YOUR GROUP INSURANCE
PLAN BENEFITS

TUSCULUM COLLEGE
CLASS 0002
AD&D, OPTIONAL LIFE, LTD, LIFE, VISION, VOLUNTARY AD&D
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.
This Booklet Includes All Benefits For Which You Are Eligible.

You are covered for any benefits provided to you by the policyholder at no cost.

But if you are required to pay all or part of the cost of insurance you will only be covered for those benefits you elected in a manner and mode acceptable to Guardian such as an enrollment form and for which premium has been received by Guardian.

"Please Read This Document Carefully".
CERTIFICATE OF COVERAGE

The Guardian
7 Hanover Square
New York, New York 10004

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.

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<th>Group Policy No.</th>
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This CERTIFICATE OF COVERAGE replaces any CERTIFICATE OF COVERAGE previously issued under the above Plan or under any other Plan providing similar or identical benefits issued to the Planholder by The Guardian.

The Guardian Life Insurance Company of America

Stuart Shaw
Vice President, Risk Mgt. & Chief Actuary
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All Options

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.


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

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

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.
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.

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.

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.
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 Continuées

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.

**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".

**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.
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.

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.
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.

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All Options

ELIGIBILITY FOR LIFE AND DISMEMBERMENT COVERAGE

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, or working outside the United States for a United States based employer in a country or region approved by us.

(b) be regularly working at least the number of hours in the normal work week set by your employer (but not less than 35 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.

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. 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.

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

Employee Coverage
All Options

Family Status Change

You may request an increase in your optional term life insurance amount, a decrease to your optional term life insurance amount, or the addition of voluntary term life for which you were not previously insured, if a change in family status has occurred. You must request the change to your optional term life insurance in writing within 31 days after the date of the family status change as described below.

Family status change will include one or more of the following: (1) marriage or divorce; (2) death of a spouse or child; (3) birth or adoption of a child; (4) your spouse’s termination of employment or a change in your spouse’s employment that results in the loss of group coverage. The term "marriage" may also refer to civil unions and domestic partnerships, as recognized by the jurisdiction in which you reside.

Proof of insurability is not required for the change to optional term life insurance due to family status change as long as the change to your optional term life insurance does not exceed the guarantee issue amount shown in the Schedule of Benefits. Proof of insurability will be required on changes that exceed the guarantee issue amount and if proof was previously submitted and declined.

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All Options

When Your Coverage Starts

Employee benefits that don’t require proof that you are insurable are scheduled to start on the effective date shown on the sticker attached to the inside front cover of this booklet.
Employee benefits that require such proof won’t start until you send us the proof and we approve it in writing. Once we have approved it, the benefits are scheduled to start on the effective date shown in the endorsement section of your application. A copy of the approved application is furnished to you.

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

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

All Options

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.

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

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

All Options

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

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

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

When Continuation Ends
Coverage may continue until the earliest of the following:

- The date you return to active work.
- In the case of a leave granted to you to care for a covered servicemember: The end of a total leave period of 26 weeks in one 12 month period. This 26 week total leave period applies to all leaves granted to you under this section for all reasons. If you take an additional leave of absence in a subsequent 12 month period, continued coverage will cease at the end of a total leave period of 12 weeks.
In any other case: The end of a total leave period of 12 weeks in any 12 month period.

The date on which your Employer’s Plan is terminated or you are no longer eligible for coverage under this Plan.

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

Definitions

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

- **Active Duty**: This term means duty under a call or order to active duty in the Armed Forces of the United States.

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

- **Covered Servicemember**: This term means a member of the Armed Forces, including a member of the National Guard or Reserves, who for a serious injury or illness: (a), is undergoing medical treatment, recuperation, or therapy; (b) is otherwise in outpatient status; or (c) is otherwise on the temporary disability retired list.

- **Next Of Kin**: This term means the nearest blood relative of the employee.

- **Outpatient Status**: This term means, with respect to a covered servicemember, that he or she is assigned to: (a) a military medical treatment facility as an outpatient; or (b) a unit established for the purpose of providing command and control of members of the Armed Forces receiving medical care as outpatients.

- **Serious Injury Or Illness**: This term means, in the case of a covered servicemember, an injury or illness incurred by him or her in line of duty on active duty in the Armed Forces that may render him or her medically unfit to perform the duties of his or her office, grade, rank, or rating.

**Dependent Life and Accidental Death and Dismemberment Coverage**
Dependent Life and Accidental Death and Dismemberment Coverage (Cont.)

All Options
CGP-3-DEP-90-1.0 B264.0639

Dependent Coverage

All Options

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

CGP-3-DEP-90-3.0 B264.0579

All Options

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

Dependents Not Eligible
We exclude any dependent who is on active duty in any armed force.

CGP-3-DEP-90-3.0 B264.0587

All Options

Proof Of Insurability
We require proof that a dependent is insurable, if you: (a) enroll a dependent and agree to make the required payments after the end of the enrollment period; (b) in the case of a newly acquired dependent, other than the first newborn child, have other eligible dependents who you have not elected to enroll; or (c) in the case of a newly acquired dependent, have other eligible dependents whose coverage previously ended because you failed to make the required contributions, or otherwise chose to end such coverage.

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

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

CGP-3-DEP-90-5.0 B200.0288
All Options

When Dependent Coverage Starts

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

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

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

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

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

A newly acquired dependent will be covered for those dependent benefits not subject to proof of insurability from the date the newly acquired dependent is first eligible, if you notify us and agree to make any additional payments within 31 days after the date the dependent becomes eligible. If you do this more than 31 days after the date the dependent becomes eligible, a newly acquired dependent will be covered from the date you notify us and agree to make any additional payments.

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

CGP-3-DEP-90-6.0

All Options

Exception

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

CGP-3-DEP-90-7.0
All Options

**When Dependent Coverage Ends**

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

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

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

Read this plan carefully if dependent coverage ends for any reason. Dependents may have the right to continue certain group benefits for a limited time. And they may have the right to replace certain group benefits with converted policies.
Employee Basic Term Life Insurance

<table>
<thead>
<tr>
<th>CGP-3-R-SCH-90</th>
<th>B265.0003</th>
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Your Basic Term Life Insurance Amount

<table>
<thead>
<tr>
<th>CGP-3-R-SCH-90</th>
<th>B265.0011</th>
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</thead>
</table>

Reduction of Basic Life Insurance Amount Based on Age

If an employee is less than age 65 when his or her insurance under this plan starts, his or her insurance amount is reduced, on the date he or she reaches age 65, by 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.
Employee Basic Term Life Insurance (Cont.)

All Options

Limitations For Future Entrants

However, regardless of any of the above reductions, we limit the amount of insurance for which you are eligible if your insurance under this plan starts both: (a) after this plan’s effective date; and (b) after you reach age 70.

If you provide us with proof of insurability, and we approve it in writing, the amount of your insurance will be 50% of the amount which otherwise applies to your classification and/or option. But in no event will this reduced amount be less than $10,000.00.

If we do not approve the proof, your insurance amount will be $10,000.00.

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

All Options

Your Basic AD&D Insurance Amount

Insurance Amount ......................................................... $20,000.00

Spousal Education and Retraining Benefit

Lifetime Maximum Benefit

$20,000

Maximum Number Of Benefit Payments

Full-Time Post Secondary Education .................................................. 8
Part-Time Post Secondary Education .................................................. 4

Dependent Child Education Benefit

Lifetime Maximum Benefit

$20,000.00 per eligible dependent

Maximum Number Of Benefit Payments

8 per lifetime per eligible dependent

Maximum Benefit Period

6 years from the date the first education benefit is made; per eligible dependent.
All Options

Reduction of Basic AD&D Amount Based on Age

If an employee is less than age 65 when his or her insurance under this plan starts, his or her insurance amount is reduced, on the date he or she reaches age 65, by 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.

Limitations For Future Entrants

However, regardless of any of the above reductions, we limit the amount of insurance for which you are eligible if your insurance under this plan starts both: (a) after this plan’s effective date; and (b) after you reach age 70.

If you provide us with proof of insurability, and we approve it in writing, the amount of your insurance will be 50% of the amount which otherwise applies to your classification and/or option. But in no event will this reduced amount be less than $10,000.00.

If we do not approve the proof, your insurance amount will be $10,000.00.

Employee Optional Contributory Term Life Insurance

All Options
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

All Options

Your Optional Term Life Insurance Amount

Plan A
You may elect amounts of optional term life insurance in increments of $10,000.00, but your amount may not be less than $10,000.00 and may not exceed $300,000.00.

CGP-3-R-SCH-90

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.

CGP-3-R-SCH-90
Employee Optional Contributory Term Life Insurance (Cont.)

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

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

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 for amounts of optional term life insurance in excess of $150,000.00.

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

All Options

We require proof for amounts of optional term life insurance in excess of $50,000.00, if an employee’s scheduled optional term life effective date is after he or she reaches age 65.

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

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

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

All Options

Your Voluntary AD&D Insurance Amount Plan A

You may elect amounts of voluntary AD&D insurance in increments of $10,000.00, but your amount may not be less than $10,000.00 and may not exceed $300,000.00.

CGP-3-R-SCH-90

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.
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

Dependent Optional Term Life Insurance

Dependent Optional Life Election

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

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

All Options

Your Optional Dependent Spouse Term Life Insurance Amount

Plan A

You may elect amounts of optional dependent spouse term life insurance in increments of $5,000.00, but the amount may not be less than $5,000.00 and may not exceed $150,000.00.

CGP-3-R-SCH-90  B265.0505
### Dependent Optional Term Life Insurance (Cont.)

#### All Options

**Your Optional Dependent Child Insurance Amount**

**Plan A**

<table>
<thead>
<tr>
<th>Child’s Age At Death</th>
<th>Benefit Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>At least 14 days but less than 6 months</td>
<td>$ 10,000.00</td>
</tr>
<tr>
<td>At least 6 months but less than 26 years</td>
<td>$ 10,000.00</td>
</tr>
<tr>
<td>At least 26 years but less than 26 years if a full-time student</td>
<td>$ 10,000.00</td>
</tr>
</tbody>
</table>

CGP-3-R-SCH-90 B265.0655-R

#### All Options

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

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

#### All Options

**Proof of Insurability Requirements**

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

We require proof as follows:

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

#### All Options

We require proof before you switch from your current increment of dependent optional term life insurance to an increment which provides a greater amount of insurance.

CGP-3-R-SCH-90 B265.0734

#### All Options

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

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

#### All Options

We require proof for any amount of dependent optional term life insurance in excess of $ 30,000.00 with respect to your dependent spouse.

CGP-3-R-SCH-90 B265.0542
Dependent Optional Term Life Insurance (Cont.)

All Options

We require proof for any amount of dependent optional term life insurance in excess of $10,000.00 with respect to your dependent spouse, if your dependent spouse’s scheduled dependent optional term life effective date is after he or she reaches age 65.

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

All Options

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

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

All Options

Dependent Voluntary Accidental Death and Dismemberment Insurance (AD&D)

CGP-3-SI B265.2526

All Options

Dependent Voluntary AD&D Election

You may choose the plan of dependent spouse voluntary AD&D insurance, and the plan of dependent child voluntary AD&D insurance which is equal to 100% of the voluntary spouse and child life amount as shown below.

CGP-3-SI B265.4172

All Options

Dependent Spouse Voluntary AD&D Insurance Amount

Plan A

You may elect amounts of voluntary dependent spouse term AD&D insurance in increments of $5,000.00, but the amount may not be less than $5,000.00 and may not exceed $150,000.00.

CGP-3-R-SCH-90 B265.2451

All Options

Dependent Child Voluntary AD&D Insurance Amount

Plan A

Child’s Age At Death Benefit Amount

At least 14 days but less than 6 months $10,000.00
At least 6 months but less than 26 years $10,000.00
At least 26 years but less than 26 years if a full-time student $10,000.00

CGP-3-SI B265.4188-R
All Options

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

CGP-3-R-SCH-90

B265.2532
Your Group Term Life Insurance

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

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

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

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

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

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

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

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

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

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

Portability Privilege

Applicability
This provision applies only to this plan’s employee Basic 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 with Catastrophic Loss Insurance.

Important Restriction
You must provide proof of insurability satisfactory to us.

Portability Of Basic Group Term Life Insurance
You may elect to continue all or part of your employee Basic 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 Basic Group Term Life Insurance Extended Life Benefit.

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 Basic 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 rate class under this plan; and (b) your age bracket as shown in the Basic 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 require proof of insurability satisfactory to us.

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

CGP-3-R-LP-00

B270.0389
Information About Conversion and Portability

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

CGP-3-R-LPN-95

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.
Your Optional Group Term Life Insurance (Cont.)

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-NPX-96

Portability Privilege

Applicability

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

Important Restriction

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

Portability Of Optional Group Term Life Insurance

You may elect to continue all or part of your employee Optional group term life insurance and dependent Optional group term life insurance, by choosing a portable certificate of coverage, subject to the following terms.
You may port your coverage if coverage under this plan ends because you: (a) have terminated employment; or (b) stop being a member of an eligible class of employees.

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

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

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

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

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

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

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

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

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

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

Defined Term

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

Information About Conversion and Portability

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

Converting This Group Term Life Insurance

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

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

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

**If The Group Plan Ends or Group Life Insurance Is Dropped**

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

If you: (a) are not disabled, as defined in the section labeled "Extended Life Benefit With Waiver of Premium", when this coverage ends; and (b) you have been insured by a Guardian group life plan for at least five years, you can convert to a permanent life insurance policy. But, the amount you can convert is limited to the lesser of: (a) $2,000.00; or (b) the amount of your insurance under this plan, less any group life benefits you become eligible for in the 31 days after this insurance ends.

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

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

**The Converted Policy**

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

**Interim Term Insurance**

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

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

**How and When to Convert**

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

**Death During the Conversion Period**

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

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

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

CGP-3-R-LCONV-99-AL

All Options

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

B275.0077

All Options

Converting This Group Term Life Insurance

If Employment or Eligibility Ends

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

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

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

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

If The Group Plan Ends or Group Life Insurance Is Dropped

Your group life insurance also ends if: (a) this group plan ends; or (b) life insurance is dropped from the group plan for all employees or for your class. If either happens, you may be eligible to convert as explained below. Conversion choices are based on your disability status.
If you: (a) are not disabled, as defined in the section labeled "Extended Life Benefit With Waiver of Premium", when this coverage ends; and (b) you have been insured by a Guardian group life plan for at least five years, you can convert to a permanent life insurance policy. But, the amount you can convert is limited to the lesser of: (a) $2,000.00; or (b) the amount of your insurance under this plan, less any group life benefits you become eligible for in the 31 days after this insurance ends.

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

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

**The Converted Policy**

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

**Interim Term Insurance**

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

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

**How and When to Convert**

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

**Death During the Conversion Period**

If you die in the 31 days allowed for conversion, we’ll pay your beneficiary the amount you could have converted. We’ll pay whether or not you applied for conversion.
Converting This Group Term Life Insurance (Cont.)

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

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

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All Options

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 Basic Group Term Life Insurance and 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 six 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) 75% of the inforce amount. The maximum benefit amount is the lesser of: (a) $250,000.00; or (b) 75% of the inforce amount.

**Discount**

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

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

**Processing Fee**

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

**Payment of An Accelerated Life Benefit**

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

**How And When To Apply**

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

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

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

Even if you are receiving an Extended Life Benefit under this plan, you can still apply for an Accelerated Life Benefit. However, once you convert your group term life insurance, the terms of the converted life policy will apply. Any amount to which you could otherwise convert is permanently reduced by the gross amount of the Accelerated Life Benefit paid to you.
Please read “Your Remaining Group Term Life Insurance” provision for restrictions that may apply.

If You Have Assigned Your Group Term Life Insurance

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

CGP-3-R-EALB-95

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.

CGP-3-R-EALB-95-1
All Options

Extended Life Benefit With Waiver of Premium

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

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

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

(a) not able to perform, on a full-time basis, the major duties of any occupation, for which you are, or could become, qualified for by training, education, or experience; 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 nine continuous months.

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

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

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

**Until You’ve Been Approved for this Extended Life Benefit**
Your life insurance under the group plan may end after you’ve become totally disabled but before we’ve approved you for this extension. During this time period, you may either:

(a) continue group premium payments, including any portion which would have been paid by the employer until you are approved or declined for this extended life benefit; or
(b) convert to an individual permanent or term policy. Please read the section labeled "Converting This Group Term Life Insurance" for details on how to convert.

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

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

When This Extension Begins

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

(a) nine 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.
If you are eligible for this plan’s Basic Life Extended Life Benefit you may also be eligible for the LifeAssist benefit.

**When And How The LifeAssist Benefit Begins**

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

(a) you are eligible for this plan’s Basic Life Extended Life Benefit; and  
(b) you are functionally disabled, as defined below.

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

(a) not able to perform 2 or more activities of daily living on a routine basis, without help; or  
(b) cognitively impaired and need verbal cueing to protect yourself or others; and  
you are:  
(c) receiving regular doctor’s care appropriate to the cause of disability; and  
(d) not working for wage or profit.

Activities of Daily Living means:

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

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

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

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

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

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

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

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

**What We Pay**

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

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

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

**Continued Eligibility For The LifeAssist Benefit**

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

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

**When The LifeAssist Benefit Ends**

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

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

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

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

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

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

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

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

**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, on a full-time basis, the major duties of any occupation, for which you are, or could become, qualified for by training, education, or experience; 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 nine continuous months.

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

Continued Eligibility For Extended Life Benefit

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

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

Until You’ve Been Approved for this Extended Life Benefit

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

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

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

However, if this group plan terminates, and you are totally disabled and eligible, but not yet approved, for this extended benefit, you must convert to an individual permanent or term policy, and remain insured under such policy until you are approved by us for the extended benefit.
Extended Life Benefit With Waiver of Premium (Cont.)

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

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

CGP-3-R-LW-TD-99-1 B275.0229

**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**

**LifeAssist**

If you are eligible for this plan’s Optional Life Extended Life Benefit you may also be eligible for the LifeAssist benefit.
When And How The LifeAssist Benefit Begins

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

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

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

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

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

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

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

you are:

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

(d) not working for wage or profit.

Activities of Daily Living means:

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

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

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

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

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

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

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

Payment Of Benefits

We pay this benefit monthly, in arrears. We pay benefits to you if you are legally competent. If you are not, we pay benefits to the legal representative of your estate.
What We Pay
Subject to all the terms of this plan, the monthly LifeAssist benefit is equal to 1% of your Optional Life Extended Life Benefit, to a monthly maximum of $2,000.00.

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

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

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

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

When The LifeAssist Benefit Ends
We stop paying this benefit on the earliest of the following dates:
(a) the date you are no longer functionally disabled;
(b) the date you are no longer eligible for this Optional Life plan’s Extended Life Benefit;
(c) the date we ask you to take part in a medical assessment and you refuse;
(d) the date you do not give us proof of disability that we require;
(e) the date you are no longer receiving regular doctor’s care appropriate to the disability; and
(f) the date the lifetime maximum LifeAssist benefit is reached.

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

CGP-3-R-LSUPP-99

All Options

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

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

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

Seatbelt and Airbag Benefits

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

Payment to a Minor or Incompetent

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

All Options

Converting This Dependent Term Life Insurance

If Your Group Life Insurance Ends or You Stop Being Eligible

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

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

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

If This Plan Ends or Life Insurance is Dropped

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

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

If a Dependent Stops Being Eligible

A dependent’s term life insurance ends when he or she stops being an eligible dependent as defined by this plan. If a dependent stops being eligible, that dependent can convert all or part of his or her insurance.
Converting This Dependent Term Life Insurance (Cont.)

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

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

Write to us for details.

How and When to Convert
To get a converted policy, the dependent must apply to us in writing and pay the required premium. He or she has 31 days after his or her group insurance ends to do this. We won’t ask for proof that he or she is insurable.

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

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

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

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

All Options

Your Basic Accidental Death And Dismemberment With Catastrophic Loss Benefits

The Benefit
We’ll pay the benefits described below if you suffer an irreversible covered loss due to an accident that occurs while you are insured. The loss must be a direct result of the accident, independent of all other causes. And, it must occur within 365 days of the date of the accident.

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

ACCIDENTAL DEATH AND DISMEMBERMENT
### Covered Loss

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

### CATASTROPHIC LOSS BENEFITS

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

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

Loss of:

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

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

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

(d) speech or hearing means that speech or hearing is lost entirely.
Your Basic Accidental Death And Dismemberment
With Catastrophic Loss Benefits (Cont.)

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

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

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

CGP-3-R-ADCL1-00

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All Options

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

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

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

Exclusions
We won’t pay for any loss caused 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;
• by your legal intoxication; this includes, but is not limited to, your operation of a motor vehicle; or
• by your voluntary use of a controlled substance, unless: (1) it was prescribed for you by a doctor; and (2) it was used as prescribed. A controlled substance is anything called a controlled substance in Title II of the Comprehensive Drug Abuse Prevention and Control Act of 1970, as amended from time to time.

SPOUSAL EDUCATION AND RETRAINING BENEFIT

If you suffer a specified loss due to an accidental bodily injury, we will pay a spousal education and retraining benefit subject to all the terms below.

When And How The Spousal Education And Retraining Benefit Begins

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

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

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

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

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

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

What We Pay Subject to all the terms of this plan, the Spousal Education and Retraining Benefit per academic term is equal to the lesser of: (i) the spouse’s net tuition expense for the term; (ii) 5% of the Employee Basic ADDCL Benefit paid as a result of the specified loss; and (iii) $2,500.00.
**Tuition Expense** means charges incurred for courses or lab fees. It does not include: (a) cost of books; (b) other related course materials; (c) student activity fees; or (d) room and board.

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

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

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

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**Continued Eligibility For The Spousal Education And Retraining Benefit**

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

---

**When The Spousal Education And Retraining Benefit Ends**

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

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

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

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

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

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

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**All Options**

**DAY CARE EXPENSE BENEFIT**

If you suffer a specified loss due to an accidental bodily injury, we will pay a Day Care Expense Benefit subject to all the terms below.

**Eligibility For The Day Care Expense Benefit**

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

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

(b) we receive proof of a qualified dependent’s enrollment in a qualified day care program. Such enrollment must commence within 12 months of the date of the specified loss.
Specified Loss means: (1) death; (2) a comatose state which lasts for a period in excess of one month; (3) spinal cord injury, resulting in: (a) quadriplegia; (b) paraplegia; or (c) hemiplegia; or (4) severe head injury resulting in loss of cognitive function. Loss of cognitive function means a significant decline or loss in intellectual aptitude. It must be supported by clinical proof or standardized tests that precisely measure decline in the areas of: (i) short term memory; (ii) orientation to time, place and person; (iii) deductive or abstract reasoning; and (iv) judgement as it relates to awareness of safety.

Qualified Dependent: For purposes of the Day Care Expense Benefit a qualified dependent is: (a) your: (i) biological child; (ii) lawfully adopted child; (iii) stepchild; or (iv) any other child who is living with you in a regular parent-child relationship; (b) dependent upon you for main support and maintenance; and (c) under the age of seven on the date of the accidental injury which results in the specified loss.

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

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

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

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

Continued Eligibility For The Day Care Expense Benefit
We require periodic proof that a qualified dependent remains enrolled in a qualified day care program. We require periodic proof of the qualified dependent’s day care expenses.

When The Day Care Expense Benefit Ends
This plan’s Day Care Expense Benefits end on the earliest of the following dates:
(a) the date the dependent is no longer qualified, as defined above;
(b) the date the dependent is no longer enrolled in a qualified day care program;
(c) the date we do not receive proof of qualified day care expenses, as required by this plan; and
(d) four years from the date the first day care expense benefit is paid.
DEPENDENT CHILD EDUCATION BENEFIT

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

When And How The Dependent Child Education Benefit Begins

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

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

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

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

Qualified Dependent: To be qualified for the Dependent Child Education Benefit, a dependent must meet the following conditions. The dependent must be: (a) your: (i) biological child; (ii) lawfully adopted child; (iii) stepchild; or (iv) any other child who is living with you in a regular parent-child relationship; (b) unmarried; and (c) dependent upon you for main support and maintenance. On the date of the accidental injury which results in the specified loss, the dependent must be: (a) 22 years of age or younger; and (b) enrolled as a full-time student in an institute of higher learning; or (c) in the 12th grade, and enroll as a full-time student in an institute of higher learning within 12 months of this date. The dependent must maintain a grade point average of at least 2.0 on a 4.0 scale, or the equivalent.

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

What We Pay

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

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

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

We pay this benefit per academic term for each qualified dependent.
We pay this benefit to the person who has primary responsibility for these expenses.

**Continued Eligibility For Dependent Education Benefit**

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

**When The Dependent Child Education Benefit Ends**

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

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

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

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

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

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

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**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.
Your Voluntary Accidental Death And Dismemberment Benefits (Cont.)

<table>
<thead>
<tr>
<th>Covered Loss</th>
<th>Benefit</th>
</tr>
</thead>
<tbody>
<tr>
<td>Loss of Life</td>
<td>100% of Insurance Amount</td>
</tr>
<tr>
<td>Loss of a hand</td>
<td>50% of Insurance Amount</td>
</tr>
<tr>
<td>Loss of a foot</td>
<td>50% of Insurance Amount</td>
</tr>
<tr>
<td>Loss of sight in one eye</td>
<td>50% of Insurance Amount</td>
</tr>
<tr>
<td>Loss of thumb and index finger of same hand</td>
<td>25% of Insurance Amount</td>
</tr>
</tbody>
</table>

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.
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;
- by your legal intoxication; this includes, but is not limited to, your operation of a motor vehicle; or
- by your voluntary use of a controlled substance, unless: (1) it was prescribed for you by a doctor; and (2) it was used as prescribed. A controlled substance is anything called a controlled substance in Title II of the Comprehensive Drug Abuse Prevention and Control Act of 1970, as amended from time to time.

Your Dependent Voluntary Accidental Death And Dismemberment Benefits

The Benefit  We’ll pay the benefits described below if a covered dependent suffers an irreversible covered loss due to an accident that occurs while he or she is 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 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 all covered losses, we pay you, if you are living. If you are not living, and the dependent was your child, we pay your spouse. If your spouse is not living, we pay the child’s living brothers and sisters in equal shares. If there are none, we pay the child’s estate. If the dependent was your spouse, we pay the spouse’s estate.

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.

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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 a dependent 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 the dependent is an instructor or crew member; or has any duties at all on that aircraft;
- by declared or undeclared war or act of war or armed aggression;
- while the dependent is a member of any armed force;
• while the dependent is a driver in a motor vehicle accident, if he or she
does not hold a current and valid driver’s license;

• by the dependent’s legal intoxication; this includes, but is not limited to,
the dependent’s operation of a motor vehicle; or

• by the dependent’s voluntary use of a controlled substance, unless: (1)
it was prescribed for the dependent 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.
ELIGIBILITY FOR DISABILITY COVERAGE

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, or working outside of the United States for a United States based employer in a country or region approved by us.

(b) be regularly working at least the number of hours in the normal work week set by your employer (but not less than 35 hours per week), at:

   (i) your employer's place of business;

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

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

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

When Your Coverage Starts

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

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

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

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

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B329.0321

All Options

When Your Coverage Ends

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

It also ends on the date you stop being a member of a class of employees eligible for insurance under this plan, or when this plan ends for all employees. And it ends when this plan is changed so that benefits for the class of employees to which you belong ends.
It ends on the date you are no longer working in the United States, or working outside of the United States for a United States based employer in a country or region approved by us.

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

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

CGP-3-EC-90-3.0 B329.0933

All Options

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

Important Notice

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

Continuation of Disability Coverage

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

If Your Group Insurance Would End

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

When Continuation Ends

Coverage may continue until the earliest of the following:

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

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

Definitions

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

- **Active Duty**: This term means duty under a call or order to active duty in the Armed Forces of the United States.

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

- **Covered Servicemember**: This term means a member of the Armed Forces, including a member of the National Guard or Reserves, who for a serious injury or illness: (a), is undergoing medical treatment, recuperation, or therapy; (b) is otherwise in outpatient status; or (c) is otherwise on the temporary disability retired list.

- **Next Of Kin**: This term means the nearest blood relative of the employee.

- **Outpatient Status**: This term means, with respect to a covered servicemember, that he or she is assigned to: (a) a military medical treatment facility as an outpatient; or (b) a unit established for the purpose of providing command and control of members of the Armed Forces receiving medical care as outpatients.

- **Serious Injury Or Illness**: This term means, in the case of a covered servicemember, an injury or illness incurred by him or her in line of duty on active duty in the Armed Forces that may render him or her medically unfit to perform the duties of his or her office, grade, rank, or rating.
LONG TERM DISABILITY HIGHLIGHTS

SCHEDULE OF BENEFITS

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

All Options

Own Occupation Period

The first 24 months of benefit payments from this plan.

Elimination Period

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

Maximum Payment Period

See the following table:

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

<table>
<thead>
<tr>
<th>Employee’s Year of Birth</th>
<th>Social Security Normal Retirement Age</th>
</tr>
</thead>
<tbody>
<tr>
<td>Before 1938</td>
<td>65</td>
</tr>
<tr>
<td>1938</td>
<td>65 and 2 months</td>
</tr>
<tr>
<td>1939</td>
<td>65 and 4 months</td>
</tr>
<tr>
<td>1940</td>
<td>65 and 6 months</td>
</tr>
<tr>
<td>1941</td>
<td>65 and 8 months</td>
</tr>
<tr>
<td>1942</td>
<td>65 and 10 months</td>
</tr>
<tr>
<td>1943-1954</td>
<td>66</td>
</tr>
<tr>
<td>1955</td>
<td>66 and 2 months</td>
</tr>
<tr>
<td>1956</td>
<td>66 and 4 months</td>
</tr>
<tr>
<td>1957</td>
<td>66 and 6 months</td>
</tr>
<tr>
<td>1958</td>
<td>66 and 8 months</td>
</tr>
<tr>
<td>1959</td>
<td>66 and 10 months</td>
</tr>
<tr>
<td>After 1959</td>
<td>67</td>
</tr>
</tbody>
</table>

For a disability starting on or after the employee reaches age 60, the maximum payment period will be determined according to the following table:
<table>
<thead>
<tr>
<th>Age When Disability Starts</th>
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<tbody>
<tr>
<td>Age 60</td>
<td>5.00 years</td>
</tr>
<tr>
<td>Age 61</td>
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</tr>
<tr>
<td>Age 62</td>
<td>3.50 years</td>
</tr>
<tr>
<td>Age 63</td>
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<td>Age 64</td>
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</tr>
<tr>
<td>Age 65</td>
<td>2.00 years</td>
</tr>
<tr>
<td>Age 66</td>
<td>1.75 years</td>
</tr>
<tr>
<td>Age 67</td>
<td>1.50 years</td>
</tr>
<tr>
<td>Age 68</td>
<td>1.25 years</td>
</tr>
<tr>
<td>Age 69 or older</td>
<td>1.00 year</td>
</tr>
</tbody>
</table>

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

**All Options**

**Maximum Monthly Benefit**

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

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

**Survivor Benefit**

3 times the last gross monthly benefit you received.
LONG TERM DISABILITY INCOME INSURANCE

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

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

Benefit Provisions

How Payments Start

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

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

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

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

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

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

When Payments End

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

(a) The date you are no longer disabled.
(b) The date you fail to provide proof of loss as required by this plan.
(c) The date you earn, or are able to earn, the maximum earnings allowed while disabled under this plan.
(d) The date you are able to perform the major duties of your own occupation on a full-time basis with reasonable accommodation.
(e) After the own occupation period, the date you are able to perform the major duties of any gainful employment 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.

All Options

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

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

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<td>1.00 year</td>
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</table>

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

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All Options

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

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

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

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

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

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

(f) During the time you return to active work, you must: (i) stay insured by this plan; and (ii) premium payments must be made on your behalf; and
(g) Your benefits must not have ended because you have used up the maximum payment period.

If the later disability is a recurring disability, you will not need to complete a new elimination period. The recurring disability will be subject to all the terms of the plan in effect on the date the earlier disability began.

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

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.

All Options

Redetermination:

This plan redetermines insured earnings for each covered person on April 1st.

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

All Options

Other Income Benefits:

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

- Commissions or monies: (1) received; (2) payable but deferred; or (3) paid after disability benefits start. This includes: (a) vested and nonvested renewal commissions; (b) bonuses; (c) royalties; and (d) other distributions.
• Disability benefits from any mandated benefit act or law. This includes all temporary disability or state disability benefits required by law.

• Disability benefits from all group plans of: (1) the plan sponsor; or (2) the employer. This includes payments made by a group life insurance plan due to your disability. This does not include payments made from a group life insurance plan’s: (a) accelerated death benefit; or (b) like provision that allows payment of such plan’s proceeds due to terminal illness.

• Disability benefits from any other group plan; but, if the other group plan was in force prior to this plan, and the other group plan also deducts for disability benefits from any other group plan or if the other group plan was from employment other than with the current plan sponsor or employer and benefits received do not total 100% of your previous income, 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. This does not include an individual policy from employment other than with the current plan sponsor or employer if benefits received do not total 100% of your previous income.

• 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 benefits more than 100% of your insured earnings.

• Income from a sick leave, salary continuance or Paid Time Off plan, but only to the extent that such income plus the amount of your gross monthly benefit is more than 100% of your insured earnings. This applies whether such plan is sponsored on a formal or informal basis. This includes donated, lump sum and recurrent payments of accrued sick leave benefits. But, if you are working while disabled, we will account for such income as described in this plan’s "Adjustment of Monthly Benefit for Disability Earnings".
• Benefits as shown below from: (1) the United States Social Security Act; (2) the Railroad Retirement Act; or (3) any other like U.S. or Canadian plan or act.

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

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

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

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

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

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

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

• That portion of retirement plan retirement benefits which the employer funds.

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

• Retirement benefits or retirement plan disability benefits, due to 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 the your disability is the result of the negligence or intentional tort liability of that third party.

• Unemployment compensation benefits.
- Payment from the covered person’s 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.

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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 your *monthly benefit* by the amount of such increase.

Claim for Other Income: You must pursue a claim for other income benefits to which you may be entitled if the expectation is the disability qualifies for other income benefits and the amount due can be estimated. If these benefits are denied, we require you to appeal such denial if it is reasonable to believe that you have a valid claim to receive the benefits. We will not reduce your *monthly benefit* if you and your spouse or children: (a) applied for; or (b) submitted an appeal regarding a requested claim for other income benefits. However, we will require you to 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.

We will assist you in applying for other income benefits.

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All Options

Adjustment of Monthly Benefit for Disability Earnings: We adjust the *monthly benefit* for *disability earnings* as follows.

For each of the first 24 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.

**All Options**

**Indexing:** We apply an indexing factor to your insured earnings on the date you have received 12 consecutive monthly payments and each anniversary thereafter. This factor increases the amount of income you may earn and still be considered disabled. This adjustment does not increase your gross monthly benefit, monthly benefit, or any other benefit under this plan.

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

The indexing factor is the lesser of: (a) 10%; or (b) one-half of the CPI-W from the prior December.

**Minimum Payment:** The minimum monthly payment for disability under this plan is $100.00.

**Limitations and Exclusions**

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

The maximum payment period for all periods of disability due to: (a) a mental illness; (b) drug or alcohol abuse; or (c) a specific condition listed below is 24 months. This is a combined maximum for all such conditions and all periods of disability.
The specific conditions subject to a limited maximum payment period include the following:

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

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

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

No benefits will be paid for disability due to a mental illness or drug or alcohol abuse if you are not receiving treatment for the cause of the disability from a provider, or in a facility that is: (a) licensed by the state to provide treatment for such condition; and (b) accredited or approved by the Joint Commission on the Accreditation of Health Care Facilities or Medicare.
If payments under this plan would end due to the limits in this section, we may extend such payments, as shown below. But, you must meet all of the following conditions: (a) you must be disabled due to a condition named above; (b) you must be an inpatient in a qualified institution because of your disability; and (c) you must have been treated as an inpatient for at least 14 days in a row. In such case, we extend payments until the earliest of: (i) 90 days from the date of your discharge; (ii) the end of this plan’s maximum payment period; or (iii) the date your disability ends.

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

All Options

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

(a) receive advice or treatment from a doctor;
(b) undergo diagnostic procedures other than routine screening in the absence of symptoms or suspicion of disease process by a doctor;
(c) are prescribed or take prescription drugs; or
(d) receive other medical care or treatment, including consultation with a doctor.

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

No benefits are payable for disability: (a) caused by; (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 12 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 12 months in a row.

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

Prior Coverage Credit: If this plan replaces a similar income replacement plan the plan sponsor had with another insurer, the pre-existing condition provision may not apply to you. This plan must start right after the old plan ends.

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

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

But, we limit your maximum monthly benefit under this plan if: (a) it is more than the maximum monthly benefit for which you were insured under the old plan; (b) you become disabled due to a pre-existing condition; and (c) this plan pays benefits for such disability because we credit time as explained above. In this case, we limit the maximum monthly benefit to the amount you would have been entitled to under the old plan.

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

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

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

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

(c) you take 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; or

(f) intentional self-inflicted injuries.

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

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

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

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

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

Services

Social Security Assistance
If we believe you are eligible for Social Security 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.

Using our help does not cancel your duties shown in the “Claim 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 family care expenses you incur in order to participate in a rehabilitation program. (See the “Dependent Care Expenses” section of this plan.)

We have the right to determine which services are appropriate.

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

We stop paying the enhanced benefit on the earliest of:

(a) The date your benefits from this plan end;
(b) The date you violate the terms of the rehabilitation agreement;
(c) The date you end the rehabilitation program; and
(d) The date the rehabilitation agreement ends.

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

Dependent Care Expenses

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

(a) you incur expense to provide care for a qualified dependent;
(b) the care is provided by a licensed provider other than a family member.

A qualified dependent is: (a) dependent upon 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) $350 per month per qualified dependent; not to exceed $1,000 per month for all qualified dependents combined; and (b) the actual monthly day care expense incurred by you.

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

CGP-3-LTD07-8.0-TN  B383.2104

**All Options**

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

CGP-3-LTD07-8.1  B383.0222
All Options

Early Intervention Services

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

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

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

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

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

CGP-3-LTD07-8.2

All Options

The Survivor Benefit

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

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

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

Your eligible survivor is your spouse, if living.

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

If you have a terminal illness, we may accelerate payment of this plan’s survivor benefit.

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

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

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

CGP-3-LTD07-9.1  B383.0292

**All Options**

**Income Recovery Benefit**

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

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

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

(b) if this plan has already paid benefits for the own occupation period, able to perform the major duties of any gainful employment; and

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

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

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

We stop paying this benefit on the earliest of:

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

(b) the date you become disabled;

(c) the date you stop working;

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

(e) the end of the maximum payment period.

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

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Authority: We have the discretionary authority to: (a) interpret the terms of this plan; and (b) determine a covered person's eligibility for: (i) coverage; and (ii) benefits under the plan. All such determinations are considered final, except that they may be modified or reversed by legal action illustrated under the Limitations of Actions provision under the Accident and Health Provisions of this plan, filing an appeal, or seeking relief from the Tennessee Department of Insurance.

Notice: You must send us written notice of his or her 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 employment.
(e) If your occupation requires that he or she 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 him or herself, 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 26025
Lehigh Valley, PA 18002-6025
**Authorization Required:** You must provide us with written, unaltered authorizations to obtain medical, financial, vocational, occupational, and governmental information required to determine our liability under this plan. You must provide us with such authorizations as often as we may require, in order that they remain current. Failure to provide such authorizations may delay, suspend or terminate your benefits.

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

**Ongoing Proof of Loss:** To continue to receive payments from this plan, you must give us current proof of loss as often as we may reasonably require. Ongoing proof of loss must be provided to us within 30 days of the date we request it.

**Payment of Benefits:** We pay benefits to you, if you are legally competent. If you are not, we pay benefits to the legal representative of your estate. Benefits are paid in US dollars.

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

No benefits are payable for this plan’s elimination period.

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

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

**Overpayment Recovery**

If we overpaid you, you must repay us in full. We have the right to reduce your payment or apply any benefits payable, including the minimum payment, toward recovery of the overpayment. If the overpayment is due to our error, this right to recovery will not be exercised after 15 months of the date the overpayment was made. Overpayments due to fraud, material misstatements, or retroactive awards of other income with which this plan integrates will not be subject to the 15 month recovery limit.

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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.

**CPI-W**
That part of the United States Department of Labor Consumer Price Index that measures the relative value of the cost of a typical urban wage earner's purchase of certain goods and services. If the Department of Labor stops publishing the CPI-W, we have the right to use some other similar standard.

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

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

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

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

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

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

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

Doctor Any medical practitioner we are required by law to recognize. He or she must: (a) be properly licensed or certified by the laws of the state where he or she practices; and (b) provide services that are within the lawful scope of his or her practice.

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

Any days during which you return to work earning more than 80% of your insured earnings will not count toward the elimination period. If you are or become eligible under any other similar group income replacement plan while you are working during the elimination period, you will not be entitled to benefits from this plan.

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

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

Gainful Employment Employment for which you are suited due to: (a) education; (b) experience; or (c) training. When you are able to perform such work on a full-time basis, you can be expected to earn at least 60% of your indexed insured earnings as much as your gross monthly benefit, within 12 months of returning to work.
Government Plan
Any of the following: (1) the United States Social Security Act; (2) the Railroad Retirement Act; (3) the Canadian Pension Plan; or (4) any other plan provided under the laws of a state, province or any other political subdivision. It also includes: (a) any public employee retirement plan; or (b) any plan provided in place of the above named plan or acts. It does not include: (i) any Workers’ Compensation Act or similar law; (ii) the Jones’ Act; (iii) the Longshoreman’s and Harbor Workers’ Compensation Act; or (iv) the Maritime Doctrine of Maintenance, Wages, or Cure.

Gross Monthly Benefit
This plan’s monthly benefit before it is integrated with other income and earnings.

Injury
A bodily injury due to an accident that occurs, independent of 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 the employer will be included as insured earnings.

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, your earnings are based on the monthly average of the sum of the listed amounts, averaged for the full number of months that you were a partner or an S Corporation shareholder during such calendar year.

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

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

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

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

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

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

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

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

For All Other Covered Persons:

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

**Maximum Capacity Earnings**

During the own occupation period, the income you could earn if working to the fullest extent you are able to in your own occupation. After the own occupation period, the income you could earn if working to the fullest extent you are able to in any gainful employment. We decide the fullest extent of work you are able to do based on data gathered regarding your medical condition, and treatment, prognosis limitations and restrictions provided by any or all of the following sources: (a) your treating doctor, (b) peer review specialists; and (c) other medical and vocational specialists whose area of expertise is appropriate to your disability. The data may include, but is not limited to: (a) impartial medical exams; (b) impartial vocational exams; or (c) functional capacities exams.

**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 Occupation**

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

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

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

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

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

Regular and Appropriate Care  Means, with respect to your: (a) disabling condition; and (b) any other condition which, if left untreated, would adversely affect your disabling condition; you (i) visit a doctor as frequently as medically required, according to generally accepted medical standards, to effectively manage these conditions; and (ii) are receiving the most appropriate treatment, according to generally accepted medical standards, designed to achieve maximum medical improvement in these conditions. Treatment must be provided by a doctor(s) whose specialty is most appropriate for your: (a) disability; and (b) any other conditions which left untreated would adversely affect your disabling condition; according to generally accepted medical standards. Generally accepted medical standards are those supported by nationally recognized authorities in the health care field including: the American Medical Association (AMA); the AMA Board of Medical Specialties; the Food and Drug Administration; the Centers for Disease Control; the National Cancer Institute; the National Institutes of Health; the Department of Health and Human Services; and any other agency of similar repute.

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

Rehabilitation Program  A program of work or job-related training for you that we approve in writing. Its aim is to restore your wage earning abilities.
Retirement Plan
A defined benefit or defined contribution plan funded wholly or in part by the employer’s deposits for your benefit. The term does not include: (a) profit sharing plans; (b) thrift plans; (c) non-qualified deferred compensation plans; (d) individual retirement accounts; (e) tax sheltered annuities; (f) 401(k), 403(b), 457 or similar plans; or (g) stock ownership plans. Retirement Plan "retirement benefits" are lump sum or periodic payments at normal or early retirement. Some retirement plans make payments for disability (as defined by those plans) that start before normal retirement age. When such payments reduce the amount that would have been paid at normal retirement age, they are retirement benefits. When such payments do not reduce the normal retirement amount, they are "disability benefits."

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

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

CGP-3-LTD07-12.15

B383.0093
ELIGIBILITY FOR VISION CARE EXPENSE COVERAGE

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 March 1st to March 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.

When Your Coverage Starts
Your coverage under this plan is scheduled to start on the effective date shown on the sticker attached to the inside front cover of this booklet. 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, the effective date shown on the sticker 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.
All Options

When Your Coverage Ends

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

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

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

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

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.
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 24; and (c) your unmarried dependent children from age 24 until their 26 birthday, who are enrolled as full-time students at accredited schools.

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

CGP-3-DEP-90-2.0

All Options

Adopted Children And Step-Children

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

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

CGP-3-DEP-90-3.0

All Options

Handicapped Children

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

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

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

The child’s coverage ends when yours does.

CGP-3-DEP-90-4.0
When Dependent Coverage Starts

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

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

If you do this within 31 days of your eligibility 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 will postpone the effective date of such benefits until the day after his discharge from such facility; until home confinement ends; or until he resumes the normal activities of someone of like age and sex.
All Options

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

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

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

All Options

When Dependent Coverage Ends
Dependent coverage ends for all of your dependents when your employee coverage ends. But if you die while insured, we’ll automatically continue dependent vision care benefits for those of your dependents who are insured when you die. We’ll do this for six months at no cost, provided: (a) the group plan remains in force; (b) the dependents remain eligible dependents; and (c) in the case of a spouse, the spouse does not remarry.

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

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

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

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

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

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All Options

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

CGP-3-VSN-96-BEN3

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VISION CARE BENEFITS

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

CGP-3-DAVIS-05-VIS

All Options

This Plan’s Vision Care Preferred Provider Organization

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

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

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

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

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

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

Choice of Preferred Providers

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

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

It is not necessary to submit a claim for services or supplies from a preferred provider.
Non-Preferred Providers

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

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

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

All Options

Appeals Process

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

Grievance Process

Registering a Complaint or Grievance

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

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

Davis Vision defines a “grievance” as a complaint that may or may not require specific corrective action and is made:
1. via the telephone;
2. in writing to Davis Vision;
3. via the Davis Vision website.

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

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

**Verbal Grievances and Telephone Communication**

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

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

**Written Grievances**

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

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

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

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

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

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

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

All Options

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

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

**Appeal Level 2**

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

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

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

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

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

**External Grievance Procedure**

**External Review**

A covered person, as required by state statute, has the right to request an impartial review of concerns that resulted in a denial of coverage. A covered person who has exhausted the internal appeals process may appeal the final decision if the denial for services was not deemed medically necessary or the requested service was deemed Investigational or Experimental.
An external review organization will refer the case for review by a neutral, independent practitioner experienced in vision care. Davis Vision will provide all requested documentation to the external review organization. The external review organizations will have up to thirty (30) days, or as required by state statute, to make their determination.

**External Review Process**

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

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

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

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

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

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

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

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

Copays

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

How We Cover Vision Examinations

A covered person must pay a $20.00 copay each time he or she receives a vision examination. If the vision examination is performed by a preferred provider, we pay benefits in full for the exam in excess of the copay. If the vision examination is performed by a non-preferred provider, we pay benefits in excess of the copay up to $50.00.

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

A vision examination includes:

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

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

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

All Options

**How We Cover**

**Vision Materials**

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

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

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

**How We Cover**

**Standard Lenses**

A covered person must pay a $20.00 copay each time he or she purchases standard lenses. If the lenses are received from a preferred provider, we pay benefits in full for the lenses in excess of the copay. If the lenses are received from a non-preferred provider, we pay benefits in excess of the copay up to:

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

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

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

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

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

- standard progressive addition lenses - $50
- premium progressives (Varilux, Kodak, Seiko, Rodenstock) - $90
• photochromatic lenses - single vision or multifocal - $20
• scratch resistant coating - single vision or multifocal - $20
• ultra violet coating - $12
• blended invisible bifocal lenses - $20
• intermediate Lenses - $30
• plastic photosensitive lenses - $65
• polarized lenses - $75
• hi-Index lenses - $55
• supershield (scratchguard) coating - $20
• glare resistant treatment (multi layer hydrophobic) - $35
• premium glare resistant treatment - $48

All Options

How We Cover Elective Contact Lenses

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

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

A covered person must pay a $20.00 copay each time he or she purchases elective contact lenses.

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

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

• If a preferred provider offers Davis’ elective contact lenses collection (the formulary), we cover any elective contact lenses selected from the formulary in full in excess of a $20.00 copay.

• We cover non-formulary elective contact lenses in full to the retail elective contact lenses allowance of $150.00. The copay is waived.

• If a covered person receives a vision examination from a preferred provider, he or she will receive a discount on the cost of a pair of non-formulary elective contact lenses, including evaluation and fitting, from the same preferred provider.
How This Plan Works (Cont.)

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

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

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

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

All Options

How We Cover Necessary Contact Lenses

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

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

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

A covered person must pay a $20.00 copay each time he or she purchases necessary contact lenses. If the contact lenses are purchased from a preferred provider, we pay benefits in full for the lenses in excess of the copay. If the contact lenses are purchased from a non-preferred provider, we pay benefits in excess of the copay up to a maximum of $210.00.

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

All Options

How We Cover Frames

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

If the frames are purchased from a non-preferred provider, we pay benefits in excess of a $20.00 copay up to $48.00.

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

- If a preferred provider offers Davis’ Tower designer frame collection (the Tower), we cover any Fashion or Designer Collection frame selected from the Tower in excess of a $20.00 copay. We cover any Premier Collection frame selected from the Tower in full in excess of a $45.00 copay.
- We cover a non-Tower frame in excess of a $20.00 copay up to the retail frame allowance of $150.00.
- If a covered person receives a vision examination from a preferred provider, he or she will receive a discount on the cost of purchasing a pair of non-Tower frames from the same preferred provider*.
The discount is an amount equal to 20% of the preferred provider’s usual and customary fee in excess of the copay and retail frame allowance.

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

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

All Options

Exclusions

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

The certificate is amended as follows:

The Life Insurance eligibility provisions applicable to dependent coverage are modified to provide that:

(a) your dependent child is a child under age 26;

(b) marital status, residency and financial dependency requirements do not apply to your dependent child; except as stated in item (c);

(c) your handicapped child can stay eligible for dependent coverage past age 26 if your child is unmarried and is unable to support himself or herself; and

(d) reference to an individual dependent’s coverage ending when he or she marries or is no longer dependent on you for support and maintenance, except as stated for a handicapped child past the age limit, is deleted.

All terms and conditions of your certificate not specifically changed herein remain in full force and effect.

The Guardian Life Insurance Company of America

Vice President, Risk Mgt. & Chief Actuary

Stuart J. Shaw
CERTIFICATE AMENDMENT

This plan’s Employee and Dependent Optional Life "Settlement Option" provision is modified as follows:

Settlement Option: Unless otherwise elected by the certificate holder or beneficiary, benefits will be paid in a single lump sum check. We may make other options available in addition to the single check option.

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

The Guardian Life Insurance Company of America

Stuart Shaw
Vice President, Risk Mgt. & Chief Actuary
CERTIFICATE AMENDMENT

The certificate is amended as follows:

The Voluntary Accidental Death and Dismemberment Insurance eligibility provisions applicable to dependent coverage are modified to provide that:

(a) your dependent child is a child under age 26;

(b) marital status, residency and financial dependency requirements do not apply to your dependent child; except as stated in item (c);

(c) your handicapped child can stay eligible for dependent coverage past age 26 if your child is unmarried and is unable to support himself or herself; and

(d) reference to an individual dependent’s coverage ending when he or she marries or is no longer dependent on you for support and maintenance, except as stated for a handicapped child past the age limit, is deleted.

All terms and conditions of your certificate not specifically changed herein remain in full force and effect.

The Guardian Life Insurance Company of America

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

CGP-A-1 B531.0021
CERTIFICATE AMENDMENT

The certificate is amended as follows:

The Vision Insurance eligibility provisions applicable to dependent coverage are modified to provide that:

(a) your dependent child is a child under age 26;

(b) marital status, residency and financial dependency requirements do not apply to your dependent child; except as stated in item (c);

(c) your handicapped child can stay eligible for dependent coverage past age 26 if your child is unmarried and is unable to support himself or herself; and

(d) reference to an individual dependent’s coverage ending when he or she marries or is no longer dependent on you for support and maintenance, except as stated for a handicapped child past the age limit, is deleted.

All terms and conditions of your certificate not specifically changed herein remain in full force and effect.

The Guardian Life Insurance Company of America

Stuart Shaw
Vice President, Risk Mgt. & Chief Actuary
<table>
<thead>
<tr>
<th><strong>Blended Lenses</strong></th>
<th>means bifocals which do not have a visible dividing line.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Coated Lenses</strong></td>
<td>means substance added to a finished lens on one or both surfaces.</td>
</tr>
<tr>
<td><strong>Copay</strong></td>
<td>means a charge, expressed as a fixed dollar amount, required to be paid by or on behalf of a <em>covered person</em> before any benefits are paid by this <em>plan</em>.</td>
</tr>
<tr>
<td><strong>Covered Person</strong></td>
<td>with respect to vision care insurance means an <em>employee</em> or <em>eligible dependent</em> who meets this <em>plan’s</em> eligibility criteria and who is covered under this <em>plan</em>.</td>
</tr>
<tr>
<td><strong>Customary</strong></td>
<td>means, when referring to a covered charge, that the charge for the covered vision condition is not more than the <em>usual</em> charge made by most other doctors with similar training and experience in the same geographic area.</td>
</tr>
<tr>
<td><strong>Eligibility Date</strong></td>
<td>for dependent coverage is the earliest date on which: (a) you have initial dependents; and (b) are eligible for dependent coverage.</td>
</tr>
<tr>
<td><strong>Eligible Dependent</strong></td>
<td>is defined in the provision entitled &quot;Dependent Coverage.&quot;</td>
</tr>
</tbody>
</table>
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.

Employee

Employer means TUSCULUM COLLEGE.

Employer

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.

Enrollment Period

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 35 hours per week), at his employer’s place of business.

Full-time

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.

Initial Dependents

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

Keratoconus

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

Lenticular Lenses
## Glossary (Cont.)

### 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**

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

CGP-3-GLOSS-90 B750.0788

### All Options

**Orthoptics**

Means the teaching and training process for the improvement of visual perception and coordination of two eyes for efficient and comfortable binocular vision.

CGP-3-GLOSS-90 B750.0789

### All Options

**Oversize Lenses**

Means larger than a standard lens blank to accommodate prescriptions.

CGP-3-GLOSS-90 B750.0790

### All Options

**Photochromic Lenses**

Means lenses which change color with the intensity of sunlight.

CGP-3-GLOSS-90 B750.0791

### 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

**Plan**

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

CGP-3-GLOSS-90 B750.0792

### All Options

**Plano Lenses**

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

CGP-3-GLOSS-90 B750.0793
Preferred Provider with respect to vision care insurance means an optometrist, ophthalmologist or optician or other licensed and qualified vision care provider who has entered into a contract with Davis Vision to provide vision care services and/or vision care materials on behalf of covered persons of the plan.

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

Standard Lenses means regular glass or plastic lenses. See “Exclusions” for what we limit or exclude.

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

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.
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.
All Options

The Guardian’s Responsibilities

CGP-3

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.

All Options

The Guardian is located at 7 Hanover Square, New York, New York 10004.

All Options

B800.0048

B800.0055

B800.0049
Disability And 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.

Disability Benefits
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 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 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 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 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.

**Group Health Benefits**

**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
Disability And Group Health Benefits Claims Procedure (Cont.)

- 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:

Disability Benefits

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.

Group Health Benefits

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.
Termination of This Group Plan

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

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

When this plan ends, you may be eligible to continue your insurance coverage. Your rights upon termination of the plan are explained in this booklet.
Life And Accidental Death And Dismemberment Insurance
Claims Procedure

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.

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"):  

(a) If a claim is wholly or partially denied, the claimant will be notified of the decision within 90 days after Guardian received the claim.

(b) If special circumstances require an extension of time for processing the claim, written notice of the extension shall be furnished to the claimant prior to the termination of the initial 90-day period. In no event shall such extension exceed a period of 90 days from the end of such initial period. The extension notice shall indicate the special circumstances requiring an extension of time and the date by which The Guardian expects to render the final decision.

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

(1) the specific reason(s) the claim was denied;

(2) specific references to the pertinent plan provision on which the denial is based;

(3) a description of any additional material or information needed to make the claim valid, and an explanation of why the material or information is needed;

(4) an explanation of the plan's claim review procedure.

A claimant must file a request for review of a denied claim within 60 days after receipt of written notification of denial of a claim.

(d) Guardian will notify the claimant of its decision within 60 days of receipt of the request for review. If special circumstances require an extension of time for processing, The Guardian will render a decision as soon as possible, but no later than 120 days after receiving the request. The Guardian will notify the claimant about the extension.

The claims procedures applicable to disability benefits under this plan apply to your application for an extension of life insurance benefits due to total disability under an Extended Life Benefit under this plan.
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
NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Effective: 9/23/2013

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/PrivacyPolicy

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 LTC 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. For example, we may use your PHI for underwriting and premium rating purposes.

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.

All Options

Guardian is required to use or disclose your PHI:

- To you or your personal representative (someone with the legal right to act for you);
- To the Secretary of the Department of Health and Human Services, when conducting a compliance investigation, review or enforcement action; and
- Where otherwise required by law.

Guardian is Required to Notify You of any Breaches of Your 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. A breach means the acquisition, access, use, or disclosure of 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, such as a family member or close personal friend, when you are incapacitated, during an emergency or when permitted by law.
- We may disclose your PHI for public health activities, such as reporting of disease, injury, birth and death, and for public health investigations.
- 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 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, and we may also disclose your PHI for other specialized government functions such as national security or intelligence activities.
- We may 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).
- Guardian 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 disclose your PHI to your employer under limited circumstances related primarily to workplace injury or illness or medical surveillance.

All Options

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 disclose 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, (ii) you were required to give us your authorization as a condition of obtaining coverage, or (iii) 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 the 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. Your request must 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).

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.

Your Right to File a Complaint. If you believe your privacy rights have been violated, you may file a complaint with the U.S. Secretary 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.

Any exercise of the Rights designated below must be submitted to the Guardian in writing. 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.

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 2457
Spokane, WA 99210-2457
Insured employees and their dependents can access helpful, secure information about their Guardian benefits(s) online at:

GuardianAnytime.com - 24 hours a day, 7 days a week.

Anytime, anywhere you have an internet connection you will be able to:

- Review your benefits
- Look up coverage amounts
- Check the status of a claim
- Print forms and plan materials
- And so much more!

To register, go to www.GuardianAnytime.com