# YOUR GROUP INSURANCE PLAN BENEFITS

**UNITY HEALTHCARE INC**

**CLASS 0002**

**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

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

## New Mexico Residents
## Consumer Complaint Notice

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

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

CCN-2019-NM B999.0042

## This Booklet Includes All Benefits For Which You Are Eligible.

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

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

**"Please Read This Document Carefully".**

## CERTIFICATE OF COVERAGE

**The Guardian**
*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

GC-CI-14-DC

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**All Options**

## DEFINITIONS

This section defines certain terms appearing in Your Certificate.

B040.0004

**All Options**

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

B040.0882

**All Options**

**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 15 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.

B005.0022

**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**

## GENERAL PROVISIONS

B005.0033

**All Options**

### Applicable Benefits

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

B005.0034

**All Options**

### Limitation of Authority

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

B005.0035

**All Options**

### Incontestability

The Policy is incontestable after two years from its date of issue, except for non-payment of premiums.

No statement in any application, 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**

## Examination and Autopsy

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

B005.0038

**All Options**

## Critical Illness Claims Provisions

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

### Notice

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

### 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

# ELIGIBILITY FOR CRITICAL ILLNESS - EMPLOYEE COVERAGE

## Eligible Employees

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

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

## Conditions of Eligibility

You are eligible for Critical Illness coverage if You are;

- Legally working in the United States, or working outside of the United States for a United States based employer in a country or region approved by Us; and
- Regularly working at least the number of hours in the normal work week set by the Employer (but not less than 15 hours per week) at: (1) the Employer's place of business; (2) some place where the Employer's business requires You to travel; or (3) any other place You and the Employer have agreed upon for the performance of occupational duties.

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

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

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

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

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

B005.0043

**All Options**

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

B005.0045

**All Options**

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

B005.0046

**All Options**

## When Employee Coverage Starts

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

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

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

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

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

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

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

Any Critical Illness benefit payable will be the lesser of:

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

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

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

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

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

B005.0078

**All Options**

## When Employee Coverage Ends

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

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

B005.0050

**All Options**

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

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

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

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

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

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

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

- **Covered Service Member:** This term means a member of the Armed Forces, including a member of the National Guard or Reserves, who for a Serious Injury or Illness is: (1) undergoing medical treatment, recuperation or therapy; (2) otherwise in Outpatient Status; or (3) otherwise on the temporary disability retired list.

- **Next Of Kin:** This term means Your nearest blood relative.

- **Outpatient Status:** This term means, in the case of a covered service member, that he or she is assigned to: (1) a military medical treatment facility as an outpatient; or (2) a unit established for the purpose of providing command and control of members of the Armed Forces receiving medical care as outpatients.

- **Serious Injury Or Illness:** This term means, in the case of a Covered Service Member, an Injury or illness incurred by him or her in line of duty on active duty in the Armed Forces that may render him or her medically unfit to perform the duties of his or her: (1) office; (2) grade; (3) rank; or (4) rating.

B005.0062

**All Options**

## ELIGIBILITY FOR CRITICAL ILLNESS COVERAGE - DEPENDENT COVERAGE

B005.0063

**All Options**

### Eligible Dependents for Dependent Critical Illness Coverage

B005.0064

**All Options**

**Eligible Dependents for Voluntary Dependent Critical Illness**

Your eligible dependents are Your spouse and unmarried dependent children from birth until they reach age 26.

B005.0080

**All Options**

### Adopted Children and Step-Children

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

B005.0065

**All Options**

### Dependents Not Eligible

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

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

B005.0066

**All Options**

## Handicapped Children

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

- His or her condition started before he or she reached the age limit.
- He or she became covered for dependent Critical Illness benefits before he or she reached the age limit, and 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

**All Options**

## Proof of Insurability

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

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

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

B005.0069

**All Options**

## When Dependent Coverage Starts

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

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

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

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

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

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

B005.0070

**All Options**

**Exception** We will postpone the effective date of a dependent's, other than a newborn child's, coverage if, on that date, he or she is: (1) confined to a hospital or other health care facility; (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

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

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

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

B005.0075

**All Options**

## CRITICAL ILLNESS COVERAGE

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

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

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

B005.0083

**All Options**

### Critical Illness Benefits

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

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

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

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

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

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

B005.0084

**All Options**

## Covered Critical Illnesses

B005.0086

**All Options**

### Cancer Related Conditions

B005.0087

**All Options**

**Benign Brain Tumor**

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

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

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

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

We deem a Benign Brain Tumor to occur on the date a Doctor of appropriate specialty makes a Diagnosis.

B005.0088

**All Options**

**Carcinoma in Situ**

We pay a benefit if a Covered Person is Diagnosed with Carcinoma In Situ, which means early forms of cancer that have not invaded surrounding tissue. Any malignant tumor classified as less than T1NOMO under TNM classification is considered Carcinoma in Situ. Carcinomas in Situ can include early forms of many common cancers such as breast and prostate cancer.

We do not pay a benefit under this provision for:

- Pre-malignant growths or lesions, such as dysplasia or Intraepithelial neoplasia;
- Any benign tumor or polyp;
- Carcinoma in Situ of the skin

Diagnosis of Carcinoma in Situ must be based on microscopic (histologic) exam of: (a) fixed tissues; or (b) preparations of blood or bone marrow. Such exam must be documented in a written report by a Doctor who is Board Certified in pathology.

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

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**

## 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**

## SCHEDULE OF BENEFITS

### CRITICAL ILLNESS COVERAGE

Effective on the latter of (i) the original effective date of the Policy; or (ii) the effective date of any applicable amendment requested by the Policyholder and approved by the Insurance Company, this Schedule of Benefits is attached to the Certificate. This Schedule of Benefits replaces any previously issued Schedule of Benefits.

B005.0141

**All Options**

**Initial Election** When You first become eligible for this Plan You may choose to become covered for one of the Plans described below and pay the required premium.

You may request to switch to another Plan at any time. But, We will require Proof of Insurability before You switch to another Plan which provides greater benefits 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** |
|---|---|---|---|
| **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** | | | |
| **Vascular Conditions:** | | | |
| **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** | | | |
| **Neurological Conditions:** | | | |
| **All Options** | | | |
| | **Alzheimer's Disease for Covered Person** | 50% | Not Covered |
| **All Options** | | | |
| | **ALS (Lou Gehrigs's Disease)** | 100% | Not Covered |
| **All Options** | | | |
| | **Huntington's Disease** | 30% | Not Covered |
| **All Options** | | | |
| | **Multiple Sclerosis** | 30% | Not Covered |
| **All Options** | | | |
| | **Advanced Parkinson's Disease** | 100% | Not Covered |

| | | | |
|---|---|---|---|
| **All Options** | | | |
| **Childhood Conditions:** **(applies only to covered dependent children)** | | | |
| **All Options** | | | |
| | **Cerebral Palsy** | 100% | Not Covered |
| **All Options** | | | |
| | **Cleft lip/cleft palate** | 100% | Not Covered |
| **All Options** | | | |
| | **Club Foot** | 100% | Not Covered |
| **All Options** | | | |
| | **Cystic Fibrosis** | 100% | Not Covered |
| **All Options** | | | |
| | **Down's Syndrome** | 100% | Not Covered |
| **All Options** | | | |
| | **Muscular Dystrophy** | 100% | Not Covered |
| **All Options** | | | |
| | **Spina Bifida** | 100% | Not Covered |
| **All Options** | | | |
| | **Type 1 Diabetes** | 100% | Not Covered |
| **All Options** | | | |
| **Other Conditions:** | | | |
| **All Options** | | | |
| | **Addison's Disease** | 30% | Not Covered |
| **All Options** | | | |
| | **Coma** | 100% | Not Covered |
| **All Options** | | | |
| | **Kidney Failure** | 100% | 100% |
| **All Options** | | | |
| | **Loss of Hearing** | 100% | Not Covered |

| | | | |
|---|---|---|---|
| **All Options** | | | |
| | **Loss of Sight** | 100% | Not Covered |
| **All Options** | | | |
| | **Loss of Speech** | 100% | Not Covered |
| **All Options** | | | |
| | **Major Organ Failure** | 100% | 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

## CERTIFICATE RIDER - Wellness Benefit

### 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
- Hemoccult 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

GC-R-CI-WELL-14-DC

## CERTIFICATE AMENDMENT - ELIGIBILITY FOR 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 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

Senior Vice President, Group and Worksite Markets

B053.1921

GC-A-CI-GI-18-DC

**All Options**

## CERTIFICATE AMENDMENT

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

## ADDITIONAL SERVICES

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

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

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

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

- 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

CGP-3-A-VAP-17

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

## STATEMENT OF ERISA RIGHTS

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

**Receive Information About Your Plan and Benefits**

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

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

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

**Prudent Actions By Plan Fiduciaries**

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

**Enforcement Of Your Rights**

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

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

**Assistance with Questions**

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

B800.0093

## Group Health Benefits Claims Procedure

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

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

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

**Definitions**

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

"Group Health Benefits" means any accident, cancer, critical illness, specified disease or hospital indemnity coverages which are a part of this plan.

**Timing For Initial Benefit Determination**

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

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

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

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

**Adverse Benefit Determination**

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

- the specific reason(s) for the adverse determination;
- reference to the specific plan provision(s) on which the determination is based;

- a description of any additional material or information necessary to make the claim valid and an explanation of why such material or information is needed;
- a description of the plan's claim review procedures and the time limits applicable to such procedures, including a statement indicating that the claimant has the right to bring a civil action under ERISA Section 502(a) following an adverse benefit determination;
- identification and description of any specific internal rule, guideline or protocol that was relied upon in making an adverse benefit determination, or a statement that a copy of such information will be provided to the claimant free of charge upon request.

**Appeal of Adverse Benefit Determinations**

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

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

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

In reviewing an appeal, Guardian will:

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

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

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

**Alternative Dispute Options**

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

B055.0061

**All Options**

## Termination of This Group Plan

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

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

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

B800.0086

## This Booklet Includes All Benefits For Which You Are Eligible.

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

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

**"Please Read This Document Carefully".**

## CERTIFICATE OF COVERAGE

**The Guardian 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

Harris Oliner, Senior Vice President,
Corporate Secretary

Raymond Marra, Senior Vice President,
Group and Worksite Markets

B442.1476

GC-ACC-18-DC

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

## Applicable Benefits

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.

## Limitation Of Authority

Only the President, a Vice President or a Secretary of Guardian, has the authority to act for Us in a written and signed statement to:

- Determine whether any 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.

## Incontestability

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.

## Examination and Autopsy

We have the right to have a Doctor of Our choice examine the person for whom a claim is being made under the Certificate as often as We feel 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

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

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

## ELIGIBILITY FOR ACCIDENT COVERAGE - EMPLOYEE COVERAGE

### Conditions of Eligibility

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**

## 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.

B442.0016

**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

**All Options**

## 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

**All Options**

## 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

## CONTINUATION OF COVERAGE

### Coverage During Temporary Layoff or Leave of Absence

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



### Coverage During 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 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

# ELIGIBILITY FOR ACCIDENT COVERAGE - DEPENDENT COVERAGE

## Conditions of Eligibility

Your eligible dependents are Your spouse; and

- Unmarried dependent child, including:
  - o 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
  - o 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.

## Dependents Not Eligible

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

**All Options**

## When Dependent Coverage Starts

**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**

## 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**

## 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.

## 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;

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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

## ACCIDENT BENEFITS

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

## ACCIDENT CLAIM PROVISIONS

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

## EXCLUSIONS

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**

## DEFINITIONS

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**

## SCHEDULE OF BENEFITS

**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<br>Your Spouse: $12,500.00<br>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.<br><br>**Multiple Losses of hand, foot or sight:**<br><br>For more than one covered loss due to the same Accident, We will pay 100% of the Accidental Death benefit.<br><br>Loss of thumb and index finger of same hand, or loss of four fingers of same hand: 25% of Accidental Death benefit.<br><br>Loss of all toes of same foot: 25% of Accidental Death benefit.<br><br>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<br><br>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**<br>From 18 sq inches up to 34 sq inches: $1,000.00<br>35 sq inches and over: $3,000.00<br><br>**3rd Degree**<br>From 9 sq inches to 17 sq inches: $2,000.00<br>From 18 sq inches to 34 sq inches: $4,000.00<br>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<br><br>Loss of speech and hearing (both ears): 100% of Accidental Death benefit<br><br>Loss of cognitive function: 100% of Accidental Death benefit<br><br>Hemiplegia: 50% of Accidental Death benefit<br><br>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<br>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 |

**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<br>Knee: $1,250.00<br>Shoulder: $1,250.00 |
| **All Options** | |
| Knee Cartilage | $500.00 |

**All Options**

| | |
|---|---|
| Laceration | No sutures required: $40.00<br>Lacerations 4cm or less: $60.00<br>Lacerations 5cm up to 14 cm: $200.00<br>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**

| | |
|---|---|
| Prosthetic Device/Artificial Limb | One: $500.00<br>Two or more: $1,000.00 |

**All Options**

| | |
|---|---|
| Reasonable Accommodation to Home or Vehicle | $2,500.00 |

**All Options**

| | |
|---|---|
| Rehabilitation Facility Confinement | $100.00 per day |

**All Options**

| | |
|---|---|
| Ruptured Disc With Surgical Repair | $500.00 |

**All Options**

| | |
|---|---|
| Surgery - cranial, open abdominal, thoracic hernia | Cranial, open abdominal, thoracic: $1,250.00<br>Hernia: $250.00 |

**All Options**

| | |
|---|---|
| Surgery - Exploratory or Arthroscopic | $400.00 |

**All Options**

| | |
|---|---|
| Tendon/Ligament/Rotator Cuff | One: $500.00<br>Two or more: $1,000.00 |

**All Options**

| | |
|---|---|
| Transportation | $.50 per mile, limited to $500.00 per round trip |

**All Options**

| | |
|---|---|
| Traumatic Brain Injury | $4,000.00 |

**All Options**

| | |
|---|---|
| X-ray | $40.00 |

## 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

## CERTIFICATE RIDER - Wellness Benefit

# 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

GC-R-ACC-WELL-18-DC

## 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

GC-R-ACC-RDF-18-DC

## CERTIFICATE RIDER - Portability Privilege

# 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

GC-R-ACC-PORT-18-DC

**All Options**

## 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 beneficiarys 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

## CERTIFICATE AMENDMENT

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

## ADDITIONAL SERVICES

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

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

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

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

- 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

CGP-3-A-VAP-17

## This Booklet Includes All Benefits For Which You Are Eligible.

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

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

**"Please Read This Document Carefully".**

## CERTIFICATE OF COVERAGE

**The Guardian**
*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

GC-HI-15-DC

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**All Options**

## DEFINITIONS

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 15 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.

B005.0548

**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**

## GENERAL PROVISIONS

B005.0033

**All Options**

### Applicable Benefits

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

B005.0034

**All Options**

### Limitation of Authority

No person, except by a writing signed by the President, a Vice President or a Secretary of Guardian, has the authority to act for Us to: (1) determine whether any contract, 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**

### 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**

## 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**

## 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**

# ELIGIBILITY FOR HOSPITAL INDEMNITY COVERAGE - EMPLOYEE

## Eligible Employees

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.

## Conditions of Eligibility

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 15 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**

## 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

**All Options**

## 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

**All Options**

## 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**

## ELIGIBILITY FOR HOSPITAL INDEMNITY COVERAGE - DEPENDENT

### Eligible Dependents

Your eligible dependents are Your Spouse and Your unmarried dependent child(ren) from birth, until the age of 26.

B005.0597

**All Options**

### Adopted Children and Step-Children

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

B005.0598

**All Options**

### Handicapped Children

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

**All Options**

## 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

**All Options**

## When Dependent Coverage Starts

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

Subject to the Exception below and to all of the other terms of this Plan, the date Your dependent coverage starts depends on when You elect to enroll Your Initial Dependents and agree to make any required payments.

If You do this on or before Your Eligibility Date, the dependent's coverage is scheduled to start on the later of Your Eligibility Date and the date You become covered for Employee coverage.

If You do this within 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**

## 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**

## HOSPITAL INDEMNITY COVERAGE

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**

### Covered Benefits

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**

## 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.

## 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

## 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

GC-HI-15-DC

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**

## SCHEDULE OF BENEFITS

### 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).

## 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

## CERTIFICATE RIDER

**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:

## PORTABILITY PRIVILEGE

**Definition:** As used in this provision, the terms "port" and "to port" mean to choose a portable certificate of coverage which provides group 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

GC-R-HI-PORT-15-DC B053.1867

**All Options**

## CERTIFICATE AMENDMENT

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

## ADDITIONAL SERVICES

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

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

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

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

- 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

CGP-3-A-VAP-17

**All Options**

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

## STATEMENT OF ERISA RIGHTS

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

**Receive Information About Your Plan and Benefits**

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

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

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

**Prudent Actions By Plan Fiduciaries**

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

**Enforcement Of Your Rights**

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

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

**Assistance with Questions**

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

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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;

- a description of any additional material or information necessary to make the claim valid and an explanation of why such material or information is needed;
- a description of the plan's claim review procedures and the time limits applicable to such procedures, including a statement indicating that the claimant has the right to bring a civil action under ERISA Section 502(a) following an adverse benefit determination;
- identification and description of any specific internal rule, guideline or protocol that was relied upon in making an adverse benefit determination, or a statement that a copy of such information will be provided to the claimant free of charge upon request.

**Appeal of Adverse Benefit Determinations**

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

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

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

In reviewing an appeal, Guardian will:

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

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

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

**Alternative Dispute Options**

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

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**All Options**

## Termination of This Group Plan

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

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

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

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## YOUR BENEFITS INFORMATION - ANYTIME, ANYWHERE

**www.GuardianAnytime.com**

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

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

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

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

To register, go to www.GuardianAnytime.com

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

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