YOUR GROUP INSURANCE PLAN BENEFITS

FIVE9 INCORPORATED

CLASS 0001

ALL OTHER ELIGIBLE EMPLOYEES

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

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

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

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

New Mexico Residents
Consumer Complaint Notice

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

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

CCN-2019-NM B999.0042

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

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

CERTIFICATE OF COVERAGE

The Guardian
10 Hudson Yards
New York, New York 10001

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

Group Policy No.	Certificate No.	Effective Date
Issued To		

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

The Guardian Life Insurance Company of America

Michael Prestileo, Senior Vice President

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

TABLE OF CONTENTS

TABLE OF CONTENTS (CONT.)

All Options

COMPLAINT NOTICE

This notice is to advise you that should any complaints arise regarding this insurance you may contact the Guardian at the following address or phone number:

The Guardian Sales Office
555 Montgomery Street, Suite 1600
San Francisco, California 94111
Telephone: (415) 788-4440
(800) 832-9555
Fax: (415) 788-4412

If you feel your complaints have not been resolved after contacting the Guardian you may contact the California Department of Insurance at the following address or phone number:

Department of Insurance
300 South Spring St.
Los Angeles, CA 90013

Consumer Hotline: 1-800-927-4357
Website: www.insurance.ca.gov/01-consumers/

CGP-3-CADISC-91 B120.0090

GENERAL PROVISIONS

As used in this booklet:

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

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

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

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

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

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

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

Limitation of Authority

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

CGP-3-R-LOA-90 B160.0004

Incontestability

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

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

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

CGP-3-R-INCY-96 B160.0061

All Options

Examination and Autopsy

We have the right to have a *doctor* of our choice examine the person for whom a claim is being made under this *plan* as often as we feel necessary. And we have the right to have an autopsy performed in the case of death, where allowed by law. We'll pay for all such examinations and autopsies.

CGP-3-R-EA-90 B160.0006

All Options

Accident and Health Claims Provisions

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

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

Proof of Loss We'll furnish you with forms for filing proof of loss within 15 days of receipt of notice. But if we don't furnish the forms on time, we'll accept a written description and adequate documentation of the *injury* or *sickness* that is the basis of the claim as proof of loss. You must detail the nature and extent of the loss for which the claim is being made. You must send us written proof within 90 days of the loss.

If this plan provides weekly loss-of-time insurance, you must send us written proof of loss within 90 days of the end of each period for which we're liable. If this plan provides long term disability income insurance, you must send us written proof of loss within 90 days of the date we request it. For any other loss, you must send us written proof within 90 days of the loss.

Late Notice of Proof We won't void or reduce your claim if you can't send us notice and proof of loss within the required time. But you must send us notice and proof as soon as reasonably possible.

Payment of Benefits We'll pay benefits for loss of income once every 30 days for as long as we're liable, provided you submit periodic written proof of loss as stated above. We'll pay all other *accident and health* benefits to which you're entitled as soon as we receive written proof of loss.

We pay all *accident and health* benefits to you, if you're living. If you're not living, we have the right to pay all *accident and health* benefits, except dismemberment benefits, to one of the following: (a) your estate; (b) your spouse; (c) your parents; (d) your children; (e) your brothers and sisters; and (f) any unpaid provider of health care services. See "Your Accidental Death and Dismemberment Benefits" for how dismemberment benefits are paid.

When you file proof of loss, you may direct us, in writing, to pay health care benefits to the recognized provider of health care who provided the covered service for which benefits became payable. We may honor such direction at our option. But we can't tell you that a particular provider must provide such care. And you may not assign your right to take legal action under this *plan* to such provider.

Limitations of Actions You can't bring a legal action against this *plan* until 60 days from the date you file proof of loss. And you can't bring legal action against this *plan* after three years from the date you file proof of loss.

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

CGP-3-R-AHC-90 B160.0014

ELIGIBILITY FOR LIFE AND DISMEMBERMENT COVERAGES

B264.0003

All Options

Employee Coverage

Eligible Employees

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

Other Conditions

You must:

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

(b) be regularly working at least the number of hours in the normal work week set by your *employer* (but not less than 30 hours per week), at:

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

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

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

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

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

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

Family Status Change

You may request a change to your Term Life Insurance coverage if you have experienced a Family Status Change.

A Family Status Change includes one or more of the following:

- Marriage or divorce;
- Death of a Spouse or child;
- Birth or adoption of a child;

- Your Spouse's termination of employment or a change in Your Spouse's employment that results in the loss of group coverage.

The term "marriage" may also refer to civil unions and domestic partnerships, as recognized by the jurisdiction in which You reside.

If a change in Family Status occurs, You may request an increase to Your Term Life Insurance amount or the addition of Employee term life for which You were not previously insured. You may also request an increase or the addition of dependent Spouse or dependent child Term Life Insurance for your living eligible dependents. You must provide proof of the Family Status Change and request the change to Your Term Life Insurance in writing within 31 days after the date of the Family Status Change as described below.

Proof Of Insurability is not required for the change to Term Life Insurance due to Family Status Change as long as the change to Your Term Life Insurance does not exceed the Proof of Insurability requirements as shown in the Schedule of Benefits.

CGP-3-EC-90-1.0 B264.2490-R

All Options

When Your Coverage Starts

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

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

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

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

CGP-3-EC-90-2.0 B264.3214

All Options

Delayed Effective Date For Employee Optional Life Coverage

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

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

CGP-3-DEF-97 B270.0384

All Options

When Your Coverage Ends

Your coverage ends on the date your active *full-time* service ends for any reason, except as noted below under "Coverage During Temporary Layoff or Leave of Absence". Such reasons include disability, death, retirement and the end of employment.

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

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

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

Coverage During Temporary Layoff or Leave of Absence

If your active *full-time* service ends because you are laid off or on an employer approved leave of absence, your insurance may be continued, 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) three 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 terms of this *plan.*

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

CGP-3-EC-90-3.0 B264.1384

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

All Options

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

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

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

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

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

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

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

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

CGP-3-EC-90-3.0 B264.2455

Dependent Life and Accidental Death and Dismemberment Coverage

All Options

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

Dependent Coverage

All Options

Eligible Dependents For Optional Dependent Life Benefits

Your *eligible dependents* are: your legal spouse who is under age 70; and your unmarried dependent children, until they reach age 26 and your unmarried dependent children, from age 26 until they reach age 26, who are enrolled as full-time students at accredited schools.

CGP-3-DEP-90-3.0 B264.2663

All Options

Adopted Children And Step-Children

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

Dependents Not Eligible

We exclude any dependent who is on active duty in any armed force.

CGP-3-DEP-90-3.1 B264.0588

All Options

Handicapped Children

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

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

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

The child's coverage ends when yours does.

CGP-3-DEP-90-4.0 B264.0541

All Options

Proof Of Insurability

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

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

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

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

All Options

When Dependent Coverage Starts

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

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

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

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

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

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

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

CGP-3-DEP-90-6.0 B264.1119

All Options

Exception

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

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

All Options

When Dependent Coverage Ends

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

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

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

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

CGP-3-DEP-90-9.0 B200.0792

CERTIFICATE AMENDMENT

Effective June 1, 2012, this rider amends the dependent coverage provisions as follows:

Your domestic partner will be eligible for coverage under this plan subject to all of the terms of this plan and the limitations below. "Domestic partner" means an adult who has chosen to share his or her life with you in an intimate and committed relationship of mutual caring.

To qualify for such coverage, you and your domestic partner must be either:

(a) registered domestic partners; or

(b) non-registered domestic partners.

As used here:

"Registered domestic partners" means an employee and his or her domestic partner who: (a) have filed a Declaration of Domestic Partnership with the California Secretary of State; (b) were registered as a domestic partner in the registry for those partnerships; and (c) were issued a copy of the registered form and a Certificate of Registered Domestic Partnership.

"Non-registered domestic partners" means an employee and his or her domestic partner who:

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

- are financially interdependent which must be demonstrated by at least four of the following:

  a. ownership of a joint bank account;

  b. ownership of a joint credit account;

  c. evidence of a joint mortgage or lease;

  d. evidence of joint obligation on a loan;

  e. joint ownership of a residence;

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

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

  h. granting each other durable powers of attorney;

  i. granting each other health care powers of attorney;

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

  k. evidence of other joint financial responsibility.

Your registered domestic partner, or non-registered domestic partner, will be eligible for dependent optional life coverage under this plan.

To cover your non-registered domestic partner, you must complete a "Declaration of Domestic Partnership" attesting to the relationship and forward it to us.

A registered or non-registered domestic partner's dependent children will be eligible for coverage under this plan on the same basis as if the children were your dependent children.

Coverage for a registered domestic partner and his or her dependent children ends when the domestic partnership is dissolved as provided under California law.

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

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

The Guardian Life Insurance Company of America

Michael Prestileo, Senior Vice President

All Options

GROUP TERM LIFE INSURANCE SCHEDULE

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

All Options

Employee Basic Term Life Insurance

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

Option C

Your Basic Term Life Insurance Amount An amount equal to 200% of your annual earnings, rounded to the next higher $1,000.00, if not already a multiple thereof, to a maximum of $1,000,000.00, but not less than $10,000.00.

CGP-3-R-SCH-90 B265.0629

Option I

Your Basic Term Life Insurance Amount An amount equal to 100% of your annual earnings, rounded to the next higher $1,000.00, if not already a multiple thereof, to a maximum of $50,000.00, but not less than $10,000.00.

CGP-3-R-SCH-90 B265.0629

All Options

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

CGP-3-R-SCH-90 B265.0012

All Options

Earnings Definition

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

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

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

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

All Options

Reduction of Basic Life Insurance Amount Based on Age

If an employee is less than age 70 when his or her insurance under this plan starts, his or her insurance amount is reduced, on the date he or she reaches age 70, by 33% of the amount which otherwise applies to his or her classification and/or option. But in no case will such reduced amount be less than $1,000.00.

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

If an employee is less than age 75 when his or her insurance under this plan starts, the employee's basic life insurance amount is reduced, when he or she reaches age 75, by 50% of the amount which otherwise applies to his or her classification and/or option. But in no case will such reduced amount be less than $1,000.00.

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

CGP-3-R-SCH-90 B265.0483

All Options

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

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

Option C

Your Basic AD&D Insurance Amount

An amount equal to 200% of your annual earnings, rounded to the next higher $1,000.00, if not already a multiple thereof, to a maximum of $1,000,000.00, but not less than $10,000.00.

CGP-3-R-SCH-90 B265.0635

Option I

Your Basic AD&D Insurance Amount

An amount equal to 100% of your annual earnings, rounded to the next higher $1,000.00, if not already a multiple thereof, to a maximum of $50,000.00, but not less than $10,000.00.

CGP-3-R-SCH-90 B265.0635

All Options

Redetermination

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

CGP-3-R-SCH-90 B265.0038

All Options

Earnings Definition

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

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

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

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

All Options

Reduction of Basic AD&D Amount Based on Age

If an employee is less than age 70 when his or her insurance under this plan starts, his or her insurance amount is reduced, on the date he or she reaches age 70, by 33% of the amount which otherwise applies to his or her classification and/or option. But in no case will such reduced amount be less than $1,000.00.

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

If an employee is less than age 75 when his or her insurance under this plan starts, the employee's insurance amount is reduced, when he or she reaches age 75, by 50% of the amount which otherwise applies to his or her classification and/or option. But in no case will such reduced amount be less than $1,000.00.

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

CGP-3-R-SCH-90 B265.0494

All Options

Employee Optional Contributory Term Life Insurance

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

All Options

Optional Life Election

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

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

All Options

Your Optional Term Life Insurance Amount

Plan A

You may elect amounts of optional term life insurance in increments of $10,000.00, but your amount may not be less than $10,000.00 and may not exceed $500,000.00.

CGP-3-R-SCH-90 B265.0063

All Options

Reduction of Optional Life Insurance Amount Based on Age

If an employee is less than age 70 when his or her insurance under this plan starts, his or her insurance amount is reduced, on the date he or she reaches age 70, by 33% of the amount which otherwise applies to his or her classification and/or option. But in no case will such reduced amount be less than $1,000.00.

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

If an employee is less than age 75 when his or her insurance under this plan starts, the employee's optional life insurance amount is reduced, when he or she reaches age 75, by 50% of the amount which otherwise applies to his or her classification and/or option. But in no case will such reduced amount be less than $1,000.00.

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

CGP-3-R-SCH-90 B265.0520

All Options

Proof of Insurability Requirements

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

We require *proof* as follows:

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

All Options

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

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

All Options

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

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

All Options

We require *proof* for amounts of optional term life insurance in excess of $200,000.00.

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

Employee Optional Contributory Term Life Insurance (Cont.)

All Options

We require *proof* for amounts of optional term life insurance in excess of $10,000.00, if an *employee*'s scheduled optional term life effective date is after he or she reaches age 65.

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

All Options

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

CGP-3-R-SCH-90 B265.0702

All Options

Voluntary Accidental Death and Dismemberment Insurance (AD&D)

All Options

Voluntary AD&D Enrollment Period

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

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

All Options

Your Voluntary AD&D Insurance Amount

Plan A

You may elect amounts of voluntary AD&D insurance in increments of $10,000.00, but your amount may not be less than $10,000.00 and may not exceed $500,000.00.

CGP-3-R-SCH-90 B265.1285

All Options

Reduction of Voluntary AD&D Amount Based on Age

If an employee is less than age 70 when his or her insurance under this plan starts, his or her insurance amount is reduced, on the date he or she reaches age 70, by 33% of the amount which otherwise applies to his or her classification and/or option. But in no case will such reduced amount be less than $1,000.00.

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

If an employee is less than age 75 when his or her insurance under this plan starts, the employee's optional life insurance amount is reduced, when he or she reaches age 75, by 50% of the amount which otherwise applies to his or her classification and/or option. But in no case will such reduced amount be less than $1,000.00.

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

CGP-3-R-SCH-90 B265.1378

All Options

Proof of Insurability Requirements

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

We require *proof* as follows:

CGP-3-R-SCH-90 B265.2534

All Options

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

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

All Options

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

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

All Options

Dependent Optional Term Life Insurance

Dependent Optional Life Election

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

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

All Options

Your Optional Dependent Spouse Term Life Insurance Amount

Plan A

You may elect amounts of optional dependent spouse term life insurance, up to 50% of the employee's optional term life amount, in increments of $5,000.00, but the amount may not be less than $5,000.00 and may not exceed $250,000.00.

CGP-3-R-SCH-90 B265.4299

All Options

Your Optional Dependent Child Insurance Amount

Plan A

The employee may elect amounts of optional dependent child term life insurance, up to 10% of the employee's optional term life amount, in increments of $1,000.00, but the amount may not be less than $1,000.00 and may not exceed $10,000.00.

GP-1-SI B265.4220

All Options

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

CGP-3-R-SCH-90 B265.4301

All Options

In no event may the insurance amount of a dependent child exceed 10% of the insurance amount of an employee.

CGP-3-R-SCH-90 B265.4303

All Options

Proof of Insurability Requirements

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

We require proof as follows:

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

All Options

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

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

All Options

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

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

All Options

We require proof for any amount of dependent optional term life insurance in excess of $ 50,000.00 with respect to your dependent spouse.

CGP-3-R-SCH-90 B265.0542

All Options

We require proof for any amount of dependent optional term life insurance in excess of $5,000.00 with respect to your dependent spouse, if your dependent spouse's scheduled dependent optional term life effective date is after he or she reaches age 65.

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

All Options

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

CGP-3-SI B265.2526

All Options

Dependent Voluntary AD&D Election

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

CGP-3-SI B265.4172

All Options

Dependent Spouse Voluntary AD&D Insurance Amount

Plan A

An amount of voluntary dependent spouse term AD&D Insurance, as elected by you, up to 50% of your amount of voluntary term AD&D insurance, in increments of $5,000.00, but the amount may not be less than $5,000.00 and may not exceed $250,000.00.

CGP-3-R-SCH-90 B265.4310

All Options

Dependent Child Voluntary AD&D Insurance Amount

Plan A

Child's Age At Death	Benefit Amount
At least 14 days but less than 6 months	An amount of voluntary dependent child term AD&D Insurance, as elected by the employee, up to 10% of the employee's voluntary term AD&D insurance, in increments of $1,000.00, but the amount may not be less than $1,000.00 and may not exceed $10,000.00.
At least 6 months but less than 26 years	An amount of voluntary dependent child term AD&D Insurance, as elected by the employee, up to 10% of the employee's voluntary term AD&D insurance, in increments of $1,000.00, but the amount may not be less than $1,000.00 and may not exceed $10,000.00.
At least 26 years but less than 26 years if a full-time student	An amount of voluntary dependent child term AD&D Insurance, as elected by the employee, up to 10% of the employee's voluntary term AD&D insurance, in increments of $1,000.00, but the amount may not be less than $1,000.00 and may not exceed $10,000.00.

All Options

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

All Options

In no event may the insurance amount of a dependent child exceed 10% of the insurance amount of an employee.

CGP-3-R-SCH-90 B265.4307

LIFE INSURANCE

B270.0070

All Options

Your Group Term Life Insurance

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

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

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

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

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

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

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

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

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

CGP-3-R-LB-90 B270.0113

Portability Privilege

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

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

Portability Of Basic Group Term Life Insurance You may elect to continue all or part of your employee Basic group term life insurance, by choosing a portable certificate of coverage, subject to the following terms.

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

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

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

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

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

The premium for the portable certificate of coverage will be based on: (a) your rate class under this plan; and (b) your age bracket as shown in the Basic Life Portability Coverage Premium Notice.

How To Port To get a portable certificate of coverage, you must: (a) apply to us in writing: and (b) pay the required premium. You have 31 days from the date your coverage under this plan ends to do this. We require proof of insurability satisfactory to us.

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

All Options

Information About Conversion and Portability

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

CGP-3-R-LPN-95 B270.0326

All Options

Your Optional Group Term Life Insurance

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

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

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

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

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

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

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

Assigning Your Life Insurance

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

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

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

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

Payment to a Minor or Incompetent

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

Payment of Funeral or Last Illness Expense

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

Settlement Option

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

CGP-3-R-EOPT-96 B273.0353

All Options

Portability Privilege

Applicability

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

Important Restriction

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

Portability Of Optional Group Term Life Insurance

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

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

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

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

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

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

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

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

If You Die While Insured

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

The Portable Certificate Of Coverage

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

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

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

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

CGP-3-R-LP-00 B273.0732

All Options

Information About Conversion and Portability

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

CGP-3-R-LPN-95 B270.0326

All Options

THE FOLLOWING PROVISION APPLIES TO YOUR BASIC TERM LIFE INSURANCE:

B275.0076

All Options

Converting This Group Term Life Insurance

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

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

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

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

If The Group Plan Ends or Group Life Insurance Is Dropped

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

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

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

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

The Converted Policy

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

Interim Term Insurance

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

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

How and When to Convert

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

Death During the Conversion Period

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

Notice of Conversion Right

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

This notice should be given at least 15 days before the end of the 31 day period allowed for conversion as described in "How and When to Convert." If the notice is not given at least 15 days before the end of such period, you will have an additional period of 25 days from the date notice is given to apply for the converted policy and pay the required premium. But, in no event shall the additional period extend more than 60 days beyond the 31 day period allowed for conversion as described above.

CGP-3-R-LCONV-99-CA B275.0217

All Options

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

B275.0077

All Options

Converting This Group Term Life Insurance

If Employment or Eligibility Ends

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

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

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

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

If The Group Plan Ends or Group Life Insurance Is Dropped

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

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

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

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

The Converted Policy

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

Interim Term Insurance

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

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

How and When to Convert

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

Death During the Conversion Period

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

Notice of Conversion Right

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

This notice should be given at least 15 days before the end of the 31 day period allowed for conversion as described in "How and When to Convert." If the notice is not given at least 15 days before the end of such period, you will have an additional period of 25 days from the date notice is given to apply for the converted policy and pay the required premium. But, in no event shall the additional period extend more than 60 days beyond the 31 day period allowed for conversion as described above.

CGP-3-R-LCONV-99-CA B275.0218

All Options

Your Accelerated Life Benefit

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

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

Accelerated Life Benefit

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

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

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

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

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

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

Maximum Benefit Amount

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

Discount

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

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

Processing Fee

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

Payment of An Accelerated Life Benefit

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

How And When To Apply

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

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

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

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

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

If You Have Assigned Your Group Term Life Insurance

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

CGP-3-R-EALB-95 B275.0021

All Options

If You Are Incompetent

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

Your Remaining Group Term Life Insurance

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

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

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

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

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

Restrictions

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

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

CGP-3-EALB-17-IL B270.0322

Your Accelerated Life Benefit

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

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

Accelerated Life Benefit

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

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

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

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

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

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

Maximum Benefit Amount

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

Discount

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

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

Processing Fee

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

Payment of An Accelerated Life Benefit

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

How And When To Apply

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

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

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

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

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

If You Have Assigned Your Group Term Life Insurance

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

CGP-3-R-EALB-95 B275.0027

All Options

If You Are Incompetent

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

Your Remaining Group Term Life Insurance

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

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

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

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

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

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

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

All Options

Your Extended Life Benefit With Waiver Of Premium

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

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

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

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

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

How And When To Apply

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

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

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

(b) remain totally disabled for 09 continuous months.

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

Continued Eligibility For Extended Life Benefit

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

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

Until You've Been Approved For This Extended Life Benefit

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

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

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

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

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

When This Extension Begins

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

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

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

When This Extension Ends

Your extension will end on the earliest of:

(a) the date you are no longer disabled;

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

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

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

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

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

If You Die While Covered By This Extension

If you die while covered by this extension we'll pay your beneficiary the amount for which you were covered as of your last day of active full-time work, subject to all reductions which would have applied had you stayed an active employee. The benefit amount is also subject to reduction which applies at retirement. We will use your Social Security Normal Retirement Age, as defined in the 1983 amendment to the Social Security Act, to determine when to apply the retirement reduction to your extended life benefit.

Proof Of Death

We'll pay as soon as we receive

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

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

Your Extended Life Benefit With Waiver Of Premium

Important Notice

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

If You Are Disabled

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

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

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

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

How And When To Apply

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

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

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

(b) remain totally disabled for 09 continuous months.

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

Continued Eligibility For Extended Life Benefit

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

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

Until You've Been Approved For This Extended Life Benefit

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

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

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

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

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

When This Extension Begins

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

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

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

When This Extension Ends

Your extension will end on the earliest of:

(a) the date you are no longer disabled;

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

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

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

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

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

If You Die While Covered By This Extension

If you die while covered by this extension we'll pay your beneficiary the amount for which you were covered as of your last day of active full-time work, subject to all reductions which would have applied had you stayed an active employee. The benefit amount is also subject to reduction which applies at retirement. We will use your Social Security Normal Retirement Age, as defined in the 1983 amendment to the Social Security Act, to determine when to apply the retirement reduction to your extended life benefit.

Proof Of Death

We'll pay as soon as we receive

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

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

Your Dependent Spouse and Child Optional Term Life Insurance

The Benefit

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

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

Suicide Exclusion

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

Your Dependent Spouse and Child Optional Term Life Insurance (Cont.)

Seatbelt and Airbag Benefits

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

Payment to a Minor or Incompetent

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

CGP-3-R-DOPT-96 B293.0132

All Options

Converting This Dependent Term Life Insurance

If Your Group Life Insurance Ends or You Stop Being Eligible

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

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

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

If This Plan Ends or Life Insurance is Dropped

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

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

If a Dependent Stops Being Eligible

A dependent's term life insurance ends when he or she stops being an eligible dependent as defined by this plan. If a dependent stops being eligible, that dependent can convert all or part of his or her insurance.

The Converted Policy

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

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

Write to us for details.

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

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

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

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

The notice should be given at least 15 days before the end of the 31 day period allowed for conversion as described in "How and When to Convert." If the notice is not given at least 15 days before the end of such period, the dependent will have an additional period of 25 days from the date notice is given to apply for the converted policy and pay the required premium. But, in no event shall the additional period extend more than 60 days beyond the 31 day period allowed for conversion as described above.

All Options

Your Basic Accidental Death And Dismemberment Benefits

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

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

ACCIDENTAL DEATH AND DISMEMBERMENT

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

For covered multiple losses due to the same accident, we will pay 100% of the Insurance Amount. We won't pay more than 100% of the Insurance Amount for all losses due to the same accident.

Loss of:

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

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

Payment Of Benefits

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

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

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

CGP-3-R-ADCL1-00 B310.1138

All Options

Exclusions

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

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

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

All Options

Your Voluntary Accidental Death And Dismemberment Benefits

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

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

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

Covered Losses Benefits will be paid according to the plan you have elected, only for losses identified in the following table. The Insurance Amount is shown in the Schedule.

ACCIDENTAL DEATH AND DISMEMBERMENT

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

For covered multiple losses due to the same accident, we will pay 100% of the Insurance Amount. We won't pay more than 100% of the Insurance Amount for all losses due to the same accident.

Loss of:

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

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

Payment Of Benefits

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

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

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

The Beneficiary

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

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

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

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

All Options

Exclusions

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

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

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

All Options

Your Dependent Voluntary Accidental Death And Dismemberment Benefits

The Benefit We'll pay the benefits described below if a covered dependent suffers an irreversible covered loss due to an accident that occurs while he or she is insured. The loss must be a direct result of the accident, independent of all other causes. And, it must occur within 365 days of the date of the accident.

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

ACCIDENTAL DEATH AND DISMEMBERMENT

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

For covered multiple losses due to the same accident, we will pay 100% of the Insurance Amount. We won't pay more than 100% of the Insurance Amount for all losses due to the same accident.

Loss of:

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

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

Payment Of Benefits

For all covered losses, we pay you, if you are living. If you are not living, and the dependent was your child, we pay your spouse. If your spouse is not living, we pay the child's living brothers and sisters in equal shares. If there are none, we pay the child's estate. If the dependent was your spouse, we pay the spouse's estate.

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

CGP-3-R-DADCL1-00 B310.1680

All Options

Exclusions

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

- by willful self-injury, suicide, or attempted suicide;
- by sickness, disease, mental infirmity, medical or surgical treatment;
- by a dependent taking part in a riot or other civil disorder; or in the commission of or attempt to commit a felony;
- by travel on any type of aircraft if the dependent is an instructor or crew member; or has any duties at all on that aircraft;
- by declared or undeclared war or act of war or armed aggression;
- while the dependent is a member of any armed force;
- while the dependent is a driver in a motor vehicle accident, if he or she does not hold a current and valid driver's license;
- by the dependent's legal intoxication; this includes, but is not limited to, the dependent's operation of a motor vehicle; or
- by the dependent's voluntary use of a controlled substance, unless: (1) it was prescribed for the dependent by a doctor; and (2) it was used as prescribed. A controlled substance is anything called a controlled substance in Title II of the Comprehensive Drug Abuse Prevention and Control Act of 1970, as amended from time to time.

CGP-3-R-DADCL2-00 B310.1542

ELIGIBILITY FOR DISABILITY COVERAGE

B329.0002

All Options

Employee Coverage

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

Other Conditions You must:

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

(b) be regularly working at least the number of hours in the normal work week set by your *employer* (but not less than 30 hours per week), at:

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

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

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

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

CGP-3-EC-90-1.0 B329.0886

All Options

When Your Coverage Starts

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

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

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

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

All Options

When Your Coverage Ends

Your short term disability coverage ends on the date your active *full-time* service ends for any reason, except as noted below under "Continuation of Coverage During Disability" and "Coverage During Temporary Layoff or Leave of Absence".

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

It ends on the date you are no longer working in the United States, or working outside of the United States for a United States based employer in a country or region approved by us.

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

Continuation of Coverage During Disability

If you are disabled, as defined by this *plan* when your active *full-time* service ends, coverage remains in force during: (a) the elimination period, subject to premium payment, if the disability is not excluded under the *plan;* and (b) the period for which benefits are payable under the *plan.*

Coverage During Temporary Layoff or Leave of Absence

If your active *full-time* service ends because you are laid off or on an *employer* approved leave of absence, your insurance may be continued, 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) three 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 terms of this *plan.*

CGP-3-EC-90-3.0 B329.0954

All Options

When Your Coverage Ends

Your long term disability coverage ends on the date your active *full-time* service ends for any reason, except as noted below under "Coverage During Temporary Layoff or Leave of Absence".

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

It ends on the date you are no longer working in the United States, or working outside of the United States for a United States based employer in a country or region approved by us.

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

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

Coverage During Temporary Layoff or Leave of Absence

If your active full-time service ends because you are laid off or on an *employer* approved leave of absence, your insurance may be continued, 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) three 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 terms of this *plan.*

CGP-3-EC-90-3.0 B329.0909

Coverage During a Temporary Leave

If your active full-time service ends because you are disabled by pregnancy, childbirth or a related medical condition you may continue your coverage for up to four months during any twelve consecutive months.

Your employer may recover from you any premium paid if: 1) you fails to return from leave after four months; and 2) your failure to return is for a reason other that one of the following: (a) your taking leave under the Moore-Brown-Roberti Family Rights Act; (b) the continuation, recurrence, or onset of a health condition that entitles you to leave is beyond your control; or (c) if your employer is a state agency, the collective bargaining agreement will govern.

CGP-3-EC-90-3.0 B329.1132

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

Important Notice

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

Continuation of Disability Coverage

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

If Your Group Insurance Would End

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

When Continuation Ends

Coverage may continue until the earliest of the following:

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

- The date on which your *Employer's Plan* is terminated or you are no longer eligible for coverage under this *Plan.*
- The end of the period for which the premium has been paid.

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

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

All Options

SHORT TERM DISABILITY HIGHLIGHTS

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

SCHEDULE OF BENEFITS

CGP-3-STD07-HL-CA B340.1063

All Options

Elimination Period

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

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

CGP-3-STD07-HL-CA B340.1065

All Options

Maximum Payment Period

For *disability* due to *injury* . . . . . 12 weeks

For *disability* due to *sickness* . . . . . 12 weeks

CGP-3-STD07-HL-CA B340.1069

All Options

Gross Weekly Benefit

60% of your *insured earnings,* rounded to the nearest $1.00, if not already a multiple thereof, limited to a maximum of $2,500.00.

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

CGP-3-STD07-HL-CA B340.1072

SHORT TERM DISABILITY INCOME INSURANCE

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

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

Benefit Provisions

How Payments Start

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

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

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

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

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

When Payments End

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

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

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

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

(d) The date you are able to perform the major duties of your *own job* on a full-time basis with *reasonable accommodation.*

(e) The date you have been outside the United States and/or Canada for more than 2 months in a 12 month period.

(f) The date he or she dies.

(g) The end of the *maximum payment period.*

(h) The date no further benefits are payable under any provision in this *plan* that limits the *maximum payment period.*

(i) The date you are no longer receiving *regular and appropriate care* from a *doctor.*

(j) The date payments end in accord with a *rehabilitation agreement.*

All Options

Maximum Payment Period

The *maximum payment period* is the longest time that benefits are paid by this *plan* for your *disability.*

For *disability* due to *injury,* the *maximum payment period* is 12 weeks.

For *disability* due to *sickness,* the *maximum payment period* is 12 weeks.

CGP-3-STD09-CA B340.1085

All Options

Recurring Disability

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

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

(b) The *disability* must recur less than two weeks after you were last entitled to benefits;

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

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

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

(f) During the time you return to *active work,* you must: (i) stay insured by this *plan;* and (ii) premium payments must be made on your behalf; and

(g) Your benefits must not have ended because you have used up the *maximum payment period.*

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

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

CGP-3-STD09-CA B340.1086

All Options

Calculation of Weekly Benefit

Your benefit is governed by the terms of the *plan* in effect on the date *disability* occurs. Any changes to this *plan* that take place: (a) while you are *disabled;* or (b) during a period of *active work* that occurs between an initial period of *disability* and a *recurring disability;* will not affect your benefit.

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

From your *gross weekly benefit,* subtract the amount of any income listed in Other Income that Affects Benefits that you receive or are entitled to receive. The result is your *weekly benefit.*

CGP-3-STD09-CA B340.1088

All Options

Redetermination

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

CGP-3-STD09-CA B340.1089

All Options

Other Income That Affects Benefits

You may receive certain other income which is payable due to the same disability for which this *plan* pays benefits. We will reduce your *gross weekly benefit* by such income to determine your *weekly benefit* from this *plan.*

- Primary (covered person) and dependents (children and/or spouse) disability benefits under: the United States Social Security Act; the Canadian Pension Plan; the Quebec Pension Plan; or any similar plan or act (e.g., Railroad Retirement Act).
- Temporary disability benefits under a workers compensation law.
- Amounts received under any other occupational disease law or similar act (e.g., the Longshoreman's and Harbor Workers' Act; or Maritime Doctrine of Maintenance, Wages and Cure).
- Disability benefits under the Jones Act.
- Disability benefits under any state compulsory/statutory benefit law (e.g., state disability income benefits).
- Disability benefits under any government retirement System (e.g., CalPERS).
- Disability benefits under your *employer's retirement plan* (e.g., private employer retirement plans).
- Third party liability payments by judgment, settlement or Otherwise (less attorney's fees).
- Retirement benefits under: (i) the United States Social Security Act; the Canadian Pension Plan; the Quebec Pension Plan; or any similar plan or act (e.g., Railroad Retirement Act); and (ii) your *employer's retirement plan* (e.g., private employer retirement plans).
- Amounts received by compromise or settlement of any claim for permitted offsets (less attorney's fees).

We reduce your *gross weekly benefit* by income shown above that you receive if it is paid for the same disability for which this *plan* pays benefits.

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

All Options

Other Income Not Subject to Deduction

We will not reduce your *gross weekly benefit* by any income you receive or are entitled to receive from the list below.

- Deferred compensation arrangements such as 401(k), 403(b) or 457 plans;
- Profit sharing plans;
- Thrift plans;
- Tax sheltered annuities;
- Stock ownership plans;
- Individual Retirement Accounts (IRA),
- Individual disability income plans;
- Credit disability insurance;
- Non qualified plans of deferred compensation;
- Pension plans for partners;
- Retirement plans of another employer not affiliated with this *plan;*
- Military pension and disability plan;
- Sick pay, salary continuation, or personal time off.

Lump Sum Payments of Other Income

Income listed in "Other Income That Affects Benefits" may be paid in a lump sum. In this case, we take the equivalent weekly rate stated in the award into account when we determine your *weekly benefit.* If no weekly rate is given, we divide the lump sum payment by the number of calendar days in the period for which it was awarded. This will determine the daily rate. Then, multiply the daily rate by seven. The result is the prorated weekly rate.

Cost of Living Freeze

You may receive a cost of living increase in income listed in "Other Income That Affects Benefits." In this case, we do not further reduce your *weekly benefit* by the amount of such increase.

Claim for Other Income

You must pursue a claim for other income benefits to which you may be entitled. If these benefits are denied, we may require you to appeal such denial if it is reasonable to believe that you have a valid claim to receive the benefits.

If you did not pursue such claim for the income benefits listed below and we have a means of reasonably estimating the amount payable, we will estimate the amount due to you and your spouse and children:

- Primary (covered person) and dependents (children and/or spouse) disability benefits under: the United States Social Security Act; the Canadian Pension Plan; the Quebec Pension Plan; or any similar plan or act (e.g., Railroad Retirement Act).
- Disability benefits under any state compulsory/statutory benefit Law (e.g., state disability income benefits).

We will take this estimated amount into account when we determine your *weekly benefit.*

If we do reduce your *gross weekly benefit* by an estimated amount, we will adjust your *weekly benefit* when we receive written proof of the amount awarded. If we underpaid you, we pay the full amount of the underpayment in a lump sum.

We offer to assist you in applying for other income benefits. Examples of the kinds of assistance we offer are: helping you fill out applications and forms; assisting you to find suitable legal counsel and providing medical and vocational data from our files to support your claims.

All Options

Adjustment of Weekly Benefit for Disability Earnings

We adjust the *weekly benefit* for *disability earnings* as follows.

We pay the greater of the amount calculated under Method 1 or Method 2.

Method 1: We reduce your *weekly benefit* by 50% of your *disability earnings.*

Method 2:

(a) Subtract your *disability earnings* from your indexed *insured earnings.*

(b) Divide the result in (a) above by your indexed *insured earnings.*

(c) Multiply the result in (b) above by your *weekly benefit.* This is the amount we pay.

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

Maximum Allowable Disability Earnings

This *plan* limits the amount of income you may earn and still be considered *disabled.*

If your *disability earnings* are 80% or more of your pre- disability earnings, payments from this plan will end. Pre-disability earnings will be adjusted for inflation using the CPI-W index.

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

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

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

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

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

(e) you being engaged in an illegal occupation; or

(f) intentional self-inflicted injuries.

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

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

(2) which starts before you are insured by this *plan.*

Services

Rehabilitation and Case Management We will review your *disability* to see if certain services are likely to help you return to work in your usual occupation. If needed, we may ask for more medical or vocational information.

When our review is complete, we may offer you a *rehabilitation program.*

The *rehabilitation program* will start when a written *rehabilitation agreement* is signed by: (1) you; (2) us; and (3) your *employer,* if needed. The program may include, but is not limited to:

(a) vocational evaluation of your work potential;

(b) coordination and transition planning with an employer for your return to work;

(c) consulting with your *doctor* on your return to work and need for accommodations;

(d) training in job seeking skills and resume preparation;

(e) retraining; and

(f) assistance with child care expenses you incur in order to participate in a *rehabilitation program.* (See the Dependent Care Expenses section of this *plan.)*

The extent of our role in this program will be determined by the written agreement.

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

We stop paying the enhanced benefit on the earliest of:

(a) The date your benefits from this *plan* end;

(b) The date you violate the terms of the *rehabilitation agreement;*

(c) The date you end the *rehabilitation program;* and

(d) The date the *rehabilitation agreement* ends.

Dependent Care Expenses

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

(a) you incur expense to provide care for a qualified dependent;

(b) the care is provided by a licensed provider other than a family member.

A qualified dependent is: (a) dependent upon you for main support and maintenance; and (b) under the age of fourteen and your: (i) biological child; (ii) lawfully adopted child; (iii) stepchild; or (iv) any other child who is living with you in a regular parent-child relationship.

The dependent care expense benefit will be the lesser of: (a) $100 per week per qualified dependent; not to exceed $300 per week for all qualified dependents combined; and (b) the actual weekly day care expense incurred by you.

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

CGP-3-STD09-CA B340.1374

All Options

Worksite Modification Benefit

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

CGP-3-STD09-CA B340.1111

All Options

Claim Provisions

Authority

We have the responsibility to fairly, thoroughly, objectively and timely investigate, evaluate and determine your eligibility for benefits under the *plan.* We will:

(1) 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 proofs of loss.

(2) consider and interpret the terms of this *plan* 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 *plan* and applicable California state law.

(3) if a claim is approved, review the determination as often as is reasonably necessary to determine continued eligibility for benefits.

(4) 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.

If a claim is wholly or partially denied, the claimant may appeal the decision. Guardian will conduct a full and fair review of an appeal. The review will take 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. If a claim is not appealed, then the decision will be Guardian's final decision.

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, or as soon thereafter as is reasonably possible. This notice should include your name and plan number.

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

Claims Forms We, upon receipt of a written notice of claim, will furnish to you such forms as are usually furnished by us for filing proofs of loss. If such forms are not furnished within 15 days after the giving of such notice, you shall be deemed to have complied with the requirements of the *plan* as to proof of loss upon submitting, within the time fixed in the *plan* for filing proofs of loss, written proof covering the occurrence, the character and the extent of the loss for which the claim is made.

Proof of Loss Written proof of loss must be furnished to us, in case of claim for loss for which the *plan* provides any periodic payment contingent upon continuing loss, within 90 days after the termination of the period for which we are liable, and in case of claim for any other loss, within 90 days after the date of such loss. Failure to furnish such proof within the time required shall not invalidate nor reduce any claim if it was not reasonably possible to give proof within such time, provided such proof is furnished as soon as reasonably possible and in no event, except in the absence of your legal capacity, later than one year from the time proof is otherwise required.

Proof of loss and other claim data should be submitted to:
The Guardian Life Insurance Company of America
Group Short Term Disability Claims Department
P.O. 14331
Lexington, KY 40512

Authorization Required You must provide us with written, unaltered authorizations to obtain medical, financial, vocational, occupational, and governmental information required to determine our liability under this *plan.* You must provide us with such authorizations as often as we may require, in order that they remain current. Failure to provide such authorizations may delay, suspend or terminate your benefits.

Examinations We, at our own expense, shall have the right and opportunity to examine you when and as often as it may reasonably require during the pendency of a claim hereunder.

Ongoing Proof of Loss

To continue to receive payments from this *plan,* you must give us current proof of loss as often as we may reasonably require. Ongoing proof of loss must be provided to us within 90 days of the date we request it. Failure to furnish such proof within the time period required shall not invalidate or reduce any claim provided such items are sent as soon as reasonably possible.

Payment of Benefits

We pay benefits to you, if you are legally competent. If you are not, we pay benefits to your legal representative. Benefits are paid in US dollars.

We pay benefits biweekly at the end of the period for which they are payable.

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

Benefits to which you are entitled may remain unpaid at your death. If any benefit is payable to your estate, or to a minor who is not otherwise competent to give a valid release, we pay the benefit, up to an amount not exceeding $1,000, to any relative by blood or connection by marriage who is considered by us to be entitled to the benefit. Any payment made in good faith pursuant to this provision shall fully discharge Guardian to the extent of such payment.

Partial Week Payment

You may be *disabled* for only part of a week. In this case, we compute your payment as 1/7th of the benefit to which you would be entitled for the full week times the number of days you are *disabled.*

Overpayment Recovery

If we overpaid you, you must repay us in full. We have the right to reduce your payment or apply any benefits payable, including the minimum payment, toward recovery of the overpayment.

Legal Actions

No action at law or in equity shall be brought to recover on the *plan* prior to the expiration of 60 days after written proof of loss has been furnished in accordance with the requirements of the *plan.* No such action shall be brought after the expiration of three years after time written proof of loss is required to be furnished.

All Options

Definitions

Active Work, Actively-At-Work or Actively Working

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

All Options

Disability or Disabled

These terms, when used alone, mean: (a)*total disability or totally disabled;* or (b)*partial or residual disability.*

Total Disability or Totally Disabled means that as a result of *sickness* or *injury* you are not able to perform with reasonable continuity the substantial and material acts necessary to pursue your usual occupation.

Substantial and material acts means the important tasks, functions and operations generally required by employers from those engaged in your usual occupation that cannot be reasonably omitted or modified.

In determining what substantial and material acts are necessary to pursue your usual occupation, we will first look at the specific duties required by the *employer* or job. If you are unable to perform one or more of these duties with reasonable continuity, we will then determine whether those duties are customarily required of other persons engaged in your usual occupation. If any specific, material duties required of you by the *employer* or job differ from the material duties customarily required of other persons engaged in your usual occupation, then we will not consider those duties in determining what substantial and material acts are necessary to pursue your usual occupation.

Usual occupation may be interpreted to mean the employment, business, trade or profession that involves the substantial and material acts of the occupation you were regularly performing for the *employer* when the disability began. Usual occupation is not necessarily limited to the specific job you performed for the *employer.*

Partial or Residual Disability means you are not *totally disabled* and that while actually working in an occupation, as a result of *sickness* or *injury,* you are unable to earn 80% or more of your pre-disability earnings. Pre-disability earnings will be adjusted for inflation using the *CPI-W* index.

All Options

Disability Earnings

The weekly income you earn from working while *disabled.* It includes salaries, wages, commissions, bonuses and any other compensation earned or accrued while working including pension, profit sharing contributions, sick pay, paid time off, holiday and vacation pay. When you have an ownership interest in the business, *disability earnings* also includes business profits, attributable to you, whether received or not. It includes any income you earn while *disabled* and return to your *employer,* partnership, or any other similar business arrangement to cover any business or overhead expenses. If you had secondary employment prior to *disability, disability earnings* will only include earnings from the secondary employment if that employment began after the beginning of your *disability.*

Doctor

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

Elimination Period The period of time you must be *disabled,* due to a covered *disability,* before this *plan's* benefits are payable. Any days during which you return to work earning more than 80% of your *insured earnings* will not count toward the *elimination period.* if you are or become eligible under any other similar group income replacement plan while you are working during the *elimination period,* you will not be entitled to benefits from this *plan.*

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

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

Gross Weekly Benefit This plan's weekly benefit before it is reduced by other income and earnings.

Injury Physical harm or damage to your body that occurs while you are insured by this plan.

All Options

Insured Earnings: Only a covered person's earnings from the *employer* will be included as *insured earnings.*

We calculate benefit amounts and limits based on the amount of the covered person's *insured earnings* as of the Redetermination date immediately prior to the start of his or her *disability.* See the "Redetermination" section of this *plan.*

For Partners and S Corporation Shareholders:

Insured earnings means the sum of the amounts listed below, divided by 52.

(a) His or her compensation as an employee or S Corporation shareholder, as reported on his or her Federal Income Tax Return, Form 1040, for the prior calendar year, less the gross total of unadjusted employee business expenses as included on the corresponding Schedule A-Itemized Deductions;

(b) His or her non-passive income (loss) from trade or business as reported on Schedule E-Part II of his or her Federal Income Tax Return, Form 1040, for the prior calendar year, less any expenses incurred and reported elsewhere on his or her Return; and

(c) His or her contributions during the prior calendar year, deposited into a: (a) cash or deferred compensation plan, or salary reduction plan, qualified under IRC Section: 401(k); 403(b); 457; or similar plan; and (b) elective employee pre-tax deferrals to a Section 125 plan or flexible spending account.

The covered person may not have been a partner or S Corporation shareholder for the entire previous calendar year. In this case, the covered person's earnings are based on the weekly average of the sum of the listed amounts, averaged for the full number of weeks that he or she was a partner or an S Corporation shareholder during such calendar year.

For Sole Proprietors:

Insured earnings means: (a) the average weekly net profit as determined from Schedule C - Part II of the covered person's Federal Income Tax Return, Form 1040, for the prior calendar year; plus (b) the covered person's average weekly contribution during the prior calendar year deposited into a: (i) cash or deferred compensation plan, or salary reduction plan, qualified under IRC Section: 401(k); 403(b); 457; or similar plan; and (ii) a Section 125 plan or flexible spending account. Weekly net profit is calculated as gross income less total expenses. The covered person may not have been a sole proprietor for the previous calendar year. In this case, we calculate average weekly net profit and average weekly contributions using the full number of weeks that he or she was a sole proprietor during such calendar year.

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

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

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

Insured earnings means the covered person's average rate of weekly earnings as figured from the 1099 form received from the *employer* for the prior calendar year, calculated as (a) minus (b), divided by 52 or the number of weeks the covered person worked for the *employer* during such calendar year, if less than 52.

(a) his or her earned income as reported on the 1099 form.

(b) business expenses, as reported on Schedule C - Part II of his or her Federal Income Tax Return, Form 1040.

Insured earnings also includes the covered person's contributions deposited into a: (a) cash or deferred compensation plan, or salary reduction plan, qualified under IRC Section: 401(k); 403(b); 457; or similar plan; and (b) elective employee pre-tax deferrals to a Section 125 plan or flexible spending account.

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

For All Other Covered Persons:

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

CGP-3-STD09-CA B340.1238

All Options

Maximum Payment Period The longest time that benefits are paid by this *plan.*

Mental Illness Means any mental disorder, regardless of cause, listed in the Diagnostic and Statistical Manual of Mental Disorders (DSM) currently in use by the American Psychiatric Association (APA). If the APA stops publishing the DSM, we have the right to use some other similar standard. A *mental illness* may be: (a) caused by; (b) contributed to by; or (c) result in; physical, biological or chemical factors or symptoms. For purposes of this *plan, mental illness* does not include: (a) irreversible dementia caused by Alzheimer's disease, stroke, trauma or viral infection; or (b) any other condition not typically treated by a psychiatrist, clinical psychologist or other qualified mental health practitioner with psychotherapy or psychotropic drugs.

Own Occupation or Usual Occupation Means the occupation: (a) you are routinely performing immediately prior to disability; (b) which is your primary source of income prior to disability; and (c) for which you are insured under this plan. Occupation includes any employment, business, trade or profession that involves the substantial and material acts of the occupation you were regularly performing for the employer when the disability began. Own occupation or usual occupation is not necessarily limited to the specific job you performed for the employer.

CGP-3-STD09-CA B340.1120

All Options

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

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

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

Rehabilitation Program A program of work or job-related training for you that we approve in writing. Its aim is to restore your wage earning abilities.

Retirement Plan A defined benefit or defined contribution plan funded wholly or in part by the *employer's* deposits for your benefit. The term does not include: (a) profit sharing plans; (b) thrift plans; (c) non-qualified deferred compensation plans; (d) individual retirement accounts; (e) tax sheltered annuities; (f) 401(k), 403(b), 457 or similar plans; or (g) stock ownership plans.

Retirement Plan **"retirement benefits"** are lump sum or periodic payments at normal or early retirement. Some *retirement plans* make payments for disability (as defined by those plans) that start before normal retirement age. When such payments reduce the amount that would have been paid at normal retirement age, they are *retirement benefits.* When such payments do not reduce the normal retirement amount, they are **"disability benefits."**

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

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

Weekly Benefit This *plan's gross weekly benefit* reduced by other income. If you are working while *disabled,* your *weekly benefit* will be further reduced based on the amount of your *disability earnings.*

All Options

LONG TERM DISABILITY HIGHLIGHTS

SCHEDULE OF BENEFITS

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

CGP-3-LTD07-HL-CA B380.3325

All Options

Own Occupation Period

The first 24 months of benefit payments from this plan.

CGP-3-LTD07-HL-CA B380.3326

All Options

Elimination Period

For disability due to injury . . . . . 90 days

For disability due to sickness . . . . . 90 days

CGP-3-LTD07-HL-CA B380.3328

All Options

Maximum Payment Period

See the following table:

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

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

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

Age When	Maximum

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

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

CGP-3-LTD07-HL-CA B380.3331

All Options

Maximum Monthly Benefit

60% of your *insured earnings,* rounded to the nearest $1.00, if not already a multiple thereof, limited to a maximum of $10,000.00.

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

CGP-3-LTD07-HL-CA B380.3338

All Options

Survivor Benefit

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

CGP-3-LTD07-HL-CA B380.3389

LONG TERM DISABILITY INCOME INSURANCE

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

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

Benefit Provisions

How Payments Start

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

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

(b) You must provide proof of loss, as described in this *plan's* Claim Provisions section. Benefits accrue as of the first day following the end of the *elimination period,* subject to all *plan* terms.

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

Waiver of Premium

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

When Payments End

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

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

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

(c) The date you earn the maximum earnings allowed while *disabled* under this *plan.*

(d) The date you have been outside the United States and/or Canada for more than 6 months in a 12 month period.

(e) The date you die.

(f) The end of the *maximum payment period.*

(g) The date no further benefits are payable under any provision in this *plan* that limits the *maximum payment period.*

(h) The date payments end in accord with a rehabilitation agreement. However, this date will not apply if the rehabilitation agreement is not fulfilled but you remain disabled in accord with the terms of the plan and the maximum payment period has not been reached.

All Options

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

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

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

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

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

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

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

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

CGP-3-LTD09-CA B383.1638

All Options

Recurring Disability

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

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

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

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

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

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

(f) During the time you return to *active work,* you must: (i) stay insured by this *plan;* and (ii) premium payments must be made on your behalf; and

(g) Your benefits must not have ended because you have used up the *maximum payment period.* If the later *disability* is a *recurring disability,* you will not need to complete a new *elimination period.* The *recurring disability* will be subject to all the terms of the *plan* in effect on the date the earlier *disability* began.

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

CGP-3-LTD09-CA B383.1658

All Options

Calculation of Monthly Benefit: Your benefit is governed by the terms of the *plan* in effect on the date *disability* occurs. Any changes to this *plan* that take place: (a) while you are *disabled;* or (b) during a period of *active work* that occurs between an initial period of *disability* and a *recurring disability;* will not affect your benefit.

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

From your *gross monthly benefit,* subtract the amount of any income listed in Other Income That Affects Benefits that you receive or are entitled to receive. The result is your *monthly benefit.*

CGP-3-LTD09-CA B383.1659

All Options

Redetermination: This *plan* redetermines *insured earnings* for each covered person on the date a change in a covered person's *insured earnings* occurs.

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

CGP-3-LTD09-CA B383.1661

All Options

Other Income That Affects Benefits You may receive certain other income which is payable due to the same disability for which this *plan* pays benefits.

- Primary (covered person) and dependents (children and/or spouse) disability benefits under: the United States Social Security Act; the Canadian Pension Plan; the Quebec Pension Plan; or any similar plan or Act (e.g., Railroad Retirement Act).
- Temporary disability benefits under a workers compensation law.
- Amounts received under any other occupational disease law or similar act (e.g., the Longshoreman's and Harbor Workers' Act; or Maritime Doctrine of Maintenance, Wages and Cure).
- Disability benefits under the Jones Act.
- Disability benefits under any state compulsory/statutory benefit law (e.g., state disability income benefits).
- Disability benefits under any government retirement System (e.g., CalPERS).
- Disability benefits under your *employer's retirement plan* (e.g., private employer retirement plans).

- Third party liability payments by judgment, settlement or Otherwise (less attorney's fees).
- Retirement benefits under: (i) the United States Social Security Act; the Canadian Pension Plan; the Quebec Pension Plan; or any similar plan or act (e.g., Railroad Retirement Act); and (ii) your *employer's retirement plan* (e.g., private employer retirement plans).
- Amounts received by compromise or settlement of any claim for permitted offsets (less attorney's fees).

We reduce your *gross monthly benefit* by income shown above that you receive if it is paid for the same disability for which this *plan* pays benefits.

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

All Options

Other Income Not Subject to Deduction

We will not reduce your *gross monthly benefit* by any income you receive or are entitled to receive from the list below.

- Deferred compensation arrangements such as 401(k), 403(b) or 457 plans;
- Profit sharing plans;
- Thrift plans;
- Tax sheltered annuities;
- Stock ownership plans;
- Individual Retirement Accounts (IRA),
- Individual disability income plans;
- Credit disability insurance;
- Non qualified plans of deferred compensation;
- Pension plans for partners;
- Retirement plans of another employer not affiliated with this *plan;*
- Military pension and disability plans;
- Sick pay, salary continuation or personal time off.

Lump Sum Payments of Other Income

Income listed in "Other Income That Affects Benefits" may be paid in a lump sum. In this case, we take the equivalent monthly rate stated in the award into account when we determine your *monthly benefit.* a If no monthly rate is given, we pro-rate the lump sum over the lesser of: (a) 60 months; or (b) the expected remaining number of months for which you would be entitled to benefits from this *plan,* based on the proof of loss submitted to us.

Cost of Living Freeze

You may receive a cost of living increase in income listed in "Other Income That Affects Benefits". In this case, we do not further reduce your monthly benefit by the amount of such increase.

Claim for Other Income

You must pursue a claim for other income benefits to which you may be entitled. If these benefits are denied, we may require you to appeal such denial if it is reasonable to believe that you have a valid claim to receive the benefits.

During the first 24 months in which this plan pays benefits, if you did not pursue such claim for the income benefits listed below and we have a means of reasonably estimating the amount payable, we will estimate the amount due to you and your spouse and children:

Primary (covered person) and dependents (children and/or spouse) disability benefits under: the United States Social Security Act; the Canadian Pension Plan; the Quebec Pension Plan; or any similar plan or Act (e.g., Railroad Retirement Act).

- Disability benefits under any state compulsory/statutory benefit Law (e.g., state disability income benefits).

We will take this estimated amount into account when we determine your *monthly benefit.*

If we do reduce your gross monthly benefit by an estimated amount, we will adjust your monthly benefit when we receive written proof of the amount awarded. If we underpaid you, we pay the full amount of the underpayment in a lump sum.

We offer to assist you in applying for other income benefits. Examples of the kinds of assistance we offer are: helping you fill out applications and forms; assisting you to find suitable legal counsel and providing medical and vocational data from our files to support your claims.

All Options

Adjustment of Monthly Benefit for Disability Earnings:

We adjust the *monthly benefit* for *disability earnings* as follows.

For each of the first 12 months of payments, following the date you first have *disability earnings,* add your *gross monthly benefit* and your *disability earnings.*

(a) If the sum is not more than 100% of your indexed *insured earnings,* we do not reduce your *monthly benefit.*

(b) If the sum is more than 100% of your indexed *insured earnings,* we reduce your *monthly benefit* by the amount over 100% of your indexed *insured earnings.*

For each month thereafter, we pay the greater of the amount calculated under Method 1 or Method 2.

Method 1:

(a) If your *disability earnings* are less than 20% of your indexed *insured earnings,* we do not reduce your *monthly benefit.*

(b) If your *disability earnings* are 20% or more of your indexed *insured earnings,* we reduce your *monthly benefit* by 50% of your *disability earnings.*

Method 2:

(a) Subtract your *disability earnings* from your indexed *insured earnings.*

(b) Divide the result in (a) above by your indexed *insured earnings.*

(c) Multiply the result in (b) above by your *monthly benefit.* This is the amount we pay.

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

Maximum Allowable Disability Earnings:

This *plan* limits the amount of income you may earn and still be considered *disabled.*

If your *disability earnings* are 80% or more of your pre-disability earnings, payments from this *plan* will end for the claimed disability. Pre-disability earnings will be adjusted for inflation using the CPI-W index.

All Options

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

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

The indexing factor is the *CPI-W* from the prior December.

Minimum Payment: The minimum monthly payment for *disability* under this *plan* is $50.00.

CGP-3-LTD09-CA B383.2093

All Options

Limitations and Exclusions

Disabilities with a Limited Maximum Payment Period

We limit the *maximum payment period,* if you are *disabled* due to: (a) a *mental illness;* or (b) a substance-related disorder. However, if you have a coexistent condition, not subject to the limitations in this section, which is *disabling* in and of itself, we will not limit benefits as described below. In addition, we will not limit benefits for a substance-related disorder if the *disability* is caused by drugs administered on the advice of a doctor.

The *maximum payment period* for all periods of *disability* due to: (a) a *mental illness;* or (b) a substance-related disorder is 24 months. This is a combined maximum for all such conditions and all periods of *disability.*

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

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

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

CGP-3-LTD09-CA B383.1677

All Options

Pre-Existing Conditions

You are not covered for a *disability* caused or substantially contributed to by a pre-existing condition or medical or surgical treatment of a pre-existing condition.

You have a pre-existing condition if:

(a) You received medical treatment, care or services for a diagnosed condition or took prescribed medication for a diagnosed condition in the three months immediately prior to the effective date of your insurance under this *plan;* or

You suffered from a physical, or mental condition, whether diagnosed or undiagnosed, which was misrepresented or not disclosed in your Application (i) for which you received a *doctor's* advice or treatment within three months before the effective date of your insurance under this *plan,* or (ii) which caused symptoms within three months before the effective date of your insurance under this *plan* for which a prudent person would usually seek medical advice or treatment; and

(b) the *disability* caused or substantially contributed to by the condition begins in the first 12 months after the effective date of your insurance under this *plan.*

CGP-3-LTD09-CA B383.1711

All Options

Prior Coverage Credit:

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

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

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

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

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

CGP-3-LTD09-CA B383.1684

All Options

Exclusions

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

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

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

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

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

(e) you being engaged in an illegal occupation; or

(f) intentional self-inflicted injuries.

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

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

(2) which starts before you are insured by this *plan.*

All Options

Services

Social Security Assistance: This *plan* requires all *disabled* covered persons to Pursue a claims for Social Security benefits. (See the "Claims for Other Income" section of this *plan.)* We may offer to assist you in applying for them. Receiving Social Security benefits will protect your earnings record for retirement and enable you to qualify for Medicare coverage after 24 months.

Services we can provide include:

(a) Help in completing your application for such benefits, and any related forms;

(b) Assistance finding suitable legal counsel; and

(c) Copies of medical and vocational data needed to file your claim.

We may also provide these and other services if your benefits are under review for possible termination by the Social Security Administration.

You must pursue a claims for all income benefits for which you may be eligible, whether or not you use our help. Using our help does not cancel your duties shown in the "Claim for Other Income" section of this *plan.*

Rehabilitation and Case Management: We will review your *disability* to see if certain services are likely to help him or her return to work in your *usual occupation.* If needed, we may ask for more medical or vocational information.

When our review is complete, we may offer you a *rehabilitation program.*

The *rehabilitation program* will start when a written *rehabilitation agreement* is signed by: (1) you; (2) us; and (3) your *employer,* if needed. The program may include, but is not limited to:

(a) vocational evaluation of your work potential;

(b) coordination and transition planning with an employer for your return to work;

(c) consulting with your *doctor* on your return to work and need for accommodations;

(d) training in job seeking skills and resume preparation;

(e) retraining; and

(f) assistance with family care expenses you incur in order to participate in a *rehabilitation program.* (See the "Dependent Care Expenses" section of this *plan.)*

The extent of our role in this program will be determined by the written agreement.

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

We stop paying the enhanced benefit on the earliest of:

(a) The date your benefits from this *plan* end;

(b) The date you violate the terms of the *rehabilitation agreement;*

(c) The date you end the *rehabilitation program;* and

(d) The date the *rehabilitation agreement* ends.

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

(a) you incur expense to provide care for a qualified dependent;

(b) the care is provided by a licensed provider other than a family member.

A qualified dependent is: (a) dependent upon the covered person for main support and maintenance; and (b) under the age of fourteen and your: (i) biological child; (ii) lawfully adopted child; (iii) stepchild; or (iv) any other child who is living with you in a regular parent-child relationship; or (c) a family member age 14 or over who is physically or mentally incapable of caring for him or herself.

The dependent care expense benefit will be the lesser of: (a) $350 per month per qualified dependent; not to exceed $1,000 per month for all qualified dependents combined; and (b) the actual monthly day care expense incurred by you.

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

All Options

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

CGP-3-LTD09-CA B383.1687

All Options

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

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

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

Your eligible survivor is your spouse, if living.

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

Accelerated Survivor Benefit If you have a terminal illness, we may accelerate payment of this *plans'* survivor benefit.

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

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

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

CGP-3-LTD09-CA B383.1692

All Options

Income Recovery Benefit

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

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

(a) able to perform the substantial and material acts of your *own occupation;* or

(b) if this *plan* has already paid benefits for the *own occupation* period, able to perform the substantial and material acts of any *gainful occupation;* and

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

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

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

We stop paying this benefit on the earliest of:

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

(b) the date you become disabled;

(c) the date you stop working;

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

(e) the end of the *maximum payment period.*

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

All Options

Claim Provisions

Authority

We have the responsibility to fairly, thoroughly, objectively and timely investigate, evaluate and determine your eligibility for benefits under the *plan.*

We will:

(1) 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 proofs of loss.

(2) consider and interpret the terms of this *plan* 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 *plan* and applicable California state law.

(3) if a claim is approved, review the determination as often as is reasonably necessary to determine continued eligibility for benefits.

(4) 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.

If a claim is wholly or partially denied, the claimant may appeal the decision. Guardian will conduct a full and fair review of an appeal. The review will take 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. If a claim is not appealed, then the decision will be Guardian's final decision.

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, or as soon thereafter as is reasonably possible. This notice should include your name and plan number.

For details, you can call Guardian at 1-800-538-4583.

Claims Forms We, upon receipt of a written notice of claim, will furnish to you such forms as are usually furnished by us for filing proofs of loss. If such forms are not furnished within 15 days after the giving of such notice, you shall be deemed to have complied with the requirements of the *plan* as to proof of loss upon submitting, within the time fixed in the *plan* for filing proofs of loss, written proof covering the occurrence, the character and the extent of the loss for which the claim is made.

Proof of Loss Written proof of loss must be furnished to us, in case of claim for loss for which the *plan* provides any periodic payment contingent upon continuing loss, within 90 days after the termination of the period for which we are liable, and in case of claim for any other loss, within 90 days after the date of such loss. Failure to furnish such proof within the time required shall not invalidate nor reduce any claim if it was not reasonably possible to give proof within such time, provided such proof is furnished as soon as reasonably possible and in no event, except in the absence of your legal capacity, later than one year from the time proof is otherwise required.

Proof of loss and other claim data should be submitted to:

The Guardian Life Insurance Company of America
Group Long Term Disability Claims Department
P.O. 14331
Lexington, KY 40512

Authorization Required You must provide us with written, unaltered authorizations to obtain medical, financial, vocational, occupational, and governmental information required to determine our liability under this *plan.* You must provide us with such authorizations as often as we may require, in order that they remain current. Failure to provide such authorizations may delay, suspend or terminate your benefits.

Examinations We, at our own expense, shall have the right and opportunity to examine you when and as often as it may reasonably require during the pendency of a claim hereunder.

Ongoing Proof of Loss To continue to receive payments from this plan, you must give us current proof of loss as often as we may reasonably require. Ongoing proof of loss must be provided to us within 90 days of the date we request it. Failure to furnish such proof within the time period required shall not invalidate or reduce any claim provided such items are sent as soon as reasonably possible.

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

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

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

Benefits to which you are entitled may remain unpaid at your death. If any benefit is payable to your estate, or to a minor who is not otherwise competent to give a valid release, we pay the benefit, up to an amount not exceeding $1,000, to any relative by blood or connection by marriage who is considered by us to be entitled to the benefit. Any payment made in good faith pursuant to this provision shall fully discharge Guardian to the extent of such payment.

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

Overpayment Recovery If we overpaid you, you must repay us in full. We have the right to reduce your payment or apply any benefits payable, including the minimum payment, toward recovery of the overpayment.

Legal Actions If we overpaid you, you must repay us in full. We have the right to reduce your payment or apply any benefits payable, including the minimum payment, toward recovery of the overpayment. No action at law or in equity shall be brought to recover on the plan prior to the expiration of 60 days after written proof of loss has been furnished in accordance with the requirements of the plan. No such action shall be brought after the expiration of three years after time written proof of loss is required to be furnished.

Definitions

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

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

Disability or Disabled These terms, when used alone, mean: (a) total disability or totally disabled; or (b) partial or residual disability.

Total Disability or Totally Disabled means that as a result of *sickness* or *injury,* during the *elimination period* and the *own occupation* period, you are not able to perform with reasonable continuity the substantial and material acts necessary to pursue your usual occupation and you are not working in your usual occupation. After the end of the *own occupation* period, **total disability or totally disabled** means that as a result of *sickness* or *injury* you are not able to engage with reasonable continuity in any occupation in which you could reasonably be expected to perform satisfactorily in light of your age, education, training, experience, station in life, and physical and mental capacity, that exists within any of the following locations: (i) a reasonable distance or travel time from your residence in light of the commuting practices of your community; or (ii) a distance or travel time equivalent to the distance or travel time you traveled to work before becoming disabled; or (iii) the regional labor market, if you reside or resided prior to becoming disabled in a metropolitan area.

Substantial and material acts means the important tasks, functions and operations generally required by employers from those engaged in your usual occupation that cannot be reasonably omitted or modified.

In determining what substantial and material acts are necessary to pursue your usual occupation, we will first look at the specific duties required by the *employer* or job. If you are unable to perform one or more of these duties with reasonable continuity, we will then determine whether those duties are customarily required of other persons engaged in your usual occupation. If any specific, material duties required of you by the *employer* or job differ from the material duties customarily required of other persons engaged in your usual occupation, then we will not consider those duties in determining what substantial and material acts are necessary to pursue your usual occupation.

Usual occupation may be interpreted to mean the employment, business, trade or profession that involves the substantial and material acts of the occupation you were regularly performing for the *employer* when the disability began. Usual occupation is not necessarily limited to the specific job you performed for the *employer.*

Partial or Residual Disability means you are not *totally disabled* and that while actually working in an occupation, as a result of *sickness* or *injury,* you are unable to earn 80% or more of your pre- disability earnings. Pre-disability earnings will be adjusted for inflation using the CPI-W index.

All Options

Disability Earnings The monthly income you earn from working while *disabled.* It includes salaries, wages, commissions, bonuses and any other compensation earned or accrued while working including pension, profit sharing contributions, sick pay, paid time off, holiday and vacation pay. When you have an ownership interest in the business, *disability earnings* also includes business profits, attributable to you, whether received or not. It includes any income you earn while *disabled* and return to your *employer,* partnership, or any other similar business arrangement to cover any business or overhead expenses. If you had secondary employment prior to *disability, disability earnings* will only include earnings from the secondary employment if that employment began after the beginning of your disability.

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

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

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

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

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

Gross Monthly Benefit This plan's monthly benefit before it is reduced by other income and earnings.

Injury Physical harm or damage to your body that occurs while you are insured by this plan.

All Options

Insured Earnings Only your earnings from the *employer* will be included as *insured earnings.*

We calculate benefit amounts and limits based on the amount of your *insured earnings* as of the Redetermination date immediately prior to the start of your *disability.* See the "Redetermination" section of this *plan.*

For Partners and S Corporation Shareholders:

Insured earnings means the sum of the amounts listed below, divided by 12.

(a) Your compensation as an employee or S Corporation shareholder, as reported on your Federal Income Tax Return, Form 1040, for the prior calendar year, less the gross total of unadjusted employee business expenses as included on the corresponding Schedule A-Itemized Deductions;

(b) Your non-passive income (loss) from trade or business as reported on Schedule E-Part II of your Federal Income Tax Return, Form 1040, for the prior calendar year, less any expenses incurred and reported elsewhere on your Return; and

(c) Your contributions during the prior calendar year, deposited into a: (a) cash or deferred compensation plan, or salary reduction plan, qualified under IRC Section: 401(k); 403(b); 457; or similar plan; and (b) elective employee pre-tax deferrals to a Section 125 plan or flexible spending account.

You may not have been a partner or S Corporation shareholder for the entire previous calendar year. In this case, your earnings are based on the monthly average of the sum of the listed amounts, averaged for the full number of months that you were a partner or an S Corporation shareholder during such calendar year.

For Sole Proprietors:

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

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

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

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

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

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

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

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

For All Other Covered Persons:

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

All Options

Maximum Payment Period The longest time that benefits are paid by this *plan.*

Mental Illness Means any mental disorder, regardless of cause, listed in the Diagnostic and Statistical Manual of Mental Disorders (DSM) currently in use by the American Psychiatric Association (APA). If the APA stops publishing the DSM, we have the right to use some other similar standard. A *mental illness* may be: (a) caused by; (b) contributed to by; or (c) result in; physical, biological or chemical factors or symptoms. For purposes of this *plan, mental illness* does not include: (a) irreversible dementia caused by Alzheimer's disease, stroke, trauma or viral infection; or (b) any other condition not typically treated by a psychiatrist, clinical psychologist or other qualified mental health practitioner with psychotherapy or psychotropic drugs.

Monthly Benefit This *plan's gross monthly benefit* reduced by other income. If you are working while *disabled,* your *monthly benefit* will be further reduced based on the amount of your *disability earnings.*

Own Occupation or Usual Occupation means the occupation: (a) you are routinely performing immediately prior to disability; (b) which is your primary source of income prior to disability; and (c) for which you are insured under this plan. Occupation includes any employment, business, trade or profession that involves the substantial and material acts of the occupation you were regularly performing for the employer when the disability began. Own occupation or usual occupation is not necessarily limited to the specific job you performed for the employer.

All Options

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

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

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

Rehabilitation Program A program of work or job-related training for you that we approve in writing. Its aim is to restore your wage earning abilities.

Retirement Plan A defined benefit or defined contribution plan funded wholly or in part by the *employer's* deposits for your benefit. The term does not include: (a) profit sharing plans; (b) thrift plans; (c) non-qualified deferred compensation plans; (d) individual retirement accounts; (e) tax sheltered annuities; (f) 401(k), 403(b), 457 or similar plans; or (g) stock ownership plans.

Retirement Plan **"retirement benefits"** are lump sum or periodic payments at normal or early retirement. Some *retirement plans* make payments for disability (as defined by those plans) that start before normal retirement age. When such payments reduce the amount that would have been paid at normal retirement age, they are *retirement benefits.* When such payments do not reduce the normal retirement amount, they are **"disability benefits."**

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

Spouse This term means your lawful spouse or registered domestic partner.

Substance-Related Disorder Means alcoholism or drug addiction listed in the Diagnostic and Statistical Manual of Mental Disorders (DSM) currently in use by the American Psychiatric Association (APA). If the APA stops publishing the DSM, we have the right to use some other similar standard. A *substance-related disorder* may be: (a) caused by; (b) contributed to by; or (c) result in; physical, biological or chemical factors or symptoms. For purposes of this *plan,* these disorders do not include: (a) irreversible dementia caused by Alzheimer's disease, stroke, trauma or viral infection; or (b) any other condition not typically treated by a psychiatrist, clinical psychologist or other qualified mental health practitioner with psychotherapy or psychotropic drugs.

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

CERTIFICATE AMENDMENT

The certificate is amended as follows:

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

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

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

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

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

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

The Guardian Life Insurance Company of America

Michael Prestileo, Senior Vice President

CERTIFICATE AMENDMENT

The certificate is amended as follows:

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

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

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

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

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

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

The Guardian Life Insurance Company of America

Michael Prestileo, Senior Vice President

CGP-A-1 B531.0021

CERTIFICATE AMENDMENT

(To be attached to certificates issued to you)

The certificate is amended as follows:

This rider amends this plan's Life Insurance certificate as follows:

1. The Examination Period provision as shown below is hereby added to your certificate:

Examination Period

A person age 65 or older insured under the policy has the right to return the policy or certificate, by mail or other delivery method, within 30 days after its receipt, and to have the full premium and any policy or membership fee paid refunded.

2. The Continuation of Coverage During a Labor Dispute provision as shown below is hereby added to your certificate:

Continuation Of Coverage During A Labor Dispute

Important Notice: This section does not apply to coverage which provide benefits for loss of income due to disability. All other coverages under the group plan are affected by this section, and are hereafter referred to as "group coverage."

If A Work Stoppage Occurs: A labor dispute may result in a work stoppage which causes an employee's group coverage to end. If this happens, an employee has the right to continue his health coverage for himself and his dependents during the work stoppage, for up to six months.

How To Continue Group Coverage: To continue his group coverage an employee must make timely payment of the total premium, including any portion of the premium the employer was paying before work stopped, to the Policyholder. If an employee fails to pay a premium on time, he waives his right to continue under this section.

The Responsibilities of the Policyholder: For an employee's group coverage to continue, the Policyholder must do the following:

(a) collect the premium payments made by an employee; and

(b) make timely payment of the collected premiums to us.

If Policyholder, after timely receipt of the employee's premium, fails to pay us on behalf of such employee, thereby causing the employee's group coverage to end, then Policyholder will be liable for the employee's benefits, to the same extent as, and in place of, us.

The Premium: The premium to be paid by an employee for continued group coverage will be at the rate that applies to the class of employees to which he belonged on the day work stopped. But, we have the right to increase this rate by up to 20%, or any higher amount approved by the Insurance Commissioner, to allow for increased costs and risks caused by this continued coverage. We may do this at any time during the continuation. Nothing in this section alters our right to change premium rates according to the "Premiums" section of the group plan.

When This Continuation Starts: Group coverage continued under this section starts on the day work stopped. But, if a premium that was due before the work stoppage began is unpaid at the time work stopped, then payment of such premium before the next premium due date will be required for this continuation to take effect.

When This Continuation Ends: An employee's continued group coverage ends on the first of the following:

(a) the end of the six month continuation period;

(b) the day on which the number of employees covered under this section is less than 75% of those insured under the group plan on the day work stopped;

(c) the day the work stoppage ends;

(d) when the employee enters full-time employment with another employer;

(e) at the end of the period for which the last premium payment is made, if the employee stops paying premium;

(f) the date the employee stops being eligible as defined in this plan, for reasons other than not meeting "actively at work" or "full-time" requirements; and

(g) with respect to a dependent, the date such dependent stops being an eligible dependent as defined in the group plan.

3. The Incontestability provision is hereby replaced, as follows:

Incontestability The validity of the policy shall not be contested, except for non-payment of premiums, after it has been in force for two years from its date of issue. No statements made by any person insured under the policy relating to his or her insurability shall be used in contesting the validity of the insurance with respect to which the statement was made after the insurance has been in force prior to the contest for a period of two years during such person's lifetime nor unless it is contained in a written statement signed by such person.

If a photographic identification is presented during the application or enrollment process, and if an imposter is substituted for an insured person in any part of the application or enrollment process, with or without the knowledge of such person, then no contract between Guardian and such person is formed, and any purported insurance contract is void from its inception.

Application or enrollment process means any or all of the steps required of an insured person in applying for a certificate under a group policy of life insurance, including, but not limited to, executing any part of the application or enrollment form, submitting to medical or physical examination or testing, or providing a sample or specimen of blood, urine, or other bodily substance

Imposter means a person other than the insured person who participates in any manner in the application or enrollment process for a certificate under a group life insurance policy and represents himself or herself to be the insured person or represents that a sample or specimen of blood, urine, or other bodily substance is that of the insured person.

A Policyholder insurance under this policy shall be incontestable after two years from the Policyholder policy date of coverage under this policy, except for nonpayment of premiums.

If this policy replaces the group policy of another insurer, we may rescind this policy based on misrepresentations made in the policyholder's or insured person's signed application for up to two years from this policy's policy date.

4. The Contract provision is hereby replaced, as follows:

The Contract The entire contract between the Guardian and the policyholder consists of this policy, the policyholder's application, a copy of which is attached hereto or endorsed hereon, and the individual applications, if any, of the employees.

We can amend this policy at any time, without the consent of the insured employees or any other person having a beneficial interest therein, as follows:

We can amend this policy: (a) upon written request made by the policyholder and agreed to by the Guardian; (b) on any date our obligation under this policy with respect to a policyholder is changed because of statutory or other regulatory requirements; or (c) if this policy supplements, or coordinates with benefits provided by any other insurer, non-profit hospital or medical service plan, or health maintenance organization, on any date our obligation under this policy is changed because of a change in such other benefits.

If we amend the policy, except upon request made by the policyholder, we must give the policyholder written notice of such amendment.

Any amendments to this policy will be without prejudice to any claim arising prior to the date of the change.

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

All personal pronouns in the masculine gender used in this policy, will be deemed to include the feminine also, unless the context clearly indicates the contrary.

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

The Guardian Life Insurance Company of America

Michael Prestileo, Senior Vice President

B531.0684

CGP-3-A-REV-CA-18

All Options

GLOSSARY

This Glossary defines the italicized terms appearing in your booklet.

CGP-3-GLOSS-90 B900.0118

All Options

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

CGP-3-GLOSS-90 B900.0003

All Options

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

CGP-3-GLOSS-90 B750.0015

All Options

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

CGP-3-GLOSS-90 B750.0006

All Options

Employer means FIVE9 INC. .

CGP-3-GLOSS-90 B900.0051

All Options

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

CGP-3-GLOSS-90 B900.0004

All Options

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

CGP-3-GLOSS-90 B750.0229

All Options

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

CGP-3-GLOSS-90 B900.0006

All Options

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

CGP-3-GLOSS-90 B900.0008

All Options

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

CGP-3-GLOSS-90 B900.0039

All Options

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

CGP-3-GLOSS-90 B900.0010

All Options

Qualified Retirees are covered as outlined in your company's benefit provisions. Please see your Plan Administrator for details.

CGP-3-GLOSS-90 B750.0008

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

STATEMENT OF ERISA RIGHTS

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

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

ERISA provides that all plan participants shall be entitled to:

Receive Information about Your Plan and Benefits

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

Prudent Actions by Plan Fiduciaries

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

Enforcement of Your Rights

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

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

Assistance with Questions

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

Life Insurance Claims Procedure

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

Guardian is the Claims Fiduciary with 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 any denial, reduction or termination of a benefit or failure to provide or make payment (in whole or in part) for a benefit.

Timing for Initial Benefit Determination of Life Insurance Claims

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

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

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

Adverse Benefit Determination of Life Insurance Claims

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

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

B752.0173

All Options

Appeals of Adverse Determinations of Life Insurance Claims

If a claim is wholly or partially denied, you will have up to 60 days to make an appeal. Guardian will conduct a full and fair review of an appeal which includes providing to claimants the following:

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

Guardian will notify the claimant of its decision not later than 60 days after receipt of the request for review of the adverse determination. This period may be extended by an additional period of up to 60 days if Guardian determines that special circumstances require an extension of the time period for processing and so notifies the claimant before the end of the initial 60-day period.

A notification with respect to an extension will indicate the special circumstances requiring an extension of the time period for review, and the date by which the final determination will be made.

In the event Guardian denies the appeal of an adverse benefit determination, it will:

- Provide the specific reason or reasons why the appeal was denied;
- Refer to the specific provisions in the Policy, Certificate, plan, or other documents on which the benefit determination is based;
- Provide a statement that the claimant is entitled to receive, upon request and free of charge, reasonably access to, and copies of all documents, records, and other information relevant to the claimant's claim for benefits; and
- Provide a statement describing any voluntary appeal procedures offered by the Plan, the claimant's right to obtain information about such procedures, and a statement that the claimant's right to bring an action under ERISA section 502(a).

Waiver of Premium

If you apply for an extension of life insurance benefits due to Total Disability under the Waiver of Premium benefit under this plan, these claim procedures will apply to such request:

Timing For Initial Benefit Determination for Waiver of Premium

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

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

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

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

Adverse Benefit Determination

If a claim for an extension of benefits is denied, Guardian will provide a notice that will set forth:

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

B752.0067

All Options

Appeals of Adverse Determinations for Waiver of Premium

If a claim for Waiver of Premium is denied, the claimant will have up to 180 days to make an appeal. Guardian will conduct a full and fair review of an appeal which includes providing to claimants the following:

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

In reviewing an appeal, Guardian will:

- Provide for a review conducted by a named fiduciary who is neither the person who made the initial adverse determination nor that person's subordinate;

- In deciding an appeal based upon a medical judgment, consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment;
- Identify medical or vocational experts whose advice was obtained in connection with an adverse benefit determination; and
- Ensure that a health care professional engaged for consultation regarding an appeal based upon a medical judgment shall be neither the person who was consulted in connection with the adverse benefit determination, nor that person's subordinate.

Guardian will notify the claimant of its decision not later than 45 days after receipt of the request for review of the adverse determination. This period may be extended by an additional period of up to 45 days if Guardian determines that special circumstances require an extension of the time period for processing and so notifies the claimant before the end of the initial 45-day period.

A notification with respect to an extension will indicate the special circumstances requiring an extension of the time period for review, and the date by which the final determination will be made.

In the event Guardian denies the appeal of an adverse benefit determination, it will:

- Provide the specific reason or reasons why the appeal was denied;
- Refer to the specific provisions in the Policy, Certificate, plan, or other documents on which the benefit determination is based;
- Provide a statement that the claimant is entitled to receive, upon request and free of charge, reasonably access to, and copies of all documents, records, and other information relevant to the claimant's claim for benefits;
- Provide a statement disclosing any internal rule, guideline, protocol or similar criterion relied on in making the adverse benefit determination (or a statement that such information will be provided free of charge upon request); or a statement that no internal rule, guideline, protocol or similar criterion was relied upon in making the adverse benefit determination;
- If applicable, provide an explanation of the basis of disagreement with or not following the views presented by you, of health care professionals who treated you, and vocational professionals who evaluated you;
- If applicable, provide an explanation of the basis for disagreeing with or not following the views of any medical or vocational expert whose advice was obtained on our behalf in connection with the adverse benefit determination, without regard to whether the advice was relied upon in making the determination;
- If applicable, provide an explanation of the basis for disagreeing with or not following a disability determination made by the Social Security Administration that you present to us;

- Provide a statement describing the claimant s right to bring a civil suit under Section 502(a) of the Employee Retirement Income Security Act of 1974 which shall also describe any applicable contractual limitations period that applies the claimant's right to bring such an action, including the calendar date on which the contractual limitations period expires for the claim, and;
- In the event the adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, provide either an explanation of the scientific or clinical judgment for the determination, applying the terms of the plan to the claimant's medical circumstances, or a statement that such explanation will be provided free of charge upon request.

Alternative Dispute Options

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

In addition to any legal rights you may have under section 502(a), if you believe that we have violated ERISA's procedural requirements, you may request that we review any claimed violation(s) and we will respond to you within ten days.

B752.0068

STATEMENT OF ERISA RIGHTS

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

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

ERISA provides that all plan participants shall be entitled to:

Receive Information about Your Plan and Benefits

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

Prudent Actions by Plan Fiduciaries

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

Enforcement of Your Rights

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

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

Assistance with Questions

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

Accidental Death and Dismemberment Insurance Claims Procedure

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

Guardian is the Claims Fiduciary with the 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 any denial, reduction or termination of a benefit or failure to provide or make payment (in whole or in part) for a benefit.

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

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

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

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

Adverse Benefit Determination of Accidental Death and Dismemberment Insurance Claims

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

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

B752.0188

Appeals of Adverse Determinations of Accidental Death and Dismemberment Insurance Claims

If a claim is wholly or partially denied, you will have up to 60 days to make an appeal. Guardian will conduct a full and fair review of an appeal which includes providing to claimants the following:

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

In reviewing an appeal, Guardian will:

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

Guardian will notify the claimant of its decision not later than 60 days after receipt of the request for review of the adverse determination. This period may be extended by an additional period of up to 60 days if Guardian determines that special circumstances require an extension of the time period for processing and so notifies the claimant before the end of the initial 60-day period.

A notification with respect to an extension will indicate the special circumstances requiring an extension of the time period for review, and the date by which the final determination will be made.

In the event Guardian denies the appeal of an adverse benefit determination, it will:

- Provide the specific reason or reasons why the appeal was denied;
- Refer to the specific provisions in the Policy, Certificate, plan, or other documents on which the benefit determination is based;
- Provide a statement that the claimant is entitled to receive, upon request and free of charge, reasonably access to, and copies of all documents, records, and other information relevant to the claimant's claim for benefits;

- In the event the adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, provide either an explanation of the scientific or clinical judgment for the determination, applying the terms of the plan to the claimant's medical circumstances, or a statement that such explanation will be provided free of charge upon request.

Waiver of Premium

If you apply for an extension of accidental death and dismemberment insurance benefits due to Total Disability under the Waiver of Premium benefit under this plan, these claim procedures will apply to such request:

Timing For Initial Benefit Determination for Waiver of Premium

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

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

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

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

Adverse Benefit Determination

If a claim for an extension of benefits is denied, Guardian will provide a notice that will set forth:

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

- A statement disclosing any internal rule, guideline, protocol or similar criterion relied on in making the adverse benefit determination (or a statement that such information will be provided free of charge upon request); or a statement that no internal rule, guideline, protocol or similar criterion was relied upon in making the adverse benefit determination;
- If applicable, an explanation of the basis of disagreement with or not following the views presented by you, of health care professionals who treated you and vocational professionals who evaluated you;
- If applicable, an explanation of the basis for disagreeing with or not following the views of any medical or vocational expert whose advice was obtained on our behalf in connection with the adverse benefit determination, without regard to whether the advice was relied upon in making the determination;
- If applicable, an explanation of the basis for disagreeing with or not following a disability determination made by the Social Security Administration that you present to us;
- A description of the plan's review procedures and the time limits applicable to such procedures, including a statement of the claimant's right to bring a civil action under ERISA Section 502(a) following an adverse benefit determination; and
- In the case of adverse benefit determination based on medical necessity or experimental treatment, notice will either include an explanation of the scientific or clinical basis for the determination, or a statement that such explanation will be provided free of charge upon request.

B752.0103

All Options

Appeals of Adverse Determinations for Waiver of Premium

If a claim for Waiver of Premium is denied, the claimant will have up to 180 days to make an appeal. Guardian will conduct a full and fair review of an appeal which includes providing to claimants the following:

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

In reviewing an appeal, Guardian will:

- Provide for a review conducted by a named fiduciary who is neither the person who made the initial adverse determination nor that person's subordinate;

- In deciding an appeal based upon a medical judgment, consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment;
- Identify medical or vocational experts whose advice was obtained in connection with an adverse benefit determination; and
- Ensure that a health care professional engaged for consultation regarding an appeal based upon a medical judgment shall be neither the person who was consulted in connection with the adverse benefit determination, nor that person's subordinate.

Guardian will notify the claimant of its decision not later than 45 days after receipt of the request for review of the adverse determination. This period may be extended by an additional period of up to 45 days if Guardian determines that special circumstances require an extension of the time period for processing and so notifies the claimant before the end of the initial 45-day period.

A notification with respect to an extension will indicate the special circumstances requiring an extension of the time period for review, and the date by which the final determination will be made.

In the event Guardian denies the appeal of an adverse benefit determination, it will:

- Provide the specific reason or reasons why the appeal was denied;
- Refer to the specific provisions in the Policy, Certificate, plan, or other documents on which the benefit determination is based;
- Provide a statement that the claimant is entitled to receive, upon request and free of charge, reasonably access to, and copies of all documents, records, and other information relevant to the claimant's claim for benefits;
- Provide a statement disclosing any internal rule, guideline, protocol or similar criterion relied on in making the adverse benefit determination (or a statement that such information will be provided free of charge upon request); or a statement that no internal rule, guideline, protocol or similar criterion was relied upon in making the adverse benefit determination;
- If applicable, provide an explanation of the basis of disagreement with or not following the views presented by you, of health care professionals who treated you, and vocational professionals who evaluated you;
- If applicable, provide an explanation of the basis for disagreeing with or not following the views of any medical or vocational expert whose advice was obtained on our behalf in connection with the adverse benefit determination, without regard to whether the advice was relied upon in making the determination;
- If applicable, provide an explanation of the basis for disagreeing with or not following a disability determination made by the Social Security Administration that you present to us;

- Provide a statement describing the claimant s right to bring a civil suit under Section 502(a) of the Employee Retirement Income Security Act of 1974 which shall also describe any applicable contractual limitations period that applies the claimant's right to bring such an action, including the calendar date on which the contractual limitations period expires for the claim, and;
- In the event the adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, provide either an explanation of the scientific or clinical judgment for the determination, applying the terms of the plan to the claimant's medical circumstances, or a statement that such explanation will be provided free of charge upon request.

Alternative Dispute Options

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

In addition to any legal rights you may have under section 502(a), if you believe that we have violated ERISA's procedural requirements, you may request that we review any claimed violation(s) and we will respond to you within ten days.

B752.0104

STATEMENT OF ERISA RIGHTS

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

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

ERISA provides that all plan participants shall be entitled to:

Receive Information about Your Plan and Benefits

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

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

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

Prudent Actions by Plan Fiduciaries

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

Enforcement of Your Rights

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

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

Assistance with Questions

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

Disability Benefits Claims Procedure

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

Guardian is the Claims Fiduciary with the 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 any denial, reduction or termination of a benefit or failure to provide or make payment (in whole or in part) for a benefit.

Timing for Initial Benefit Determination

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

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

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

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

All Options

Adverse Benefit Determination

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

- The specific reason(s) for the adverse determination;
- References to the specific provisions in the Policy, Certificate, plan or other documents, on which the determination is based;
- A description of any additional material or information necessary to perfect the claim and an explanation of why such material or information is necessary;
- A description of the plan's claim review procedures which a claimant may follow to have a claim for benefits reviewed and the time limits applicable to such procedures;
- A statement disclosing any internal rule, guideline, protocol or similar criterion relied on in making the adverse benefit determination (or a statement that such information will be provided free of charge upon request); or a statement that no internal rule, guideline, protocol or similar criterion was relied upon in making the adverse benefit determination;
- If applicable, an explanation of the basis of disagreement with or not following the views presented by you, of health care professionals who treated you and vocational professionals who evaluated you;

- If applicable, an explanation of the basis for disagreeing with or not following the views of any medical or vocational expert whose advice was obtained on our behalf in connection with the adverse benefit determination, without regard to whether the advice was relied upon in making the determination;
- If applicable, an explanation of the basis for disagreeing with or not following a disability determination made by the Social Security Administration that you present to us;
- A description of the plan's review procedures and the time limits applicable to such procedures, including a statement of the claimant's right to bring a civil action under ERISA Section 502(a) following an adverse benefit determination on appeal, and;
- In the case of an adverse benefit determination based on medical necessity or experimental treatment, notice will either include an explanation of the scientific or clinical basis for the determination, or a statement that such explanation will be provided free of charge upon request.

Appeal of Adverse Benefit Determinations

If a claim is wholly or partially denied, the claimant will have up to 180 days to make an appeal. Guardian will conduct a full and fair review of an appeal which includes providing to claimants the following:

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

In reviewing an appeal, Guardian will:

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

Guardian will notify the claimant of its decision not later than 45 days after receipt of the request for review of the adverse determination. This period may be extended by an additional period of up to 45 days if Guardian determines that special circumstances require an extension of the time period for processing and so notifies the claimant before the end of the initial 45-day period.

A notification with respect to an extension will indicate the special circumstances requiring an extension of the time period for review, and the date by which the final determination will be made.

In the event Guardian denies the appeal of an adverse benefit determination, it will:

- Provide the specific reason or reasons why the appeal was denied;
- Refer to the specific provisions in the Policy, Certificate, plan, or other documents on which the benefit determination is based;
- Provide a statement that the claimant is entitled to receive, upon request and free of charge, reasonably access to, and copies of all documents, records, and other information relevant to the claimant's claim for benefits;
- Provide a statement disclosing any internal rule, guideline, protocol or similar criterion relied on in making the adverse benefit determination (or a statement that such information will be provided free of charge upon request); or a statement that no internal rule, guideline, protocol or similar criterion was relied upon in making the adverse benefit determination;
- If applicable, provide an explanation of the basis of disagreement with or not following the views presented by you, of health care professionals who treated you, and vocational professionals who evaluated you;
- If applicable, provide an explanation of the basis for disagreeing with or not following the views of any medical or vocational expert whose advice was obtained on our behalf in connection with the adverse benefit determination, without regard to whether the advice was relied upon in making the determination;
- If applicable, provide an explanation of the basis for disagreeing with or not following a disability determination made by the Social Security Administration that you present to us;
- Provide a statement describing the claimant's right to bring a civil suit under Section 502(a) of the Employee Retirement Income Security Act of 1974 which shall also describe any applicable contractual limitations period that applies the claimant's right to bring such an action, including the calendar date on which the contractual limitations period expires for the claim, and;

- In the event the adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, provide either an explanation of the scientific or clinical judgment for the determination, applying the terms of the plan to the claimant's medical circumstances, or a statement that such explanation will be provided free of charge upon request.

Alternative Dispute Options

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

In addition to any legal rights you may have under section 502(a), if you believe that we have violated ERISA s procedural requirements, you may request that we review any claimed violation(s) and we will respond to you within ten days.

B752.0141

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

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

CERTIFICATE OF COVERAGE

The Guardian
10 Hudson Yards
New York, New York 10001

The group Critical Illness coverage described in this Certificate Is attached to the group Policy effective January 1, 2025. This Certificate replaces any Certificate previously issued under this Certificate or under any other Certificate 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 Certificate carefully to fully understand what it covers, limits, and excludes.

This is a supplement to health insurance. It is not a substitute for essential health benefits or minimum essential coverage as defined in federal law.

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 Certificate; 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 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: FIVE9 INC.

Group Policy Number: 00477224

Michael Prestileo, Senior Vice President

B007.0233

GC-CI-14-CA

TABLE OF CONTENTS

All Options

COMPLAINT NOTICE

This notice is to advise you that should any complaints arise regarding this insurance you may contact the Guardian at the following address or phone number:

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

Telephone: (212) 598-8000
(800) 541-7846

If you feel your complaints have not been resolved after contacting the Guardian you may contact the California Department of Insurance at the following address and phone number:

California Department of Insurance
Consumer Communications Bureau
300 South Spring Street, South Tower
Los Angeles, California 90013

Consumer Hotline: 1 (800) 927-4357
TDD 1 (800) 482-4833)
Website: www.insurance.ca.gov/01-consumers/

B007.1169

GC-CI-14-CA

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

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

B007.0238

All Options

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

B007.0239

All Options

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

B007.0241

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 Certificate. Clinical diagnosis is permitted whenever such diagnosis is consistent with professional medical standards.

B007.0242

All Options

Doctor: This term means any qualified 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. "Doctor" includes a qualified medical professional, which means an individual whose education, training, experience and licensing qualify him or her, acting within the scope of that license, to diagnose or treat Sickness or Injury.

B007.0243

All Options

Domestic Partner: This term means Your domestic partner who is an adult who has chosen to share his or her life with You in an intimate and committed relationship of mutual caring as defined under Section 297 of the California Family Code.

B007.0244

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 Initial Dependents; and (2) are eligible for dependent coverage.

B007.0245

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 FIVE9 INC. .

B005.0019

All Options

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

B005.0020

All Options

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

B005.0021

All Options

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

B005.0023

All Options

Injury: This term means all damage to a Covered Person's body.

B007.0253

All Options

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

(1) needed to Diagnose or treat a Sickness or Injury;

(2) consistent in type, frequency, and length of treatment with scientifically based guidelines of national medical research or health care coverage organizations or government agencies;

(3) needed for reasons other than comfort or convenience of the Covered Person or Doctor.

B007.0254

All Options

Newly Acquired Dependent: This term means an eligible dependent You acquire after You already have coverage in force for Initial Dependents. This includes a newly acquired dependent of Your Domestic Partner.

B007.0255

All Options

Certificate: This term means the group Critical Illness coverage described in the policy and this Certificate.

B007.0257

All Options

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

B007.0258

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 Your Domestic Partner.

B007.0260

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

Entire Contract, Changes

The Policy, the application of the Policyholder and the individual applications, if any, of the individuals insured shall constitute the entire contract between the parties, and any statements made by the Policyholder, or by the individuals insured shall, in the absence of fraud, be deemed representations and not warranties. No such statement shall be used in defense to a claim under the policy, unless it is contained in a written application. No change in this policy shall be valid unless approved by an executive officer of Guardian and evidenced by endorsement hereon, or by amendment hereto signed by the Policyholder and by an executive officer of Guardian. No agent has authority to change this policy or waive any of its provisions.

B007.0263

All Options

Time Limit On Certain Defenses

After the Policy has been in force for a period of two years, no statements of the Policyholder contained in the application, and no statement relating to insurability made by any Employee eligible for coverage under the Policy shall be used to deny a claim or in contesting the validity of the insurance with respect to which such statement was made after the insurance has been in force prior to the contest for a period of two years during the lifetime of the person with respect to whom any such statement was made.

No claim for loss incurred or disability commencing after two years from the effective date of the insurance coverage with respect to which the claim is made shall be reduced or denied on the ground that a disease or physical condition, not excluded from coverage by name or specific description effective on the date of loss, had existed prior to the effective date of the coverage with respect to which the claim is made.

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.

B007.0264

Notice Of Claim

Written notice of claim must be given to Us within 20 days after the occurrence or commencement of any loss covered by the Policy, or as soon thereafter as is reasonably possible.

Claim Forms

Upon receipt of a written notice of claim, We will furnish to the claimant the forms for filing proofs of loss. If such forms are not furnished within 15 days after the giving of such notice the claimant shall be deemed to have complied with the requirements of this Policy as to proof of loss upon submitting, within the time fixed in the Policy for filing proofs of loss, written proof covering the occurrence, the character and the extent of the loss for which claim is made.

Proof of Loss

Written proof of loss must be furnished to Us within 90 days after the date of such loss. Failure to furnish such proof within the time required shall not invalidate nor reduce any claim if it was not reasonably possible to give proof within such time, provided such proof is furnished as soon as reasonably possible and in no event, except in the absence of legal capacity of the Covered Person, later than one year from the time proof is otherwise required.

Time Of Payment Of Claim

Subject to due written proof of loss, all indemnities for loss for which this Policy provides payment will be paid to the Covered Person as they accrue and any balance remaining unpaid at termination of the period of liability will be paid to the Covered Person immediately upon receipt of due written proof.

Unless otherwise required by law or regulation, or stated otherwise in this Certificate, 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 action at law or in equity shall be brought to recover on this Policy prior to the expiration of 60 days after written proof of loss has been furnished in accordance with the requirements of this Policy. No such action shall be brought after the expiration of three years after the time written proof of loss is required to be furnished.

B007.0265

All Options

Conformity With State Statutes

Any provision of this policy which, on its effective date, is in conflict with the statutes of the state in which this policy was delivered or issued for delivery is hereby amended to conform to the minimum requirements of such statute.

B007.0267

All Options

Physical 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 may reasonably require during the pendency of a claim hereunder. 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. **Workers' Compensation:** The Critical Illness benefits provided by this Certificate are not in place of and do not affect requirements for coverage by Workers' Compensation.

B007.0268

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 Certificate, 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 Certificate'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 30 hours per week) at: (1) the Employer's place of business; (2) some place where the Employer's business requires You to travel; or (3) any other place You and the Employer have agreed upon for the performance of occupational duties.

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

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

Proof of Insurability: If You: (1) do not meet this Certificate'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.

B007.0269

All Options

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

B007.0271

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 Certificate. But, if this Certificate 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.

B007.0272

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 last day of the month in which Your active full-time 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 last day of the month in which You stop being an eligible Employee under this Certificate.
- 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 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.

B007.1251

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

Important Notice: This section may not apply to Your Employer's Certificate. 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 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 coverage under Your Employer's Certificate 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 above 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.

B007.0277

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, including adopted children and step-children of your Domestic Partner. 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.

B007.0282

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 Certificate as 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 Critical Illness benefits by only one Employee at a time.

B007.0283

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 Certificate 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 Certificate 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 Certificate again until You give Us new Proof of Insurability that they are insurable and We approve that Proof of Insurability in writing.

B007.0287

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 Certificate, 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.

B007.0288

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 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.

B007.0289

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 Certificate ends, or when dependent coverage is dropped from this Certificate 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 Certificate'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.

B007.0294

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

B007.0297

All Options

Critical Illness Benefits

This Certificate 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 Certificate.

This Certificate 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 Certificate. This Certificate 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 results from 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 Certificate 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 Certificate. By Recurrence, We mean the second time a Covered Person is diagnosed with the same Critical Illness while insured by this Certificate. We pay no benefits for occurrences beyond the second time.

B007.0298

All Options

Covered Critical Illnesses

B005.0086

All Options

Cancer Related Conditions

B005.0087

All Options

We cover four categories of Cancer: Benign Brain Tumor, Carcinoma in Situ (Non-invasive Cancer); Invasive Cancer and Specified Skin Cancers. Each category of Cancer is described below. Covered types of Cancer will be covered under one of the categories below. Different benefit amounts may be payable for each category, as well as whether it is a First occurrence or Recurrence of that Cancer, as shown in the Schedule of Benefits.

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 makes a Diagnosis.

B007.0302

All Options

Carcinoma in Situ

"Carcinoma in Situ" means "Cancer in place", or early forms of localized cancer that have not invaded surrounding tissue (metastasized). We pay a benefit if a Covered Person is Diagnosed with Carcinoma In Situ as follows. 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 category for:

- Pre-Malignant growths or lesions, such as dysplasia or Intraepithelial neoplasia;
- Any benign tumor or polyp;
- Basal or Squamous cell carcinoma;
- Non Malignant melanoma.

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.

We deem Carcinoma in Situ to occur on the date a Doctor makes a Diagnosis.

"TNM classification" means the classification standards for cancer developed by the American Joint Committee on Cancer.

B007.0303

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 also includes Malignant melanoma classified as Clark's level III and higher or a Breslow level greater than or equal to 1.5mm.

Invasive Cancer must be supported by pathological diagnosis. But, a clinical diagnosis may be used instead if such diagnosis is consistent with professional medical standards.

We do not pay a benefit under this category for:

- Pre-Malignant growths or lesions, such as dysplasia or intraepithelial neoplasia;
- Any benign tumor or polyp;
- Any condition that is Carcinoma in Situ (a non-invasive cancer which has not metastasized).
- Non Malignant melanoma.

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.

We deem Invasive Cancer to occur on the date a Doctor makes a Diagnosis.

Malignant: As used in this Certificate, means a tumor that grows in an uncontrolled manner, may invade surrounding tissue, and has a tendency to spread (metastasize).

B007.0304

All Options

Specified Skin Cancer

We pay a benefit if a Covered Person is Diagnosed with the types of Specified Skin Cancer known as basal cell carcinoma, squamous cell carcinoma or Malignant melanoma not covered under Carcinoma in Situ or Invasive Cancer. We don't pay a benefit under this category for pre-Malignant conditions, conditions with Malignant potential, non-Malignant melanoma or any other type of skin cancer. We deem Specified Skin Cancer to occur on the date a Doctor makes a Diagnosis.

We limit what We pay to one benefit in a Covered Person's lifetime.

B007.0305

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 makes a Diagnosis of Arteriosclerosis of sufficient severity to warrant one or more coronary artery bypass graft(s).

B007.0307

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. Two or more of the following criteria for acute myocardial infarction must be present:

(1) typical clinical symptoms such as central chest pain;

(2) diagnostic increase of specific cardiac markers to evaluate heart function;

(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.

Proof of Heart Attack requires submission of medical records. We deem a heart attack to occur on the date a Doctor 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.

B007.0308

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.

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 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.

B007.0309

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) short term blockage of blood flow to the brain (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.

Transient Ishemic Attack, also known as mini stroke, occurs when the neurological defects following a blockage of blood flow to the brain are temporary and last less than 24 hours.

Diagnosis of Stroke must be:

(1) confirmed in writing by a Doctor; 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.

B007.0310

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 psychiatrist, neurologist or Doctor 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.

In addition to memory impairment (impaired ability to learn new information or to recall previously learned information), one or more of the following cognitive disturbances must be present:

- aphasia (language disturbance);
- apraxia (impaired ability to carry out motor activities despite intact motor function);
- angosia (failure to recognize or identify objects despite intact sensory function); and
- disturbance in executive functioning (i.e. planning, organizing, sequencing, abstracting).

No other dementing organic brain disorders or psychiatric illnesses are included in this definition.

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 makes a Diagnosis. The Diagnosis must occur while the Covered Person is insured under this Certificate.

B007.0312

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 makes a Diagnosis.

B007.0313

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 makes a Diagnosis.

The Diagnosis must occur while the Covered Person is insured under this Certificate.

B007.0314

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 makes a Diagnosis. Diagnosis must occur while the Covered Person is insured under this Certificate.

B007.0315

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 neurologist or Doctor 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 makes a Diagnosis that the person has progressed to Stage 4. The Diagnosis must occur while the Covered Person is covered under this Certificate.

B007.0316

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 makes a Diagnosis.

B007.0318

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 makes a definite clinical Diagnosis of a cleft lip or palate.

B007.0319

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 makes a definite Diagnosis of Clubfoot.

B007.0320

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 mmof/L.

We deem Cystic Fibrosis to occur on the first date after live birth where Cystic Fibrosis has been definitively Diagnosed by a Doctor via sweat test.

B007.0321

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 completes a chromosome test that positively reveals Down Syndrome.

B007.0322

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 makes a Diagnosis.

B007.0323

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 makes a Diagnosis.

B007.0324

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 makes a Diagnosis.

B007.0325

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 makes a Diagnosis.

B007.0327

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 makes a Diagnosis.

B007.0328

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 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.

B007.0329

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 Sickness 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 a licensed audiologist or Doctor.

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 Certificate, and the Diagnosis is confirmed on or after the child reaches age 3 and remains insured by this Certificate.

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.

B007.0330

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 Certificate, and the Diagnosis is confirmed on or after the child reaches age 3 and remains insured by this Certificate.

We deem Loss of Sight to occur on the date on which a licensed ophthalmologist or Doctor 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.

B007.0331

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 sickness 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 or Doctor.

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 Certificate, and the Diagnosis is confirmed on or after the child reaches age 3 and remains insured by this Certificate.

We deem Loss of Speech to occur on the date on which a Doctor physically examines the Covered Person and certifies that the Covered Person meets the definition above.

B007.0332

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 makes a Diagnosis.

B007.0334

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

Specific Organ Failure

We pay a benefit if a Covered Person is Diagnosed with Specific Organ Failure. By Specific Organ Failure, we mean the irreversible failure of any of the following major organs: both lungs, liver, pancreas, or bone marrow, which requires a human to human transplant determined to be Medically Necessary by a Doctor. Heart Failure and Kidney Failure are covered a separate benefits.

We deem Specific 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 Specific Organ Failure to occur on the date a Doctor 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 or the Kidney Failure provision at the same time.

We pay no benefits for autologous bone marrow transplants.

B007.0333

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

Exclusions

1) This Certificate will not pay benefits for any Critical Illness:

- That is not listed as a Critical Illness in the section entitled Covered Critical Illnesses.
- Resulting from: (1) participating in a riot or insurrection; (2) committing or attempting to commit a felony, (3) intentionally causing a self-inflicted Injury; (4) committing or attempting to commit suicide while sane or insane; or (5) engaging in an illegal occupation.
- Voluntary use of any poison or chemical, or being intoxicated or under the influence of any narcotic unless administered on the advice of a physician.
- 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 Certificate.
- 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 Certificate 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 Certificate 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 Certificate will not pay benefits for a Recurrence of a Critical Illness unless the Covered Person has not 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 Certificate will not pay benefits for more than one Recurrence of any Critical Illness.

B007.0351

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 coverage under this Certificate 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. You must notify the Employer of any desired switch and pay the required premium.

B007.1173

All Options

Annual Election After You are initially covered under this Certificate You may increase Your coverage by selecting the next higher Critical Illness Benefit Amount, up to the 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.

B007.1202

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

GC-SCH-CI-18-CA

All Options			
	Carcinoma in Situ (Non-Invasive Cancer)	30%	Not Covered
All Options			
	Invasive Cancer	100%	50%
All Options			
	Specified Skin Cancer	$250.00	Not Covered
All Options			
Vascular Conditions:			
All Options			
	Arteriosclerosis	30%	Not Covered
All Options			
	Heart Attack	100%	50%
All Options			
	Heart Failure	100%	50%
All Options			
	Stroke	100%	50%
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%	50%

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%	50%
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

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 $30,000.00.

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 $30,000.00.

B007.1207

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 $15,000.00.

B005.0404

All Options

Dependent Child Critical Illness Benefit Amount

$7,500.00 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 $15,000.00.

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 - Portability Privilege

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 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 Critical Illness coverage.

Portability Conditions: Portability is subject to all of the Conditions described below.

- You may port if Your coverage under this Certificate ends because: (1) You have terminated employment; (2) You stop being a member of an eligible class of Employees; or (3) the Policy providing this coverage ends.
- You may **not** port Your coverage if You have reached Your 70th birthday on the date coverage under this Certificate 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 Certificate ends.
- You may **not** port if coverage under this Certificate ends due to Your failure to pay any required premium.

Portability Options: You may port Your Critical Illness coverage, subject to any benefit amount reductions based on age, less the amount of any Critical Illness benefits paid by this Certificate.

You may port Your dependent's Critical Illness coverage, subject to any benefit amount reductions based on Your age, less the amount of any Critical Illness benefits paid by this Certificate.

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 Certificate ends in order to be eligible for portability.

If You die while covered for dependent Critical Illness coverage, Your Spouse may port Your dependent Critical Illness coverage as described above. Your Spouse and dependent children must be covered under this Certificate 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 Critical Illness. The benefits provided by the portable certificate of coverage are the same as the benefits provided by this Certificate. 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 Certificate; and (2) Your surviving Spouse's age bracket as shown in the Critical Illness 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 Certificate 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

Michael Prestileo, Senior Vice President

B007.0648

GC-R-CI-PORT-14-CA

CERTIFICATE RIDER - Wellness Benefit

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 Certificate by the addition of the following:

Wellness Benefit

This Certificate 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 Certificate and Your dependent Spouse and Covered Dependent Child(ren).

This Certificate 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
- Human papillomavirus screening
- Cervical Cancer Screening
- 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

Michael Prestileo, Senior Vice President

B007.0664

GC-R-CI-WELL-14-CA

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 the Certificate 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 Certificate 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 Certificate 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 Certificate 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 Certificate 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 Certificate 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; 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.

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

The Guardian Life Insurance Company of America

Michael Prestileo, Senior Vice President

B005.0758

GC-A-CI-GI-18-CA

AMENDATORY RIDER

This Rider amends the Certificate and Policy as follows and is effective on the later of the Policy Date or the date requested by the Policyholder.

The definition of **Spouse** and **Domestic Partner** is replaced with the following:

Spouse: The person to whom You are legally married or Your **Domestic Partner** or civil union partner.

Domestic Partner: The same-sex or different-sex person with whom You have registered Your relationship with any state or local governmental domestic partner registry

Or

the same-sex or different-sex person with whom you have not registered your relationship if you satisfy the following requirements:

- You live and share financial assets and obligations with this person.
- This person is at least 18 years of age, is able to provide legal consent, and is not a blood relative.
- Neither you nor this person are in a marriage or domestic partnership with anyone else or legally separated from anyone else.
- You submit acceptable documentation that you meet the above criteria. An affidavit attesting to these facts may be required.

Except as specifically noted above for relationships that are not registered, **Domestic Partners** are not subject to any proof of relationship or waiting period requirements that are not also imposed upon marriages. A **Domestic Partner** registry certificate will be accepted as fully equivalent to a marriage certificate. Similarly, a dissolution of domestic partnership notice will be accepted as fully equivalent to a divorce decree.

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

The Guardian Life Insurance Company of America

Michael Prestileo, Senior Vice President

B601.0243

GC-A-DP-21-CA

CERTIFICATE AMENDATORY RIDER - Dependent Termination

This Rider amends the Certificate as follows and is effective on the Policy Date. If this Rider is effective after the Policy Date, the Rider becomes effective on its issue date.

The **When Dependent Coverage Ends** provision is replaced in its entirety with the following:

When Dependent Coverage Ends

Dependent coverage ends for all of Your dependent(s) as follows:

- When Your Employee coverage ends;
- When You stop being a member of a class of Employees eligible for such coverage;
- When this Certificate ends, or dependent coverage is discontinued for a class of Employees to which You belong;
- On the last day of the period for which required payments are made for Your dependent(s);
- For Your child, on the last day of the month in which he or she attains the age limit or no longer qualifies under Continuing Coverage For Dependent Children Past the Age Limit.
- It also happens on the last day of the month in which Your stepchild is no longer dependent on You for at least 50% of his or her support and maintenance.
- For Your Spouse, on the last day of the month in which Your marriage is lawfully terminated.
- On the date Your dependent dies.

The **Handicapped Children** provision is replaced in its entirety with the following:

Continuing Coverage For Dependent Children Past the Age Limit

An unmarried child that meets all of the conditions below may continue coverage past the child age limit:

- The child must be incapable of living independently due to a mental, physical, or developmental disability;
- The child must be primarily dependent upon You for support and maintenance;
- The child's mental, physical, or developmental disability must have begun before he or she reached the age limit; and
- The child must have been covered by this Certificate, or the prior carrier's group plan that it replaced, before he or she reached the age limit, and remained continuously covered until he or she reached the age limit.

You will have to send us documentation that your child meets these requirements within 31 days of the date the age limit was reached.

After two years has passed from the date the age limit was reached, we may periodically ask for documentation that your child continues to meet these requirements. We won't ask for this more than once a year.

Any coverage provided under this section ends when Your coverage ends, or your child no longer meets the conditions above.

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

The Guardian Life Insurance Company of America

Michael Prestileo, Senior Vice President

B005.0836

GC-A-DCE-20

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

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

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

CERTIFICATE OF COVERAGE

The Guardian 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, 2025. 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.

GROUP ACCIDENT COVERAGE

NOTE: This is a supplement to health insurance. It is not a substitute for essential health benefits or minimum essential coverage as defined in federal law. It is also not a substitute for hospital or medical expense insurance, a health maintenance organization (HMO) contract, or major medical expense insurance.

READ YOUR CERTIFICATE CAREFULLY.

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: FIVE9 INC.

Group Policy Number: 00477224

The Guardian Life Insurance Company of America

Harris Oliner, Senior Vice President,
Corporate Secretary

Michael Prestileo,
Senior Vice President

B442.1777

GC-ACC-18-CA

COMPLAINT NOTICE

This notice is to advise you that should any complaints arise regarding this insurance you may contact the Guardian at the following address or phone number:

The Guardian Life Insurance Company of America
10 Hudson Yards
New York, New York 10001
Telephone: (212) 598-8794
(800) 541-7846

If you feel your complaints have not been resolved after contacting the Guardian you may contact the California Department of Insurance at the following address and phone number:

California Department of Insurance
Consumer Communications Bureau
300 South Spring Street, South Tower
Los Angeles, California 90013

Consumer Hotline: 1 (800) 927-4357 or TDD 1 (800) 482-4833)
CA Department of Insurance's consumer affairs unit:
www.insurance.ca.gov/01-consumers/

B442.1778

GC-ACC-18-CA

TABLE OF CONTENTS

GENERAL PROVISIONS

Entire Contract; Changes

The Policy, the application of the Policyholder and the individual applications, if any, of the individuals insured shall constitute the entire contract between the parties, and any statements made by the Policyholder, or by the individuals insured shall, in the absence of fraud, be deemed representations and not warranties. No such statement shall be used in defense to a claim under the policy, unless it is contained in a written application.

No change in this policy shall be valid unless approved by an executive officer of Guardian and evidenced by endorsement hereon, or by amendment hereto signed by the Policyholder and by an executive officer of Guardian. No agent has authority to change this policy or waive any of its provisions.

Time Limit On Certain Defenses

After the Policy has been in force for a period of three years, no statements of the Policyholder contained in the application, and no statement relating to insurability made by any Employee eligible for coverage under the Policy shall be used to deny a claim or in contesting the validity of the insurance with respect to which such statement was made after the insurance has been in force prior to the contest for a period of three years during the lifetime of the person with respect to whom any such statement was made.

No claim for loss incurred or disability commencing after three years from the effective date of the insurance coverage with respect to which the claim is made shall be reduced or denied on the grounds that a disease or physical condition, not excluded from coverage by name or specific description effective on the date of loss, had existed prior to the effective date of the coverage with respect to which the claim is made.

Fraudulent Statement

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.

B442.1780

Notice Of Claim

Written notice of claim must be given to Us within 20 days after the occurrence or commencement of any loss covered by the Policy, or as soon thereafter as is reasonably possible.

Claim Forms

Upon receipt of a written notice of claim, We will furnish to the claimant the forms for filing proofs of loss. If such forms are not furnished within 15 days after the giving of such notice the claimant shall be deemed to have complied with the requirements of this Policy as to proof of loss upon submitting, within the time fixed in the Policy for filing proofs of loss, written proof covering the occurrence, the character and the extent of the loss for which claim is made.

Proof of Loss

Written proof of loss must be furnished to Us within 90 days after the date of such loss. Failure to furnish such proof within the time required shall not invalidate nor reduce any claim if it was not reasonably possible to give proof within such time, provided such proof is furnished as soon as reasonably possible and in no event, except in the absence of legal capacity of the Covered Person, later than one year from the time proof is otherwise required.

Time Of Payment Of Claim

Subject to due written proof of loss, all indemnities for loss for which this Policy provides payment will be paid to the Covered Person as they accrue and any balance remaining unpaid at termination of the period of liability will be paid to the Covered Person immediately upon receipt of due written proof.

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

B442.1781

Legal Actions

No action at law or in equity shall be brought to recover on this Policy prior to the expiration of 60 days after written proof of loss has been furnished in accordance with the requirements of this Policy. No such action shall be brought after the expiration of three years after the time written proof of loss is required to be furnished.

Conformity With State Statutes

Any provision of this policy which, on its effective date, is in conflict with the statutes of the state in which this policy was delivered or issued for delivery is hereby amended to conform to the minimum requirements of such statute.

Physical 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.

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.

B442.1782

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.

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 Group Accident coverage Your Employer offers. A group enrollment period is usually held once a year and often lasts for 30 days.

B442.0014

All Options

On the date all or part of Your coverage is scheduled to start, You must be: (1) Actively At Work; and (2) 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 return to Active Work and are working Your regular number of hours. 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 able to work in 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.

B442.1881

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 last day of the month in which Your Active Work ends for any reason.
- The last day of the month in which 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.

B442.0020

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 3 month(s) following the date the leave or layoff begins.
- The end of the time period covered under a severance agreement not to exceed 3 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 Your Domestic Partner's natural child, adopted child, or stepchild 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.

B442.1784

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, on the last day of the month in which Your marriage ends in legal divorce or annulment;
- The date Your dependent dies.

B442.0034

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 on the last day of the month in which 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;

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.

B442.0036

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 Person's 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 directly resulting from 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 $20,000.00 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.

B442.1785

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 Accident.

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 result in the death of the Covered Person. It must be directly resulting from 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 directly resulting from 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.

B442.1787

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 a licensed outpatient facility. This benefit is payable once per Covered Person per Covered Accident.

B442.1788

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 a 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.

B442.1789

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 a licensed outpatient facility. This benefit is payable once per Covered Person per Covered Accident.

B442.1790

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

ADDITIONAL 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 of Claim 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.

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

For details, the Covered Person can call Us at 1-800-268-2525.

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.

Workers' Compensation: The Accident benefits provided by this Certificate are not in place of and do not affect requirements for coverage by Workers' Compensation.

B442.1791

EXCLUSIONS

This Certificate will not pay benefits for any Injury or Accident that directly results from any of the following:

- 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 directly resulting from use of the drug 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.
- 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.
- Job related or on the job injuries for the Employee.
- An Accident that occurs before the Covered Person is covered by this Certificate.
- Injuries to a dependent child received during birth.

B442.1883

All Options

DEFINITIONS

This section defines certain terms appearing in Your Certificate.

B442.0088

All Options

Accident: This term means an unexpected event or occurrence. The term Accident does not include a Sickness.

B442.1794

All Options

Accidental Death: This term means death resulting from an Accident.

B442.1795

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

Arthroscopic Surgery: This term means a minimally invasive surgical procedure in which an examination, and sometimes treatment, of damage of the interior of a joint is performed using an arthroscope, a type of endoscope that is inserted into the joint through a small incision. Arthroscopic procedures can be performed either to evaluate or to treat many orthopaedic conditions including torn floating cartilage, torn surface cartilage, ACL reconstruction, and trimming damaged cartilage.

B442.1796

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 directly resulting from 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.

B442.1797

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 qualified 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. **"Doctor"** includes a qualified medical professional, which means an individual whose education, training, experience and licensing qualify him or her, acting within the scope of that license, to diagnose or treat Sickness or Injury.

B442.1798

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

Exploratory Surgery: This term means surgery performed for diagnostic purposes, rather than to treat a condition.

B442.1800

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

Hernia Surgery: This term means surgery to repair a hernia, which is a weakness in a muscle allowing part of an internal organ to push through.

B442.1801

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 physical damage or harm inflicted on the Covered Person's body; not directly resulting from Sickness or disease. The Injury must occur while a Covered Person is insured under this Certificate.

B442.1802

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; and 3) performs services which are allowed by his or her license.

B442.1803

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 accomplish the ordinary tasks of daily living, and those tasks required by a Covered Person's particular occupational role.

B442.1804

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; and 3) practices according to the code of ethics of the American Physical Therapy Association.

B442.1805

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 a 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.

B442.1806

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; and 3) has passed a national certifying examination and performs services which are allowed by his or her certification. The NBRC (National Board for Respiratory Care) is the not for profit organization responsible for credentialing the seven areas of Respiratory Therapy.

B442.1807

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, which includes 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.

B442.1808

All Options

Thoracic Surgery: This term means surgery of the thorax or chest.

B442.1809

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

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: $20,000.00 Your Spouse: $10,000.00 Your Children: $5,000.00
All Options	
Accidental Death Common Carrier	200% of the Accidental Death benefit amount
All Options	
Accidental Death Common Disaster	200% of the Spouse Accidental Death benefit amount
All Options	
Accidental Dismemberment	Loss of a hand, foot or sight: 50% of Accidental Death benefit. **Multiple Losses of hand, foot or sight:** For more than one covered loss due to the same Accident, We will pay 100% of the Accidental Death benefit. Loss of thumb and index finger of same hand, or loss of four fingers of same hand: 25% of Accidental Death benefit. Loss of all toes of same foot: 25% of Accidental Death benefit. We will not pay more than $20,000.00 for all losses due to the same Covered Accident.

All Options

Accidental Death Seatbelt and Airbag benefit	Seatbelt: $10,000.00 Seatbelt and Airbag: $15,000.00

All Options

Air Ambulance	$1,000.00

All Options

Ambulance	$200.00

All Options

Blood/Plasma/Platelets	$300.00

All Options

Burn	**2nd Degree** From 18 sq inches up to 34 sq inches: $1,000.00 35 sq inches and over: $3,000.00 **3rd Degree** From 9 sq inches to 17 sq inches: $2,000.00 From 18 sq inches to 34 sq inches: $4,000.00 35 sq inches and over: $12,000.00

All Options

Burn-Skin Graft	50% of burn benefit

All Options

Catastrophic Loss	Quadriplegia: 100% of Accidental Death benefit Loss of speech and hearing (both ears): 100% of Accidental Death benefit Loss of cognitive function: 100% of Accidental Death benefit Hemiplegia: 50% of Accidental Death benefit Paraplegia: 50% of Accidental Death benefit

All Options

Child Organized Sport (applies only to covered dependent children age 18 or younger)	Additional 25% of payable benefits

All Options

Chiropractic Visits	$50.00 per visit

All Options	
Coma	$10,000.00
All Options	
Concussions	$200.00
All Options	
Concussion Baseline Study (applies only to covered dependent children age 18 or younger	$25.00
All Options	

Dislocations	**Closed/Open**
All Options	
● Hip	$2,000.00/$5,000.00
All Options	
● Knee	$1,625.00/$3,250.00
All Options	
● Shoulder	$1,250.00/$2,500.00
All Options	
● Collar bone (sternoclavicular)	$500.00/$1,000.00
All Options	
● Collar bone (acromioclavicular and separation)	$100.00/$200.00
All Options	
● Ankle or Foot	$1,000.00/$2000.00
All Options	
● Lower jaw	$750.00/$1,500.00
All Options	
● Wrist or elbow	$625.00/$1,250.00
All Options	
● Toe or finger	$200.00/$400.00

All Options

● Bones of the hand	$875.00/$1,750.00

All Options

Diagnostic Exam (Major)	$200.00

All Options

Doctor Follow-Up Visit	$50.00

All Options

Emergency Dental Work	Crown: $300.00 Extraction: $75.00

All Options

Emergency Room Treatment	$200.00

All Options

Epidural Anesthesia Pain Management	$100.00

All Options

Eye Injury	$300.00

All Options

Family Care	$20.00 per day

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 per day

All Options

Hospital ICU Admission	$2,000.00

All Options

Hospital ICU Confinement	$500.00 per day

All Options

Initial Doctor's Office/Urgent Care Facility Treatment	$100.00

All Options

Joint Replacement	Hip: $2,500.00 Knee: $1,250.00 Shoulder: $1,250.00

All Options

Knee Cartilage	$500.00

All Options

Laceration	No sutures required: $40.00 Lacerations 4cm or less: $60.00 Lacerations 5cm up to 14 cm: $200.00 Lacerations 15cm or more: $400.00

All Options

Lodging	$125.00 per day

All Options

Medical Appliance	**Limit for all Medical Appliances combined, per Covered Person, per Covered Accident is $500.00**

All Options

● Brace for back, leg or neck	$100.00

All Options

● Cane	$50.00

All Options	
● Crutches	$50.00
All Options	
● Walker	$200.00
All Options	
● Walking Boot	$100.00
All Options	
● Wheel Chair or Motorized Scooter	$250.00
All Options	
● Other medical device used for mobility	$50.00
All Options	
Outpatient Therapy	$35.00 per day
All Options	
Post-Traumatic Stress Disorder	$400.00
All Options	
Prosthetic Device/Artificial Limb	One: $500.00 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 Hernia: $250.00
All Options	
Surgery - Exploratory or Arthroscopic	$400.00

All Options

Tendon/Ligament/Rotator Cuff	One: $500.00 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 - Sickness Hospital Confinement Benefit

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:

NOTE: This is a limited insurance benefit and is a supplement to health insurance. It is not a substitute for essential health benefits or minimum essential coverage as defined in federal law. It is also not a substitute for hospital or medical expense insurance, a health maintenance organization (HMO) contract, or major medical expense insurance.

Sickness Hospital Confinement Benefit

SCHEDULE OF BENEFITS

Daily Hospital Confinement Benefit:	Employee: $25.00 Dependent: $25.00
Elimination Period:	Employee: 3 days Dependent: 3 days
Maximum Benefit Period Confinement:	Employee: 10 days Dependent: 10 days

BENEFITS

Hospital Confinement: We pay the Daily Hospital Confinement Benefit shown in the Schedule of Benefits above if a Covered Person is confined to a Hospital as the result of a Sickness. This benefit is payable up to the Maximum Benefit Period Per Confinement shown in the Schedule of Benefits above, per Covered Person, after the Elimination Period, if applicable. If a Covered Person is Hospital Confined for more than one Sickness at the same time, We will only pay one Daily Hospital Confinement Benefit per day.

Recurrent Hospital Confinement: If the Covered Person is Hospital Confined within 90 days of a prior Hospital Confinement for which a benefit was payable, We will treat the later Hospital Confinement as a continuation of the prior Hospital Confinement and the Daily Hospital Confinement Benefit will be paid until the Maximum Benefit Period Per Confinement is reached. If the Maximum Benefit Period Per Confinement has already been reached, no additional benefit will be paid. If more than 90 days have passed between the periods of Hospital Confinement, We will treat the later Hospital Confinement as a new and separate Hospital Confinement.

LIMITATIONS AND EXCLUSIONS

Pre-Existing Conditions: A Pre-existing Condition is a Sickness for which, in the "look back period" a diagnosis, care or treatment, including the use of prescription medications, was recommended by or received from a Doctor for the Covered Person.

The "look back period" is the 3 months before the latest of:

- The effective date of the Covered Person's coverage under this Rider;
- The effective date of a change that increases the benefits payable by this Rider; and
- The effective date of a change in the Covered Person's benefit election that increases the benefit payable by this Rider.

No benefits are payable for Hospital Confinement caused by a Pre-existing Condition, unless the Hospital Confinement starts after the date the Covered Person has been covered under this Rider for 12 months in a row.

We do not cover any Hospital Confinement that starts before Your coverage under this Rider.

Exclusions: This Rider does not pay benefits for Hospital Confinement caused by:

- Injury;
- Treatment for dental care or dental care procedures;
- Elective procedures and/or cosmetic surgery or reconstructive surgery; unless it is needed to (a) correct a deformity caused by: (i) a congenital or developmental abnormality; or (ii) a disfiguring Sickness, physical disease, trauma, infection, tumor or Injury. or (b) restore and achieve symmetry for the patient following mastectomy.

CLAIM PROVISIONS

Notice: Written notice of claim must be given to Us within 20 days after the occurrence or commencement of any loss covered by the Policy, or as soon thereafter as is reasonably possible. 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: Written proof of loss must be furnished to Us within 90 days after the date of such loss. Failure to furnish such proof within the time required shall not invalidate nor reduce any claim if it was not reasonably possible to give proof within such time, provided such proof is furnished as soon as reasonably possible and in no event, except in the absence of legal capacity of the Covered Person, later than one year from the time proof is otherwise required.

Proof of Loss should be submitted to:

The Guardian Life Insurance Company of America
Group Accident Claims Department

Authorization Required: The Covered Person must provide Us with written, unaltered authorizations to obtain medical information required to determine Our liability under this Rider. The Covered Person must provide Us with such authorizations as often as We may require, in order that they remain current. Failure to provide such authorizations may delay, suspend or terminate benefits.

Payment Of Benefits: We pay benefits to the Covered Person, if legally competent. If the Covered Person is not legally competent, We pay benefits to the legal representative of the Covered Person's estate. Benefits are paid in U.S. dollars.

No benefits are payable for this Rider's Elimination Period.

Benefits to which the Covered Person is entitled may remain unpaid at his or her death. Such benefits may be paid to one of the following: estate, Spouse, parent, child, brother or sister of the Covered Person.

Overpayment Recovery: If We overpaid the Covered Person, he or she must repay Us in full. We have the right to reduce payment, or apply any future benefits payable toward recovery of the overpayment.

DEFINITIONS

This section defines certain terms appearing in this Rider. Any terms not listed here, are defined in the Certificate.

Covered Person: This term means You, as an Employee covered under this Rider or Your covered dependent Spouse or child.

Doctor: This term means any qualified 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. **"Doctor"** includes a qualified medical professional, which means an individual whose education, training, experience and licensing qualify him or her, acting within the scope of that license, to diagnose or treat Sickness or Injury.

Elimination Period: This term means the period which starts on the date the Covered Person is first admitted to the Hospital.

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.

Employee: This term means You as 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.

Employer: This term means the entity that purchased the Policy.

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.

Hospital Confinement: This term means admission to a Hospital as an Inpatient for at least 24 consecutive hours by a Doctor for treatment or diagnosis of a Sickness. Hospital Confinement does not include Confinement for a newborn child following birth, unless the newborn child is Confined to the Hospital Intensive Care Unit of the Hospital. We do not pay this benefit for a Hospital stay less than 20 hours in an observation unit, or when a charge for room and board is not made. This benefit is not payable for Emergency Room treatment or Outpatient Treatment.

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.

Inpatient: This term means a patient who is admitted to a Hospital.

Outpatient Treatment: This term means medical services that a Covered Person receives when not confined as an Inpatient in a Hospital.

Recurrent Hospital Confinement: This term means a Hospital Confinement that is caused by a Sickness, which is the same as, or related to the Sickness, for which We paid a prior Hospital Confinement Benefit.

Sickness: This term means an illness or disease that results in Hospital Confinement and which begins while a Covered Person is covered under this Rider. Pregnancy is treated as a Sickness under this Rider.

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

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

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

The Guardian Life Insurance Company of America

Michael Prestileo, Senior Vice President

B442.0508

GC-R-ACC-HC-18-CA

CERTIFICATE RIDER - Wellness Benefit

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:

NOTE: This is a limited insurance benefit and is a supplement to health insurance. It is not a substitute for essential health benefits or minimum essential coverage as defined in federal law. It is also not a substitute for hospital or medical expense insurance, a health maintenance organization (HMO) contract, or major medical expense insurance.

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. Generally medically accepted cancer screening tests are included on the same terms as other screenings. Wellness tests or procedures are:

- 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.

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

Michael Prestileo, Senior Vice President

B442.2378

GC-R-ACC-WELL-18-CA

CERTIFICATE RIDER - Portability Privilege

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

Michael Prestileo, Senior Vice President

B442.0553

GC-R-ACC-PORT-18

CERTIFICATE AMENDATORY RIDER - Telemed

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 replacing the **Doctor Follow-Up Visit** provision in the **Accident Benefits** section as shown below.

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, through Telemedicine Services, 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.

This Rider also amends the **Definitions** section of the Certificate by adding the definition shown below.

Telemedicine Services: A medical inquiry with a Doctor via the use of telecommunication and information technologies (including, but not limited to, audio or video communications) for the Covered Person's evaluation, diagnosis, or treatment as would be practiced in person. This does not include requests for prescription refills, test results or medical records.

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

The Guardian Life Insurance Company of America

Michael Prestileo, Senior Vice President

B442.2096

GC-A-TELEMED2.0-20

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

AMENDATORY RIDER

This Rider amends the Certificate and Policy as follows and is effective on the later of the Policy Date or the date requested by the Policyholder.

The definition of **Spouse** and **Domestic Partner** is replaced with the following:

Spouse: The person to whom You are legally married or Your **Domestic Partner** or civil union partner.

Domestic Partner: The same-sex or different-sex person with whom You have registered Your relationship with any state or local governmental domestic partner registry

Or

the same-sex or different-sex person with whom you have not registered your relationship if you satisfy the following requirements:

- You live and share financial assets and obligations with this person.
- This person is at least 18 years of age, is able to provide legal consent, and is not a blood relative.
- Neither you nor this person are in a marriage or domestic partnership with anyone else or legally separated from anyone else.
- You submit acceptable documentation that you meet the above criteria. An affidavit attesting to these facts may be required.

Except as specifically noted above for relationships that are not registered, **Domestic Partners** are not subject to any proof of relationship or waiting period requirements that are not also imposed upon marriages. A **Domestic Partner** registry certificate will be accepted as fully equivalent to a marriage certificate. Similarly, a dissolution of domestic partnership notice will be accepted as fully equivalent to a divorce decree.

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

The Guardian Life Insurance Company of America

Michael Prestileo, Senior Vice President

B601.0243

GC-A-DP-21-CA

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

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

CERTIFICATE OF COVERAGE

The Guardian
10 Hudson Yards
New York, New York 10001

The group Hospital Indemnity coverage described in this Certificate is attached to the group Policy effective January 1, 2025. This Certificate replaces any Certificate previously issued under this Certificate or under any other Certificate providing similar or identical benefits issued to the Policyholder by Guardian.

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 Certificate carefully to fully understand what it covers, limits, and excludes. This Certificate does not meet the Federal requirement for health coverage under the Affordable Care Act.

This is a supplement to health insurance. It is not a substitute for essential health benefits or minimum essential coverage as defined by federal law.

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 Certificate's eligibility and effective date requirements; (b) be listed in Our and/or the Policyholder's records as a validly covered Employee under this Certificate; 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 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: FIVE9 INC.

Group Policy Number: 00477224

The Guardian Life Insurance Company of America

Michael Prestileo, Senior Vice President

B007.0902

GC-HI-15-CA

COMPLAINT NOTICE

This notice is to advise you that should any complaints arise regarding this insurance you may contact the Guardian at the following address or phone number:

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

Telephone: (212) 598-8000
(800) 541-7846

If you feel your complaints have not been resolved after contacting the Guardian you may contact the California Department of Insurance at the following address and phone number:

California Department of Insurance
Consumer Communications Bureau
300 South Spring Street, South Tower
Los Angeles, California 90013

Consumer Hotline: 1 (800) 927-4357 or TDD 1 (800) 482-4833
Website: www.insurance.ca.gov/01-consumers/

B007.1151

GC-HI-15-CA

TABLE OF CONTENTS

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

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 results from, 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.

B007.0910

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 Certificate.

B007.0912

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 Certificate and Your covered dependents.

B007.0914

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 Certificate is in force; and is not excluded by name or specific description in the Certificate. All related conditions and recurring symptoms of Sickness to the same person will be considered one Sickness.

B007.0916

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 Certificate. Clinical diagnosis is permitted whenever such diagnosis is consistent with professional medical standards.

B007.0918

All Options

Doctor: This term means any qualified 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. "Doctor" includes a qualified medical professional, which means an individual whose education, training, experience and licensing qualify him or her, acting within the scope of that license, to diagnose or treat Sickness or Injury.

B007.0919

All Options

Domestic Partner: This term means Your domestic partner who is an adult who has chosen to share his or her life with You in an intimate and committed relationship of mutual caring as defined under Section 297 of the California Family Code.

B010.0625

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 (a) correct a deformity resulting from: (i) a congenital or developmental abnormality; or (ii) a disfiguring Sickness, physical disease, trauma, infection, tumor or Injury or (b) restore and achieve symmetry for the patient following mastectomy.

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.

B007.0921

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 You: (1) have Initial Dependents; and (2) are eligible for dependent coverage.

B007.0922

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 FIVE9 INC. .

B005.0546

All Options

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

B005.0547

All Options

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

(1) is primarily engaged in providing, by or under the continuous supervision of Doctors, to Inpatients, Diagnostic services and therapeutic services, for Diagnosis, treatment and care of sick or injured persons;

(2) has organized departments of medicine and major surgery;

(3) has a requirement that every patient must be under the care of a Doctor or dentist;

(4) provides 24 hour Nursing service by or under the supervision of a registered professional Nurse (R.N.);

(5) is duly licensed by the agency responsible for licensing such Hospitals; and

(6) is not, other than incidentally: (a) a place of rest; (b) a place primarily for the treatment of tuberculosis; (c) a place for the aged; (d) a place for drug addicts or alcoholics; or (e) a place for convalescent, custodial, educational or rehabilitative care.

B005.0550

All Options

Hospital Intensive Care Unit: This term means a designated area of a Hospital that:

(1) provides the highest quality of medical care and is restricted to patients who are critically ill and who require intensive comprehensive observation and care;

(2) is separate and apart from the surgical recovery room and from rooms, beds, wards, and units customarily used for patient Confinement;

(3) is permanently equipped with special lifesaving equipment for the care of the critically ill;

(4) is under continuous observation by a specially trained Nursing staff assigned exclusively to the Intensive Care Unit on a 24 hour basis and is assigned a Doctor on a full-time basis.

B005.0551

All Options

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

B005.0552

All Options

Injury: This term means 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 Certificate.

B007.0931

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 recommended by a Doctor acting within the scope of his or her license.

B007.0934

All Options

Newly Acquired Dependent: This term means an eligible dependent You acquire after You already have coverage in force for Initial Dependents. This includes a newly acquired dependent of your Domestic Partner.

B007.0936

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

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 your Domestic Partner.

B010.0630

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

Entire Contract, Changes

The Policy, the application of the Policyholder and the individual applications, if any, of the individuals insured shall constitute the entire contract between the parties, and any statements made by the Policyholder, or by the individuals insured shall, in the absence of fraud, be deemed representations and not warranties. No such statement shall be used in defense to a claim under the policy, unless it is contained in a written application. No change in this policy shall be valid unless approved by an executive officer of Guardian and evidenced by endorsement hereon, or by amendment hereto signed by the Policyholder and by an executive officer of Guardian. No agent has authority to change this policy or waive any of its provisions.

B007.0263

All Options

Time Limit On Certain Defenses

After the Policy has been in force for a period of two years, no statements of the Policyholder contained in the application, and no statement relating to insurability made by any Employee eligible for coverage under the Policy shall be used to deny a claim or in contesting the validity of the insurance with respect to which such statement was made after the insurance has been in force prior to the contest for a period of two years during the lifetime of the person with respect to whom any such statement was made.

No claim for loss incurred for Covered Sickness or Injury commencing after two years from the effective date of the insurance coverage with respect to which the claim is made shall be reduced or denied on the ground that a disease or physical condition, not excluded from coverage by name or specific description effective on the date of loss, had existed prior to the effective date of the coverage with respect to which the claim is made.

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.

B007.0950

Notice Of Claim

Written notice of claim must be given to Us within 20 days after the occurrence or commencement of any loss covered by the Policy, or as soon thereafter as is reasonably possible.

Claim Forms

Upon receipt of a written notice of claim, We will furnish to the claimant the forms for filing proofs of loss. If such forms are not furnished within 15 days after the giving of such notice the claimant shall be deemed to have complied with the requirements of this Policy as to proof of loss upon submitting, within the time fixed in the Policy for filing proofs of loss, written proof covering the occurrence, the character and the extent of the loss for which claim is made.

Proof of Loss

Written proof of loss must be furnished to Us within 90 days after the date of such loss. Failure to furnish such proof within the time required shall not invalidate nor reduce any claim if it was not reasonably possible to give proof within such time, provided such proof is furnished as soon as reasonably possible and in no event, except in the absence of legal capacity of the Covered Person, later than one year from the time proof is otherwise required.

Time Of Payment Of Claim

Subject to due written proof of loss, all indemnities for loss for which this Policy provides payment will be paid to the Covered Person as they accrue and any balance remaining unpaid at termination of the period of liability will be paid to the Covered Person immediately upon receipt of due written proof.

Unless otherwise required by law or regulation, or stated otherwise in this Certificate, 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 action at law or in equity shall be brought to recover on this Policy prior to the expiration of 60 days after written proof of loss has been furnished in accordance with the requirements of this Policy. No such action shall be brought after the expiration of three years after the time written proof of loss is required to be furnished.

All Options

Conformity With State Statutes

Any provision of this policy which, on its effective date, is in conflict with the statutes of the state in which this policy was delivered or issued for delivery is hereby amended to conform to the minimum requirements of such statute.

B007.0954

All Options

Physical 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. 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.

B007.0955

All Options

Workers' Compensation

The Hospital Indemnity benefits provided by this Certificate are not in place of and do not affect requirements for coverage by Workers' Compensation.

B007.0956

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 Certificate, 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 Certificate'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 30 hours per week) at: (1) the Employer's place of business; (2) some place where the Employer's business requires You to travel; or (3) any other place You and the Employer have agreed upon for the performance of occupational duties.

You are **not** eligible for Hospital Indemnity 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.

B007.0961

All Options

The Service Waiting Period If You are in an eligible class, You are eligible for Hospital Indemnity coverage under this Certificate after You complete the Service Waiting Period, if any, established by the Employer.

B007.0962

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 Certificate. But, if this Certificate 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.

B007.0963

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) 3 months following the date the temporary layoff or approved leave of absence begins. If You become Disabled under this Certificate 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 Certificate.

B007.0964

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; and (2) 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 return to Active Work and are working Your regular number of hours. 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 are able to work in 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 Actively at Work or able to work in 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.

B007.0965

All Options

When Employee Coverage Ends

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

- The last day of the month 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 last day of the month You stop being an eligible Employee under this Certificate.
- 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 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.

B007.0972

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 Certificate. 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 Certificate 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 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.

B007.0973

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, including adopted children and step-children of your Domestic Partner. 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.

B007.0977

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

GC-HI-15-CA

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 Certificate as 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 Hospital Indemnity benefits by only one Employee at a time.

B007.0979

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 Certificate, 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.

B007.0980

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 Certificate ends, or when dependent coverage is dropped from this Certificate 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 Certificate'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.

B007.0983

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 Certificate'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 Certificate. This Certificate pays no benefits for the treatment of a Covered Sickness or Injury other than those listed below in Covered Benefits.

B007.0985

All Options

Covered Benefits

B005.0608

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. 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 Certificate 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.

B007.1002

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.

B007.1006

All Options

Exclusions

This Certificate will not pay benefits for the treatment of any Covered Sickness or Injury 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

And this Certificate 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.
- Rest cures or custodial care, or treatment of sleep disorders;
- 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.

B007.1227

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 Certificate is in force, We will waive the premium for the Certificate 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 Certificate 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 Certificate. 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 Certificate, including the premium for any covered Spouse or Covered Dependent Child if insured under the Certificate.

B007.1068

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

Hospital Admission: $1,000.00 per day

Limited to 1 days per Benefit Year 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: $1,000.00 per day

Limited to 1 days per Benefit Year combined with Hospital Admission.

All Options

Hospital ICU Confinement: $200.00 per day

for first 15 days Hospital ICU Confinement combined with Hospital Confinement.

All Options

Initial Election

When You first become eligible for this Certificate 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.

B007.1093

All Options

EMPLOYEE VOLUNTARY HOSPITAL INDEMNITY COVERAGE

All Options

DEPENDENT VOLUNTARY HOSPITAL INDEMNITY COVERAGE

All Options

Changes To Coverage

Changes in Coverage Amounts

If You are not Actively At Work on a Full-Time basis, any change in Your coverage or the coverage on a covered dependent will not become effective prior to the date You return to Active Work on a Full-Time basis.

Changes In Insurance Classification

If Your classification changes, coverage will not be changed to the new amount until the first day on which You are: (1) Actively At Work on a Full-Time basis; and (2) make a contribution, if required, for the new classification.

If a contribution is required for the new classification for which greater coverage is provided, You must make the required contribution for the new coverage within 31 days of the change. If You do not make the required contribution within 31 days of the change or within 31 days of becoming Actively At Work on a Full-Time basis, if You are not Actively At Work on a Full-Time basis, when Your classification changes, no increase will be allowed due to such change or any later change. In that case, in order to become covered for the greater coverage, You must: (1) make the required contribution for the greater coverage; and (2) furnish Proof of Insurability to Us, which We approve in writing.

B005.0743

CERTIFICATE RIDER

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

Michael Prestileo, Senior Vice President

GC-R-HI-PORT-15 B005.0740

GC-R-HI-PORT-15

AMENDATORY RIDER

This Rider amends the Certificate and Policy as follows and is effective on the later of the Policy Date or the date requested by the Policyholder.

The definition of **Spouse** and **Domestic Partner** is replaced with the following:

Spouse: The person to whom You are legally married or Your **Domestic Partner** or civil union partner.

Domestic Partner: The same-sex or different-sex person with whom You have registered Your relationship with any state or local governmental domestic partner registry

Or

the same-sex or different-sex person with whom you have not registered your relationship if you satisfy the following requirements:

- You live and share financial assets and obligations with this person.
- This person is at least 18 years of age, is able to provide legal consent, and is not a blood relative.
- Neither you nor this person are in a marriage or domestic partnership with anyone else or legally separated from anyone else.
- You submit acceptable documentation that you meet the above criteria. An affidavit attesting to these facts may be required.

Except as specifically noted above for relationships that are not registered, **Domestic Partners** are not subject to any proof of relationship or waiting period requirements that are not also imposed upon marriages. A **Domestic Partner** registry certificate will be accepted as fully equivalent to a marriage certificate. Similarly, a dissolution of domestic partnership notice will be accepted as fully equivalent to a divorce decree.

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

The Guardian Life Insurance Company of America

Michael Prestileo, Senior Vice President

B601.0243

GC-A-DP-21-CA

The Guardian Life Insurance Company of America

CERTIFICATE AMENDATORY RIDER

This Rider amends the Certificate as follows and is effective on the Policy Date. If this Rider is effective after the Policy Date, the Rider becomes effective on its issue date.

All Options

The **Hospital Admission or Intensive Care Unit Admission** benefit is replaced with the following:

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. A Covered Person includes a newborn with a Covered Sickness or Injury that incurs a separate Hospital Admission or Intensive Care Unit Admission charge (N.I.C.U.). 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 payable for a Hospital stay of 20 hours or more. 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.

B005.0878

All Options

The **Hospital Confinement or Intensive Care Unit Confinement** benefit is replaced with the following:

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. A Covered Person includes a newborn with a Covered Sickness or Injury that incurs a separate Hospital Confinement or Intensive Care Unit Confinement charge (N.I.C.U.). 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.

B007.1268

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

The Guardian Life Insurance Company of America

Michael Prestileo, Senior Vice President

B005.0888

CERTIFICATE AMENDATORY RIDER - Dependent Termination

This Rider amends the Certificate as follows and is effective on the Policy Date. If this Rider is effective after the Policy Date, the Rider becomes effective on its issue date.

The **When Dependent Coverage Ends** provision is replaced in its entirety with the following:

When Dependent Coverage Ends

Dependent coverage ends for all of Your dependent(s) as follows:

- When Your Employee coverage ends;
- When You stop being a member of a class of Employees eligible for such coverage;
- When this Certificate ends, or dependent coverage is discontinued for a class of Employees to which You belong;
- On the last day of the period for which required payments are made for Your dependent(s);
- For Your child, on the last day of the month in which he or she attains the age limit or no longer qualifies under Continuing Coverage For Dependent Children Past the Age Limit.
- It also happens on the last day of the month in which Your stepchild is no longer dependent on You for at least 50% of his or her support and maintenance.
- For Your Spouse, on the last day of the month in which Your marriage is lawfully terminated.
- On the date Your dependent dies.

The **Handicapped Children** provision is replaced in its entirety with the following:

Continuing Coverage For Dependent Children Past the Age Limit

An unmarried child that meets all of the conditions below may continue coverage past the child age limit:

- The child must be incapable of living independently due to a mental, physical, or developmental disability;
- The child must be primarily dependent upon You for support and maintenance;
- The child's mental, physical, or developmental disability must have begun before he or she reached the age limit; and
- The child must have been covered by this Certificate, or the prior carrier's group plan that it replaced, before he or she reached the age limit, and remained continuously covered until he or she reached the age limit.

You will have to send us documentation that your child meets these requirements within 31 days of the date the age limit was reached.

After two years has passed from the date the age limit was reached, we may periodically ask for documentation that your child continues to meet these requirements. We won't ask for this more than once a year.

Any coverage provided under this section ends when Your coverage ends, or your child no longer meets the conditions above.

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

The Guardian Life Insurance Company of America

Michael Prestileo, Senior Vice President

B005.0851

GC-A-DCE-20

SUMMARY PLAN DESCRIPTION SUPPLEMENT TO CERTIFICATE

You participate in a single or multiple employer insured Welfare Plan. This supplement and your certificate of insurance together may constitute the Summary Plan Description as required by the Employee Retirement Income Security Act of 1974 (ERISA). This supplement should be retained with your certificate.

- **Name of Plan:**

  FIVE9 INC. Plan

- **Employer's Name:** (Plan Sponsor)

  FIVE9 INC.

  Address: 3001 BISHOP RANCH SUITE 350
  SAN RAMON CA 94583

  Phone Number: 925-201-2000

- If you participate in a multiple employer insured Welfare Plan, you may obtain a complete list of the employers sponsoring the plan upon written request to the plan administrator. You may also receive information as to whether a particular employer is a plan sponsor, and if the employer is a plan sponsor, the sponsor's address.

- **IRS Employer Identification Number (EIN):**943394123

- **Plan Number:** 501

- **Type of Administration:**contract administration

- **Plan Administrator:** (if other than Plan Sponsor)

  FIVE9 INC.

  Address: 3001 BISHOP RANCH SUITE 350
  SAN RAMON CA 94583

  Phone Number: 925-201-2000

- **Agent for the Service of Legal Process:**

  FIVE9 INC.

  Address: 3001 BISHOP RANCH SUITE 350
  SAN RAMON CA 94583

  Phone Number: 925-201-2000

  (Legal process may also be served on the Plan Administrator.)

- If the plan is maintained pursuant to one or more collective bargaining agreements, the following information may be obtained by participants and beneficiaries upon written request to the plan administrator, and is available for examination by participants and beneficiaries: a copy of any such collective bargaining agreement; a complete list of the employers and employee organizations sponsoring the plan; and information as to whether a particular employer or employee organization is a sponsor of the plan, and if so, the sponsor's address. For the purpose of this paragraph, a plan is maintained pursuant to a collective bargaining agreement if such agreement controls any duties, rights or benefits under the plan, even though such agreement has been superseded in part for other purposes.

- **Date of End of Record Year:** January 1st .

- **Sources of Contribution:**Contributions to the plan are provided by:

  - the Employer

  - the Employee

  - Both the Employer and the Employee (assuming there are situations where both contribute).

- A class or classes of full-time employees are eligible to apply for insurance provided they have completed the service waiting period established by the employer, if any. Qualified dependents of these employees may also be eligible for insurance. (Your certificate provides details.)

- Participants and beneficiaries under this Plan can obtain, without charge, a copy of procedures governing qualified domestic relations order (QDRO) determinations from the plan administrator.

- **Termination/Amendment/Elimination:**Conditions may exist in the Group Policy where the plan sponsor or others have the authority to terminate the plan, amend or eliminate benefits under the plan. Please see the Plan Administrator for more information regarding these specific conditions and to request a copy of the Group Policy.

- **Assistance:** For information regarding rights under ERISA, contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in the telephone directory, or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, D.C. 20210.

B055.0383

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

YOUR BENEFITS INFORMATION - ANYTIME, ANYWHERE

www.guardianlife.com

You can access helpful, secure information about your Guardian benefits online 24 hours a day, 7 days a week.

Anytime, anywhere you have internet access, you'll be able to:

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

To register, go to **www.guardianlife.com**

B101.0002

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

0000/9999/ /0001/O62173/B/*EOD*