dependent spouse, the *newly acquired dependent* spouse, when enrolled, is a late entrant and is subject to any applicable late entrant penalties. The spouse's coverage is scheduled to start on the date the employee signs the enrollment form.

If you fail to notify us on time after having acquired a dependent child, the *newly acquired dependent* child may not be enrolled until the next yearly dental dependent enrollment period. And, that child will be subject to any applicable late entrant penalties.

The yearly dental dependent enrollment period is a period that begins 30 days prior to the plan's renewal date and ends on the plan's renewal date.

CGP-3-DEP-90-6.0 B489.0292

All Options

Exception

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

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

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 you do not have dependent 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.

CGP-3-DEP-IL-93 B489.0007

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 your 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 his or her dependent benefits 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 other continuation provision.

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 she stops being an *eligible dependent.* This happens to a child at 12:01 a.m. on the date the child attains this coverage's age limit, 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 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 B489.0054

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 90%
  For Group III Services 60%

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

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

CGP-3-DENT-HL-90 B497.0088

All Options

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

  For Group I, II and III Services . . . . . Up to $2,000.00

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 B497.1431

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 B497.2411

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 a *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 B498.0161

Covered Charges

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

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

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

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

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

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

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

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.

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.

Pre-Treatment Review

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

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

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

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

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

CGP-3-DGY2K-PTR B498.0004

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

All Options

The Benefit Provision - Qualifying For Benefits

CGP-3-DGY2K-BEN B498.0072

All Options

Penalty For Late Entrants

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

- All Group II Services.

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

- All Group III Services.

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

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

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

CGP-3-DGY2K-LE B498.0232

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 $2,000.00.

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

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

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

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

Note: If all of the benefits that a *covered person* receives in a *benefit year* are for services provided by a *preferred provider,* he or she may be entitled to a greater *Reward* than if any of the benefits are for services of a *non-preferred provider.*

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

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

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

- *Rollover Threshold* $800.00
- *Reward* (if all benefits are for services provided by a *preferred provider)* $600.00
- *Reward* (if any benefits are for services provided by a *non-preferred provider)* $400.00
- *Bank Maximum* $1,500.00

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 provision of this *plan* called Penalty for Late Entrants, this rollover provision will not apply to the *covered person* until the end of such period. And, if such period ends within the three months prior to the start of this plan's next *benefit year,* this rollover provision will not apply to the *covered person* until the next *benefit year,* and:

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

Definitions of terms used in this provision:

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

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

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

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

CGP-3-DG-ROLL-04-2 B498.9137

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

CGP-3-DGY2K-PR B498.0078

All Options

After This Insurance Ends

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

CGP-3-DGY2K-END B498.0234

All Options

Plus Services Program

If *you* receive dental services from a *Plus* provider in accordance with the terms of this program, *you* may receive additional benefits.

A *Plus* provider is a *non-preferred provider* who is listed in the online directory of *Plus* Providers at www.guardianlife.com.

The *Plus provider* must be listed in the Directory of *Plus* Providers on the date the *covered services* are provided. *Plus providers* may be removed from the list without prior notice at Guardian's discretion.

To be covered under this program, a service must be: (a) necessary; (b) appropriate for a given condition; and (c) included in the List of Covered Dental Services under Preventive Services, Basic Services or Major Services. Cosmetic services, Orthodontic services and services for the treatment of TMJ are not eligible for reimbursement under this program. Coinsurance amounts and charges for non-covered services are not eligible for reimbursement.

A Plus claim is a claim you submit for any amount that the Plus provider balance bills for covered services after the initially paid claim, excluding coinsurance and deductibles. We will reimburse you or the Plus provider on the same basis as we would have had you used the services of any other non-preferred provider. And, if a Plus claim is filed, Guardian will reimburse you an additional amount. The additional amount will be calculated by multiplying the billed charges, not to exceed 200 percent of the reasonable and customary charges for the particular covered service in the geographic area, by the applicable payment rate for services furnished by a non-preferred provider less the amount Guardian initially paid.

If benefits have not been assigned to the Plus provider, we will pay benefits in accordance with all terms of the policy, including the amount of the Plus benefit directly to the covered person. If benefits have been assigned to the Plus provider, the covered person should send(1) a copy of the Plus provider's bill for the balance of amounts that exceed reasonable and customary charges for covered services and (2) a copy of the Explanation of Benefits for the initially paid claim to the address shown on his or her Explanation of Benefits.

Subject to all the terms of this program and of this plan, any amounts paid to the Plus provider or to you under this program will count towards your non-PPO benefit year payment limits. Covered charges will count toward your Non-PPO deductible.

CGP-3-DGY2K-PLUS-09a B498.4435

All Options

Special Limitations

CGP-3-DGY2K-LMT B498.0138

All Options

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

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

CGP-3-DGY2K-TL B498.0133

If This Plan Replaces The Prior Plan

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

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

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. This includes, but is 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. This includes root canal therapy on teeth that support an overdenture.
- Any restoration, procedure, or *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, which includes but is not limited to nitrous oxide. But, this does not apply 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. This includes traditional photographs and images obtained by intraoral camera. But, these services are covered 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.* But, this does not include interim partial dentures/stayplates to replace *anterior teeth* extracted while insured under this *plan.*
- Any service furnished solely for cosmetic reasons, unless the "List of Covered Dental Services" provides benefits for specific cosmetic services. Excluded cosmetic services include, but are not limited to: (1) characterization and personalization of a *dental prosthesis;* and (2) odontoplasty.
- Replacing an existing appliance or *dental prosthesis* with any *appliance* or prosthesis, unless it is: (1) at least 10 years old and is no longer usable; or (2) damaged while in the *covered person's* mouth in an *injury* suffered while insured, and can not 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 Workers' Compensation or similar laws.
- Treatment for which no charge is made. This usually means treatment furnished by: (1) the *covered person's* employer, labor union or similar group, in its dental or medical department or clinic; (2) a facility owned or run by any governmental body; and (3) any public program, except Medicaid, paid for or sponsored by any governmental body.
- Evaluations and consultations for non-covered services; detailed and extensive oral evaluations.
- *Orthodontic treatment.*

CGP-3-DGY2K-EXCH-01 B498.2181

All Options

List of Covered Dental Services

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

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

CGP-3-DNTL-90-13 B490.0148

Group I - Preventive Dental Services
(Non-Orthodontic)

Prophylaxis And Fluorides

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

- Adult prophylaxis covered age 12 and older.

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

Fluoride treatment, topical application - limited to *covered persons* under age 19 and limited to 1 treatment(s) in any 6 consecutive month period.

Office Visits, Evaluations And Examination

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

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

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

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-DNTL-90-14 B498.0164

All Options

Radiographs

Allowance includes evaluation and diagnosis.
Full mouth, complete series or panoramic radiograph - Either, but not both, of the following procedures, limited to one in any 60 consecutive month period.

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

Other diagnostic radiographs:

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

Intraoral periapical or occlusal films - single films

CGP-3-DNTL-90-14 B498.0165

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

All Options

Group II - Basic Dental Services
(Non-Orthodontic)

Diagnostic Services

Allowance includes examination and diagnosis.

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

Diagnostic Services: Allowance includes examination and diagnosis.

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

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

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 - 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.

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.

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

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

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

All Options

Periodontal Services

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

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

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

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

All Options

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

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

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-90-15.0 B498.1124

All Options

Other Services

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

Injectable antibiotics needed solely for treatment of a dental condition.

CGP-3-DNTL-90-15 B498.0206

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. Facings on dental prostheses for teeth posterior to the second bicuspid are not covered. Post and cores are covered only when needed due to decay or *injury.* Allowance includes insulating bases, temporary or provisional restorations and associated gingival involvement. 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. Facings on dental prostheses for teeth posterior to the second bicuspid are not covered. Allowance includes insulating bases, temporary or provisional restorations and associated gingival involvement.

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
3/4 cast metal crowns
3/4 porcelain crowns

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

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 September 1st to September 30th 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. But your coverage will still start on that date if you were actively at work on your last regularly scheduled work day.

CGP-3-EC-90-2.0 B505.1681

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 your (a) legal spouse; (b) unmarried dependent children who are under age 26; and (c) unmarried dependent children who are under age 30, if the children (i) are Illinois residents, (ii) served as members of the active or reserve components of any of the branches of the Armed Forces of the United States; and (iii) have received a release or discharge other than a dishonorable discharge.

Legal spouse includes a partner to a civil union when that union is in accordance with Illinois law. We treat the civil union partner as a spouse in marriage, and the civil union as a marriage. Such unions also include same-sex relationships from other jurisdictions that provide substantially all of the rights and benefits of marriage.

CGP-3-DEP-90-2.0 B505.1314

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 time the child is placed in your home for the purpose of adoption. We treat such a child this way whether or not a final adoption order is ever issued.

We exclude any dependent who is insured by this *plan* as an *employee.* And we exclude any dependent who is on active duty in any armed force.

CGP-3-DEP-90-3.0 B505.0112

All Options

Handicapped Children

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

The child will stay eligible as long as he stays unmarried and unable to support himself, if: (a) his conditions started before he reached this *plan's* age limit; (b) he became insured by this *plan* before he reached the age limit, and stayed continuously insured until he reached such limit; and (c) he depends on you for most of his support and maintenance.

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

The child's coverage ends when yours does.

CGP-3-DEP-90-4.0 B505.0119

All Options

When Dependent Coverage Starts

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

If you do this on or before your *eligibility date,* your dependent coverage is scheduled to start on the later of the date you sign the enrollment form and the date you become covered for employee coverage.

If you do this during the *enrollment period,* your dependent coverage is scheduled to start on the date you become covered for employee coverage.

If you do this for an *initial dependent* spouse after the *enrollment period* ends, you can't enroll your spouse until the next vision open enrollment period.

If you do this for a initial dependent child after the enrollment period ends, you can't enroll your child until the next yearly vision dependent 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 once a dependent spouse is acquired, the spouse can't be enrolled until the next vision open enrollment period.

If you fail to notify us on time once a dependent child is acquired, the child can't be enrolled until the next yearly vision dependent 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 for a dependent spouse or yearly vision dependent enrollment period for a dependent child. And once coverage is dropped for a dependent, the dependent can't be enrolled again until the next vision open enrollment period for a dependent spouse and next yearly vision dependent enrollment period for a dependent child.

The yearly vision dependent enrollment period is a period that begins 30 days prior to the plan's renewal date and ends on the plan's renewal date.

CGP-3-DEP-90-6.0 B505.0774

All Options

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

CGP-3-DEP-90-7.0 B505.0132

All Options

Newborn Children We cover your newborn child from the moment of birth if you're already insured for dependent vision coverage, and you notify us within 31 days of the child's birth. If you fail to notify us on time, you can't enroll the child until the next vision open enrollment period.

If the newborn child is your first *eligible dependent,* we cover the child from the moment of birth if you enroll for dependent coverage and agree to make any required payments within 31 days of the child's birth. If you fail to enroll on time, you can't enroll the child until the next vision open enrollment period.

If the newborn child is not your first *eligible dependent,* but you did not previously enroll your other *eligible dependents* for vision care expense coverage, you can enroll the child during the next vision open enrollment period, if you also enroll all of your other *eligible dependents* at this time.

CGP-3-DEP-90-8.0 B505.0153

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 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 other continuation provision.

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

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

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

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

CGP-3-DEP-90-9.0 B505.0141

All Options

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 and/or Standard Lenses	$25.00
Contact Lenses	$25.00

Non-PPO Cash Deductibles

Examinations	$10.00
Standard Frames and/or Standard Lenses	$25.00
Contact Lenses	$25.00

CGP-3-VSN-96-BEN3 B505.0519

All Options

If a member receives elective contact lenses from a preferred provider that is not part of the formulary, we waive the plan's materials copay. We also waive the copay for elective contact lenses received from a non-preferred provider.

CGP-3-VSN-96-BEN3 B505.0516

VISION CARE BENEFITS

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

CGP-3-DAVIS-05-VIS B505.0466

All Options

This Plan's Vision Care Preferred Provider Organization

Davis Vision: This *plan* is designed to provide a high quality vision care benefit while controlling the cost of such care. To do this, the *plan* encourages a *covered person* to seek vision care from doctors and vision care facilities that belong to Davis Vision's Preferred Provider Network.

This vision care *preferred provider* organization (PPO) is made up of *preferred providers* in a *covered person's* geographic area. A vision care *preferred provider* is a vision care practitioner or a vision care facility that: (a) is a credentialed provider in Davis Vision's network; and (b) has a current participatory agreement in force with Davis Vision.

Use of the vision care PPO is voluntary. A *covered person* may receive vision care from either a *preferred provider* or a *non-preferred provider.* And, he or she is free to change providers at any time. But, this *plan* usually pays more in benefits for covered services furnished by a vision care *preferred provider.* Conversely, it usually pays less for covered services not furnished by a vision care *preferred provider.*

When an *employee* and his or her dependents enroll in this *plan,* they will get an enrollment packet which will tell them how to obtain benefits and information about current vision care *preferred providers.*

What we pay is based on all of the terms of this *plan.* The *covered person* should read this material with care and have it available when seeking vision care. Read this *plan* carefully for specific benefit levels, frequencies, *copayments* and payment limits.

The *covered person* can call Davis Vision if he or she has any questions after reading this material.

Choice of Preferred Providers

When a person becomes enrolled in this *plan,* he or she will receive information about Davis Vision *preferred providers* in his or her area. A *covered person* may receive vision services from any current Davis Vision *preferred provider.*

When a *covered person* wants to receive services from a *preferred provider,* he or she must contact the *preferred provider* before receiving treatment. The *preferred provider* will contact Davis Vision to verify the *covered person's* eligibility before any treatment takes place.

It is not necessary to submit a claim for services or supplies from a *preferred provider.*

Non-Preferred Providers

If a *covered person* receives services or supplies from a *non-preferred provider,* he or she must submit a claim form along with the itemized bill to Davis for claims payment. All claims must be sent to Davis within 90 days of the date services are completed or supplies are received.

Claims for services or supplies from a *non-preferred provider* must be sent to:

Davis Vision - Vision Care Processing Unit
P.O. Box 1525
Latham, NY 12110

All Options

Appeals Process

In the event that a claim is denied, Davis Vision will consult with the provider involved with the *covered person's* vision care treatment. If the issue cannot be resolved, the provider or patient has the right to request a review of the adverse determination. The provider, *covered person* or patient may appeal denied authorizations or claim decisions. Should a *covered person* request a review of an authorization or claim decision, Davis Vision must notify the *covered person,* or his or her designee, within five (5) business days of receipt of the request and the review must be conducted by a clinical peer who was not involved in the original vision care determination. Pre-service review decisions are to be completed within fifteen (15) days and post-service review decisions are to be completed within thirty (30) days, or as required by state statute, from the date that Davis Vision receives notification from the *covered person* or his or her designee and be mailed within five (5) days of the date of decision. Denials can be appealed through Davis Vision's Grievance Resolution Process or as per plan contract. A *covered person* has the right to appeal through an external review organization at any time during the grievance process. A *covered person* has the right to designate a representative, including his or her provider, to act on his or her behalf with regard to review of a vision care claim determination. Use of the Appeals Process does not waive the *covered person's* legal rights.

Grievance Process

Registering a Complaint or Grievance

A *covered person* has the right to file a grievance or make an appeal to any claim decision at any time. The *covered person* has the right to designate a representative to file complaints and appeals on his or her behalf.

A *covered person* is entitled to a copy of the Grievance Resolution process upon request and a copy will be provided to a *covered person* should the determination be made that vision care benefits are not available.

Davis Vision defines a "grievance" as a complaint that may or may not require specific corrective action and is made:

1. via the telephone;
2. in writing to Davis Vision;
3. via the Davis Vision website.

A grievance or complaint can arise from and includes but is not limited to the following:

1. benefit denials.
2. an adverse determination as to whether a service is covered pursuant to the terms of the contract.
3. difficulty accessing or utilizing a benefit, and issues regarding the quality of vision care services.
4. challenges with vision care services or products received.
5. dissatisfaction with the resolution of a complaint/grievance or appeal.

Verbal Grievances and Telephone Communication

A *covered person* may file a verbal grievance by contacting Davis Vision. Registering a grievance by telephone will be considered filing a "formal grievance". A Davis Vision associate will acknowledge receipt of all complaints in writing within five (5) business days from the date the grievance or appeal is received.

A *covered person* has access to the Davis Vision toll free number twenty-four (24) hours a day seven (7) days a week to voice any concern or grievance and also has the right to contact their Human Resources Department or Benefits Administration Department. The Davis Vision Toll Free number is: **1 (800) 584-1487.**

Written Grievances

Written notice of grievances received via e-mail, U.S. Mail or other written correspondence will be acknowledged within five (5) business days. All written correspondence should be addressed to:

Davis Vision
159 Express Street
Plainview, New York 11803
Attention: Quality Assurance/Patient Advocate Department

A *covered person* can register any concern or grievance by logging on to Davis' website: www.davisvision.com and entering the "Contact Davis Vision" area.

Appeal Level 1 Upon receipt of a concern or grievance by a Davis Vision associate, the *covered person* is contacted by telephone, or in writing, within five (5) business days to confirm that the concern or grievance was received and is being investigated. Every attempt is made to contact the *covered person* or his or her designated representative. Contact may include but is not limited to telephone contact, e-mail or U.S. Mail. A designated Davis Vision associate reviews the appeal with the *covered person* and may request additional information. Details of the complaint are documented in the *covered person's* file. The *covered person* is given the Associate's name, phone number, department and the estimated time needed to perform the research. The *covered person* is informed of their right to have a representative, including their provider, present during the review of the concern and final outcome of the investigation. The *covered person* is informed of their right to appeal to an external review organization at any time during the grievance procedure or as required by state statute.

The review committee will include a licensed (peer) health care professional when grievances pertain to clinical decisions. All decisions are reviewed and approved by the Vice President of Professional Affairs, a licensed optometrist.

The investigation may involve contacting the provider or the point of service location to determine the cause of the concern. If necessary, the Regional Quality Assurance Representative (RQAR) or Professional Field Consultant (PFC) will be contacted and a site visit may be scheduled. Davis Vision will contact the *covered person* when further information is required and inform them of the status of the investigation or the need for more information.

CGP-3-DAVIS-05-APP-2 B505.0470

All Options

The determination will be communicated to the *covered person* within fifteen (15) days for pre-service review decisions and within thirty (30) days for post-service review decisions, or as required by state statute. An additional ten (10) days may be requested in order to complete further research. The written decision will be mailed to the *covered person* within five (5) days of the decision. The appeal determination will include the following:

- the decision, and will include a summary of the facts related to the issue,
- the criteria that was used, summary of the evidence, including the documentation supporting the decision,
- a statement indicating that the decision will be final and binding unless the *covered person* appeals in writing to the Quality Assurance/Patient Advocate Department within fifteen (15) business days of the date of the notice of the decision,
- a copy of the appeals process, if applicable, and
- the name, position, phone number, and department of the person(s) responsible for the decision.

The decision of the Quality Assurance/Patient Advocate Department shall be final and binding unless appealed by the *covered person* to Davis Vision within fifteen (15) business days of the date of notice of the decision.

Appeal Level 2 Should Davis Vision uphold a denial, as the result of a Level 1 review, the *covered person* has the right to request a Level 2 appeal.

A Level 2 appeal will not include associate(s) or licensed (peer) health care professional(s) that were involved in the Level 1 review.

A Level 2 appeal requires the *covered person* to contact Davis Vision in writing or by telephone within fifteen (15) days following receipt of the Level 1 summary statement. The *covered person* requesting a Level 2 appeal must indicate the reason they believe the denial of coverage was incorrect. Davis Vision reserves the right to request further information from the *covered person* or provider.

Davis Vision has thirty (30) days, or as required by state statue, from the date the requested information is received, to respond to the Level 2 pre-service review. Davis Vision has thirty (30) days, or as required by state statute, from the date the requested information is received, to respond to the Level 2 post-service review. The Vice President of Professional Affairs will review all clinical appeals. A Davis Vision Associate(s) and a Regional Quality Assurance Representative(s) (RQAR), a licensed optometrist, not involved in the initial determination will review the Level 1 decision. If the Level 2 appeal upholds the Level 1 determination the *covered person* will be notified in writing of this decision. Notification will include, but not be limited to:

- the decision, and contain a summary stating the nature of the concern and the facts related to the issue,
- the criteria that was used, summary of the evidence, including documentation that was used to support the decision,
- a statement indicating that the decision will be final and binding unless the *covered person* appeals in writing or by telephone to the Quality Assurance/Patient Advocacy Department within forty-five (45) days of the date of the notice of the Level 2 decision,
- a copy of the appeals process, if applicable, and
- the name, position, phone number, and department of person(s) responsible for the decision.

External Grievance Procedure

External Review A *covered person,* as required by state statute, has the right to request an impartial review of concerns that resulted in a denial of coverage. A *covered person* who has exhausted the internal appeals process may appeal the final decision if the denial for services was not deemed medically necessary or the requested service was deemed Investigational or Experimental.

An external review organization will refer the case for review by a neutral, independent practitioner experienced in vision care. Davis Vision will provide all requested documentation to the external review organization. The external review organizations will have up to thirty (30) days, or as required by state statute, to make their determination.

External Review Process

A *covered person* has the right to an external review of a denial of coverage. A *covered person* has the right to an external review of a final adverse decision under the following circumstances:

- the *covered person* has been denied a vision care service, which should have been covered under the terms of the contract.
- services were denied on the basis that requested services were not medically necessary.
- a treatment or service that will have a significant positive impact on the *covered person* has been denied and any alternative service or treatment will not affect the *Covered person's* ocular health and/or produce a negative outcome.
- services denied are related to a current illness or injury.
- the cost of the requested services will not exceed that of any equally effective treatment.
- the denied service, procedure or treatment is a covered benefit under the *Covered person's* policy.
- the *covered person* has exhausted all internal appeal processes with an adverse determination upheld at each level.

Investigational or Experimental Treatment means an approved ocular diagnostic procedure warranted by the ocular health of the *covered person* and the subsequent diagnostic findings could alter the *covered person's* treatment plan. The risk of a negative outcome utilizing the approved treatment would be no greater than utilizing an alternative treatment.

The vision care provider may contact the appropriate State Agency to determine if other documentation may be required for the appeal process.

Once the determination is made, notification is made, in writing, within two (2) business days. This notification will include an explanation and the clinical criteria used in the decision.

How This Plan Works

We pay benefits for the covered charges a *covered person* incurs as follows. What we pay is subject to all of the terms of this *plan.* Read the entire *plan* to find out what we limit or exclude.

Covered charges are the *usual* charges for the services and supplies described below. We pay benefits only for covered charges incurred by a *covered person* while he or she is insured by this *plan.* Charges in excess of any payment limits shown in this *plan* are not covered charges.

When a payment limit is for a pair of materials (such as lenses), the limit is halved if only one item is purchased.

CGP-3-DAVIS-05-HPW B505.0472

All Options

Copays A *covered person* must pay a copay each time he or she receives a vision examination. A *covered person* must pay a copay each time he or she receives any vision materials covered by this *plan.*

CGP-3-DAVIS-05-COP B505.0474

All Options

How We Cover Vision Examinations A *covered person* must pay a $10.00 copay each time he or she receives a vision examination. If the vision examination is performed by a *preferred provider,* we pay benefits in full for the exam in excess of the copay. If the vision examination is performed by a *non-preferred provider,* we pay benefits in excess of the copay up to $50.00.

We pay benefits for one vision examination in any calendar year.

A vision examination includes:

- case history - chief complaint, eye and vision history, medical history;
- entrance distance acuities;
- external ocular evaluation including slit lamp examination;
- internal ocular examination;
- tonometry;
- distance refraction - objective and subjective;
- binocular coordination and ocular motility evaluation;
- evaluation of papillary function;
- biomicroscopy;
- gross visual fields;
- assessment and plan;

- advice to a Covered Person on matters pertaining to vision care;
- form completion - school, motor vehicle, etc.

If the doctor recommends vision correction, we cover the fitting of eyeglasses and follow-up adjustments.

CGP-3-DAVIS-05-VE B505.0802

All Options

How We Cover Vision Materials

We pay benefits for either glass or plastic prescription single vision, bifocal, trifocal or *lenticular lenses.* We pay benefits for frames. We pay benefits for prescription contact lenses.

In any calendar year period, we pay benefits for either one pair of standard lenses or one pair of contact lenses, but not both.

In any period of 2 calendar years, we pay benefits for one set of frames.

CGP-3-DAVIS-05-VM B505.0805

All Options

How We Cover Standard Lenses

A *covered person* must pay a $25.00 copay each time he or she purchases *standard lenses.* If the lenses are received from a *preferred provider,* we pay benefits in full for the lenses in excess of the copay. If the lenses are received from a *non-preferred provider,* we pay benefits in excess of the copay up to:

- $48.00 for single vision lenses;
- $67.00 for bifocal lenses;
- $86.00 for trifocal lenses; and
- $126.00 for *lenticular lenses.*

We cover one pair of *standard lenses* in any calendar year.

We cover charges for glass or plastic lenses in single vision, bifocal or trifocal prescriptions, including charges for the following cosmetic extras;

- oversized lenses;
- fashion and gradient tinting of plastic lenses;
- polycarbonate lenses (for children up to age 20 and monocular I individuals and *Covered Persons* with prescriptions of greater than +/-6.00 diopters);
- glass-grey #3 prescription sunglasses.

The following cosmetic lens extras are not covered. But if a *covered person* purchases his or her lenses from a *preferred provider,* the price will be discounted as follows:

- standard progressive addition lenses - $50

- premium progressives (Varilux, Kodak, Seiko, Rodenstock) - $90
- photochromatic lenses - single vision or multifocal - $20
- scratch resistant coating - single vision or multifocal - $20
- ultra violet coating - $12
- blended invisible bifocal lenses - $20
- intermediate Lenses - $30
- plastic photosensitive lenses - $65
- polarized lenses - $75
- hi-Index lenses - $55
- supershield (scratchguard) coating - $20
- glare resistant treatment (multi layer hydrophobic) - $35
- premium glare resistant treatment - $48

CGP-3-DAVIS-05-SL B505.0825

All Options

How We Cover Elective Contact Lenses

We cover charges for standard, soft, daily-wear, disposable or planned replacement contact lenses, but only in lieu of *standard lenses* and frames.

If we cover charges for elective contact lenses, we will not cover charges for *standard lenses* and frames until the next following calendar year.

A *covered person* must pay a $25.00 copay each time he or she purchases elective contact lenses.

If the contact lenses are purchased from a *non-preferred provider,* we pay benefits in excess of the copay up to a maximum of $105.00.

If the contact lenses are purchased from a *preferred provider,* we pay benefits in excess of the copay as follows:

- If a *preferred provider* offers Davis' elective contact lenses collection (the formulary), we cover any elective contact lenses selected from the formulary in full in excess of a $25.00 copay.
- We cover non-formulary elective contact lenses in full to the retail elective contact lenses allowance of $120.00. The copay is waived.
- If a covered person receives a vision examination from a *preferred provider,* he or she will receive a discount on the cost of a pair of non-formulary elective contact lenses, including evaluation and fitting, from the same *preferred provider*.*

The discount is an amount equal to 15% of the *preferred provider's* usual and customary fee in excess of the copay and retail elective contact lenses allowance.

*At Wal-Mart locations, covered persons will receive Wal-Mart's every day low price on purchases of elective contact lenses.

We cover one pair of elective contact lenses in any calendar year.

CGP-3-DAVIS-05-ECL B505.0833

All Options

How We Cover Necessary Contact Lenses

We cover charges for necessary contact lenses, including charges for related professional services:

- only if the lenses are needed for the correction of *keratoconus;* and
- the *covered person* complies with the following requirements regarding prior notification.

The *covered person* or the provider must send a completed request to Davis Vision for necessary contact lenses for the correction of *keratoconus* before the lenses are dispensed. If the required notification is not obtained, no benefits will be paid for such lenses.

A *covered person* must pay a $25.00 copay each time he or she purchases necessary contact lenses. If the contact lenses are purchased from a *preferred provider,* we pay benefits in full for the lenses in excess of the copay. If the contact lenses are purchased from a *non-preferred provider,* we pay benefits in excess of the copay up to a maximum of $210.00.

CGP-3-DAVIS-05-NCL B505.0489

All Options

How We Cover Frames

A *covered person* must pay a copay each time he or she purchases a set of frames.

If the frames are purchased from a *non-preferred provider,* we pay benefits in excess of a $25.00 copay up to $48.00.

If the frames are purchased from a *preferred provider,* we pay benefits in excess of the copay as follows:

- If a *preferred provider* offers Davis' Tower designer frame collection (the Tower), we cover any Fashion or Designer Collection frame selected from the Tower in excess of a $25.00 copay. We cover any Premier Collection frame selected from the Tower in full in excess of a $50.00 copay.
- We cover a non-Tower frame in excess of a $25.00 copay up to the retail frame allowance of $120.00.

- If a *covered person* receives a vision examination from a *preferred provider,* he or she will receive a discount on the cost of purchasing a pair of non-Tower frames from the same *preferred provider*.*

  The discount is an amount equal to 20% of the *preferred provider's* usual and customary fee in excess of the copay and retail frame allowance.

  *At Wal-Mart locations, *covered persons* will receive Wal-Mart's every day low price on frame purchases.

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

CGP-3-DAVIS-05-FRM B505.0853

All Options

Exclusions

- We won't pay for *orthoptics* or vision training and any associated supplemental training.
- We won't pay for medical or surgical treatment of the eyes.
- We won't pay for any eye examination or corrective eyewear required by an *employer* as a condition of employment.
- We won't pay for *plano lenses* (lenses with less than a +/-.38 diopter power).
- We won't pay for two sets of glasses in lieu of bifocals.
- We won't pay for replacement of lenses and frames furnished under this *Plan* which are lost or broken, except at normal intervals when services are otherwise available.
- We won't pay for necessary contact lenses prescribed for a *covered person* affected with *keratoconus* for which prior notification was not sent to Davis Vision.
- We won't pay for lens cosmetic extras that are not specifically listed in this *Plan* as covered.

CGP-3-DAVIS-05-EXC B505.0492

CERTIFICATE AMENDMENT

Effective on the 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.

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

Michael Prestileo, Senior Vice President

CGP-3-A-DGOPT-10 B531.0030

CERTIFICATE AMENDMENT

This rider amends this Plan to provide additional services as described below.

ADDITIONAL SERVICES

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

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

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

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

- Comprehensive Employee Assistance Program (EAP) Services e.g. WorkLife Services.

All Options

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

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

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

The Guardian Life Insurance Company of America

Michael Prestileo, Senior Vice President

B531.0623

CGP-3-A-VAP-IL-15

COORDINATION OF BENEFITS

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

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

Definitions

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

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

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

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

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

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

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

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

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

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.

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 and group subscriber contracts; (2) uninsured arrangements of group or group-type coverage; (3) group or group-type coverage through health maintenance organizations (HMOs) and other prepayment, group practice and individual practice plans; (4) group-type contracts; (5) amounts of group or group- type hospital indemnity benefits in excess of $100.00 per day; (6) medical benefits under group automobile contracts, group or individual automobile "no-fault" contracts, and under traditional "fault" type contracts to the extent that such contracts are primary plans; and (7) Medicare or other governmental benefits, as permitted by law.

This term does not include individual or family: (a) insurance contracts; (b) subscriber contracts; (c) coverage through HMOs; or (d) coverage under other prepayment, group practice and individual practice plans. This term also does not include: (i) amounts of group or group-type hospital indemnity benefits of $100.00 or less per day; (ii) school accident type coverage; or (iii) 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 following 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; and (c) the plan 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 any applicable benefit limit of this plan.

If the primary plan is an HMO and an HMO member has elected to have health care services provided by a non-HMO provider this plan will pay as if it is the primary plan.

Right To Receive And Release Needed Information

Certain facts about health care coverage and services are needed to apply these rules and to determine benefits payable under this plan and other plans. This plan may get the facts it needs from, or give them to, other organizations or persons to apply these rules and determine benefits payable under this plan and other plans which cover the person claiming benefits. This plan need not tell, or get the consent of, any person to do this. Each person claiming benefits under this plan must provide any facts it needs to apply these rules and determine benefits payable.

Facility Of Payment

A payment made under another plan may include an amount that should have been paid by this plan. If it does, this plan may pay that amount to the organization that made the payment. That amount will then be treated as though it were a benefit paid by this plan. This plan will not have to pay that amount again.

As used here, the term "payment made" includes the reasonable cash value of any benefits provided in the form of services.

Right Of Recovery

If the amount of the payments made by this plan is more than it should have paid under this section, it may recover the excess: (a) from one or more of the persons it has paid or for whom it has paid; or (b) from any other person or organization that may be responsible for benefits or services provided for the covered person.

As used here, the term "amount of the payments made" includes the reasonable cash value of any benefits provided in the form of services.

WORKER'S COMPENSATION

For Persons Not Covered By Worker's Compensation

A covered person may not be eligible for, or may choose not to be covered by Worker's Compensation. Such person may sustain an on-the-job or job-related injury. If this occurs, we provide benefits as described below:

(1) For all coverages under this plan, except those that provide benefits for loss of life or loss of income due to disability, we pay benefits for covered charges incurred by the covered person for care and treatment of such injury or condition to the same extent we'd pay benefits for covered charges due to any other sickness or injury.

But what we pay is based on all the terms of this plan.

(2) For any coverages that provide benefits for loss of income due to disability, we pay benefits for disability due to such injury or condition the same way we'd pay benefits for any other disability.

But what we pay is based on all the terms of this plan.

CGP-3-R-WCOMP-85 B595.0004

CERTIFICATE AMENDMENT

This rider amends this plan to include the following provision:

Right of Reimbursement

If a covered person recovers expenses for sickness or injury that occurred due to the negligence of a third party, we have the right to first reimbursement for all medical, dental, or loss of earnings benefits we paid from any and all damages collected from the negligent third party for those same expenses whether by action at law, settlement, or compromise, by the covered person, the covered person's parents if the covered person is a minor, or the covered person's legal representative, as a result of that sickness or injury. We are to be furnished any information or assistance, and be provided any documents that we may reasonably require, in order to exercise our rights under this provision. This provision applies whether or not the third party admits liability. As used here, "third party" means anyone, other than Guardian, the employer or the covered person.

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

Michael Prestileo, Senior Vice President

CGP-3-A-TBL-IL-07 B600.0011

All Options

GLOSSARY

This Glossary defines the italicized terms appearing in your booklet.

CGP-3-GLOSS-90 B900.0118

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 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-GLOSS-90 B750.0781

All Options

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

CGP-3-GLOSS-90 B750.0782

All Options

Copay means a charge, expressed as a fixed dollar amount, required to be paid by or on behalf of a *covered person* before any benefits are paid by this *plan.*

CGP-3-GLOSS-90 B750.0783

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-GLOSS-90 B750.0784

All Options

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

CGP-3-GLOSS-90 B750.0785

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

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 LOCKMANN KRANE INTERNATIONAL INC .

CGP-3-GLOSS-90 B900.0051

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

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 cone shaped due to a thinning and stretching of the tissue in its central area.

CGP-3-GLOSS-90 B750.0786

All Options

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

CGP-3-GLOSS-90 B750.0787

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, ophthalmologist or optician or other licensed and qualified vision care provider who has not entered into a contract with Davis Vision to provide vision care services and/or vision care materials on behalf of the *covered persons* of the *plan.*

CGP-3-GLOSS-90 B750.0788

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. This *plan* does not pay benefits for *orthodontic treatment.*

CGP-3-GLOSS-90 B750.0685

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-GLOSS-90 B750.0789

All Options

Oversize Lenses means larger than a standard lens blank to accommodate prescriptions.

CGP-3-GLOSS-90 B750.0790

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 means lenses which change color with the intensity of sunlight.

CGP-3-GLOSS-90 B750.0791

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 means the Davis Vision plan of vision care services described herein.

CGP-3-GLOSS-90 B750.0792

All Options

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

CGP-3-GLOSS-90 B750.0793

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 entered into a contract with Davis Vision to provide vision care services and/or vision care materials on behalf of *covered persons* of the *plan.*

CGP-3-GLOSS-90 B750.0794

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 Lenses means regular glass or plastic lenses. See "Exclusions" for what we limit or exclude.

CGP-3-GLOSS-90 B750.0795

All Options

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

CGP-3-GLOSS-90 B750.0796

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-GLOSS-90 B750.0797

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

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 Benefits 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.

B800.0095

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

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, 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, you may file suit in a federal court. If it should happen that plan fiduciaries misuse the plan's money or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds that your claim is frivolous.

Assistance with Questions

If you have questions about the plan, you should contact the plan administrator. If you have questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the plan administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor listed in your telephone directory or the Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

Life Insurance Claims Procedure

If you seek benefits under the plan you should complete, execute and submit a claim form. Claim forms and instructions for filing claims may be obtained from the Guardian Life Insurance Company of America (hereinafter referenced as Guardian.)

Guardian is the Claims Fiduciary with discretionary authority to interpret and construe the terms of the Policy, the Certificate, the Schedule of Benefits, and any riders, or other documents or forms that may be attached to the Certificate or the Policy, and any other plan documents. Guardian has discretionary authority to determine eligibility for benefits and coverage under those documents. Guardian has the right to secure independent professional healthcare advice and to require such other evidence as needed to decide your claim.

In addition to the basic claim procedure explained in your certificate, Guardian will also observe the procedures listed below. These procedures are the minimum requirements for benefit claims procedures of employee benefit plans covered by Title 1 of ERISA.

Definitions

"Adverse determination" means any denial, reduction or termination of a benefit or failure to provide or make payment for a benefit.

Timing for Initial Benefit Determination of Life Insurance Claims

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

Guardian will provide a benefit determination not later than 90 days from the date of receipt of a claim. This period may be extended by up to 90 days if Guardian determines that an extension is necessary due to special circumstances, and so notifies the claimant before the end of the initial 90-day period. Such notification will include the reason for the special circumstances requiring the extension and a date by which the determination l is expected to be made.

A notification of an extension to the time period in which a benefit determination will be made will include an explanation of the standards upon which entitlement to a benefit is based, any unresolved issues that prevent a decision of the claim, and the additional information needed to resolve those issues.

Adverse Benefit Determination of Life Insurance Claims

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

- The specific reason(s) for the adverse determination;
- References to the specific provisions in the Policy, Certificate, plan or other documents, on which the determination is based;
- A description of any additional material or information needed to perfect the claim, and an explanation of why such material or information is necessary;
- A description of the plan's claim review procedures which a claimant may follow to have a claim for benefits reviewed and the time limits applicable to such procedures; and
- A description of the plan's review procedures and the time limits applicable to such procedures, including a statement of the claimant's right to bring a civil action under ERISA Section 502(a) following an adverse benefit determination.

B752.0174

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.

B752.0070

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.

B752.0071

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, 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, 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 discretionary authority to interpret and construe the terms of the Policy, the Certificate, the Schedule of Benefits, and any riders, or other documents or forms that may be attached to the Certificate or the Policy, and any other plan documents. Guardian has discretionary authority to determine eligibility for benefits and coverage under those documents. Guardian has the right to secure independent professional healthcare advice and to require such other evidence as needed to decide your claim.

In addition to the basic claim procedure explained in your certificate, Guardian will also observe the procedures listed below. These procedures are the minimum requirements for benefit claims procedures of employee benefit plans covered by Title 1 of ERISA.

Definitions

"Adverse determination" means any denial, reduction or termination of a benefit or failure to provide or make payment 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.

B752.0201

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.

B752.0106

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.

B752.0107

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, 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, you may file suit in a federal court. If it should happen that plan fiduciaries misuse the plan's money or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds that your claim is frivolous.

Assistance with Questions

If you have questions about the plan, you should contact the plan administrator. If you have questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the plan administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor listed in your telephone directory or the Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

Disability Benefits Claims Procedure

If you seek benefits under the plan you should complete, execute and submit a claim form. Claim forms and instructions for filing claims may be obtained from The Guardian Life Insurance Company of America (hereinafter referenced as Guardian).

Guardian is the Claims Fiduciary with discretionary authority to interpret and construe the terms of the Policy, the Certificate, the Schedule of Benefits, and any riders, or other documents or forms that may be attached to the Certificate or the Policy, and any other plan documents. Guardian has discretionary authority to determine eligibility for benefits and coverage under those documents. Guardian has the right to secure independent professional healthcare advice and to require such other evidence as needed to decide your claim.

In addition to the basic claim procedure explained in your certificate, Guardian will also observe the procedures listed below. These procedures are the minimum requirements for benefit claims procedures of employee benefit plans covered by Title 1 of ERISA.

Definitions

"Adverse determination" means any denial, reduction or termination of a benefit or failure to provide or make payment 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.

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.

B752.0143

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.

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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

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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The Guardian Life Insurance Company of America
10 Hudson Yards
New York, New York 10001

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