



# **YOUR GROUP INSURANCE PLAN BENEFITS**

**UNITY HEALTHCARE INC**

**CLASS 0001**

**DENTAL, VISION, CRITICAL ILLNESS, ACCIDENT BENEFITS,  
HOSPITAL INDEMNITY COVERAGE**

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

**The Guardian Life Insurance Company of America**

10 Hudson Yards  
New York, New York 10001  
(212) 598-8000  
[www.GuardianAnytime.com](http://www.GuardianAnytime.com)

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

**New Mexico Residents**  
**Consumer Complaint Notice**

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

**<http://www.osi.stat.nm.us/ConsumerAssistance/index.aspx>**

CCN-2019-NM

B999.0042



**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".**



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**CERTIFICATE OF COVERAGE**

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**The Guardian**  
10 Hudson Yards  
New York, New York 10001

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

Group Policy No.	Certificate No.	Effective Date
Issued To		

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

**The Guardian** Life Insurance Company of America

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

**LIMITED BENEFIT, PLEASE READ CAREFULLY**

CGP-3-R-STK-15-3-DC

B110.0071





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All Options

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**GENERAL PROVISIONS**

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As used in this booklet:

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

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

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

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

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

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

CGP-3-R-GENPRO-90

B160.0002

All Options

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**Limitation of Authority**

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

CGP-3-R-LOA-90

B160.0004

## Incontestability

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

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

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

CGP-3-R-INCY-90

B160.0003

## 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.

## Accident and Health Claims Provisions (Cont.)

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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.

CGP-3-R-AHC-90

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**An Important Notice About Continuation Rights**

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

CGP-3-R-NCC-87

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## YOUR CONTINUATION RIGHTS

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### Federal Continuation Rights

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

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

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

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

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

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

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

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

## Federal Continuation Rights (Cont.)

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

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

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

CGP-3-R-COBRA-96-1

B235.0630

### All Options

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

CGP-3-R-COBRA-96-2

B235.0075

### All Options

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

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

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

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



## Federal Continuation Rights (Cont.)

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

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

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

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

CGP-3-R-COBRA-96-3

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## All Options

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

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

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

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

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

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

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

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

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

## Federal Continuation Rights (Cont.)

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

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

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

- (1) with respect to continuation upon your termination of employment or reduction of work hours, the end of the 18 month period which starts on the date the group health benefits would otherwise end;
- (2) with respect to a qualified continuee who has an additional 11 months of continuation due to disability, the earlier of: (a) the end of the 29 month period which starts on the date the group health benefits would otherwise end; or (b) the first day of the month which coincides with or next follows the date which is 30 days after the date on which a final determination is made that the disabled qualified continuee is no longer disabled under Title II or Title XVI of the Social Security Act;
- (3) with respect to continuation upon your death, your legal divorce, or legal separation, or the end of an insured dependent's eligibility, the end of the 36 month period which starts on the date the group health benefits would otherwise end;
- (4) the date the employer ceases to provide any group health plan to any employee;
- (5) the end of the period for which the last premium payment is made;
- (6) the date, after the date of election, he or she becomes covered under any other group health plan which does not contain any pre-existing condition exclusion or limitation affecting him or her; or
- (7) the date, after the date of election, he or she becomes entitled to Medicare.

CGP-3-R-COBRA-96-4

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## Uniformed Services Continuation Rights

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

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

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

CGP-3-R-COBRA-96-4

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All Options

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**ELIGIBILITY FOR DENTAL COVERAGE**

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All Options

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**Employee Coverage**

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

**Other Conditions** If you must pay all or part of the cost of *employee* coverage, we won't insure you until you enroll and agree to make the required payments. If you do this: (a) more than 31 days after you first become eligible; or (b) after you previously had coverage which ended because you failed to make a required payment, we consider you to be a late entrant.

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

But you must enroll in the dental coverage under this *plan* within 30 days of the date that any of the events described above occur.

CGP-3-EC-90-1.0

B489.0122

All Options

**When Your Coverage Starts** *Employee* benefits are scheduled to start on your effective date.

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

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

CGP-3-EC-90-2.0

B489.0070

All Options

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

Your coverage ends on the date you die.

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

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

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

CGP-3-EC-90-3.0

B489.0075

### All Options

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

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**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.

## Your Right To Continue Group Coverage During A Family Leave Of Absence (Cont.)

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

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

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

CGP-3-EC-90-3.0

B449.0727

### All Options

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### Dependent Coverage

B200.0271

### All Options

**Eligible Dependents For Dependent Dental Benefits** Your *eligible dependents* are: (a) your legal spouse; (b) your dependent children who are under age 26.

CGP-3-DEP-90-2.0

B489.0460

## Dependent Coverage (Cont.)

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### All Options

**Adopted Children And Step-Children** Your "dependent children" include your legally adopted children and, your step-children. We treat a child as legally adopted from the time the child is placed in your home for the purpose of adoption. We treat such a child this way whether or not a final adoption order is ever issued.

**Dependents Not Eligible** We exclude any dependent who is insured by this *plan* as an *employee*. And we exclude any dependent who is on active duty in any armed force.

CGP-3-DEP-90-3.0

B489.0463

### All Options

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

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

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

The child's coverage ends when yours does.

CGP-3-DEP-90-4.0

B449.0042



## All Options

### Waiver Of Dental Late Entrants Penalty

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

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

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

CGP-3-DEP-90-5.0

B200.0749

## All Options

### When Dependent Coverage Starts

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

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

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

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

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

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

CGP-3-DEP-90-6.0

B489.0254

## Dependent Coverage (Cont.)

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### All Options

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

CGP-3-DEP-90-7.0

B200.0692

### All Options

**Newborn Children** We cover your newborn child for dependent benefits, from the moment of birth. If you do not have dependent child coverage when the child is born, we cover the child for the first 31 days from the moment of birth. To continue the child's coverage past the 31 days, you must enroll the child and agree to make any required premium payments within 31 days of the date the child is born. If you fail to do this, the child's coverage will terminate at the end of the 31 days. If you enroll the child after 31 days, the child will be considered a late entrant, and is subject to any applicable late entrant penalties. The child's coverage starts on the date the enrollment form is signed.

CGP-3-DEP-90-8.0

B489.0289

### All Options

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

If a surviving dependent elects to continue his or her dependent benefits under 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.

## Dependent Coverage (Cont.)

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

An individual dependent's coverage ends when he or she stops being an *eligible dependent*. This happens to a child on the last day of the month in which the child attains this coverage's age limit. It happens to a spouse on the last day of the month in which a marriage ends in legal divorce or annulment.

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

CGP-3-DEP-90-9.0

B489.0465

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**CERTIFICATE AMENDMENT**

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

The employee and his or her domestic partner must qualify for coverage. To qualify for coverage, the employee and his or her domestic partner must:

- complete a declaration of domestic partnership attesting to the relationship;
- be 18 years of age or older;
- be unmarried, constitute each other's sole domestic partner and not have had another domestic partner in the last 12 months;
- share the same permanent address for at least 12 consecutive months and intend to do so indefinitely;
- share joint financial responsibility for basic living expenses including food, shelter and medical expenses;
- not be related by blood to a degree that would prohibit marriage in the employee's state of residence; and
- be financially interdependent as demonstrated by at least four of the following:
  - a. ownership of a joint bank account;
  - b. ownership of a joint credit account;
  - c. evidence of a joint mortgage or lease;
  - d. evidence of joint obligation on a loan;
  - e. joint ownership of a residence;
  - f. evidence of common household expenses such as utilities or telephone;
  - g. execution of wills naming each other as executor and/or beneficiary;
  - h. granting each other durable powers of attorney;
  - i. granting each other health care powers of attorney;
  - j. designation of each other as beneficiary under a retirement benefit account; or
  - k. evidence of other joint financial responsibility.

The domestic partner's dependent children will be eligible for coverage under this plan. They will be eligible on the same basis as if the children were the employee's dependent children. Coverage for the domestic partner and his or her dependent children can end. Coverage ends when the domestic partner no longer meets the qualifications of a domestic partner as indicated above. Upon termination of a domestic partnership, a "Statement of Termination" must be completed. It must also be filed with the employer. The termination shall take effect six months after the statement is filed. Benefits will continue to accrue during this period. Once the employee submits a "Statement of Termination," he or she may not enroll another domestic partner for a period of 12 months from the date of the previous termination.

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

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

**The Guardian** Life Insurance Company of America

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

CGP-3-A-DMST-DC-06

B489.0287

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## DENTAL HIGHLIGHTS

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

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

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

CGP-3-DENT-HL-90

B497.0507

**Options A , B**

● **Payment Rates:**

For Group I Services . . . . . 100%  
For Group II Services . . . . . 90%  
For Group III Services . . . . . 60%  
For Group IV Services . . . . . 50%

CGP-3-DENT-HL-90

B497.0086

**Options C , D**

● **Payment Rates:**

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

CGP-3-DENT-HL-90

B497.0086

**Options A , B**

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

For Group I, II and III Services . . . . . Up to \$5,000.00

● **Lifetime Payment Limit for Orthodontic Treatment**

For Group IV Services . . . . . Up to \$2,500.00

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

CGP-3-DENT-HL-90

B497.1432

**Options C , D**

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

For Group I, II and III Services . . . . . Up to \$1,000.00

- **Lifetime Payment Limit for Orthodontic Treatment**

For Group IV Services . . . . . Up to \$1,500.00

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

CGP-3-DENT-HL-90

B497.1432

**All Options**

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

Once each year, during a special election period you may select to transfer to another dental expense plan option offered by your employer. The special election period is a time period agreed to by your employer and us. Coverage under the new plan option starts of the first day of the month that follows election. Coverage under the former plan option ends on that date.

The group enrollment period and the special election periods are time periods agreed to by your employer and us. Such open enrollment period and special election period may occur during the same time period.

CGP-3-DENT-HLTS

B497.2409

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## DENTAL EXPENSE INSURANCE

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

CGP-3-DG2000

B498.0007

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### DentalGuard Preferred - This Plan's Dental Preferred Provider Organization

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

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

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

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

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

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

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

CGP-3-DGY2K-PPO

B498.0151



## Covered Charges

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

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

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

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

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

CGP-3-DGY2K-CC

B498.0061

## Grievance Procedures

**External Review** If you or your representative does not agree with the handling of a claim or has any other grievance you may file a request for an external review. Requests should be sent to the Commissioner. This must be done within 30 business days after the date of receipt of a grievance decision rendered in a formal review. If the request is accepted by the Commissioner, an external review will be conducted by an Independent Review Organization (IRO). Within 5 business days of our receipt of the IRO's recommendation, a written report will be submitted to you or your representative and the Commissioner indicating our decision with respect to the IRO's recommendation.

The Commissioner may refer matters not within his or her jurisdiction to any other appropriate federal or District government agency for disposition or resolution.

You may contact the Commissioner at: The District of Columbia Insurance and Securities Regulation  
Gennet Purcell, Commissioner.

The address and phone number is:

Department of Insurance, Securities and Banking  
810 First Street, NE 7th Floor  
Washington, DC 20002  
Phone: 202-727-8000  
Fax 1-202-354-1085

**Definitions** "Commissioner" means the Commissioner of Insurance.

"Grievance" means a written request by you or a person on your behalf for review of Guardian's decision to deny, reduce, limit, terminate or delay your covered health care services.

"Grievance decision" means a determination accepting or denying the basis or requested remedy of the grievance.

"Independent Review Organization (IRO)" means an impartial, certified health entity engaged by the Commissioner or the Director to review any adverse grievance decision made by Guardian.

CGP-3-GRV-11-DC

B498.8707

## All Options

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### **Alternate Treatment**

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

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### **Proof Of Claim**

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

CGP-3-DGY2K-AT

B498.1141

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## Pre-Treatment Review

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

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

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

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

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

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

CGP-3-DGY2K-PTR

B498.0003

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## Benefits From Other Sources

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

CGP-3-DGY2K-OS

B498.0005

## All Options

### The Benefit Provision - Qualifying For Benefits

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CGP-3-DGY2K-BEN

B498.0072

## All Options

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

- All Group II Services.

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

- All Group III Services.

During the first 24 months a late entrant is covered by this *plan*, we won't pay for the following services:

- All Group IV Services.

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

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

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

CGP-3-DGY2K-LE

B498.0231

## All Options

**How We Pay Benefits For Group I, II And III Non-Orthodontic Services** There is no deductible for Group I services. We pay for Group I covered charges at the applicable *payment rate*.

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

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

CGP-3-DGY2K-BP

B498.0187

## Options A , B

All covered charges must be incurred while insured. And we limit what we pay each benefit year to \$5,000.00.

CGP-3-DGY2K-BP

B498.0192

**Options C , D**

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

CGP-3-DGY2K-BP

B498.0192

**All Options**

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**The Benefit Provision - Qualifying For Benefits**

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

CGP-3-DG-ROLL-04-2.1

B498.2041

**Options A , B**

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

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

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

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

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

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

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

- *Rollover Threshold* . . . . . \$1,000.00
- *Reward* (if all benefits are for services provided by a *preferred provider*) . . . . . \$750.00
- *Reward* (if any benefits are for services provided by a *non-preferred provider*) . . . . . \$500.00
- *Bank Maximum* . . . . . \$1,500.00

## **Rollover of Benefit Year Payment Limit for Group I, II and III Non-Orthodontic Services (Cont.)**

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

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

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

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

Definitions of terms used in this provision:

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

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

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

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

CGP-3-DG-ROLL-04-2

B498.9137

**Options C , D**

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

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

## Rollover of Benefit Year Payment Limit for Group I, II and III Non-Orthodontic Services (Cont.)

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

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

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

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

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

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

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

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

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

- only claims incurred on or after the start of the next *benefit year* will count toward the *Rollover Threshold*; and

## Rollover of Benefit Year Payment Limit for Group I, II and III Non-Orthodontic Services (Cont.)

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- *Rewards* will not be applied to a *covered person's Bank* until the *benefit year* that starts one year from the date the rollover provision first applies.

Definitions of terms used in this provision:

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

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

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

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

CGP-3-DG-ROLL-04-2

B498.9137

### Options A , B

#### **How We Pay Benefits For Group IV Orthodontic Services**

This *plan* provides benefits for Group IV orthodontic services.

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

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

*We* make the initial payment when the *active orthodontic appliance* is first placed. *We* make further payments at the end of each subsequent three month period, upon receipt of verification of ongoing treatment. But, treatment must continue and the *covered person* must remain covered by this *plan*. *We* limit what *we* pay for orthodontic services to the lifetime payment of \$2,500.00. What *we* pay is based on all of the terms of this *plan*.

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

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



## The Benefit Provision - Qualifying For Benefits (Cont.)

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

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

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

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

CGP-3-DGY2K-OR

B498.0057

### Options C , D

#### How We Pay Benefits For Group IV Orthodontic Services

This *plan* provides benefits for Group IV orthodontic services.

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

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

We make the initial payment when the *active orthodontic appliance* is first placed. We make further payments at the end of each subsequent three month period, upon receipt of verification of ongoing treatment. But, treatment must continue and the *covered person* must remain covered by this *plan*. We limit what we pay for orthodontic services to the lifetime payment of \$1,500.00. What we pay is based on all of the terms of this *plan*.

## The Benefit Provision - Qualifying For Benefits (Cont.)

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

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

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

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

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

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

CGP-3-DGY2K-OR

B498.0057

### All Options

#### **Non-Orthodontic Family Deductible Limit**

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

CGP-3-DGY2K-FL

B498.0073

**Options A , B**

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

- Benefits for Group I Services performed by  
a *preferred provider* . . . . . 100%
- Benefits for Group I Services performed by  
a *non-preferred provider* . . . . . 100%
- Benefits for Group II Services performed by  
a *preferred provider* . . . . . 90%
- Benefits for Group II Services performed by  
a *non-preferred provider* . . . . . 90%
- Benefits for Group III Services performed by  
a *preferred provider* . . . . . 60%
- Benefits for Group III Services performed by  
a *non-preferred provider* . . . . . 60%
- Benefits for Group IV Services performed by  
a *preferred provider* . . . . . 50%
- Benefits for Group IV Services performed by  
a *non-preferred provider* . . . . . 50%

CGP-3-DGY2K-PR

B498.0080

**Options C , D**

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

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

CGP-3-DGY2K-PR

B498.0080

**All Options**

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**After This Insurance Ends**

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

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

CGP-3-DGY2K-END

B498.0233

**All Options**

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**Special Limitations**

CGP-3-DGY2K-LMT

B498.0138

## All Options

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

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

CGP-3-DGY2K-TL

B498.0133

## All Options

### **If This Plan Replaces The Prior Plan**

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

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

CGP-3-DGY2K-PP

B498.0129

## All Options

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## Exclusions

We will not pay for:

- Any service or supply which is not specifically listed in this *plan's* List of Covered Dental Services.
- Any procedure performed in conjunction with, as part of, or related to a procedure which is not covered by this *plan*.
- Educational services. This includes, but is not limited to: oral hygiene instruction; plaque control; tobacco counseling; or diet instruction.
- Precision attachments and the replacement of part of a precision attachment; magnetic retention; or overdenture attachments.

## Exclusions (Cont.)

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- Overdentures and related services. This includes root canal therapy on teeth that support an overdenture.
- Any restoration, procedure, or *appliance* or prosthetic device used solely to: (1) alter vertical dimension; (2) restore or maintain occlusion, except to the extent that this *plan* covers *orthodontic treatment*; (3) treat a condition necessitated by attrition or abrasion; or (4) splint or stabilize teeth for periodontal reasons.
- The use of: general anesthesia; intramuscular sedation; intravenous sedation; non-intravenous sedation; or inhalation sedation, which includes but is not limited to nitrous oxide. But, this does not apply when administered in conjunction with: covered periodontal surgery; surgical extractions; the surgical removal of impacted teeth; apicoectomies; root amputations; and services listed under the "Other Oral Surgical Procedures" section of this *plan*.
- The use of local anesthetic.
- Cephalometric radiographs; oral/facial images. This includes traditional photographs and images obtained by intraoral camera. But, these services are covered when performed as part of the *orthodontic treatment* plan and records for a covered course of *orthodontic treatment*.
- Replacement of a lost, missing or stolen *appliance* or *dental prosthesis*; or the fabrication of a spare *appliance* or *dental prosthesis*.
- Prescription medication.
- Desensitizing medicaments; and desensitizing resins for cervical and/or root surface.
- Duplication of radiographs; the completion of claim forms; OSHA or other infection control charges.
- Pulp vitality tests; or caries susceptibility tests.
- Bite registration; or bite analysis.
- Gingival curettage.
- The localized delivery of chemotherapeutic agents.
- Tooth transplants.
- Maxillofacial prosthetics that repair or replace facial and skeletal anomalies; maxillofacial surgery; orthognathic surgery; or any oral surgery requiring the setting of a fracture or dislocation.
- Temporary or provisional *dental prosthesis* or *appliances*. But, this does not include interim partial dentures/stayplates to replace *anterior teeth* extracted while insured under this *plan*.
- Any service furnished solely for cosmetic reasons, unless the "List of Covered Dental Services" provides benefits for specific cosmetic services. Excluded cosmetic services include, but are not limited to: (1) characterization and personalization of a *dental prosthesis*; and (2) odontoplasty.

## Exclusions (Cont.)

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- Replacing an existing appliance or *dental prosthesis* with any *appliance* or prosthesis, unless it is: (1) at least 10 years old and is no longer usable; or (2) damaged while in the *covered person's* mouth in an *injury* suffered while insured, and can not be made serviceable.
- A fixed bridge replacing the extracted portion of a hemisected tooth; or the placement of more than one unit of crown and/or bridge per tooth.
- The replacement of extracted or missing third molars/wisdom teeth.
- Treatment of congenital or developmental malformations; or the replacement of congenitally missing teeth
- Any endodontic, periodontal, crown or bridge abutment procedure or *appliance* performed for a tooth or teeth with a guarded, questionable or poor prognosis.
- Any procedure or treatment method which does not meet professionally recognized standards of dental practice or which is considered to be experimental in nature.
- Any procedure, *appliance*, *dental prosthesis*, modality or surgical procedure intended to treat or diagnose disturbances of the temporomandibular joint (TMJ).
- Treatment needed due to: (1) an on-the-job or job-related *injury*; or (2) a condition for which benefits are payable by Workers' Compensation or similar laws.
- Treatment for which no charge is made. This usually means treatment furnished by: (1) the *covered person's* employer, labor union or similar group, in its dental or medical department or clinic; (2) a facility owned or run by any governmental body; and (3) any public program, except Medicaid, paid for or sponsored by any governmental body.
- Evaluations and consultations for non-covered services; detailed and extensive oral evaluations.
- The repair of an orthodontic *appliance*.
- The replacement of a lost or broken orthodontic retainer.

CGP-3-DGY2K-EXC-01

B498.2157

All Options

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**List of Covered Dental Services**

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

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

CGP-3-DNTL-90-13

B490.0048

All Options

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**Group I - Preventive Dental Services**  
(Non-Orthodontic)

**Prophylaxis And Fluorides**

Prophylaxis - limited to 1 prophylaxis in any 6 consecutive month period, to a maximum of 4 total prophylaxis and periodontal maintenance cleanings in any 12 consecutive month period. Allowance includes scaling and polishing procedures to remove coronal plaque, calculus, and stains.

- Adult prophylaxis covered age 12 and older.

Periodontal maintenance procedure - limited to 1 periodontal maintenance procedure(s) in any 3 consecutive month period, to a maximum of 4 total prophylaxis and periodontal maintenance procedures in a 12 consecutive month period. Allowance includes periodontal charting, scaling and polishing.

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

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

**Office Visits, Evaluations And Examination**

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

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

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

CGP-3-DNTL-90-14

B498.8537



**All Options**

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

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

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

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

CGP-3-DNTL-90-14

B498.0164

**All Options**

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

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

Other diagnostic radiographs:

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

Intraoral periapical or occlusal films - single films

CGP-3-DNTL-90-14

B498.0165

**All Options**

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

CGP-3-DNTL-90-14

B498.0166

**All Options**

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**Group II - Basic Dental Services**  
(Non-Orthodontic)

**Diagnostic Services** Allowance includes examination and diagnosis.

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## Group II - Basic Dental Services (Cont.) (Non-Orthodontic)

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

Diagnostic Services: Allowance includes examination and diagnosis.

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

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

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

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

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

Resin restorations - Allowance includes light curing, acid etching, adhesives, including resin bonding agents and local anesthetic.

Silicate cement, per restoration

Composite resin

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

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

CGP-3-DNTL-90-15

B498.2779

**All Options**

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

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

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

CGP-3-DNTL-90-15.0

B498.2852

**All Options**

**Non-Surgical Extractions** Allowance includes the treatment plan, local anesthetic and post-treatment care.

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

**Surgical Extractions** Allowance includes the treatment plan, local anesthetic and post-surgical care. Services listed in this category and related services, may be covered by your medical plan.

Surgical removal of erupted teeth, involving tissue flap and bone removal  
Surgical removal of residual tooth roots  
Surgical removal of impacted teeth

**Other Oral Surgical Procedures** Allowance includes diagnostic and treatment radiographs, the treatment plan, local anesthetic and post-surgical care. Services listed in this category and related services, may be covered by your medical plan.

Alveoplasty, per quadrant  
Removal of exostosis, per site  
Incision and drainage of abscess  
Frenulectomy, Frenectomy, Frenotomy  
Biopsy and examination of tooth related oral tissue  
Surgical exposure of impacted or unerupted tooth to aid eruption  
Excision of tooth related tumors, cysts and neoplasms  
Excision or destruction of tooth related lesion(s)  
Excision of hyperplastic tissue  
Excision of pericoronal gingiva, per tooth  
Oroantral fistula closure  
Sialolithotomy  
Sialodochoplasty  
Closure of salivary fistula  
Excision of salivary gland  
Maxillary sinusotomy for removal of tooth fragment or foreign body  
Vestibuloplasty

CGP-3-DNTL-90-15.0

B498.1124

## All Options

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

Injectable antibiotics needed solely for treatment of a dental condition.

CGP-3-DNTL-90-15

B498.0206

## All Options

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### Group III - Major Dental Services (Non-Orthodontic)

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

#### Single Crowns

Resin with metal

Porcelain

Porcelain with metal

Full cast metal (other than stainless steel)

3/4 cast metal crowns

3/4 porcelain crowns

#### Inlays

Onlays, including inlay

Labial veneers

Posts and buildups - only when done in conjunction with a covered unit of crown or bridge and only when necessitated by substantial loss of natural tooth structure.

Cast post and core in addition to a unit of crown or bridge, per tooth

Prefabricated post and composite or amalgam core in addition to a unit of crown or bridge, per tooth

Crown or core buildup, including pins

## **Group III - Major Dental Services (Cont.)**

(Non-Orthodontic)

Implant supported prosthetics - Allowance includes the treatment plan and local anesthetic, when done in conjunction with a covered surgical placement of an implant, on the same tooth.

Abutment supported crown

Implant supported crown

Abutment supported retainer for fixed partial denture

Implant supported retainer for fixed partial denture

Implant/abutment supported removable denture for completely edentulous arch

Implant/abutment supported removable denture for partially edentulous arch

Implant/abutment supported fixed denture for completely edentulous arch

Implant/abutment supported fixed denture for partially edentulous arch

Dental implant supported connecting bar

Prefabricated abutment

Custom abutment

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

Surgical placement of implant body, endosteal implant

Surgical placement, eposteal implant

Surgical placement, transosteal implant

### Other Implant services

Bone replacement graft for ridge preservation, per site, when done in conjunction with a covered surgical placement of an implant in the same site, limited to once per tooth, per lifetime

Radiographic/surgical implant index - limited to once per arch in any 24 month period

Repair implant supported prosthesis

Repair implant abutment

Implant removal

CGP-3-DNTL-90-16

B498.1148

## All Options

**Prosthodontic Services** Specialized techniques and characterizations are not covered. Facings on dental prostheses for teeth posterior to the second bicuspid are not covered. Allowance includes insulating bases, temporary or provisional restorations and associated gingival involvement.

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

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

Bridge Pontics

Resin with metal

Porcelain

Porcelain with metal

Full cast metal

3/4 cast metal crowns

3/4 porcelain crowns

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

Complete or Immediate dentures, upper or lower

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

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

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

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

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

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

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

Simple stress breakers, per unit

CGP-3-DNTL-90-16

B498.1146

**All Options**

**Crown And  
Prosthodontic  
Restorative Services**

Facings on dental prostheses for teeth posterior to the second bicuspid are not covered. Also see the "Major Restorative Services" section.

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

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

- Inlay or onlay
- Crown
- Bridge

Adding teeth to partial dentures to replace extracted natural teeth

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

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

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

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

Denture adjustments - Denture adjustments done within 12 months are considered to be part of the denture placement when the adjustment is done by the *dentist* who furnished the denture. Limited to adjustments that are done more than 6 consecutive months after a denture rebase, denture reline or the initial insertion of the denture.

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

## All Options

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

Pulp capping, limited to permanent teeth and limited to one pulp cap per tooth, per lifetime.

Pulp capping, direct

Pulp capping, indirect - includes sedative filling.

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

Gross pulpal debridement

Pulpal therapy, limited to primary teeth only coinsurance

Root Canal Treatment

Root canal therapy

Root canal retreatment, limited to once per tooth, per lifetime

Treatment of root canal obstruction, no-surgical access

Incomplete endodontic therapy, inoperable or fractured tooth

Internal root repair of perforation defects

Other Endodontic Services

Apexification, limited to a maximum of three visits

Apicoectomy, limited to once per root, per lifetime

Root amputation, limited to once per root, per lifetime

Retrograde filling, limited to once per root, per lifetime

Hemisection, including any root removal, once per tooth

CGP-3-DNTL-90-16

B498.0209



## All Options

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

The following treatment is limited to a total of one of the following, once per tooth in any 12 consecutive months.

Gingivectomy, per tooth (less than 3 teeth)  
Crown lengthening - hard tissue

The following treatment is limited to a total of one of the following once per quadrant, in any 36 consecutive months.

Gingivectomy or gingivoplasty, per quadrant  
Osseous surgery, including scaling and root planing, flap entry and closure, per quadrant  
Gingival flap procedure, including scaling and root planing, per quadrant  
Distal or proximal wedge, not in conjunction with osseous surgery  
Surgical revision procedure, per tooth

The following treatment is limited to a total of one of the following, once per quadrant in any 36 consecutive months.

Pedicle or free soft tissue grafts, including donor site, or subepithelial connective tissue graft procedure, when the tooth is present, or when dentally necessary as part of a covered surgical placement of an implant.

The following treatment is limited to a total of one of the following, once per area or tooth, per lifetime.

Guided tissue regeneration, resorbable barrier or nonresorbable barrier bone replacement grafts, when the tooth is present

Periodontal surgery related

Limited occlusal adjustment -limited to a total of two visits, covered only when done within a 6 consecutive month period after covered scaling and root planing or osseous surgery. Must have radiographic evidence of vertical defect or widened periodontal ligament space.

Occlusal guards, covered only when done within a 6 consecutive month period after osseous surgery, and limited to one per lifetime

CGP-3-DNTL-90-16

B498.0212

## All Options

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### Group IV - Orthodontic Services

**Orthodontic Services** Any covered Group I, II or III service in connection with *orthodontic treatment*.

Transseptal fiberotomy

Surgical exposure of impacted or unerupted teeth in connection with *orthodontic treatment* - Allowance includes treatment and final radiographs, local anesthetics and post-surgical care.

Treatment *plan* and records, including initial, interim and final records.

## Group IV - Orthodontic Services (Cont.)

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Limited *orthodontic treatment*, Interceptive *orthodontic treatment* or Comprehensive *orthodontic treatment*, including fabrication and insertion of any and all fixed *appliances* and periodic visits.

Orthodontic retention, including any and all necessary fixed and removable *appliances* and related visits - limited to initial *appliance(s)* only.

CGP-3-DNTL-90-8

B498.0071

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**DISCOUNT - THIS IS NOT INSURANCE**

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**Discounts on Dental Services Not Covered By This Plan**

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A covered person under this plan can receive discounts on certain services not covered by this plan, as described below, if:

- (a) he or she receives services or supplies from a dentist that is under contract with our DentalGuard Preferred Provider Organization (PPO) network; and
- (b) the service or supply is on the fee schedule the dentist has agreed to accept as payment in full as a member of the PPO network.

The services described in this provision are not covered by this plan. The covered person must pay the entire discounted fee directly to the dentist. There is no need to file a claim.

When a person is no longer covered by this plan, access to the network discounts ends.

B499.0077

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**Discounts on Services Not Covered Due To Contractual Provisions**

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If a covered person receives dental services from a dentist who is under contract with Guardian's DentalGuard Preferred PPO, such services will be provided at the discounted fee the dentist agreed to accept as payment in full as a member of our DentalGuard Preferred PPO network, even if such services are not covered by the plan due to:

- Meeting the plan's benefit year payment limit provision;
- Frequency limitations; or
- Plan exclusions.

B499.0078

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**ELIGIBILITY FOR VISION CARE EXPENSE COVERAGE**

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B505.0152

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**Employee Vision Care Expense Coverage**

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**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 November 1st to November 30th of each year.

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

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

CGP-3-EC-90-1.0

B505.0060

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

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

CGP-3-EC-90-2.0

B505.1681

## Options A , C

**When Your Coverage Ends** Your coverage under this *plan* ends on the last day of the month in which your active *full-time* service ends for any reason. Such reasons include disability, retirement, layoff, leave of absence and the end of employment.

Your coverage ends on the date you die.

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

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

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

CGP-3-EC-90-3.0

B505.0083

## Options A , C

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

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**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.

## Your Right To Continue Group Coverage During A Family Leave Of Absence (Cont.)

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

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

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

CGP-3-EC-90-3.0

B449.0727

**Options A , C**

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## Dependent Vision Care Expense Coverage

CGP-3-DEP-90-1.0

B505.0099

## Options A , C

### Eligible Dependents For Dependent Vision Care Benefits

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

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

CGP-3-DEP-90-2.0

B505.0782

## Options A , C

### Adopted Children And Step-Children

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

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

CGP-3-DEP-90-3.0

B505.0112

## Options A , C

### Handicapped Children

An *employee* may have an unmarried child, grandchild, niece or nephew 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 dependent 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 the *employee* for most of his support and maintenance. With respect to grandchildren, nieces or nephews, the child must also remain (a) under the primary care of the *employee*; and (b) his legal guardian, if other than the *employee*, must not be covered under another plan.

But, for the child to stay eligible, the *employee* must send us written proof that the child is handicapped and depends on the *employee* for most of his support and maintenance. The *employee* has 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 the *employee's* does.

CGP-3-DEP-90-4.0

B505.0128

## Options A , C

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

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

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

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

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

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

CGP-3-DEP-90-6.0

B505.0714

## Options A , C

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

CGP-3-DEP-90-7.0

B505.0132

## Options A , C

**Newborn Children** We cover your newborn child for dependent benefits, from the moment of birth. If you do not have dependent child coverage when the child is born, we cover the child for the first 31 days from the moment of birth. To continue the child's coverage past the 31 days, you must enroll the child and agree to make any required premium payments within 31 days of the date the child is born. If you fail to do this, the child's coverage will terminate at the end of the 31 days and the child cannot be enrolled until the next vision open enrollment period.

CGP-3-DEP-90-8.0

B505.0772



## Options A , C

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

If a surviving dependent elects to continue his 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, grandchild, niece or nephew on the last day of the month in which the child attains this *plan's* age limit or when he marries. A step-child's coverage also when which he is no longer dependent on the *employee* for support and maintenance. A grandchild, niece or nephew's coverage also ends on the last day of the month in which (a) he is no longer in the primary care of the *employee* or (b) his legal guardian, if other than the *employee*, becomes covered under another plan. A spouses's coverage ends on the last day of the month in which a marriage ends in legal divorce or annulment.

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

CGP-3-DEP-90-9.0

B505.0751

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**CERTIFICATE AMENDMENT**

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

The employee and his or her domestic partner must qualify for coverage. To qualify for coverage, the employee and his or her domestic partner must:

- complete a declaration of domestic partnership attesting to the relationship;
- be 18 years of age or older;
- be unmarried, constitute each other's sole domestic partner and not have had another domestic partner in the last 12 months;
- share the same permanent address for at least 12 consecutive months and intend to do so indefinitely;
- share joint financial responsibility for basic living expenses including food, shelter and medical expenses;
- not be related by blood to a degree that would prohibit marriage in the employee's state of residence; and
- be financially interdependent as demonstrated by at least four of the following:
  - a. ownership of a joint bank account;
  - b. ownership of a joint credit account;
  - c. evidence of a joint mortgage or lease;
  - d. evidence of joint obligation on a loan;
  - e. joint ownership of a residence;
  - f. evidence of common household expenses such as utilities or telephone;
  - g. execution of wills naming each other as executor and/or beneficiary;
  - h. granting each other durable powers of attorney;
  - i. granting each other health care powers of attorney;
  - j. designation of each other as beneficiary under a retirement benefit account; or
  - k. evidence of other joint financial responsibility.

The domestic partner's dependent children will be eligible for coverage under this plan. They will be eligible on the same basis as if the children were the employee's dependent children. Coverage for the domestic partner and his or her dependent children can end. Coverage ends when the domestic partner no longer meets the qualifications of a domestic partner as indicated above. Upon termination of a domestic partnership, a "Statement of Termination" must be completed. It must also be filed with the employer. The termination shall take effect six months after the statement is filed. Benefits will continue to accrue during this period. Once the employee submits a "Statement of Termination," he or she may not enroll another domestic partner for a period of 12 months from the date of the previous termination.

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

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

**The Guardian** Life Insurance Company of America

*Stuart J Shaw*

Vice President, Risk Mgt. & Chief Actuary

CGP-3-A-DMST-DC-06

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**VISION CARE HIGHLIGHTS**

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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.

<b>PPO Copayments</b>	Examinations . . . . .	\$10.00
	Standard Frames and/or Standard Lenses . . . . .	\$25.00
	Necessary Contact Lenses . . . . .	\$25.00
<b>Non-PPO Cash Deductibles</b>	Examinations . . . . .	\$10.00
	Standard Frames and/or Standard Lenses . . . . .	\$25.00
	Necessary Contact Lenses . . . . .	\$25.00
<b>Payment Rates</b>	For Covered Charges . . . . .	100%

CGP-3-VSN-96-BEN3

B505.0004

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## VISION CARE EXPENSE INSURANCE

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

CGP-3-VSN-96-VIS

B505.0007

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

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

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

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

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

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

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

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

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

**Vision Service Plan**

**This Plan's Vision Care Preferred Provider Organization (Cont.)**

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

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

CGP-3-VSN-96-PPOA

B505.0009

**Options A , C**

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

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

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

CGP-3-VSN-96-PTR2

B505.0014

**Options A , C**

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

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

**Vision Service Plan**

**This Plan's Vision Care Preferred Provider Organization (Cont.)**

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

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

**Preferred Provider  
Grievance  
Procedures**

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

- (1) The patient's written complaint will be referred to VSP's Professional Relations Vice President for action.
- (2) The complaint will be evaluated and, if deemed appropriate, the original examining doctor will be contacted.
- (3) If the complaint can be resolved within fifteen (15) days, the disposition of the complaint will be forwarded to the *covered person*. Otherwise, a notice of receipt of the complaint will be forwarded to the *covered person* advising the time for resolution.
- (4) Grievance procedures and complaint forms will be maintained in each *preferred provider's* office.
- (5) All complaints will be retained in the Professional Relations Department.

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

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

CGP-3-VSN-96-APP

B505.0015

**How This Plan Works**

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

**Services or Supplies From a Preferred Provider**

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

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

For each vision examination from a *preferred provider* . . . . . \$10.00

For each pair of *standard frames* and/or  
*standard lenses* from a *preferred provider* . . . . . \$25.00

For Necessary Contact Lenses from a *preferred provider* . . . . . \$25.00

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

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

For covered charges . . . . . 100%

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

The discounts are:

For Prescription Glasses . . . . . 20% off of the *preferred provider's*  
*usual and customary fee*



## Services or Supplies From a Preferred Provider (Cont.)

For Non-Prescription Sunglasses . . . . 20% off of the *preferred provider's usual and customary fee*

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

CGP-3-VSN-96-BEN1

B505.0933

### Options A , C

## Services or Supplies From a Non-Preferred Provider

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

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

For each vision examination provided by a *non-preferred provider* . . . \$10.00

For each pair of *standard frames* and/or *standard lenses* from a *non-preferred provider* . . . . . \$25.00

For each pair of Necessary Contact Lenses from a *non-preferred provider* . . . . . \$25.00

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

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

For covered charges . . . . . 100%

CGP-3-VSN-96-BEN2

B505.0021

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## Covered Charges

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

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## Covered Services and Supplies

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

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

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

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

We don't cover more than one vision examination in any calendar year period.

And if a *covered person* uses a *non-preferred provider*, we limit what we pay for each vision examination to \$39.00.

CGP-3-VSN-96-LIST1

B505.0935

**Standard Lenses** We cover charges for single vision, bifocal, trifocal or *lenticular lenses*. We cover glass, plastic or for dependent children to age 26, polycarbonate lenses.

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

- \$23.00 for each pair of single vision lenses

## Covered Services and Supplies (Cont.)

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- \$37.00 for each pair of bifocal lenses
- \$49.00 for each pair of trifocal lenses and
- \$64.00 for each pair of *lenticular lenses*.

CGP-3-VSN-09-SL

B505.0941

### Options A , C

We cover charges for one pair of *standard lenses* in any calendar year *benefit period*.

CGP-3-VSN-09-SL

B505.0962

### Options A , C

**Standard Frames** We cover charges for standard frames.

If a covered person uses a preferred provider, we cover charges up to a retail frame allowance of \$130.00, plus 20% of any amount over the allowance.

If a covered person uses a non-preferred provider, we limit what we pay for each set of standard frames to \$46.00.

If the covered person chooses elective contact lenses, we do not cover standard frames until the beginning of the calendar year following the date the elective contacts are purchased.

We cover charges for one set of standard frames in any calendar year period.

CGP-3-VSN-09-SF

B505.0989

### Options A , C

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

- (a) following cataract surgery;
- (b) to correct extreme visual acuity problems that cannot be corrected with spectacle lenses;
- (c) for certain conditions of *anisometropia*; or
- (d) for *keratoconus*.

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

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

CGP-3-VSN-96-LIST7

B505.0996

## Options A , C

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

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

If a covered person uses a preferred provider, we limit what we pay for elective contact lenses to \$130.00

If a covered person uses a non-preferred provider, we limit what we pay for elective contact lenses to \$100.00.

We cover charges for one set of elective contact lenses in any calendar year period.

CGP-3-VSN-09-ECL

B505.1007

Options A , C

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**Special Limitations**

**If This VSP Plan Replaces Another VSP Plan**

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

CGP-3-VSN-96-SL1

B505.0031

Options A , C

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**Exclusions**

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

CGP-3-VSN-96-EXC1

B505.0034

Options A , C

- We will not pay for *plano lenses* (lenses with less than a +/- .38 diopter power).
- We will not pay for two sets of glasses in lieu of bifocals.
- We will not pay for replacement of lenses and frames furnished under this *plan* which are lost or broken, except at normal intervals when services are otherwise available.
- We will not pay for cosmetic lenses or any cosmetic process, unless specifically shown as covered in the "Covered Services and Supplies" section.
- We will not pay for a frame that costs more than the plan allowance.
- We will not pay for refitting of contact lenses after the initial 90 day fitting period.
- We will not pay for routine maintenance of contact lenses such as polishing or cleaning.
- We will not pay for Corneal Refractive Therapy (CRT) or Orthokeratology (procedure using contact lenses to change the shape of the cornea in order to reduce myopia).

CGP-3-VSN-09-EXC

B505.0998

**Options A , C**

- We will not pay for photochromic lenses and tinted lenses, except for pink #1 and pink #2.

B505.1015

**Options A , C**

- We will not pay for UV (ultraviolet) protected lenses.

B505.1016

**Options A , C**

- We will not pay for the scratch resistant coating of the lens or lenses.

B505.1017

**Options A , C**

- We will not pay for blended lenses.

B505.1018

**Options A , C**

- We will not pay for high index lenses.

B505.1019

**Options A , C**

- We will not pay for the mirror/ski coating of the lens or lenses.

B505.1020

**Options A , C**

- We will not pay for oversized lenses.

B505.1021

**Options A , C**

- We will not pay for laminating of the lens or lenses.

B505.1022

**Options A , C**

- We will not pay for edge treatment.

B505.1023

**Options A , C**

- We will not pay for progressive lenses.
- We will not pay for progressive multifocal lenses.

B505.1024

**Options A , C**

- We will not pay for the anti-reflective coating of the lens or lenses.

B505.1025

**Options A , C**

- We will not pay for polycarbonate lenses.

B505.1026

**Options A , C**

CGP-3-VSN-09-EXC

B505.1027

**Options A , C**

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

CGP-3-VSN-96-EXC17

B505.0037

**Options B , D**

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**VISION DISCOUNT PROGRAM**

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**Employee Vision Discount Program**

An employee's eligibility for this vision discount program is contingent upon his or her eligibility for dental coverage under this plan.

If an employee is covered for dental coverage under this plan, he or she is eligible for this vision discount program.

If an employee is not covered under this plan's dental coverage, he or she is not eligible for this vision discount program.

An employee's participation in this vision discount program starts on the later of: (a) the effective date of this program; or (b) the date he or she becomes covered for dental benefits under this plan.

An employee's participation in this vision discount program ends on the earlier of: (a) the date this program ends; or (b) the date he or she is no longer covered for dental benefits under this plan.

CGP-3-EC-90-1.0

B506.0002

**Options B , D**

**Dependent Vision Discount Program**

An employee's covered dependent's eligibility for this vision discount program is contingent upon his or her eligibility for dental coverage under this plan.

If a dependent is covered for dental coverage under this plan, he or she is eligible for this vision discount program.

If the dependent is not covered under this plan's dental coverage, he or she is not eligible for this vision discount program.

A dependent's participation in this vision discount program starts on the later of: (a) the effective date of this program; or (b) the date he or she becomes covered for dental benefits under this plan.

The dependent's participation in this vision discount program ends on the earlier of: (a) the date this program ends; or (b) the date he or she is no longer covered for dental benefits under this plan.

CGP-3-DEP-90-1.0

B506.0003



### Options B , D

### This Is Not Insurance

#### Discounts on Vision Services and Supplies

A member of this program can receive discounts on vision care services or supplies from a vision provider who is under contract with Vision Service Plan's (VSP's) network, as described below. Discounts are not available from providers who are not members of VSP's network.

The member must pay the entire discounted fee directly to the VSP network doctor. There is no need to file a claim.

A member must make an appointment with a VSP network doctor. To find a VSP network doctor, the member can visit [www.vsp.com](http://www.vsp.com) or call 1-800-877-7195.

When a person is no longer a member of this program, access to the network discounts ends.

The discounts provided by this program are as follows:

**Eye Exams** - 20% off the VSP doctor's usual charge.

**Glasses and Lenses:** Discounts are given for an unlimited number of glasses or contact lens professional services visits, as long as the VSP network doctor has provided an eye exam to the member within the last 12 months.

- Standard lenses - 20% off the VSP doctor's usual charge, when a complete set of prescription glasses is purchased.
- Lens options - 20% off the VSP doctor's usual charge for all lens options, such as tints and coatings.
- Frames - 20% off the VSP doctor's usual charge when a complete set of prescription glasses is purchased.
- Elective contact lenses - 15% off the VSP doctor's usual charge for professional services. The lenses are not discounted.

VSP network doctors are not required to extend a discount if they have not provided an eye exam to the patient within the last 12 months.

No discounts will be given for:

- sundry items such as lens cleaners and solutions,
- artistically painted lenses,
- additional office visits associated with contact lens pathology,
- contact lens modification, polishing or cleaning,
- orthoptics or vision training and any associated supplemental testing,
- plano lenses,
- expenses associated with securing materials such as lenses and frames,
- medical or surgical treatment of the eyes except as described in the "Laser Surgery" section below.

## Vision Discount Program (Cont.)

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**Laser Surgery:** The discount program provides access to a network of laser surgery centers where members and their dependents can obtain vision laser surgery at a discounted fee. Members save an average of 15% off the laser surgeon's usual charge. And, if the laser center is offering a temporary price reduction, the member will receive 5% off the promotional price if it is less than the usual discounted price.

No one will have to pay more than \$1,800 per eye for laser-assisted in-situ keratomileusis (LASIK), and \$1,500 per eye for photorefractive keratectomy (PRK), two of the most common procedures.

If a member or a member's dependent is interested in the discount program, he or she must schedule a screening and consultation with a VSP doctor to discuss whether vision laser surgery is an appropriate procedure.

If the member or dependent decides to proceed with the surgery, the doctor will refer him or her to a VSP laser surgeon for further evaluation.

The laser center's fee includes the fee for the initial screening and consultation, the surgery itself and all post-operative care.

If the doctor determines that the member or dependent is an appropriate candidate for the laser surgery, but he or she does not have the surgery performed, he or she must pay the fee for the screening and consultation directly to the VSP network doctor. If the doctor determines that the enrollee or dependent is not an appropriate candidate for laser surgery, no fee is charged for the consultation.

B506.0004

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**CERTIFICATE AMENDMENT**

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This amendment is effective November 24, 2010, or the earlier of your coverage effective date or first renewal date following November 24, 2010.

The plan's Group Dental Benefits Claims Procedure is revised to read as follows:

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**Group Dental Benefits Claims Procedure**

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If you want to receive benefits under the plan, you should complete and submit a claim form. See your plan administrator for forms and instructions.

As a part of our routine operations; we apply the terms of this plan for making decisions affecting eligibility, benefits and claims, or explaining our administrative policies, procedures and processes. 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 the plan, Guardian will also observe the procedures listed below. These procedures are the minimum requirements for benefit claims procedures of employee benefit plans covered by Title 1 of the Employee Retirement Income Security Act of 1974(ERISA).

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

**The Guardian** Life Insurance Company of America

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

All Options

**Limited Benefits, Please Read Carefully**

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**CERTIFICATE AMENDMENT**

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

The Major Restorative Services are modified to provide that titanium or high noble metal (gold) is covered when used in a *dental prosthesis*.

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

**The Guardian** Life Insurance Company of America

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

CGP-3-A-DGOPT-10

B531.0026

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**CERTIFICATE AMENDMENT**

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The certificate is amended as follows:

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

- (a) your dependent child is a child under age 26;
- (b) marital status, residency and financial dependency requirements do not apply to your dependent child; except as stated in item (c);
- (c) your handicapped child can stay eligible for dependent coverage past age 26 if your child is unmarried and is unable to support himself or herself; and
- (d) reference to an individual dependent's coverage ending when he or she marries or is no longer dependent on you for support and maintenance, except as stated for a handicapped child past the age limit, is deleted.

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

**The Guardian** Life Insurance Company of America

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

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**CERTIFICATE RIDER**

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**Limited Benefits, Please Read Carefully**

To add the following to the Vision Care Covered Services and Supplies:

**Diabetic Eye Care Plus Program:** We pay benefits for covered charges for diabetic eye care from a Preferred Provider. The Covered Person must pay a \$20.00 Copayment for each office visit. In order to be covered, the services for diabetic eye care must be within the scope of the Preferred Provider's optometric license.

We cover charges for the treatment of non-surgical medical eye conditions for Covered Persons with type 1 or type 2 diabetes.

We cover charges for:

- Medical follow up exams.
- Specialized screenings and tests.
- Medically necessary retinal imaging.

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

**The Guardian** Life Insurance Company of America

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

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**CERTIFICATE RIDER**

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**Limited Benefits, Please Read Carefully**

To add the following to the Vision Care Covered Services and Supplies:

**Elective Contact Lens Fitting and Evaluation Services:** We cover charges for fitting and evaluation services received from a Preferred Provider for elective contact lenses that are covered under this plan. Coverage under this section does not include charges for contact lens materials.

We cover charges for no more than one elective contact lens fitting and evaluation for each Covered Person in any one calendar year *benefit period*.

The Covered Person must pay a Copayment of up to \$60.00 each time he or she receives an elective contact lens fitting and evaluation. We pay benefits in full for the covered charges a Covered Person incurs in excess of the Copayment.

As used herein:

**Elective Contact Lenses** means contact lenses that are not prescribed for conditions in which visual acuity cannot be adequately corrected with eyeglasses as determined by the Preferred Provider.

The Covered Person determines if he or she wants to receive elective contact lenses.

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

**The Guardian** Life Insurance Company of America

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

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**CERTIFICATE RIDER**

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**Limited Benefits, Please Read Carefully**

To add the following to the Vision Care Covered Services and Supplies:

**Services and Supplies Received from Affiliate Providers:** Vision care services and supplies that are covered by this Plan when received from a Preferred Provider or a Non-Preferred Provider may also be covered by this Plan when such services and supplies are received from, an Affiliate Provider, subject to the limitations and exclusions below.

If services and supplies are received from an Affiliate Provider, We pay benefits for covered charges after the Copayment, as shown below:

<b>SERVICES AND SUPPLIES</b>	<b>AFFILIATE PROVIDER - COSTCO</b>	<b>OTHER AFFILIATE PROVIDERS</b>
<b>Eye Exam</b> - one in any one calendar year Period.	Covered In Full.	Covered In Full.

B531.0329

**Options A , C**

**Standard Lenses** - one pair in any one calendar year Period.

● Single Vision	Covered In Full. (Not all lens types may be available at all locations.)	Covered In Full. (Not all lens types may be available at all locations.)
● Bifocal	Covered In Full. (Not all lens types may be available at all locations.)	Covered In Full. (Not all lens types may be available at all locations.)
● Trifocal	Covered In Full. (Not all lens types may be available at all locations.)	Covered In Full. (Not all lens types may be available at all locations.)
● Lenticular	Not Available.	Covered In Full. (Not all lens types may be available at all locations.)
<b>Lens Options</b> - once in any one calendar year Period.	Covered In Full. (Not all lens types may be available at all locations.)	Covered In Full. (Not all lens types may be available at all locations.)

B505.1436



**Options A , C**

**SERVICES AND SUPPLIES**

**Standard Frames** - one set in any one calendar year Period.

**AFFILIATE PROVIDER - COSTCO**

Covered In full up to \$70.00.  
● No discount available on charges in excess of the benefit amount.

**OTHER AFFILIATE PROVIDERS**

Covered In full up to \$130.00

B531.0324

**Options A , C**

**Elective Contact Lenses** - one set in any one calendar year Period.

- Contact Lens (Materials Only)

Covered In full up to \$130.00.

Covered In full up to \$130.00

B531.0326

**Options A , C**

**Limitations and Exclusions:**

1. Limitations and exclusions of benefits described in the Plan for VSP Preferred Providers shall also apply to services and supplies received from Affiliate Providers.
2. If a service or supply is not covered by this Plan when received from a Preferred Provider or a Non-Preferred Provider, such service or supply is not covered by this Plan when received from an Affiliate Provider.
3. Services and supplies received from an Affiliate Provider are in lieu of services and supplies received from a VSP Preferred Provider or a Non-Preferred Provider. Membership may be required in order to access benefits through an Affiliate Provider. Membership fees are not covered under this Plan.

B505.1566

**Options A , C**

4. We do not cover charges for:
  - Medically Necessary Contact Lenses.
  - Diabetic Eye Care Plus Program.

B505.1540

**Options A , C**

**Definitions:**

The following definition is added to the definitions shown in the Plan.

The term "Affiliate Provider" means vision care providers who are not contracted as VSP Preferred Providers but who have agreed to bill VSP directly for covered vision services and supplies provided as set forth in this section. Not all Affiliate Providers may be able to provide all such covered vision services and supplies. Covered Persons should discuss requested services with their provider or contact VSP Customer Care at (800) 877-7195 for details.

The following definition replaces the definition of the term "Copayment" as it is shown in the Plan.

The term "Copayment" means a charge, expressed as a fixed dollar amount, required to be paid by, or on behalf of, a Covered Person to a Preferred Provider or an Affiliate Provider at the time covered vision services or supplies are received.

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

**The Guardian** Life Insurance Company of America

*Stuart J Shaw*

Vice President, Risk Mgt. & Chief Actuary

CGP-A-VSN-AFFIL-DC-13

B531.0319

CGP-A-VSN-AFFIL-DC-13

**Options B , D**

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**CERTIFICATE AMENDMENT**

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

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**ADDITIONAL SERVICES**

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

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

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

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

- Financial Planning and Wellness Services.

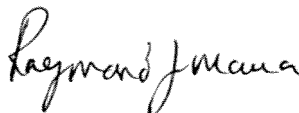
**Options B , D**

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

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

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

**The Guardian** Life Insurance Company of America



Raymond Marra, Senior Vice President, Group and Worksite Markets

B531.0621

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## COORDINATION OF BENEFITS

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

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

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### Definitions

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

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

- (1) If a person is confined in a private hospital room, the difference between the cost of a semi-private room in the hospital and the private room is **not** an allowable expense. This does not apply if: (a) the stay in the private room is medically necessary in terms of generally accepted medical practice; or (b) one of the plans routinely provides coverage for private hospital rooms.
- (2) The amount a benefit is reduced by the primary plan because a person does not comply with the plan's provisions is **not** an allowable expense. Examples of these provisions are: (a) precertification of admissions and procedures; (b) continued stay reviews; and (c) preferred provider arrangements.
- (3) If a person is covered by two or more plans that compute their benefit payments on the basis of reasonable and customary charges, any amount in excess of the primary plan's reasonable and customary charges for a specific benefit is **not** an allowable expense.
- (4) If a person is covered by two or more plans that provide benefits or services on the basis of negotiated fees, an amount in excess of the primary plan's negotiated fees for a specific benefit is **not** an allowable expense.

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

- Claim** This term means a request that benefits of a plan be provided or paid.
- Claim Determination Period** This term means a calendar year. It does not include any part of a year during which a person has no coverage under this plan, or before the date this section takes effect.
- Closed Panel Plan** This term means a health maintenance organization (HMO), preferred provider organization (PPO), exclusive provider organization (EPO), or other plan that provides health benefits to covered persons primarily in the form of services through a panel of providers that have contracted with or are employed by the plan; and that limits or excludes benefits for services provided by other providers, except in cases of emergency or referral by a panel member.
- Coordination Of Benefits** This term means a provision which determines an order in which plans pay their benefits, and which permits secondary plans to reduce their benefits so that the combined benefits of all plans do not exceed total allowable expenses.
- Custodial Parent** This term means a parent awarded custody by a court decree. In the absence of a court decree, it is the parent with whom the child resides more than one half of the calendar year without regard to any temporary visitation.
- Group-Type Contracts** This term means contracts: (a) which are not available to the general public; and (b) can be obtained and maintained only because of membership in or connection with a particular organization or group. This includes, but is not limited to, franchise and blanket coverage.
- Hospital Indemnity Benefits** This term means benefits that are not related to expenses incurred. This term does not include reimbursement-type benefits even if they are designed or administered to give the insured the right to elect indemnity-type benefits at the time of claim.
- Plan** This term means any of the following that provides benefits or services for health care or treatment: (1) group insurance; (2) closed panel or other forms of group or group-type coverage, whether insured or uninsured; (3) group-type contracts; (4) amounts of group or group-type hospital indemnity benefits in excess of \$200.00 per day; (5) medical components of group long-term care contracts such as skilled nursing care; (6) medical benefits under group or individual automobile contracts; and (7) governmental benefits, except Medicare, as permitted by law.

## Definitions (Cont.)

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

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

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

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

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

**This Plan** This term means the group health benefits, except prescription drug and vision coverage, if any, provided under this group plan.

CGP-3-R-COB-05

B555.0289

### All Options

## Order Of Benefit Determination

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

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

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

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

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

## Order Of Benefit Determination (Cont.)

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But, if the person is a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the plan that covers the person as a dependent; and primary to the plan that covers the person other than as a dependent (for example, as a retiree); then the order of payment between the two plans is reversed. In that case, the plan that covers the person as an employee, member, subscriber, or retiree is secondary and the other plan is primary.

### **Child Covered Under More Than One Plan**

The order of benefit determination when a child is covered by more than one plan is:

- (1) If the parents are married, or are not separated (whether or not they ever have been married), or a court decree awards joint custody without specifying that one party must provide health care coverage, the plan of the parent whose birthday is earlier in the year is primary. If both parents have the same birthday, the plan that covered either of the parents longer is primary. If a plan does not have this birthday rule, then that plan's coordination of benefits provision will determine which plan is primary.
- (2) If the specific terms of a court decree state that one of the parents must provide health care coverage and the plan of the parent has actual knowledge of those terms, that plan is primary. This rule applies to claim determination periods that start after the plan is given notice of the court decree.
- (3) In the absence of a court decree, if the parents are not married, or are separated (whether or not they ever have been married), or are divorced, the order of benefit determination is: (a) the plan of the custodial parent; (b) the plan of the spouse of the custodial parent; (c) the plan of the noncustodial parent; and (d) the plan of the spouse of the noncustodial parent.

### **Active Or Inactive Employee**

The plan that covers a person as an active employee, or as that person's dependent, is primary. An active employee is one who is neither laid off nor retired. The plan that covers a person as a laid off or retired employee, or as that person's dependent, is secondary. If a plan does not have this rule and as a result the plans do not agree on the order of benefit determination, this rule is ignored.

### **Continuation Coverage**

The plan that covers a person as an active employee, member, subscriber, or retired employee, or as that person's dependent, is primary. The plan that covers a person under a right of continuation provided by federal or state law is secondary. If a plan does not have this rule and as a result the plans do not agree on the order of benefit determination, this rule is ignored.

### **Length Of Coverage**

The plan that covered the person longer is primary.

### **Other**

If the above rules do not determine the primary plan, the allowable expenses will be shared equally between the plans that meet the definition of plan under this section. But, this plan will not pay more than it would have had it been the primary plan.

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### Effect On The Benefits Of This Plan

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**When This Plan Is Primary** When this plan is primary, its benefits are determined before those of any other plan and without considering any other plan's benefits.

**When This Plan Is Secondary** When this plan is secondary, it may reduce its benefits so that the total benefits paid or provided by all plans during a claim determination period are not more than 100% of total allowable expenses. When the benefits of this plan are reduced, each benefit is reduced in proportion. It is then charged against the applicable benefit limit of this plan.

**Closed Panel Plans** If the primary plan is a closed panel plan and the secondary plan is not a closed panel plan, the secondary plan will pay or provide benefits as if it were primary when a covered person uses a non-panel provider; except for emergency services or authorized referrals that are paid or provided by the primary plan.

A person may be covered by two or more closed panel plans. If, for any reason including the provision of service by a non-panel provider, benefits are not payable by one closed panel plan, coordination of benefits will not apply between that plan and other closed panel plans.

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### Right To Receive And Release Needed Information

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

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### Facility Of Payment

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

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



## **Right Of Recovery**

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

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

CGP-3-R-COB-05

B555.0292

All Options

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**GLOSSARY**

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This Glossary defines the italicized terms appearing in your booklet.

CGP-3-GLOSS-90

B900.0118

**Options A , C**

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

CGP-3-VSN-96-DEF1

B750.0457

**All Options**

**Active Orthodontic** means an *appliance*, like a fixed or removable appliance, braces or a functional orthotic used for orthodontic treatment to move teeth or reposition the jaw.

CGP-3-GLOSS-90

B750.0663

**All Options**

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

CGP-3-GLOSS-90

B750.0664

**All Options**

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

CGP-3-GLOSS-90

B750.0665

**Options A , C**

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

CGP-3-VSN-96-DEF3

B750.0458

**All Options**

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

CGP-3-GLOSS-90

B750.0666

**Options A , C**

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

CGP-3-VSN-96-DEF3

B750.0459

Options A , C

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

CGP-3-VSN-96-DEF3

B750.0460

Options A , C

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

CGP-3-VSN-96-DEF3

B750.0461

All Options

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

CGP-3-GLOSS-90

B750.0667

All Options

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

CGP-3-GLOSS-90

B750.0668

All Options

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

CGP-3-GLOSS-90

B750.0669

Options A , C

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

CGP-3-VSN-96-DEF3

B750.0462

Options A , C

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

CGP-3-VSN-96-DEF3

B750.0484

Options A , C

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

CGP-3-VSN-96-DEF3

B750.0483

All Options

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

CGP-3-GLOSS-90

B750.0670

All Options

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

CGP-3-GLOSS-90

B750.0671

All Options

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

CGP-3-GLOSS-90

B900.0003

All Options

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

CGP-3-GLOSS-90

B750.0015

All Options

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

CGP-3-GLOSS-90

B750.0672

All Options

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

CGP-3-GLOSS-90

B750.0006

All Options

**Employer** means UNITY HEALTHCARE INC .  
CGP-3-GLOSS-90 B900.0051

All Options

**Enrollment Period** with respect to dependent coverage, means the 31 day period which starts on the date that you first become eligible for dependent coverage.  
CGP-3-GLOSS-90 B900.0004

All Options

**Full-time** means the *employee* regularly works at least the number of hours in the normal work week set by the *employer* (but not less than 30 hours per week), at his *employer's* place of business.  
CGP-3-GLOSS-90 B750.0229

Options A , C

**Incurred, Or Incurred Date** with respect to Vision Care Insurance, means the placing of an order for lenses, frames or contact lenses, or the date on which such an order was placed.  
CGP-3-VSN-96-DEF3 B750.0466

All Options

**Initial Dependents** means those *eligible dependents* you have at the time you first become eligible for *employee* coverage. If at this time you do not have any *eligible dependents*, but you later acquire them, the first *eligible dependents* you acquire are your *initial dependents*.  
CGP-3-GLOSS-90 B900.0006

All Options

**Injury** means all damage to a *covered person's* mouth due to an accident which occurred while he or she is covered by this *plan*, and all complications arising from that damage. But the term *injury* does not include damage to teeth, *appliances* or *dental prostheses* which results solely from chewing or biting food or other substances.  
CGP-3-GLOSS-90 B750.0673

Options A , C

**Keratoconus** means a development or dystrophic deformity of the cornea in which it becomes coneshaped due to a thinning and stretching of the tissue in its central area.  
CGP-3-VSN-96-DEF11 B750.0467

Options A , C

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

CGP-3-VSN-96-DEF11

B750.0485

All Options

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

CGP-3-GLOSS-90

B900.0008

All Options

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

CGP-3-GLOSS-90

B750.0674

Options A , C

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

CGP-3-VSN-96-DEF14

B750.0487

All Options

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

CGP-3-GLOSS-90

B750.0675

Options A , C

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

CGP-3-VSN-96-DEF16

B750.0472

Options A , C

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

CGP-3-VSN-96-DEF17

B750.0489

All Options

**Payment Limit** means the maximum amount this *plan* pays for covered services during either a *benefit year* or a *covered person's* lifetime, as applicable.  
CGP-3-GLOSS-90 B750.0676

All Options

**Payment Rate** means the percentage rate that this *plan* pays for covered services.  
CGP-3-GLOSS-90 B750.0677

Options A , C

**Photochromic Lenses** mean lenses which change color with the intensity of sunlight.  
CGP-3-VSN-96-DEF17 B750.0490

All Options

**Posterior Teeth** means the bicuspid (pre-molars) and molar teeth. These are the teeth located behind the cuspids.  
CGP-3-GLOSS-90 B750.0679

All Options

**Plan** means the Guardian group dental plan purchased by the planholder.  
CGP-3-GLOSS-90 B750.0678

Options A , C

**Plan Benefits** with respect to Vision Care Insurance, mean the vision care services and vision care materials which a *covered person* is entitled to receive by virtue of coverage under this *plan*.  
CGP-3-VSN-96-DEF17 B750.0492

Options A , C

**Plano Lenses** mean lenses which have no refractive power (lenses with less than a +/- .38 diopter power).  
CGP-3-VSN-96-DEF17 B750.0491

All Options

**Preferred Provider** means a *dentist* or dental care facility that is under contract with DentalGuard Preferred as a preferred provider.  
CGP-3-GLOSS-90 B750.0680

**Options A , C**

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

CGP-3-VSN-96-DEF14

B750.0488

**All Options**

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

CGP-3-GLOSS-90

B750.0681

**All Options**

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

CGP-3-GLOSS-90

B750.0682

**Options A , C**

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

CGP-3-VSN-96-DEF17

B750.0478

**Options A , C**

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

CGP-3-VSN-96-DEF17

B750.0479

**Options A , C**

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

CGP-3-VSN-96-DEF17

B750.0480

**Options A , C**

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

CGP-3-VSN-96-DEF17

B750.0481



**Options A , C**

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

CGP-3-VSN-96-DEF17

B750.0482

**All Options**

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

CGP-3-GLOSS-90

B750.0683



## All Options

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

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## STATEMENT OF ERISA RIGHTS

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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.

## Statement of Erisa Rights (Cont.)

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

### **Assistance with Questions**

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

### **Qualified Medical Child Support Order**

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

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

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

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

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

B800.0094

**All Options**

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**The Guardian's Responsibilities**

B800.0048

**All Options**

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

B800.0053

**Options A , C**

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

B800.0055

**All Options**

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

B800.0049

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## 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.

## Group Health Benefits Claims Procedure (Cont.)

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**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.



## Group Health Benefits Claims Procedure (Cont.)

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**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;

## Group Health Benefits Claims Procedure (Cont.)

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

In reviewing an appeal, Guardian will:

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

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

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

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

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

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

B800.0076

## Termination of This Group Plan

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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

## All Options

### NOTICE OF PRIVACY PRACTICES

**THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.**

**PLEASE REVIEW IT CAREFULLY.**

Effective: 5/01/2016

This Notice of Privacy Practices describes how Guardian and its subsidiaries may use and disclose your Protected Health Information (PHI) in order to carry out treatment, payment and health care operations and for other purposes permitted or required by law.

Guardian is required by law to maintain the privacy of PHI and to provide you with notice of our legal duties and privacy practices concerning PHI. We are required to abide by the terms of this Notice so long as it remains in effect. We reserve the right to change the terms of this Notice of Privacy Practices as necessary and to make the new Notice effective for all PHI maintained by us. If we make material changes to our privacy practices, copies of revised notices will be made available on request and circulated as required by law. Copies of our current Notice may be obtained by contacting Guardian (using the information supplied below), or on our Web site at: [www.guardianlife.com/privacy-policy](http://www.guardianlife.com/privacy-policy).

#### **What is Protected Health Information (PHI):**

PHI is individually identifiable information (including demographic information) relating to your health, to the health care provided to you or to payment for health care. PHI refers particularly to information acquired or maintained by us as a result of your having health coverage (including medical, dental, vision and long term care coverage).

#### **In What Ways may Guardian Use and Disclose your Protected Health Information (PHI):**

Guardian has the right to use or disclose your PHI without your written authorization to assist in your treatment, to facilitate payment and for health care operations purposes. There are certain circumstances where we are required by law to use or disclose your PHI. And there are other purposes, listed below, where we are permitted to use or disclose your PHI without further authorization from you. Please note that examples are provided for illustrative purposes only and are not intended to indicate every use or disclosure that may be made for a particular purpose.

Guardian has the right to use or disclose your PHI for the following purposes :

Treatment.Guardian may use and disclose your PHI to assist your health care providers in your diagnosis and treatment. For example, we may disclose your PHI to providers to supply information about alternative treatments.

Payment.Guardian may use and disclose your PHI in order to pay for the services and resources you may receive. For example, we may disclose your PHI for payment purposes to a health care provider or a health plan. Such purposes may include: ascertaining your range of benefits; certifying that you received treatment; requesting details regarding your treatment to determine if your benefits will cover, or pay for, your treatment.

Health Care Operations.Guardian may use and disclose your PHI to perform health care operations, such as administrative or business functions. For example, we may use your PHI for underwriting and premium rating purposes. However, we will not use or disclose your genetic information for underwriting purposes and are prohibited by law from doing so.

Appointment Reminders.Guardian may use and disclose your PHI to contact you and remind you of appointments.

## **The Guardian Life Insurance Company of America, 10 Hudson Yards, New York, NY**

Health Related Benefits and Services.Guardian may use and disclose PHI to inform you of health related benefits or services that may be of interest to you.

Plan Sponsors.Guardian may use or disclose PHI to the plan sponsor of your group health plan to permit the plan sponsor to perform plan administration functions. For example, a plan may contact us regarding benefits, service or coverage issues. We may also disclose summary health information about the enrollees in your group health plan to the plan sponsor so that the sponsor can obtain premium bids for health insurance coverage, or to decide whether to modify, amend or terminate your group health plan.

B998.0051

### **All Options**

Guardian is required to use or disclose your PHI :

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

Guardian is Required to Notify You of any Breaches of Your Unsecured PHI.

Although Guardian takes reasonable, industry-standard measures to protect your PHI, should a breach occur, Guardian is required by law to notify affected individuals. Under federal medical privacy law, a breach means the acquisition, access, use, or disclosure of unsecured PHI in a manner not permitted by law that compromises the security or privacy of the PHI.

Other Uses and Disclosures .

Guardian may also use and disclose your PHI for the following purposes without your authorization:

- We may disclose your PHI to persons involved in your care or payment for care, such as a family member or close personal friend, when you are present and do not object, when you are incapacitated, under certain circumstances during an emergency or when otherwise permitted by law.
- We may use or disclose your PHI for public health activities, such as reporting of disease, injury, birth and death, and for public health investigations.
- We may use or disclose your PHI in an emergency, directly to or through a disaster relief entity, to find and tell those close to you of your location or condition
- We may disclose your PHI to the proper authorities if we suspect child abuse or neglect; we may also disclose your PHI if we believe you to be a victim of abuse, neglect, or domestic violence.
- We may disclose your PHI to a government oversight agency authorized by law to conducting audits, investigations, or civil or criminal proceedings.
- We may use or disclose your PHI in the course of a judicial or administrative proceeding (e.g., to respond to a subpoena or discovery request).
- We may disclose your PHI to the proper authorities for law enforcement purposes.

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

- We may disclose your PHI to coroners, medical examiners, and/or funeral directors consistent with law.
- We may use or disclose your PHI for organ or tissue donation.
- We may use or disclose your PHI for research purposes, but only as permitted by law.
- We may use or disclose PHI to avert a serious threat to health or safety.
- We may use or disclose your PHI if you are a member of the military as required by armed forces services.
- We may use disclose your PHI to comply with workers' compensation and other similar programs.
  
- We may disclose your PHI to third party business associates that perform services for us, or on our behalf (e.g. vendors).
- We may use and disclose your PHI to federal officials for intelligence and national security activities authorized by law. We also may disclose your PHI to authorized federal officials in order to protect the President, other officials or foreign heads of state, or to conduct investigations authorized by law.
- We may disclose your PHI to correctional institutions or law enforcement officials if you are an inmate or under the custody of a law enforcement official (e.g., for the institution to provide you with health care services, for the safety and security of the institution, and/or to protect your health and safety or the health and safety of other individuals).
- We may use or disclose your PHI to your employer under limited circumstances related primarily to workplace injury or illness or medical surveillance.

B998.0052

### All Options

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

B998.0053

**All Options**

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

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

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

**How to Contact Us:**

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

**Attention:**

Guardian Corporate Privacy Officer  
National Operations

**Address:**

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

B998.0055



**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".**



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## CERTIFICATE OF COVERAGE

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### The Guardian

10 Hudson Yards  
New York, New York 10001

The group Critical Illness coverage described in this Certificate is attached to the group Policy effective January 1, 2020. This Certificate replaces any Certificate previously issued under this Plan or under any other plan providing similar or identical benefits issued to the planholder by Guardian.

**Important Notice: This is a limited plan of Critical Illness insurance. It is a supplement to health insurance. It is not a substitute for hospital or medical expense insurance, a health maintenance organization (HMO) contract, or major medical expense insurance. Please read this Plan carefully to fully understand what it covers, limits, and excludes.**

**This Certificate does not meet the Federal requirement for minimum essential coverage under the Affordable Care Act. You may be liable for a federal tax penalty if you do not purchase a health benefit plan that provides minimum essential coverage. This limited plan of Critical Illness insurance cannot coordinate benefits with health benefit plans.**

### GROUP CRITICAL ILLNESS COVERAGE

Guardian certifies that the Employee to whom this Certificate is issued is entitled to the benefits described herein. However, the Employee must: (a) satisfy all of this Plan's eligibility and effective date requirements; (b) be listed in Our and/or the Policyholder's records as a validly covered Employee under this Plan; and (c) all required premium payments must have been made by or on behalf of the Employee.

The Employee and/or his or her Dependents are not covered by any part of this Plan for which he or she has waived coverage. Such a waiver of coverage is shown in Our and/or the Policyholder's records.

Policyholder: UNITY HEALTHCARE INC

Group Policy Number: 00505565

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

B053.1233



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All Options

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**DEFINITIONS**

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This section defines certain terms appearing in Your Certificate.

B040.0004

All Options

**Active Work or Actively At Work:** These terms mean Your performance of all the duties that pertain to Your work at the place: (1) where it is normally done; or (2) where it is required to be done by Your Employer.

B040.0882

All Options

**Air Ambulance Transport:** This term means the use of a licensed professional air ambulance to transport a Covered Person to a Hospital.

B053.1235

All Options

**Ambulance Transport:** This term means the use of a licensed professional air ambulance is used to transport a Covered Person to a Hospital.

B053.1236

All Options

**Board Certified:** This term means a Doctor who has been certified in the appropriate medical specialty by a member board of the American Board of Medical Specialties.

B005.0010

All Options

**Covered Dependent Child:** This term means Your eligible dependent child covered under this Plan.

B005.0011

All Options

**Covered Person:** This term means You, if You are covered under this Plan and Your covered dependents.

B005.0012

All Options

**Critical Illness:** This term means any of the conditions shown in the Covered Critical Illnesses section of this Plan.

B005.0013

**All Options**

**Diagnosis:** This term means the establishment of a Critical Illness by a Doctor through the use of clinical and/or lab findings, as described in the Covered Critical Illnesses section of this Plan.

B005.0042

**All Options**

**Doctor:** This term means any medical practitioner We are required by law to recognize. He or she must: (1) be properly licensed or certified by the laws of the state where he or she practices; and (2) provide services that are within the lawful scope of his or her practice.

B005.0014

**All Options**

**Domestic Partner:** This term means an opposite or same sex partner who has met either of the following requirements:

- Domestic Partners that are registered with the District of Columbia must assert that they have completed the required Domestic Partnership Registration Form (DC Law 9-114) and have received a certificate of domestic partnership under the Health Care Benefits Expansion Act of 1992.

For those domestic partners that have not registered with the District of Columbia, both You and Your domestic partner must meet all of the following conditions: (1) be at least 18 years of age; (2) be unmarried and constitute each other's sole domestic partner; (3) not have had another domestic partner in the last 12 months; (4) share the same permanent address for at least 12 months in a row and intend to do so indefinitely; (5) share joint financial responsibility for basic living expenses (which include food, shelter, and medical expenses); (6) not be related by blood to a degree that would prohibit marriage in Your state of residence; and (7) be financially interdependent.

B053.1234

**All Options**

**Eligibility Date:** For Employee coverage, this term means the earliest date You are eligible for coverage under this Plan. For dependent coverage, this term means the earliest date on which: (1) You have Initial Dependents; and (2) are eligible for dependent coverage.

B005.0016

**All Options**

**Emergency Services:** This term means (1) health care services furnished in the emergency department of a hospital for the treatment of a medical emergency; and (2) ancillary services, which are standard medical procedures that are reasonably necessary for the diagnosis and treatment of a patient and are routinely available to the emergency department of a hospital for the treatment of a medical emergency.

B053.1237

**All Options**

**Employee:** This term means a person who works for the Employer and whose income is reported for tax purposes using a W-2 form.

B005.0018

**All Options**

**Employer:** This term means UNITY HEALTHCARE INC .

B005.0019

**All Options**

**Enrollment Period:** This term means the 31 day period which starts on the date You first become eligible for dependent coverage.

B005.0020

**All Options**

**Full-Time:** This term means You regularly work at least the number of hours in the normal work week set by the Employer (but not less than 30 hours per week), at: (1) Your Employer's place of business; (2) some place where the Employer's business requires You to travel; or (3) any other place You and Your Employer have agreed upon for the performance of occupational duties.

B005.0021

**All Options**

**Initial Dependents:** This term means eligible dependents You have at the time You first become eligible for Employee coverage. If at this time You do not have any eligible dependents, but You later acquire them, the first eligible dependents You acquire are Your initial dependents.

B005.0023

**All Options**

**Injury:** This term means: (1) all damage to a Covered Person's body due to an accident; and (2) all complications arising from that damage.

B005.0024



**All Options**

**Hospital:** This term means a short-term, acute care general facility, which:

- (1) is primarily engaged in providing, by or under the continuous supervision of Doctors, to Inpatients, Diagnostic services and therapeutic services for Diagnosis, treatment and care of sick or injured persons;
- (2) has organized departments of medicine and major surgery;
- (3) has a requirement that every patient must be under the care of a Doctor or dentist;
- (4) provides 24 hour Nursing service by or under the supervision of a registered professional Nurse (R.N.);
- (5) is duly licensed by the agency responsible for licensing such Hospitals; and
- (6) is not, other than incidentally: (a) a place of rest; (b) a place primarily for the treatment of tuberculosis; (c) a place for the aged; (d) a place for drug addicts or alcoholics; or (e) a place for convalescent, custodial, educational or rehabilitative care.

**Medical Emergency:** This term means the sudden onset or sudden worsening of a medical condition that manifests itself by symptoms of sufficient severity, including severe pain, that the absence of immediate medical attention could reasonably be expected by a prudent layperson, who possesses an average knowledge of health and medicine, to result in: (1) placing the patients health in serious jeopardy; (2) serious impairment to bodily functions; or (3) serious dysfunction of any bodily organ or part.

B053.1242

**All Options**

**Medically Necessary** This term means health services and supplies that are all of the following:

- (1) medically appropriate;
- (2) needed to Diagnose or treat a Sickness or Injury;
- (3) consistent in type, frequency, and length of treatment with scientifically based guidelines of national medical research or health care coverage organizations or government agencies;
- (4) needed for reasons other than comfort or convenience of the Covered Person or Doctor;
- (5) of proven medical value; and
- (6) done with the appropriate level of service or supply needed to provide safe and adequate care.

The fact that a physician may prescribe, authorize or direct a service does not of itself make it Medically Necessary or covered by the Group Policy.

B053.1243

**All Options**

**Newly Acquired Dependent:** This term means an eligible dependent You acquire after You already have coverage in force for Initial Dependents.

B005.0026

**All Options**

**Plan:** This term means the group Critical Illness coverage plan described in the Policy and this Certificate.

B005.0028

**All Options**

**Proof of Insurability:** This term means the completion of an evidence of insurability form, acceptable to Us, showing that a person is insurable.

B005.0029

**All Options**

**Sickness:** This term means any illness or disease suffered by a Covered Person.

B005.0030

**All Options**

**Spouse:** This term means Your lawful spouse, which shall include the marriage between opposite or same-sex partners legally performed in other jurisdictions. This term shall also include registered Domestic Partners.

B005.0566

**All Options**

**We, Us, Our and Guardian:** These terms mean The Guardian Life Insurance Company of America.

**Your or Your:** These terms mean the insured Employee.

B005.0032

All Options

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**GENERAL PROVISIONS**

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B005.0033

All Options

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**Applicable Benefits**

This Certificate may include multiple benefit options and types of benefits. In the event that the Certificate includes such multiple benefit options and types of benefits, each Covered Person will only be covered for those applicable benefits that (1) were previously selected in a manner and mode acceptable to Guardian such as an enrollment form and (2) for which applicable premium has been received by Guardian.

B005.0034

All Options

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**Limitation of Authority**

No person, except by a writing signed by the President, a Vice President or a Secretary of Guardian, has the authority to act for Us to: (1) determine whether any contract, Policy or certificate is to be issued; (2) waive or alter any provisions of any contract or Policy, or any of Our requirements; (3) bind Us by any statement or promise relating to any contract, Policy or certificate issued or to be issued; or (4) accept any information or representation which is not in a signed application.

B005.0035

All Options

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**Incontestability**

The Policy 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 Covered Person will be used to contest the validity of his or her insurance or to deny a claim for a loss incurred after such insurance has been in force for two years during his or her lifetime.

If the Policy replaces a plan your Employer had with another insurer, we may rescind the Plan based on misrepresentations made by the Employer or an Employee in a signed application for up to two years from the effective date of the Plan.

In the event Your insurance is rescinded due to a fraudulent statement made in Your application We will refund premiums paid for the periods such insurance is void. The premium paid by You will be sent to Your last known address on file with Your Employer or Us.

B005.0036

## All Options

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### Examination and Autopsy

We have the right to have a doctor of our choice examine the person for whom a claim is being made under the Plan as often as We feel necessary. We also have the right to have an autopsy performed in the case of death where allowed by law. We will pay for all such examinations and autopsies.

B005.0038

## All Options

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### Critical Illness Claims Provisions

Your right to make a claim for Critical Illness benefits provided by the Policy is governed as shown below.

#### Notice

You must send Us written notice of an Injury or sickness for which a claim is being made within 20 days of the date the Injury occurs or the sickness starts. This notice should include Your name and the Policy number. If the claim is being made for any other Covered Person, his or her name should also be shown.

#### Claim Forms

We will furnish You with forms for filing proof of loss within 15 days of receipt of notice. If We do not furnish the forms on time, We will accept a written description and adequate proof of the Injury or sickness that is the basis of the claim as proof of loss. You must detail the nature and extent of the loss for which the claim is being made.

#### Proof Of Loss

You must send written proof to Our designated office within 90 days of the loss.

#### Late Notice Of Proof

We will not void or reduce Your claim if You cannot send Us notice and proof of loss within the required time. In that case, You must send Us notice and proof as soon as reasonably possible.

#### **Payment Of Benefits**

We will pay Critical Illness benefits as soon as we receive written proof of loss.

Unless otherwise required by law or regulation, We pay all Critical Illness benefits to You if you are living. If You are not living, We have the right to pay all Critical Illness benefits to one of the following: (1) Your estate; (2) Your spouse; (3) Your parents; (4) Your children; or (5) Your brothers and sisters.

#### **Legal Actions**

No legal action against this Plan shall be brought until 60 days from the date proof of loss has been given as shown above. No legal action shall be brought against this Plan after three years from the date written proof of loss is required to be given.

#### **Workers' Compensation**

The Critical Illness benefits provided by this Plan are not in place of and do not affect requirements for coverage by Workers' Compensation.

B005.0039

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## ELIGIBILITY FOR CRITICAL ILLNESS - EMPLOYEE COVERAGE

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### Eligible Employees

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Subject to the conditions of eligibility set forth below, and to all of the other conditions of the Plan, You are eligible if You are in an eligible class of Employees and are an active Full-Time Employee.

If You are a partner or proprietor, We will treat You like an Employee if You meet the Plan's conditions of eligibility.

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### Conditions of Eligibility

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You are eligible for Critical Illness coverage if You are;

- Legally working in the United States, or working outside of the United States for a United States based employer in a country or region approved by Us; and
- Regularly working at least the number of hours in the normal work week set by the Employer (but not less than 30 hours per week) at: (1) the Employer's place of business; (2) some place where the Employer's business requires You to travel; or (3) any other place You and the Employer have agreed upon for the performance of occupational duties.

You are **not** eligible for Critical Illness coverage if You are a temporary or seasonal Employee.

**Enrollment Requirement:** If You must pay all or part of the cost of Your coverage, We will not cover You until You enroll and agree to make the required payments.

**Proof of Insurability:** If You: (1) do not meet this Plan's enrollment requirement within 31 days after You first become eligible; or (2) enroll after You previously had coverage which ended because You failed to make a required payment, We will ask for Proof of Insurability. And, You will not be covered until We approve that Proof of Insurability in writing.

Part or all of Your insurance amounts may be subject to Proof of Insurability. The Schedule of Benefits explains if and when We require Proof of Insurability. You will not be covered for any amount that requires such Proof of Insurability until You give the Proof of Insurability to Us and We approve that Proof of Insurability in writing.

If Your active Full-Time service ends before You meet any Proof of Insurability requirements that apply You will still have to meet those requirements if You are later re-employed by the Employer or an associated company.

B005.0043

## All Options

**The Waiting Period** If You are in an eligible class, You are eligible for Critical Illness coverage under this Plan after You complete the service waiting period, if any, established by the Employer.

B005.0045

## All Options

**Multiple Employment** If You work for both the Employer and a covered associated company, or for more than one covered associated company, We will treat You as if only one firm employs You. You will not have multiple Critical Illness coverages under this plan. But, if this Plan uses the amount of Your earnings to set the rates, determine class, figure coverage amounts, or for any other reason, such earnings will be figured as the sum of Your earnings from all covered Employers.

B005.0046

## All Options

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### **When Employee Coverage Starts**

Your eligibility date is the date You have met all of the conditions of eligibility.

Whether You must pay all or part of the cost of Your coverage, You must elect to enroll and agree to make the required payments before Your coverage will start. If You do this on or before Your Eligibility Date, Your coverage is scheduled to start on Your Eligibility Date. If You do this within 31 days after Your Eligibility Date, Your coverage is scheduled to start on Your Eligibility Date. If You elect to enroll and agree to make the required payments more than 31 days after Your Eligibility Date, Your coverage will not be scheduled to start until You send Us Proof of Insurability. Once We have approved such Proof of Insurability, Your coverage is scheduled to start on the effective date shown in the endorsement section of Your evidence of insurability form.

Any part of Your coverage which is subject to Proof of Insurability will not start unless You send such Proof of Insurability to Us, and We approve it in writing. Once We have approved it, that part of Your coverage is scheduled to start on the effective date shown in the endorsement section of Your evidence of insurability form. If Your active service ends before You meet any Proof of Insurability requirements that apply You will still have to meet those requirements if You are later re-employed by the Employer or an associated company.

On the date all or part of Your coverage is scheduled to start, You must be: (1) Actively At Work; (2) fully capable of performing the major duties of Your regular occupation; and (3) working Your regular number of hours. In that case, Your coverage will start at 12:01 A.M. Standard Time for Your place of residence on that date. In any other case, We will postpone the start of Your coverage until the date You: (a) return to Active Work; (b) are working Your regular number of hours; and (c) are fully capable of performing the major duties of Your regular occupation. Sometimes, a scheduled effective date is not a regularly scheduled work day. If the scheduled effective date falls: on a holiday; on a vacation day; on a non-scheduled work day; during a layoff of less than 180 days in duration; during an approved leave of absence not due to sickness or injury, of 90 days or less; or on a day during a period of absence that is less than 7 days in duration; and if: (a) You were fully capable of performing the major duties of Your regular occupation for the Employer on a full-time basis at 12:01 AM Standard Time for Your place of residence on the scheduled effective date; and (b) You were performing the major duties of Your regular occupation and working Your regular number of hours on Your last regularly scheduled work day; Your coverage will start on the scheduled effective date.

**Delayed Effective Date For Voluntary Critical Illness Coverage:** If You are not Actively At Work on the date Your Voluntary Critical Illness coverage is scheduled to start due to Sickness or Injury, We will postpone coverage for an otherwise covered loss due to that Sickness or Injury. We will postpone such coverage until You complete ten days in a row without missing a work day due to that Sickness or Injury in which You are: (1) Actively At Work; (2) fully capable of performing the major duties of Your regular occupation; and (3) working Your regular number of hours. Coverage for an otherwise covered loss due to all other conditions will start on the date You are: (a) Actively At Work; (b) fully capable of performing the major duties of Your regular occupation; and (c) working Your regular number of hours.

**Exception to When Employee Coverage Starts:** If You are not capable of performing the major duties of Your regular occupation for Your Employer on a full-time basis on the date Your coverage is scheduled to start, You will be insured for Critical Illness insurance if:

1. You were insured under the prior insurer's group critical illness policy at the time of the transfer;
2. You are a member of an eligible class; and
3. premiums for You were paid up to date; and
4. You are not receiving or eligible to receive benefits under the prior insurer's group critical illness policy.

Any Critical Illness benefit payable will be the lesser of:

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

The Critical Illness benefit payable will be reduced by any amount paid by the prior insurer's group critical illness policy.



All other provisions under this Policy will apply under the Exception to When Employee Coverage Starts.

You will remain insured under this provision until the first to occur of:

1. the date You are fully capable of performing the major duties of Your regular occupation for Your Employer on a full-time basis;
2. the date insurance terminates for one of the reasons stated in When Employee Coverage Ends;
3. the last day of a period of 12 consecutive months which begins on the Policy effective date; or
4. the last day You would have been covered under the prior insurer's group critical illness policy, had the prior plan not terminated.

B005.0078

## All Options

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### **When Employee Coverage Ends**

Your coverage will end on the first of the following dates:

- The date in which Your active service ends for any reason. Your active service ends when You are no longer: (1) Actively At Work; and (2) working Your regular number of hours.
- The date You stop being an eligible Employee under this Plan.
- The date You are no longer working in the United States or working outside of the United States for a United States based Employer in a country or region approved by Us.
- The date the group Plan ends, or is discontinued for a class of Employees to which You belong.
- The last day of the period for which required payments are made for You.

B005.0050

## All Options

### **Your Right to Continue Critical Illness Coverage During a Family Leave of Absence**

**Important Notice:** This section may not apply to Your Employer's Plan. You must contact Your Employer to find out if he or she must allow for a family leave of absence under federal law. If he or she must allow for such leave, this section applies.

**If Your Coverage Would End:** Your Critical Illness coverage would normally end because You cease work due to an approved leave of absence. But, You may continue Your coverage if the leave has been granted: (1) to allow You to care for a seriously injured or ill spouse, child or parent; (2) after the birth or adoption of a child; (3) due to Your own serious health condition; or (4) because of a serious Injury or illness arising out of the fact that Your spouse, child, parent or next of kin who is a covered service member is on active duty, or has been notified of an impending call or order to active duty, in the Armed Forces in support of a contingency operation. To continue Your coverage, You will be required to pay the same share of the premium as You paid before the leave of absence.

**When Continuation Ends:** Continued coverage will end on the earliest of the following:

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

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

- **Active Duty:** This term means duty under a call or order to active duty in the Armed Forces of the United States.
- **Contingency Operation:** This term means a military operation that: (1) is designated by the Secretary of Defense as an operation in which members of the Armed Forces are or may become involved in military actions, operations or hostilities against an enemy of the United States or against an opposing military force; or (2) results in the call or order to, or retention on, active duty of members of the uniformed services under any provision of law or during a national emergency declared by the President or Congress.

- **Covered Service Member:** This term means a member of the Armed Forces, including a member of the National Guard or Reserves, who for a Serious Injury or Illness is: (1) undergoing medical treatment, recuperation or therapy; (2) otherwise in Outpatient Status; or (3) otherwise on the temporary disability retired list.
- **Next Of Kin:** This term means Your nearest blood relative.
- **Outpatient Status:** This term means, in the case of a covered service member, that he or she is assigned to: (1) a military medical treatment facility as an outpatient; or (2) a unit established for the purpose of providing command and control of members of the Armed Forces receiving medical care as outpatients.
- **Serious Injury Or Illness:** This term means, in the case of a Covered Service Member, an Injury or illness incurred by him or her in line of duty on active duty in the Armed Forces that may render him or her medically unfit to perform the duties of his or her: (1) office; (2) grade; (3) rank; or (4) rating.

B005.0062

All Options

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**ELIGIBILITY FOR CRITICAL ILLNESS COVERAGE -  
DEPENDENT COVERAGE**

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B005.0063

All Options

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**Eligible Dependents for Dependent Critical Illness Coverage**

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B005.0064

All Options

**Eligible Dependents  
for Voluntary  
Dependent Critical  
Illness** Your eligible dependents are Your spouse and unmarried dependent children  
from birth until they reach age 26.

B005.0080

All Options

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**Adopted Children and Step-Children**

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

B005.0065

All Options

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**Dependents Not Eligible**

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We exclude any dependent who is on active duty in any armed force. And, We exclude any dependent who is covered by this Plan as an Employee.

A child may be an eligible dependent of more than one Employee who is insured under this Plan. In that case, the child may be insured for dependent Critical Illness benefits by only one Employee at a time.

B005.0066

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## Handicapped Children

You may have an unmarried child who is: (a) incapable of self-sustaining employment by reason of a mental or physical handicap or developmental disability; and (b) chiefly dependent upon You for support and maintenance. In that case such a child may remain eligible for dependent benefits past the age limit subject to the conditions shown below.

- His or her condition started before he or she reached the age limit.
- He or she became covered for dependent Critical Illness benefits before he or she reached the age limit, and remained continuously covered until he or she reached the age limit.
- He or she stays unmarried and remains: (i) incapable of self-sustaining employment; and (ii) dependent upon You for most of his or her support and maintenance.
- You send Us written proof, and We approve such proof, of the child's disability and dependence within 31 days from the date he or she reaches the age limit. After the two year period following the child's attainment of the age limit, We can ask for periodic proof that the child's condition continues, but We cannot ask for this proof more than once a year.

The child's coverage ends when Your coverage ends.

B005.0067

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## Proof of Insurability

We require Proof of Insurability that a dependent is insurable if You: (1) enroll a dependent who was previously declined or would have been considered a late enrollee under a group critical illness coverage plan providing dependent coverage which this Plan replaced; (2) enroll a dependent and agree to make the required payments after the end of the Enrollment Period.

A dependent is not covered by any part of this Plan that requires such Proof of Insurability until You give Us this Proof of Insurability and We approve it in writing.

If Your dependent coverage ends for any reason, including failure to make the required payments, Your dependent will not be covered by this Plan again until You give Us new Proof of Insurability that they are insurable and We approve that Proof of Insurability in writing.

B005.0069

## All Options

### When Dependent Coverage Starts

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In order for Your dependent coverage to start, You must already be covered for Employee coverage, or enroll for Employee and dependent coverage at the same time.

Subject to the Exception below and to all of the other terms of this Plan, the date Your dependent coverage starts depends on when You elect to enroll Your Initial Dependents and agree to make any required payments. If You do this on or before Your Eligibility Date, the dependent's coverage is scheduled to start on the later of Your eligibility date and the date you become covered for Employee coverage.

If You do this within the Enrollment Period, the coverage is scheduled to start on the date You become covered for Employee coverage.

If You do this after the Enrollment Period ends, Your dependent coverage is subject to Proof of Insurability and will not start until We approve that Proof of Insurability in writing.

Once You have dependent child coverage for Your Initial Dependent child(ren) any Newly Acquired Dependent children will be covered as of the date he or she is first eligible.

If Proof of Insurability is required for dependent benefits as explained above, those benefits will not be scheduled to start until You give Us Proof of Insurability that the dependent is insurable. Once We have approved that Proof of Insurability, those benefits will be scheduled to start on the effective date shown in the endorsement section of Your application.

B005.0070

## All Options

**Exception** We will postpone the effective date of a dependent's, other than a newborn child's, coverage if, on that date, he or she is: (1) confined to a hospital or other health care facility; (2) home confined; or (3) unable to perform two or more Activities of Daily Living. In that case, We will postpone the effective date of his or her coverage until the day after the date: (a) of his or her discharge from such facility; (b) his or her home confinement ends; or (c) he or she is no longer requires assistance with two or more Activities of Daily Living. If a dependent was covered under a prior plan at transfer, this language will not apply to the amount of coverage that was in force with the prior plan.

B005.0071

## **When Dependent Coverage Ends**

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Dependent coverage ends for all of Your dependents when Your Employee coverage ends. Dependent coverage also ends for all of Your dependents when You stop being a member of a class of Employees eligible for such coverage. And, it ends when this Plan ends, or when dependent coverage is dropped from this Plan for all Employees or for Your class.

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

Your dependent's coverage ends when he or she stops being an eligible dependent. This happens to a child at 12:01 A.M. on the date the child attains this Plan's age limit, when he or she marries, or when a step-child is no longer dependent on You for support and maintenance. It happens to a spouse: (1) when a marriage ends in legal divorce or annulment; and (2) at 12:01 A.M. on the date the spouse reaches the limiting age, if applicable.

B005.0075

All Options

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**CRITICAL ILLNESS COVERAGE**

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This Certificate includes the Schedule of Benefits form. Your class and benefit options are shown in the Schedule of Benefits that applies to You.

Subject to all of this Plan's terms, We will pay the benefits described below if a Covered Person is Diagnosed with a listed Critical Illness on or after the date he or she becomes covered by this Plan.

This Plan pays no Critical Illness benefits for any condition other than those listed below in Covered Critical Illnesses.

B005.0083

All Options

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**Critical Illness Benefits**

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This Plan will pay a benefit based on the benefit amount for which a Covered Person is covered. The benefit will be subject to all of the terms of this Plan.

This Plan only pays benefits for the occurrence of the Critical Illnesses listed and defined in the Covered Critical Illnesses section below.

Each Critical Illness must occur while the Covered Person is covered by this Plan. This Plan deems each Critical Illness to occur on the date described for each Critical Illness in the Covered Critical Illnesses section below.

Where one Critical Illness is caused by or contributes to another Critical Illness, only one benefit is payable. We will pay the greater of the benefits payable. If the amount payable for each Critical Illness is the same, You may choose which benefit to receive.

This Plan may pay a different level of benefits for the First Occurrence and the Recurrence of a Critical Illness. For some Critical Illnesses We pay no benefits for a Recurrence. The benefit levels are shown in the Schedule of Benefits.

By First Occurrence We mean the first time a Covered Person is Diagnosed with a Critical Illness while insured by this Plan. By Recurrence, We mean the second time a Covered Person is diagnosed with the same Critical Illness while insured by this Plan. We pay no benefits for occurrences beyond the second time.

B005.0084



All Options

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**Covered Critical Illnesses**

B005.0086

All Options

**Cancer Related Conditions**

B005.0087

All Options

**Benign Brain Tumor** We pay a benefit if a Covered Person is Diagnosed with a Benign Brain Tumor, which means a non-cancerous brain tumor confirmed by the examination of tissue (biopsy or surgical excision) or specific neuroradiological examination. The tumor must result in persistent neurological deficits, including but not limited to:

- loss of vision;
- loss of hearing; or
- balance disruption

We do not consider the following to be Benign Brain Tumors:

- tumors of the skull;
- pituitary adenomas; and
- germanomas.

We deem a Benign Brain Tumor to occur on the date a Doctor of appropriate specialty makes a Diagnosis.

B005.0088

All Options

**Carcinoma in Situ** We pay a benefit if a Covered Person is Diagnosed with Carcinoma In Situ, which means early forms of cancer that have not invaded surrounding tissue. Any malignant tumor classified as less than T1NOMO under TNM classification is considered Carcinoma in Situ. Carcinomas in Situ can include early forms of many common cancers such as breast and prostate cancer.

We do not pay a benefit under this provision for:

- Pre-malignant growths or lesions, such as dysplasia or Intraepithelial neoplasia;
- Any benign tumor or polyp;
- Carcinoma in Situ of the skin

Diagnosis of Carcinoma in Situ must be based on microscopic (histologic) exam of: (a) fixed tissues; or (b) preparations of blood or bone marrow. Such exam must be documented in a written report by a Doctor who is Board Certified in pathology.

We deem Carcinoma in Situ to occur on the date a Doctor of appropriate specialty makes a Diagnosis.

"TNM classification" means the classification standards for cancer developed by the American Joint Committee on Cancer.

B005.0089

## All Options

**Invasive Cancer** We pay a benefit if a Covered Person is Diagnosed with Invasive Cancer, which means a malignant tumor which is characterized by the uncontrolled growth and spread of malignant cells and the invasion of neighboring tissue.

Invasive Cancer also includes leukemia and lymphoma.

Invasive Cancer must be supported by pathological diagnosis.

We do not pay a benefit under this provision for:

- Pre-malignant growths or lesions, such as dysplasia or intraepithelial neoplasia;
- Any benign tumor or polyp;
- Any condition that is Carcinoma in Situ.
- Any skin cancer, including carcinoma in situ of the skin, unless there is metastasis.

Diagnosis of Invasive Cancer must be based on microscopic (histologic) exam of: (a) fixed tissues; or (b) preparations of blood or bone marrow. Such exam must be documented in a written report by a Doctor who is Board Certified in pathology.

We deem Invasive Cancer to occur on the date a Doctor of appropriate specialty makes a Diagnosis.

B005.0090

## All Options

**Skin Cancer** We pay a benefit if a Covered Person is Diagnosed with the types of Skin Cancer known as either basal cell carcinoma or squamous cell carcinoma. We don't pay a benefit under this provision for any other type of skin cancer. We deem Skin Cancer to occur on the date a Doctor of appropriate specialty makes a Diagnosis.

We limit what We pay to one benefit in a Covered Person's lifetime.

B005.0091

**All Options**

**Vascular Conditions**

B005.0123

**All Options**

**Arteriosclerosis** We pay a benefit if a Covered Person is diagnosed with Arteriosclerosis, which means blockage of a coronary artery of sufficient severity to require one or more coronary artery bypass graft(s).

Diagnosis must include demonstrated need for intervention.

We deem Arteriosclerosis to occur on the date a Doctor of appropriate specialty makes a Diagnosis of Arteriosclerosis of sufficient severity to warrant one or more coronary artery bypass graft(s).

B005.0092

**All Options**

**Heart Attack** We pay a benefit if a Covered Person is Diagnosed with a Heart Attack, which means death of heart muscle due to inadequate blood supply. Symptoms of cardiac ischemia must be present, as well as two or more of the following criteria for acute myocardial infarction:

- (1) typical clinical symptoms such as central chest pain;
- (2) diagnostic increase of specific cardiac markers;
- (3) new electrocardiographic changes indicative of new ischemia (new ST-T changes or new left bundle branch block (LBBB));
- (4) development of pathological Q waves in the ECG; or
- (5) imaging evidence of new loss of viable myocardium or new regional wall motion abnormality.

Sudden Cardiac Arrest is not a Heart Attack.

Proof of Heart Attack requires submission of medical records. We deem a heart attack to occur on the date a Doctor of appropriate specialty makes a Diagnosis. A Heart Attack that results in death or is Diagnosed after death will be covered under this provision.

We don't pay a benefit for a Heart Attack that occurs during a medical procedure, including, but not limited to, surgery.

B005.0093

## All Options

**Heart Failure** We pay a benefit if a Covered Person is Diagnosed with Heart Failure. By Heart Failure We mean the irreversible failure of the heart, which requires a human to human heart, heart/lung or heart combined with any other organ transplant determined to be Medically Necessary by a Doctor of the appropriate specialty.

We deem Heart Failure to occur on the date the Covered Person is accepted onto the transplant waiting list of a recognized transplant program in the United States. We pay the benefit whether or not the transplant is ever performed. If the Covered Person is too ill for a transplant, but otherwise meets the criteria for being on the waiting list of a recognized transplant program, the waiting list requirement will be waived. In this instance We deem Heart Failure to occur on the date a Doctor of appropriate specialty deems the Covered Person is too ill for a transplant, but otherwise meets the criteria for being on a waiting list of a recognized transplant program in the United States.

B005.0094

## All Options

**Stroke** We pay a benefit if a Covered Person is diagnosed with a Stroke, which means death of brain tissue due to an acute cerebrovascular event. All of the following criteria must be satisfied: (1) clinical evidence of infarction of brain tissue, or intracranial or subarachnoid hemorrhage; (2) clear evidence on a CT, MRI or similar imaging techniques that a stroke has occurred; and (3) permanent neurologic deficit measured 30 days or more after the event that results in functional impairment rated at a score of two or higher on the Modified Rankin Scale for stroke outcome. The term does not mean symptoms due to: (a) transient ischemic attack; (b) migraine; (c) hypoxia; (d) traumatic injury to brain tissue or blood vessels; and (e) vascular disease affecting the eye, optic nerve or vestibular functions.

Diagnosis of Stroke must be:

- (1) confirmed in writing by a Doctor of the appropriate specialty; and
- (2) based on medical records. These records must show objective evidence of significant neurological impairment.

Such impairment must be documented by meeting all of the following criteria:

- (a) clinical evidence of infarction of brain tissue, or intracranial or subarachnoid hemorrhage;
- (b) clear evidence on a CT, MRI or similar imaging techniques that a stroke has occurred; and
- (c) permanent neurologic deficit measured 30 days or more after the event that results in a score of two or higher on the Modified Rankin Scale for stroke outcome.

We deem the Stroke to occur on the date of the event. In the event of death, an autopsy confirmation and/or death certificate identifying Stroke as the cause of death will be accepted.

B005.0095

**All Options**

**Neurological Conditions**

B005.0096

**All Options**

**Alzheimer's Disease** We pay a benefit if a Covered Person is Diagnosed with Alzheimer's Disease, which means a progressive degenerative disease of the brain that is Diagnosed by a Board Certified psychiatrist or Board Certified neurologist as Alzheimer's Disease. The Diagnosis must be supported by medical evidence that the Covered Person exhibits the loss of intellectual capacity resulting in impairment of memory and judgment as documented and demonstrated by cognitive testing and supported by neuroradiological tests (e.g., CT Scan, MRI, PET of the brain). This impairment must result in a significant reduction in mental and social functioning, resulting in the Covered Person's inability to permanently perform two or more of the Activities of Daily Living without the continuing assistance of another person. No other dementing organic brain disorders or psychiatric illnesses are included in this definition.

Activities of Daily Living include:

- Bathing: wash in a tub or shower; or take a sponge bath; and towel dry.
- Dressing: put on and take off all clothes; and those medically necessary braces or prosthetic limbs usually worn; and fasten or unfasten them.
- Toileting: get to and from and on and off the toilet; to maintain personal hygiene; and care for clothes.
- Transferring: move in and out of a chair or bed.
- Continence: control bowel and bladder function; or, in the event of incontinence, maintain personal hygiene.
- Eating: get food into the body by any means once it has been prepared and made available.

Diagnosis must be based on clinical and/or diagnostic findings as supported by the Covered Person's medical records. We deem Alzheimer's Disease to occur on the date a Doctor of appropriate specialty makes a Diagnosis. The Diagnosis must occur while the Covered Person is insured under this Plan.

B005.0097

**All Options**

**Amyotrophic Lateral Sclerosis (also known as ALS or Lou Gehrig's Disease)** We pay a benefit if a Covered Person is Diagnosed with Amyotrophic Lateral Sclerosis (ALS), which means motor neuron disease, marked by muscular weakness and atrophy with spasticity and hyperreflexia due to a loss of motor neurons of the spinal cord, medulla and cortex.

We deem ALS to occur on the date a Doctor of appropriate specialty makes a Diagnosis.

B005.0098

**All Options**

**Huntington's Disease** We pay a benefit if a Covered Person is Diagnosed with Huntington's Disease, which is a neurodegenerative genetic disorder that affects muscle coordination and leads to cognitive decline and psychiatric problems.

Diagnosis must document symptoms and verify the presence of the gene via genetic testing. We don't pay a benefit for the presence of the Huntington's Disease gene in absence of symptoms.

Symptoms include

- Personality changes, mood swings and depression;
- Forgetfulness and impaired judgment;
- Unsteady gait and involuntary movements;
- Slurred speech and difficulty in swallowing.

We deem Huntington's Disease to occur on the date a Doctor of appropriate specialty makes a Diagnosis.

The Diagnosis must occur while the Covered Person is insured under this Plan.

B005.0099

**All Options**

**Multiple Sclerosis (MS)** We pay a benefit if a Covered Person is diagnosed with Multiple Sclerosis (MS), which means demonstrated neurological deficits that have been present for 6 months or more. Diagnosis must be made on the basis of:

- (1) neurological examination demonstrating functional impairments;
- (2) imaging studies of the brain or spine demonstrating lesions consistent with MS; and
- (3) analysis of cerebrospinal fluid consistent with the diagnosis.

We deem MS to occur on the date a Doctor of appropriate specialty makes a Diagnosis. Diagnosis must occur while the Covered Person is insured under this Plan.

B005.0100

**All Options**

**Advanced Parkinson's Disease** We pay a benefit if a Covered Person is Diagnosed with Advanced Parkinson's Disease, which means Parkinson's Disease that has progressed to Stage 4, as Diagnosed by a Board Certified, or board-eligible, neurologist based on abnormal findings from neurological examination, cognitive testing, and results of imaging studies.

We deem Advanced Parkinson's Disease to occur on the date a Doctor of appropriate specialty makes a Diagnosis that the person has progressed to Stage 4. The Diagnosis must occur while the Covered Person is covered under this Plan.

B005.0101

**All Options**

**Childhood Conditions**

B005.0102

**All Options**

**Cerebral Palsy** We pay a benefit if a Covered Dependent Child is Diagnosed with Cerebral Palsy, which means a group of disorders of the development of movement and posture causing activity limitation that are attributed to progressive disturbances that occurred in the developing fetal or infant brain. The motor disorders of cerebral palsy are often accompanied by disturbances of sensation, cognition, communication, perception and/or behavior and/or a seizure disorder. Other similar conditions such as degenerative nerve disorders, genetic diseases, muscle diseases, metabolic disorders, nervous system tumors, coagulation disorders, or other injuries or disorders which delay early development, but can be outgrown, are not included in this definition.

We deem Cerebral Palsy to occur on the first date after live birth where a Doctor of appropriate specialty makes a Diagnosis.

B005.0103

**All Options**

**Cleft Lip or Palate** We pay a benefit if a Covered Dependent Child is Diagnosed with Cleft Lip or Cleft Palate. A Cleft Lip appears as a narrow opening or gap in the skin of the upper lip that extends all the way to the base of the nose. A Cleft Palate is an opening between the roof of the mouth and the nasal cavity, including clefts that occur on one side of the mouth or both sides.

We pay a benefit for either a Cleft Lip or Cleft Palate, but not both.

We deem Cleft Lip or Cleft Palate to occur on the first date after live birth where a Doctor of appropriate specialty makes a definite clinical Diagnosis of a cleft lip or palate.

B005.0104

**All Options**

**Clubfoot** We pay a benefit if a Covered Dependent Child is Diagnosed with Clubfoot, which means a congenital deformity of the foot.

We pay the benefit only once even if Clubfoot is present in both of the child's feet.

We deem Clubfoot to occur on the first day after live birth where a Doctor of appropriate specialty makes a definite Diagnosis of Clubfoot.

B005.0105

**All Options**

**Cystic Fibrosis** We pay a benefit if a Covered Dependent Child is Diagnosed with Cystic Fibrosis, which means chronic lung disease and pancreatic insufficiency. The Diagnosis of Cystic Fibrosis made via sweat test is based upon sweat chloride concentrations greater than 60 mmol/L.

We deem Cystic Fibrosis to occur on the first date after live birth where Cystic Fibrosis has been definitively Diagnosed by a Doctor of appropriate specialty via sweat test.

B005.0106

**All Options**

**Down Syndrome** We pay a benefit if a Covered Dependent Child is Diagnosed with Down Syndrome, which means a Diagnosis of Down Syndrome through study of the 21st chromosome. Down Syndrome includes:

- Trisomy - an individual has three instead of two number 21 chromosomes;
- Translocation - an extra part of the 21st chromosome is attached to another chromosome;
- Mosaicism - the individual has an extra 21st chromosome in only some of the cells but not all of them. The other cells have the usual pair of 21st chromosomes.

We deem Down Syndrome to occur on the first date after live birth where a Doctor of appropriate specialty completes a chromosome test that positively reveals Down Syndrome.

B005.0107

**All Options**

**Muscular Dystrophy** We pay a benefit if a Covered Dependent Child is Diagnosed with Muscular Dystrophy, which means a hereditary condition that is marked by progressive weakening and wasting of muscles. The Covered Dependent Child must have well defined neurological abnormalities, confirmed by electromyography and muscle biopsy.

We deem Muscular Dystrophy to occur on the first date after live birth where a Doctor of appropriate specialty makes a Diagnosis.

B005.0108



**All Options**

**Spina Bifida** We pay a benefit if a Covered Dependent Child is Diagnosed with Spina Bifida, which means either of the following types of Spina Bifida:

- (1) Meningocele - the protective coatings (meninges) come through the open part of the spine like a sac that is pushed out. Cerebrospinal fluid is in the sac and there is usually no nerve damage.
- (2) Myelomeningocele - This occurs when the meninges (protective covering of the spinal cord) and spinal nerves come through the open part of the spine.

We pay no benefits for spina bifida occulta.

We deem Spina Bifida to occur on the first date after live birth where a Doctor of appropriate specialty makes a Diagnosis

B005.0109

**All Options**

**Type 1 Diabetes** We pay a benefit if a Covered Dependent Child is Diagnosed with Type 1 Diabetes, which means the child has a total insulin deficiency and a continuous dependence on exogenous insulin for survival. Dependence on insulin must persist for a continuous period of at least 3 months.

We deem Type 1 Diabetes to occur on the date a Doctor of appropriate specialty makes a Diagnosis.

B005.0110

**All Options**

**Other Critical Illnesses**

B005.0111

**All Options**

**Addison's Disease** We pay a benefit if a Covered Person is Diagnosed with Addison's disease, which means an endocrine or hormonal disorder resulting in the adrenal glands not producing sufficient cortisol.

Diagnosis must be made by laboratory tests designed to show insufficient levels of cortisol.

We deem Addison's Disease to occur on the date a Doctor of appropriate specialty makes a Diagnosis.

B005.0112

## All Options

**Coma** We pay a benefit if a Covered Person is Diagnosed with a Coma, which means a state of complete mental unresponsiveness with no evidence of appropriate responses to stimulation, lasting for a period of 7 or more consecutive days and characterized by the absence of eye opening, verbal response and motor response. The condition must require intubation for respiratory assistance. This benefit is not payable for a medically induced Coma.

We deem a Coma to occur on the date a Doctor of appropriate specialty makes a Diagnosis.

B005.0113

## All Options

**Kidney Failure** We pay a benefit if a Covered Person is Diagnosed with Kidney Failure, which means chronic irreversible failure of both kidneys to function, as a result of which either weekly or bi-weekly renal or peritoneal dialysis is started, or renal transplant is performed.

Proof of Kidney Failure requires submission of medical records. Diagnosis of Kidney Failure will be deemed to occur on the earlier of the date: (a) renal or peritoneal dialysis is started; or (b) the date the Covered Person is accepted onto the kidney transplant waiting list of a recognized transplant program in the United States. If the Covered Person is too ill for a transplant, but otherwise meets the criteria for being on the waiting list of a recognized transplant program, the waiting list requirement will be waived. In this instance We deem Kidney Failure to occur on the date a Doctor of appropriate specialty deems the Covered Person is too ill for a transplant, but otherwise meets the criteria for being on a waiting list of a recognized transplant program in the United States.

B005.0114

## All Options

**Loss of Hearing** We pay a benefit if a Covered Person is Diagnosed with Loss of Hearing, which means clinically-proven irreversible loss of hearing in both ears, with an auditory threshold of more than 90 decibels, as a result of illness or injury that has continued without interruption for at least 6 consecutive months after Diagnosis.

No benefit will be paid if, in general medical opinion, surgery, a hearing aid, device, or implant could result in the partial or total restoration of hearing.

The Diagnosis must be made by physical examination by an licensed audiologist.

A Covered Dependent Child must be at least 3 years old on the date of Diagnosis in order to receive a benefit. However, if a Covered Dependent Child is Diagnosed prior to age 3, We will pay a benefit if the initial Diagnosis occurred while insured by this Plan, and the Diagnosis is confirmed on or after the child reaches age 3 and remains insured by this Plan.

We deem Loss of Hearing to occur on the date on which a licensed audiologist physically examines the Covered Person and certifies that the Covered Person meets the definition above.

B005.0115

### **All Options**

**Loss of Sight** We pay a benefit if a Covered Person is diagnosed with Loss of Sight, based on best corrected visual acuity of 20/400 or less or visual field of 20 degrees or less in the better eye. No benefit will be paid if, in general medical opinion, surgery, device, or implant could result in the partial or total restoration of sight.

A Covered Dependent Child must be at least 3 years old on the date of Diagnosis in order to receive a benefit. However, if a Covered Dependent Child is Diagnosed prior to age 3, We will pay a benefit if the initial diagnosis occurred while insured by this Plan, and the Diagnosis is confirmed on or after the child reaches age 3 and remains insured by this Plan.

We deem Loss of Sight to occur on the date on which a licensed ophthalmologist physically examines the Covered Person and certifies that the Covered Person has best corrected visual acuity of 20/400 or less or visual field of 20 degrees or less in the better eye.

B005.0116

### **All Options**

**Loss of Speech** We pay a benefit if a Covered Person is Diagnosed with Loss of Speech, which means the clinically proven total, permanent and irreversible loss of the ability to speak as a result of Illness or injury that has continued without interruption for a period of at least 6 consecutive months.

No benefit will be payable if, in general medical opinion, surgery, a device or implant could result in the partial or total restoration of speech.

The Diagnosis must be made by physical examination by a speech pathologist.

A Covered Dependent Child must be at least 3 years old on the date of Diagnosis in order to receive a benefit. However, if a Covered Dependent Child is Diagnosed prior to age 3, We will pay a benefit if the initial diagnosis occurred while insured by this Plan, and the Diagnosis is confirmed on or after the child reaches age 3 and remains insured by this Plan.

We deem Loss of Speech to occur on the date on which a Doctor of appropriate specialty physically examines the Covered Person and certifies that the Covered Person meets the definition above.

B005.0117

## All Options

**Major Organ Failure** We pay a benefit if a Covered Person is Diagnosed with Major Organ Failure. By Major Organ Failure We mean the irreversible failure of both lungs, liver, pancreas, or bone marrow, which requires a human to human transplant determined to be Medically Necessary by a Doctor of the appropriate specialty.

We deem Major Organ Failure to occur on the date the Covered Person is accepted onto the transplant waiting list of a recognized transplant program in the United States. We pay the benefit whether or not the transplant is ever performed. If the Covered Person is too ill for a transplant, but otherwise meets the criteria for being on the waiting list of a recognized transplant program, the waiting list requirement will be waived. In this instance We deem Major Organ Failure to occur on the date a Doctor of appropriate specialty deems the Covered Person is too ill for a transplant, but otherwise meets the criteria for being on a waiting list of a recognized transplant program in the United States.

We don't pay a benefit under both this provision and the Heart Failure provision at the same time.

We pay no benefits for autologous bone marrow transplants.

B005.0118

## All Options

**Permanent Paralysis** We pay a benefit if a Covered Person is Diagnosed with Permanent Paralysis, which means a complete and irreversible condition marked by loss of muscle function in any combination of arms and legs. Permanent Paralysis must be the direct result of a Sickness or Injury, other than a Stroke.

We pay 100% of the benefit amount for the Permanent Paralysis of two or more limbs. We pay 50% of the benefit amount for the Permanent Paralysis of one limb.

We deem Permanent Paralysis to occur on the date a Doctor of appropriate specialty makes a Diagnosis.

B005.0119

**All Options**

**Severe Burns** We pay a benefit if a Covered Person is Diagnosed with Severe Burns, which means full-thickness or third-degree burn, as determined by a Doctor covering at least 25% of the body. A full-thickness or third-degree burn is the destruction of the skin through the entire thickness or depth of the dermis and possibly into underlying tissues, with loss of fluid and sometimes shock, by means of exposure to fire, heat, caustics, electricity or radiation.

We deem Severe Burns to occur on the date of the Injury.

B005.0120

**All Options**

**Mandated Benefits**

**Emergency Services and Ambulance Transport:** This Plan provides a lump sum payment for Emergency Services and Ambulance Transport that are due to a Medical Emergency for Covered Persons. The amount payable is shown in the Schedule of Benefits. In order for benefits to be payable, You must provide us with proof of services received in a hospital emergency department or by a licensed professional ambulance service, including information on the presenting symptoms as well as the services provided.

The benefit may be used by the Covered Person for any purpose, including transportation via ambulance and emergency room visit due to an accident.

B053.1244

**All Options**

**Limitations**

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B005.0124

**All Options**

**Proof Of Insurability** The Covered Person's benefit amount, part of it, or increases in it, may not become effective until he or she submits Proof of Insurability to Us. We must approve such Proof of Insurability in writing. These requirements are shown in the Schedule of Benefits.

B005.0127

**All Options**

**Pre-Existing Conditions** A pre-existing condition is a Injury or Sickness, whether diagnosed or misdiagnosed, and any symptoms of it, for which in the 3 months before a person becomes covered by this Plan he or she: (1) receives advice or treatment from a Doctor; (2) undergoes diagnostic procedures, other than routine screening in the absence of symptoms or suspicion of disease process by a Doctor; (3) is prescribed or has taken prescription drugs; or (4) receives other medical care or treatment, including consultation with a Doctor. This Plan will not pay benefits for a Critical Illness that is caused by, or results from, a Pre-Existing Condition if the Critical Illness occurs during the first 12 months the person is covered by this Plan.

This Plan also limits the Covered Person's benefits under this Plan if a Critical Illness that is caused by, or results from, a Pre-Existing Condition occurs after: (a) a change which provides for an increase in the benefits payable by this Plan; or (b) a change in Your benefit election which increased the benefit payable by this Plan, In this case, Your benefit will be limited to the amount that would have been payable had the change not taken place. This limit does not apply if the Critical Illness occurs after the Covered Person completes at least one full day of active work after the change has been in force for 12 months in a row.

B005.0137

## All Options

**If This Plan Replaces Another Plan** This Plan may be replacing a similar plan that the Employer had with some other carrier. In that case, the Pre-Existing Condition limitation will not apply to any Covered Person who: (1) was covered under the Employer's old plan on the day before this Plan started; and (2) has met the requirements of any Pre-Existing Condition or limitation of the old plan; and (3) in Your case, are Actively At Work on a Full-Time basis on the effective date of this Plan.

This Plan will credit any time used to meet the old plan's Pre-Existing Condition provision toward meeting this Plan's Pre-Existing Condition provision, if the Covered Person: (1) was covered under the old plan when it ended; (2) enrolls for coverage under this Plan on or before this Plan's effective date; and (3) is Actively Working on the effective date of this Plan; but (4) has not fulfilled the requirements of any Pre-Existing Condition provision of the old plan.

But, this Plan limits a Covered Person's benefit under this Plan if: (1) it is more than the Critical Illness benefit for which he or she was covered under the old plan; (2) the illness is due to a Pre-Existing Condition; and (3) this Plan pays benefits because this Plan credits time as explained above. In this case, this Plan limits the benefit to the amount the Covered Person to which he or she would have been entitled under the old plan.

This Plan deducts all payments made by the old plan under an extension provision.

B005.0130

## All Options

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### Exclusions

- 1) This Plan will not pay benefits for any Critical Illness:
  - That is not listed as a Critical Illness in the section entitled Covered Critical Illnesses.
  - Caused by, contributed to by, or resulting from: (1) participating in a felony, riot or insurrection; (2) intentionally causing a self-inflicted Injury; (3) committing or attempting to commit suicide while sane or insane; (4) engaging in any illegal activity; or (5) serving in the armed forces or any auxiliary unit of the armed forces of any country.
  - Caused by, contributed to by, or resulting from voluntary use of any poison, chemical, prescription or non-prescription drug or controlled substance unless: (1) it was prescribed for the Covered Person by a Doctor, and (2) it was used as prescribed. In the case of a non-prescription drug, this Plan does not pay for any Critical Illness resulting from or contributed to by use in a manner inconsistent with package instructions. "Controlled substance" means anything called a controlled substance in Title II of the Comprehensive Drug Abuse Prevention and Control Act of 1970, as amended from time to time.
  - Arising from war or act of war, even if war is not declared.

- For which Diagnosis is made outside the United States, unless the Diagnosis is confirmed in the United States. In that case, the Critical Illness will be deemed to occur on the date the Diagnosis was made outside the United States.
- That is Diagnosed while the person is not covered by this Plan.
- For which Diagnosis is made by a Doctor who is the Covered Person, his or her spouse, child, parent, sibling or business associate.
- For which Diagnosis is made while the Covered Person is not alive, unless otherwise specified under Covered Critical Illnesses.

2) This Plan will not pay benefits for the First Occurrence of a Critical Illness if it occurs less than 3 months after the First Occurrence of a related Critical Illness for which this Plan paid benefits. By related we mean either: (a) both Critical Illnesses are contained within the Cancer Related Conditions category; or (b) both Critical Illnesses are contained within the Vascular Conditions category; or (c) both Critical Illnesses are contained within the Childhood Conditions category.

3) This Plan will not pay benefits for a Recurrence of a Critical Illness unless the Covered Person has not exhibited symptoms or received care or treatment for that Critical Illness for at least 12 months in a row prior to the Recurrence. For purposes of this exclusion, care or treatment does not include: (1) preventive medications in the absence of disease; and (2) routine scheduled follow-up visits to a Doctor.

4) This Plan will not pay benefits for more than one Recurrence of any Critical Illness.

B005.0134

## All Options

### Grievance Procedures - External Review

If You or Your representative does not agree with the handling of a claim or has any other grievance, You may file a request for an external review. Requests should be sent to the Commissioner. This must be done within 30 business days after the date of receipt of a grievance decision rendered in a formal review. If the request is accepted by the Commissioner, an external review will be conducted by an Independent Review Organization (IRO). Within 5 business days of Our receipt of the IRO's recommendation, a written report will be submitted to You or Your representative and the Commissioner indicating Our decision with respect to the IRO's recommendation.

The Commissioner may refer matters not within his or her jurisdiction to any other appropriate federal or District government agency for disposition or resolution.

If You are dissatisfied with the resolution reached through the insurer's internal grievance system regarding medical necessity, You may contact the Director, Office of the Health Care Ombudsman and Bill of Rights at the following:



For Medical Necessity cases, District of Columbia Department of Health Care Finance Office of the Health Care Ombudsman and Bill of Rights

441 4th St. NW900S  
Washington, D.C. 20002  
Phone: (202) 442-5988  
Fax: (202) 442-4790

If You are dissatisfied with the resolution reached through the insurer's internal grievance system regarding all other grievances, You may contact the Commissioner at the following

For Non-Medical Necessity cases, Acting Commissioner Stephen C. Taylor  
Department of Insurance, Securities and Banking  
810 First Street, NE 7th Floor  
Washington, D.C. 20002  
Phone: 1-202-727-8000  
Fax: 1-202-354-1085

### **Definitions**

"Commissioner" means the Commissioner of Insurance.

"Grievance" means a written request by You or a person on Your behalf for review of Guardian s decision to deny, reduce, limit, terminate or delay Your covered health care services.

"Grievance Decision" means a determination accepting or denying the basis or requested remedy of the grievance.

"Independent Review Organization (IRO)" means an impartial, certified health entity engaged by the Commissioner or the Director to review any adverse grievance decision made by Guardian.

B053.1246

All Options

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**SCHEDULE OF BENEFITS**

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**CRITICAL ILLNESS COVERAGE**

Effective on the latter of (i) the original effective date of the Policy; or (ii) the effective date of any applicable amendment requested by the Policyholder and approved by the Insurance Company, this Schedule of Benefits is attached to the Certificate. This Schedule of Benefits replaces any previously issued Schedule of Benefits.

B005.0141

All Options

**Initial Election** When You first become eligible for this Plan You may choose to become covered for one of the Plans described below and pay the required premium.

You may request to switch to another Plan at any time. But, We will require Proof of Insurability before You switch to another Plan which provides greater benefits if You do this outside of the group enrollment period (See Conditions of Eligibility for more information). You must notify the Employer of any desired switch and pay the required premium.

B005.0762

All Options

**Annual Election** After You are initially covered under this Plan You may increase Your coverage by selecting the next higher Critical Illness Benefit Amount, up to this Plan's guaranteed issue amount, without submitting Proof of Insurability. This option is available during Your open enrollment period specified by Your Employer. (See Conditions of Eligibility for more information).

If the next available option is greater than the guaranteed issue amount You will need to supply Proof of Insurability. If Proof of Insurability is required and has been declined, You will not be eligible for additional increases. Also, any increase in dependent coverage due to Your annual election will require Proof of Insurability.

B005.0763

All Options

Benefit Levels	Critical Illness	% of Benefit Amount for First Occurrence	% of Benefit Amount for Recurrence
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All Options

Cancer Related  
Conditions:

All Options

Benign Brain Tumor	75%	Not Covered
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All Options	Carcinoma in Situ	30%	Not Covered
All Options	Invasive Cancer	100%	50%
All Options	Skin Cancer	\$250.00	Not Covered
All Options	<b><u>Vascular Conditions:</u></b>		
All Options	Arteriosclerosis	30%	Not Covered
All Options	Heart Attack	100%	100%
All Options	Heart Failure	100%	100%
All Options	Stroke	100%	100%
All Options	<b><u>Neurological Conditions:</u></b>		
All Options	Alzheimer's Disease for Covered Person	50%	Not Covered
All Options	ALS (Lou Gehrig's Disease)	100%	Not Covered
All Options	Huntington's Disease	30%	Not Covered
All Options	Multiple Sclerosis	30%	Not Covered
All Options	Advanced Parkinson's Disease	100%	Not Covered

**All Options**

**Childhood**

**Conditions:**

(applies only to covered dependent children)

**All Options**

<b>Cerebral Palsy</b>	100%	Not Covered
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**All Options**

<b>Cleft lip/cleft palate</b>	100%	Not Covered
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**All Options**

<b>Club Foot</b>	100%	Not Covered
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**All Options**

<b>Cystic Fibrosis</b>	100%	Not Covered
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**All Options**

<b>Down's Syndrome</b>	100%	Not Covered
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**All Options**

<b>Muscular Dystrophy</b>	100%	Not Covered
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**All Options**

<b>Spina Bifida</b>	100%	Not Covered
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**All Options**

<b>Type 1 Diabetes</b>	100%	Not Covered
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**All Options**

**Other Conditions:**

**All Options**

<b>Addison's Disease</b>	30%	Not Covered
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**All Options**

<b>Coma</b>	100%	Not Covered
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**All Options**

<b>Kidney Failure</b>	100%	100%
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**All Options**

<b>Loss of Hearing</b>	100%	Not Covered
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**All Options**

**Loss of Sight** 100% Not Covered

**All Options**

**Loss of Speech** 100% Not Covered

**All Options**

**Major Organ Failure** 100% 100%

**All Options**

**Permanent Paralysis** 100% for 2 or more limbs; 50% for 1 limb Not Covered

**All Options**

**Severe Burns** 100% Not Covered

**All Options**

**Mandated Benefits**

**Emergency Services** \$100.00 per Covered Person per Calendar Year

**Air Ambulance Transport** \$500.00 per Covered Person per Calendar Year

**Ambulance Transport** \$250.00 per Covered Person per Calendar Year

B053.1427

**All Options**

**EMPLOYEE VOLUNTARY CRITICAL ILLNESS COVERAGE**

**All Options**

**Critical Illness Insurance Amount *Plan A***

You may elect amounts of critical illness insurance in increments of \$5,000.00, but the amount may not be less than \$5,000.00 and may not exceed \$20,000.00.

B005.0317

**All Options**

**Proof of Insurability Requirements**

Proof of Insurability requirements may apply to this coverage. Such requirements may apply to the full benefit amount, or just part of it. When Proof of Insurability requirements apply, it means You must submit to Us, Proof of Insurability, and We must approve the Proof of Insurability in writing before the coverage, or the specified part becomes effective.

We require Proof of Insurability as follows:

We require Proof of Insurability before We will cover You if You enroll for Critical Illness coverage after 31 days from Your Eligibility Date or outside of the group enrollment period specified by Your Employer. (See Conditions of Eligibility for more information).

We require Proof of Insurability when You switch from Your current Plan of Critical Illness coverage to a Plan with a higher benefit amount if You elect a higher Plan outside of the group enrollment period specified by Your Employer. (See Conditions of Eligibility for more information).

You must provide Proof of Insurability for amounts of Critical Illness coverage in excess of \$20,000.00.

B005.0768

**All Options**

**DEPENDENT VOLUNTARY CRITICAL ILLNESS COVERAGE**

**All Options**

**Dependent Spouse  
Critical Illness  
Benefit Amount** An amount up to 50% of Your Critical Illness Benefit Amount, but not more than \$10,000.00.

B005.0404

**All Options**

**Dependent Child  
Critical Illness  
Benefit Amount** \$5,000.00 not to exceed 25% of Your Critical Illness Benefit Amount.

B005.0427

**All Options**

**Dependent Spouse  
Proof of Insurability  
Requirements** Proof of Insurability requirements may apply to this coverage. Such requirements may apply to the full benefit amount, or just part of it. When Proof of Insurability requirements apply, it means You must submit to Us, Proof of Insurability for Your dependent spouse, and We must approve the Proof of Insurability in writing before the coverage, or the specified part becomes effective.

We require Proof of Insurability as follows:

We require Proof of Insurability before We will cover Your Spouse if You enroll him or her for Critical Illness coverage after 31 days from Your Eligibility Date or outside of the group enrollment period specified by Your Employer. (See Conditions of Eligibility for more information).

We require Proof of Insurability for Your Spouse when You switch from Your current plan of dependent Spouse Critical Illness coverage to a plan with a higher benefit amount if You elect a higher Plan outside of the group enrollment period specified by Your Employer. (See Conditions of Eligibility for more information).

Your Spouse must provide Proof of Insurability for amounts of dependent Spouse Critical Illness coverage in excess of \$10,000.00.

B005.0774

## All Options

### Changes To Coverage

**Changes in Coverage Amounts** If You are not Actively At Work on a Full-Time basis, any change in Your amount of coverage or the amount of coverage on a covered dependent will not become effective prior to the date You return to Active Work on a Full-Time basis.

**Changes in Insurance Classification** If Your classification changes, coverage will not be changed to the new amount until the first day on which You are: (1) Actively At Work on a Full-Time basis; and (2) make a contribution, if required, for the new classification.

If a contribution is required for the new classification for which a larger amount of coverage is provided, You must make the required contribution for the new amount within 31 days of the change. If You do not make the required contribution within 31 days of the change or within 31 days of becoming Actively At Work on a Full-Time basis, if You are not Actively At Work on a Full-Time basis, when Your classification changes, no increase will be allowed due to such change or any later change. In that case, in order to become covered for the larger amount, You must: (1) make the required contribution for the new amount; and (2) furnish Proof of Insurability to Us, which We approve in writing.

If the coverage amount was previously reduced because of age or retirement, it will be retained at the reduced amount.

B005.0450

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**CERTIFICATE RIDER - Wellness Benefit**

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**LIMITED BENEFIT - PLEASE READ CAREFULLY**

Effective on the latter of (i) the original effective date of the Policy; or (ii) the effective date of any applicable amendment requested by the Policyholder and approved by the Insurance Company, this rider amends this Plan by the addition of the following:

**Wellness Benefit**

This Plan will pay a benefit if a Covered Person has one of the following wellness tests or procedures performed.

We limit what we pay to \$50.00 per day of wellness tests or procedures. We limit what we pay to one day per Covered Person per Benefit Year.

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

By Covered Person, we mean You, as the Employee insured under this Plan and Your dependent Spouse and Covered Dependent Child(ren).

This Plan pays this benefit regardless of the results of the test or procedure.



Wellness tests or procedures are limited to:

- Blood test for triglycerides
- Bone marrow testing
- Breast ultrasound
- Cancer genetic mutation test
- CA 15-3 (blood test for breast cancer)
- CA125 (blood test for ovarian cancer)
- CEA (blood test for colon cancer)
- Chest x-ray
- Colonoscopy
- Completion of a smoking cessation program
- Completion of a weight reduction program
- Fasting blood glucose test
- Flexible Sigmoidoscopy
- Hemocult stool analysis
- Mammography
- Pap smear
- PSA (blood test for prostate cancer)
- Serum cholesterol test to determine level of
- HDL and LDL
- Serum Protein Electrophoresis (blood test for myeloma)
- Stress test on a bicycle or treadmill
- Thermography
- ThinPrep pap test
- Virtual colonoscopy

The Covered Person must submit proof of the test or procedure.

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

**The Guardian** Life Insurance Company of America

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

B053.1272

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## CERTIFICATE AMENDMENT - ELIGIBILITY FOR CRITICAL ILLNESS COVERAGE

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Effective on the latter of (i) the original effective date of the Policy; or (ii) the effective date of any applicable amendment requested by the Policyholder and approved by the Insurance Company, this rider amends this Plan by replacing the following sections:

### Conditions of Eligibility

**Proof of Insurability:** Part or all of Your insurance amounts may be subject to Proof of Insurability. The Schedule of Benefits explains if and when We require Proof of Insurability. You will not be covered for any amount that requires such Proof of Insurability until You give the Proof of Insurability to Us and We approve that Proof of Insurability in writing.

If You elect to enroll within 31 days after Your Eligibility Date, coverage is scheduled to start on Your Eligibility Date.

If You do not elect this coverage within 31 days of Your Eligibility Date, You must answer health questions, or wait until the next scheduled group enrollment period. Once each year, during the group enrollment period, You may elect to enroll in this coverage as offered by the Employer. As used here, "group enrollment period" means an annual open enrollment period set by the Employer and agreed to by Us. If You elect to enroll outside of the group open enrollment period, You must provide Proof of Insurability by answering health questions, or wait until the next group enrollment period.

If Proof of Insurability is required, You will not be covered by this Plan until We approve that Proof of Insurability in writing and notify You of Your effective date of coverage.

### When Employee Coverage Starts

Your eligibility date is the date You have met all of the conditions of eligibility.

Whether You must pay all or part of the cost of Your coverage, You must elect to enroll and agree to make the required payments before Your coverage will start. If You do this on or before Your Eligibility Date, Your coverage is scheduled to start on Your Eligibility Date. If You do this within 31 days after Your Eligibility Date, Your coverage is scheduled to start on Your Eligibility Date. If You elect to enroll and agree to make the required payments more than 31 days after Your Eligibility Date, Your coverage will not be scheduled to start until You send Us Proof of Insurability or until You enroll during the next group enrollment period. If Proof of Insurability is required, You will not be covered by this Plan until We approve that Proof of Insurability in writing and notify You of Your effective date of coverage.

If Your active service ends before You meet any Proof of Insurability requirements that apply, You will still have to meet those requirements if You are later re-employed by the Employer or an associated company.

On the date all or part of Your coverage is scheduled to start, You must be: (1) Actively At Work; (2) fully capable of performing the major duties of Your regular occupation; and (3) working Your regular number of hours. In that case, Your coverage will start at 12:01 A.M. Standard Time for Your place of residence on that date. In any other case, We will postpone the start of Your coverage until the date You: (a) return to Active Work; (b) are working Your regular number of hours; and (c) are fully capable of performing the major duties of Your regular occupation. Sometimes, a scheduled effective date is not a regularly scheduled work day. If the scheduled effective date falls: on a holiday; on a vacation day; on a non-scheduled work day; during a layoff of less than 180 days in duration; during an approved leave of absence not due to sickness or injury, of 90 days or less; or on a day during a period of absence that is less than 7 days in duration; and if: (a) You were fully capable of performing the major duties of Your regular occupation for the Employer on a full-time basis at 12:01 AM Standard Time for Your place of residence on the scheduled effective date; and (b) You were performing the major duties of Your regular occupation and working Your regular number of hours on Your last regularly scheduled work day; Your coverage will start on the scheduled effective date.

**Delayed Effective Date For Voluntary Critical Illness Coverage:** If You are not Actively At Work on the date Your Voluntary Critical Illness coverage is scheduled to start due to Sickness or Injury, We will postpone coverage for an otherwise covered loss due to that Sickness or Injury. We will postpone such coverage until You complete ten days in a row without missing a work day due to that Sickness or Injury in which You are: (1) Actively At Work; (2) fully capable of performing the major duties of Your regular occupation; and (3) working Your regular number of hours. Coverage for an otherwise covered loss due to all other conditions will start on the date You are: (a) Actively At Work; (b) fully capable of performing the major duties of Your regular occupation; and (c) working Your regular number of hours.

**Exception to When Employee Coverage Starts:** If You are not capable of performing the major duties of Your regular occupation for Your Employer on a full-time basis on the date Your coverage is scheduled to start, You will be insured for Critical Illness insurance if:

1. You were insured under the prior insurer's group critical illness policy at the time of the transfer;
2. You are a member of an eligible class; and
3. premiums for You were paid up to date; and
4. You are not receiving or eligible to receive benefits under the prior insurer's group critical illness policy.

Any Critical Illness benefit payable will be the lesser of:

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

The Critical Illness benefit payable will be reduced by any amount paid by the prior insurer's group critical illness policy.

All other provisions under this Policy will apply under the Exception to When Employee Coverage Starts.

You will remain insured under this provision until the first to occur of:

1. the date You are fully capable of performing the major duties of Your regular occupation for Your Employer on a full-time basis;
2. the date insurance terminates for one of the reasons stated in When Employee Coverage Ends;
3. the last day of a period of 12 consecutive months which begins on the Policy effective date; or
4. the last day You would have been covered under the prior insurer's group critical illness policy, had the prior plan not terminated.

## **DEPENDENT COVERAGE**

### **Proof of Insurability**

Part or all of Your Initial Dependents insurance amounts may be subject to Proof of Insurability. The Schedule of Benefits explains if and when We require Proof of Insurability. Your Initial Dependents will not be covered for any amount that requires such Proof of Insurability until You give the Proof of Insurability to Us and We approve that Proof of Insurability in writing.

If You elect to enroll Your Initial Dependents within 31 days after Your Eligibility Date, coverage is scheduled to start on Your Eligibility Date.

If You do not elect Initial Dependent coverage within 31 days of Your Eligibility Date, Your Initial Dependents must answer health questions, or wait until the next scheduled group enrollment period to enroll. Once each year, during the group enrollment period, You may elect to enroll Initial Dependents in this coverage as offered by the Employer. As used here, "group enrollment period" means an annual open enrollment period set by the Employer and agreed to by Us. If You elect to enroll Your Initial Dependents outside of the group open enrollment period, You must provide Proof of Insurability by answering health questions, or wait until the next group enrollment period.

If Proof of Insurability is required, Your Initial Dependents will not be covered by this Plan until We approve that Proof of Insurability in writing and notify You of Your Initial Dependent's effective date of coverage.

In the case of a Newly Acquired Dependent, other than the first newborn child, You may elect to enroll a Newly Acquired Dependent within 31 days. If You do not elect to enroll a Newly Acquired Dependent within 31 days of his or her Eligibility Date, Your Newly Acquired Dependent(s) may have to answer health questions, or wait until the next scheduled group enrollment period to enroll.

If Your dependent coverage ends for any reason, including failure to make the required payments, Your dependent will not be covered by this Plan again until You give Us new Proof of Insurability that they are insurable and We approve that Proof of Insurability in writing, or wait until the next group enrollment period.

### **When Dependent Coverage Starts**

In order for Your dependent coverage to start, You must already be covered for Employee coverage, or enroll for Employee and dependent coverage at the same time.

If You enroll Your dependents on or before Your Eligibility Date, the dependent's coverage is scheduled to start on the later of the 1st day of the month which coincides with or next follows Your Eligibility Date and the date You become covered for Employee coverage.

If You do this within the group enrollment period, the coverage is scheduled to start on the later of the 1st day of the month which coincides with or next follows the date You sign the enrollment form and the date You become covered for Employee coverage.

If You do this after the group enrollment period ends, Your dependent coverage may be subject to Proof of Insurability and will not start until We approve that Proof of Insurability in writing.

Once You have dependent child coverage for Your Initial Dependent child(ren) any Newly Acquired Dependent children will be covered as of the date he or she is first eligible.

Whether You must pay all or part of the cost of Your coverage, You must elect to enroll and agree to make the required payments before Your coverage will start. If You do this on or before Your Eligibility Date, Your coverage is scheduled to start on Your Eligibility Date. If You do this within 31 days after Your Eligibility Date, Your coverage is scheduled to start on Your Eligibility Date. If You elect to enroll and agree to make the required payments more than 31 days after Your Eligibility Date, Your coverage will not be scheduled to start until You send Us Proof of Insurability or until You enroll during the next group enrollment period. If Proof of Insurability is required, You will not be covered by this Plan until We approve that Proof of Insurability in writing and notify You of Your effective date of coverage.

If Proof of Insurability is required for dependent benefits as explained above, those benefits will not be scheduled to start until You give Us Proof of Insurability that the dependent is insurable. Once We have approved that Proof of Insurability, those benefits will be scheduled to start on the effective date shown in the endorsement section of Your application.

**Exception:** We will postpone the effective date of a dependent's, other than a newborn child's, coverage if, on that date, he or she is: (1) confined to a hospital or other health care facility; (2) home confined; or (3) unable to perform two or more Activities of Daily Living. In that case, We will postpone the effective date of his or her coverage until the day after the date: (a) of his or her discharge from such facility; (b) his or her home confinement ends; or (c) he or she is no longer requires assistance with two or more Activities of Daily Living. If a dependent was covered under a prior plan at transfer, this language will not apply to the amount of coverage that was in force with the prior plan.

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

**The Guardian** Life Insurance Company of America

A handwritten signature in black ink, appearing to read "Raymond J. Manna". The signature is written in a cursive style with a large initial 'R'.

Senior Vice President, Group and Worksite Markets

B053.1921

## Options B , D

### This Is Not Insurance

#### Discounts on Vision Services and Supplies

A member of this program can receive discounts on vision care services or supplies from a vision provider who is under contract with Vision Service Plan's (VSP's) network, as described below. Discounts are not available from providers who are not members of VSP's network.

The member must pay the entire discounted fee directly to the VSP network doctor. There is no need to file a claim.

A member must make an appointment with a VSP network doctor. To find a VSP network doctor, the member can visit [www.vsp.com](http://www.vsp.com) or call 1-800-877-7195.

When a person is no longer a member of this program, access to the network discounts ends.

The discounts provided by this program are as follows:

**Eye Exams** - 20% off the VSP doctor's usual charge.

**Glasses and Lenses:** Discounts are given for an unlimited number of glasses or contact lens professional services visits, as long as the VSP network doctor has provided an eye exam to the member within the last 12 months.

- Standard lenses - 20% off the VSP doctor's usual charge, when a complete set of prescription glasses is purchased.
- Lens options - 20% off the VSP doctor's usual charge for all lens options, such as tints and coatings.
- Frames - 20% off the VSP doctor's usual charge when a complete set of prescription glasses is purchased.
- Elective contact lenses - 15% off the VSP doctor's usual charge for professional services. The lenses are not discounted.

VSP network doctors are not required to extend a discount if they have not provided an eye exam to the patient within the last 12 months.

No discounts will be given for:

- sundry items such as lens cleaners and solutions,
- artistically painted lenses,
- additional office visits associated with contact lens pathology,
- contact lens modification, polishing or cleaning,
- orthoptics or vision training and any associated supplemental testing,
- plano lenses,
- expenses associated with securing materials such as lenses and frames,
- medical or surgical treatment of the eyes except as described in the "Laser Surgery" section below.

**Laser Surgery:** The discount program provides access to a network of laser surgery centers where members and their dependents can obtain vision laser surgery at a discounted fee. Members save an average of 15% off the laser surgeon's usual charge. And, if the laser center is offering a temporary price reduction, the member will receive 5% off the promotional price if it is less than the usual discounted price.

No one will have to pay more than \$1,800 per eye for laser-assisted in-situ keratomileusis (LASIK), and \$1,500 per eye for photorefractive keratectomy (PRK), two of the most common procedures.

If a member or a member's dependent is interested in the discount program, he or she must schedule a screening and consultation with a VSP doctor to discuss whether vision laser surgery is an appropriate procedure.

If the member or dependent decides to proceed with the surgery, the doctor will refer him or her to a VSP laser surgeon for further evaluation.

The laser center's fee includes the fee for the initial screening and consultation, the surgery itself and all post-operative care.

If the doctor determines that the member or dependent is an appropriate candidate for the laser surgery, but he or she does not have the surgery performed, he or she must pay the fee for the screening and consultation directly to the VSP network doctor. If the doctor determines that the enrollee or dependent is not an appropriate candidate for laser surgery, no fee is charged for the consultation.

B506.0004



All Options

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**CERTIFICATE AMENDMENT**

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

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**ADDITIONAL SERVICES**

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

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

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

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

- Financial Planning and Wellness Services.

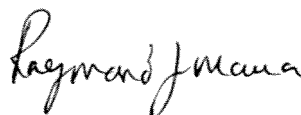
All Options

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

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

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

**The Guardian** Life Insurance Company of America



Raymond Marra, Senior Vice President, Group and Worksite Markets

B055.0288



## All Options

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

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## STATEMENT OF ERISA RIGHTS

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

### **Receive Information About Your Plan and Benefits**

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

### **Prudent Actions By Plan Fiduciaries**

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

## Statement of Erisa Rights (Cont.)

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

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

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

B800.0093

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## Group Health Benefits Claims Procedure

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

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

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

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

"Group Health Benefits" means any accident, cancer, critical illness, specified disease or hospital indemnity coverages which are a part of this plan.

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

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

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

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

**Adverse Benefit Determination** If a claim is denied, Guardian will provide a notice that will set forth:

- the specific reason(s) for the adverse determination;
- reference to the specific plan provision(s) on which the determination is based;

## Group Health Benefits Claims Procedure (Cont.)

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- a description of any additional material or information necessary to make the claim valid and an explanation of why such material or information is needed;
- a description of the plan's claim review procedures and the time limits applicable to such procedures, including a statement indicating that the claimant has the right to bring a civil action under ERISA Section 502(a) following an adverse benefit determination;
- identification and description of any specific internal rule, guideline or protocol that was relied upon in making an adverse benefit determination, or a statement that a copy of such information will be provided to the claimant free of charge upon request.

### **Appeal of Adverse Benefit Determinations**

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

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

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

In reviewing an appeal, Guardian will:

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

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

## **Group Health Benefits Claims Procedure (Cont.)**

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

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

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### **All Options**

### **Termination of This Group Plan**

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

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

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

B800.0086



**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".**



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**CERTIFICATE OF COVERAGE**

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**The Guardian Life Insurance Company of America**

10 Hudson Yards  
New York, New York 10001  
www.GuardianAnytime.com

The Group Accident coverage described in this Certificate is attached to the group Policy effective January 1, 2020. This Certificate replaces any Certificate previously issued under the Policy or under any other plan providing similar or identical benefits issued to the Policyholder by Guardian.

**LIMITED BENEFIT, PLEASE READ CAREFULLY****GROUP ACCIDENT COVERAGE**

**THIS IS AN ACCIDENT ONLY CERTIFICATE. THIS CERTIFICATE PROVIDES LIMITED BENEFITS. BENEFITS PROVIDED ARE SUPPLEMENTAL AND ARE NOT INTENDED TO COVER ALL MEDICAL EXPENSES. READ YOUR CERTIFICATE CAREFULLY.**

**THIS IS A SUPPLEMENT TO HEALTH INSURANCE AND IS NOT A SUBSTITUTE FOR MAJOR MEDICAL COVERAGE.**

Guardian certifies that the Employee to whom this Certificate is issued is eligible for the coverage, and in the amount, described herein. In order to be eligible for coverage, the Employee must: (a) satisfy all of this Certificate's eligibility and effective date requirements; (b) be listed in Our and/or the Policyholder's records as a validly covered Employee under the Certificate; and all required premium payments have been made by or on behalf of the Employee.

The Employee and/or his or her dependents are not covered by any part of this Certificate for which he or she has waived coverage. Such a waiver of coverage is shown in Our and/or the Policyholder's records.

Policyholder: UNITY HEALTHCARE INC

Group Policy Number: 00505565

**The Guardian** Life Insurance Company of America



Harris Oliner, Senior Vice President,  
Corporate Secretary



Raymond Marra, Senior Vice President,  
Group and Worksite Markets

B442.1476

Please read this Certificate carefully. If You are not satisfied for any reason, You may return this Certificate to Us within 30 days from the date You receive it. If You return it within the 30 day period, this Certificate will be void from the beginning. We will refund any premium paid.

B442.0005



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## GENERAL PROVISIONS

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### Applicable Benefits

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This Certificate may include multiple benefit options and types of benefits.

- They were previously selected in an acceptable manner, such as an enrollment form or other required form; and
- We have received any required premium.

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### Limitation Of Authority

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Only the President, a Vice President or a Secretary of Guardian, has the authority to act for Us in a written and signed statement to:

- Determine whether any Policy or Certificate is to be issued;
- Waive or alter any Policy or Certificate provisions, or any of Our requirements;
- Bind Us by any statement or promise relating to the Policy or Certificate issued, or to be issued; or
- Accept any information, or representation, which is not in a signed application.

Agents and brokers do not have the authority to change the Policy or Certificate, or waive any of its provisions.

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### Incontestability

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

In the event Your insurance is rescinded, We will refund premiums paid for the periods such insurance is void.

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### Examination and Autopsy

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We have the right to have a Doctor of Our choice examine the person for whom a claim is being made under the Certificate as often as We feel reasonably necessary. We also have the right to have an autopsy performed in the case of death where allowed by law. We will pay for all such examinations and autopsies.



## **Conformity with Statutes**

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Any provision of this Certificate which, on its effective date, is in conflict with statutes of the jurisdiction in which the Covered Person resides on such date is hereby amended to conform to the minimum requirements of such statutes.

## **Overpayment Recovery**

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We will recover any benefit payments made if We overpaid a Covered Person. The Covered Person must repay Us in full. We have the right to recover an overpayment from any future benefits payable.

B442.1478

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**ELIGIBILITY FOR ACCIDENT COVERAGE - EMPLOYEE COVERAGE**

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**Conditions of Eligibility**

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You are eligible for Accident coverage if You are:

- In an eligible class of Employees;
- An active Full-Time Employee;
- Legally working in the United States or working outside of the United States for a United States based Employer in a country or region approved by Us; and
- Working at least the minimum number of hours of an Employee in Your eligible class at:
  - o The Employer's place of business;
  - o Some place where the Employer's business requires You to travel; or
  - o Any other place You and the Employer have agreed upon for the performance of Your occupational duties.

You are **not** eligible for Accident coverage if You are

- A temporary or seasonal Employee.

**Enrollment Requirement** If You must pay all or part of the cost of Your coverage, We will not cover You until You enroll and agree to make the required payments.

**The Service Waiting Period** If You are in an eligible class, You are eligible for Accident coverage under this Plan after You complete the service waiting period, if any, established by the Employer.

**Multiple Employment** If You work for both the Employer and a covered associated company, or for more than one covered associated company, We will treat You as if only one firm employs You. You will not have multiple Accident coverages under this Plan. But, if this Plan uses the amount of Your earnings to set the rates, determine class, figure coverage amounts, or for any other reason, such earnings will be figured as the sum of Your earnings from all covered Employers.

B442.0009

**All Options**

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**When Employee Coverage Starts**

Whether You must pay all or part of the cost of Your coverage, You must elect to enroll and agree to make the required payments before Your coverage will start. If You do this on or before Your Eligibility Date, Your coverage is scheduled to start on Your Eligibility Date. If You do this within 31 days after Your Eligibility Date, Your coverage is scheduled to start on Your Eligibility Date.

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**All Options**

On the date all or part of Your coverage is scheduled to start, You must be: (1) Actively At Work; (2) fully capable of performing the major duties of Your regular occupation; and (3) working Your regular number of hours. In that case, Your coverage will start at 12:01 A.M. Standard Time for Your place of residence on that date. In any other case, We will postpone the start of Your coverage until the date You: (a) return to Active Work; (b) are working Your regular number of hours; and (c) are fully capable of performing the major duties of Your regular occupation. Sometimes, a scheduled effective date is not a regularly scheduled work day. If the scheduled effective date falls: on a holiday; on a vacation day; on a non-scheduled work day; during a layoff of less than 90 days in duration; during an approved leave of absence not due to Sickness or Injury, of 90 days or less; or on a day during a period of absence that is less than 7 days in duration; and if: (a) You were fully capable of performing the major duties of Your regular occupation for the Employer on a Full-Time basis at 12:01 AM standard time for Your place of residence on the scheduled effective date; and (b) You were performing the major duties of Your regular occupation and working Your regular number of hours on Your last regularly scheduled work day; Your coverage will start on the scheduled effective date.

B442.0018

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### Exception to When Employee Coverage Starts

**Transfer Business Exception:** If due to Sickness or Injury, You are not Actively At Work and not working the minimum number of hours of an Employee in Your eligible class, on Your scheduled Eligibility Date, You will be insured for this Group Accident insurance if:

- You were insured under the Employer's prior group accident plan at the time the prior insurer's group accident plan ended and this Group Accident Plan became effective with Us, with no break in coverage;
- You were a member of an eligible class under the Employer's prior group accident plan and are eligible under this Certificate;
- Premiums for You were paid up to date for the Employer's prior group accident plan and this Certificate; You are not receiving or eligible to receive benefits under the Employer's prior group accident plan.
- You are not receiving or eligible to receive benefits under the Employer's prior group accident plan.

B442.0023

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### When Employee Coverage Ends

**When Employee Coverage Ends**

Your coverage will end on the first of the following dates:

- The date Your Active Work ends for any reason.
- The date You stop being an eligible Employee under this Certificate.
- The date You are no longer working in the United States, or no longer working outside the United States for a United States based Employer in a country or region approved by Us. Any incidental business or personal travel outside of the United States or outside of a country or region approved by Us, is covered. Such travel will be considered incidental if it is for a period not to exceed 30 consecutive days.
- The date the group Certificate ends, or is discontinued for a class of Employees to which You belong.
- The last day of the period for which required payments are made for You.
- The date you die.

You may have the right to continue certain group benefits for a limited time after Your coverage would otherwise end. Contact Your Employer regarding any continuation options available.

B442.0021

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**CONTINUATION OF COVERAGE**

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**Coverage During Temporary  
Layoff or Leave of Absence**

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If Your Active Work ends because of a temporary layoff or leave of absence, You and Your Employer may agree to continue Your insurance, subject to continued payment of all required premium, until the earliest of:

- The end of the temporary layoff or leave of absence; or
- The end of the month of the leave or layoff plus 1 month(s) following the date the leave or layoff begins.
- The end of the time period covered under a severance agreement not to exceed 1 month(s).

Your Employer must notify Us of the date your Active Work ends and the date You return to Active Work. If You do not return to Active Work at the end of the approved layoff or leave of absence, Your coverage will end. See When Employee Coverage Ends for further explanation.

See Portability Privilege for continuing coverage when You are no longer covered under this Policy and Certificate.

B442.0022

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**Coverage During Family  
Leave of Absence**

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**Important Notice** This section may not apply to Your Employer's Plan. You must contact Your Employer to find out if he or she must allow for a family leave of absence under federal law. If he or she must allow for such leave, this section applies.

**If Your Coverage Would End** Your Accident coverage would normally end because You cease work due to an approved leave of absence. But, You may continue Your coverage if the leave has been granted to: (1) allow You to care for a seriously injured or ill spouse, child or parent; (2) after the birth or adoption of a child; (3) due to Your own serious health condition; or (4) because of a serious injury or illness arising out of the fact that Your spouse, child, parent or Next of Kin who is a Covered Service Member is on Active Duty, or has been notified of an impending call or order to active duty, in the Armed Forces in support of a contingency operation. To continue Your coverage, You will be required to pay the same share of the premium as You paid before the leave of absence.

**When Continuation Ends** Continued coverage will end on the earliest of the following:

- The date You return to Active Work.
- In the case of a leave granted to You to care for a Covered Service Member, the end of a total leave period of 26 weeks in one 12 month period. This 26 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 Policy is terminated or You are no longer eligible for coverage under this Certificate.
- The end of the period for which premium has been paid.

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

- **Active Duty:** This term means duty under a call or order to active duty in the Armed Forces of the United States.
- **Contingency Operation:** This term means a military operation that: (1) is designated by the Secretary of Defense as an operation in which members of the Armed Forces are or may become involved in military actions, operations or hostilities against an enemy of the United States or against an opposing military force; or (2) results in the call or order to, or retention on, active duty of members of the uniformed services under any provision of law or during a national emergency declared by the President or Congress.
- **Covered Service Member:** This term means a member of the Armed Forces, including a member of the National Guard or Reserves, who for a serious injury or illness is: (1) undergoing medical treatment, recuperation or therapy; (2) otherwise in outpatient status; or (3) otherwise on the temporary disability retired list.
- **Next Of Kin:** This term means Your nearest blood relative.
- **Outpatient Status:** This term means, in the case of a Covered Service Member, that he or she is assigned to: (1) a military medical treatment facility as an outpatient; or (2) a unit established for the purpose of providing command and control of members of the Armed Forces receiving medical care as outpatients.
- **Serious Injury Or Sickness:** This term means, in the case of a Covered Service Member, an Injury or Sickness incurred by him or her in line of duty on Active Duty in the Armed Forces that may render him or her medically unfit to perform the duties of his or her: (1) office; (2) grade; (3) rank; or (4) rating.

See Portability Privilege for continuing coverage when You are no longer covered under this Policy and Certificate.

### Rehire

If You were previously covered under this Certificate and Your coverage ended, You will be eligible for insurance under this Certificate on the date You return to Active Work, provided You:

- Return to Active Work within 6 month(s) of the date Your coverage ended;
- Were covered for Group Accident under this Certificate on the day before Your coverage ended; and
- Enroll for coverage within 31 days of the date You return to Active Work.

Upon return to Active Work, a new Eligibility Date will be established according to the When Coverage Starts rules above.

Upon returning to Active Work, subject to the limitations noted under the Rehire provision of this Certificate, Your coverage under this Certificate will be reinstated at the amount of coverage in place prior to the coverage ending due to temporary layoff or leave of absence. Coverage will be re-established on the date You return to Active Work if all of the required conditions are satisfied. Employee coverage under this Certificate that is reinstated will not be subject to the waiting period established by the Employer, if any.

See Portability Privilege for continuing coverage when You are no longer covered under this Policy and Certificate.

B442.0024

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## ELIGIBILITY FOR ACCIDENT COVERAGE - DEPENDENT COVERAGE

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### Conditions of Eligibility

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Your eligible dependents are Your spouse; and

- Unmarried dependent child, including:
  - A newborn child, natural child, stepchild, grandchild(ren) who are dependents for federal income tax purposes at the time of application or a child placed with You for adoption or foster care who is under age 26; and
  - A child who is incapable of self-support because of a physical or mental incapacity. See Continuing Coverage For Dependent Children Past the Limiting Age to remain an eligible dependent child.

Eligible dependent does not include anyone who is insured under this Certificate as the Employee.

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### Dependents Not Eligible

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We exclude:

- A dependent who is on Active Duty in any armed force;
- A dependent who is covered by this Certificate as a/an Employee.

A child may be an eligible dependent of more than one Employee who is insured under this Certificate. In that case, the child may be insured for dependent Group Accident benefits by only one Employee at a time.

B442.0027

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### When Dependent Coverage Starts

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**When Dependent Coverage Starts** In order for Your dependent coverage to start, You must already be covered for Employee coverage, or enroll for Employee and dependent coverage at the same time.

Subject to all of the other terms of this Certificate, the date Your dependent coverage starts depends on when You elect to enroll Your dependents and agree to make any required payments.

When You enroll Your dependents, coverage begins on the later of Your Eligibility Date and the date You become covered for Employee coverage.

B442.0028



All Options

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**When Dependent Coverage Ends**

**When Dependent Coverage Ends**

Dependent coverage ends for all of Your dependents as follows:

- Your Employee coverage ends;
- You stop being a member of a class of Employees eligible for such coverage;
- This Certificate ends, or dependent coverage is discontinued for a class of Employees to which You belong;
- The last day of the period for which required payments are made for Your dependent(s);
- For Your Spouse, at 12:01 A.M. on the date Your marriage ends in legal divorce or annulment;
- The date Your dependent dies.

B442.0035

All Options

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**When Dependent Coverage Ends**

**When Dependent Coverage Ends**

Dependent coverage ends for all of Your dependents as follows:

- Your Employee coverage ends;
- You stop being a member of a class of Employees eligible for such coverage;
- This Certificate ends, or dependent coverage is discontinued for a class of Employees to which You belong;
- The last day of the period for which required payments are made for Your dependent(s);
- For Your child, this happens at 12:01 A.M. on the date the child attains this Certificate's age limit;
- The date Your dependent dies.

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**Continuing Coverage For Dependent Children Past the Limiting Age**

**Continuing Coverage For Dependent Children Past the Limiting Age**

If You have an unmarried child:

- Incapable of independent living by reason of a mental, physical, or developmental disability; and
- Primarily dependent upon You for support and maintenance;

Then, the child or children may remain eligible for dependent benefits past the age limit provided all the conditions shown below are satisfied. Each such child:

- Must have a mental, physical, or developmental disability that began before he or she reached the dependent age limit;
- Became covered by this Certificate, or the prior carrier's group accident plan that it replaced, before he or she reached the dependent age limit, and remained continuously covered until he or she reached the age limit;
- Is unmarried and remains:
  - o Incapable of independent living; and
  - o Dependent upon You for most of his or her support and maintenance.

You must send Us written proof, and we approve such proof, of the child's disability and dependence within 31 days from the date he or she reaches the dependent age limit. After the two year period following the child's attainment of the age limit, We can ask for periodic proof that the child's condition continues, but We cannot ask for this proof more than once a year.

Any coverage provided under this section ends when Your coverage ends.

B442.0037

## All Options

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### ACCIDENT BENEFITS

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This Certificate will pay the benefits described below if a Covered Person sustains an Injury, or incurs a loss, as a result of a Covered Accident. The Covered Accident and/or treatment must occur on or after the date the Covered Person becomes insured by this Certificate. This Certificate pays no benefits other than what is specifically listed below.

We pay no benefits for any Accident that occurs before a person is a Covered Person under this Certificate.

Subject to a Covered Person's right to port this coverage, if a Covered Person's coverage under this Certificate ends for any reason other than non-payment of premium, We will pay benefits for the Covered Accident that occurs while a Covered Person is insured by this Certificate. The treatment must be performed within 90 days of the date the Covered Persons coverage ends.

B442.0038

## All Options

**Accidental Death** We pay the amount shown in the Schedule of Benefits if the Covered Person sustains an Injury in a Covered Accident that causes the Covered Person's death. The Injury must cause the Covered Person's death within 90 days of the Covered Accident. If We pay this benefit, We will not pay the Accidental Death Common Carrier benefit.

If an Accidental Death and Accidental Dismemberment result from the same Covered Accident, We will pay the higher amount. This benefit is payable once per Covered Person per Covered Accident.

**Accidental Death  
Common Carrier:** We pay the amount shown in the Schedule of Benefits if the Covered Person's Accidental Death is due to a Covered Accident which occurs while riding as a fare-paying passenger in a Common Carrier. If We pay this benefit, We will not pay the Accidental Death benefit. This benefit is payable once per Covered Person per Covered Accident.

**Accidental Death  
Common Disaster:** We pay the increased amount shown in the Schedule of Benefits if both You and Your covered Spouse die in a Covered Accident or separate Covered Accidents within the same 24 hour period. The benefit increase applies to Your covered Spouse's benefit. This benefit is payable once per Covered Person per Covered Accident.

**Accidental  
Dismemberment:** We pay the amount shown in the Schedule of Benefits if a loss listed below is sustained by a Covered Person due to Injuries caused by a Covered Accident:

- "Loss of a hand" means the hand is completely severed at or above the wrist.
- "Loss of a foot" means the foot is completely severed at or above the ankle.

- "Loss of sight" means total and permanent loss of all sight in both eyes that is irrecoverable by natural, surgical or artificial means.
- "Loss of thumb and index finger of same hand" or "Loss of four fingers of same hand" means complete severance through or above the metacarpophalangeal joints of the same hand. This benefit is not payable if benefits have been paid for "Loss of a hand".
- "Loss of all toes on same foot" means complete severance at the metatarsophalangeal joint. This benefit is not payable if benefits have been paid for "Loss of a foot".

We will not pay more than \$25,000.00 for all losses due to the same Covered Accident.

If an Accidental Death and Accidental Dismemberment result from the same Covered Accident, We will pay the higher amount. This benefit is payable once per Covered Person per Covered Accident.

**Accidental Death Seatbelt and Airbag:** We pay the seatbelt amount shown in the Schedule of Benefits if a Covered Person dies due to Injuries sustained in a Covered Accident while properly wearing a seatbelt. We will pay the Seatbelt & Airbag amount shown in the Schedule of Benefits if a Covered Person dies as a direct result of an automobile Accident while both properly wearing a seatbelt and sitting in a seat equipped with an airbag. We will not pay both the Seatbelt, and Seatbelt and Airbag benefit, for the same Covered Accident.

B442.0039

#### All Options

**Air Ambulance** We pay the amount shown in the Schedule of Benefits if a Covered Person is transported by Air Ambulance to or from a Hospital or between medical facilities for treatment of Injuries sustained as the result of a Covered Accident within 48 hours of a Covered Accident. This benefit is payable once per Covered Person per Covered Accident.

B442.0041

#### All Options

**Ambulance:** We pay the amount shown in the Schedule of Benefits if a licensed ambulance company transports a Covered Person by ground, to or from a Hospital, or between medical facilities, for treatment of Injuries sustained as a result of a Covered Accident, within 90 days of a Covered Accident. This benefit is payable once per Covered Person per Covered Accident.

B442.0049

#### All Options

**Blood / Plasma / Platelets** We pay the amount shown in the Schedule of Benefits if, as the result of a Covered Accident, a Covered Person receives a transfusion, administration, cross matching, typing and processing of Blood/Plasma/Platelets, within 90 days of the Covered Accident. This benefit is payable once per Covered Person per Covered Accident.

B442.0042

**All Options**

**Burn** We pay the amount shown in the Schedule of Benefits if a Covered Person suffers one or more burns as a result of a Covered Accident, and is treated by a Doctor within 72 hours of the Covered Accident. If the burn(s) sustained by the Covered Person meets more than one of the burn classifications, We pay the higher amount. This benefit is payable once per Covered Person per Covered Accident.

**Burn - Skin Graft** We pay the amount shown in the Schedule of Benefits when grafting of the skin is necessary, as determined by a medical professional, for a burn that was payable under the Burn benefit. This benefit is payable once per Covered Person per Covered Accident.

B442.0043

**All Options**

**Catastrophic Loss** We pay the amount shown in the Schedule of Benefits if a Covered Person suffers a Catastrophic Loss within 365 days of a Covered Accident, due to Injuries sustained in a Covered Accident. This benefit is payable once per Covered Person per Covered Accident. If a Catastrophic Loss benefit is paid, an Accidental Dismemberment benefit will not be paid for the same, or attached body part.

B442.0044

**All Options**

**Child Organized Sport** We pay the additional amount shown in the Schedule of Benefits if the Covered Accident occurred while Your covered dependent child is participating in an Organized Sport. The child must be insured by this Certificate on the date the Covered Accident occurred. The covered dependent child must be 18 years of age or younger.

B442.0045

**All Options**

**Chiropractic Visits** We pay the amount shown in the Schedule of Benefits if, as the result of a Covered Accident, a Covered Person suffers a structural imbalance and receives Chiropractic Care Services by a chiropractor in a chiropractors office. Treatment must begin within 60 days after a Covered Accident and be completed within 180 days of the Covered Accident. We will pay a benefit for up to 6 visits per Covered Person per Covered Accident, but no more than 12 visits per calendar year.

B442.0046

**All Options**

**Coma** We pay the amount shown in the Schedule of Benefits if, as the result of a Covered Accident, a Covered Person is in a Coma lasting at least 7 consecutive days characterized by the absence of eye opening, verbal response, and motor response. The condition must require intubation for respiratory assistance, and be diagnosed or treated by a Doctor within 90 days of the Covered Accident. This benefit is not payable for a medically-induced Coma. If a Coma and Traumatic Brain Injury result from the same Covered Accident, We will pay the higher amount.

B442.0047

**All Options**

**Concussions** We pay the amount shown in the Schedule of Benefits if a Covered Person sustains a concussion as the result of a Covered Accident, and is diagnosed within 72 hours of the Covered Accident. This benefit is payable once per Covered Person per Covered Accident.

B442.0048

**All Options**

**Concussion Baseline Study** We pay the amount shown in the Schedule of Benefits if a covered dependent child 18 years of age or younger completes a baseline concussion test.

As a preventive measure, these baseline tests are typically taken prior to a sport season when an athlete has not yet had exposure to training and/or competition. In the event a concussion is sustained during the season, the same test ("post-injury") is taken again by the athlete, yielding comparative scores from before and after the Injury.

These baseline tests and post-injury tests are computerized assessments that measure reaction time, memory capacity, speed of mental processing, and executive functioning of the brain. They also record baseline concussion symptoms and provide extensive information about the athlete's history with concussions.

This benefit is payable once per covered dependent child per year. We do not pay a benefit for "post-injury" tests.

B442.0053

**All Options**

**Dislocations** We pay the amount shown in the Schedule of Benefits if a Covered Person is Injured and suffers a Dislocation as a result of a Covered Accident. A Dislocation must be diagnosed by a Doctor within 90 days of the Covered Accident. The Dislocation must be corrected by open (surgical) or closed (non-surgical) reduction.

For multiple Dislocations due to the same Covered Accident, We will pay no more than 2 times the benefit amount for the joint involved with the highest benefit amount.

For partial Dislocation, We will pay 25% of the benefit shown in the Schedule of Benefits for a closed reduction.

We will pay this benefit only for the first Dislocation of a joint per Covered Person per Covered Accident; subsequent Dislocations of the same joint will not be covered for the same Covered

B442.0050

**All Options**

**Diagnostic Exam (Major)** We pay the amount shown in the Schedule of Benefits if a Covered Person receives one of the following imaging studies due to a Covered Accident: Computerized Tomography (CT scan), computerized axial tomography (CAT), magnetic resonance imaging (MRI or electroencephalography (EEG). The imaging study must be prescribed by a Doctor and performed in a Doctor's office or Hospital within 90 days of the Covered Accident, on an Inpatient or outpatient basis. This benefit is payable once per Covered Person per Covered Accident.

B442.0051

**All Options**

**Doctor Follow-Up Visit** We pay the amount shown in the Schedule of Benefits if a Covered Person requires additional follow up treatments (not including Outpatient Therapies) after initial Emergency Room treatment or Initial Doctor's Office/Urgent Care Facility Treatment. This benefit is payable to a Covered Person for up to 6 treatments per Covered Accident. The follow-up treatment must be provided by a Doctor in a Doctor's office or in a Hospital on an outpatient basis. Treatment must begin within 60 days from initial treatment from a Covered Accident and be completed within 365 days.

B442.0052

**All Options**

**Emergency Dental Work** We pay the amount shown in the Schedule of Benefits if a Covered Person suffers a broken tooth as the result of a Covered Accident, and it is repaired by a Dentist using a dental crown and/or dental extraction. The dental services must begin within 60 days of the Covered Accident. One dental crown and one dental extraction is payable once per Covered Person per Covered Accident.

B442.0054

**All Options**

**Emergency Room Treatment** We pay the amount shown in the Schedule of Benefits if a Covered Person is examined or treated by a Doctor in a Hospital Emergency Room for the initial treatment of Injuries sustained in a Covered Accident within 72 hours after the Covered Accident. This benefit is payable once per Covered Person per Covered Accident. We will not pay the Emergency Room Treatment benefit and the Initial Doctor's Office/Urgent Care Facility benefit for the same Covered Accident.

B442.0055

**All Options**

**Epidural Anesthesia Pain Management** We pay the amount shown in the Schedule of Benefits if a Covered Person is prescribed and receives an epidural administered for pain management as a result of a Covered Accident. The epidural must be administered in a Hospital or Doctor's office and is payable twice per Covered Person per Covered Accident. This benefit is not payable for an epidural administered during a surgical procedure.

B442.0056

**All Options**

**Eye Injury** We pay the amount shown in the Schedule of Benefits if a Covered Person suffers an Eye Injury as the result of a Covered Accident. The Eye Injury must require surgery or the removal of a foreign object by a Doctor within 90 days of a Covered Accident. This benefit is payable once per Covered Person per Covered Accident.

B442.0057

**All Options**

**Family Care** We pay the amount shown in the Schedule of Benefits if a Covered Person is confined in a Hospital, ICU or Alternate Care or Rehabilitative Facility as the result of a Covered Accident and the Covered Person has a child or children attending a Child Care Center. The benefit is payable for each child attending a Child Care Center while the Covered Person is confined. The child attending the Child Care Center does not need to be insured under this Certificate for Accident coverage, but must meet the eligibility requirements found in the Dependent Eligibility section. This benefit is payable for up to 30 days within 365 days of the Covered Accident. This benefit is payable once per Covered Person per Covered Accident.

B442.0058



## All Options

**Fracture (Bone)** We pay the amount shown in the Schedule of Benefits if a Covered Person suffers a Fracture as a result of a Covered Accident and it is diagnosed within 90 days of the Covered Accident. The Fracture must require open (surgical) or closed (non-surgical) reduction by a Doctor. This benefit is payable for up to 2 Fracture(s) per Covered Person per Covered Accident. If there are more than 2 Fractures, We will pay the highest two benefit amounts per Covered Accident. We pay 25% of the amount shown in the Schedule of Benefits for the closed reduction of a bone with a chip Fracture that was a result of a Covered Accident.

B442.0059

## All Options

**Gunshot Wound** We pay the amount shown in the Schedule of Benefits if a Covered Person suffers a Gunshot Wound in a Covered Accident in which the Covered Person did not intentionally shoot himself/herself and which does not cause the Covered Person to die. It must be caused by a shot from a conventional firearm.

A "conventional firearm" is a weapon which fires a shot (bullet) by gun powder or compressed gas. The Gunshot Wound must require treatment by a Doctor, including overnight care in a Hospital, within 24 hours after the Covered Accident. If the Covered Person is shot more than once in a 24 hour period, We will pay benefits only for the first wound. We do not pay a benefit under this provision for wounds caused by a shot from spring-loaded (BB) guns, compressed air pellet guns, paint ball guns or catapult type (cross-bow, dart, etc.) guns.

If, within 90 days, the Covered Person loses a finger/toe, a hand/foot or the sight of an eye or eyes or dies as the result of the same Gunshot Wound, We will pay only one benefit. We will pay the largest applicable benefit. If We paid a benefit for a Gunshot Wound and then receive a claim for Accidental Death or Dismemberment benefit, We will subtract what We paid for the Gunshot Wound from the Accidental Death or Dismemberment benefit amount due.

B442.0060

**All Options**

**Hospital Admission** We pay the amount shown in the Schedule of Benefits if a Covered Person is admitted to a Hospital within 180 days of a Covered Accident. This benefit is payable once per Covered Person per Covered Accident. If the Covered Person is admitted to a Hospital or a Hospital Intensive Care Unit for the same Covered Accident within 30 days of an Admission for which a benefit was payable, We will treat this later Admission as a continuation of the previous Admission and no additional benefit will be paid. If more than 30 days have passed between the periods of Hospital or Hospital Intensive Care Unit Admission, We will treat this later Admission as a new and separate Hospital or Hospital Intensive Care Unit Admission. This benefit is not payable for Emergency Room treatment, Outpatient Treatment, or a Hospital stay less than 20 hours in an observation unit, or when a charge for room and board is not made. We will not pay the Hospital Admission and Hospital Intensive Care Unit Admission benefits for the same Covered Accident. We will pay the higher of the Hospital Admission or the Hospital Intensive Care Unit Admission benefit if both occur on the same day for the same Covered Accident.

B442.0061

**All Options**

**Hospital Confinement** We pay the amount shown in the Schedule of Benefits if a Covered Person is confined to a bed in a Hospital as an Inpatient within 180 days of a Covered Accident. This benefit is payable up to 365 days per Covered Person per Covered Accident. This benefit is not payable for a Hospital stay less than 20 hours. We do not pay the Hospital Confinement or Hospital Intensive Care Unit Confinement benefit on the same day as the Hospital Admission or Hospital Intensive Care Unit Admission. We will pay the higher of the Hospital Confinement or Intensive Care Unit Confinement benefit if both occur on the same day.

B442.0062

**All Options**

**Hospital Intensive  
Care Unit Admission**

We pay the amount shown in the Schedule of Benefits if a Covered Person is admitted directly to a Hospital Intensive Care Unit within 30 days of a Covered Accident. This benefit is payable once per Covered Person per Covered Accident. If the Covered Person is admitted to a Hospital or a Hospital Intensive Care Unit for the same Covered Accident within 30 days of an Admission for which a benefit was payable, We will treat this later Admission as a continuation of the previous Admission and no additional benefit will be paid. If more than 30 days have passed between the periods of Hospital or Hospital Intensive Care Unit Admission, We will treat this later Admission as a new and separate Hospital or Hospital Intensive Care Unit Admission. This benefit is not payable for Emergency Room treatment, Outpatient Treatment, or a Hospital stay less than 20 hours in an observation unit, or when a charge for room and board is not made. We will not pay the Hospital Admission and Hospital Intensive Care Unit Admission benefits for the same Covered Accident. We will pay the higher of the Hospital Admission or the Hospital Intensive Care Unit Admission benefit if both occur on the same day for the same Covered Accident.

B442.0063

**All Options**

**Hospital Intensive  
Care Unit  
Confinement**

We pay the amount shown in the Schedule of Benefits if a Covered Person is confined to a Hospital Intensive Care Unit within 30 days of a Covered Accident. This benefit is payable up to 15 days per Covered Person per Covered Accident. This benefit is not payable for a Hospital Intensive Care Unit stay less than 20 hours. We do not pay the Hospital Confinement or Hospital Intensive Care Unit Confinement benefit on the same day as the Hospital Admission or Hospital Intensive Care Unit Admission.

We will pay the higher of the Hospital Confinement or Intensive Care Unit Confinement benefit if both occur on the same day.

B442.0064

**All Options**

**Initial Doctor's  
Office/Urgent Care  
Facility Treatment**

We pay the amount shown in the Schedule of Benefits if a Covered Person is examined or treated by a Doctor in a Doctor's office or Urgent Care Facility for the initial treatment from a Covered Accident. The initial treatment must begin within 30 days after the Covered Accident. This benefit is payable once per Covered Person per Covered Accident. We will not pay the Emergency Room Treatment benefit and the Initial Doctor's Office/Urgent Care Facility benefit for the same Covered Accident.

B442.0065

**All Options**

**Joint Replacement** We pay the amount shown in the Schedule of Benefits if a Covered Person requires a hip, knee, or shoulder Joint Replacement as a direct result of a Covered Accident. The Joint Replacement must be scheduled by a Doctor within 90 days of a Covered Accident and is payable once per Covered Person per Covered Accident.

B442.0066

**All Options**

**Knee Cartilage** We pay the amount shown in the Schedule of Benefits if a Covered Person tears, ruptures or severs knee cartilage (meniscus) as the direct result of a Covered Accident and requires surgical repair. Treatment by a Doctor must begin within 60 days after the Covered Accident and be repaired through surgery within 365 days. This benefit is payable only once per Covered Person per Covered Accident.

B442.0067

**All Options**

**Laceration** We pay the amount shown in the Schedule of Benefits if a Covered Person sustains a Laceration as a result of a Covered Accident, and it is repaired by a Doctor within 72 hours of the Covered Accident. The amount We pay will be based on the total length of all Lacerations received in any one Covered Accident which require repair. This benefit is payable once per Covered Person per Covered Accident for a Laceration:

- With no sutures; and
- Which requires sutures.

B442.0068

**All Options**

**Lodging** We pay the amount shown in the Schedule of Benefits for a Companion's hotel/motel stay during the period of time a Covered Person is confined to the Hospital as the direct result of a Covered Accident. This benefit is payable up to 30 days per Covered Person per Covered Accident and is only payable while the Covered Person is confined to the Hospital. The Hospital must be more than 50 miles from the residence of the Covered Person.

B442.0069

**All Options**

**Medical Appliance** We pay the amount shown in the Schedule of Benefits if a Doctor requires and prescribes an appliance for a Covered Person as a direct result of a Covered Accident.

An appliance includes wheelchairs; a brace for back, leg or neck; cane, crutches, walkers, and walking boots that extend above the ankle. We will not pay for casts, splints, slings or an arm/hand/wrist brace. The medical prescription for the appliance must begin within 90 days of a Covered Accident.

We limit what We pay for all Medical Appliances combined, per Covered Person per Covered Accident, to the amount shown in the Schedule of Benefits.

B442.0070

**All Options**

**Outpatient Therapy** We pay the amount shown in the Schedule of Benefits if a Covered Person requires Cognitive Behavioral, Occupational, Physical, Respiratory, Speech or Vocational therapy due to a Covered Accident. Therapy must begin within the later of: (a) 60 days from the Covered Accident; or (b) 60 days from any required surgery. Therapy must be completed within 6 month(s), and be performed by a licensed Cognitive Behavioral, Occupational, Physical, Respiratory, Speech or Vocational Therapist. This benefit is payable up to 10 treatment(s) per Covered Person per Covered Accident.

B442.0071

**All Options**

**Post-Traumatic Stress Disorder** We pay the amount shown in the Schedule of Benefits if a Covered Person is diagnosed with Post-Traumatic Stress Disorder (PTSD) that is triggered by a Covered Accident for which We paid a benefit. PTSD is a mental health condition, and for this benefit to be payable, it must meet the diagnostic criteria for PTSD, stipulated in the Diagnostic and Statistical Manual of Mental disorders IV (DSM IV-TR), or the most current version, and a Covered Person must be under the active care of either a psychiatrist or Ph.D.-level psychologist.

This benefit is payable only once per Covered Person per Covered Accident.

B442.0072

**All Options**

**Prosthetic Device/Artificial Limb** We pay the amount shown in the Schedule of Benefits if a Covered Person receives one or more Prosthetic Devices/Artificial Limbs as prescribed by a Doctor for functional use due to the loss of a limb, hand, or foot as a direct result of a Covered Accident. The device or limb must be prescribed within 365 days of the Covered Accident and is payable once per Covered Person per Covered Accident. This benefit is not payable for hearing aids, dental aids (including false teeth), eyeglasses, or cosmetic prostheses such as hair wigs.

B442.0073

**All Options**

**Reasonable  
Accommodation to  
Home or Vehicle**

We pay the amount shown in the Schedule of Benefits if a Covered Person requires modification to his or her place of residence or vehicle if he or she suffers an Accidental Dismemberment or Catastrophic Loss due to a Covered Accident. The modification must be made within 2 year(s) of the Covered Accident and is payable once per Covered Person per Covered Accident.

B442.0074

**All Options**

**Rehabilitation  
Facility  
Confinement**

We pay the amount shown in the Schedule of Benefits if a Covered Person is confined to a Rehabilitation Facility due to a Covered Accident. This benefit is payable up to 15 days per Covered Person per Covered Accident but cannot exceed 30 days per calendar year. We will not pay the Rehabilitation Facility Confinement and the Hospital Confinement benefits for the same day.

B442.0075

**All Options**

**Ruptured Disc with  
Surgical Repair**

We pay the amount shown in the Schedule of Benefits if a Covered Person suffers a ruptured disc in his or her spine as a direct result of a Covered Accident. The ruptured disc must be treated by a Doctor within 60 days of the Covered Accident and be surgically repaired within 365 days of the Covered Accident. This benefit is payable once per Covered Person per Covered Accident.

B442.0076

**All Options**

**Surgery (cranial,  
open-abdominal,  
thoracic, hernia)**

We pay the amount shown in the Schedule of Benefits if a Covered Person undergoes cranial, open-abdominal, thoracic, or hernia surgery as a direct result of a Covered Accident. Cranial, open-abdominal, and thoracic surgery must be performed within 72 hours from the initial treatment from the Covered Accident. Hernia surgery must be diagnosed within 30 days of Covered Accident and surgery must be performed within 60 days from the initial treatment from the Covered Accident. If more than one surgery is performed, We pay the benefit with the highest dollar amount. Surgeries can be performed in a Hospital, Emergency Room, Doctor's Office or an appropriate outpatient facility. This benefit is payable once per Covered Person per Covered Accident.

B442.0077

**All Options**

**Surgery (Exploratory and Arthroscopic)** We pay the amount shown in the Schedule of Benefits if a Covered Person undergoes exploratory or arthroscopic surgery as a direct result of a Covered Accident. The surgery must take place within 60 days from the initial treatment from the Covered Accident. Surgeries can be performed in a Hospital, Emergency Room, Doctor's Office or an appropriately licensed outpatient facility. Hernia repair is not covered under this benefit. This benefit is not payable if the Surgery or Tendon/Ligament/Rotator Cuff benefits are payable for the same surgery. This benefit is payable once per Covered Person per Covered Accident.

B442.0078

**All Options**

**Tendon / Ligament / Rotator Cuff** We pay the amount shown in the Schedule of Benefits if a Covered Person sustains a torn, ruptured or severed tendon, ligament, or rotator cuff as the direct result of a Covered Accident. Treatment must be initiated within 60 days of the Covered Accident and the condition must be repaired through surgery within 365 days of the Covered Accident. Surgery can be performed in a Hospital, Emergency Room, Doctor's Office or an appropriate outpatient facility. This benefit is payable once per Covered Person per Covered Accident.

B442.0079

**All Options**

**Transportation** We pay the amount shown in the Schedule of Benefits if a Covered Person must travel more than 50 miles one way to receive special treatment at a Hospital or free standing treatment facility as a direct result of a Covered Accident. The treatment must be prescribed by a Doctor and not available locally. This benefit is payable 3 times per Covered Person per Covered Accident and is not payable if Transportation is provided by Ambulance or Air Ambulance.

B442.0080

**All Options**

**Traumatic Brain Injury** We pay the amount shown in the Schedule of Benefit if a Covered Person is diagnosed with a Traumatic Brain Injury which is a direct result of a Covered Accident.

A Traumatic Brain Injury is a nondegenerative, non-congenital injury to the brain from an external non-biological force, requiring Hospital Confinement for 48 hours or more, and resulting in a permanent neurological deficit with significant loss of muscle function and persistent clinical symptoms. Traumatic Brain Injury must be positively diagnosed by a Doctor based upon documented neurological deficits and confirmatory neuroimaging studies.

A Concussion is not a Traumatic Brain Injury.

If a Coma and Traumatic Brain Injury result from the same Covered Accident, We will pay the higher amount.

This benefit is payable once per Covered Person per Covered Accident.

B442.0081

### **All Options**

**X-Ray** We pay the amount shown in the Schedule of Benefits if a Covered Person receives a series of X-Rays as the direct result of a Covered Accident. The X-rays must be prescribed by a Doctor and performed in a Doctor's office or a Hospital or an Urgent Care Facility on an Inpatient or outpatient basis and performed within 90 days of the Covered Accident. This benefit is payable once per Covered Person per Covered Accident. By "series", we mean one or more X-rays performed within a 24-hour period.

B442.0082



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## ACCIDENT CLAIM PROVISIONS

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The Covered Person's right to make a claim for Group Accident Insurance Benefits provided by this Certificate is governed as follows:

**Administration:** We have the responsibility to fairly, thoroughly, objectively and timely investigate, evaluate and determine a Covered Person's eligibility for benefits under this Certificate.

We will:

- Obtain only such information that is necessary to evaluate a claim for benefits. This information will be obtained as set forth herein with respect to Notice and Proof of Loss.
- Consider and interpret the terms of this Certificate and all information obtained by Us and submitted that relates to a claim for benefits and make a determination based on that information and in accordance with the terms of this Certificate and applicable state law.
- If a claim is approved, review the determination as often as is reasonably necessary to determine continued eligibility for benefits.
- If a claim is denied, provide the claimant, within a reasonable period of time, a written notification of an adverse determination. Such notification will include the specific reason(s) for the adverse determination.

**Notice:** Written Notice of intent to file a claim under this Certificate must be sent to Us within 30 days of the date of the loss. This Notice should include the name of the Covered Person and the Policy number. For details, the Covered Person can call Us at 1-800-268-2525. We will not void or reduce a claim if We do not receive Notice within the required time. Notice must be sent as soon as reasonably possible.

**Proof of Loss:** The Covered Person must send written Proof of Loss to Our designated office within 90 days of the loss. We will not void or reduce a claim if We do not receive Proof of Loss within the required time. Proof of Loss must be sent as soon as reasonably possible and in no event, except in the absence of legal capacity, later than one year from the time proof is otherwise required.

**Claim Forms:** Upon request, We will furnish forms for filing Proof of Loss or Proof of death. If We do not furnish the forms, We will accept a written Notice and adequate Proof of Loss or Proof of death that is the basis of the claim.

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

**The Guardian Life Insurance Company of America**  
Group Accident Claims Department  
P.O. Box 14315  
Lexington, KY 40512

**Payment Of Benefits:** We will pay Accident benefits as soon as We receive written Proof of Loss. Unless otherwise required by law or regulation, We pay all Accident benefits to the Covered Person if living.

If the Covered Person is not living, We have the right to pay all Accident benefits to one of the following: estate; Spouse; parent; child; or brother or sister of the Covered Person.

**Change of Beneficiary:** If the Covered Person has named a beneficiary, the beneficiary designation should be maintained by Your Employer. The Covered Person has the right to change the beneficiary.

**Legal Actions:** No legal action against Guardian related to this Certificate may be brought until 60 days from the date Proof of Loss has been given as shown above. No legal action may be brought against Guardian related to claims for benefits under this Certificate after 3 years from the date of the final benefit determination.

**Workers' Compensation:** The Accident benefits provided by this Certificate are not in place of and do not affect requirements for coverage by Workers' Compensation.

B442.0083

## All Options

### Grievance Procedures - External Review

If You or Your representative do not agree with the handling of a claim or has any other grievance, You may file a request for an external review. Requests should be sent to the Commissioner. This must be done within 30 business days after the date of receipt of a grievance decision rendered in a formal review. If the request is accepted by the Commissioner, an external review will be conducted by an Independent Review Organization (IRO). Within 5 business days of Our receipt of the IRO's recommendation, a written report will be submitted to You or Your representative and the Commissioner indicating Our decision with respect to the IRO's recommendation.

The Commissioner may refer matters not within his or her jurisdiction to any other appropriate federal or District government agency for disposition or resolution.

For non-medical necessity cases, You may contact the Commissioner of the District of Columbia Department of Insurance, Securities and Banking at:

Commissioner, Department of Insurance, Securities and Banking  
1050 First Street, NE, Suite 801  
Washington, DC 20002  
Phone: 1-202-727-8000  
Fax: 1-202-354-1085

For medical necessity cases, You may contact the District of Columbia Department of Health Care Finance at:

Office of the Health Care Ombudsman and Bill of Rights  
One Judiciary Square  
441 4th St. NW, 900 South  
Washington, DC. 20001  
1-877-685-6391, 1-202-724-7491  
Fax: 1-202-442-6724

**Definitions**

"Commissioner" means the Commissioner of Insurance.

"Grievance" means a written request by You or a person on Your behalf for review of Guardian's decision to deny, reduce, limit, terminate or delay Your covered health care services.

"Grievance Decision" means a determination accepting or denying the basis or requested remedy of the grievance.

"Independent Review Organization (IRO)" means an impartial, certified health entity engaged by the Commissioner or the Director to review any adverse grievance decision made by Guardian.

B442.1479

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## EXCLUSIONS

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This Certificate will not pay benefits for any Injury or Accident caused by, or related directly or indirectly to:

- Sickness, disease, mental infirmity or medical or surgical treatment.
- Voluntary use of any poison, chemical, prescription or non-prescription drug or controlled substance unless:
  - (1) it was prescribed for a Covered Person by a Doctor, and
  - (2) it was used as prescribed. In the case of a non-prescription drug, this Certificate does not pay for any Accident resulting from or contributed to or by use in a manner inconsistent with package instructions. "Controlled substance" means anything called a controlled substance in Title II of the Comprehensive Drug Abuse Prevention and Control Act of 1970, as amended from time to time.
- The Covered Person being legally intoxicated.
- Declared or undeclared war, act of war, or armed aggression.
- Service in the armed forces, National Guard, or military reserves of any state or country.
- Taking part in a riot or insurrection.
- Participation in the commission of a felony.
- Treatment rendered, or hospital confinement, outside the United States, or its possessions or Canada.
- Intentional self-inflicted Injury.
- Suicide or attempted suicide.
- Travel or flight in any kind of aircraft, including any aircraft owned by, or for the, Covered Person, except as a fare-paying passenger on a Common Carrier.
- Participation in any kind of sporting activity for compensation or profit, including coaching or officiating.
- Riding in, or driving any motor-driven vehicle in a race, stunt show or speed test.
- Participation in hang gliding, bungee jumping, sail gliding, parasailing, parakiting, ballooning, parachuting, zorbing or skydiving.
- An Accident that occurs before the Covered Person is covered by this Certificate.
- Injuries to a dependent child received during birth.

B442.0085

All Options

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**DEFINITIONS**

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This section defines certain terms appearing in Your Certificate.

B442.0088

All Options

**Accident:** This term means an event or occurrence that was not reasonably foreseeable, or that could not have been reasonably expected or anticipated. The term Accident does not include a Sickness.

B442.0089

All Options

**Accidental Death:** This term means death caused by an Accident independent of Sickness, bodily infirmity, or any other cause and which is not excluded under the Exclusions section.

B442.0090

All Options

**Active Work or Actively at Work:** These terms mean Your performance of all the duties that pertain to Your work at the place: (1) where it is normally done; or (2) where it is required to be done by Your Employer.

B442.0091

All Options

**Alternate Care Facility:** This term means a facility that is licensed according to state and/or local laws to provide skilled care, intermediate care, intermingled care, custodial care, or rehabilitative care as an alternative to care at a Hospital.

B442.0092

All Options

**Catastrophic Loss:** This term means the aggregate impact of loss or loss from, but not limited to, the following: a loss of cognitive function, loss of speech and hearing (both ears), a quadriplegia, hemiplegia or paraplegia.

B442.0093

All Options

**Certificate:** This term means the Guardian group Accident insurance plan that covers You and Your dependents, if insured.

B442.0094

**All Options**

**Child Care Center:** This term means a program of child care which: (1) is provided in a facility that is licensed as a day care center or is operated by a licensed day care provider; and (2) charges a fee for the care of children. The term does not include child care provided by a: (a) parent; (b) stepparent; (c) grandparent; (d) sibling; (e) aunt; or (f) uncle.

B442.0095

**All Options**

**Chiropractic Care Services:** This term means spinal manipulation by a licensed chiropractor to correct a structural imbalance caused by a Covered Accident. This does not include services for massage therapy or treatment of chronic conditions or other injuries not related to structural imbalance.

B442.0096

**All Options**

**Cognitive Behavioral Therapist:** This term means a person, other than Covered Person or a family member, who: 1) has a Masters or Doctoral degree in psychology, counseling, social work, psychiatry, or related field; 2) is certified by The National Association of Cognitive-Behavioral Therapists; 3) performs services which are allowed by his or her certificate; and 4) performs services for which benefits are provided by this Certificate.

B442.0097

**All Options**

**Cognitive Behavioral Therapy (CBT):** This term means a type of psychotherapy. CBT helps one become aware of inaccurate or negative thinking in order to view challenging situations, such as recovering from an Accident, more clearly and respond to them in a more effective way.

B442.0098

**All Options**

**Coma:** This term means a state of complete mental unresponsiveness, due to Injury, with no evidence of appropriate responses to stimulation, as diagnosed by a Doctor.

B442.0099

**All Options**

**Common Carrier:** This term means any land, air or water conveyance operated under a license to transport passengers for hire.

B442.0100

## All Options

**Companion:** This term means a Spouse, domestic partner, civil union partner, sibling, child, parent, grandparent, or any primary caregiver.

B442.0101

## All Options

**Covered Accident:** This term means an Accident that:

- Occurs while a Covered Person's coverage under this Certificate is in effect;
- Results in a bodily Injury; and
- Is not otherwise excluded under the terms of this Certificate.

B442.0102

## All Options

**Covered Person:** This term means the Employee or dependent insured by this Certificate.

B442.0134

## All Options

**Dentist:** This term means a licensed Dentist, operating within the scope of his or her license, in the state in which he or she is licensed.

B442.0104

## All Options

**Dislocation:** This term means a completely separated joint due to an Injury. A partial Dislocation means the joint is misaligned but not completely dislocated, as diagnosed by a Doctor.

B442.0105

## All Options

**Doctor:** This term means any medical practitioner We are required by law to recognize as a physician. He or she must: (1) be properly licensed or certified by the laws of the state where he or she practices; and (2) provide services that are within the lawful scope of his or her practice.

B442.0106

**All Options**

**Domestic Partner:** This term means an opposite or same sex partner who has met all of the following requirements for at least 12 months: (1) resides with the Covered Person; (2) shares financial assets and obligations with the Covered Person; (3) is not related by blood to the Covered Person to a degree of closeness that would prohibit a legal marriage; (4) is at least the age of consent in the state in which they reside; and (5) neither the Covered Person or Domestic Partner is married to anyone else, nor has any other Domestic Partner. We require proof of the Domestic Partner relationship in the form of a signed and completed Affidavit of Domestic Partnership.

B442.0107

**All Options**

**Eligibility Date:** For Employee coverage, this term means the earliest date You are eligible for coverage under this Certificate. For dependent coverage, this term means the earliest date on which: (1) You have dependents; and (2) are eligible for dependent coverage.

B442.0135

**All Options**

**Emergency Room:** This term means a department of the Hospital that is designated for emergency care. This area must be staffed and equipped to handle trauma, be supervised and provide treatment by Doctors, and provide care seven days per week, 24 hours per day.

B442.0109

**All Options**

**Employee:** This term means a person who works for the Employer and whose income is reported to the United States Internal Revenue Service, and/or a state, for tax purposes.

B442.0110

**All Options**

**Employer:** This term means the entity that purchased the Policy.

B442.0111

**All Options**

**Epidural Anesthesia:** This term means a form of regional anesthesia involving injection of drugs through a catheter placed into the epidural space. The epidural must be administered due to a Covered Accident and does not include treatment for childbirth or diseases.

B442.0112



## All Options

**Fracture:** This term means a partial or complete break of a bone that can be determined by a diagnostic exam. A chip Fracture is a Fracture in which a piece of the bone is broken off near a joint at a place where a ligament is usually attached.

B442.0113

## All Options

**Full-Time:** This term means You regularly work at least the number of hours in the normal work week set by the Employer for Full-Time work at: (1) Your Employer's place of business; (2) some place where the Employer's business requires You to travel; or (3) any other place You and Your Employer have agreed upon for the performance of occupational duties.

B442.0114

## All Options

**Hospital:** This term means a short-term, acute care general facility, which:

- Is primarily engaged in providing, by or under the continuous supervision of Doctors, to Inpatients diagnostic services and therapeutic services for diagnosis, treatment and care of sick or injured persons;
- Has organized departments of medicine and major surgery;
- Has a requirement that every patient must be under the care of a Doctor or Dentist;
- Provides 24 hour nursing service by or under the supervision of a registered professional nurse (R.N.);
- Is duly licensed by the agency responsible for licensing such Hospitals; and
- Is not, other than incidentally: (a) a place of rest; (b) a place primarily for the treatment of tuberculosis; (c) a place for the aged; (d) a place for drug addicts or alcoholics; or (e) a place for convalescent, custodial, educational or rehabilitative care.

B442.0115

**All Options**

**Hospital Intensive Care Unit:** This term means a designated area of a Hospital that:

- Provides the highest quality of medical care and is restricted to patients who are critically ill or injured and who require intensive comprehensive observation and care;
- Is separate and apart from the surgical recovery room and from rooms, beds, wards, and units customarily used for patient confinement;
- Is permanently equipped with special lifesaving equipment for the care of the critically ill or injured;

Is under continuous observation by a specially trained nursing staff assigned exclusively to the intensive care unit on a 24 hour basis and is assigned a Doctor on a full-time basis.

B442.0116

**All Options**

**Injury:** This term means unintentional physical damage or harm caused directly by an Accident and not due to Sickness, disease or any other causes. The Injury must occur while a Covered Person is insured under this Certificate.

B442.0117

**All Options**

**Inpatient:** This term means a patient who is admitted to a Hospital.

B442.0118

**All Options**

**Occupational Therapist:** This term means a person, other than the Covered Person or a family member, who: 1) possesses the designation "Occupational Therapist, Registered (OTR)"; 2) is licensed by the state to practice Occupational Therapy; 3) performs services which are allowed by his or her license; and 4) performs services for which benefits are provided by this Certificate.

B442.0119

**All Options**

**Occupational Therapy:** This term means the treatment of a person by means of constructive activities designed and adapted to promote the restoration of a Covered Person's ability to satisfactorily accomplish the ordinary tasks of daily living, and those tasks required by a Covered Person's particular occupational role. Occupational Therapy does not include diversional, recreational, vocational therapies (i.e. hobbies, arts and crafts).

B442.0120

**All Options**

**Organized Sport** This term means a sport activity that is governed by an organization and requires formal registration to participate. Proof of registration will be required at claim time.

B442.0121

**All Options**

**Outpatient Treatment:** This term means medical services that a Covered Person receives when not confined as an Inpatient in a Hospital.

B442.0122

**All Options**

**Physical Therapist:** This term means a person, other than a Covered Person or a family member, who: 1) is licensed by the state to practice Physical Therapy; 2) performs services which are allowed by his or her license; 3) performs services for which benefits are provided by this Certificate and 4) practices according to the code of ethics of the American Physical Therapy Association.

B442.0124

**All Options**

**Physical Therapy:** This term means treatment by physical means, hydrotherapy, heat, or similar modalities, physical agents, bio-mechanical and neuro-physiological principles and devices. Such therapy is given to relieve pain, restore function, and to prevent disability following Injury or loss of a body part.

B442.0125

**All Options**

**Policy:** This term means the Guardian Group Accident Insurance Policy purchased by the Policyholder.

B442.0126

**All Options**

**Rehabilitation Facility:** This term means an appropriately licensed facility or separate section of a Hospital that provides rehabilitation care services on an Inpatient basis and is designated, staffed and equipped to provide restorative services under the supervision of a trained and experienced rehabilitation Doctor. A Rehabilitation Unit is not: a nursing home; an extended care facility; a skilled nursing facility; a rest home or home for the aged; a hospice care facility; a place for alcoholics or drug addicts; or an assisted living facility.

B442.0127

**All Options**

**Respiratory Therapist:** This term means a person, other than a Covered Person or a family member, who: 1) is a specialized healthcare practitioner trained in pulmonary medicine in order to work therapeutically with people suffering from pulmonary disease; 2) has graduated from a technical college with a certification in Respiratory Therapy; 3) has passed a national board certifying examination and performs services which are allowed by his or her certification; and 4) performs services which are covered by this Certificate. The NBRC (National Board for Respiratory Care) is the not for profit organization responsible for credentialing the seven areas of Respiratory Therapy.

B442.0128

**All Options**

**Respiratory Therapy:** This term means exercises and treatments that help patients recover lung function, such as after surgery.

B442.0136

**All Options**

**Sickness:** This term means a disease, illness or other condition not related to Injury, including diseases or infections except when due to an accidental cut or wound.

B442.0129

**All Options**

**Spouse:** This term means the person to whom You are legally married, or Your Domestic Partner, civil union partner or equivalent as recognized and allowed by federal law, or state law in Your state of residence or the state in which the marriage was recorded.

B442.0130

**All Options**

**Urgent Care Facility:** This term means a health care facility that is organizationally separate from a Hospital and whose primary purpose is the offering and provision of immediate, short-term medical care, without appointment, for urgent care.

B442.0131

**All Options**

**We, Us, Our and Guardian:** These terms mean The Guardian Life Insurance Company of America.

B442.0132

**All Options**

**You or Your:** These terms mean the insured Employee.

B442.0133

**All Options**

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**SCHEDULE OF BENEFITS**

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**EMPLOYEE ACCIDENT COVERAGE**

**LIMITED BENEFIT, PLEASE READ CAREFULLY**

This Schedule of Benefits is attached to the Certificate and is effective the later of: 1) the Policy Effective Date or; 2) the Effective Date of any amendment. This Schedule of Benefits replaces any previously issued Schedule of Benefits.

For more details regarding limitations and the number of benefit payments per Covered Accident please refer to the ACCIDENT BENEFITS section of the Certificate.

**All Options**

**Accident Benefit**

**Benefit Levels**

**All Options**

Accidental Death

Yourself: \$25,000.00  
Your Spouse: \$12,500.00  
Your Children: \$5,000.00

**All Options**

Accidental Death Common  
Carrier

200% of the Accidental Death benefit amount

**All Options**

Accidental Death Common  
Disaster

200% of the Spouse Accidental Death benefit  
amount

**All Options**

Accidental Dismemberment

Loss of a hand, foot or sight: 50% of Accidental Death benefit.

**Multiple Losses of hand, foot or sight:**

For more than one covered loss due to the same Accident, We will pay 100% of the Accidental Death benefit.

Loss of thumb and index finger of same hand, or loss of four fingers of same hand: 25% of Accidental Death benefit.

Loss of all toes of same foot: 25% of Accidental Death benefit.

We will not pay more than \$25,000.00 for all losses due to the same Covered Accident.

**All Options**

Accidental Death Seatbelt and Airbag benefit

Seatbelt: \$10,000.00

Seatbelt and Airbag: \$15,000.00

**All Options**

Air Ambulance

\$1,000.00

**All Options**

Ambulance

\$200.00

**All Options**

Blood/Plasma/Platelets

\$300.00

**All Options**

Burn

**2nd Degree**

From 18 sq inches up to 34 sq inches: \$1,000.00  
35 sq inches and over: \$3,000.00

**3rd Degree**

From 9 sq inches to 17 sq inches: \$2,000.00  
From 18 sq inches to 34 sq inches: \$4,000.00  
35 sq inches and over: \$12,000.00

**All Options**

Burn-Skin Graft

50% of burn benefit

**All Options**

Catastrophic Loss

Quadriplegia: 100% of Accidental Death benefit

Loss of speech and hearing (both ears): 100% of Accidental Death benefit

Loss of cognitive function: 100% of Accidental Death benefit

Hemiplegia: 50% of Accidental Death benefit

Paraplegia: 50% of Accidental Death benefit

**All Options**

Child Organized Sport  
(applies only to covered dependent children age 18 or younger)

Additional 25% of payable benefits

**All Options**

Chiropractic Visits

\$50.00 per visit

**All Options**

Coma

\$10,000.00

**All Options**

Concussions

\$200.00

**All Options**

Concussion Baseline Study  
(applies only to covered dependent children age 18 or younger)

\$25.00

**All Options**

**Dislocations**

**Closed/Open**

**All Options**

● Hip

\$2,000.00/\$5,000.00

**All Options**

● Knee

\$1,625.00/\$3,250.00

**All Options**

● Shoulder

\$1,250.00/\$2,500.00

**All Options**

- Collar bone (sternoclavicular) \$500.00/\$1,000.00

**All Options**

- Collar bone (acromioclavicular and separation) \$100.00/\$200.00

**All Options**

- Ankle or Foot \$1,000.00/\$2000.00

**All Options**

- Lower jaw \$750.00/\$1,500.00

**All Options**

- Wrist or elbow \$625.00/\$1,250.00

**All Options**

- Toe or finger \$200.00/\$400.00

**All Options**

- Bones of the hand \$875.00/\$1,750.00

**All Options**

Diagnostic Exam (Major) \$200.00

**All Options**

Doctor Follow-Up Visit \$50.00

**All Options**

Emergency Dental Work  
Crown: \$300.00  
Extraction: \$75.00

**All Options**

Emergency Room Treatment \$200.00

**All Options**

Epidural Anesthesia Pain Management \$100.00

**All Options**

Eye Injury \$300.00

**All Options**

Family Care \$20.00 per day

GC-SCH-ACC-18-DC



**All Options**  
**Fractures**

**Closed/Open**

**All Options**

- Skull (depressed) \$2,250.00/\$4,500.00

**All Options**

- Skull (non-depressed) \$1,050.00/\$2,100.00

**All Options**

- Hip, Thigh (femur) \$3,000.00/\$6,000.00

**All Options**

- Vertebrae, body of (excluding vertebrae processes) \$2,700.00/\$5,400.00

**All Options**

- Pelvis \$2,400.00/\$4,800.00

**All Options**

- Leg \$1,800.00/\$3,600.00

**All Options**

- Bones of the face or nose \$900.00/\$1,800.00

**All Options**

- Upper jaw, maxilla \$1,050.00/\$2,100.00

**All Options**

- Upper arm (humerus) \$1,050.00/\$2,100.00

**All Options**

- Lower jaw, mandible \$1,200.00/\$2,400.00

**All Options**

- Shoulder blade \$1,200.00/\$2,400.00

**All Options**

- Vertebral process \$600.00/\$1,200.00

**All Options**

- Forearm \$1,500.00/\$3,000.00

**All Options**

- Kneecap \$1,200.00/\$2,400.00

**All Options**

● Foot (except toes) \$1,200.00/\$2,400.00

**All Options**

● Ankle \$1,200.00/\$2,400.00

**All Options**

● Rib \$240.00/\$480.00

**All Options**

● Coccyx \$240.00/\$480.00

**All Options**

● Finger, toe \$240.00/\$480.00

**All Options**

Gunshot Wound \$750.00

**All Options**

Hospital Admission \$1,000.00

**All Options**

Hospital Confinement \$250.00

**All Options**

Hospital ICU Admission \$2,000.00

**All Options**

Hospital ICU Confinement \$500.00

**All Options**

Initial Doctor's  
Office/Urgent Care  
Facility Treatment \$100.00

**All Options**

Joint Replacement Hip: \$2,500.00  
Knee: \$1,250.00  
Shoulder: \$1,250.00

**All Options**

Knee Cartilage \$500.00

**All Options**

Laceration  
No sutures required: \$40.00  
Lacerations 4cm or less: \$60.00  
Lacerations 5cm up to 14 cm: \$200.00  
Lacerations 15cm or more: \$400.00

**All Options**

Lodging \$125.00 per day

**All Options**

**Medical Appliance**

**Limit for all Medical Appliances combined,  
per Covered Person, per Covered Accident is  
\$500.00**

**All Options**

● Brace for back, leg or neck \$100.00

**All Options**

● Cane \$50.00

**All Options**

● Crutches \$50.00

**All Options**

● Walker \$200.00

**All Options**

● Walking Boot \$100.00

**All Options**

● Wheel Chair or Motorized Scooter \$250.00

**All Options**

● Other medical device used for mobility \$50.00

**All Options**

Outpatient Therapy \$35.00 per day

**All Options**

Post-Traumatic Stress Disorder \$400.00



## All Options

### Changes To Coverage

**Changes in Coverage Amounts** If You are not Actively At Work on a Full-Time basis, any change in Your amount of coverage or the amount of coverage on a covered dependent will not become effective prior to the date You return to Active Work on a Full-Time basis.

**Changes in Insurance Classification** If Your classification changes, coverage will not be changed to the new amount until the first day on which You are: (1) Actively At Work on a Full-Time basis; and (2) make a contribution, if required, for the new classification.

If a contribution is required for the new classification for which a larger amount of coverage is provided, You must make the required contribution for the new amount within 31 days of the change.

B442.0489

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**CERTIFICATE RIDER - Wellness Benefit**

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**LIMITED BENEFIT, PLEASE READ CAREFULLY**

This Rider is effective as of the effective date of the Employee's Certificate. If this Rider is added to an inforce Certificate, the Rider becomes effective on its issue date. This Rider amends the Certificate By the addition of the following:

This Rider will pay a benefit if a Covered Person has one of the following wellness tests or procedures performed while the Accident coverage is in force. This Rider pays this benefit regardless of the results of the test or procedure. Wellness tests or procedures are limited to:

- Abdominal aortic aneurysm ultrasonography
- Blood test for triglycerides
- Bone marrow testing
- Bone density screening
- Breast ultrasound
- CA 15-3(blood test for breast cancer)
- CA125(blood test for ovarian cancer)
- Cancer genetic mutation test
- Carotid ultrasound
- CEA (blood test for colon cancer)
- Chest x-ray
- Colonoscopy
- Completion of a smoking cessation program
- Completion of a weight reduction program
- Double contrast barium enema
- EKG
- Fasting blood glucose test
- Flexible sigmoidoscopy
- Hemoccult stool analysis
- Immunizations
- Lymphocyte Genome Sensitivity test (LGS)
- Mammography

- Pap smear
- PSA (blood test for prostate cancer)
- Registration of a covered dependent child age 18 or younger for an organized sport
- Routine/annual physical
- Serum cholesterol test to determine level of HDL and LDL
- Serum Protein Electrophoresis (blood test for myeloma)
- Skin cancer biopsy
- Stress test on a bicycle or treadmill
- Thermography
- ThinPrep pap test
- Virtual colonoscopy

The Wellness Benefit is \$50.00.

The Covered Person must submit proof of the test, procedure or registration.

We limit what We pay to 1 Wellness Benefit(s) per Covered Person per calendar year.

The calendar year limits above apply inclusively to any combination of Accident, Critical Illness or Hospital Indemnity Wellness/Health Screening benefit provided by Us for which each Covered Person is insured.

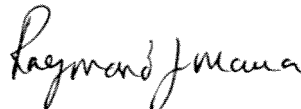
The Wellness Benefit does not qualify for additional limits or payments under this Certificate's Rainy Day Fund, if this Rider is also included with this Certificate.

A Covered Person is an Employee or any of his or her covered dependents.

If You port Your Accident coverage, and the Wellness Benefit was already paid in the same calendar year under this Rider, the Wellness Benefit will not be paid again in that calendar year under the ported certificate.

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

**The Guardian** Life Insurance Company of America



Raymond Marra, Senior Vice President, Group and Worksite Markets

B442.1486

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**CERTIFICATE RIDER - Rainy Day Fund**

---

**LIMITED BENEFIT, PLEASE READ CAREFULLY**

This Rider is effective as of the effective date of the Employee's Certificate. If this Rider is added to an inforce Certificate, the Rider becomes effective on its issue date. This Rider amends the Certificate by the addition of the following:

**Rainy Day Fund**

The "Rainy Day Fund" provides a Covered Person with additional benefits when he or she has exhausted a benefit frequency limitation, which applies to a particular benefit, as shown in the Certificate's Schedule of Benefits and/or the Accident Benefits section of the Certificate.

Each Benefit Year, the Rainy Day Fund is available to extend a benefit which the Covered Person has exhausted due to a frequency limitation in that Benefit Year.

We will pay from the Rainy Day Fund, the amounts shown in the Certificate's Schedule of Benefits, for each covered benefit or service. However, We limit what We pay to the amount remaining in the Covered Person's Rainy Day Fund.

**Benefit Amounts**

Initial Rainy Day Fund Amount: \$400.00

Rainy Day Rollover Maximum: \$200.00

Rainy Day Fund Maximum: \$800.00

Each Covered Person starts each Benefit Year with at least the Initial Rainy Day Fund Amount in their Rainy Day Fund. Each Benefit Year, we will use the fund to pay claims until it's exhausted.

If, at the end of a Benefit Year, all available funds are not used to pay claims, the remaining amount is rolled over to the next Benefit Year, subject to the Rainy Day Rollover Maximum. The amount rolled over is added to the next Benefit Year's Initial Rainy Day Fund Amount. However, we limit the amount in each Covered Person's Rainy Day Fund to the Rainy Day Fund Maximum.

By Covered Person, We mean You, as an Employee covered under this Rider or Your covered dependent Spouse or child.

Benefit Year means a 12 month calendar year.

The Rainy Day Fund does not apply to the following benefits, if these benefits are shown in this Certificate, including any Riders:

- Burn;




- Burn Skin Graft;
- Coma;
- Concussion;
- Concussion Baseline Study;
- Disability;
- Dislocations;
- Emergency Room Treatment;
- Hospital Admission/Hospital ICU Admission;
- Hospitalization for Sickness;
- Initial Doctor's Office/Urgent Care visit;
- Laceration;
- Medical Appliance;
- Post-Traumatic Stress Disorder;
- Prosthetic Device;
- Tendon/Ligament/Rotator Cuff;
- Traumatic Brain Injury;
- Wellness.

If a Covered Person ports Accident coverage, his or her Rainy Day Fund balance under this Rider is transferred to the ported certificate.

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

**The Guardian** Life Insurance Company of America



Raymond Marra, Senior Vice President, Group and Worksite Markets

B442.1496

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**CERTIFICATE RIDER - Portability Privilege**

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### **LIMITED BENEFIT, PLEASE READ CAREFULLY**

This Rider is effective as of the effective date of the Employee's Certificate. If this Rider is added to an inforce Certificate, the Rider becomes effective on its issue date. This Rider amends the Certificate by the addition of the following:

#### **Portability Privilege**

As used in this Rider, the terms "Port" and "to Port" mean to choose a Portable Certificate of Coverage which provides Group Accident coverage. Portability is subject to all the conditions described below.

- You may Port Your own coverage, and coverage for any of Your dependents, if coverage under this Policy and Certificate ends because You:
  - Have terminated employment;
  - Stop being a member of an eligible class of Employees; or
  - Have terminated or lost coverage under the Group Accident Policy and Certificate.
- You may not Port Your coverage, or coverage for any of Your dependents, if coverage under this Policy and Certificate ends due to failure to pay any required premium.

#### **Portability Options**

You may Port:

- Your coverage only;
- Your coverage and the coverage of your Spouse;
- Your coverage and the coverage of all of Your dependents;
- Your coverage and the coverage of all of Your dependent child(ren), if You are a single parent;

No other combinations will be allowed.

A dependent must be covered as of the date Your coverage under this Policy and Certificate ends in order to be eligible to Port.

If You die while covered for Group Accident coverage, Your Spouse may Port the dependent coverage on behalf of himself or herself, and the dependent child(ren). The Spouse and dependent child(ren) must be covered under this Policy and Certificate on the date of Your death. This option is not available if there is no surviving Spouse.

### **How to Port Coverage**

You or Your surviving Spouse or dependent child(ren) must:

- Apply to Us in writing; and
- Pay the required premium.

You or Your surviving Spouse or dependent child(ren) must do this within 31 days from the date Your coverage under this Policy and Certificate ends.

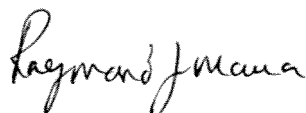
We will not ask for proof that You or Your surviving Spouse or dependent child(ren) are in good health.

### **The Portable Certificate of Coverage**

The Portable Certificate of Coverage provides Group Accident coverage. The premium for the Portable Certificate of Coverage will be based on Your rate class under this Policy and Certificate or Your surviving Spouse's rate shown in the Accident Portability Coverage Premium Notice.

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

**The Guardian** Life Insurance Company of America



Raymond Marra, Senior Vice President, Group and Worksite Markets

B442.1504

## STATEMENT OF ERISA RIGHTS

### The Guardian Life Insurance Company of America

10 Hudson Yards  
New York, New York 10001  
(212) 598-8000

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

ERISA provides that all plan participants shall be entitled to:

#### Receive Information about Your Plan and Benefits

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

#### Prudent Actions by Plan Fiduciaries

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

#### Enforcement of Your Rights

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

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report from the plan and do not receive them within 30 days, you may file suit in 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 state or federal court. If it should happen that plan fiduciaries misuse the plans 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.

B442.0581

### **Accident Insurance Claims Procedure**

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

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

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

### **Definitions**

"Adverse determination" means a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit, including any such denial, reduction, termination, or failure to provide or make payment that is based on a determination of a participants or beneficiary's eligibility to participate in a plan.

### **Timing for Initial Benefit Determination of Accident Insurance Claims**

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

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

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

### **Adverse Benefit Determination of Accident Insurance Claims**

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

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

B442.0582

### **Appeals of Adverse Determinations of Accident Insurance Claims**

If a claim is wholly or partially denied, you will have up to 60 days to make an appeal. Guardian will conduct a full and fair review of an appeal which includes providing to claimants the following:

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

In reviewing an appeal, Guardian will notify the claimant of its decision not later than 60 days after receipt of the request for review of the adverse determination. This period may be extended by an additional period of up to 60 days if Guardian determines that special circumstances require an extension of the time period for processing and so notifies the claimant before the end of the initial 60-day period.

A notification with respect to an extension will indicate the special circumstances requiring an extension of the time period for review, and the date by which the final determination will be made. In the event Guardian denies the appeal of an adverse benefit determination, it will:

- Provide the specific reason or reasons why the appeal was denied;
- Refer to the specific provisions in the Policy, Certificate, plan, or other documents on which the benefit determination is based;
- Provide a statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of all documents, records, and other information relevant to the claimants claim for benefits.

### **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.

B442.0583

All Options

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**CERTIFICATE AMENDMENT**

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

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**ADDITIONAL SERVICES**

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

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

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

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

- Financial Planning and Wellness Services.

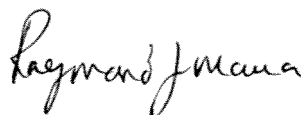
All Options

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

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

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

**The Guardian** Life Insurance Company of America



Raymond Marra, Senior Vice President, Group and Worksite Markets

B055.0288



**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".**



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**CERTIFICATE OF COVERAGE**

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**The Guardian**  
10 Hudson Yards  
New York, New York 10001

The group Hospital Indemnity coverage described in this Certificate is attached to the group Policy effective January 1, 2020. This Certificate replaces any Certificate previously issued under this Plan or under any other plan providing similar or identical benefits issued to the Policyholder by Guardian.

**LIMITED BENEFIT - PLEASE READ CAREFULLY**

Important Notice: This is a limited plan of Hospital Indemnity insurance. It is a supplement to health insurance. It is not a substitute for hospital or medical expense insurance, a health maintenance organization (HMO) contract, or major medical expense insurance. Please read this Plan carefully to fully understand what it covers, limits, and excludes. This Certificate does not meet the Federal requirement for health care coverage under the Affordable Care Act. You may be liable for a federal tax penalty if you do not purchase a health benefit plan that provides minimum essential coverage. This limited plan of Hospital Indemnity insurance cannot coordinate benefits with health benefit plans.

**GROUP HOSPITAL INDEMNITY COVERAGE**

Guardian certifies that the Employee to whom this Certificate is issued is entitled to the benefits described herein. However, the Employee must: (a) satisfy all of this Plan's eligibility and effective date requirements; (b) be listed in Our and/or the Policyholder's records as a validly covered Employee under this Plan; and (c) all required premium payments must have been made by or on behalf of the Employee.

The Employee and/or his or her Dependents are not covered by any part of this Plan for which he or she has waived coverage. Such a waiver of coverage is shown in Our and/or the Policyholder's records.

Policyholder: UNITY HEALTHCARE INC

Group Policy Number: 00505565

**The Guardian** Life Insurance Company of America



Raymond Marra, Senior Vice President, Group and Worksite Markets

B053.1660



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## All Options

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### DEFINITIONS

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The terms shown below have the meaning given in this section. Whenever used throughout this Certificate, they will be capitalized. Additional terms may be defined within the provision to which they apply.

B005.0526

## All Options

**Active Work** or **Actively At Work** or **Actively Working:** These terms mean Your performance of all the duties that pertain to Your work at the place: (1) where it is normally done; or (2) where it is required to be done by Your Employer.

B005.0527

## All Options

**Air Ambulance Transport:** This term means the use of a licensed professional air ambulance to transport a Covered Person to a Hospital.

**Ambulance Transport:** This term means the use of a licensed professional ambulance is used to transport a Covered Person to a Hospital.

B053.1665

## All Options

**Benefit Year:** This term means a 12 month period which starts on January 1st and ends on December 31st.

B005.0695

**All Options**

**Complications of Pregnancy:** This term means:

- (1) Conditions requiring Confinement to a Hospital or treatment in an Outpatient Surgery facility (when the pregnancy is not terminated) whose diagnoses are distinct from pregnancy, but are adversely affected by, or caused by, pregnancy, including but not limited to: non-scheduled cesarean section, acute nephritis, nephrosis, cardiac decompensation, hyperemesis gravidarum, pre-eclampsia, missed abortion, and similar medical and surgical conditions of comparable severity.
- (2) Termination of ectopic pregnancy and spontaneous termination of pregnancy occurring during a time that a viable birth is not possible.

Complications of Pregnancy does not mean: false labor, occasional spotting, Doctor-prescribed rest during the period of pregnancy, morning sickness, scheduled cesarean section, and similar conditions associated with the management of a difficult pregnancy.

B005.0529

**All Options**

**Confined/ Confinement:** This term means the admission to, and subsequent continued stay in, a Hospital as an overnight bed patient and a charge for room and board is made. **If** death occurs before a Covered Person completes one overnight stay, that person will be deemed to have been Confined for one day.

B005.0530

**All Options**

**Covered Dependent Child:** This term means Your eligible dependent child covered under this Plan.

B005.0531

**All Options**

**Covered Family:** This term means You, and all of Your covered dependents.

B005.0532

**All Options**

**Covered Person:** This term means You, if You are covered under this Plan and Your covered dependents.

B005.0535

**All Options**

**Covered Sickness:** This term means an illness or disease, including Complications of Pregnancy, which occurs on or after the Covered Person's effective date of this coverage and while this Plan is in force; and is not excluded by name or specific description in the Plan. All related conditions and recurring symptoms of Sickness to the same person will be considered one Sickness.

B005.0537

**All Options**

**Diagnosis/ Diagnose:** This term means the establishment of the presence or existence of a Covered Sickness or Injury by a Doctor through the use of clinical and/or lab findings, as described in the Covered Benefits section of this Plan.

B005.0539

**All Options**

**Doctor:** This term means any medical practitioner We are required by law to recognize. He or she must: (1) be properly licensed or certified by the laws of the state where he or she practices; and (2) provide services that are within the lawful scope of his or her practice.

B005.0540

**All Options**

**Domestic Partner:** This term means an opposite or same sex partner who has met either of the following requirements:

- Domestic partners that are registered with the District of Columbia must assert that they have completed the required Domestic Partnership Registration Form (DC Law 9-114) and have received a certificate of domestic partnership under the Health Care Benefits Expansion Act of 1992.
- For those domestic partners that have not registered with the District of Columbia, both You and Your domestic partner must meet all of the following conditions: (1) be at least 18 years of age; (2) be unmarried and constitute each other's sole domestic partner; (3) not have had another domestic partner in the last 12 months; (4) share the same permanent address for at least 12 months in a row and intend to do so indefinitely; (5) share joint financial responsibility for basic living expenses (which include food, shelter, and medical expenses); (6) not be related by blood to a degree that would prohibit marriage in Your state of residence; and (7) be financially interdependent.

B053.1678

**All Options**

**Elective Surgery:** This term means surgery that:

- (1) is not Medically Necessary;



- (2) does not promote the proper function of the Covered Person's body or prevent or treat Sickness; or
- (3) is directed at improving appearance; unless such surgery is needed to correct a deformity resulting from: (a) a congenital abnormality; or (b) a disfiguring Sickness, physical disease or Injury.

Laser correction or other surgery to correct vision or hearing will be deemed Elective Surgery when similar results could be provided by use of eyeglasses, contact lenses, hearing aid or other device. Medically Necessary surgery for glaucoma, cataracts or other Sickness or Injury is not considered Elective Surgery.

B005.0542

#### All Options

**Eligibility Date:** For Employee coverage, this term means the earliest date You are eligible for coverage under this Plan. For dependent coverage, this term means the earliest date on which You: (1) have Initial Dependents; and (2) are eligible for dependent coverage.

B005.0543

#### All Options

**Emergency Room:** This term means a department of the Hospital that is designated for emergency care. This area must be staffed and equipped to handle trauma, be supervised and provide treatment by Doctors, and provide care seven days per week, 24 hours per day.

B005.0545

#### All Options

**Employee:** This term means a person who works for the Employer and whose income is reported for tax purposes using a W-2 form.

**Employer:** This term means UNITY HEALTHCARE INC .

B005.0546

#### All Options

**Full-Time:** This term means You regularly work at least the number of hours in the normal work week set by the Employer (but not less than 30 hours per week), at: (1) Your Employer's place of business; (2) some place where the Employer's business requires You to travel; or (3) any other place You and Your Employer have agreed upon for the performance of occupational duties.

B005.0547

## All Options

**Hospital:** This term means a short-term, acute care general facility, which:

- (1) is primarily engaged in providing, by or under the continuous supervision of Doctors, to Inpatients, Diagnostic services and therapeutic services, for Diagnosis, treatment and care of sick or injured persons;
- (2) has organized departments of medicine and major surgery;
- (3) has a requirement that every patient must be under the care of a Doctor or dentist;
- (4) provides 24 hour Nursing service by or under the supervision of a registered professional Nurse (R.N.);
- (5) is duly licensed by the agency responsible for licensing such Hospitals; and
- (6) is not, other than incidentally: (a) a place of rest; (b) a place primarily for the treatment of tuberculosis; (c) a place for the aged; (d) a place for drug addicts or alcoholics; or (e) a place for convalescent, custodial, educational or rehabilitative care.

B005.0550

## All Options

**Hospital Intensive Care Unit:** This term means a designated area of a Hospital that:

- (1) provides the highest quality of medical care and is restricted to patients who are critically ill and who require intensive comprehensive observation and care;
- (2) is separate and apart from the surgical recovery room and from rooms, beds, wards, and units customarily used for patient Confinement;
- (3) is permanently equipped with special lifesaving equipment for the care of the critically ill;
- (4) is under continuous observation by a specially trained Nursing staff assigned exclusively to the Intensive Care Unit on a 24 hour basis and is assigned a Doctor on a full-time basis.

B005.0551

## All Options

**Initial Dependents:** This term means those eligible dependents You have at the time You first become eligible for Employee coverage. If at this time You do not have any eligible dependents, but You later acquire them, the first eligible dependents You acquire are Your Initial Dependents.

B005.0552

**All Options**

**Injury:** This term means unintentional physical damage or harm caused directly to the Covered Person's body; not due to Sickness or disease. The Injury must occur while You or Your covered dependents are insured under this Plan.

B005.0553

**All Options**

**Inpatient:** This term means a patient who is admitted to a Hospital, as an overnight bed patient with a charge for room and board for a Covered Sickness or Injury.

B005.0555

**All Options**

**Medically Necessary:** This term means health services, treatment and supplies that are all of the following:

- (1) medically appropriate;
- (2) needed to Diagnose or treat a Covered Sickness or Injury;
- (3) consistent in type, frequency, and length of treatment with scientifically based guidelines of national medical research or health care coverage organizations or government agencies;
- (4) needed for reasons other than comfort or convenience of the Covered Person or Doctor;
- (5) of proven medical value; and
- (6) done with the appropriate level of service or supply needed to provide safe and adequate care.

The fact that a Doctor may prescribe, authorize or direct a service does not of itself make it Medically Necessary or covered by the Group Plan.

B053.1695

**All Options**

**Newly Acquired Dependent:** This term means an eligible dependent You acquire after You already have coverage in force for Initial Dependents.

B005.0558

**All Options**

**Nurse:** This term means either a professional, licensed, graduate registered Nurse (R.N.) or a professional, licensed practical Nurse (L.P.N.).

B005.0559

## All Options

**Observation Unit:** This term means a specified area within a Hospital, apart from the Emergency Room, where a patient can be monitored following Outpatient Surgery or treatment in the Emergency Room by a Doctor, and that fully meets each of the following requirements:

- (1) It is under the direct supervision of a Doctor or registered Nurse.
- (2) It is staffed by Nurses assigned specifically to that unit.
- (3) It provides care seven days per week, 24 hours per day.

B005.0560

## All Options

**Outpatient Treatment:** This term means medical services that a Covered Person receives when not Confined as an Inpatient in a Hospital.

B005.0562

## All Options

**Plan:** This term means the group Hospital Indemnity coverage described in the policy and this Certificate.

B005.0564

## All Options

**Rehabilitation Unit Confinement:** This term means an appropriately licensed facility or separate section of a Hospital that provides rehabilitation care services on an Inpatient basis and is designated, staffed and equipped to provide restorative services under the supervision of a trained and experienced rehabilitation Doctor. A Rehabilitation Unit is not: a nursing home; an extended care facility; a skilled nursing facility; a rest home or home for the aged; a hospice care facility; a place for alcoholics or drug addicts; or an assisted living facility.

B005.0565

## All Options

**Spouse:** This term means Your lawful spouse, which shall include the marriage between opposite or same-sex partners legally performed in other jurisdictions. This term shall also include registered Domestic Partners.

B005.0566

## All Options

**Urgent Care Facility:** This term means a health care facility that is organizationally separate from a Hospital and whose primary purpose is the offering and provision of immediate, short term medical care, without appointment, for urgent care.

B005.0568

**All Options**

**We, Us, Our and Guardian:** These terms mean The Guardian Life Insurance Company of America.

**You or Your:** These terms mean the covered Employee.

B005.0570

All Options

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**GENERAL PROVISIONS**

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B005.0033

All Options

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**Applicable Benefits**

This Certificate may include multiple benefit options and types of benefits. In the event that the Certificate includes such multiple benefit options and types of benefits, each Covered Person will only be covered for those applicable benefits that (1) were previously selected in a manner and mode acceptable to Guardian such as an enrollment form and (2) for which applicable premium has been received by Guardian.

B005.0034

All Options

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**Limitation of Authority**

No person, except by a writing signed by the President, a Vice President or a Secretary of Guardian, has the authority to act for Us to: (1) determine whether any contract, Plan or certificate is to be issued; (2) waive or alter any provisions of any contract or plan, or any of Our requirements; (3) bind Us by any statement or promise relating to the contract issued or to be issued; or (4) accept any information or representation which is not in a signed application.

B005.0573

All Options

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**Incontestability**

The 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 Covered Person will be used to contest the validity of his or her insurance or to deny a claim for a loss incurred after such insurance has been in force for two years during his or her lifetime.

If the Plan replaces a plan Your Employer had with another insurer, We may rescind the Plan based on misrepresentations made by the Employer or an Employee in a signed application for up to two years from the effective date of the Plan.

In the event Your insurance is rescinded due to a fraudulent statement made in Your application We will refund premiums paid for the periods such insurance is void. The premium paid by You will be sent to Your last known address on file with Your Employer or Us.

B005.0574

## All Options

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### Examination and Autopsy

We have the right to have a Doctor of Our choice examine the person for whom a claim is being made under the Plan. We also have the right to have an autopsy performed in the case of death where allowed by law. We will pay for all such examinations and autopsies.

B005.0576

## All Options

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### Hospital Indemnity Claim Provisions

Your right to make a claim for Hospital Indemnity benefits provided by this Plan is governed as follows:

**Notice** You must send Us written notice of a Covered Sickness or Injury for which a claim is being made within 20 days of the date the Covered Sickness starts or Injury occurs. This notice should include Your name and the Policy number. If the claim is being made for any other Covered Person, his or her name should also be shown.

**Claim Forms** We will furnish You with forms for filing proof of loss within 15 days of receipt of notice. If We do not furnish the forms on time, We will accept a written description and adequate proof of the Covered Sickness or Injury that is the basis of the claim as proof of loss. You must detail the nature and extent of the loss for which the claim is being made.

**Proof Of Loss** You must send written proof to Our designated office within 90 days of the loss.

**Late Notice Of Proof** We will not void or reduce Your claim if You cannot send Us notice and proof of loss within the required time. In that case, You must send Us notice and proof as soon as reasonably possible.

**Payment Of Benefits** We will pay Hospital Indemnity benefits as soon as We receive written proof of loss. Unless otherwise required by law or regulation, We pay all Hospital Indemnity benefits to You if You are living. If You are not living, We have the right to pay all Hospital Indemnity benefits to one of the following: (1) Your estate; (2) Your Spouse; (3) Your parents; (4) Your children; or (5) Your brothers and sisters.

**Legal Actions** No legal action against this Plan shall be brought until 60 days from the date proof of loss has been given as shown above. No legal action shall be brought against this Plan after three years from the date written proof of loss is required to be given.

**Workers' Compensation** The Hospital Indemnity benefits provided by this Plan are not in place of and do not affect requirements for coverage by Workers' Compensation.

B005.0578



All Options

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**ELIGIBILITY FOR HOSPITAL INDEMNITY COVERAGE - EMPLOYEE**

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**Eligible Employees**

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Subject to the conditions of eligibility set forth below, and to all of the other conditions of this Plan, You are eligible if You are in an eligible class of Employees and are an active Full-Time Employee.

If You are a partner or proprietor, We will treat You like an Employee if You meet this Plan's conditions of eligibility.

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**Conditions of Eligibility**

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You are eligible for Hospital Indemnity coverage if You are:

- Legally working in the United States, or working outside of the United States for a United States based Employer in a country or region approved by Us; and
- Regularly working at least the number of hours in the normal work week set by the Employer (but not less than 30 hours per week) at: (1) the Employer's place of business; (2) some place where the Employer's business requires You to travel; or (3) any other place You and the Employer have agreed upon for the performance of occupational duties.
- Age 69 or below at the time of Your enrollment.

You are **not** eligible for Hospital Indemnity coverage if You are:

- A temporary or seasonal Employee;
- Age 70 or older at the time of Your enrollment

**Enrollment Requirement:** If You must pay all or part of the cost of Your coverage, We will not cover You until You enroll and agree to make the required payments.

B005.0583

All Options

**The Service Waiting Period** If You are in an eligible class, You are eligible for Hospital Indemnity coverage under this Plan after You complete the Service Waiting Period, if any, established by the Employer.

B005.0581

## All Options

**Multiple Employment** If You work for both the Employer and a covered associated company, or for more than one covered associated company, We will treat You as if only one firm employs You. You will not have multiple Hospital Indemnity coverages under this Plan. But, if this Plan uses the amount of Your earnings to set the rates, determine class, figure coverage amounts, or for any other reason, such earnings will be figured as the sum of Your earnings from all covered Employers.

B005.0582

## All Options

**Coverage During Temporary Layoff or Leave of Absence:** If Your active Full-Time service ends because You were laid off or go on a leave of absence approved by Your Employer, You may continue Your insurance, subject to continued payment of premium, until the earlier of: (a) the end of the temporary layoff or Employer approved leave of absence; and (b) 1 months following the date the temporary layoff or approved leave of absence begins. If You become Disabled under this Plan while Your coverage is being continued during a temporary layoff or leave of absence, Your eligibility for benefits will be governed by all the term of this Plan.

B005.0585

## All Options

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### **When Employee Coverage Starts**

Your Eligibility Date is the date You have met all of the conditions of eligibility.

Whether You must pay all or part of the cost of Your coverage, You must elect to enroll and agree to make the required payments before Your coverage will start. If You do this on or before Your Eligibility Date, Your coverage is scheduled to start on Your Eligibility Date. If You do this within 31 days after Your Eligibility Date, Your coverage is scheduled to start on Your Eligibility Date. If You do not elect this coverage within 31 days of Your Eligibility Date, You must wait until the next scheduled group enrollment period. Once each year, during the group enrollment period You may elect to enroll in this coverage as offered by Your Employer. As used here, "group enrollment period" means an annual open enrollment period set by Your Employer and agreed to by Us. During this period, You can choose the Hospital Indemnity coverage Your Employer offers. An open enrollment period is usually held once a year and usually lasts for 30 days.

On the date all or part of Your coverage is scheduled to start, You must be: (1) Actively At Work; (2) fully capable of performing the major duties of Your regular occupation; and (3) working Your regular number of hours. In that case, Your coverage will start at 12:01 A.M. Standard Time for Your place of residence on that date. In any other case, We will postpone the start of Your coverage until the date You: (a) return to Active Work; (b) are working Your regular number of hours; and (c) are fully capable of performing the major duties of Your regular occupation. Sometimes, a scheduled effective date is not a regularly scheduled work day. If the scheduled effective date falls: on a holiday; on a vacation day; on a non-scheduled work day; during a layoff of less than 180 days in duration; during an approved leave of absence not due to Sickness or Injury, of 90 days or less; or on a day during a period of absence that is less than 7 days in duration; and if: (a) You were fully capable of performing the major duties of Your regular occupation for the Employer on a Full-Time basis at 12:01 AM standard time for Your place of residence on the scheduled effective date; and (b) You were performing the major duties of Your regular occupation and working Your regular number of hours on Your last regularly scheduled work day; Your coverage will start on the scheduled effective date.

**Exception to When  
Employee Coverage  
Starts:**

If You are not capable of performing the major duties of Your regular occupation for Your Employer on a Full-Time basis on the date Your coverage is scheduled to start, You will be insured for Hospital Indemnity insurance if:

1. You were insured under the prior insurer's group or individual Hospital Indemnity policy at the time of the transfer;
2. You are a member of an eligible class;
3. premiums for You were paid up to date; and
4. You are not receiving or eligible to receive benefits under the prior insurer's group or individual Hospital Indemnity policy.

Any Hospital Indemnity benefit payable will be the lesser of:

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

B005.0586

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### When Employee Coverage Ends

Your coverage will end on the first of the following dates:

- The date Your active service ends for any reason. Your active service ends when You are no longer: (1) Actively At Work; and (2) working Your regular number of hours.
- The date You stop being an eligible Employee under this Plan.
- The date You are no longer working in the United States or working outside of the United States for a United States based Employer in a country or region approved by Us.
- The date this group Plan ends, or is discontinued for a class of Employees to which You belong.
- The last day of the period for which required payments are made for You.

B005.0591

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### Your Right to Continue Hospital Indemnity Coverage During a Family Leave of Absence

**Important Notice:** This section may not apply to Your Employer's Plan. You must contact Your Employer to find out if he or she must allow for a family leave of absence under federal law. If he or she must allow for such leave, this section applies.

**If Your Coverage Would End:** Your Hospital Indemnity coverage would normally end because You cease work due to an approved leave of absence. But, You may continue Your coverage if the leave has been granted to: (1) allow You to care for a seriously injured or ill Spouse, child or parent; (2) after the birth or adoption of a child; (3) due to Your own serious health condition; or (4) because of a Serious Injury or Illness arising out of the fact that Your Spouse, child, parent or Next of Kin who is a Covered Service Member is on Active Duty, or has been notified of an impending call or order to Active Duty, in the Armed Forces in support of a Contingency Operation. To continue Your coverage, You will be required to pay the same share of the premium as You paid before the leave of absence.

**When Continuation Ends:** Continued coverage will end on the earliest of the following:

- The date You return to Active Work.

- In the case of a leave granted to You to care for a Covered Service Member, the end of a total leave period of 26 weeks in one 12 month period. This 26 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 premium has been paid.

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

- **Active Duty:** This term means duty under a call or order to Active Duty in the Armed Forces of the United States.
- **Contingency Operation:** This term means a military operation that: (1) is designated by the Secretary of Defense as an operation in which members of the Armed Forces are or may become involved in military actions, operations or hostilities against an enemy of the United States or against an opposing military force; or (2) results in the call or order to, or retention on, Active Duty of members of the uniformed services under any provision of law or during a national emergency declared by the President or Congress.
- **Covered Service Member:** This term means a member of the Armed Forces, including a member of the National Guard or Reserves, who for a Serious Injury or Illness is: (1) undergoing medical treatment, recuperation or therapy; (2) otherwise in Outpatient Status; or (3) otherwise on the temporary disability retired list.
- **Next Of Kin:** This term means Your nearest blood relative.
- **Outpatient Status:** This term means, in the case of a Covered Service Member, that he or she is assigned to: (1) a military medical treatment facility as an outpatient; or (2) a unit established for the purpose of providing command and control of members of the Armed Forces receiving medical care as outpatients.
- **Serious Injury Or Illness:** This term means, in the case of a Covered Service Member, an Injury or illness incurred by him or her in line of duty on Active Duty in the Armed Forces that may render him or her medically unfit to perform the duties of his or her: (1) office; (2) grade; (3) rank; or (4) rating.

B005.0594

All Options

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**ELIGIBILITY FOR HOSPITAL INDEMNITY COVERAGE - DEPENDENT**

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**Eligible Dependents**

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Your eligible dependents are Your Spouse and Your unmarried dependent child(ren) from birth, until the age of 26.

B005.0597

All Options

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**Adopted Children and Step-Children**

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

B005.0598

All Options

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**Handicapped Children**

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You may have an unmarried child (a) with a mental or physical handicap or developmental disability and (b) chiefly dependent upon You for support and maintenance. In that case such a child may remain eligible for dependent benefits past the age limit subject to the conditions shown below.

- His or her condition started before he or she reached the age limit.
- He or she became covered for dependent Hospital Indemnity benefits before he or she reached the age limit, and remained continuously covered until he or she reached the age limit.
- He or she is unmarried and remains: (i) incapable of self-sustaining employment; and (ii) dependent upon You for most of his or her support and maintenance.
- You send Us written proof, and We approve such proof, of the child's disability and dependence within 31 days from the date he or she reaches the age limit. After the two year period following the child's attainment of the age limit, We can ask for periodic proof that the child's condition continues, but We cannot ask for this proof more than once a year.

The child's coverage ends when Your coverage ends.

B005.0599

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### Dependents Not Eligible

We exclude:

- A dependent who is on Active Duty in any armed force;
- A dependent who is covered by this Plan as an Employee.

A child may be an eligible dependent of more than one Employee who is insured under this Plan. In that case, the child may be insured for dependent Hospital Indemnity benefits by only one Employee at a time.

B005.0601

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### When Dependent Coverage Starts

In order for Your dependent coverage to start, You must already be covered for Employee coverage, or enroll for Employee and dependent coverage at the same time.

Subject to the Exception below and to all of the other terms of this Plan, the date Your dependent coverage starts depends on when You elect to enroll Your Initial Dependents and agree to make any required payments.

If You do this on or before Your Eligibility Date, the dependent's coverage is scheduled to start on the later of Your Eligibility Date and the date You become covered for Employee coverage.

If You do this within 31 days of Your Eligibility Date, the coverage is scheduled to start on the later of Your Eligibility Date and the date You become covered for Employee coverage.

If You do not elect dependent coverage within 31 days of Your Eligibility Date, You must wait until the next scheduled group enrollment period to add dependent coverage. Once each year, during the group enrollment period You may elect to enroll dependents in this coverage as offered by Your Employer. As used here, "group enrollment period" means an annual open enrollment period set by Your Employer and agreed to by Us. During this period, You can choose the dependent Hospital Indemnity coverage Your Employer offers. An open enrollment period is usually held once a year and usually lasts for 30 days.

You may enroll Your dependents outside of the group enrollment period only as follows:

- You may enroll a new Spouse within 31 days of marriage;
- You may enroll for dependent child coverage within 31 days of the birth or adoption of Your first eligible child.

Once You have dependent child coverage for Your Initial Dependent child(ren) any Newly Acquired Dependent children will be covered as of the date he or she is first eligible.

**Exception:** We will postpone the effective date of a dependent's, other than a newborn child's, coverage if, on that date, he or she is: (1) Confined to a Hospital or other health care facility or (2) home confined. In that case, We will postpone the effective date of his or her coverage until the day after the date: (a) of his or her discharge from such facility or (b) his or her home confinement ends. If a dependent was covered under a prior plan at transfer, this language will not apply to the amount of coverage that was in force with the prior plan.

B005.0602

## All Options

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### When Dependent Coverage Ends

Dependent coverage ends for all of Your dependents when Your Employee coverage ends. Dependent coverage also ends for all of Your dependents when You stop being a member of a class of Employees eligible for such coverage. And, it ends when this Plan ends, or when dependent coverage is dropped from this Plan for all Employees or for Your class.

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

Your dependent's coverage ends when he or she stops being an eligible dependent. This happens to a child at 12:01 A.M. on the date the child attains this Plan's age limit, when he or she marries, or when a step-child is no longer dependent on You for support and maintenance or for Your handicapped child who has reached the age limit, when he or she marries or is no longer dependent on You for support and maintenance. It happens to a Spouse when a marriage ends in legal divorce or annulment or a Domestic Partnership ends or no longer qualifies as a Domestic Partnership.

B005.0605



All Options

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**HOSPITAL INDEMNITY COVERAGE**

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This Certificate includes the Schedule of Benefits. Your class and benefit options are shown in the Schedule of Benefits that applies to You. Subject to all of this Plan's terms, We will pay the benefits described below if a Covered Person receives care or treatment for a Covered Sickness or Injury. The care or treatment must occur while the Covered Person is insured by this Plan. This Plan pays no benefits for the treatment of a Covered Sickness or Injury other than those listed below in Covered Benefits.

B005.0607

All Options

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**Covered Benefits**

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B005.0608

All Options

**Ambulance:** We pay the amount shown in the Schedule of Benefits if a licensed ambulance company transports a Covered Person to or from a Hospital or between medical facilities for treatment of a Covered Sickness or Injury. We limit what We cover to 2 day(s) of benefits per Covered Person per Benefit Year for all types of Ambulance transportation combined. If the Air Ambulance transportation is needed due to a covered Injury, it must occur within 48 hours after the covered Injury.

B005.0610

All Options

**Emergency Room or Urgent Care Facility Treatment:** We pay the amount shown in the Schedule of Benefits if a Covered Person is examined or treated by a Doctor in an Emergency Room or Urgent Care Facility for the initial treatment of a Covered Sickness or Injury. We limit what We cover to 1 day(s) of benefits per Covered Person per Benefit Year for either Emergency Room or Urgent Care Facility treatment. We will pay the higher of the Emergency Room or Urgent Care Facility Treatment benefit if both occur on the same day.

B005.0620

All Options

**Health Screening:** We will pay the amount in the Schedule of Benefits if You provide proof that a Covered Person received at least one of the following tests:

- Stress test on a bicycle or treadmill
- Fasting blood glucose test
- Blood test for triglycerides
- Hemoccult stool analysis
- Mammography
- Pap smear

- Serum Cholesterol test to determine level of HDL and LDL Arteriogram
- Bone marrow testing
- Breast ultrasound
- CA 15-3 (blood test for breast cancer)
- CA 125 (blood test for ovarian cancer)
- CEA (blood test for colon cancer)
- Chest x-ray (preventative screening, not diagnostic)
- Colonoscopy (blood test for colon cancer)
- Flexible sigmoidoscopy
- PSA (blood test for prostate cancer)
- Serum protein electrophoresis (blood test for myeloma)
- Thermography
- ThinPrep pap test
- Virtual colonoscopy
- Lymphocyte Genome Sensitivity test (LGS)
- Cancer genetic mutation test
- Completion of smoking cessation program
- Completion of a weight reduction program

We limit what We cover to 1 day(s) of benefits per Covered Person per Benefit Year.

B005.0621

## All Options

### **Hospital Admission or Intensive Care Unit Admission:**

We pay the amount shown in the Schedule of Benefits if a Covered Person is admitted to a Hospital as a result of a Covered Sickness or Injury. We limit what We cover to 1 day(s) of benefits per Covered Person per Benefit Year for either Hospital Admission or Intensive Care Unit Admission. We limit what We cover to 3 day(s) of benefits per Covered Family per Benefit Year. If a Covered Person is admitted to the Hospital or the Intensive Care Unit for the same or related condition within 30 day(s) of an Admission for which this Plan has paid a benefit, We will treat this later Admission as a continuation of the previous Admission and no additional benefit will be paid. If more than 30 day(s) have passed between the periods of Hospital or Intensive Care Unit Admission, We will treat this later Admission as a new and separate Hospital or Intensive Care Unit Admission. This benefit is not payable for Emergency Room treatment, Outpatient Surgery or Treatment, or a Hospital stay of less than 20 hours in an Observation Unit, or when a charge for room and board is not made. We will pay the higher of the Hospital Admission or Intensive Care Unit Admission benefit if both occur on the same day or same Benefit Year. Hospital Admission or Intensive Care Unit Admission does not include Hospice Care in a Hospice facility. The admission must be within 180 day(s) of an Injury.

B005.0629

## All Options

### **Hospital Confinement or Intensive Care Unit Confinement**

We will pay the amount shown in the Schedule of Benefits for days of Hospital Confinement or Intensive Care Unit Confinement following a Hospital Admission or Intensive Care Unit Admission, if a Covered Person is Confined in a Hospital or Intensive Care Unit for the treatment of a Covered Sickness or Injury. We limit what We cover to 15 day(s) of benefits per Covered Person per Benefit Year. We do not pay the Hospital Confinement or Intensive Care Unit Confinement benefit on the same day as the Hospital Admission or Intensive Care Unit Admission.

We will pay the higher of the Hospital Confinement or Intensive Care Unit Confinement benefit if both occur on the same day. Hospital Confinement or Intensive Care Unit Confinement does not include Hospice Care in a Hospice facility.

B005.0631

## All Options

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### **Exclusions**

This Plan will not pay benefits for the treatment of any Covered Sickness or Injury caused by, or resulting from any of the following:

- Suicide or any intentionally self-inflicted Injury;
- Participation in a riot or insurrection;
- Declared or undeclared war, or act of war;
- Commission of, or attempt to commit, a felony, or participating in an illegal occupation;
- Commission of, or attempt to commit, an act of terrorism

And this Plan will not pay benefits for:

- Elective Surgery;
- Dental care, dental x-rays, or dental treatment;
- Gastric or intestinal bypass services including lap banding, gastric stapling, and other similar procedures to facilitate weight loss; the reversal, or revision of such procedures; or services required for the treatment of complications from such procedures. This exclusion does not apply to completion of a weight reduction program that may be payable under the Health Screening benefit;
- Rest cures or custodial care, or treatment of sleep disorders;
- Services, treatment or supplies rendered outside the United States or Canada;
- Treatment of a Covered Dependent Child's child(ren);
- Cosmetic surgery. This Exclusion does not apply to reconstructive surgery:

- (a) on an injured part of the body following infection or disease of the involved part;
  - (b) of a congenital disease or anomaly of a covered dependent newborn or adopted infant; or
  - (c) on a non-diseased breast to restore and achieve symmetry between two breasts following a covered mastectomy;
- Treatment or removal of warts, moles, boils, skin blemishes or birthmarks, bunions, acne, corns, calluses, the cutting and trimming of toenails, care for flat feet, fallen arches or chronic foot strain;
  - Service, treatment or loss related to alcoholism or drug addiction, except for drugs prescribed by the Covered Person's Doctor and taken as prescribed;
  - Care or treatment for mental or nervous disorders;
  - Services, treatment or loss rendered in any Veterans Administration or Federal Hospital, except if there is a legal obligation to pay;
  - Services or treatment provided by a Doctor, Nurse or any other person who is employed or retained by a Covered Person or who is a Covered Person's Spouse, parent, brother, sister, child, Domestic Partner, or partner in a civil union;
  - Sickness or Injury sustained while on Active Duty in the armed forces of any country. This does not include Reserve or National Guard duty for training;
  - Surgery and treatment, procedures, products or services that are Experimental or Investigative. "Experimental or Investigative" means a drug, device or medical treatment or procedure that:
    - (a) Cannot lawfully be marketed without approval of the United States Food and Drug Administration and approval for marketing has not been given at the time of being furnished;
    - (b) Has Reliable Evidence indicating it is the subject of ongoing clinical trials or is under study to determine its maximum tolerated dose, toxicity, safety, efficacy, or its efficacy as compared with the standard means of treatments or Diagnosis; or
    - (c) Has Reliable Evidence indicating that the consensus of opinion among experts is that further studies or clinical trials are necessary to determine its maximum tolerated dose, toxicity, efficacy, or its efficacy as compared with the standard means of treatment or Diagnosis.
- "Reliable Evidence" means (i) published reports and articles in authoritative medical and scientific literature; (ii) the written protocol(s) of the treating facility or the protocols of another facility studying substantially the same drug, device, medical treatment or procedure; or (iii) the written informed consent used by the treating facility or by another facility studying substantially the same drug, device, or medical treatment or procedure.

B005.0690

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**Waiver of Premium Benefit**

After the Covered Person has been Confined to a Hospital due to a Covered Sickness or Injury for more than 30 continuous days while this Plan is in force, We will waive the premium for the Plan for as long as the Covered Person remains Confined to a Hospital or Rehabilitation Unit.

The Covered Person must pay all premiums to keep the Plan in force until he or she has been Confined to a Hospital for more than 30 continuous days and the waiver becomes effective.

The Waiver of Premium Benefit does not apply to any period that the Covered Person is Confined to a Hospital or Rehabilitation Unit due to a Sickness or Injury which is excluded by name or specific description in this Plan. This benefit does not apply to the Hospital Confinement of a Spouse or Covered Dependent Child. We will waive the premium only if the Covered Person insured is Confined to a Hospital for more than 30 continuous days, and the premium will be waived for the entire Plan, including the premium for any covered Spouse or Covered Dependent Child if insured under the Plan.

B005.0694

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**Grievance Procedures - External Review**

If You or Your representative does not agree with the handling of a claim or has any other grievance, You may file a request for an external review. Requests should be sent to the Commissioner. This must be done within 30 business days after the date of receipt of a grievance decision rendered in a formal review. If the request is accepted by the Commissioner, an external review will be conducted by an Independent Review Organization (IRO). Within 5 business days of Our receipt of the IRO's recommendation, a written report will be submitted to You or Your representative and the Commissioner indicating Our decision with respect to the IRO's recommendation.

The Commissioner may refer matters not within his or her jurisdiction to any other appropriate federal or District government agency for disposition or resolution.

If You are dissatisfied with the resolution reached through the insurer's internal grievance system regarding medical necessity, You may contact the Director, Office of the Health Care Ombudsman and Bill of Rights at the following:

For Medical Necessity cases, District of Columbia Department of Health Care Finance Office of the Health Care Ombudsman and Bill of Rights

441 4th St. NW900S  
Washington, D.C. 20002  
Phone: (202) 442-5988  
Fax: (202) 442-4790

If You are dissatisfied with the resolution reached through the insurer's internal grievance system regarding all other grievances, You may contact the Commissioner at the following

For Non-Medical Necessity cases, Acting Commissioner Stephen C. Taylor  
Department of Insurance, Securities and Banking  
810 First Street, NE 7th Floor  
Washington, D.C. 20002  
Phone: 1-202-727-8000  
Fax: 1-202-354-1085

### **Definitions**

"Commissioner" means the Commissioner of Insurance.

"Grievance" means a written request by You or a person on Your behalf for review of Guardian's decision to deny, reduce, limit, terminate or delay Your covered health care services.

"Grievance Decision" means a determination accepting or denying the basis or requested remedy of the grievance.

"Independent Review Organization (IRO)" means an impartial, certified health entity engaged by the Commissioner or the Director to review any adverse grievance decision made by Guardian.

B053.1873

All Options

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**SCHEDULE OF BENEFITS**

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**HOSPITAL INDEMNITY**

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

B005.0703

All Options

**Covered Benefits**

All Options

**Ambulance - Ground:** \$100.00 per day  
Limited to 2 days per Benefit Year combined with Air Ambulance.

All Options

**Ambulance - Air:** \$500.00 per day  
Limited to 2 days per Benefit Year combined with Ground Ambulance

All Options

**Emergency Room:** \$50.00 per day  
Limited to 1 days per Benefit Year combined with Urgent Care.

All Options

**Urgent Care Facility:** \$25.00 per day  
Limited to 1 days per Benefit Year combined with Emergency Room.

All Options

**Health Screening:** \$50.00 per day  
Limited to 1 days per Benefit Year.

All Options

**Hospital Admission:** \$500.00 per day  
Limited to 1 days per Benefit Year and 3 days per Covered Family combined with Hospital ICU Admission.

**All Options**

**Hospital Confinement:** \$100.00 per day  
for first 15 days Hospital Confinement combined with Hospital ICU Confinement.

**All Options**

**Hospital ICU Admission:** \$500.00 per day  
Limited to 1 days per Benefit Year combined with Hospital Admission.

**All Options**

**Hospital ICU Confinement:** \$100.00 per day  
for first 15 days Hospital ICU Confinement combined with Hospital Confinement.

**All Options**

**Initial Election**

When You first become eligible for this Plan You must choose to be covered for a Plan Option as described below. You may only be covered under one plan at a time. You must notify Your Employer of Your election and pay the required premium.

B005.0728

**All Options**

**EMPLOYEE VOLUNTARY HOSPITAL INDEMNITY COVERAGE**

**All Options**

**Election of Hospital Indemnity Plan Option Based on Age** If You are less than age 69 you may elect Hospital Indemnity coverage. If you are age 70 or above, you may not elect Hospital Indemnity coverage.

B005.0732

**All Options**

**DEPENDENT VOLUNTARY HOSPITAL INDEMNITY COVERAGE**

**All Options**

**Election of Hospital Indemnity Plan Option Based on Age** If You, as the Employee, are less than age 69, You may elect Hospital Indemnity coverage for Your Dependent(s). If You as the Employee are age 70 or above, You may not elect Hospital Indemnity coverage for Your Dependent(s).



**All Options**

**Changes To Coverage**

**Changes in Coverage Amounts** If You are not Actively At Work on a Full-Time basis, any change in Your coverage or the coverage on a covered dependent will not become effective prior to the date You return to Active Work on a Full-Time basis.

**Changes In Insurance Classification** If Your classification changes, coverage will not be changed to the new amount until the first day on which You are: (1) Actively At Work on a Full-Time basis; and (2) make a contribution, if required, for the new classification.

If a contribution is required for the new classification for which greater coverage is provided, You must make the required contribution for the new coverage within 31 days of the change. If You do not make the required contribution within 31 days of the change or within 31 days of becoming Actively At Work on a Full-Time basis, if You are not Actively At Work on a Full-Time basis, when Your classification changes, no increase will be allowed due to such change or any later change. In that case, in order to become covered for the greater coverage, You must: (1) make the required contribution for the greater coverage; and (2) furnish Proof of Insurability to Us, which We approve in writing.

B005.0743

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**CERTIFICATE RIDER**

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**LIMITED BENEFIT- PLEASE READ CAREFULLY**

Effective on the latter of (i) the original effective date of the Policy; or (ii) the effective date of any applicable amendment requested by the Planholder and approved by the Insurance Company, this rider amends this Certificate by the addition of the following:

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**PORTABILITY PRIVILEGE**

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**Definition:** As used in this provision, the terms "port" and "to port" mean to choose a portable certificate of coverage which provides group Hospital Indemnity coverage.

**Portability Conditions:** Portability is subject to all of the conditions described below.

- You may port if Your coverage under this Plan ends because: (1) You have terminated employment; (2) You stop being a member of an eligible class of Employees; or (3) this Plan ends.
- You may **not** port Your coverage if You have reached Your 70th birthday on the date coverage under this Plan ends.
- You may **not** port coverage for any of Your dependents if he or she has reached his or her 70th birthday on the date coverage under this Plan ends.
- You may **not** port if coverage under this Plan ends due to Your failure to pay any required premium.

**Portability Options:** You may port Your Hospital Indemnity coverage, subject to any benefit amount reductions based on age, less the amount of any Hospital Indemnity benefits paid by this Plan.

You may port Your dependent's Hospital Indemnity coverage, less the amount of any Hospital Indemnity benefits paid by this Plan.

You may port: (1) Your coverage only; (2) Your coverage and coverage of Your covered Spouse; (3) Your coverage and the coverage of all of Your covered dependents; or (4) if You are a single parent, Your coverage and the coverage of all of Your covered dependent children. No other combinations will be allowed.

A dependent must be covered as of the date Your coverage under this Plan ends in order to be eligible for portability.

If You die while covered for dependent Hospital Indemnity coverage, Your Spouse may port Your dependent Hospital Indemnity coverage as described above. Your Spouse and dependent children must be covered under this Plan on the date of Your death. But, this option is not available if: (1) there is no surviving Spouse; or (2) Your surviving Spouse has reached his or her 70th birthday on the date of Your death.

**The Portable Certificate of Coverage:** The portable certificate of coverage provides group Hospital Indemnity. The benefits provided by the portable certificate of coverage are the same as the benefits provided by this Plan. The portable certificate provides seamless coverage. Benefit limits, maximums and timeframes do not reset when someone becomes covered under the portable certificate. The premium for the portable certificate of coverage will be based on: (1) the Covered Person's rate class under this Plan; and (2) Your or Your surviving Spouse's age bracket as shown in the Hospital Indemnity Portability Coverage Premium Notice.

**How to Port:** You or Your surviving Spouse must: (1) apply to Us in writing; and (2) pay the required premium. You or Your surviving Spouse must do this within 31 days from the date Your coverage under this Plan ends. We will not ask for proof that You or Your surviving Spouse are in good health.

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

**The Guardian** Life Insurance Company of America



Raymond Marra, Senior Vice President, Group and Worksite Markets

All Options

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**CERTIFICATE AMENDMENT**

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

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**ADDITIONAL SERVICES**

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

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

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

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

- Financial Planning and Wellness Services.


All Options

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

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

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

**The Guardian** Life Insurance Company of America



Raymond Marra, Senior Vice President, Group and Worksite Markets

B055.0288

## All Options

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

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## STATEMENT OF ERISA RIGHTS

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

### **Receive Information About Your Plan and Benefits**

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

### **Prudent Actions By Plan Fiduciaries**

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

## Statement of Erisa Rights (Cont.)

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

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

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

B800.0093

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## Group Health Benefits Claims Procedure

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

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

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

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

"Group Health Benefits" means any accident, cancer, critical illness, specified disease or hospital indemnity coverages which are a part of this plan.

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

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

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

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

**Adverse Benefit Determination** If a claim is denied, Guardian will provide a notice that will set forth:

- the specific reason(s) for the adverse determination;
- reference to the specific plan provision(s) on which the determination is based;



## Group Health Benefits Claims Procedure (Cont.)

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- a description of any additional material or information necessary to make the claim valid and an explanation of why such material or information is needed;
- a description of the plan's claim review procedures and the time limits applicable to such procedures, including a statement indicating that the claimant has the right to bring a civil action under ERISA Section 502(a) following an adverse benefit determination;
- identification and description of any specific internal rule, guideline or protocol that was relied upon in making an adverse benefit determination, or a statement that a copy of such information will be provided to the claimant free of charge upon request.

### **Appeal of Adverse Benefit Determinations**

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

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

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

In reviewing an appeal, Guardian will:

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

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

## **Group Health Benefits Claims Procedure (Cont.)**

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

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

B055.0061

### **All Options**

### **Termination of This Group Plan**

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

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

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

B800.0086

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## **YOUR BENEFITS INFORMATION - ANYTIME, ANYWHERE**

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**[www.GuardianAnytime.com](http://www.GuardianAnytime.com)**

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

[GuardianAnytime.com](http://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](http://www.GuardianAnytime.com)



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

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