YOUR GROUP INSURANCE PLAN BENEFITS

EMPLOYER SOLUTIONS GROUP

CLASS 0003

OPTIONAL LIFE, STD, VOLUNTARY LTD, VOLUNTARY AD&D, DENTAL, 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

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

Group Policy No.	Certificate No.	Effective Date
Issued To		

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

The Guardian Life Insurance Company of America

Michael Prestileo, Senior Vice President

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GENERAL PROVISIONS

As used in this booklet:

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

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

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

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

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

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

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

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.

An Important Notice About Continuation Rights

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

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

YOUR CONTINUATION RIGHTS

Federal Continuation Rights

Important Notice

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

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

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

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

Conversion

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

If Your Group Health Benefits End

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

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

Extra Continuation for Disabled Qualified Continuees

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

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

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

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

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

All Options

If You Die While Insured

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

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

All Options

If Your Marriage Ends

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

If a Dependent Child Loses Eligibility

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

Concurrent Continuations

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

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

Special Medicare Rule

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

The Qualified Continuee's Responsibilities

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

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

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

All Options

Your Employer's Responsibilities

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

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

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

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

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

Your Employer's Liability

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

Election of Continuation

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

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

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

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

Grace in Payment of Premiums

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

When Continuation Ends

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

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

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

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

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

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

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

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

Uniformed Services Continuation Rights

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

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

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

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

ELIGIBILITY FOR ACCIDENTAL DEATH AND DISMEMBERMENT COVERAGES

B264.0477

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 also ask for proof that you're insurable. And you won't be covered until we approve that proof in writing.

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

Part or all of your insurance amounts may be subject to proof that you're insurable. The Accidental Death and Dismemberment 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 B264.0637

All Options

When Your Coverage Starts

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

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

But you must be fully capable of performing the major duties of your regular occupation for your *employer* on a full-time basis at 12:01AM Standard Time for your place of residence on the scheduled effective date or dates. And you must have met all of the applicable conditions explained above, and any applicable waiting period. If you are not fully capable of performing the major duties of your occupation on any date part of your insurance is scheduled to start, we will postpone that part of your coverage until the date you are so capable and are working your regular number of hours.

Sometimes, your effective date is not a regularly scheduled work day. If the scheduled effective date falls: on a holiday; on a vacation day; on a non-scheduled work day; 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.

CGP-3-EC-90-2.0 B264.3210

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

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

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 B264.1369

All Options

Parental Leave Of Absence

If your active *full-time* service ends because you go on parental leave, as described in Sections 181 93 through 181 98 of Chapter 181 of the Minnesota Code, your *employer* must continue your group insurance for the duration of the parental leave. Subject to all of the terms of this *plan.* But your *employer* may require you to pay the full cost of your coverage during such parental leave.

CGP-3-EC-90-4.0 B180.0087

All Options

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

Important Notice

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

Continuation of Coverage

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

If Your Group Coverage Would End

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

When Continuation Ends

Insurance may continue until the earliest of the following:

- The date you return to active work.

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

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

- **Active Duty:** This term means duty under a call or order to active duty in the Armed Forces of the United States.
- **Contingency Operation:** This term means a military operation that: (a) is designated by the Secretary of Defense as an operation in which members of the armed forces are or may become involved in military actions, operations, or hostilities against an enemy of the United States or against an opposing military force; or (b) results in the call or order to, or retention on, active duty of members of the uniformed services under any provision of law during a war or during a national emergency declared by the President or Congress.
- **Covered Servicemember:** This term means a member of the Armed Forces, including a member of the National Guard or Reserves, who for a serious injury or illness: (a), is undergoing medical treatment, recuperation, or therapy; (b) is otherwise in outpatient status; or (c) is otherwise on the temporary disability retired list.
- **Next Of Kin:** This term means the nearest blood relative of the *employee.*
- **Outpatient Status:** This term means, with respect to a covered servicemember, that he or she is assigned to: (a) a military medical treatment facility as an outpatient; or (b) a unit established for the purpose of providing command and control of members of the Armed Forces receiving medical care as outpatients.
- **Serious Injury Or Illness:** This term means, in the case of a covered servicemember, an injury or illness incurred by him or her in line of duty on active duty in the Armed Forces that may render him or her medically unfit to perform the duties of his or her office, grade, rank, or rating.

All Options

GROUP ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE SCHEDULE

CGP-3-R-SCH-90 B265.0803

All Options

Voluntary Accidental Death and Dismemberment Insurance (AD&D)

All Options

Voluntary AD&D Enrollment Period

You may choose to be insured under the plan of voluntary AD&D insurance which is equal to 100% of the voluntary life amount. You may only be insured under one plan at a time. You must notify the employer of your election and pay the required premium.

CGP-3-R-SCH-90 B265.1275

All Options

Your Voluntary AD&D Insurance Amount

Plan A $50,000.00

CGP-3-R-SCH-90 B265.1278

All Options

Reduction of Voluntary 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 35% of the amount which otherwise applies to his or her classification and/or option. But in no case will such reduced amount be less than $1,000.00.

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

If an employee is less than age 70 when his or her insurance under this plan starts, the employee's insurance amount is reduced, when he or she reaches age 70, by 60% of the amount which otherwise applies to his or her classification and/or option. But in no case will such reduced amount be less than $1,000.00.

The preceding reduction also applies to an employee's initial insurance amount if his or her insurance starts after he or she reaches age 70 but before he or she reaches age 75.

If an employee is less than age 75 when his or her insurance under this plan starts, the employee's insurance amount is reduced, when he or she reaches age 75, by 75% 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 75 but before he or she reaches age 80.

If an employee is less than age 80 when his or her insurance under this plan starts, the employee's insurance amount is reduced, when he or she reaches age 80, by 85% 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 80.

CGP-3-R-SCH-90 B265.1379

All Options

Proof of Insurability Requirements

Proof of insurability requirements apply to your voluntary 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 B265.2534

All Options

We require *proof* before we will insure any *employee* who enrolls for voluntary accidental death and dismemberment insurance after the time allowed for enrolling as specified in this *plan.*

CGP-3-R-SCH-90 B265.2538

All Options

We require *proof* before an *employee* switches from his or her current *plan* of voluntary accidental death and dismemberment insurance to a *plan* which provides greater benefits.

CGP-3-R-SCH-90 B265.2540

All Options

Your Voluntary Accidental Death And Dismemberment Benefits

The Choices

You may elect to be insured for any of the plans of employee voluntary accidental death and dismemberment (ADD) insurance offered by the employer. These plans are shown in the schedule. However, you can only be insured under one plan at a time. You must notify the employer of your election and pay the required premium.

You may switch to another plan of benefits at any time, subject to any of this plan's proof of insurability requirements. You must notify the employer of any desired switch.

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 all other causes. And, it must occur within 365 days of the date of the accident.

Covered Losses Benefits will be paid according to the plan you have elected, 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

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.

Loss of:

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

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

Payment Of Benefits For covered loss of life, we pay the beneficiary described below.

For all other covered losses, we pay you, if you are living. If not, we pay the beneficiary described below.

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

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

If you named more than one person, but didn't tell us what their shares should be, your insurance will be divided equally by the beneficiaries still alive, unless you tell 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.

CGP-3-R-ADCL1-00 B310.1677

All Options

Exclusions We won't pay for any loss caused directly or indirectly:

- 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;
- while you are operating a motor vehicle under the influence of alcohol as evidenced by a blood alcohol level in excess of the state legal intoxication limit; 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.

CGP-3-R-ADCL2-00-MN B310.1544

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 last day of the month in which your active *full-time* service ends for any reason, other than disability. Such reasons include retirement, layoff, leave of absence and the end of employment.

Your coverage ends on the date you die.

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 B489.0075

All Options

Your Right To Continue Group Coverage During A Family Leave Of Absence

Important Notice

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

If Your Group Coverage Would End

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

When Continuation Ends

Coverage may continue until the earliest of the following:

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

- The end of the period for which the premium has been paid.

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

- **Active Duty:** This term means duty under a call or order to active duty in the Armed Forces of the United States.
- **Contingency Operation:** This term means a military operation that: (a) is designated by the Secretary of Defense as an operation in which members of the armed forces are or may become involved in military actions, operations, or hostilities against an enemy of the United States or against an opposing military force; or (b) results in the call or order to, or retention on, active duty of members of the uniformed services under any provision of law during a war or during a national emergency declared by the President or Congress.
- **Covered Servicemember:** This term means a member of the Armed Forces, including a member of the National Guard or Reserves, who for a serious injury or illness: (a) is undergoing medical treatment, recuperation, or therapy; (b) is otherwise in outpatient status; or (c) is otherwise on the temporary disability retired list.
- **Next Of Kin:** This term means the nearest blood relative of the *employee.*
- **Outpatient Status:** This term means, with respect to a covered servicemember, that he or she is assigned to: (a) a military medical treatment facility as an outpatient; or (b) a unit established for the purpose of providing command and control of members of the Armed Forces receiving medical care as outpatients.
- **Serious Injury Or Illness:** This term means, in the case of a covered servicemember, an injury or illness incurred by him or her in line of duty on active duty in the Armed Forces that may render him or her medically unfit to perform the duties of his or her office, grade, rank, or rating.

CGP-3-EC-90-3.0 B449.0727

All Options

Parental Leave Of Absence If your active *full-time* service ends because you go on parental leave, as described in Sections 181 93 through 181 98 of Chapter 181 of the Minnesota Code, your *employer* must continue your group insurance for the duration of the parental leave. Subject to all of the terms of this *plan.* But your *employer* may require you to pay the full cost of your coverage during such parental leave.

CGP-3-EC-90-4.0 B180.0087

Dependent Coverage

B200.0271

All Options

Eligible Dependents For Dependent Dental Benefits

Your *eligible dependents* are: (a) your legal spouse; (b) your unmarried dependent children who are under age 25; and (c) your unmarried dependent children from age 25 until their 26th birthday, who are enrolled as full-time students at accredited schools.

An unmarried dependent child who is not able to remain enrolled as a full-time student due to a *medically necessary* leave of absence may continue to be an *eligible dependent* until the earlier of: (a) the date that is one year after the first day of the *medically necessary* leave of absence; or (b) the date on which coverage would otherwise end under this *plan.* You must provide written certification by a treating physician which states that the child is suffering from a serious illness or injury and that the leave of absence is *medically necessary.*

Your "unmarried dependent children" include your dependent grandchildren who reside with you.

CGP-3-DEP-90-2.0 B489.0308

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 if the child is in your legal custody under an interim court order 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-90-3.1 B264.0008

All Options

Handicapped Children

You may have a 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 unable to support himself or herself and 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 B449.0044

All Options

Waiver Of Dental Late Entrants Penalty

If you initially waived dental coverage for your spouse or eligible dependent children under this plan because they were covered under another group plan, and you now elect to enroll them in the dental coverage under this plan, the Penalty for Late Entrants provision will not apply to them with regard to dental coverage provided their coverage under the other plan ends due to one of the following events: (a) termination of your spouse's employment; (b) loss of eligibility under your spouse's plan; (c) divorce; (d) death of your spouse; or (e) termination of the other plan.

But you must enroll your spouse or eligible dependent children in the dental coverage under this plan within 30 days of the date that any of the events described above occur.

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

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

All Options

When Dependent Coverage Starts

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

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

If you do this within the *enrollment period,* the coverage is scheduled to start on the date you become insured for employee coverage.

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

Once you have dependent coverage for your *initial dependents,* you must notify us when you acquire any new dependents and agree to make any additional payments required for their 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 first becomes eligible. If you fail to notify us on time, the *newly acquired dependent,* when enrolled, is a late entrant and is subject to any applicable late entrant penalties. The late entrant's coverage is scheduled to start on the date you sign the enrollment form.

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'll 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.

However, if this *plan* replaces a similar plan you had with some other insurer, and a dependent is confined or unable to carry out normal activities as explained above, the dependent may still be eligible for coverage under this *plan,* subject to the terms set forth below, and all of the terms of this *plan.*

He is eligible under this section for those coverages which he was insured for on the premium paying basis under the old plan if: (a) he was covered for such coverages by the old plan on a premium paying basis on the date the old plan ended; (b) the coverages are provided for a similarly situated dependent under this *plan;* and (c) this *plan* starts right after the old plan ends. If all of these conditions are met, the dependent will become insured under this *plan* for those coverages he is eligible for from this *plan's* effective date, subject to payment of premium. He will become so insured without regard to any "non-confinement" requirements contained in this *plan.*

A dependent's coverage under this section will end on the first of the following dates:

- the date he becomes insured on a regular basis under this or any other group plan;
- the last day of the period for which payments are made for the dependent;

- the date this group plan ends, or is discontinued for the class of employees to which the employee, to whom the dependent is related, belongs;
- with respect to any specific coverage provided by this *plan,* the date the dependent stops being a *covered person* under that coverage for reasons other than disability;
- with respect to a dependent who is confined or unable to carry-out normal activities, as explained above, the date he is no longer classified as such.

CGP-3-DEP-90-7.0-MN B200.0691

All Options

Newborn Children

We cover your newborn child for dependent benefits, from the moment of birth. If you do not have dependent child 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 terminate at the end of the 31 days. If you enroll the child after 31 days, the child will be considered a late entrant, and is subject to any applicable late entrant penalties. The child's coverage starts on the date the enrollment form is signed. Your "newborn children" include your newborn dependent grandchildren who reside with you.

CGP-3-DEP-90-8.0 B489.0303

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, if: (a) the dependent doesn't elect to continue his or her group health benefits under this *plan's* "Dependent Continuation Rights" section; and either (b) the dependent doesn't elect to continue his group health benefits under this *plan's* "Federal Continuation Rights" section; or (c) the employer's plan is not subject to this *plan's* "Federal Continuation Rights" section.

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.

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 or grandchild on the last day of the month in which the child attains this coverage's age limit; when he or she marries, except for a handicapped child; or when a step-child is no longer dependent on you for support and maintenance. A grandchild's coverage also ends on the last day of the month in which he or she no longer resides with you. It happens to a spouse on the last day of the month in which 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 B489.0267

CERTIFICATE AMENDMENT

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

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

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

- be 18 years of age or older;
- be unmarried, constitute each other's sole domestic partner and not have had another domestic partner in the last 12 months;
- share the same permanent address for at least 12 consecutive months and intend to do so indefinitely;
- share joint financial responsibility for basic living expenses including food, shelter and medical expenses;
- not be related by blood to a degree that would prohibit marriage in the employee's state of residence; and
- be financially interdependent which must be demonstrated by at least four of the following:

  a. ownership of a joint bank account;

  b. ownership of a joint credit account;

  c. evidence of a joint mortgage or lease;

  d. evidence of joint obligation on a loan;

  e. joint ownership of a residence;

  f. evidence of common household expenses such as utilities or telephone;

  g. execution of wills naming each other as executor and/or beneficiary;

  h. granting each other durable powers of attorney;

  i. granting each other health care powers of attorney;

  j. designation of each other as beneficiary under a retirement benefit account; or

  k. evidence of other joint financial responsibility.

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

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

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

And, the domestic partner and his or her children will be not eligible for:

a. survivor benefits upon the employee's death as explained under the "When Dependent Coverage Ends" section; or

b. continuation of dental coverage as explained under the "Federal Continuation Rights" section and under any other continuation rights section of this plan, unless the employee is also eligible for and elects continuation.

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

The Guardian Life Insurance Company of America

Michael Prestileo, Senior Vice President

CGP-3-A-DMST-96 B210.0016

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, II and III Services . . . . . None

- **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 B497.1252

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 $1,000.00

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

CGP-3-DENT-HL-90 B497.1431

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 B497.2407

All Options

DENTAL EXPENSE INSURANCE

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

CGP-3-DG2000 B498.0007

All Options

Premier Dental Network - 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 Premier Dental Network.

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

All Options

Reimbursement Of Providers

PPO Providers are reimbursed for services that are covered by this *plan.* Non-PPO Providers are also reimbursed for services that are covered by this *plan.* Reimbursement of PPO Providers is based on a discounted fee for their services. Reimbursement of Non-PPO Providers is based on the reasonable and customary charge for their services. Reasonable and customary charges are defined in the Covered Charges section, below. PPO Providers and Non-PPO Providers receive no financial incentive to limit or restrict their services.

CGP-3-DE-DIS-MN-02 B498.1741

All Options

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.

CGP-3-DGY2K-CC B498.0067

All Options

Alternate Treatment

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

Proof Of Claim

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

CGP-3-DGY2K-AT B498.0002

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

Benefits From Other Sources

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

CGP-3-DGY2K-OS B498.0005

The Benefit Provision - Qualifying For Benefits

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 and for Group II and III services provided by a *preferred provider. We* pay for all Group I and for Group II and III PPO covered charges at the applicable *payment rate.*

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 the applicable deductible before *we* pay him or her any benefits for such charges. These charges must be incurred while the *covered person* is insured.

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

CGP-3-DGY2K-BP B498.0439

All Options

All covered charges must be incurred while insured. And we limit what we pay each benefit year to $1,000.00.

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

All Options

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

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

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

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* $500.00
- *Reward* (if all benefits are for services provided by a *preferred provider)* $350.00
- *Reward* (if any benefits are for services provided by a *non-preferred provider)* $250.00
- *Bank Maximum* $1,000.00

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

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

All Options

If This Plan Replaces The Prior Plan

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

- **Teeth Extracted While Insured By The Prior Plan** - The "Teeth Lost, Extracted or Missing Before A Covered Person Becomes Covered By This Plan" provision above, does not apply to a *covered person's dental prosthesis* which replaces teeth: (a) that were extracted while the *covered person* was insured by the *prior plan;* and (b) for which extraction benefits were paid by the *prior plan.*

- **Deductible Credit** - In the first *benefit year* of this *plan,* we reduce a *covered person's* deductibles required under this *plan,* by the amount of covered charges applied against the *prior plan's* deductible. The *covered person* must give us proof of the amount of the *prior plan's* deductible which he or she has satisfied.

- ***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.

All Options

Exclusions

We will not pay for:

- Any service or supply which is not specifically listed in this *plan* 's List of Covered Dental Services.

- Any procedure performed in conjunction with, as part of, or related to a procedure which is not covered by this *plan.*

- Educational services. 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 or procedure associated with the placement, prosthodontic restoration or maintenance of a dental implant. This includes any incremental charges to other covered services as a result of the presence of a dental implant.
- Any service furnished solely for cosmetic reasons. This includes, but is not limited to: (1) characterization and personalization of a *dental prosthesis;* and (2) facings on a *dental prosthesis* for any teeth posterior to the second bicuspid; (3) bleaching of discolored teeth; and (4) odontoplasty.

- Replacing an existing *appliance* or *dental prosthesis* with a like or unlike *appliance* or *dental prosthesis,* unless 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.
- 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.
- 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-MN B498.1117

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 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.

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.

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

Silicate cement, per restoration
Composite resin

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

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

CGP-3-DNTL-90-15 B498.2778

All Options

Crown And Prosthodontic Restorative Services

Also see the "Major Restorative Services" section.

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

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

Inlay or onlay
Crown
Bridge

Adding teeth to partial dentures to replace extracted natural teeth

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

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

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

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

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

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

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

All Options

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

CGP-3-DNTL-90-15.0 B498.0201

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

All Options

Prosthodontic Services

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

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

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

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

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

Complete or Immediate dentures, upper or lower

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

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

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

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

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

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

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

Simple stress breakers, per unit

All Options

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 December 1st to December 31st of each year.

Once you enroll in this *plan,* you can't drop your vision coverage until this *plan's* next vision open enrollment period. And if you drop your vision coverage, you can't enroll again until the next vision open enrollment period.

If you initially waived vision coverage under this *plan* because you were covered for vision care benefits under another group plan, and you wish to enroll in this *plan* because your coverage under the other plan ends, you may do so without waiting until the next vision open enrollment period. However, your coverage under the other plan must have ended due to one of the following events: (a) termination of your spouse's employment; (b) loss of eligibility under your spouse's plan; (c) divorce; (d) death of your spouse; or (e) termination of the other plan. But you must enroll in this *plan* within 30 days of the date that any of these events occur.

CGP-3-EC-90-1.0 B505.0060

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 last day of the month in which your active *full-time* service ends for any reason. Such reasons include disability, retirement, layoff, leave of absence and the end of employment.

Your coverage ends on the date you die.

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 B505.0083

All Options

Your Right To Continue Group Coverage During A Family Leave Of Absence

Important Notice

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

If Your Group Coverage Would End

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

When Continuation Ends

Coverage may continue until the earliest of the following:

- The date you return to active work.
- The end of a total leave period of 26 weeks in one 12 month period, in the case of an *employee* who cares for a covered servicemember. This 26 week total leave period applies to all leaves granted to the *employee* under this section for all reasons.
- The end of a total leave period of 12 weeks in: (a) any 12 month period, in the case of any other *employee;* or (b) any later 12 month period in the case of an *employee* who cares for a covered servicemember.

- The date on which your coverage would have ended had you not been on leave.
- The end of the period for which the premium has been paid.

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

- **Active Duty:** This term means duty under a call or order to active duty in the Armed Forces of the United States.
- **Contingency Operation:** This term means a military operation that: (a) is designated by the Secretary of Defense as an operation in which members of the armed forces are or may become involved in military actions, operations, or hostilities against an enemy of the United States or against an opposing military force; or (b) results in the call or order to, or retention on, active duty of members of the uniformed services under any provision of law during a war or during a national emergency declared by the President or Congress.
- **Covered Servicemember:** This term means a member of the Armed Forces, including a member of the National Guard or Reserves, who for a serious injury or illness: (a) is undergoing medical treatment, recuperation, or therapy; (b) is otherwise in outpatient status; or (c) is otherwise on the temporary disability retired list.
- **Next Of Kin:** This term means the nearest blood relative of the *employee.*
- **Outpatient Status:** This term means, with respect to a covered servicemember, that he or she is assigned to: (a) a military medical treatment facility as an outpatient; or (b) a unit established for the purpose of providing command and control of members of the Armed Forces receiving medical care as outpatients.
- **Serious Injury Or Illness:** This term means, in the case of a covered servicemember, an injury or illness incurred by him or her in line of duty on active duty in the Armed Forces that may render him or her medically unfit to perform the duties of his or her office, grade, rank, or rating.

CGP-3-EC-90-3.0 B449.0727

All Options

Parental Leave Of Absence If your active *full-time* service ends because you go on parental leave, as described in Sections 181 93 through 181 98 of Chapter 181 of the Minnesota Code, your *employer* must continue your group vision care expense insurance for the duration of the parental leave, subject to all of the terms of this *plan.* But your *employer* may require you to pay the full cost of your coverage during such parental leave.

CGP-1-3-EC-90-4.0 B505.0096

Dependent Vision Care Expense Coverage

CGP-3-DEP-90-1.0 B505.0099

All Options

Eligible Dependents For Dependent Vision Care Benefits

Your *eligible dependents* are: (a) your legal spouse; (b) your unmarried dependent children who are under age 25; and (c) your unmarried dependent children from age 25 until their 26th birthday, who are enrolled as full-time students at accredited schools.

An unmarried dependent child who is not able to remain enrolled as a full-time student due to a *medically necessary* leave of absence may continue to be an *eligible dependent* until the earlier of: (a) the date that is one year after the first day of the *medically necessary* leave of absence; or (b) the date on which coverage would otherwise end under this *plan.* You must provide written certification by a treating physician which states that the child is suffering from a serious illness or injury and that the leave of absence is *medically necessary.*

Your "unmarried dependent children" include your dependent grandchildren who reside with you.

CGP-3-DEP-90-2.0 B505.0788

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 if the child is in your legal custody under an interim court order 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-90-3.1 B505.0118

All Options

Handicapped Children

You may have a 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 unable to support himself and 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 B505.0125

All Options

When Dependent Coverage Starts

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

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

If you do this within 31 days of your *eligibility date,* date, your dependent coverage is scheduled to start on the date you become covered for employee coverage.

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

Once you have coverage for your initial *dependents,* you must notify us when you acquire any new dependents, and agree to make any additional payments required for the coverage. If you do this within 31 days of the date the newly *acquired dependent* becomes eligible, the dependent's coverage will start on the date the dependent becomes eligible. If you fail to notify us on time, you can't enroll the newly *acquired dependent* until the next vision open enrollment period.

Once a dependent is enrolled for vision care expense insurance, the coverage can't be dropped until the next vision open enrollment period. And once coverage is dropped for a dependent, the dependent can't be enrolled again until the next vision open enrollment period.

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'll 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.

However, if this *plan* replaces a similar plan you had with some other insurer, and a dependent is confined or unable to carry out normal activities as explained above, the dependent may still be eligible for coverage under this *plan,* subject to the terms set forth below, and all of the terms of this *plan.*

He is eligible under this section for those coverages which he was insured for on the premium paying basis under the old plan if: (a) he was covered for such coverages by the old plan on a premium paying basis on the date the old plan ended; (b) the coverages are provided for a similarly situated dependent under this *plan;* and (c) this *plan* starts right after the old plan ends. If all of these conditions are met, the dependent will become insured under this *plan* for those coverages he is eligible for from this *plan's* effective date, subject to payment of premium. He will become so insured without regard to any "non-confinement" requirements contained in this *plan.*

A dependent's coverage under this section will end on the first of the following dates:

- the date he becomes insured on a regular basis under this or any other group plan;
- the last day of the period for which payments are made for the dependent;
- the date this group *plan* ends, or is discontinued for the class of employees to which the *employee,* to whom the dependent is related, belongs;
- with respect to any specific coverage provided by this *plan,* the date the dependent stops being a *covered person* under that coverage for reasons other than disability;
- with respect to a dependent who is confined or unable to carry-out normal activities, as explained above, the date he is no longer classified as such.

CGP-3-DEP-90-7.0-MN B505.0135

All Options

Newborn Children

We cover your newborn child for dependent benefits, from the moment of birth. If you do not have dependent child 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 terminate at the end of the 31 days and the child cannot be enrolled until the next vision open enrollment period. Your "newborn children" include your newborn dependent grandchildren who reside with you.

CGP-3-DEP-90-8.0 B505.0784

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, if: (a) the dependent doesn't elect to continue his group vision care benefits under this *plan's* "Federal Continuation Rights" section; or (b) the *employer's* plan is not subject to this *plan's* "Federal Continuation Rights" section.

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.

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 or grandchild on the last day of the month in which the child attains this *plan's* age limit, when he marries, except for a handicapped child; or when a step-child is no longer dependent on the *employee* for support and maintenance. A grandchild's coverage also ends on the last day of the month in which he no longer resides with you. It happens to a spouse on the last day of the month in which a marriage ends in legal divorce or annulment.

Read this booklet 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 B505.0754

CERTIFICATE AMENDMENT

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

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

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

- be 18 years of age or older;
- be unmarried, constitute each other's sole domestic partner and not have had another domestic partner in the last 12 months;
- share the same permanent address for at least 12 consecutive months and intend to do so indefinitely;
- share joint financial responsibility for basic living expenses including food, shelter and medical expenses;
- not be related by blood to a degree that would prohibit marriage in the employee's state of residence; and
- be financially interdependent which must be demonstrated by at least four of the following:

  a. ownership of a joint bank account;

  b. ownership of a joint credit account;

  c. evidence of a joint mortgage or lease;

  d. evidence of joint obligation on a loan;

  e. joint ownership of a residence;

  f. evidence of common household expenses such as utilities or telephone;

  g. execution of wills naming each other as executor and/or beneficiary;

  h. granting each other durable powers of attorney;

  i. granting each other health care powers of attorney;

  j. designation of each other as beneficiary under a retirement benefit account; or

  k. evidence of other joint financial responsibility.

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

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

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

And, the domestic partner and his or her children will be not eligible for:

a. survivor benefits upon the employee's death as explained under the "When Dependent Coverage Ends" section; or

b. continuation of vision care coverage as explained under the "Federal Continuation Rights" section and under any other continuation rights section of this plan, unless the employee is also eligible for and elects continuation.

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

The Guardian Life Insurance Company of America

Michael Prestileo, Senior Vice President

CGP-3-A-DMST-96 B505.0161

VISION CARE HIGHLIGHTS

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

PPO Copayments	Examinations	$20.00
	Standard Frames and/or Standard Lenses	$20.00
	Necessary Contact Lenses	$20.00
Non-PPO Cash Deductibles	Examinations	$20.00
	Standard Frames and/or Standard Lenses	$20.00
	Necessary Contact Lenses	$20.00
Payment Rates	For Covered Charges	100%

CGP-3-VSN-96-BEN3 B505.0004

VISION CARE EXPENSE INSURANCE

This insurance will pay many of your and your covered dependent's vision care expenses. What we pay and the terms for payment are explained below.

CGP-3-VSN-96-VIS B505.0007

All Options

Vision Service Plan - This Plan's Vision Care Preferred Provider Organization

Vision Service Plan

This *plan* is designed to provide high quality vision care while controlling the cost of such care. To do this, the *plan* encourages a *covered person* to seek vision care from doctors and vision care facilities that belong to Vision Service Plan (VSP), a vision care *preferred provider* organization (PPO).

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

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

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

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

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

Choice Of Preferred Providers

When a person becomes enrolled in this *plan,* he or she will receive a list of VSP *preferred providers* in his or her area. A *covered person* may receive vision services from any VSP *preferred provider.*

Replacement Of Preferred Provider

If a *preferred provider* terminates his or her relationship with VSP for any reason, VSP shall be responsible for furnishing vision services to *covered persons* either through that provider or through another VSP *preferred provider.*

Pre-Authorization Of Preferred Provider Services

When a *covered person* desires to receive treatment from a *preferred provider,* the *covered person* must contact the *preferred provider* BEFORE receiving treatment. The *preferred provider* will contact VSP to verify the *covered person's* eligibility and VSP will notify the *preferred provider* of the 60 day time period during which the *covered person* may schedule an appointment. If the *covered person* cancels an appointment and reschedules it, it must be done within those 60 days. If the appointment is not rescheduled during the previously approved time period, the *covered person* must contact the *preferred provider* again to receive authorization.

What we pay is subject to all the terms of this *plan.*

CGP-3-VSN-96-PPOA B505.0009

All Options

Pre-Treatment Review For Necessary Contact Lenses

Subject to prior approval by VSP consultants, we will pay benefits for Necessary Contact Lenses provided to a *covered person.* A *covered person's* doctor must request approval for Necessary Contact Lenses from VSP.

No benefits will be paid for Necessary Contact Lenses if prior approval is not received from VSP.

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

CGP-3-VSN-96-PTR2 B505.0014

All Options

Claim Appeals And Arbitration Of Disputes

If, under the provisions of this *plan,* a claim for benefits is denied in whole or in part, a request, in writing, may be submitted to VSP for a full review of the denial.

The written request must be made to the Plan Administrator within 60 days following the denial of benefits. The request should contain sufficient information to identify the *covered person* whose benefits were denied. This includes the name of the *covered person,* the *employee's* social security number and the *employee's* date of birth. The *covered person* may state the reasons he or she believes that the denial of the claim was in error and may provide any pertinent documents which he or she wishes to be reviewed. The Plan Administrator will review the claim and give the *covered person* the opportunity to review pertinent documents, submit any statements, documents or written arguments in support of the claim, and appear personally to present materials or arguments. The determination of the Plan Administrator, including specific reasons for the decision, shall be provided and communicated to the *covered person* in writing within one hundred twenty (120) days after receipt of a request to review.

Any dispute or question arising between VSP and any *covered person* involving the application, interpretation or performance under this *plan* shall be settled, if possible, by amicable and informal negotiations, allowing such opportunity as may be appropriate under the circumstances for fact finding and mediation. If any issue cannot be resolved in this fashion, it may be submitted to arbitration, if both parties agree.

The procedure for arbitration shall be conducted pursuant to the rules of the American Arbitration Association.

Preferred Provider Grievance Procedures

Grievances are handled by VSP's Professional Relations Vice President for action. The grievance process is designed to address *covered persons'* concerns quickly and satisfactorily. The following grievance procedures have been established:

(1) The patient's written complaint will be referred to VSP's Professional Relations Vice President for action.

(2) The complaint will be evaluated and, if deemed appropriate, the original examining doctor will be contacted.

(3) If the complaint can be resolved within fifteen (15) days, the disposition of the complaint will be forwarded to the *covered person.* Otherwise, a notice of receipt of the complaint will be forwarded to the *covered person* advising the time for resolution.

(4) Grievance procedures and complaint forms will be maintained in each *preferred provider's* office.

(5) All complaints will be retained in the Professional Relations Department.

Complaints and grievances may be sent to the Professional Relations Vice President at:

Vision Service Plan, Inc.
3333 Quality Drive
Rancho Cordova, California 95670
(877) 814-8970 or (800) 877-7195

CGP-3-VSN-96-APP B505.0015

How This Plan Works

We pay benefits for the covered charges a *covered person* incurs as follows. The services and supplies covered under this *plan* are explained in the "Covered Services and Supplies" section of this *plan.* What we pay is subject to all of the terms of this *plan.* Read the entire *plan* to find out what we limit or exclude.

Services or Supplies From a Preferred Provider

If a *covered person* uses the services of a *preferred provider,* the *preferred provider* must receive approval from VSP prior to providing the *covered person* with any service or supply. See the "Pre-Authorization of Preferred Provider Services" section of this *plan* for specific requirements.

Copayments The *covered person* must pay a *copayment* when he or she receives services from a *preferred provider.* We pay benefits for the covered charges a *covered person* incurs in excess of the *copayment.* This *plan's copayments* are as follows:

For each vision examination from a *preferred provider* $20.00

For each pair of *standard frames* and/or *standard lenses* from a *preferred provider* $20.00

For Necessary Contact Lenses from a *preferred provider* $20.00

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

Payment Rates Once a *covered person* has paid any applicable *copayment,* we pay benefits for covered charges under this *plan* as follows. What we pay is subject to all of the terms of this *plan.*

For covered charges 100%

Discounts If a *covered person* receives a vision examination, and lenses or frames from a *preferred provider,* he or she will receive a discount on the cost of purchasing an unlimited number of prescription glasses from the same *preferred provider.* The *covered person* may also receive a discount on the costs of evaluation and fitting of contact lenses. No discount applies to contact lenses or materials. The discount is available for 12 months after the initial examination.

The discounts are:

For Prescription Glasses	20% off of the *preferred provider's usual* and *customary* fee
For Contact Lens Evaluation and Fitting Costs	15% off of the *preferred provider's usual* and *customary* fee

CGP-3-VSN-96-BEN1 B505.0016

All Options

Services or Supplies From a Non-Preferred Provider

If a *covered person* uses the services of a *non-preferred provider,* the *covered person* must submit the itemized bill to VSP for claims payment. All claims must be sent to VSP within 180 days of the date services are completed or supplies are received. The benefits we pay are subject to all of the terms of this *plan.*

Cash Deductible For Services Of A Non-Preferred Provider

There are separate cash *deductibles* for each covered service provided by a *non-preferred provider.* These cash *deductibles* are shown below. The *covered person* must have covered charges in excess of the cash *deductible* before we pay him or her any benefits for the service or supply.

For each vision examination provided by a *non-preferred provider* . . .	$20.00
For each pair of *standard frames* and/or *standard lenses* from a non-preferred provider	$20.00
For each pair of Necessary Contact Lenses from a *non-preferred provider*	$20.00

Payment Limits

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

Payment Rates

Once a *covered person* has met any applicable *deductible,* we pay benefits for covered charges under this *plan* as follows. What we pay is subject to all of the terms of this *plan.*

For covered charges	100%

CGP-3-VSN-96-BEN2 B505.0021

All Options

Reimbursement Of Providers

Preferred Providers are reimbursed for services that are covered by this *plan. Non-Preferred Providers* are also reimbursed for services that are covered by this *plan.* Reimbursement of all providers is based on a discounted fee for their services. None of the providers receive financial incentive to limit or restrict their services.

CGP-3-VI-DIS-MN-02 B505.0375

Covered Charges

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

Covered Services and Supplies

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

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

Vision Examinations

We cover charges for comprehensive vision care examinations. Such examinations include a complete analysis of the eyes and related structures to determine the presence of vision problems or other abnormalities. When a vision examination indicates that new lenses or frames or both are *visually necessary and appropriate* for the proper visual health of a *covered person,* professional services covered by this *plan* include:

- prescribing and ordering of proper lenses;
- assisting in the selection of frames;
- verifying the accuracy of finished lenses;
- proper fitting and adjustment of frames;
- subsequent adjustments to frames to maintain comfort and efficiency; and
- progress or follow-up work as necessary.

We don't cover more than one vision examination in any 12 month period.

And if a *covered person* uses a *non-preferred provider,* we limit what we pay for each vision examination to $46.00.

CGP-3-VSN-96-LIST1 B505.0025

All Options

Standard Lenses

We cover charges for single vision, bifocal, trifocal or *lenticular lenses.* We cover glass, plastic or for dependent children to age 25, polycarbonate lenses.

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

- $47.00 for each pair of single vision lenses

- $66.00 for each pair of bifocal lenses
- $85.00 for each pair of trifocal lenses and
- $125.00 for each pair of *lenticular lenses.*

CGP-3-VSN-05-SL B505.0453

All Options

We do not cover charges for more than one set of *standard lenses* in any 12 month period.

CGP-3-VSN-05-SL B505.0455

All Options

Standard Frames

We cover charges for standard frames.

If a covered person uses a preferred provider, we cover charges up to a retail frame allowance of $120.00, plus 20% of any amount over the allowance.

If a covered person uses a non-preferred provider, we limit what we pay for each set of standard frames to $47.00.

We don't cover charges for more than one set of standard frames in any 24 month period.

If the covered person chooses elective contact lenses, we do not cover standard frames for 24 months from the date the elective contacts are purchased.

CGP-3-VSN-16-SF B505.1637

All Options

Necessary Contact Lenses

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

(a) following cataract surgery;

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

(c) for certain conditions of *anisometropia;* or

(d) for *keratoconus.*

We don't cover charges for more than one pair of Necessary Contact Lenses in any 12 month period.

If a *covered person* receives Necessary Contact Lenses from a *preferred provider,* we pay 100% of covered charges. If he or she receives Necessary Contact Lenses from a *non-preferred provider,* we limit what we pay to $210.00 in any 12 month period.

CGP-3-VSN-96-LIST7 B505.0028

All Options

Elective Contact Lenses

We cover charges for elective contact lenses, but only in lieu of standard lenses and standard frames. We cover charges for hard, rigid gas permeable, soft, disposable, 30-day extended wear, daily-wear and planned replacement elective lenses.

If we cover charges for elective contact lenses, we will not cover charges for standard lenses for 12 months and standard frames for at least 24 months.

We limit what we pay for elective contact lenses to $120.00 once every 12 months.

CGP-3-VSN-05-ECL B505.0427

All Options

Special Limitations

If This VSP Plan Replaces Another VSP Plan

If, prior to being covered under this *plan,* a *covered person* was covered by another vision care plan with VSP under which he or she received a covered service within 6 months prior to the effective date of this *plan,* the date he or she received such a covered service will be used as the last date of service when applying the *benefit period* limitations under this *plan.* We apply this provision only if the *covered person* was enrolled in another VSP plan immediately before enrolling in this *plan.*

CGP-3-VSN-96-SL1 B505.0031

All Options

Exclusions

- We won't pay for *orthoptics* or vision training and any associated supplemental testing.
- We won't pay for medical or surgical treatment of the eyes.
- We won't pay for any eye examination or corrective eyewear required by an employer as a condition of employment.

CGP-3-VSN-96-EXC1 B505.0034

All Options

- We will not pay for plano lenses (lenses with less than a .38 diopter power).
- We will not pay for two sets of glasses in lieu of bifocals.
- We will not pay for replacement of lenses and frames furnished under this plan which are lost or broken, except at normal intervals when services are otherwise available.
- We will not pay for blended lenses.
- We will not pay for oversized lenses.
- We will not pay for the laminating of the lens or lenses.
- We will not pay for a frame that costs more than the plan allowance.
- We will not pay for UV (ultraviolet protected lenses).
- We will not pay for cosmetic lenses or any cosmetic process, unless specifically shown as covered in the "Covered Services and Supplies" section.

- We will not pay for progressive multifocal lenses.
- We will not pay for the coating of the lens or lenses.
- We will not pay for photochromic lenses and tinted lenses, except for pink #1 and pink #2.

CGP-3-VSN-05-EXC B505.0428

All Options

Charges not covered due to this provision are not considered covered vision services and cannot be used to satisfy this *plan's copayments* or *deductibles,* if any.

CGP-3-VSN-96-EXC17 B505.0037

CERTIFICATE AMENDMENT

Effective on the latter of (i) the original effective date of the Policy; or (ii) the effective date of any applicable amendment requested by the Policyholder and approved by the Insurance Company, this rider amends the Dental Expense Insurance provisions of the Group Policy as follows:

The Alternate Treatment provision is changed to read as follows when titanium or high noble metal (gold) is used in a *dental prosthesis.*

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

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

The Guardian Life Insurance Company of America

Michael Prestileo, Senior Vice President

CGP-3-A-DGOPT-10 B531.0029

COORDINATION OF BENEFITS

Important Notice This section applies to all group dental benefits under this plan. 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 dental 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 a dental care service or 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) 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 preferred provider arrangements.

(2) 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.

(3) 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. This includes, but is not limited to, franchise and blanket coverage.

Hospital Indemnity Benefits This term means benefits that are not related to expenses incurred. This term does not include reimbursement-type benefits even if they are designed or administered to give the insured the right to elect indemnity-type benefits at the time of claim.

Plan This term means any of the following that provides benefits or services for dental care or treatment: (1) group insurance; (2) closed panel or other forms of group or group-type coverage, whether insured or uninsured; (3) group-type contracts; (4) amounts of group or group-type hospital indemnity benefits in excess of $200.00 per day; (5) medical components of group long-term care contracts such as skilled nursing care; (6) medical benefits under group or individual automobile contracts; and (7) governmental benefits, except Medicare, as permitted by law.

This term does not include: (a) individual or family insurance; (b) closed panel or other individual coverage, except for group-type coverage; (c) amounts of group or group-type hospital indemnity benefits of $200.00 or less per day; (d) school accident type coverage; (e) benefits for non-medical components of group long-term care policies; or (f) Medicare, Medicare supplement policies, Medicaid, and coverage under other governmental plans, unless permitted by law.

This term also does not include any plan that this plan supplements. Plans that this plan supplements are named in the benefit description.

Each type of coverage listed above is treated separately. If a plan has two parts and coordination of benefits applies only to one of the two, each of the parts is treated separately.

Primary Plan This term means a plan that pays first without regard that another plan may cover some expenses. A plan is a primary plan if either of the following is true: (1) the plan either has no order of benefit determination rules, or its rules differ from those explained in this section; or (2) all plans that cover the person use the order of benefit determination rules explained in this section, and under those rules the plan pays its benefits first.

Secondary Plan This term means a plan that is not a primary plan.

This Plan This term means the group dental provided under this group plan.

The primary plan pays or provides its benefits as if the secondary plan or plans did not exist.

A plan may consider the benefits paid or provided by another plan to determine its benefits only when it is secondary to that other plan. If a person is covered by more than one secondary plan, the rules explained below decide the order in which secondary plan benefits are determined in relation to each other.

A plan that does not contain a coordination of benefits provision is always primary.

When all plans have coordination of benefits provisions, the rules to determine the order of payment are listed below. The first of the rules that applies is the rule to use.

Non-Dependent Or Dependent

The plan that covers the person other than as a dependent (for example, as an employee, member, subscriber, or retiree) is primary. The plan that covers the person as a dependent is secondary.

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.

Right To Receive And Release Needed Information

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

Facility Of Payment

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

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

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

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

CGP-3-R-COB-05 B555.0376

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

All Options

GLOSSARY

This Glossary defines the italicized terms appearing in your booklet.

CGP-3-GLOSS-90 B900.0118

All Options

Anisometropia means a condition of unequal refractive state for the two eyes, one eye requiring different lens correction than the other.

CGP-3-VSN-96-DEF1 B750.0457

All Options

Anterior Teeth means the incisor and cuspid teeth. The teeth are located in front of the bicuspids (pre-molars).

CGP-3-GLOSS-90 B750.0664

All Options

Appliance means any dental device other than a *dental prosthesis.*

CGP-3-GLOSS-90 B750.0665

All Options

Benefit Period with respect to Vision Care Insurance, means the time period beginning when a covered service is received and extending to the date on which, according to the time limitations contained in this *plan,* the covered service is again available to a *covered person.*

CGP-3-VSN-96-DEF3 B750.0458

All Options

Benefit Year means a 12 month period which starts on January 1st and ends on December 31st of each year.

CGP-3-GLOSS-90 B750.0666

All Options

Blended Lenses means bifocals which do not have a visible dividing line.

CGP-3-VSN-96-DEF3 B750.0459

All Options

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

CGP-3-VSN-96-DEF3 B750.0460

All Options

Copayment with respect to Vision Care Insurance, means a charge, expressed as a fixed dollar amount, required to be paid by or on behalf of a *covered person* to a *preferred provider* at the time covered vision services are received.

CGP-3-VSN-96-DEF3 B750.0461

All Options

Covered Dental Specialty means any group of procedures which falls under one of the following categories, whether performed by a specialist *dentist* or a general *dentist:* restorative/prosthodontic services; endodontic services, periodontic services, oral surgery and pedodontics.

CGP-3-GLOSS-90 B750.0667

All Options

Covered Family means an employee and those of his or her dependents who are covered by this *plan.*

CGP-3-GLOSS-90 B750.0668

All Options

Covered Person means an employee or any of his or her covered dependents.

CGP-3-GLOSS-90 B750.0669

All Options

Covered Person with respect to Vision Care Insurance, means an *employee* or eligible dependent who meets this *plan's* eligibility criteria and who is covered under this *plan.*

CGP-3-VSN-96-DEF3 B750.0462

All Options

Customary with respect to Vision Care Insurance, means, when referring to a covered charge, that the charge for the covered vision condition isn't more than the *usual* charge made by most other doctors with similar training and experience in the same geographic area.

CGP-3-VSN-96-DEF3 B750.0484

All Options

Deductible with respect to Vision Care Insurance, means any amount which a *covered person* must pay before he or she is reimbursed for covered services provided by a *non-preferred provider.*

CGP-3-VSN-96-DEF3 B750.0483

All Options

Dental Prosthesis means a restorative service which is used to replace one or more missing or lost teeth and associated tooth structures. It includes all types of abutment crowns, inlays and onlays, bridge pontics, complete and immediate dentures, partial dentures and unilateral partials. It also includes all types of crowns, veneers, inlays, onlays, implants and posts and cores.

CGP-3-GLOSS-90 B750.0670

All Options

Dentist means any dental or medical practitioner we are required by law to recognize who: (a) is properly licensed or certified under the laws of the state where he or she practices; and (b) provides services which are within the scope of his or her license or certificate and covered by this *plan.*

CGP-3-GLOSS-90 B750.0671

All Options

Eligibility Date for dependent coverage is the earliest date on which: (a) you have initial dependents; and (b) are eligible for dependent coverage.

CGP-3-GLOSS-90 B900.0003

All Options

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

CGP-3-GLOSS-90 B750.0015

All Options

Emergency Treatment means bona fide emergency services which: (a) are reasonably necessary to relieve the sudden onset of severe pain, fever, swelling, serious bleeding, severe discomfort, or to prevent the imminent loss of teeth; and (b) are covered by this *plan.*

CGP-3-GLOSS-90 B750.0672

All Options

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

CGP-3-GLOSS-90 B750.0006

All Options

Employer means EMPLOYER SOLUTIONS GROUP .

CGP-3-GLOSS-90 B900.0051

All Options

Enrollment Period with respect to dependent coverage, means the 31 day period which starts on the date that you first become eligible for dependent coverage.

CGP-3-GLOSS-90 B900.0004

All Options

Full-time means the *employee* regularly works at least the number of hours in the normal work week set by the *employer* (but not less than 25 hours per week), at his *employer's* place of business.

CGP-3-GLOSS.1 B750.0230

All Options

Incurred, Or Incurred Date with respect to Vision Care Insurance, means the placing of an order for lenses, frames or contact lenses, or the date on which such an order was placed.

CGP-3-VSN-96-DEF3 B750.0466

All Options

Initial Dependents means those *eligible dependents* you have at the time you first become eligible for *employee* coverage. If at this time you do not have any *eligible dependents,* but you later acquire them, the first *eligible dependents* you acquire are your *initial dependents.*

CGP-3-GLOSS-90 B900.0006

All Options

Injury means all damage to a *covered person's* mouth due to an accident which occurred while he or she is covered by this *plan,* and all complications arising from that damage. But the term *injury* does not include damage to teeth, *appliances* or *dental prostheses* which results solely from chewing or biting food or other substances.

CGP-3-GLOSS-90 B750.0673

All Options

Keratoconus means a development or dystrophic deformity of the cornea in which it becomes coneshaped due to a thinning and stretching of the tissue in its central area.

CGP-3-VSN-96-DEF11 B750.0467

All Options

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

CGP-3-VSN-96-DEF11 B750.0485

All Options

Newly Acquired Dependent means an *eligible dependent* you acquire after you already have coverage in force for *initial dependents.*

CGP-3-GLOSS-90 B900.0008

All Options

Non-Preferred Provider means a *dentist* or dental care facility that is not under contract with DentalGuard Preferred as a *preferred provider.*

CGP-3-GLOSS-90 B750.0674

All Options

Non-Preferred Provider with respect to Vision Care Insurance, means any optometrist, optician, ophthalmologist, or other licensed and qualified vision care provider who has not contracted with the *plan* to provide vision care services and/or vision care materials to *covered persons* of the *plan.*

CGP-3-VSN-96-DEF14 B750.0487

All Options

Orthodontic Treatment means the movement of one or more teeth by the use of *active appliances.* it includes: (a) treatment plan and records, including initial, interim and final records; (b) periodic visits, limited orthodontic treatment, interceptive orthodontic treatment and comprehensive orthodontic treatment, including fabrication and insertion of any and all fixed appliances; (c) orthodontic retention, including any and all necessary fixed and removable appliances and related visits. 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-VSN-96-DEF16 B750.0472

All Options

Oversize lenses mean larger than a *standard lens* blank, to accommodate prescriptions.

CGP-3-VSN-96-DEF17 B750.0489

All Options

Payment Limit means the maximum amount this *plan* pays for covered services during either a *benefit year* or a *covered person's* lifetime, as applicable.

CGP-3-GLOSS-90 B750.0676

All Options

Payment Rate means the percentage rate that this *plan* pays for covered services.

CGP-3-GLOSS-90 B750.0677

All Options

Photochromic Lenses mean lenses which change color with the intensity of sunlight.

CGP-3-VSN-96-DEF17 B750.0490

All Options

Posterior Teeth means the bicuspid (pre-molars) and molar teeth. These are the teeth located behind the cuspids.

CGP-3-GLOSS-90 B750.0679

All Options

Plan means the Guardian group dental plan purchased by the planholder.

CGP-3-GLOSS-90 B750.0678

All Options

Plan Benefits with respect to Vision Care Insurance, mean the vision care services and vision care materials which a *covered person* is entitled to receive by virtue of coverage under this *plan.*

CGP-3-VSN-96-DEF17 B750.0492

All Options

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

CGP-3-VSN-96-DEF17 B750.0491

All Options

Preferred Provider means a *dentist* or dental care facility that is under contract with DentalGuard Preferred as a preferred provider.

CGP-3-GLOSS-90 B750.0680

All Options

Preferred Provider with respect to Vision Care Insurance, means an optometrist, ophthalmologist or optician or other licensed and qualified vision care provider who has contracted with the *plan* to provide vision care services and/or vision care materials on behalf of *covered persons* of the *plan.*

CGP-3-VSN-96-DEF14 B750.0488

All Options

Prior Plan means the planholder's plan or policy of group dental insurance which was in force immediately prior to this *plan.* To be considered a prior plan, this *plan* must start immediately after the prior coverage ends.

CGP-3-GLOSS-90 B750.0681

All Options

Proof Of Claim means dental radiographs, study models, periodontal charting, written narrative or any documentation that may validate the necessity of the proposed treatment.

CGP-3-GLOSS-90 B750.0682

All Options

Proof or Proof of Insurability means an application for insurance showing that a person is insurable.

CGP-3-GLOSS-90 B900.0010

All Options

Standard Frames mean frames valued up to the limit published by VSP which is given to *preferred providers.*

CGP-3-VSN-96-DEF17 B750.0478

All Options

Standard Lenses mean regular glass or plastic lenses. See the "Special Limitations" section for what we limit or exclude.

CGP-3-VSN-96-DEF17 B750.0479

All Options

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

CGP-3-VSN-96-DEF17 B750.0480

All Options

Usual means, when referring to a covered charge, that the charge is the doctor's standard charge for the service furnished. If more than one type of service can be used to treat a vision condition, "usual" refers to the charge for the least expensive type of service which meets the accepted standards of vision care practice.

CGP-3-VSN-96-DEF17 B750.0481

All Options

Visually Necessary Or Appropriate means medically or visually necessary for the restoration or maintenance of a *covered person's* visual acuity and health and for which there is no less expensive professionally acceptable alternatives.

CGP-3-VSN-96-DEF17 B750.0482

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

All Options

The following notice applies if your plan is governed by the Employee Retirement Income Security Act of 1974 and its amendments. This notice is not part of the Guardian plan of insurance or any employer funded benefits, not insured by Guardian.

STATEMENT OF ERISA RIGHTS

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

Receive Information About Your Plan and Benefits

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

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

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

Continue Group Health Plan Coverage

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

Prudent Actions By Plan Fiduciaries

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

Enforcement Of Your Rights

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

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

Assistance with Questions

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

Qualified Medical Child Support Order

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

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

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

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

If you have questions about this statement, see the plan administrator.

B800.0094

All Options

The Guardian's Responsibilities

B800.0048

All Options

The dental expense benefits provided by this plan are guaranteed by a policy of insurance issued by The Guardian. The Guardian also supplies administrative services, such as claims services, including the payment of claims, preparation of employee certificates of insurance, and changes to such certificates.

B800.0053

All Options

The vision care expense benefits provided by this plan are guaranteed by a policy of insurance issued by The Guardian. The Guardian also supplies administrative services, such as claims services, including the payment of claims, preparation of employee certificates of insurance, and changes to such certificates.

B800.0055

All Options

The Guardian is located at 10 Hudson Yards, New York, New York 10001.

B800.0049

Group Health Benefits Claims Procedure

If you seek benefits under the plan you should complete, execute and submit a claim form. Claim forms and instructions for filing claims may be obtained from the Plan Administrator.

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

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

Definitions

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

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

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

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

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

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

Timing For Initial Benefit Determination

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Adverse Benefit Determination

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

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

Appeal of Adverse Benefit Determinations

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

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

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

- the opportunity to submit written comments, documents, records and other information relating to the claim;

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

In reviewing an appeal, Guardian will:

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

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

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

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

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

Alternative Dispute Options

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

B800.0076

Termination of This Group Plan

Your *employer* may terminate this group *plan* at any time by giving us 31 days advance written notice. This *plan* will also end if your *employer* fails to pay a premium due by the end of this grace period.

We may have the option to terminate this *plan* if the number of people insured falls below a certain level.

When this *plan* ends, you may be eligible to continue or convert your insurance coverage. Your rights upon termination of the *plan* are explained in this booklet.

B800.0007

STATEMENT OF ERISA RIGHTS

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

Your group term accidental death and dismemberment insurance benefits may be covered by the Employee Retirement Income Security Act of 1974 (ERISA). If so, you are entitled to certain rights and protections under ERISA.

ERISA provides that all plan participants shall be entitled to:

Receive Information about Your Plan and Benefits

- Examine, without charge, at the plan administrator's office and at other specified locations, such as worksites and union halls, all documents governing the plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the plan with the U. S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.
- Obtain, upon written request to the plan administrator, copies of documents governing the operation of the plan, including insurance contracts, collective bargaining agreements and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The administrator may make a reasonable charge for the copies.
- Receive a summary of the plan's annual financial report. The plan administrator is required by law to furnish each participant with a copy of this summary annual report.

Prudent Actions by Plan Fiduciaries

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

Enforcement of Your Rights

If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules (see Claims Procedures below).

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

Assistance with Questions

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

Accidental Death and Dismemberment Insurance Claims Procedure

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

Guardian is the Claims Fiduciary with the responsibility to apply 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 for making decisions, including making a reasonable determination about eligibility for benefits and coverage under those documents. Guardian has the right to secure independent professional healthcare advice and to require such other evidence as needed to decide your claim.

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

Definitions

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

Timing for Initial Benefit Determination of Accidental Death and Dismemberment Insurance Claims

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

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

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

Adverse Benefit Determination of Accidental Death and Dismemberment Insurance Claims

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

- The specific reason(s) for the adverse determination;
- References to the specific provisions in the Policy, Certificate, plan or other documents, on which the determination is based;
- A description of any additional material or information needed to perfect the claim, and an explanation of why such material or information is necessary;
- A description of the plan's claim review procedures which a claimant may follow to have a claim for benefits reviewed and the time limits applicable to such procedures;
- Identification and description of any specific internal rule, guideline or protocol that was relied upon in making an adverse benefit determination, or a statement, that a copy of such information will be provided to the claimant free of charge upon request;
- A description of the plan's review procedures and the time limits applicable to such procedures, including a statement of the claimant's right to bring a civil action under ERISA Section 502(a) following an adverse benefit determination; and
- In the case of adverse benefit determination based on medical necessity or experimental treatment, notice will either include an explanation of the scientific or clinical basis for the determination, or a statement that such explanation will be provided free of charge upon request.

B752.0190

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.

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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.

B752.0113

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.

All Options

We generally will not sell your PHI, or use or disclose PHI about you for marketing purposes without your authorization unless otherwise permitted by law.

Your Rights with Regard to Your Protected Health Information (PHI):

Your Authorization for Other Uses and Disclosures. Other than for the purposes described above, or as otherwise permitted by law, Guardian must obtain your written authorization to use or disclosure your PHI. You have the right to revoke that authorization in writing except to the extent that: (i) we have taken action in reliance upon the authorization prior to your written revocation, or (ii) you were required to give us your authorization as a condition of obtaining coverage, and we have the right, under other law, to contest a claim under the coverage or the coverage itself.

Under federal and state law, certain kinds of PHI will require enhanced privacy protections. These forms of PHI include information pertaining to:

- HIV/AIDS testing, diagnosis or treatment
- Venereal and /or communicable Disease(s)
- Genetic Testing
- Alcohol and drug abuse prevention, treatment and referral
- Psychotherapy notes

We will only disclose these types of delineated information when permitted or required by law or upon your prior written authorization.

Your Right to an Accounting of Disclosures . An 'accounting of disclosures' is a list of certain disclosures we have made, if any, of your PHI. You have the right to receive an accounting of certain disclosures of your PHI that were made by us. This right applies to disclosures for purposes other than those made to carry out treatment, payment and health care operations as described in this notice. It excludes disclosures made to you, or those made for notification purposes.

We ask that you submit your request in writing by completing our form. Your request may state a requested time period not more than six years prior to the date when you make your request. Your request should indicate in what form you want the list (e.g., paper, electronically). Our form for Account of Disclosure requests is available at www.guardianlife.com/privacy-policy.

Your Right to Obtain a Paper Copy of This Notice . You have a right to request a paper copy of this notice even if you have previously agreed to accept this notice electronically. You may obtain a paper copy of this notice by sending a request to the contact information listed at the end of this notice.

Your Right to File a Complaint . If you believe your privacy rights have been violated, you may file a complaint with Guardian or the Secretary of U.S. Department of Health and Human Services. If you wish to file a complaint with Guardian, you may do so using the contact information below. You will not be penalized for filing a complaint.

Please submit any exercise of the Rights designated below to Guardian in writing using the contact information listed below. For some requests, Guardian may charge for reasonable costs associated with complying with your requests; in such a case, we will notify you of the cost involved and provide you the opportunity to modify your request before any costs are incurred.

Your Right to Request Restrictions . You have the right to request a restriction on the PHI we use or disclose about you for treatment, payment or health care operations as described in this notice. You also have the right to request a restriction on the medical information we disclose about you to someone who is involved in your care or the payment for your care.

Guardian is not required to agree to your request; however, if we do agree, we will comply with your request until we receive notice from you that you no longer want the restriction to apply (except as required by law or in emergency situations). Your request must describe in a clear and concise manner: (a) the information you wish restricted; (b) whether you are requesting to limit Guardian's use, disclosure or both; and (c) to whom you want the limits to apply.

Your Right to Request Confidential Communications . You have the right to request that Guardian communicate with you about your PHI be in a particular manner or at a certain location. For example, you may ask that we contact you at work rather than at home. We are required to accommodate all reasonable requests made in writing, when such requests clearly state that your life could be endangered by the disclosure of all or part of your PHI.

B998.0053

All Options

Your Right to Amend Your PHI . If you feel that any PHI about you, which is maintained by Guardian, is inaccurate or incomplete, you have the right to request that such PHI be amended or corrected. Within your written request, you must provide a reason in support of your request. Guardian reserves the right to deny your request if: (i) the PHI was not created by Guardian, unless the person or entity that created the information is no longer available to amend it (ii) if we do not maintain the PHI at issue (iii) if you would not be permitted to inspect and copy the PHI at issue or (iv) if the PHI we maintain about you is accurate and complete. If we deny your request, you may submit a written statement of your disagreement to us, and we will record it with your health information.

Your Right to Access to Your PHI. You have the right to inspect and obtain a copy of your PHI that we maintain in designated record sets. Under certain circumstances, we may deny your request to inspect and copy your PHI. In an instance where you are denied access and have a right to have that determination reviewed, a licensed health care professional chosen by Guardian will review your request and the denial. The person conducting the review will not be the person who denied your request. Guardian promises to comply with the outcome of the review.

How to Contact Us:

If you have any questions about this Notice or need further information about matters covered in this Notice, please call the toll-free number on the back of your Guardian ID card. If you are a broker please call 800-627-4200. All others please contact us at 800-541-7846. You can also write to us with your questions, or to exercise any of your rights, at the address below:

Attention:
Guardian Corporate Privacy Officer
National Operations

Address:
The Guardian Life Insurance Company of America
Group Quality Assurance - Northeast
P.O. Box 981573
El Paso, TX 79998-1573

B998.0055

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

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

CERTIFICATE OF COVERAGE

The Guardian
10 Hudson Yards
New York, New York 10001

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

Group Policy No.	Certificate No.	Effective Date
Issued To		

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

The Guardian Life Insurance Company of America

Michael Prestileo, Senior Vice President

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

All Options

GENERAL PROVISIONS

As used in this booklet:

"Covered person" means an employee 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 B160.0013

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

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

ELIGIBILITY FOR LIFE COVERAGES

B264.0002

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 also ask for *proof* that you're insurable. And you won't be covered until we approve that *proof* in writing.

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

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

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

All Options

When Your Coverage Starts

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

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

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

Sometimes, the effective date shown on the sticker or in the endorsement 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 B180.0066

All Options

Delayed Effective Date For Employee Optional Life Coverage

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

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

CGP-3-DEF-97 B270.0384

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 on the date the *employer* cancels involvement with the group policy. 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.

Some coverages under this *plan* may end at other times for other reasons.

Read this booklet carefully if your coverage ends. You may have the right to continue group benefits after your coverage would otherwise end. And you may have the right to replace group benefits with converted policies. When your insurance under this *plan* ends, you must surrender your certificate.

CGP-3-EC-90-3.0 B190.0004

All Options

Parental Leave Of Absence

If your active *full-time* service ends because you go on parental leave, as described in Sections 181 93 through 181 98 of Chapter 181 of the Minnesota Code, your *employer* must continue your group insurance for the duration of the parental leave. Subject to all of the terms of this *plan.* But your *employer* may require you to pay the full cost of your coverage during such parental leave.

CGP-3-EC-90-4.0 B180.0087

All Options

An Employee's Right To Continue Group Life 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:

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

Continuation Of Life Coverages

Your loss of life coverage may be continued at your *employer's* option. You must contact your *employer* to find out if you may continue this coverage.

If Your Group Insurance Ends

Group insurance may end for you because you cease full-time work due to an approved leave of absence. Such leave of absence must have been granted to allow you to care for a seriously ill spouse, child or parent, or after the birth or adoption of a child, or due to your own serious health condition. If so, your group insurance will be continued at your *employer's* option. You will be required to pay the same share of the premium as before the leave of absence.

When Continuation Ends

Insurance may continue until the earliest of: (a) the date you return to full-time work; (b) the end of a total leave period of 12 weeks in any 12 month period; (c) the date on which your coverage would have ended had you not been on leave; or (d) the end of the period for which the premium has been paid.

CGP-3-EC-90-3.0 B190.0010

All Options

GROUP TERM LIFE INSURANCE SCHEDULE

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

All Options

Employee Optional Contributory Term Life Insurance

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

All Options

Optional Life Election

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

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

All Options

Your Optional Term Life Insurance Amount

Plan A $50,000.00

CGP-3-R-SCH-90 B265.0061

All Options

Reduction of Optional Life Insurance Amount Based on Age

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

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

If an employee is less than age 70 when his or her insurance under this plan starts, the employee's insurance amount is reduced, when he or she reaches age 70, by 60% of the amount which otherwise applies to his or her classification and/or option. But in no case will such reduced amount be less than $1,000.00.

The preceding reduction also applies to an employee's initial insurance amount if his or her insurance starts after he or she reaches age 70 but before he or she reaches age 75.

If an employee is less than age 75 when his or her insurance under this plan starts, the employee's insurance amount is reduced, when he or she reaches age 75, by 75% 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 75 but before he or she reaches age 80.

If an employee is less than age 80 when his or her insurance under this plan starts, the employee's insurance amount is reduced, when he or she reaches age 80, by 85% 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 80.

CGP-3-R-SCH-90 B265.0522

All Options

Proof of Insurability Requirements

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

We require *proof* as follows:

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

All Options

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

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

All Options

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

CGP-3-R-SCH-90 B265.0436

All Options

We require *proof* for amounts of optional term life insurance in excess of $10,000.00, if an *employee*'s scheduled optional term life effective date is after he or she reaches age 70.

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

LIFE INSURANCE

B270.0070

All Options

Your Optional Group Term Life Insurance

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

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

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

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

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

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

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

Assigning Your Life Insurance

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

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

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

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

Payment to a Minor or Incompetent

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

Payment of Funeral or Last Illness Expense

We have the option of paying up to $500.00 of this insurance to any person who incurs expenses for your funeral or last illness.

Settlement Option

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

CGP-3-R-EOPT-96 B273.0480

All Options

Minnesota Continuance of Loss of Life Benefits

Important Notice

This provision applies to any loss of life coverages provided by this *plan.* Continuing the group life benefits under this section does not stop you from converting these benefits when this continuance ends. But, such conversion will be based on any applicable sections of this *plan.* And, you may elect to continue group life benefits under the "Continuance" section in place of this continuance. You should read this *plan,* as well as any related materials, carefully before making an election.

If Your Group Life Benefits End

You may elect to continue your group life benefits under this section if they would otherwise end due to your: (a) voluntary or involuntary termination of employment, except for gross misconduct; (b) lay-off; or (c) reduction in work hours resulting in your loss of membership in an eligible class of employees. The continuance will last up to 18 months, subject to "When This Continuance Ends".

The Employer's Responsibilities

The *employer* must give you written notice of:

(a) your right to continue this *plan's* group life benefits under this section;

(b) the monthly premium you must pay in order to continue such benefits; and

(c) the times and manner in which such monthly payments must be made.

The *employer* must send the written notice by first class certified mail to your last known address within ten days of your termination, lay-off, or reduction of work hours.

The Employer's Liability

The *employer* will be liable for your continued group life benefits under this section to the same extent as, and in place of, us if:

(a) the *employer* fails to notify you of your continuance rights as described above; or

(b) the *employer* fails, after timely receipt of your premium payment, to pay us on your behalf, thereby causing your continued group life benefits to end.

Your Responsibilities

To continue the group life benefits under this section, you must give the *employer* written notice that you elect to continue, and pay the first month's premium. You must do this within 60 days of the later of:

(a) the date the group life benefits would otherwise end; and

(b) the date you receive the written notice of your continuance rights from the *employer.*

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

The monthly premium will not exceed 102% of the amount which would have been charged for the group life benefits had you stayed insured under the group *plan* on a regular basis. It includes any amount which would have been paid by the *employer.*

You waive your continuance rights under this section if you either fail to notify the *employer* of your intent to continue, or you fail to make any required premium payment in a timely manner.

When This Continuance Ends

A covered person's continued group life benefits under this section end on the first of the following:

(a) the date which is 18 months from the date the group life benefits would otherwise end;

(b) the date he or she becomes covered under another group life insurance plan;

(c) the date the *employer's* involvement under the group policy ends; or

(d) the end of the period for which the last premium payment is made.

Continuance

Important Restrictions

You may not elect to continue your optional term life insurance under this section; unless you have been covered by this group *plan,* or the one it replaced, for such insurance for at least three consecutive months prior to the date your coverage under this *plan* would otherwise end. When you elect to continue insurance under this section, no further increases or decreases in your amount of insurance are permitted, except for any scheduled reductions based on age. And, this continued insurance does not include any extended life or waiver of premium benefits.

Continuance Of Optional Term Life Insurance

You may elect to continue your optional term life insurance under this section, subject to the following terms and conditions.

You may continue your insurance if coverage under this *plan* would otherwise end for any reason other than: (a) termination of employment due to sickness or injury; (b) the end of your Minnesota continuance of loss of life benefits; (c) failure to pay any required premium; or (d) the end of this group *plan.*

You may not continue your insurance if you have reached your 70th birthday on the day your insurance under this *plan* would otherwise end.

How To Continue

To continue, you must apply to us in writing and pay the required premium. You have 31 days from the date coverage would otherwise end under this *plan* to do this. We won't ask for proof that you are insurable.

The premium for this continued insurance may not be the same as the premium for active employees. It will be based on: (a) your rate class under this *plan* on the date insurance would otherwise end; and (b) your age bracket as specified in the Optional Life Continuance Premium Notice.

When This Continuance Ends

Your continued optional term life insurance under this section ends on the earliest of the following dates:

(a) the date the group policy is terminated by us;

(b) the date you fail to pay any required premium;

(c) the date you die; or

(d) the date you reach age 70.

If your continued optional term life insurance ends, we will return any unearned portion of the premium paid by you on a pro-rata basis.

You may be able to convert optional term life insurance to individual insurance policies if continued coverage ends. Read the conversion privilege sections of this *plan* for details.

All Options

Information About Conversion and Continuance

No covered person is allowed to convert his or her insurance, and continue his or her insurance at the same time. If a situation arises in which a covered person would be eligible to both convert and continue, he or she may only exercise one of these privileges. A covered person may never be insured under both a converted policy and this *plan* at the same time. But, a covered person may elect to convert his or her insurance after his or her continued insurance ends.

You are not allowed to continue your insurance under more than one continuance section at the same time. If a situation arises in which you would be eligible to continue under more than one section, you may only elect one of these privileges. A covered person may never be insured under more than one continuance section at the same time. And, if you have elected to continue insurance under one continuance section, you may not elect to continue insurance under any other section when that continuance ends.

The covered person should read this *plan,* as well as any related materials, carefully before making an election.

CGP-3-R-LCI-98-MN B190.0016

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.

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 Employer's Involvement With The Group Policy Ends, The Group Policy Terminates Or Group Life Insurance Is Dropped

Your group life insurance also ends if: (a) this group plan ends; (b) the employer's involvement with the group policy ends; or (c) 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 are not disabled, as defined in the section labeled "Extended Life Benefit With Waiver of Premium" when this coverage ends, you can convert to a permanent life insurance policy. You can convert the full amount for which you were covered under this plan.

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.

If Continued Insurance Ends

When your continued group life insurance ends for any reason, other than non-payment of premiums, as described in this plan's "Minnesota Continuance and Loss of Life Benefits" or "Continuance" sections, you can also convert.

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.

Your Accelerated Life Benefit

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

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

Accelerated Life Benefit

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

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

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

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

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

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

Maximum Benefit Amount

The amount of the Accelerated Life Benefit for which you may apply is based on the amount of group term life insurance for which you are insured on the day before you apply for the benefit. The minimum benefit amount is the lesser of: (a) $10,000.00; or (b) 50% of the inforce amount. The maximum benefit amount is the lesser of: (a) $250,000.00; or (b) 50% of the inforce amount.

Discount

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

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

Processing Fee

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

Payment of An Accelerated Life Benefit

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

How And When To Apply

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

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

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

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

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

If You Have Assigned Your Group Term Life Insurance

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

All Options

If You Are Incompetent

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

Your Remaining Group Term Life Insurance

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

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

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

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

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

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

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

All Options

Your Extended Life Benefit With Waiver Of Premium

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

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

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

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

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

How And When To Apply

To apply for this extension, you must submit satisfactory written medical proof of your total disability 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: (a) this group plan terminates; or (b) the employer's involvement with the group policy terminates; and (c) you are totally disabled and eligible, but not yet approved, for this extended benefit; then you must: (i) convert to an individual permanent or term policy; and (ii) 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.

All Options

When This Extension Ends

Your extension will end on the earliest of:

(a) the date you are no longer disabled;

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

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

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

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

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

If You Die While Covered By This Extension

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

Proof Of Death

We'll pay as soon as we receive

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

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

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

All Options

GLOSSARY

This Glossary defines the italicized terms appearing in your booklet.

CGP-3-GLOSS-90 B900.0118

All Options

Eligibility Date for dependent coverage is the earliest date on which: (a) you have initial dependents; and (b) are eligible for dependent coverage.

CGP-3-GLOSS-90 B900.0003

All Options

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

CGP-3-GLOSS-90 B750.0015

All Options

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. This term will also include an employee who has become insured and who has elected to continue his or her insurance as provided in this plan after: (a) he or she ceases to work for the employer; (b) he or she ceases to be a member in the classes of employees eligible for insurance; (c) the employer cancels involvement with the group policy; or (d) this rider is amended to discontinue the eligibility of a class of employees to which he or she belongs.

CGP-3-GLOSS-90 B190.0020

All Options

Employer means EMPLOYER SOLUTIONS GROUP .

CGP-3-GLOSS-90 B900.0051

All Options

Enrollment Period with respect to dependent coverage, means the 31 day period which starts on the date that you first become eligible for dependent coverage.

CGP-3-GLOSS-90 B900.0004

All Options

Full-time means the *employee* regularly works at least the number of hours in the normal work week set by the *employer* (but not less than 25 hours per week), at his *employer's* place of business.

CGP-3-GLOSS.1 B750.0230

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

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

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

CGP-3-GLOSS-90 B900.0039

All Options

Proof or Proof of Insurability means an application for insurance showing that a person is insurable.

CGP-3-GLOSS-90 B900.0010

CERTIFICATE AMENDMENT

This rider amends this plan's Optional Term Life Insurance provisions by the addition of the following:

PORTABILITY PRIVILEGE

Applicability

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

Important Restrictions

You may not elect a portable certificate of coverage unless we have offered to continue your coverage under this group plan.

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

Portability of Optional Group Term Life Insurance

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

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

You may not port your coverage, if you: (a) have reached your 70th birthday on the day coverage under this plan ends; or (b) are eligible for this plan's Optional Group Term Life Insurance Extended Life Benefit. However, if: (a) you have been approved for this plan's Optional Group Term Life Insurance Extended Life Benefit; and (b) such Extended Life Benefit ends because this group plan terminates; then you may elect a portable certificate of coverage.

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

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

The Portable Certificate of Coverage

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

The premium for the portable certificate of coverage will be based on: (a) your age bracket as shown in the Optional Life Portability Coverage Premium Notice.

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

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

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

The Guardian Life Insurance Company of America

Michael Prestileo, Senior Vice President

CGP-3-A-LP-MN-15 B985.0067

CERTIFICATE AMENDMENT

This rider amends this plan's Optional Term Life Insurance provisions by the addition of the following:

Information About Conversion and Portability

No covered person is allowed to convert his or her coverage or elect a portable certificate of coverage unless the Policyholder has offered to continue their group coverage under this group plan.

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

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

The Guardian Life Insurance Company of America

Michael Prestileo, Senior Vice President

CGP-3-A-LPN-MN-15 B985.0072

All Options

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

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

Your group term life insurance benefits may be covered by the Employee Retirement Income Security Act of 1974 (ERISA). If so, you are entitled to certain rights and protections under ERISA.

ERISA provides that all plan participants shall be entitled to:

Receive Information about Your Plan and Benefits

- Examine, without charge, at the plan administrator's office and at other specified locations, such as worksites and union halls, all documents governing the plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the plan with the U. S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.
- Obtain, upon written request to the plan administrator, copies of documents governing the operation of the plan, including insurance contracts, collective bargaining agreements and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The administrator may make a reasonable charge for the copies.
- Receive a summary of the plan's annual financial report. The plan administrator is required by law to furnish each participant with a copy of this summary annual report.

Prudent Actions by Plan Fiduciaries

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

Enforcement of Your Rights

If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules (see Claims Procedures below).

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

Assistance with Questions

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

Life Insurance Claims Procedure

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

Guardian is the Claims Fiduciary with responsibility to apply 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 for making decisions, including making a reasonable determination about eligibility for benefits and coverage under those documents. Guardian has the right to secure independent professional healthcare advice and to require such other evidence as needed to decide your claim.

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

Definitions

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

Timing for Initial Benefit Determination of Life Insurance Claims

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

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

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

Adverse Benefit Determination of Life Insurance Claims

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

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

B752.0075

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.

B752.0076

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.

B752.0077

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

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

CERTIFICATE OF COVERAGE

The Guardian
10 Hudson Yards
New York, New York 10001

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

Group Policy No.	Certificate No.	Effective Date
Issued To		

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

The Guardian Life Insurance Company of America

Michael Prestileo, Senior Vice President

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

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 25 hours per week), at:

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

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

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

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

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

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.

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

CGP-3-EC-90-1.0 B329.0153

All Options

When Your Coverage Starts

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

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

But you must be fully capable of performing the major duties of your regular occupation for your *employer* on a full-time basis at 12:01AM Standard Time for your place of residence on the scheduled effective date or dates. And you must have met all of the applicable conditions explained above, and any applicable waiting period. If you are not fully capable of performing the major duties of your regular occupation on any date part of your insurance is scheduled to start we will postpone that part of your coverage. We will postpone that part of your coverage until the date you are so capable and are working your regular number of hours for one full day, with the expectation that you could do so for one full week.

Sometimes, your effective date is not a regularly scheduled work day. If the scheduled effective date falls: on a holiday; on a vacation day; on a non-scheduled work day; 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.

CGP-3-EC-90-2.0 B329.1152

All Options

Delayed Effective Date For Disability Coverage

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

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

CGP-3-DEF-97 B329.0103

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

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

Continuation of Coverage During Disability

If you are disabled, as defined by this *plan* when your active *full-time* service ends, coverage remains in force during: (a) the elimination period, subject to premium payment, if: (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.* 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.

All Options

An Employee's Right To Continue Group Short 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.

Continuation of Disability Coverage

Short 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 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* . . . . . 13 weeks

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

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

CGP-3-STD07-HL B340.0091

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

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

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

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

Waiver of Premium

We waive your premiums for this insurance while you are entitled to receive a *weekly 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 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.*

But, it may be less than that shown due to: (a) the date you were first treated for the cause of your *disability;* and (b) the length of time you have been insured by this *plan.* See the section entitled "Pre-Existing Conditions" and the Schedule of Benefits.

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

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

CGP-3-STD07-2.0 B340.0010

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.

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 B340.0014

All Options

Redetermination

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

CGP-3-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.

CGP-3-STD07-4.2 B340.0022

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.

CGP-3-STD07-4.3 B340.0105

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.*

CGP-3-STD07-5.0 B340.0074

All Options

Minimum Payment

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

CGP-3-STD07-5.1 B340.0076

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 3 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.*

For any *disability:* (a) caused by; (b) contributed to by; or (c) resulting from; a pre-existing condition, we limit the *maximum payment period* to 2 weeks; 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; (b) contributed to by; or (c) resulting from; a pre-existing condition may begin after: (a) a change which provides for an increase in the benefits payable by this *plan;* or (b) a change in your benefit election which increases the benefit payable by this *plan.* In this case, your benefit will be limited to the amount that would have been payable had the change not taken place. But, this limit does not apply if your *disability* starts after 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.*

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 weekly benefit* under this *plan* if: (a) it is more than the maximum weekly 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 weekly 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.

CGP-3-STD07-6.2 B340.0053

All Options

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

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

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

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

(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 or contributed to by 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.*

CGP-3-STD07-7.0 B340.1253

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

Authority

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

Notice

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

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

Proof of Loss

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

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

(a) The date *disability* began;

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

(c) The cause of *disability;*

(d) The extent of *disability,* including limitations and restrictions preventing you from performing 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 B340.1495

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 all other causes, while you are insured by this *plan.* We will cover a *disability* caused by an *injury* when the *disability* starts within 90 days of the date of such *injury.*

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.*

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

All Options

GLOSSARY

This Glossary defines the italicized terms appearing in your booklet.

CGP-3-GLOSS-90 B900.0118

All Options

Eligibility Date for dependent coverage is the earliest date on which: (a) you have initial dependents; and (b) are eligible for dependent coverage.

CGP-3-GLOSS-90 B900.0003

All Options

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

CGP-3-GLOSS-90 B750.0015

All Options

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 EMPLOYER SOLUTIONS GROUP .

CGP-3-GLOSS-90 B900.0051

All Options

Enrollment Period with respect to dependent coverage, means the 31 day period which starts on the date that you first become eligible for dependent coverage.

CGP-3-GLOSS-90 B900.0004

All Options

Full-time means the *employee* regularly works at least the number of hours in the normal work week set by the *employer* (but not less than 25 hours per week), at his *employer's* place of business.

CGP-3-GLOSS.1 B750.0230

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

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

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

CGP-3-GLOSS-90 B900.0039

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

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

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

Your group Short Term and/or Long Term Disability Income benefits may be covered by the Employee Retirement Income Security Act of 1974 (ERISA). If so, you are entitled to certain rights and protections under ERISA.

ERISA provides that all plan participants shall be entitled to:

Receive Information about Your Plan and Benefits

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

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

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

Prudent Actions by Plan Fiduciaries

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

Enforcement of Your Rights

If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules (see Claims Procedures below).

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

Assistance with Questions

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

Disability Benefits Claims Procedure

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

Guardian is the Claims Fiduciary with the responsibility to apply 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 for making decisions, including making a reasonable determination about eligibility for benefits and coverage under those documents. Guardian has the right to secure independent professional healthcare advice and to require such other evidence as needed to decide your claim.

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

Definitions

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

Timing for Initial Benefit Determination

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

Guardian will provide a benefit determination not later than 45 days from the date of receipt of a claim. This period may be extended by up to 30 days if Guardian determines that an extension is necessary due to matters beyond the control of the plan, and so notifies the claimant before the end of the initial 45-day period. Such notification will include the reason for the extension and a date by which the determination will be made. If prior to the end of the 30-day period Guardian determines that an additional extension is necessary due to matters beyond the control of the plan, and so notifies the claimant, the time period for making a benefit determination may be extended for up to an additional period of up to 30 days. Such notification will include the special circumstances requiring the extension and a date by which the final determination will be made.

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

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

B752.0146

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.

B752.0147

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

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

Group Policy No.	Certificate No.	Effective Date
Issued To		

This certificate of coverage replaces any certificate of coverage previously issued to the employee under the above policy or under any other policy providing similar or identical benefits issued to the policyholder by Guardian.

Michael Prestileo, Senior Vice President

B808.0005

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GENERAL PROVISIONS

Incontestability

This plan shall be incontestable after two years from its policy date, except for non-payment of premiums.

If this *plan* replaces the group plan of another insurer, we may rescind this plan based on misrepresentations made in your planholder's or your signed application for up to two years from this *plan's* Policy Date.

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

No statement made by you or a *covered person* shall be used in any contest unless a copy of the instrument containing the statement is or has been furnished to you or the *covered person.*

Examination

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. We will pay for all such examinations.

Accident and Health Claims Provisions

Your right to make a claim for any Accidental 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.

Proof Of Loss: We will furnish you with forms For filing proof of the loss within 15 days of receipt of notice. But, if we do not furnish the forms on time, we will accept a Written description and adequate documentation of the *injury* or sickness that is the basis of the claims as proof of loss. Your must detail the nature and extent of the loss for which the claims is being made. Your must send Us written proof within 90 days of the loss.

If this *plan* provides weekly loss of time benefits, 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 replacement benefits, 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 of loss within 90 days of the loss.

Late Notice OR Proof: We will not void or reduce your claims if you cannot send us notice and proof of loss within the required time. But, you must send us notice and proof of loss as soon as reasonably possible.

Payment Of Benefits: If this *plan* provides benefits for loss of time, we'll pay them once every 30 days for as long as we're liable, provided you submit periodic written proof of loss as stated above. We will pay all other accident and health benefits to which you are entitled as soon as we receive written proof of loss.

We pay all accident and health benefits to you, if you are living. If you are not living, we have the right to pay all accidental and health benefits to one of the following: (a) your estate; (b) your spouse; (c) your parents; (d) your children; (e) your bother and sisters; and (f) any unpaid provider of health care services.

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

Limitations Of Actions: You cannot bring a legal action against this *plan* until 60 days from the date you file proof of loss. And, you cannot bring legal action against the *plan* after three years from the date you file proof of loss.

Workers' Compensation: The disability benefits provided by the *plan* are not in place of, and do not affect requirements for coverage by, Workers' Compensation.

Note

Please examine this *plan* carefully. If any error or omission is found, send full particulars with the number of the *plan* to Guardian.

B808.0011

All Options

SCHEDULE OF BENEFITS

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.

B808.0012

All Options

Gross Monthly Benefit 60% of your prior monthly earnings, rounded to the nearest $1.00, if not already a multiple thereof, to a maximum of $5,000.00.

You must notify your employer of your election and pay the required premium.

Integration We integrate your *Gross Monthly 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.

B808.0480

All Options

Own Occupation Period The first 24 months of benefit payments from this plan.

B808.0018

All Options

Elimination Period

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

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

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

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

Age when disability starts	Maximum payment period
Under age 60	To age 67
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

B808.0022

LONG TERM DISABILITY INCOME INSURANCE BENEFIT PROVISIONS

How Payments Start

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

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

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

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

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

Waiver of Premium

We waive your premiums for this insurance 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 any 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.*

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

B808.0446

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 6 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.

B808.0027

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.

B808.0675

All Options

Redetermination

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

B808.0030

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; (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.
- Disability benefits from any individual policy; but only to the extent that such income plus the amount of your *gross monthly benefit* is more than 100% of your *insured earnings.*
- Disability income from any other plan that you are eligible to receive: (1) because you are employed by, or associated with: (a) the *plan sponsor;* or (b) the *employer;* or (2) because you are a member of any: (a) union; (b) fraternal benefit society; (c) association; or (d) other like organization; but only to the extent that such income plus the amount of your *gross monthly benefit* is more than 100% of your *insured 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 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 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.

- 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.

B808.0717

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

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

We will assist you in applying for other income benefits.

B808.0033

All Options

Adjustment of Monthly Benefit for Disability Earnings

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.*

B808.0093

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 $50.00.

B808.0631

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;* or (b) drug or alcohol abuse. 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;* or (b) drug or alcohol abuse; is 24 months. This is a combined maximum for all such conditions and all periods of *disability.*

No benefits will be paid for *disability* due to a *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.*

B808.0036

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 six 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 the your benefit election that increases the benefit payable by this *plan.*

No benefits are payable for *disability:* (a) caused by; (b) contributed to by; or (c) resulting from; a pre-existing condition; unless the *disability* starts after you complete at least one full day of *active work* after the date you are insured under this *plan* for 24 months in a row.

Your *disability:* (a) caused by; (b) contributed to by; or (c) resulting from; a pre-existing condition may begin after: (a) a change which provides for an increase in the benefits payable by this *plan;* or (b) a change in your benefit election which increases the benefit payable by this *plan.* In this case, your benefit will be limited to the amount that would have been payable had the change not taken place. But, this limit does not apply if your *disability* starts after you complete at least one full day of *active work* after the change has been in force for 24 months in a row.

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

B808.0038

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.

B808.0039

Exclusions

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

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

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

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

(d) you being engaged in an illegal occupation;

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

(f) 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 or contributed to by 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;

(g) intentional self-inflicted injuries.

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

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

(2) which starts before you are insured by this plan;

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

B808.0635

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 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 you return to *gainful work.* If needed, we may ask for more medical or vocational information.

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

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

(a) vocational assessment of your work potential;

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

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

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

(e) retraining; 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 *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 benefit 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) $300 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.*

B808.0636

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.

B808.0044

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: (1) stay-at work agendas; and (2) 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.

B808.0045

Claim Provisions

Administration

We as a part of our routine operations apply the terms of this *plan* for making decisions, including making determination regarding eligibility, receipt of benefits and claims, or explaining our administrative policies, procedures, and processes.

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
P.O. Box 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 once, twice 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.

B808.0789

ADDITIONAL CLAIMS PROCEDURES ASSOCIATED WITH ERISA

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

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

In addition to the basic claim procedure explained in the *plan,* 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).

As used in this section, the term **Adverse Determination** means any denial, reduction or termination of a benefit or failure to provide or make payment, in whole or in part, for a benefit.

Timing For Initial Benefit Determination

Guardian will provide a benefit determination not later than 45 days after 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 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 an additional period of up to 30 days. Such notification will include 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 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 not later than 45 days after receipt of the claim.

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.

B808.0049

All Options

Adverse 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 policy 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 determination;
- identification and description of any specific internal rule, guideline or protocol that was relied upon in making an adverse determination, or a statement that a copy of such information will be provided to the claimant free of charge upon request; and
- in the case of an adverse determination based on lack of necessity or appropriateness for a given condition, 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 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 the claimant 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 the 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 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 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.

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.

B808.0050

Definitions

If they are used in this certificate, the terms listed below generally have the meanings shown below. However, in specific sections a term shown below may have a different meaning. In that case, the term is defined in the section in which it is used.

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.

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 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.

Cognitive Impairment or Cognitively Impaired

A decline or loss in intellectual aptitude. Such loss may result from: (a) *injury;* (b) *sickness;* (c) Alzheimer's disease, or (d) like 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) judgment as it relates to awareness of safety. Cognitive impairment does not include decline or loss due to a *mental illness.*

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.

B808.0176

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:

(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.*

B808.0056

All Options

Plan A

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

Doctor Any medical practitioner we are required by law to recognize. He or she must: (a) be properly licensed or certified by the laws of the state where he or she practices; and (b) provide services that are within the lawful scope of his or her practice.

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.*

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

(a) not able to perform two 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.

Financial Lending Institution means an organization duly chartered and licensed by the state or federal government and regularly engaged in the lending of funds.

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

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

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

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

All Options

Insured Earnings Only your earnings from your 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" section 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, the 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 Return, 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.

If You 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 the 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.

If Your 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 Others:

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

B808.0642

All Options

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

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

Mental Illness Means any mental disorder, regardless of cause, listed in the Diagnostic and Statistical Manual of Mental Disorders (DSM) currently in use by the American Psychiatric Association (APA). If the APA stops publishing the DSM, we have the right to use some other similar standard. A *mental illness* may be: (a) caused by; (b) contributed to by; or (c) result in; physical, biological or chemical factors or symptoms. For purposes of this *plan, mental illness* does not include: (a) irreversible dementia caused by Alzheimer's disease, stroke, trauma or viral infection; or (b) any other condition not typically treated by a psychiatrist, clinical psychologist or other qualified mental health practitioner with psychotherapy or psychotropic drugs.

Monthly Benefit This *plan's gross monthly benefit* reduced by other income. If you are working while *disabled,* your *monthly benefit* will be further reduced based on the amount of your *disability earnings.*

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.

Own Occupation For a doctor, means the medical specialty or sub-specialty practiced by the doctor right before the start of disability, provided: (a) he or she is certified in such specialty or sub-specialty by the American Board of Medical Specialties (ABMS); (b) he or she carries malpractice insurance covering the full range of duties performed in this specialty or sub-specialty; and (c) for the 24 months immediately prior to disability, at least 60% of his or her insured earnings was professional service fee income attributable to the practice of this specialty or sub-specialty.

If you are not a doctor, 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.

B808.0066

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.

B808.0068

SUPPLEMENTAL BENEFIT RIDERS

B808.0070

All Options

CERTIFICATE AMENDMENT

Income Recovery Benefit

This rider amends the group long term disability *plan* to provide an Income Recovery Benefit.

Definitions of terms are defined in the plan.

When and How the Income Recovery Benefit Will be Paid:

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;*

(b) if this plan has already paid benefits for the own occupation period, able to perform the major duties of any gainful occupation;

(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.

When and How the Income Recovery Benefit Will End:

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 stops 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.

The Guardian Life Insurance Company of America

Michael Prestileo, Senior Vice President

CGP-3-A-LTD07-MN-IRB B808.0617

All Options

THE GUARDIAN LIFE INSURANCE COMPANY OF AMERICA
A Mutual Life Insurance Company
10 Hudson Yards, New York, New York 10001

Incorporated 1860 By The Laws of The State of New York

Amendment to Group Certificate CGP-3-LTD-10-MN

(To be attached to and made a part of the Certificate)

The following provisions are added to form number CGP-3-LTD-10-MN, Certificate of Coverage, before the Long Term Disability Income Insurance Benefit Provisions:

ELIGIBILITY FOR LONG TERM DISABILITY INSURANCE

EMPLOYEE COVERAGE

Eligible Employees

Subject to the Conditions of Eligibility set forth below, and to all of the other conditions of the plan, you must be an active full-time employee. And you must belong to a class of employees covered by this plan.

Conditions of Eligibility: 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 the employer (but not less than 25 hours per week), at:

  (i) your employer's place of business;

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

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

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

If you must pay all or part of the cost of your 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 will ask for proof that you are insurable. And you won't be covered until we approve that proof in writing.

When Employee Coverage Starts

Subject to all of this plan's conditions of eligibility, your Disability coverage under this plan starts on the effective date of this plan.

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

Sometimes, a scheduled effective date is not a regularly scheduled work day. If the scheduled effective date falls: on a holiday; on a vacation day; on a non-scheduled work day; 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.

Whether you must pay all or part of the cost of your coverage, you must elect to enroll and agree to make the required payments. If you do this on or before the eligibility date, or within 31 days of your eligibility date, coverage is scheduled to start on your eligibility date. However, if you elect to enroll and agree to make the required payments more than 31 days after your eligibility date, your coverage won't start until you send us proof that you are insurable. Once we've approved it, your coverage is scheduled to start on the effective date shown in the endorsement section of your application.

Any part of your coverage which is subject to proof that you are insurable won't start unless you send this proof to us, and we approve it in writing. Once we have approved it, that part of your coverage is scheduled to start on the effective date shown in the endorsement section of your application.

When Employee Coverage Ends

Your long term disability insurance under this plan will end on the first of the following dates:

- the date your active full-time service ends.
- the date you stop being an eligible employee under this plan.
- the date you are no longer working in the United States or its territories, unless you are on a temporary assignment: (1) not exceeding one year in a country or region that is not under a travel warning issued by the US Department of State; or (2) for which we have agreed, in writing, to provide coverage.
- the date the group plan ends, or is discontinued for a class of employees to which you belong.
- the last day of the period for which required payments are made for you.

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.

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

The Guardian Life Insurance Company of America

Michael Prestileo, Senior Vice President

PLEASE RETAIN THIS COPY FOR YOUR RECORDS

CGP-1A B808.0695

CERTIFICATE AMENDMENT

This amendment is effective January 1, 2016 or your first renewal date following thereafter.

This plan's Authority provision in the Claim Provisions section is replaced by the Administration provision as follows:

Administration: We, as part of our routine operations, apply the terms of this Plan for making decisions, including making determinations regarding eligibility, receipt of benefits and claims, or explaining our administrative policies, procedures, and processes. We will notify you of the final determination of any review, although it may be modified or reversed by a court or regulatory agency with appropriate jurisdiction.

The Guardian Life Insurance Company of America

Michael Prestileo, Senior Vice President

CGP-3-LTD15-11.0-MN B531.0351

CERTIFICATE RIDER

(To be attached to certificates issued to employees)

This rider amends the Long Term Disability Income Insurance provisions of your certificate as follows:

1. The Long Term Disability Income Insurance Rehabilitation and Case Management provision is modified to provide that:

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.* We have the right to suspend or end your *monthly benefit* if you do not accept it.

The *rehabilitation program* will start when a written *rehabilitation program* 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 the *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 *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 benefit 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 may repay any enhanced benefits paid.

2. The Long Term Disability Income Insurance Dependent Care Expenses provision is modified to provide that:

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; 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 expenses 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.*

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

The Guardian Life Insurance Company of America

Michael Prestileo, Senior Vice President

CGP-3-A-LTD-FCE-12 B808.0705

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www.guardianlife.com

You can access helpful, secure information about your Guardian benefits online 24 hours a day, 7 days a week.

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