

**The Guardian** Life Insurance Company of America

A Mutual Company - Incorporated 1860 by the State of New York  
7 Hanover Square, New York, New York 10004

**POLICYHOLDER:** UPLIFT EDUCATION

<b>GROUP POLICY NUMBER</b>	<b>DELIVERED IN</b>	<b>POLICY DATE</b>
G-00551834	Texas	September 1, 2018

**POLICY ANNIVERSARIES:** September 1st of each year, beginning in 2019

**THE GUARDIAN LIFE INSURANCE COMPANY OF AMERICA** (herein called the Insurance Company) in consideration of the Application for this Policy and of the payment of premiums as stated herein, **AGREES** to pay benefits in accordance with and subject to the terms of this Policy.

Premiums are payable by the Policyholder as hereinafter provided. The first premium is due on the Policy Date, and subsequent premiums are, during the continuance of this Policy, due on the 1st of each month

This Policy is delivered in the jurisdiction specified above and is governed by the laws thereof.

The provisions set forth on the following pages are part of this Policy.

This Policy takes effect on the Policy Date specified above.

IN WITNESS WHEREOF, THE GUARDIAN LIFE INSURANCE COMPANY OF AMERICA has caused this Policy to be executed as of August 20, 2018 which is its date of issue.

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

**GROUP INSURANCE POLICY  
PROVIDING  
BENEFITS AS DESCRIBED HEREIN**

Dividends Apportioned Annually

GP-1

P100.9000



## IMPORTANT NOTICE

- 1) To obtain information or make a complaint:
- 2) You may call The Guardian's toll-free telephone number for information or to make a complaint at:

1-800-459-9401

- 3) You may also write to The Guardian at:

The Guardian Life Insurance  
Company of America  
East 777 Magnesium Road  
Spokane, Washington 99208-5884

- 4) You may contact the Texas Department of Insurance on companies, coverages, rights, or complaints at:

1-800-252-3439

- 5) You may write the Texas Department of Insurance  
P.O. Box 149104  
Austin, TX 78714-9104  
FAX # (512) 475-1771  
Web: <http://www.tdi.state.tx.us>  
E-mail: [ConsumerProtection@tdi.state.us](mailto:ConsumerProtection@tdi.state.us)

- 6) **PREMIUM OR CLAIM DISPUTES:** Should you have a dispute concerning your premium or about a claim, you should contact The Guardian Life Insurance Company first. If the dispute is not resolved, you may contact the Texas Department of Insurance.

- 7) **ATTACH THIS NOTICE TO YOUR POLICY:** This notice is for information only and does not become a part or condition of the attached document.

GP-1-R-DISC-TX-92

## AVISO IMPORTANTE

Para obtener informacion o para someter una queja:

Usted puede llamar al numero de telefono gratis de The Guardian's para informacion o para someter una queja al:

1-800-459-9401

Usted tambien puede escribir a The Guardian:

The Guardian Life Insurance  
Company of America  
East 777 Magnesium Road  
Spokane, Washington 99208-5884

Puede comunicarse con el Departamento de Seguros de Texas para obtener informacion acerca de companias, coberturas, derechos o quejas al:

1-800-252-3439

Puede escribir al Departamento de Seguros de Texas  
P.O. Box 149104  
Austin, TX 78714-9104  
FAX # (512) 475-1771  
Web: <http://www.tdi.state.tx.us>  
E-mail: [ConsumerProtection@tdi.state.us](mailto:ConsumerProtection@tdi.state.us)

**DISPUTAS SOBRE PRIMAS O RECLAMOS:** Si tiene una disputa concerniente a su prima o a un reclamo, debe comunicarse con el The Guardian Life Insurance Company primero. Si no se resuelve la disputa, puede entonces comunicarse con el departamento (TDI).

**UNA ESTE AVISO A SU POLIZA:** Este aviso es solo para proposito de informacion y no se convierte en parte o condicion del documento adjunto.

P120.0062



## **IMPORTANT NOTICE**

**This is not a policy of Workers' Compensation insurance. The employer does not become a subscriber to the Workers' Compensation system by purchasing this policy, and if the employer is a non-subscriber, the employer loses those benefits which would otherwise accrue under the Workers' Compensation laws. The employer must comply with the Workers' Compensation law as it pertains to non-subscribers and the required notifications that must be filed and posted.**

GP-1-R-COMP-TX-92

P120.0014

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## SCHEDULE OF INSURANCE AND PREMIUM RATES

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This plan's classifications, and the option packages of benefits which are available to covered persons who are members of each classification, are shown below.

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### Class Description

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**Class 0001** ALL ELIGIBLE EMPLOYEES

GP-1-SI

P130.1566

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### Option Packages Available

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Employees may choose from the benefit packages available to members of their class. The option packages are summarized in "Summary of Option Packages" below.

GP-1-SI

P130.1710

Members of Class 0001 may choose from benefit option packages A, B and C.

GP-1-SI

P130.1568

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### Summary of Option Packages

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The following are summaries of the benefit option packages available. For a complete explanation of the benefits provided by this plan, including all limitations and exclusions, please read the entire plan.

GP-1-SI

P130.1585

**Option A** Employee and Dependent Cancer Coverage with an initial diagnosis benefit included.

GP-1-SI

P130.8823

**Option B** Employee and Dependent Cancer Coverage with an initial diagnosis benefit included.

GP-1-SI

P130.8823

**Option C** Employee and Dependent Cancer Coverage with an initial diagnosis benefit included.

GP-1-SI

P130.8823

**Cancer Benefit**

<b>Air Ambulance:</b>	\$250.00 per trip. Limited to 2 one-way trips per <i>hospital confinement</i> .
<b>Ambulance:</b>	\$200.00 per trip. Limited to 2 one-way trips per <i>hospital confinement</i> .
<b>Anesthesia:</b>	25% of surgery benefit.
<b>Attending Doctor:</b>	\$25.00 per day. Limited to 75 visits per <i>hospital confinement</i> .
<b>Extended Care Facility/Skilled Nursing Care:</b>	\$100.00 per day. Limited to 90 days per <i>benefit year</i> .
<b>Hormone Therapy</b>	\$25.00 per treatment. Limited to 12 per benefit year.
<b>Hospice:</b>	\$50.00 per day. Limited to 100 days per lifetime.
<b>Hospital Confinement:</b>	\$300.00 for first 30 days per <i>period of hospital confinement</i> . \$600.00 for 31st day and thereafter per <i>period of hospital confinement</i> .
<b>Immunotherapy:</b>	\$500.00 per month. \$2,500.00 per lifetime.
<b>Intensive Care Unit Confinement:</b>	\$400.00 for first 30 days per confinement. \$600.00 for 31st day and thereafter Confinement.
<b>Surgically Implanted Prosthetic Devices:</b>	\$2,000.00 per device. Limited to \$4,000.00 per lifetime.
<b>Non-Surgically Implanted Prosthetic Devices:</b>	\$200.00 per device. Limited to \$400.00 per lifetime.
<b>Second Surgical Opinion:</b>	\$200.00 Limited to one per surgical procedure.
<b>Skin Cancer:</b>	
Biopsy only	\$100.00
Reconstructive surgery following excision of a skin cancer	\$250.00
Excision of a skin cancer with no flap or graft	\$375.00
Excision of a skin cancer with flap or graft	\$600.00
<b>Surgical Benefits:</b>	
<b>Surgery</b>	<b>Surgical Benefit</b>
Abdomen - Cholecystectomy	\$385.00
Abdomen - Exploratory laparotomy	\$290.00
Abdomen - Paracentesis	\$75.00

Bladder - (TUR) transurethral resection bladder tumors	\$290.00
Bladder - Cystectomy (complete)	\$990.00
Bladder - Cystectomy (partial)	\$495.00
Bladder - Cystectomy (with ureteroileal conduit)	\$1,980.00
Bladder - Cystoscopy	\$75.00
Brain - Burr holes not followed by surgery	\$385.00
Brain - Excision brain tumor	\$1,925.00
Brain - Exploratory craniotomy	\$825.00
Brain - Ventriculoperitoneal shunt	\$385.00
Brain - Hemispherectomy	\$2,750.00
Breast - lumpectomy	\$190.00
Breast - mastectomy partial	\$290.00
Breast - mastectomy radical	\$575.00
Breast - mastectomy simple	\$385.00
Chest - Bronchoscopy	\$165.00
Chest - Lobectomy	\$825.00
Chest - Mediastinoscopy	\$165.00
Chest - Pneumonectomy	\$1,155.00
Chest - Thoracentesis	\$75.00
Chest - Thoracostomy	\$165.00
Chest - Thoracotomy	\$385.00
Chest - Wedge resection	\$660.00
Esophagus - Esophagogastrectomy	\$825.00
Esophagus - Esophagoscopy	\$150.00
Esophagus - Resection of esophagus	\$1,100.00
Eye - Enucleation	\$275.00
Eye - P32 uptake	\$135.00
Female Reproductive - Abdominal hysterectomy/uterus only	\$495.00
Female Reproductive - Colposcopy	\$95.00
Female Reproductive - D&C	\$95.00
Female Reproductive - Oophorectomy	\$290.00
Female Reproductive - Uterus, tubes & ovaries	\$960.00
Female Reproductive - Uterus, tubes & ovaries with exenteration	\$2,750.00
Female Reproductive - Vaginal hysterectomy/uterus only	\$290.00



Intestines - Abdominal-perineal resection	\$1,375.00
Intestines - Colectomy	\$495.00
Intestines - Colonoscopy (does not include virtual or CT Colonography)	\$150.00
Intestines - Colostomy/or revision of	\$190.00
Intestines - ERCP	\$190.00
Intestines - Excesional on rectum for biopsy	\$150.00
Intestines - Ileostomy	\$190.00
Intestines - Proctosigmoidoscopy	\$75.00
Intestines - Resection of small intestine	\$1,155.00
Intestines - Sigmoidoscopy	\$75.00
Kidney - Nephrectomy (radical)	\$1,980.00
Kidney - Nephrectomy (simple)	\$1,155.00
Liver - Resection of liver	\$1,375.00
Lymphatic - Axillary node dissection	\$385.00
Lymphatic - Excision of lymph nodes	\$95.00
Lymphatic - Lymphadenectomy (bilateral)	\$495.00
Lymphatic - Lymphadenectomy (unilateral)	\$385.00
Lymphatic - Splenectomy	\$385.00
Mandible - Mandibulectomy	\$770.00
Misc - Bone marrow aspiration	\$75.00
Misc - Pathological hip fracture (chemo)	\$480.00
Misc - Venous-Catheters/venous port (chemo)	\$75.00
Misc - Peripherally inserted central catheter (PICC)	\$75.00
Misc - Pathological fracture (chemo)	\$220.00
Mouth - Glossectomy	\$385.00
Mouth - Hemiglossectomy	\$190.00
Mouth - Resection of palate	\$385.00
Mouth - Tonsil/Mucous membranes	\$290.00
Pancreas - Jejunostomy	\$495.00
Pancreas - Pancreatectomy	\$1,155.00
Pancrease - Whipple procedure	\$1,980.00
Penis - amputation, complete	\$385.00
Penis - amputation, partial	\$190.00
Penis - amputation, radical	\$495.00

Prostate - (TUR) transurethral resection prostate	\$290.00
Prostate - Cystoscopy	\$75.00
Prostate - Radical Prostatectomy	\$770.00
Radium Implants - Insertion	\$550.00
Radium Implants - Removal	\$275.00
Salivary glands - Parotidectomy	\$385.00
Salivary glands - Radical neck dissection	\$990.00
Spine - Cordotomy	\$290.00
Spine - Laminectomy	\$495.00
Stomach - Gastrectomy (complete)	\$770.00
Stomach - Gastrectomy (partial)	\$495.00
Stomach - Gastrojejunostomy	\$495.00
Stomach - Gastroscopy	\$165.00
Testis - Orchiectomy (bilateral)	\$265.00
Testis - Orchiectomy (unilateral)	\$190.00
Throat - Laryngectomy (w/out neck dissection)	\$495.00
Throat - Laryngectomy (with neck dissection)	\$990.00
Throat - Laryngoscopy	\$165.00
Throat - Tracheostomy	\$165.00
Thyroid - Thyroidectomy (partial: one lobe)	\$290.00
Thyroid - Thyroidectomy (total: both lobes)	\$385.00
Vulva - Vulvectomy (partial)	\$290.00
Vulva - Vulvectomy (radical)	\$770.00
GP-1-SI	P131.0030

## Cancer Benefit

<b>Air Ambulance:</b>	\$1,500.00 per trip. Limited to 2 one-way trips per <i>hospital confinement</i> .
<b>Ambulance:</b>	\$200.00 per trip. Limited to 2 one-way trips per <i>hospital confinement</i> .
<b>Anesthesia:</b>	25% of surgery benefit.
<b>Anti-Nausea Medication:</b>	\$50.00 per day up to \$150.00 per month.
<b>Attending Doctor:</b>	\$25.00 per day. Limited to 75 visits per <i>hospital confinement</i> .
<b>Bone Marrow and Stem Cells:</b>	\$7,500.00 for <i>bone marrow transplant</i> . \$1,500.00 for <i>stem cell transplant</i> . 50% for second transplant. Limited to two of each in a covered person's lifetime \$1,000.00 if a covered person donates bone marrow, limited to one benefit in a covered person's lifetime.
<b>Cancer Screening:</b>	\$100.00 per <i>benefit year</i> .
<b>Cancer Screening Follow-Up:</b>	\$100.00 per <i>benefit year</i> .
<b>Experimental Treatment:</b>	\$100.00 per day. Limited to \$1,000.00 per month.
<b>Extended Care Facility/Skilled Nursing Care:</b>	\$100.00 per day. Limited to 90 days per <i>benefit year</i> .
<b>Government or Charity Hospital:</b>	\$300.00 per day in lieu of other benefits provided by this <i>plan</i> .
<b>Home Health Care:</b>	\$50.00 per visit. Limited to 30 visits per <i>benefit year</i> .
<b>Hormone Therapy</b>	\$25.00 per treatment. Limited to 12 per <i>benefit year</i> .
<b>Hospice:</b>	\$50.00 per day. Limited to 100 days per lifetime.
<b>Hospital Confinement:</b>	\$300.00 for first 30 days per <i>period of hospital confinement</i> . \$600.00 for 31st day and thereafter per <i>period of hospital confinement</i> .
<b>Immunotherapy:</b>	\$500.00 per month. \$2,500.00 per lifetime.
<b>Intensive Care Unit Confinement:</b>	\$400.00 for first 30 days per confinement. \$600.00 for 31st day and thereafter confinement.
<b>Inpatient Special Nursing:</b>	\$100.00 per day. Limited to 30 days per <i>benefit year</i> .
<b>Medical Imaging:</b>	\$100.00 per image. Limited to 2 images per <i>benefit year</i> .

<b>Outpatient and Family Member Lodging:</b>	\$75.00 per day. Limited to 90 days per <i>benefit year</i> .
<b>Outpatient or Ambulatory Surgical Center:</b>	\$250.00 per day. Limited to 3 days per procedure.
<b>Physical or Speech Therapy:</b>	\$25.00 per visit. Limited to 4 visits per month. Limited to \$400.00 per lifetime.
<b>Surgically Implanted Prosthetic Devices:</b>	\$2,000.00 per device. Limited to \$4,000.00 per lifetime.
<b>Non-Surgically Implanted Prosthetic Devices:</b>	\$200.00 per device. Limited to \$400.00 per lifetime.
<b>Reconstructive Surgery:</b>	
Breast TRAM flap	\$2,000.00
Breast reconstruction	\$500.00
Breast symmetry	\$250.00
Facial reconstruction	\$500.00
<b>Second Surgical Opinion:</b>	\$200.00 Limited to one per surgical procedure.
<b>Skin Cancer:</b>	
Biopsy only	\$100.00
Reconstructive surgery following excision of a skin cancer	\$250.00
Excision of a skin cancer with no flap or graft	\$375.00
Excision of a skin cancer with flap or graft	\$600.00
<b>Surgical Benefits:</b>	
<b>Surgery</b>	<b>Surgical Benefit</b>
Abdomen - Cholecystectomy	\$575.00
Abdomen - Exploratory laparotomy	\$435.00
Abdomen - Paracentesis	\$110.00
Bladder - (TUR) transurethral resection bladder tumors	\$435.00
Bladder - Cystectomy (complete)	\$1,485.00
Bladder - Cystectomy (partial)	\$740.00
Bladder - Cystectomy (with ureteroileal conduit)	\$2,970.00
Bladder - Cystoscopy	\$110.00
Brain - Burr holes not followed by surgery	\$575.00
Brain - Excision brain tumor	\$2,885.00
Brain - Exploratory craniotomy	\$1,235.00
Brain - Ventriculoperitoneal shunt	\$575.00
Brain - Hemispherectomy	\$4,125.00

Breast - lumpectomy	\$285.00
Breast - mastectomy partial	\$435.00
Breast - mastectomy radical	\$860.00
Breast - mastectomy simple	\$575.00
Chest - Bronchoscopy	\$245.00
Chest - Lobectomy	\$1,235.00
Chest - Mediastinoscopy	\$245.00
Chest - Pneumonectomy	\$1,730.00
Chest - Thoracentesis	\$110.00
Chest - Thoracostomy	\$245.00
Chest - Thoracotomy	\$575.00
Chest - Wedge resection	\$990.00
Esophagus - Esophagogastrectomy	\$1,235.00
Esophagus - Esophagoscopy	\$225.00
Esophagus - Resection of esophagus	\$1,650.00
Eye - Enucleation	\$410.00
Eye - P32 uptake	\$200.00
Female Reproductive - Abdominal hysterectomy/uterus only	\$740.00
Female Reproductive - Colposcopy	\$140.00
Female Reproductive - D&C	\$140.00
Female Reproductive - Oophorectomy	\$435.00
Female Reproductive - Uterus, tubes & ovaries	\$1,440.00
Female Reproductive - Uterus, tubes & ovaries with exenteration	\$4,125.00
Female Reproductive - Vaginal hysterectomy/uterus only	\$435.00
Intestines - Abdominal-perineal resection	\$2,060.00
Intestines - Colectomy	\$740.00
Intestines - Colonoscopy (does not include virtual or CT Colonography)	\$225.00
Intestines - Colostomy/or revision of	\$285.00
Intestines - ERCP	\$285.00
Intestines - Excisional on rectum for biopsy	\$225.00
Intestines - Ileostomy	\$285.00
Intestines - Proctosigmoidoscopy	\$110.00
Intestines - Resection of small intestine	\$1,730.00
Intestines - Sigmoidoscopy	\$110.00

Kidney - Nephrectomy (radical)	\$2,970.00
Kidney - Nephrectomy (simple)	\$1,730.00
Liver - Resection of liver	\$2,060.00
Lymphatic - Axillary node dissection	\$575.00
Lymphatic - Excision of lymph nodes	\$140.00
Lymphatic - Lymphadenectomy (bilateral)	\$740.00
Lymphatic - Lymphadenectomy (unilateral)	\$575.00
Lymphatic - Splenectomy	\$575.00
Mandible - Mandibulectomy	\$1,155.00
Misc - Bone marrow aspiration	\$110.00
Misc - Pathological hip fracture (chemo)	\$720.00
Misc - Venous-Catheters/venous port (chemo)	\$110.00
Misc - Peripherally inserted central catheter (PICC)	\$110.00
Misc - Pathological fracture (chemo)	\$330.00
Mouth - Glossectomy	\$575.00
Mouth - Hemiglossectomy	\$285.00
Mouth - Resection of palate	\$575.00
Mouth - Tonsil/Mucous membranes	\$435.00
Pancreas - Jejunostomy	\$740.00
Pancreas - Pancreatectomy	\$1,730.00
Pancrease - Whipple procedure	\$2,970.00
Penis - amputation, complete	\$575.00
Penis - amputation, partial	\$285.00
Penis - amputation, radical	\$740.00
Prostate - (TUR) transurethral resection prostate	\$435.00
Prostate - Cystoscopy	\$110.00
Prostate - Radical Prostatectomy	\$1,155.00
Radium Implants - Insertion	\$825.00
Radium Implants - Removal	\$410.00
Salivary glands - Parotidectomy	\$575.00
Salivary glands - Radical neck dissection	\$1,485.00
Spine - Cordotomy	\$435.00
Spine - Laminectomy	\$740.00
Stomach - Gastrectomy (complete)	\$1,155.00

Stomach - Gastrectomy (partial)	\$740.00
Stomach - Gastrojejunostomy	\$740.00
Stomach - Gastroscopy	\$245.00
Testis - Orchiectomy (bilateral)	\$395.00
Testis - Orchiectomy (unilateral)	\$285.00
Throat - Laryngectomy (w/out neck dissection)	\$740.00
Throat - Laryngectomy (with neck dissection)	\$1,485.00
Throat - Laryngoscopy	\$245.00
Throat - Tracheostomy	\$245.00
Thyroid - Thyroidectomy (partial: one lobe)	\$435.00
Thyroid - Thyroidectomy (total: both lobes)	\$575.00
Vulva - Vulvectomy (partial)	\$435.00
Vulva - Vulvectomy (radical)	\$1,155.00

**Transportation/Companion Transportation:** \$0.50 per mile.  
Limited to \$1,000 per round trip.

GP-1-SI P131.0027

## Cancer Benefit

<b>Air Ambulance:</b>	\$2,000.00 per trip. Limited to 2 one-way trips per <i>hospital confinement</i> .
<b>Alternative Care (Palliative Care or Lifestyle Benefits):</b>	\$50.00 per visit. Limited to 20 visits per <i>benefit year</i> combined.
<b>Ambulance:</b>	\$250.00 per trip. Limited to 2 one-way trips per <i>hospital confinement</i> .
<b>Anesthesia:</b>	25% of surgery benefit.
<b>Anti-Nausea Medication:</b>	\$50.00 per day up to \$250.00 per month.
<b>Attending Doctor:</b>	\$25.00 per day. Limited to 75 visits per <i>hospital confinement</i> .
<b>Bone Marrow and Stem Cells:</b>	\$10,000.00 for <i>bone marrow transplant</i> . \$2,500.00 for <i>stem cell transplant</i> . 50% for second transplant. Limited to two of each in a covered person's lifetime \$1,500.00 if a covered person donates bone marrow, limited to one benefit in a covered person's lifetime.
<b>Cancer Screening:</b>	\$100.00 per <i>benefit year</i> .
<b>Cancer Screening Follow-Up:</b>	\$100.00 per <i>benefit year</i> .
<b>Experimental Treatment:</b>	\$200.00 per day. Limited to \$2,400.00 per month.
<b>Extended Care Facility/Skilled Nursing Care:</b>	\$150.00 per day. Limited to 90 days per <i>benefit year</i> .
<b>Government or Charity Hospital:</b>	\$400.00 per day in lieu of other other benefits provided by this <i>plan</i> .
<b>Home Health Care:</b>	\$100.00 per visit. Limited to 30 visits per <i>benefit year</i> .
<b>Hormone Therapy</b>	\$50.00 per treatment. Limited to 12 per benefit year.
<b>Hospice:</b>	\$100.00 per day. Limited to 100 days per lifetime.
<b>Hospital Confinement:</b>	\$400.00 for first 30 days per <i>period of hospital confinement</i> . \$800.00 for 31st day and thereafter per <i>period of hospital confinement</i> .
<b>Immunotherapy:</b>	\$500.00 per month. \$2,500.00 per lifetime.
<b>Intensive Care Unit Confinement:</b>	\$600.00 for first 30 days per confinement. \$800.00 for 31st day and thereafter confinement.



<b>Inpatient Special Nursing:</b>	\$150.00 per day. Limited to 30 days per <i>benefit year</i> .
<b>Medical Imaging:</b>	\$200.00 per image. Limited to 2 images per <i>benefit year</i> .
<b>Outpatient and Family Member Lodging:</b>	\$100.00 per day. Limited to 90 days per <i>benefit year</i> .
<b>Outpatient or Ambulatory Surgical Center:</b>	\$350.00 per day. Limited to 3 days per procedure.
<b>Physical or Speech Therapy:</b>	\$50.00 per visit. Limited to 4 visits per month. Limited to \$1,000.00 per lifetime.
<b>Surgically Implanted Prosthetic Devices:</b>	\$3,000.00 per device. Limited to \$6,000.00 per lifetime.
<b>Non-Surgically Implanted Prosthetic Devices:</b>	\$300.00 per device. Limited to \$600.00 per lifetime.
<b>Reconstructive Surgery:</b>	
Breast TRAM flap	\$3,000.00
Breast reconstruction	\$700.00
Breast symmetry	\$350.00
Facial reconstruction	\$700.00
<b>Reproductive Benefits:</b>	\$1,500.00 for egg Harvesting \$500.00 for egg storage. \$500.00 for sperm storage. \$2,000.00 lifetime limit for all reproductive benefits.
<b>Second Surgical Opinion:</b>	\$300.00 Limited to one per surgical procedure.
<b>Skin Cancer:</b>	
Biopsy only	\$100.00
Reconstructive surgery following excision of a skin cancer	\$250.00
Excision of a skin cancer with no flap or graft	\$375.00
Excision of a skin cancer with flap or graft	\$600.00
<b>Surgical Benefits:</b>	
<b>Surgery</b>	<b>Surgical Benefit</b>
Abdomen - Cholecystectomy	\$770.00
Abdomen - Exploratory laparotomy	\$580.00
Abdomen - Paracentesis	\$150.00
Bladder - (TUR) transurethral resection bladder tumors	\$580.00
Bladder - Cystectomy (complete)	\$1,980.00
Bladder - Cystectomy (partial)	\$990.00

Bladder - Cystectomy (with ureteroileal conduit)	\$3,960.00
Bladder - Cystoscopy	\$150.00
Brain - Burr holes not followed by surgery	\$770.00
Brain - Excision brain tumor	\$3,850.00
Brain - Exploratory craniotomy	\$1,650.00
Brain - Ventriculoperitoneal shunt	\$770.00
Brain - Hemispherectomy	\$5,500.00
Breast - lumpectomy	\$380.00
Breast - mastectomy partial	\$580.00
Breast - mastectomy radical	\$1,150.00
Breast - mastectomy simple	\$770.00
Chest - Bronchoscopy	\$330.00
Chest - Lobectomy	\$1,650.00
Chest - Mediastinoscopy	\$330.00
Chest - Pneumonectomy	\$2,310.00
Chest - Thoracentesis	\$150.00
Chest - Thoracostomy	\$330.00
Chest - Thoracotomy	\$770.00
Chest - Wedge resection	\$1,320.00
Esophagus - Esophagogastrectomy	\$1,650.00
Esophagus - Esophagoscopy	\$300.00
Esophagus - Resection of esophagus	\$2,200.00
Eye - Enucleation	\$550.00
Eye - P32 uptake	\$270.00
Female Reproductive - Abdominal hysterectomy/uterus only	\$990.00
Female Reproductive - Colposcopy	\$190.00
Female Reproductive - D&C	\$190.00
Female Reproductive - Oophorectomy	\$580.00
Female Reproductive - Uterus, tubes & ovaries	\$1,920.00
Female Reproductive - Uterus, tubes & ovaries with exenteration	\$5,500.00
Female Reproductive - Vaginal hysterectomy/uterus only	\$580.00
Intestines - Abdominal-perineal resection	\$2,750.00
Intestines - Colectomy	\$990.00
Intestines - Colonoscopy (does not include virtual or CT Colonography)	\$300.00

Intestines - Colostomy/or revision of	\$380.00
Intestines - ERCP	\$380.00
Intestines - Excesional on rectum for biopsy	\$300.00
Intestines - Ileostomy	\$380.00
Intestines - Proctosigmoidoscopy	\$150.00
Intestines - Resection of small intestine	\$2,310.00
Intestines - Sigmoidoscopy	\$150.00
Kidney - Nephrectomy (radical)	\$3,960.00
Kidney - Nephrectomy (simple)	\$2,310.00
Liver - Resection of liver	\$2,750.00
Lymphatic - Axillary node dissection	\$770.00
Lymphatic - Excision of lymph nodes	\$190.00
Lymphatic - Lymphadenectomy (bilateral)	\$990.00
Lymphatic - Lymphadenectomy (unilateral)	\$770.00
Lymphatic - Splenectomy	\$770.00
Mandible - Mandibulectomy	\$1,540.00
Misc - Bone marrow aspiration	\$150.00
Misc - Pathological hip fracture (chemo)	\$960.00
Misc - Venous-Catheters/venous port (chemo)	\$150.00
Misc - Peripherally inserted central catheter (PICC)	\$150.00
Misc - Pathological fracture (chemo)	\$440.00
Mouth - Glossectomy	\$770.00
Mouth - Hemiglossectomy	\$380.00
Mouth - Resection of palate	\$770.00
Mouth - Tonsil/Mucous membranes	\$580.00
Pancreas - Jejunostomy	\$990.00
Pancreas - Pancreatectomy	\$2,310.00
Pancrease - Whipple procedure	\$3,960.00
Penis - amputation, complete	\$770.00
Penis - amputation, partial	\$380.00
Penis - amputation, radical	\$990.00
Prostate - (TUR) transurethral resection prostate	\$580.00
Prostate - Cystoscopy	\$150.00
Prostate - Radical Prostatectomy	\$1,540.00

Radium Implants - Insertion	\$1,100.00
Radium Implants - Removal	\$550.00
Salivary glands - Parotidectomy	\$770.00
Salivary glands - Radical neck dissection	\$1,980.00
Spine - Cordotomy	\$580.00
Spine - Laminectomy	\$990.00
Stomach - Gastrectomy (complete)	\$1,540.00
Stomach - Gastrectomy (partial)	\$990.00
Stomach - Gastrojejunostomy	\$990.00
Stomach - Gastroscopy	\$330.00
Testis - Orchiectomy (bilateral)	\$530.00
Testis - Orchiectomy (unilateral)	\$380.00
Throat - Laryngectomy (w/out neck dissection)	\$990.00
Throat - Laryngectomy (with neck dissection)	\$1,980.00
Throat - Laryngoscopy	\$330.00
Throat - Tracheostomy	\$330.00
Thyroid - Thyroidectomy (partial: one lobe)	\$580.00
Thyroid - Thyroidectomy (total: both lobes)	\$770.00
Vulva - Vulvectomy (partial)	\$580.00
Vulva - Vulvectomy (radical)	\$1,540.00
<b>Transportation/Companion Transportation:</b>	\$0.50 per mile. Limited to \$1,500 per round trip.
GP-1-SI	P131.0025

## **All Options**

## **Schedule of Benefits**

### ***Effective Dates for Changes to Insurance***

GP-1-SI

P130.3343

### ***All Options***

#### ***Changes in Insurance Amounts***

Any increase or decrease in the amount of insurance on any individual shall become effective on the effective date of a change in the Employee's classification, except that any increase in the amount of insurance on an Employee or a Qualified Dependent eligible for benefits under an established benefit period shall become effective:

- in the case of an Employee not actively at work, on the day on which he returns to active work on a full-time basis (or the day on which his benefit period terminates, whichever is later) or

## **Schedule of Benefits**

### ***Effective Dates for Changes to Insurance (Cont.)***

- in the case of an Eligible Dependent confined to a hospital, on the day on which the dependent is discharged from the hospital (or the day on which his benefit period terminates, whichever is later).

In no event shall the insurance of an Eligible Dependent of an Employee who is not actively at work on a full-time basis be increased or decreased prior to the date such Employee returns to active work on a full-time basis.

GP-1-SI

P130.9324

## Schedule of Premium Rates

The monthly premium rates, in U.S. dollars, for the insurance provided under this plan are listed below.

GP-1-SI

P130.9260

### All Options

### Premium Rates

#### *Employee Cancer Insurance*

GP-1-SI

P130.8722

**Option A** Class 0001

**Rate per Employee**

\$ 10.87

GP-1-SI

P130.8735

**Option B** Class 0001

**Rate per Employee**

\$ 21.69

GP-1-SI

P130.8735

**Option C** Class 0001

**Rate per Employee**

\$ 28.08

GP-1-SI

P130.8735

### All Options

### Premium Rates

#### *Dependent Spouse Cancer Insurance*

GP-1-SI

P130.8723

**Option A** Class 0001

**Rate per Insured Spouse**

\$ 9.10

GP-1-SI

P130.8736

**Option B** Class 0001

**Rate per Insured Spouse**

\$ 18.92

GP-1-SI

P130.8736

**Option C** Class 0001

**Premium Rates**

**Spouse Cancer Insurance (Cont.)**

**Rate per Insured Spouse**

\$ 23.96

GP-1-SI

P130.8736

**All Options**

**Premium Rates**

**Dependent Cancer Insurance**

GP-1-SI

P130.8724

**Option A** Class 0001

**Rate per Insured Child Unit**

\$ 1.85

GP-1-SI

P130.8728

**Option B** Class 0001

**Rate per Insured Child Unit**

\$ 6.14

GP-1-SI

P130.8728

**Option C** Class 0001

**Rate per Insured Child Unit**

\$ 7.06

GP-1-SI

P130.8728

We have the right to change any premium rate(s) set forth above at the times and in the manner established by the provision of the group plan entitled "Premiums".

GP-1-SI

P130.9298

**All Options**

**GENERAL PROVISIONS**

**Definitions**

As used in this policy:

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

"Plan" means this group insurance policy.

"Covered person" means an employee or dependent insured by this policy.

GP-1-R-GENPRO-90

P140.0136

**All Options**

**Incontestability**

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

No statement in any application, except a fraudulent statement, made by a person insured under this policy 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 policy replaces the group policy of another insurer, we may rescind this policy based on misrepresentations made in the policyholder's or a covered person's signed application for up to two years from this policy's policy date.

GP-1-R-INCY-90

P140.0150

**All Options**

**Associated Companies**

An associated company is a corporation or other business entity affiliated with the policyholder through common ownership of stock or assets.

If the policyholder asks us in writing to include an associated company under this policy, and we give our written approval, we'll treat employees of that company like the policyholder's employees. Our written approval will include the starting date of the company's coverage under this policy. But each eligible employee of that company must still meet all of the terms and conditions of this policy before he'll be insured.

The policyholder must notify us in writing when a company stops being associated with him. On the date a company stops being an associated company, this policy will end for all of that company's employees, except those employed by the policyholder or another covered associated company as eligible employees, on such date.

GP-1-R-AC-90

P140.0151

**All Options**

**Premiums**

Premiums due under this policy must be paid by the policyholder at an office of the Guardian or to a representative that we have authorized. The premiums must be paid as specified on the first page of this policy, unless by agreement between the policyholder and the Guardian, the interval of payment is changed. In that event, adjustment will be made to provide for payment annually, semi- annually, quarterly or monthly.

The premium due under this policy on each policy due date will be the sum of the premium charges for the insurance coverages provided under this policy. The premium charges are based upon the rates set forth in this policy's "Schedule of Insurance and Premium Rates" section.



However, we may change such rates: (a) on the first day of any policy month; (b) on any date the extent or terms of coverage for a policyholder are changed by amendment of this policy; (c) on any date our obligation under this policy with respect to a policyholder is changed because of statutory or other regulatory requirements; or (d) 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.

We must give the policyholder 31 days written notice of the rate change. Such change will apply to any premium due on and after the effective date of the change stated in such notice.

### **Adjustment of Premiums Payable Other Than Monthly or Quarterly**

Under the above provision, if a premium rate is changed after an annual or semi-annual premium became payable with respect to coverage on and after the date of such change, the premium will be adjusted by a proportionate increase or decrease for the unexpired period for which the premium became payable. If the adjustment results in a decrease, the amount of the decrease will be paid to the policyholder by us. If the adjustment results in an increase, the amount of the increase will be considered a premium due on the date of the rate change. This policy's grace period provisions will apply to any such premium due.

### **Grace in Payment of Premiums - Termination of Policy**

A grace period of 60 days, without interest charge, will be allowed the policyholder for each premium payment except the first. If any premium is not paid before the end of the grace period, this policy automatically ends at the end of the grace period. However, if the policyholder gives us advance written notice of an earlier termination date during the grace period, this policy will end as of such earlier date.

If this policy ends during or at the end of the grace period, the policyholder will still owe us premium for all the time this policy was in force during the grace period.

This policy ends immediately on any date when an insurance coverage under this policy ends and, as a result, no benefits remain in effect under this policy.

GP-1-R-PREM-90

P140.0529

### **All Options**

#### **Term of Policy - Renewal Privilege**

This policy is issued for a term of one (1) year from the policy date shown on the first page of this policy. All policy years and policy months will be calculated from the policy date. All periods of insurance hereunder will begin and end at 12:01 A.M. Standard Time at the policyholder's place of business.

If this policy provides coverage on a non-contributory basis, 100% of the employees eligible for insurance must be enrolled for coverage. If dependent coverage is provided on a non-contributory basis, all eligible dependents must be enrolled.

The policyholder may renew this policy for a further term of one (1) year, on the first and each subsequent policy anniversary. All renewals are subject to the payment of premiums then due, computed as provided in this policy's "Premiums" section.

However, we have the right to decline to renew this policy, or any coverage hereunder on any policy anniversary or premium due date, if, on that date: (a) less than 10 employees are insured under this policy; or (b) with respect to a non-contributory policy, less than 100% of those employees eligible are insured under this policy; or (c) with respect to a contributory policy, less than 75% of those employees eligible are insured under this policy.

P140.0626

If this policy provides dependents coverage, we may decline to renew such coverage on any policy anniversary or premium due date, if: (a) with respect to a non-contributory policy, less than 100% of all eligible dependents are enrolled for coverage under this policy; or (b) with respect to a contributory policy, less than 75% of those employees eligible for dependents coverage are insured as such.

The policyholder may cancel this policy at any time by giving us 31 days advance written notice. This notice must be sent to our Home Office. And the employer will owe us all unpaid premiums for the period this plan is in force.

## **The Contract**

The entire contract between the Guardian and the policyholder consists of this policy, and the policyholder's application, a copy of which is attached hereto or endorsed hereon.

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.

GP-1-R-TERM-90

P140.0627

### **All Options**

#### **Clerical Error - Misstatements**

Neither clerical error by the policyholder, a participating employer or the Guardian in keeping any records pertaining to insurance under this policy, nor delays in making entries thereon, will invalidate insurance otherwise validly in force or continue insurance otherwise validly terminated. However, upon discovery of such error or delay, an equitable adjustment of premiums will be made.

Premium adjustments involving return of unearned premium to the policyholder will be limited to the period of 90 days preceding the date of our receipt of satisfactory evidence that such adjustments should be made.

If the age of an employee, or any other relevant facts, are found to have been misstated, and the premiums are thereby affected, an equitable adjustment of premiums will be made. If such misstatement involves whether or not an insurance risk would have been accepted by us, or the amount of insurance, the true facts will be used in determining whether insurance is in force under the terms of this policy, and in what amount.

#### **Statements**

No statement will void the insurance under this policy, or be used in defense of a claim hereunder unless: (a) in the case of the policyholder, it is contained in the application signed by him; or (b) in the case of a covered person, it is contained in a written instrument signed by him.

All statements will be deemed representations and not warranties.

GP-1-R-CE-90

P140.0309

## **All Options**

### **Assignment**

An employee's right to assign any interest under this policy is governed as follows:

- Any death benefits (including any basic term life, supplemental term life, optional term life or accidental death and dismemberment coverages) provided by this policy, may not be assigned.
- With respect to accident and health insurance, both the employee's certificate and his right to insurance benefits under this policy are not assignable. However, the employee may direct us, in writing, to pay hospital, surgical, major medical, or dental benefits to the recognized provider who provided the covered service for which benefits became payable. We may honor such request at our option. But, the employee may not assign his right to take legal action under this policy to such provider. And we assume no responsibility as to the validity or effect of any such direction.

### **Assignment By Policyholder**

Assignment or transfer of the interest of the policyholder will not bind us without our written consent thereto.

GP-1-R-ASSIGN-90

P140.0165

## **All Options**

### **Dividends**

The portion, if any, of the divisible surplus of the Guardian allocable to this policy at each policy anniversary will be determined annually by the Board of Directors of the Guardian and will be credited to this policy as a dividend on such anniversary, provided this policy is continued in force by the payment of all premiums to such anniversary.

Any dividend under this policy will be paid to the policyholder in cash, or at the option of the policyholder it may be applied to the reduction of the premiums then due.

In the event that the employees are contributing toward the cost of the coverage under any group policy issued to the policyholder and the aggregate dividends under this policy and any other group policy or policies issued to the policyholder are in excess of the policyholder's share of the aggregate cost, such excess will be applied by the policyholder for the sole benefit of the employees.

Payment of any dividend to the policyholder will completely discharge our liability with respect to the dividend so paid.

GP-1-R-DIV-90

P140.0168

## **All Options**

### **Employee's Certificate**

We will issue to the policyholder, for delivery to each employee insured under this policy, a certificate of coverage. The certificate will state the essential features of the insurance to which the employee is entitled and to whom the benefits are payable. But the certificate does not constitute a part of this policy and will in no way modify any of the terms and conditions set forth in this policy.

In the event this policy is amended, and such amendment affects the material contained in the certificate of coverage, a rider or revised certificate reflecting such amendment will be issued to the policyholder for delivery to affected employees.

### **Claims of Creditors**

Except when prohibited by the laws of the jurisdiction in which this policy was issued, the insurance and other benefits under this policy will be exempt from execution, garnishment, attachment, or other legal or equitable process, for the debts or liabilities of the covered persons or their beneficiaries.

## Records - Information To Be Furnished.

The policyholder must keep a record of the insured employees containing, for each employee, the essential particulars of the insurance which apply to the employee. The policyholder must periodically forward to us, on our forms, such information concerning the employees in the classes eligible for insurance under this policy as may reasonably be considered to have a bearing on the administration of the insurance under this policy and on the determination of the premium rates. For benefits which are based on an employee's salary, changes in an employee's salary must promptly be reported to us. The policyholder's payroll and other such records which have a bearing on the insurance must be furnished to us at our request at any reasonable time.

GP-1-R-CERT-90

P140.0167

### *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 policy 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.

GP-1-R-EA-90

P140.0166

### *All Options*

## Accident And Health Claims Provisions

An employee's right to make a claim for any accident and health benefits provided by this plan is governed as follows:

**Notice:** The employee 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 his name and plan number.

**Proof of Loss:** We'll furnish the employee 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. The employee must detail the nature and extent of the loss for which the claim is being made. He must send us written proof within 90 days of the loss.

If this plan provides weekly loss-of-time insurance, the employee 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, he must send us written proof of loss within 90 days of the date we request. For any other loss, he must send us written proof within 90 days of the loss.

**Late Notice or Proof:** We won't void or reduce a claim if the employee can't send us notice or proof of loss within the required time. But he 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 the employee submits periodic written proof of loss as stated above. We'll pay all other accident and health benefits to which the employee's entitled as soon as we receive written proof of loss.

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

When the employee files proof of loss, he 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 the employee that a particular provider must provide such care. And the employee may not assign his right to take legal action under this plan to such provider.

**Limitation of Actions:** The employee can't bring a legal action against this plan until 60 days from the date he files proof of loss. And he can't bring legal action against this plan after three years from the date he files 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 Worker's Compensation.

GP-1-R-AH-90

P140.0170

**All Options**

**ELIGIBILITY FOR CANCER COVERAGE  
EMPLOYEE COVERAGE**

**Eligible Employees**

Subject to the conditions of eligibility set forth below, and to all of the other conditions of this plan, an employee is eligible if he is in an eligible class of employees and is an active full-time employee or part-time employee.

If an employee is a partner or proprietor, we will treat him like an employee if he meets this plan's conditions of eligibility.

**Conditions Of Eligibility**

An employee is eligible for cancer coverage if he is:

- 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 at: (1) the employer's place of business; (2) some place where the employer's business requires the employee to travel; or (3) any other place the employee and the employer have agreed upon for the performance of occupational duties.

An employee is **not** eligible for cancer coverage if he is:

- A temporary or seasonal employee; or
- An employee for whom, pursuant to a collective bargaining agreement, the employer makes any payments to any kind of health and welfare benefit plan other than under this plan.

**Enrollment Requirement:** If an employee must pay all or part of the cost of coverage, we will not cover him until he enrolls and agrees to make the required payments.

GP-1-EC-90-1.0

P477.0046

**All Options**

**Proof of Insurability:** We require that the employee answer insurability questions with respect to the employee and his or her dependents. The answers to these questions will determine whether or not the employee and his or her dependents will be covered by this Plan.

We require that the employee answer insurability questions again to change to a richer Plan of benefits, if offered by you. The answers to these questions will determine whether or not the employee and his or her dependents will be covered for the richer benefits.

GP-1-EC-90-4.0

P477.0047

**All Options**

**The Service Waiting Period:** If the employee is in an eligible class, he is eligible for cancer coverage under this plan after he completes the service waiting period, if any, established by the employer.

GP-1-EC-90-4.0

P477.0048

### **All Options**

**Multiple Employment:** If an employee works for both the employer and a covered associated company, or for more than one covered associated company, we will treat the employee as if only one firm employs him. The employee will not have multiple cancer coverages under this plan. But, if this plan uses the amount of an employee's earnings to set the rates, determine class, figure coverage amounts, or for any other reason, such earnings will be figured as the sum of earnings from all covered employers.

GP-1-EC-90-5.0

P477.0302

### **All Options**

**Coverage During Temporary Layoff or Leave of Absence:** If an employee's active Full-Time service ends because of lay off or leave of absence approved by the employer, the employee may continue his insurance, subject to continued payment of premium, until the earlier of: (a) the end of the temporary layoff or employer approved leave of absence; and (b) 1 months following the date the temporary layoff or approved leave of absence begins. If the employee becomes disabled under this plan while coverage is being continued during a temporary layoff or leave of absence, an employee's eligibility for benefits will be governed by all the term of this Plan.

GP-1-EC-90-5.0

P477.0303

### **All Options**

## **When Employee Coverage Starts**

An employee's eligibility date is the date he has met all of the conditions of eligibility.

Whether the employee must pay all or part of the cost of coverage, he must elect to enroll and agree to make the required payments before coverage will start. If the employee does this on or before his eligibility date, his coverage is scheduled to start on his eligibility date. If the employee does this within 31 days after his eligibility date, his coverage is scheduled to start on his eligibility date. If the employee elects to enroll and agrees to make the required payments more than 31 days after his eligibility date, his coverage is scheduled to start on the date he signs the enrollment form.

On the date all or part of the employee's coverage is scheduled to start, he must be: (1) actively at work; (2) fully capable of performing the major duties of his regular occupation; and (3) working his regular number of hours. In that case, the employee's coverage will start at 12:01 A.M. Standard Time for his place of residence on that date. In any other case, we will postpone the start of his coverage until the date he: (a) returns to active work; (b) is working his regular number of hours; and (c) is fully capable of performing the major duties of his 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) the employee was fully capable of performing the major duties of his regular occupation for the employer on a regular basis at 12:01 AM standard time for his place of residence on the scheduled effective date; and (b) he was performing the major duties of his regular occupation and working his regular number of hours on his last regularly scheduled work day; his coverage will start on the scheduled effective date.

**Exception to When Employee Coverage Starts:** If an employee is not capable of performing the major duties of his regular occupation for the employer on a full-time basis on the date his coverage is scheduled to start, he will be insured for cancer insurance if:

1. he was insured under the prior insurer's group or individual cancer policy at the time of the transfer;
2. he is a member of an eligible class;
3. premiums for the employee were paid up to date ;and
4. he is not receiving or eligible to receive benefits under the prior insurer's group or individual cancer policy.

Any cancer benefit payable will be the lesser of:

1. the cancer benefit payable under the Group Policy; or
2. the cancer benefit payable under the prior insurer's group cancer or individual policy had it remained in force.

The cancer benefit payable will be reduced by any amount paid by the prior insurer's group or individual cancer policy.

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

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

1. the date he is fully capable of performing the major duties of his regular occupation for the 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 the employee would have been covered under the prior insurer's group or individual Cancer policy, had the prior plan not terminated.

GP-1-EC-90-6.0

P477.0050

### **All Options**

## **An Employee's Right To Continue Cancer Coverage During A Family Leave Of Absence**

**Important Notice:** This section may not apply to the employer's plan. The employee must contact his 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 An Employee's Coverage Would End:** An employee's cancer coverage would normally end because he ceases work due to an approved leave of absence. But, he may continue his coverage if the leave has been granted to: (1) allow him to care for a seriously injured or ill spouse, child or parent; (2) after the birth or adoption of a child; (3) due to his own serious health condition; or (4) because of a Serious Injury or Illness arising out of the fact that his 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 employee's coverage, he will be required to pay the same share of the premium as he paid before the leave of absence.

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

- The date the employee returns to active work.
- In the case of a leave granted to the employee 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 the employee under this section for all reasons. If the employee takes 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 the employer's plan is terminated or he is no longer eligible for coverage under this Plan.
- The end of the period for which premium has been paid.

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

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



- **Contingency Operation:** This term means a military operation that: (1) is designated by the Secretary of Defense as an operation in which members of the Armed Forces are or may become involved in military actions, operations or hostilities against an enemy of the United States or against an opposing military force; or (2) results in the call or order to, or retention on, active duty of members of the uniformed services under any provision of law or during a national emergency declared by the President or Congress.
- **Covered Service member:** This term means a member of the Armed Forces, including a member of the National Guard or Reserves, who for a Serious Injury or Illness is: (1) undergoing medical treatment, recuperation or therapy; (2) otherwise in Outpatient Status; or (3) otherwise on the temporary disability retired list.
- **Next Of Kin:** This term means the employee's 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.

GP-1-EC-90-7.0

P477.0052

### **All Options**

#### **When Employee Coverage Ends**

The employee's coverage will end on the first of the following dates:

- The last day of the month in which his active service ends for any reason. Active service ends when the employee no longer: (1) is actively at work; and (2) working his regular number of hours.
- The date he stops being an eligible employee under this plan.
- The date he no longer is working in the United States or working outside of the United States for a United States based Employer in a country or region approved by us.
- The date this group Plan ends, or is discontinued for a class of employees to which he belongs.
- The last day of the period for which required payments are made for the employees.

GP-1-EC-90-8.0

P477.0054

**All Options**

**Definitions**

GP-1-EC-90-DEF-1

P473.0014

**All Options**

**Employee:** This term means a person who works for you at your place of business, and whose income is reported for tax purposes using a W-2 form.

GP-1-EC-90-DEF-3

P473.0015

**All Classes**

**Full-time:** This term means the employee regularly works at least the number of hours in the normal work week set by you, but not less than 30 hours per week.

GP-1-EC-90-DEF-4

P473.0016

**All Options**

**Plan:** This term means the Guardian group Cancer Insurance plan purchased by you.

GP-1-EC-90-DEF-6

P477.0055

**All Options**

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

GP-1-EC-90-DEF-7

P473.0023

**All Options**

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

GP-1-EC-90-DEF-9

P473.0024

**All Options**

**You and Your:** These terms mean the employer who purchased this Cancer Insurance plan.

GP-1-EC-90-DEF-10

P477.0056

**All Options**

**DEPENDENT COVERAGE**

GP-1-DEP-90-1.0

P473.0027

**All Options**

**Eligible Dependents For Dependent Cancer Coverage**

An employee's eligible dependents are: (1) his legal spouse; (2) unmarried dependent children from birth until they reach age 26.

GP-1-DEP-90-2.0

P477.0065

**All Options**

**Handicapped Children**

An employee 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 the employee 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 cancer 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 the employee for most of his or her support and maintenance.
- The employee 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 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 the employee's coverage ends.

GP-1-DEP-90-4.0

P477.0068

**All Options**

**Proof Of Insurability**

We require that the employee answer insurability questions with respect to his or her dependents. The answers to these questions will determine whether or not the employee's dependents will be covered by this Plan.

GP-1-EC-90-6.0

P477.0069

**All Options**

**When Dependent Coverage Starts**

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

Subject to the Exception below and to all of the other terms of this plan, the date dependent coverage starts depends on when the employee elects to enroll his initial dependents and agrees to make any required payments.

If an employee does this on or before his 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 his eligibility date and the date the employee becomes covered for employee coverage.

If the employee does this after his eligibility date, the coverage is scheduled to start on the later of the 1st day of the month which coincides with or next follows the date he signs the enrollment form and the date he becomes covered for employee coverage.

Once an employee has dependent child coverage for his initial dependent child(ren) any newly acquired dependent children will be covered as of the date he or she is first eligible.

GP-1-DEP-90-6.0

P477.0070

**All Options**

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

GP-1-DEP-90-7.0

P477.0072

**All Options**

**When Dependent Coverage Ends**

Dependent coverage ends for all of an employee's dependents when his employee coverage ends. Dependent coverage also ends for all of an employee's dependents when he stops 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 his class.

If the employee is required to pay all or part of the cost of dependent coverage, and fails to do so, his dependent coverage ends. It ends on the last day of the period for which he made the required payments, unless coverage ends earlier for other reasons.

An employee's 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 last day of the month in which the child attains this Plan's age limit, when he or she marries, or when a step-child is no longer dependent on the employee for support and maintenance. or for an employee's handicapped child who has reached the age limit, when he or she marries or 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.

GP-1-DEP-90-9.0

P477.0073-R

**All Options**

**Definitions**

GP-1-DEP-90-DEF-1

P473.0036

**All Options**

**Eligibility Date:** For dependent coverage, this term means the earliest date on which: (a) the employee has eligible dependents; and (b) is eligible for dependent coverage.

GP-1-DEP-90-DEF-2

P473.0037

**All Options**

**Eligible Dependent:** This term is defined in the "Eligible Dependents For Cancer Coverage" section.

GP-1-DEP-90-DEF-3

P477.0089

**All Options**

**Enrollment Period:** This term means the 31 day period which starts on the date that the employee is eligible for dependent coverage.

GP-1-DEP-90-DEF-4

P473.0040

**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.

GP-1-DEP-90-DEF-5

P473.0041

**All Options**

**Initial Dependents:** This term means those eligible dependents the employee has at the time he or she first becomes eligible for employee coverage. He or she may not have any dependents at this time. If he or she later acquires them, the first eligible dependents he or she acquires are his or her initial dependents.

GP-1-DEP-90-DEF-8

P473.0042

**All Options**

**Newly Acquired Dependent:** This term means an eligible dependent the employee acquires after he or she already has coverage in force for initial dependents.

GP-1-DEP-90-DEF-9

P473.0043

**All Options**

**Plan** means the Guardian group Cancer Coverage plan purchased by you.

GP-1-DEP-90-DEF-11

P477.0094

**All Options**

**Proof or Proof Of Insurability:** This term means an application for insurance which shows that a person is insurable.

GP-1-DEP-90-DEF-12

P473.0046

## All Options

### CANCER COVERAGE

**Important Notice:** This is *Cancer* coverage. It provides a limited specified benefit. It is a supplement to, and not a substitute for, medical coverage. Please read this *plan* carefully to fully understand what it covers, limits, and excludes.

Subject to all of this *plan's* terms, this *plan* will pay the benefits described below if a *covered person* is diagnosed with *cancer* after the date he or she becomes insured by this *plan*. This *plan* pays no benefits other than what is specifically listed below.

All services or treatment must be received by the covered person within 120 days of the date his or coverage under this *plan* ends.

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.

GP-1-CAN-IC-12-TX

P477.0078

#### Option A

##### Benefits

**Air Ambulance:** We will pay the amount shown in the schedule of insurance if a licensed professional air ambulance is used to transport a *covered person* to a *hospital* where a *covered person* is confined as an *inpatient* for internal *cancer* treatment. We limit what we pay to two one-way trips per *period of hospital confinement*.

**Ambulance:** We will pay the amount shown in the schedule of insurance if a licensed professional ambulance is used to transport a *covered person* to a *hospital* where a *covered person* is confined as an *inpatient* for internal *cancer* treatment. We limit what we pay to two one-way trips per *period of hospital confinement*.

**Anesthesia:** If general anesthesia is provided to a *covered person* in connection with a surgical procedure covered under the Surgical Benefits section, we will pay 25% of the amount shown in the schedule of insurance for the surgical procedure.

**Attending Doctor:** We will pay the amount shown in the schedule of insurance if a *covered person* is visited by a *doctor* for the treatment of *internal cancer* while confined in a *hospital*. We don't pay for visits by the operating surgeon. We limit what we pay per *period of hospital confinement* to the number of days shown in the schedule of insurance.

**Blood, Plasma and Platelets:** We will pay the amount shown in the schedule of insurance for each day a *covered person* receives blood, plasma and/or platelets for the treatment of *internal cancer*. We pay whether the blood, plasma and/or platelets is received as an *inpatient* in a *hospital* or as an outpatient in a *doctor's* office, *hospital* or *ambulatory surgical center*. We don't pay for blood, plasma and/or platelets for any other reason, including replacement of blood during surgery. And we limit what we pay in the 12 months which starts on the date of the first treatment to the amount shown in the schedule of insurance.

**Extended Care Facility/Skilled Nursing Care:** If we pay benefits under this *plan's* *hospital* confinement section for a *covered person*, and such *covered person* subsequently is confined to an *extended care* or *skilled nursing facility* for the treatment of *internal cancer*, we will pay the amount in the schedule of insurance. The *extended care* or *skilled nursing facility* confinement must start within 30 days of the end of the *hospital* confinement. We limit what we pay each *benefit year* to the number of days shown in the schedule of insurance.

**Hormone Therapy:** If a *doctor* prescribes, and a *covered person* receives hormone therapy as a treatment for *internal cancer*, we will pay the amount shown in the schedule of insurance. We limit what we pay to the number of treatments shown in the schedule of insurance each *benefit year*.

**Hospice:** We pay the amount shown in the schedule of insurance per day if a covered person receives hospice care. We limit what we pay to the number of days shown in the schedule of insurance during the covered person's lifetime.

We require that the covered person's doctor certify in writing that the covered person is terminally ill as a result of internal cancer, with a life expectancy of less than six months.

This benefit is not payable on the same day the extended care facility, home health care or hospital confinement benefit is payable. However, if a covered person is eligible for the extended care facility, home health care, hospice or hospital confinement benefit on the same day, we will pay the highest benefit.

**Hospital Confinement:** We will pay the amount shown in the schedule of insurance for each day during a period of hospital confinement in which a covered person is confined in a hospital for the treatment of internal cancer.

**Intensive Care Unit Confinement:** We will pay the amount shown in the schedule of insurance if a covered person is confined in a hospital's intensive care unit for the treatment of internal cancer. We don't pay for intensive care unit confinement and hospital confinement on the same day.

GP-1-CAN-BEN-12

P477.0008

### **Option B**

#### **Benefits**

**Air Ambulance:** We will pay the amount shown in the schedule of insurance if a licensed professional air ambulance is used to transport a *covered person* to a *hospital* where a *covered person* is confined as an *inpatient* for *internal cancer* treatment. We limit what we pay to two one-way trips per *period of hospital confinement*.

**Ambulance:** We will pay the amount shown in the schedule of insurance if a licensed professional ambulance is used to transport a *covered person* to a *hospital* where a *covered person* is confined as an *inpatient* for *internal cancer* treatment. We limit what we pay to two one-way trips per *period of hospital confinement*.

**Anesthesia:** If general anesthesia is provided to a *covered person* in connection with a surgical procedure covered under the Surgical Benefits section, we will pay 25% of the amount shown in the schedule of insurance for the surgical procedure.

**Anti-Nausea Medication:** We will pay the amount shown in the schedule of insurance if a *doctor* prescribes a *covered person* drugs to control nausea related to chemotherapy or radiation for *internal cancer* treatments. We limit what we pay each month to the amount shown in the schedule of insurance.

**Attending Doctor:** We will pay the amount shown in the schedule of insurance if a *covered person* is visited by a *doctor* for the treatment of *internal cancer* while confined in a *hospital*. We don't pay for visits by the operating surgeon. We limit what we pay per *period of hospital confinement* to the number of days shown in the schedule of insurance.

**Blood, Plasma and Platelets:** We will pay the amount shown in the schedule of insurance for each day a *covered person* receives blood, plasma and/or platelets for the treatment of *internal cancer*. We pay whether the blood, plasma and/or platelets is received as an *inpatient* in a *hospital* or as an outpatient in a *doctor's* office, *hospital* or *ambulatory surgical center*. We don't pay for blood, plasma and/or platelets for any other reason, including replacement of blood during surgery. And we limit what we pay in the 12 months which starts on the date of the first treatment to the amount shown in the schedule of insurance.

**Bone Marrow and Stem Cells:** We will pay the amount shown in the schedule of insurance if a *covered person* receives a *bone marrow transplant* or *stem cell transplant* to treat *internal cancer*.

**Cancer Screening:** Once per *benefit year*, we will pay the amount in the schedule of insurance if you provide *proof* satisfactory to us that a *covered person* received at least one of the following tests for *internal cancer* : (1) bone marrow testing; (2) BRCA testing; (3) breast ultrasound; (4) breast MRI; (5) colonoscopy or virtual colonoscopy; (6) CA 125 test (blood test for ovarian *cancer* ); (7) CA 15-3 test (blood test for breast *cancer* ); (8) CEA (blood test for colon *cancer* ) (9) chest x-ray; (10) CT scans or MRI scans; (11) flexible sigmoidoscopy; (12) hemocult stool specimen (lab confirmed); (13) mammogram; (14) pap smear; (15) PSA (blood test for prostate *cancer* ); (16) Serum Protein Electrophoresis (test for myeloma); (17) testicular ultrasound; (18) thermography; or (19) ThinPrep.

We will pay this benefit once per *benefit year* for each *covered person* regardless of whether multiple tests are performed. We will pay this benefit whether or not *cancer* is *diagnosed*.

**Cancer Screening Follow-Up:** Once per *benefit year*, we will pay the amount shown in the schedule of insurance for an additional invasive diagnostic procedure provided to a *covered person*. We will pay this benefit only if the procedure is recommended by a *doctor* as necessary due to the results of the initial *cancer* screening procedure.

**Experimental Treatment:** We pay the amount shown in the schedule of insurance if a *doctor* prescribes experimental treatment for a *covered person* for the purpose of destroying or changing abnormal tissue, and the treatment is administered by medical personnel in a *doctor's* office, *clinic* or *hospital*. All treatment must be *NCI-listed* as viable experimental treatment for *internal cancer*.

We will not pay benefits under this provision for laboratory tests, *immunotherapy*, diagnostic x-rays, and therapeutic devices or other procedures related to the treatments. We will not pay benefits under this provision for the same day the radiation and chemotherapy benefit is payable. However if a *covered person* is eligible for both the experimental treatment benefit and the radiation and chemotherapy benefit on the same day, then we will pay the higher benefit.

**Extended Care Facility/Skilled Nursing Care:** If we pay benefits under this *plan's* *hospital* confinement section for a *covered person*, and such *covered person* subsequently is confined to an *extended care* or *skilled nursing facility* for the treatment of *internal cancer*, we will pay the amount in the schedule of insurance. The *extended care* or *skilled nursing facility* confinement must start within 30 days of the end of the *hospital* confinement. We limit what we pay each *benefit year* to the number of days shown in the schedule of insurance.

**Government or Charity Hospital:** In lieu of all the other benefits provided by this *plan*, we will pay the amount shown in the schedule of insurance per day when a *covered person* is confined to: (a) a *hospital* operated by or for the U.S. Government (including the Veteran's Administration); or (b) a *hospital* that does not charge for its services (charity). The confinement must be for the treatment of *internal cancer*.

**Home Health Care:** We pay the amount shown in the schedule of insurance if a *covered person* receives home health care or health support services for the treatment of *internal cancer*. We limit what we pay each *benefit year* to the limit shown in the schedule of insurance.

However, these services must start within seven days of release from a *hospital*. And the *covered person's* *doctor* must certify that the *covered person* would need to be *hospital* confined if home health care was not available.

We will pay benefits under this section only if the home health care or health support services providers are licensed or certified and as qualified as caregivers providing comparable services at a *hospital* or other appropriate medical facility. This benefit will not be paid for any day a benefit is paid under the *hospice* section. If a *covered person* is eligible for both a benefit under the home health care and *hospice* sections on the same day, we will pay the higher amount.

**Hormone Therapy:** If a *doctor* prescribes, and a *covered person* receives hormone therapy as a treatment for *internal cancer*, we will pay the amount shown in the schedule of insurance. We limit what we pay to the number of treatments shown in the schedule of insurance each *benefit year*.



**Hospice:** We pay the amount shown in the schedule of insurance per day if a covered person receives hospice care. We limit what we pay to the number of days shown in the schedule of insurance during the covered person's lifetime.

We require that the covered person's doctor certify in writing that the covered person is terminally ill as a result of internal cancer, with a life expectancy of less than six months.

This benefit is not payable on the same day the extended care facility, home health care or hospital confinement benefit is payable. However, if a covered person is eligible for the extended care facility, home health care, hospice or hospital confinement benefit on the same day, we will pay the highest benefit.

**Hospital Confinement:** We will pay the amount shown in the schedule of insurance for each day during a period of hospital confinement in which a covered person is confined in a hospital for the treatment of internal cancer.

**Intensive Care Unit Confinement:** We will pay the amount shown in the schedule of insurance if a covered person is confined in a hospital's intensive care unit for the treatment of internal cancer. We don't pay for intensive care unit confinement and hospital confinement on the same day.

GP-1-CAN-BEN-12

P477.0005

### **Option C**

#### **Benefits**

**Air Ambulance:** We will pay the amount shown in the schedule of insurance if a licensed professional air ambulance is used to transport a *covered person* to a *hospital* where a *covered person* is confined as an *inpatient* for internal cancer treatment. We limit what we pay to two one-way trips per *period of hospital confinement*.

**Alternative Care:** We pay the amount shown in the schedule of insurance for alternative care benefits if a *covered person* is *diagnosed with internal cancer*. We will require that the *cancer diagnosis* be reconfirmed on a regular basis, either by proof of ongoing treatment, or by a *doctor's* recertification. We limit what we pay each *benefit year* to the number of visits shown in the schedule of insurance for *palliative care* and lifestyle benefits combined. And we limit what we pay for *palliative care* and Lifestyle Benefits combined to two *benefit years* in a *covered person's* lifetime.

1. *Palliative Care Benefit:* We will pay the amount shown in the schedule of insurance for each visit to an *accredited practitioner* for *bio-feedback* and hypnosis.
2. *Lifestyle Benefit -* We will pay the amount shown in the schedule of insurance for each visit to an *accredited practitioner* for smoking cessation, yoga, meditation, relaxation techniques and nutritional counseling.

**Ambulance:** We will pay the amount shown in the schedule of insurance if a licensed professional ambulance is used to transport a *covered person* to a *hospital* where a *covered person* is confined as an *inpatient* for *internal cancer* treatment. We limit what we pay to two one-way trips per *period of hospital confinement*.

**Anesthesia:** If general anesthesia is provided to a *covered person* in connection with a surgical procedure covered under the Surgical Benefits section, we will pay 25% of the amount shown in the schedule of insurance for the surgical procedure.

**Anti-Nausea Medication:** We will pay the amount shown in the schedule of insurance if a *doctor* prescribes a *covered person* drugs to control nausea related to chemotherapy or radiation for *internal cancer* treatments. We limit what we pay each month to the amount shown in the schedule of insurance.

**Attending Doctor:** We will pay the amount shown in the schedule of insurance if a *covered person* is visited by a *doctor* for the treatment of *internal cancer* while confined in a *hospital*. We don't pay for visits by the operating surgeon. We limit what we pay per *period of hospital confinement* to the number of days shown in the schedule of insurance.

**Blood, Plasma and Platelets:** We will pay the amount shown in the schedule of insurance for each day a *covered person* receives blood, plasma and/or platelets for the treatment of *internal cancer*. We pay whether the blood, plasma and/or platelets is received as an *inpatient* in a *hospital* or as an outpatient in a *doctor's* office, *hospital* or *ambulatory surgical center*. We don't pay for blood, plasma and/or platelets for any other reason, including replacement of blood during surgery. And we limit what we pay in the 12 months which starts on the date of the first treatment to the amount shown in the schedule of insurance.

**Bone Marrow and Stem Cells:** We will pay the amount shown in the schedule of insurance if a *covered person* receives a *bone marrow transplant* or *stem cell transplant* to treat *internal cancer*.

**Cancer Screening:** Once per *benefit year*, we will pay the amount in the schedule of insurance if you provide *proof* satisfactory to us that a *covered person* received at least one of the following tests for *internal cancer* : (1) bone marrow testing; (2) BRCA testing; (3) breast ultrasound; (4) breast MRI; (5) colonoscopy or virtual colonoscopy; (6) CA 125 test (blood test for ovarian cancer ); (7) CA 15-3 test (blood test for breast cancer ); (8) CEA (blood test for colon cancer ) (9) chest x-ray; (10) CT scans or MRI scans; (11) flexible sigmoidoscopy; (12) hemocult stool specimen (lab confirmed); (13) mammogram; (14) pap smear; (15) PSA (blood test for prostate cancer ); (16) Serum Protein Electrophoresis (test for myeloma); (17) testicular ultrasound; (18) thermography; or (19) ThinPrep.

We will pay this benefit once per *benefit year* for each *covered person* regardless of whether multiple tests are performed. We will pay this benefit whether or not *cancer* is *diagnosed*.

**Cancer Screening Follow-Up:** Once per *benefit year*, we will pay the amount shown in the schedule of insurance for an additional invasive diagnostic procedure provided to a *covered person*. We will pay this benefit only if the procedure is recommended by a *doctor* as necessary due to the results of the initial *cancer* screening procedure.

**Experimental Treatment:** We pay the amount shown in the schedule of insurance if a *doctor* prescribes experimental treatment for a *covered person* for the purpose of destroying or changing abnormal tissue, and the treatment is administered by medical personnel in a *doctor's* office, *clinic* or *hospital*. All treatment must be *NCI-listed* as viable experimental treatment for *internal cancer*.

We will not pay benefits under this provision for laboratory tests, *immunotherapy*, diagnostic x-rays, and therapeutic devices or other procedures related to the treatments. We will not pay benefits under this provision for the same day the radiation and chemotherapy benefit is payable. However if a *covered person* is eligible for both the experimental treatment benefit and the radiation and chemotherapy benefit on the same day, then we will pay the higher benefit.

**Extended Care Facility/Skilled Nursing Care:** If we pay benefits under this *plan's* *hospital* confinement section for a *covered person*, and such *covered person* subsequently is confined to an *extended care* or *skilled nursing facility* for the treatment of *internal cancer*, we will pay the amount in the schedule of insurance. The *extended care* or *skilled nursing facility* confinement must start within 30 days of the end of the *hospital* confinement. We limit what we pay each *benefit year* to the number of days shown in the schedule of insurance.

**Government or Charity Hospital:** In lieu of all the other benefits provided by this *plan*, we will pay the amount shown in the schedule of insurance per day when a *covered person* is confined to: (a) a *hospital* operated by or for the U.S. Government (including the Veteran's Administration); or (b) a *hospital* that does not charge for its services (charity). The confinement must be for the treatment of *internal cancer*.

**Home Health Care:** We pay the amount shown in the schedule of insurance if a *covered person* receives home health care or health support services for the treatment of *internal cancer*. We limit what we pay each *benefit year* to the limit shown in the schedule of insurance.

However, these services must start within seven days of release from a *hospital*. And the *covered person's* *doctor* must certify that the *covered person* would need to be *hospital* confined if home health care was not available.

We will pay benefits under this section only if the home health care or health support services providers are licensed or certified and as qualified as caregivers providing comparable services at a *hospital* or other appropriate medical facility. This benefit will not be paid for any day a benefit is paid under the *hospice* section. If a *covered person* is eligible for both a benefit under the home health care and *hospice* sections on the same day, we will pay the higher amount.

**Hormone Therapy:** If a *doctor* prescribes, and a *covered person* receives hormone therapy as a treatment for *internal cancer*, we will pay the amount shown in the schedule of insurance. We limit what we pay to the number of treatments shown in the schedule of insurance each *benefit year*.

**Hospice:** We pay the amount shown in the schedule of insurance per day if a covered person receives hospice care. We limit what we pay to the number of days shown in the schedule of insurance during the covered person's lifetime.

We require that the covered person's doctor certify in writing that the covered person is terminally ill as a result of internal cancer, with a life expectancy of less than six months.

This benefit is not payable on the same day the extended care facility, home health care or hospital confinement benefit is payable. However, if a covered person is eligible for the extended care facility, home health care, hospice or hospital confinement benefit on the same day, we will pay the highest benefit.

**Hospital Confinement:** We will pay the amount shown in the schedule of insurance for each day during a period of hospital confinement in which a covered person is confined in a hospital for the treatment of internal cancer.

**Intensive Care Unit Confinement:** We will pay the amount shown in the schedule of insurance if a covered person is confined in a hospital's intensive care unit for the treatment of internal cancer. We don't pay for intensive care unit confinement and hospital confinement on the same day.

GP-1-CAN-BEN-12

P477.0003

### **Option A**

**Immunotherapy:** If a doctor prescribes immunotherapy for a covered person as treatment for internal cancer, we will pay the amount shown in the schedule of insurance each month. And we limit what we pay in a covered person's lifetime to the amount shown in the schedule of insurance.

We will not pay benefits under this provision for the same treatment under this plan's radiation or chemotherapy provision or the experimental treatment provision. However, if a covered person is eligible for the immunotherapy, radiation therapy or chemotherapy and the experimental treatment benefit on the same day, then we will pay the highest benefit.

**Prosthetic Devices:** We will pay the amount shown in the schedule of insurance for prosthetic devices provided to a covered person as a direct result of treatment of internal cancer. There are separate amounts shown in the schedule of insurance for surgically implanted prosthetic devices and non-surgically implanted prosthetic devices. We limit what we pay for prosthetic devices in a covered person's lifetime to the amounts shown in the schedule of insurance.

Surgically implanted prosthetic devices must be the direct result or consequence of the surgical treatment of internal cancer.

The prosthetic device coverage does not include coverage for a Breast Transverse Rectus Abdominis Myocutaneous (TRAM) Flap procedure as listed under the Reconstructive Surgery benefit.

**Radiation Therapy or Chemotherapy:** We will pay the amounts shown in the schedule of insurance if a covered person receives radiation therapy or chemotherapy as internal cancer treatment for the purpose of changing or destroying abnormal tissue. Such therapy must be administered by medical personnel in a hospital, doctor's office or clinic. Benefits will be paid only for days on which treatment is performed.

Benefits will not be paid for office visits, laboratory tests, diagnostic x-rays, treatment planning, simulation, treatment devices, dosimetry, radiation physics, teletherapy or other treatments related to radiation therapy or chemotherapy treatments. Hormone therapy and immunotherapy is not covered under this provision.

Radiation therapy and chemotherapy treatments must be approved for the treatment of cancer by the United States Food and Drug Administration.

**Second Surgical Opinion:** If a doctor has diagnosed a covered person with internal cancer requiring surgery and a covered person obtains a second surgical opinion, we will pay the amount shown in the schedule of insurance. However, the second surgical opinion must be from a different doctor than the one who recommended the surgery. We limit what we pay to one benefit per surgical procedure.

**Skin Cancer:** We will pay the amount shown in the schedule of insurance if a doctor performs any of the following procedures for the purpose of treating diagnosed skin cancer in a covered person: (a) biopsy; (b) reconstructive surgery following previous excision of skin cancer; (c) excision of skin cancer without flap or graft; or (d) excision of skin cancer with flap or graft.

The amount shown in the schedule of insurance includes the amount payable for anesthesia services.

**Surgical Benefits:** We pay the amount shown in the schedule of insurance if a doctor performs one of the procedures shown in the of insurance for the purpose of treating internal cancer diagnosed in a covered person. The schedule of insurance for surgical procedures does not apply to surgery for skin cancer, which will be covered only under the skin cancer section. And the schedule of insurance for surgical procedures does not apply to reconstructive surgery, which is covered only under the reconstructive surgery section.

If more than one surgical procedure is performed through the same incision, benefits will be paid for only one procedure based upon the highest eligible benefit.

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### ***Option B***

**Immunotherapy:** If a doctor prescribes immunotherapy for a covered person as treatment for internal cancer, we will pay the amount shown in the schedule of insurance each month. And we limit what we pay in a covered person's lifetime to the amount shown in the schedule of insurance.

We will not pay benefits under this provision for the same treatment under this plan's radiation or chemotherapy provision or the experimental treatment provision. However, if a covered person is eligible for the immunotherapy, radiation therapy or chemotherapy and the experimental treatment benefit on the same day, then we will pay the highest benefit.

**Inpatient Special Nursing:** While a covered person is an inpatient being treated for internal cancer, we pay the amount shown in the schedule of insurance each day for inpatient special nursing if a covered person requires full-time nursing care. Full-time means at least 8 hours of attendance in a 24 hour period. We limit what we pay each benefit year to the number of days shown in the schedule of insurance.

Nursing care must be ordered by a doctor for the treatment of internal cancer, and must be provided by a licensed registered graduate nurse or licensed practical or vocational nurse. Care can't be provided by a family member.

**Medical Imaging:** We will pay the amount shown in the schedule of insurance if a covered person receives a medical imaging procedure related to a diagnosed internal cancer. We limit what we pay each benefit year to the number of images shown in the schedule of insurance.

**Outpatient and Family Member Lodging:** We pay the amount in the schedule of insurance per day for lodging as described below. We limit what we pay for lodging to the number of days shown in the schedule of insurance.

We pay a daily lodging benefit when a covered person stay in a hotel, motel or other commercial accommodation in conjunction with receiving treatment of internal cancer. Such treatment must be ordered by a doctor and must not be able to be obtained locally. Lodging must occur more than 50 miles from the covered person's home.

We pay a daily lodging benefit for one adult family member who stays in a hotel, motel or other commercial accommodation in order to be near the covered person while confined in a hospital for internal cancer treatment. The hospital must be at least 50 miles from the covered person's home.

We don't pay for any day that a stay begins more than 24 hours prior to treatment or more than 24 hours after treatment.

**Outpatient or Ambulatory Surgical Center:** We will pay the amount shown in the schedule of insurance when a covered person uses an outpatient or ambulatory surgical center for a surgical procedure covered under this plan's surgical benefits section. We limit what we pay to three days per surgical procedure.

**Physical or Speech Therapy:** We will pay the amount shown in the schedule of insurance for physical or speech therapy provided to a covered person for restoration of normal body function following treatment of internal cancer. Such therapy must be provided by a licensed or certified physical or speech therapist.

We limit what we pay combined for physical and speech therapy to the number of visits per month shown in the schedule of insurance. We limit what we pay for physical and speech therapy combined to the lifetime limit shown in the schedule of insurance.

**Prosthetic Devices:** We will pay the amount shown in the schedule of insurance for prosthetic devices provided to a covered person as a direct result of treatment of internal cancer. There are separate amounts shown in the schedule of insurance for surgically implanted prosthetic devices and non-surgically implanted prosthetic devices. We limit what we pay for prosthetic devices in a covered person's lifetime to the amounts shown in the schedule of insurance.

Surgically implanted prosthetic devices must be the direct result or consequence of the surgical treatment of internal cancer.

The prosthetic device coverage does not include coverage for a Breast Transverse Rectus Abdominis Myocutaneous (TRAM) Flap procedure as listed under the Reconstructive Surgery benefit.

**Radiation Therapy or Chemotherapy:** We will pay the amounts shown in the schedule of insurance if a covered person receives radiation therapy or chemotherapy as internal cancer treatment for the purpose of changing or destroying abnormal tissue. Such therapy must be administered by medical personnel in a hospital, doctor's office or clinic. Benefits will be paid only for days on which treatment is performed.

Benefits will not be paid for office visits, laboratory tests, diagnostic x-rays, treatment planning, simulation, treatment devices, dosimetry, radiation physics, teletherapy or other treatments related to radiation therapy or chemotherapy treatments. Hormone therapy and immunotherapy is not covered under this provision.

Radiation therapy and chemotherapy treatments must be approved for the treatment of cancer by the United States Food and Drug Administration.

**Reconstructive Surgery:** We will pay the amount shown in the schedule of insurance if a covered person has reconstructive surgery performed related to the treatment of internal cancer. We pay only for the following procedures: (a) Breast symmetry (modification of the non-cancerous breast performed within 5 years of reconstructing the cancerous breast); (b) Breast reconstruction; (c) Facial reconstruction; and (d) Breast transverse rectus abdominis myocutaneous (TRAM) flap.

Also, we will pay 25% of the reconstructive surgery amounts shown in the schedule of insurance for general anesthesia used during these procedures.

**Second Surgical Opinion:** If a doctor has diagnosed a covered person with internal cancer requiring surgery and a covered person obtains a second surgical opinion, we will pay the amount shown in the schedule of insurance. However, the second surgical opinion must be from a different doctor than the one who recommended the surgery. We limit what we pay to one benefit per surgical procedure.

**Skin Cancer:** We will pay the amount shown in the schedule of insurance if a doctor performs any of the following procedures for the purpose of treating diagnosed skin cancer in a covered person: (a) biopsy; (b) reconstructive surgery following previous excision of skin cancer; (c) excision of skin cancer without flap or graft; or (d) excision of skin cancer with flap or graft.

The amount shown in the schedule of insurance includes the amount payable for anesthesia services.

**Surgical Benefits:** We pay the amount shown in the schedule of insurance if a doctor performs one of the procedures shown in the of insurance for the purpose of treating internal cancer diagnosed in a covered person. The schedule of insurance for surgical procedures does not apply to surgery for skin cancer, which will be covered only under the skin cancer section. And the schedule of insurance for surgical procedures does not apply to reconstructive surgery, which is covered only under the reconstructive surgery section.

If more than one surgical procedure is performed through the same incision, benefits will be paid for only one procedure based upon the highest eligible benefit.

**Transportation/Companion Transportation:** We pay the amount shown in the schedule of insurance for transportation and companion transportation as follows.

We pay a transportation benefit upon completion of a round trip to transport a covered person to a hospital or clinic for the purpose of internal cancer treatment. However the hospital or clinic must be at least 50 miles from the covered person's home. And transportation cannot be by the use of an ambulance or air ambulance.

If commercial travel (coach-class plane, train or bus) is necessary, we will pay for one additional person to accompany the covered person. If treatment is for a covered dependent child, we will pay for up to two adults to accompany the covered dependent child

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### ***Option C***

**Immunotherapy:** If a doctor prescribes immunotherapy for a covered person as treatment for internal cancer, we will pay the amount shown in the schedule of insurance each month. And we limit what we pay in a covered person's lifetime to the amount shown in the schedule of insurance.

We will not pay benefits under this provision for the same treatment under this plan's radiation or chemotherapy provision or the experimental treatment provision. However, if a covered person is eligible for the immunotherapy, radiation therapy or chemotherapy and the experimental treatment benefit on the same day, then we will pay the highest benefit.

**Inpatient Special Nursing:** While a covered person is an inpatient being treated for internal cancer, we pay the amount shown in the schedule of insurance each day for inpatient special nursing if a covered person requires full-time nursing care. Full-time means at least 8 hours of attendance in a 24 hour period. We limit what we pay each benefit year to the number of days shown in the schedule of insurance.

Nursing care must be ordered by a doctor for the treatment of internal cancer, and must be provided by a licensed registered graduate nurse or licensed practical or vocational nurse. Care can't be provided by a family member.

**Medical Imaging:** We will pay the amount shown in the schedule of insurance if a covered person receives a medical imaging procedure related to a diagnosed internal cancer. We limit what we pay each benefit year to the number of images shown in the schedule of insurance.

**Outpatient and Family Member Lodging:** We pay the amount in the schedule of insurance per day for lodging as described below. We limit what we pay for lodging to the number of days shown in the schedule of insurance.

We pay a daily lodging benefit when a covered person stay in a hotel, motel or other commercial accommodation in conjunction with receiving treatment of internal cancer. Such treatment must be ordered by a doctor and must not be able to be obtained locally. Lodging must occur more than 50 miles from the covered person's home.

We pay a daily lodging benefit for one adult family member who stays in a hotel, motel or other commercial accommodation in order to be near the covered person while confined in a hospital for internal cancer treatment. The hospital must be at least 50 miles from the covered person's home.

We don't pay for any day that a stay begins more than 24 hours prior to treatment or more than 24 hours after treatment.

**Outpatient or Ambulatory Surgical Center:** We will pay the amount shown in the schedule of insurance when a covered person uses an outpatient or ambulatory surgical center for a surgical procedure covered under this plan's surgical benefits section. We limit what we pay to three days per surgical procedure.

**Physical or Speech Therapy:** We will pay the amount shown in the schedule of insurance for physical or speech therapy provided to a covered person for restoration of normal body function following treatment of internal cancer. Such therapy must be provided by a licensed or certified physical or speech therapist.

We limit what we pay combined for physical and speech therapy to the number of visits per month shown in the schedule of insurance. We limit what we pay for physical and speech therapy combined to the lifetime limit shown in the schedule of insurance.

**Prosthetic Devices:** We will pay the amount shown in the schedule of insurance for prosthetic devices provided to a covered person as a direct result of treatment of internal cancer. There are separate amounts shown in the schedule of insurance for surgically implanted prosthetic devices and non-surgically implanted prosthetic devices. We limit what we pay for prosthetic devices in a covered person's lifetime to the amounts shown in the schedule of insurance.

Surgically implanted prosthetic devices must be the direct result or consequence of the surgical treatment of internal cancer.

The prosthetic device coverage does not include coverage for a Breast Transverse Rectus Abdominis Myocutaneous (TRAM) Flap procedure as listed under the Reconstructive Surgery benefit.

**Radiation Therapy or Chemotherapy:** We will pay the amounts shown in the schedule of insurance if a covered person receives radiation therapy or chemotherapy as internal cancer treatment for the purpose of changing or destroying abnormal tissue. Such therapy must be administered by medical personnel in a hospital, doctor's office or clinic. Benefits will be paid only for days on which treatment is performed.

Benefits will not be paid for office visits, laboratory tests, diagnostic x-rays, treatment planning, simulation, treatment devices, dosimetry, radiation physics, teletherapy or other treatments related to radiation therapy or chemotherapy treatments. Hormone therapy and immunotherapy is not covered under this provision.

Radiation therapy and chemotherapy treatments must be approved for the treatment of cancer by the United States Food and Drug Administration.

**Reconstructive Surgery:** We will pay the amount shown in the schedule of insurance if a covered person has reconstructive surgery performed related to the treatment of internal cancer. We pay only for the following procedures: (a) Breast symmetry (modification of the non-cancerous breast performed within 5 years of reconstructing the cancerous breast); (b) Breast reconstruction; (c) Facial reconstruction; and (d) Breast transverse rectus abdominis myocutaneous (TRAM) flap.

Also, we will pay 25% of the reconstructive surgery amounts shown in the schedule of insurance for general anesthesia used during these procedures.

**Reproductive Benefits:** We pay the amount shown in the insurance for a covered person to have oocytes extracted and harvested.

Also, once per covered person, we will pay the amount shown in the schedule of insurance for the storage of a covered person's oocytes or sperm with a licensed reproductive tissue bank or a similarly licensed facility. Any such extraction, harvesting or storage must occur prior to chemotherapy or radiation treatment that has been prescribed for the covered person's treatment of cancer.

We limit what we pay in a covered person's lifetime for covered reproductive benefits to the amount shown in the schedule of insurance.

**Second Surgical Opinion:** If a doctor has diagnosed a covered person with internal cancer requiring surgery and a covered person obtains a second surgical opinion, we will pay the amount shown in the schedule of insurance. However, the second surgical opinion must be from a different doctor than the one who recommended the surgery. We limit what we pay to one benefit per surgical procedure.

**Skin Cancer:** We will pay the amount shown in the schedule of insurance if a doctor performs any of the following procedures for the purpose of treating diagnosed skin cancer in a covered person: (a) biopsy; (b) reconstructive surgery following previous excision of skin cancer; (c) excision of skin cancer without flap or graft; or (d) excision of skin cancer with flap or graft.

The amount shown in the schedule of insurance includes the amount payable for anesthesia services.

**Surgical Benefits:** We pay the amount shown in the schedule of insurance if a doctor performs one of the procedures shown in the schedule of insurance for the purpose of treating internal cancer diagnosed in a covered person. The schedule of insurance for surgical procedures does not apply to surgery for skin cancer, which will be covered only under the skin cancer section. And the schedule of insurance for surgical procedures does not apply to reconstructive surgery, which is covered only under the reconstructive surgery section.

If more than one surgical procedure is performed through the same incision, benefits will be paid for only one procedure based upon the highest eligible benefit.

**Transportation/Companion Transportation:** We pay the amount shown in the schedule of insurance for transportation and companion transportation as follows.

We pay a transportation benefit upon completion of a round trip to transport a covered person to a hospital or clinic for the purpose of internal cancer treatment. However the hospital or clinic must be at least 50 miles from the covered person's home. And transportation cannot be by the use of an ambulance or air ambulance.

If commercial travel (coach-class plane, train or bus) is necessary, we will pay for one additional person to accompany the covered person. If treatment is for a covered dependent child, we will pay for up to two adults to accompany the covered dependent child



## Option A

### DEFINITIONS

This section defines certain terms appearing in this *plan*.

**Ambulatory Surgical Center:** This term means a facility in which outpatient surgery is done. It must meet all of the requirements shown below:

- have a medical staff of *doctors*, nurses, and licensed anesthesiologist;
- maintain at least two operating rooms; and one recovery room;
- maintain diagnostic lab and x-ray facilities;
- be staffed and equipped to give emergency care;
- have a blood supply;
- maintain medical records;
- have agreements with *hospitals* for immediate acceptance of patients who need *inpatient* confinement; and
- be licensed in accord with the laws of the appropriate legally authorized agency.

A facility is not an *ambulatory surgical center* if it is part of a *hospital*.

**Benefit Year:** This term means each period of 12 months in a row which starts on starts on January 1st and ends on December 31st.

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

**Cancer:** This term means a *covered person* has been *diagnosed* with a disease manifested by the presence of a malignant tumor characterized by the uncontrolled growth and spread of malignant cells in any part of the body. This includes leukemia, Hodgkin's disease, lymphoma, sarcoma, malignant tumors and melanoma. *Cancer* includes carcinomas in-situ (in the natural or normal place, confined to the site of origin, without having invaded neighboring tissue). Pre-malignant conditions or conditions with malignant potential, such as myelodysplastic and myeloproliferative disorders, carcinoid, leukoplakia, hyperplasia, actinic keratosis, polycythemia, and nonmalignant melanoma, moles or similar diseases or lesions will not be considered *cancer*.

**Clinic:** This term means an institution, building or part of a building where outpatients receive treatment for Diagnoses.

**Covered Person:** This term means an *employee* or dependent insured by this *plan*.

**Diagnosed or Diagnosis:** These terms mean the establishment of *cancer* by a *doctor* through the use of clinical and/or lab findings.

Diagnosis of *cancer* must be based on microscopic (histologic) exam of: (a) fixed tissues; or (b) preparations of blood or bone marrow. Such exam must be documented in a written report by a *doctor* who is *board certified* in pathology. If, however, in the opinion of the attending *doctor*, a pathological diagnosis is medically inappropriate, a clinical diagnosis of *cancer* will be accepted.

**Doctor:** This term means any practitioner of the healing arts that: (a) is properly licensed or certified by the laws of the state in which he or she practices; and (b) provides services that are within the lawful scope of his or license.

**Extended Care Facility or Skilled Nursing Facility:** This term means a facility which mainly provides full-time *inpatient* skilled nursing care for sick or injured people who do not need to be in a *hospital*. This *plan* recognizes such a place if it carries out its stated purpose under all relevant state and local laws, and it is: (a) accredited for its stated purpose by the Joint Commission of Healthcare Organizations; or (b) approved for its stated purpose by Medicare. In some places an extended care facility is called: (a) a rehabilitation facility; or (b) a skilled nursing facility; or (c) a sub-acute facility.

**Family Member:** This term means *you* are a *covered person's* spouse, brother or sister (including stepbrother or stepsister), children (including stepchildren), parents (including stepparents), grandchildren, father or mother-in-law, and spouses, if applicable, of any of these.

**Hospice:** This term means a licensed facility or program which provides a coordinated set of services at home or in a facility for persons who are certified by a *doctor* as terminally ill.

**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 *inpatient s*, 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 *Hospital s*; 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.

**Immunotherapy:** This term means treatments intended to improve the immune system by providing antibodies, colony stimulating factors, or immunoglobulins for the purpose of treating *cancer*.

**Inpatient:** This term means: (a) a *covered person* who is physically confined as a registered bed patient in a *hospital* or other recognized health care facility; or (b) the confinement, itself.

**Intensive Care Unit:** This term means a *hospital* area of special care, which at the time of admission is separate and apart from the surgical recovery room, other rooms, beds or wards normally used for patient confinement. In addition, the unit must provide the following: (a) 24 hour continuous nursing care attended by nurses assigned to the unit on a full-time basis; (b) direction and/or supervision by a full time doctor director or a standing "intensive care" committee of the medical staff; and (c) special medical apparatus used to treat the critically ill.

**Internal Cancer:** This term means a *cancer* contained within the body. Internal cancers do not include skin *cancer* except for melanomas classified as Clark's level III and higher or a Breslow level greater than or equal to 1.5mm.

**Period of Hospital Confinement:** This term means *hospital* confinement for a continuous and uninterrupted period of time while under the regular care and attendance of a *doctor*. A new period of *hospital* confinement will begin if a new *hospital* confinement occurs 30 or more days after the end of the previous *hospital* confinement or if the *hospital* confinement results from a completely independent cause from the previous *hospital* confinement.

**Plan:** This term means the group *cancer* coverage described in the *plan* and the certificate.

**Pre-Existing Conditions:** A *pre-existing condition* is a *cancer*, whether diagnosed or misdiagnosed, for which in the 3 months before a person becomes covered by this *plan*, he or she: (1) received advice or treatment from a *doctor*; (2) underwent diagnostic procedures; (3) was prescribed or took prescription drugs; or (4) received other medical care or treatment, including consultation with a *doctor*.

**Proof or Proof of Insurability:** These terms mean an application for coverage showing that a person is insurable.

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

**You or Your:** These terms mean the insured *employee*.

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## Option B

### DEFINITIONS

This section defines certain terms appearing in this *plan*.

**Ambulatory Surgical Center:** This term means a facility in which outpatient surgery is done. It must meet all of the requirements shown below:

- have a medical staff of *doctors*, nurses, and licensed anesthesiologist;
- maintain at least two operating rooms; and one recovery room;
- maintain diagnostic lab and x-ray facilities;
- be staffed and equipped to give emergency care;
- have a blood supply;
- maintain medical records;
- have agreements with *hospitals* for immediate acceptance of patients who need *inpatient* confinement; and
- be licensed in accord with the laws of the appropriate legally authorized agency.

A facility is not an *ambulatory surgical center* if it is part of a *hospital*.

**Benefit Year:** This term means each period of 12 months in a row which starts on starts on January 1st and ends on December 31st.

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

**Bone Marrow Transplant:** This term means a procedure in which a patient's bone marrow is replaced with cellular elements to reconstitute the bone marrow. It may be preceded by chemotherapy, radiotherapy, or other treatments which cause residual bone marrow to be destroyed. The collection of stem cells or other peripheral blood cells and their reinfusion is not a *bone marrow transplant*.

**Cancer:** This term means a *covered person* has been *diagnosed* with a disease manifested by the presence of a malignant tumor characterized by the uncontrolled growth and spread of malignant cells in any part of the body. This includes leukemia, Hodgkin's disease, lymphoma, sarcoma, malignant tumors and melanoma. *Cancer* includes carcinomas in-situ (in the natural or normal place, confined to the site of origin, without having invaded neighboring tissue). Pre-malignant conditions or conditions with malignant potential, such as myelodysplastic and myeloproliferative disorders, carcinoid, leukoplakia, hyperplasia, actinic keratosis, polycythemia, and nonmalignant melanoma, moles or similar diseases or lesions will not be considered *cancer*.

**Clinic:** This term means an institution, building or part of a building where outpatients receive treatment for Diagnoses.

**Covered Person:** This term means an *employee* or dependent insured by this *plan*.

**Diagnosed or Diagnosis:** These terms mean the establishment of *cancer* by a *doctor* through the use of clinical and/or lab findings.

Diagnosis of *cancer* must be based on microscopic (histologic) exam of: (a) fixed tissues; or (b) preparations of blood or bone marrow. Such exam must be documented in a written report by a *doctor* who is *board certified* in pathology. If, however, in the opinion of the attending *doctor*, a pathological diagnosis is medically inappropriate, a clinical diagnosis of *cancer* will be accepted.

**Doctor:** This term means any practitioner of the healing arts that: (a) is properly licensed or certified by the laws of the state in which he or she practices; and (b) provides services that are within the lawful scope of his or license.

**Extended Care Facility or Skilled Nursing Facility:** This term means a facility which mainly provides full-time *inpatient* skilled nursing care for sick or injured people who do not need to be in a *hospital*. This *plan* recognizes such a place if it carries out its stated purpose under all relevant state and local laws, and it is: (a) accredited for its stated purpose by the Joint Commission of Healthcare Organizations; or (b) approved for its stated purpose by Medicare. In some places an extended care facility is called: (a) a rehabilitation facility; or (b) a skilled nursing facility; or (c) a sub-acute facility.

**Family Member:** This term means *you* are a *covered person's* spouse, brother or sister (including stepbrother or stepsister), children (including stepchildren), parents (including stepparents), grandchildren, father or mother-in-law, and spouses, if applicable, of any of these.

**Hospice:** This term means a licensed facility or program which provides a coordinated set of services at home or in a facility for persons who are certified by a *doctor* as terminally ill.

**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 *inpatient s*, 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 *Hospital s*; 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.

**Immunotherapy:** This term means treatments intended to improve the immune system by providing antibodies, colony stimulating factors, or immunoglobulins for the purpose of treating *cancer*.

**Inpatient:** This term means: (a) a *covered person* who is physically confined as a registered bed patient in a *hospital* or other recognized health care facility; or (b) the confinement, itself.

**Intensive Care Unit:** This term means a *hospital* area of special care, which at the time of admission is separate and apart from the surgical recovery room, other rooms, beds or wards normally used for patient confinement. In addition, the unit must provide the following: (a) 24 hour continuous nursing care attended by nurses assigned to the unit on a full-time basis; (b) direction and/or supervision by a full time doctor director or a standing "intensive care" committee of the medical staff; and (c) special medical apparatus used to treat the critically ill.

**Internal Cancer:** This term means a *cancer* contained within the body. Internal cancers do not include skin *cancer* except for melanomas classified as Clark's level III and higher or a Breslow level greater than or equal to 1.5mm.

**NCI-Listed:** This term means a *cancer* treatment protocol that is listed in the National Cancer Institute's (NCI) Physician Data Query (PDQ). The PDQ is an on-line database that contains *cancer* information summaries, listings of clinical trials, and directories of *doctors* and organization involved in *cancer* care.

**Period of Hospital Confinement:** This term means *hospital* confinement for a continuous and uninterrupted period of time while under the regular care and attendance of a *doctor*. A new period of *hospital* confinement will begin if a new *hospital* confinement occurs 30 or more days after the end of the previous *hospital* confinement or if the *hospital* confinement results from a completely independent cause from the previous *hospital* confinement.

**Plan:** This term means the group *cancer* coverage described in the *plan* and the certificate.

**Pre-Existing Conditions:** A *pre-existing condition* is a *cancer*, whether diagnosed or misdiagnosed, for which in the 3 months before a person becomes covered by this *plan*, he or she: (1) received advice or treatment from a *doctor*; (2) underwent diagnostic procedures; (3) was prescribed or took prescription drugs; or (4) received other medical care or treatment, including consultation with a *doctor*.

**Proof or Proof of Insurability:** These terms mean an application for coverage showing that a person is insurable.

**Stem Cell Transplant:** This term means the delivery of autologous or allogeneic stem cells to a person who has received chemotherapy or radiology to treat *internal cancer*. This definition does not include allogeneic or autogeneic bone marrow collection and infusion of bone marrow under general anesthesia.

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

**You or Your:** These terms mean the insured *employee*.

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## Option C

### DEFINITIONS

This section defines certain terms appearing in this *plan*.

**Accredited Practitioner:** This term means a *naturopathic doctor*, *ayurvedic practitioner*, *bio-feedback practitioner* or *hypnotherapist* who is licensed (if applicable) under the laws of the state where treatment is received as qualified to treat the type of condition for which a claim is being made. If licensed, the practitioner must be practicing within the scope of his or her license.

**Ayurvedic Medicine:** This term means a practice of health promotion, disease prevention, and personal growth that includes physical, psychological and spiritual aspects. Ayurvedic practices are intended to promote well being and reduce stress and may include yoga, meditation, massage, dietary changes and herbs.

**Ayurvedic Practitioner:** This term means an *accredited practitioner* who has been certified through the American Association of Drugless Accredited Practitioners for Ayurvedic Medicine.

**Ambulatory Surgical Center:** This term means a facility in which outpatient surgery is done. It must meet all of the requirements shown below:

- have a medical staff of *doctors*, nurses, and licensed anesthesiologist;
- maintain at least two operating rooms; and one recovery room;
- maintain diagnostic lab and x-ray facilities;
- be staffed and equipped to give emergency care;
- have a blood supply;
- maintain medical records;
- have agreements with *hospitals* for immediate acceptance of patients who need *inpatient* confinement; and
- be licensed in accord with the laws of the appropriate legally authorized agency.

A facility is not an *ambulatory surgical center* if it is part of a *hospital*.

**Benefit Year:** This term means each period of 12 months in a row which starts on starts on January 1st and ends on December 31st.

**Bio-Feedback:** This term means a therapy that trains and uses the mind to control body functions that are typically regulated automatically such as muscle tension, heart rate, blood pressure or temperature.

**Bio-Feedback Practitioner:** This term means an *accredited practitioner* who has a bachelor's degree in a health related profession, such as a degree in medicine, osteopathy or Naturopathic medicine and who has received certification from the Biofeedback Society of America and is currently licensed in the state where he or she practices.

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

**Bone Marrow Transplant:** This term means a procedure in which a patient's bone marrow is replaced with cellular elements to reconstitute the bone marrow. It may be preceded by chemotherapy, radiotherapy, or other treatments which cause residual bone marrow to be destroyed. The collection of stem cells or other peripheral blood cells and their reinfusion is not a *bone marrow transplant*.

**Cancer:** This term means a *covered person* has been *diagnosed* with a disease manifested by the presence of a malignant tumor characterized by the uncontrolled growth and spread of malignant cells in any part of the body. This includes leukemia, Hodgkin's disease, lymphoma, sarcoma, malignant tumors and melanoma. *Cancer* includes carcinomas in-situ (in the natural or normal place, confined to the site of origin, without having invaded neighboring tissue). Pre-malignant conditions or conditions with malignant potential, such as myelodysplastic and myeloproliferative disorders, carcinoid, leukoplakia, hyperplasia, actinic keratosis, polycythemia, and nonmalignant melanoma, moles or similar diseases or lesions will not be considered *cancer*.

**Clinic:** This term means an institution, building or part of a building where outpatients receive treatment for Diagnoses.

**Covered Person:** This term means an *employee* or dependent insured by this *plan*.

**Diagnosed or Diagnosis:** These terms mean the establishment of *cancer* by a *doctor* through the use of clinical and/or lab findings.

Diagnosis of *cancer* must be based on microscopic (histologic) exam of: (a) fixed tissues; or (b) preparations of blood or bone marrow. Such exam must be documented in a written report by a *doctor* who is *board certified* in pathology. If, however, in the opinion of the attending *doctor*, a pathological diagnosis is medically inappropriate, a clinical diagnosis of *cancer* will be accepted.

**Doctor:** This term means any practitioner of the healing arts that: (a) is properly licensed or certified by the laws of the state in which he or she practices; and (b) provides services that are within the lawful scope of his or license.

**Extended Care Facility or Skilled Nursing Facility:** This term means a facility which mainly provides full-time *inpatient* skilled nursing care for sick or injured people who do not need to be in a *hospital*. This *plan* recognizes such a place if it carries out its stated purpose under all relevant state and local laws, and it is: (a) accredited for its stated purpose by the Joint Commission of Healthcare Organizations; or (b) approved for its stated purpose by Medicare. In some places an extended care facility is called: (a) a rehabilitation facility; or (b) a skilled nursing facility; or (c) a sub-acute facility.

**Family Member:** This term means *you* are a *covered person's* spouse, brother or sister (including stepbrother or stepsister), children (including stepchildren), parents (including stepparents), grandchildren, father or mother-in-law, and spouses, if applicable, of any of these.

**Hospice:** This term means a licensed facility or program which provides a coordinated set of services at home or in a facility for persons who are certified by a *doctor* as terminally ill.

**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 *inpatient s*, 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 *Hospital s*; 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.

**Hypnotherapist:** This term means an *accredited practitioner* who has been certified by the American Board of Hypnotherapy or the American Clinical Board of Hypnotherapy.



**Hypnotherapy:** This term means a change in a person's conscious awareness, induced by another person, which may alter memory and consciousness, increase susceptibility to suggestions, and bring about responses and ideas that may be considered unusual.

**Immunotherapy:** This term means treatments intended to improve the immune system by providing antibodies, colony stimulating factors, or immunoglobulins for the purpose of treating *cancer*.

**Inpatient:** This term means: (a) a *covered person* who is physically confined as a registered bed patient in a *hospital* or other recognized health care facility; or (b) the confinement, itself.

**Intensive Care Unit:** This term means a *hospital* area of special care, which at the time of admission is separate and apart from the surgical recovery room, other rooms, beds or wards normally used for patient confinement. In addition, the unit must provide the following: (a) 24 hour continuous nursing care attended by nurses assigned to the unit on a full-time basis; (b) direction and/or supervision by a full time doctor director or a standing "intensive care" committee of the medical staff; and (c) special medical apparatus used to treat the critically ill.

**Internal Cancer:** This term means a *cancer* contained within the body. Internal cancers do not include skin *cancer* except for melanomas classified as Clark's level III and higher or a Breslow level greater than or equal to 1.5mm.

**Naturopathic Doctor:** this term means an *accredited practitioner* who has graduated from a four year naturopathic medical school, which is accredited by the Council on Naturopathic Medical Education.

**NCI-Listed:** This term means a *cancer* treatment protocol that is listed in the National Cancer Institute's (NCI) Physician Data Query (PDQ). The PDQ is an on-line database that contains *cancer* information summaries, listings of clinical trials, and directories of *doctors* and organization involved in *cancer* care.

**Palliative Care:** This term means treatment or services designed to reduce the severity of a condition or symptoms without curing the underlying disease.

**Period of Hospital Confinement:** This term means *hospital* confinement for a continuous and uninterrupted period of time while under the regular care and attendance of a *doctor*. A new period of *hospital* confinement will begin if a new *hospital* confinement occurs 30 or more days after the end of the previous *hospital* confinement or if the *hospital* confinement results from a completely independent cause from the previous *hospital* confinement.

**Plan:** This term means the group *cancer* coverage described in the *plan* and the certificate.

**Pre-Existing Conditions:** A *pre-existing condition* is a *cancer*, whether diagnosed or misdiagnosed, for which in the 3 months before a person becomes covered by this *plan*, he or she: (1) received advice or treatment from a *doctor*; (2) underwent diagnostic procedures; (3) was prescribed or took prescription drugs; or (4) received other medical care or treatment, including consultation with a *doctor*.

**Proof or Proof of Insurability:** These terms mean an application for coverage showing that a person is insurable.

**Stem Cell Transplant:** This term means the delivery of autologous or allogeneic stem cells to a person who has received chemotherapy or radiology to treat *internal cancer*. This definition does not include allogeneic or autogeneic bone marrow collection and infusion of bone marrow under general anesthesia.

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

**You or Your:** These terms mean the insured *employee*.

## All Options

### LIMITATIONS

**Proof Of Insurability:** The *covered person's* coverage may not become effective until he or she submits *proof of insurability* to us. These requirements are shown in the schedule of insurance.

**Pre-Existing Conditions:** A *pre-existing condition* is a *cancer*, whether *diagnosed* or misdiagnosed, for which in the 3 months before a person becomes covered by this *plan*, he or she: (1) received advice or treatment from a *doctor*; (2) underwent diagnostic procedures; (3) was prescribed or took prescription drugs; or (4) received other medical care or treatment, including consultation with a *doctor*.

This *plan* will not pay benefits for *cancer* that is caused by, or results from, a *pre-existing condition* until the earlier of: (a) during the first a 6 months that a *covered person* is covered by this *plan* during which the person does not receive medical advice or treatment in connection with the *cancer*; or (b) the 12 month period commencing on the effective date of the person's coverage.

**If This Plan Replaces Another Plan:** This *plan* may be replacing a similar plan that the *employer* had with some other insurer. In that case, the *pre-existing condition* limitation will not apply to any *covered person* who: (1) was covered under the *employer's* old plan on the day before this *plan* started; and (2) has met the requirements of any *pre-existing conditions* limitation of the old plan; and (3) with respect to the employee, is *actively at work on a full-time* basis on the effective date of this *plan*.

If the *covered person*: (1) was covered under the old plan when it ended; (2) enrolls for insurance under this *plan* on or before this *plan's* effective date; and (3) is actively working on the effective date of this *plan*; but(4) has not fulfilled the requirements of any pre-existing condition provision of the old plan; this *plan* will credit any time used to meet the old plan's pre-existing condition provision toward meeting this *plan's* pre-existing condition provision.

But, this *plan* limits a *covered person's* benefit under this *plan* if: (1) the *cancer* is a *pre-existing condition*; and (2) this *plan* pays benefit because this *plan* credits time as explained above. In this case, this *plan* limits the benefit to the amount the *covered person* would have been entitled to under the old plan.

This *plan* deducts all payments made by the old plan under an extension provision.

GP-1-CAN-LIMIT-12-TX

P477.0119

## All Options

### EXCLUSIONS

This *plan* will not pay benefits for:

- Services or treatment not included in the Schedule of Insurance.
- Services or treatment provided by a *family member*.
- Services or treatment rendered outside the United States or Canada.
- Treatment of any *cancer* diagnosed solely outside of the United States or Canada.
- Services or treatment provided primarily for cosmetic purposes.
- Services or treatment for premalignant conditions.
- Services or treatment for conditions with malignant potential.
- Services or treatment for non-cancer *sicknesses*.
- *Cancer* caused by, contributed to by, or resulting from: (1) participating in a felony, riot or insurrection; (2) intentionally causing a self- inflicted injury; (3) committing or attempting to commit suicide while sane or insane; (4) a *covered person's* mental or emotional disorder, alcoholism or drug addiction; (5) engaging in any illegal activity; or (6) serving in the armed forces or any

auxiliary unit of the armed forces of any country.

- *Cancer* arising from war or act of war, even if war is not declared.

GP-1-CAN-EXC-12

P477.0030

### **All Options**

#### **Waiver of Premium**

If, while covered by this *plan*, an *employee* becomes disabled due to *cancer* that is diagnosed after the *employee's* effective date, and such *employee* remains disabled for 90 days, we will waive the premium due after such 90 days for as long as the *employee* remains disabled.

To be considered disabled the *employee* must: (1) be unable to work at any job for which he or she is qualified by education, training or experience; and (2) not be working at any job for pay or benefits; and (3) be under the care of a *doctor* for the treatment of *cancer*.

GP-1-CAN-WP-12

P477.0031

### **All Options**

#### **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 *cancer* coverage.

**Portability Conditions:** Portability is subject to all of the conditions described below.

- The *employee* may port his or her coverage or coverage for any of *his or her* dependents if coverage under this *plan* ends because he or she: (a) has terminated employment; (2) stops being a member of an eligible class of *employees*; or (3) this *plan* ends.
- The *employee* may not Port his or her coverage or coverage for any of *his or her* dependents if (1) coverage under this *plan* ends due to his or her failure to pay any required premium; or (2) he or she has reached age 70 on or before *his or her* coverage under this *plan* ends.

**Portability Options:** The *employee* may port: (1) his or her coverage only; (2) his or her coverage and the coverage of his or her covered spouse; (3) his or her coverage and the coverage of all of his or her covered dependents; or (4) if the *employee* is a single parent, his or her coverage and the coverage of all of his or her covered dependent children. No other combinations will be allowed.

A dependent must be covered as of the date the *employee* coverage under this *plan* ends in order to be eligible to port.

If an *employee* dies while covered for dependent *cancer* coverage, his or her spouse may port the dependent *cancer* coverage as described above. The *employee's* spouse and dependent children must be covered under this *plan* on the date of his or her death. But this option is not available if (1) there is no surviving spouse; or (2) the surviving spouse has reached age 70 on the date the *employee* dies.

**The Portable Certificate of Coverage:** The portable certificate of coverage provides group *cancer* coverage. The benefits provided by the portable certificate of coverage are the same as the benefits provided by this *plan*.

The premium for the portable certificate of coverage will be based on: the *covered person's* rate class under this *plan*; and (2) Your or Your surviving spouse's age bracket as shown in the Cancer Portability Coverage Premium Notice.

**How to Port:** The *employee* or his or her surviving spouse must: (1) apply to us in writing; and (2) pay the required premium. The *employee* or his or her surviving spouse must do this within 31 days from the date his or her coverage under this *plan* ends.

We will not ask for *proof* that the employee or his or her surviving spouse are in good health.

GP-1-CAN-PORT-12

P477.0034

**All Options**

**The Guardian Life Insurance Company of America  
DOMICILED IN NEW YORK  
7 Hanover Square, New York, New York 10004**

**POLICY AMENDMENT**

**ELIGIBILITY FOR CANCER COVERAGE**

Effective on the latter of (i) the original effective date of the Policy; or (ii) the effective date of any applicable amendment requested by the Policyholder and approved by the Insurance Company, this rider amends this Plan by replacing the following:

**Conditions of Eligibility**

**Proof of Insurability**

Part or all the employee's insurance amounts may be subject to Proof of Insurability. The employee and dependents will not be covered for any amount that requires such Proof of Insurability until the employee gives the Proof of Insurability to us and we approve that Proof of Insurability in writing.

If the employee elects to enroll within 31 days after his or her eligibility date, coverage is scheduled to start on his or her eligibility date.

If the employee does not elect this coverage within 31 days of his or her eligibility date, he or she must answer health questions, or wait until the next scheduled group enrollment period. Once each year, during the group enrollment period, the employee 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 the employee elects to enroll outside of the group open enrollment period, he or she must provide Proof of Insurability by answering health questions, or wait until the next group enrollment period.

If Proof of Insurability is required, the employee and dependents will not be covered by this Plan until we approve that Proof of Insurability in writing and notify the employee of the effective date of coverage.

**When Employee Coverage Starts**

The employee's eligibility date is the date he or she has met all of the conditions of eligibility.

Whether the employee must pay all or part of the cost of the coverage, he or she must elect to enroll and agree to make the required payments before his or her coverage will start. If the employee does this on or before his or her eligibility date, his or her coverage is scheduled to start on his or her eligibility date. If the employee does this within 31 days after his or her eligibility date, his or her coverage is scheduled to start on the eligibility date. If the employee elects to enroll and agrees to make the required payments more than 31 days after his or her eligibility date, his or her coverage will not be scheduled to start until he or she sends us Proof of Insurability or until he or she enrolls during the next group enrollment period. If Proof of Insurability is required, the employee will not be covered by this Plan until we approve that Proof of Insurability in writing and notify the employee of his or her effective date of coverage.

If the employee's active service ends before he or she meets any Proof of Insurability requirements that apply, he or she will still have to meet those requirements if he or she is later re-employed by the employer or an associated company.

On the date all or part of the employee's coverage is scheduled to start, he or she must be: (1) actively at work; (2) fully capable of performing the major duties of his or her regular occupation; and (3) working his or her regular number of hours. In that case, the employee's coverage will start at 12:01 A.M. Standard Time for his or her place of residence on that date. In any other case, we will postpone the start of the employee's coverage until the date he or she: (a) returns to active work; (b) is working his or her regular number of hours; and (c) is fully capable of performing the major duties of his or her 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) the employee was fully capable of performing the major duties of his or her regular occupation for the employer on a full-time basis at 12:01 AM Standard Time for his or her place of residence on the scheduled effective date; and (b) he or she was performing the major duties of his or her regular occupation and working his or her regular number of hours on his or her last regularly scheduled work day; his or her coverage will start on the scheduled effective date.

## **DEPENDENT COVERAGE**

### **Proof of Insurability**

Part or all of the employee's initial dependents insurance amounts may be subject to Proof of Insurability. The employee's initial dependents will not be covered for any amount that requires such Proof of Insurability until the employee gives the Proof of Insurability to us and we approve that Proof of Insurability in writing.

If the employee elects to enroll his or her initial dependents within 31 days after his or her eligibility date, coverage is scheduled to start on his or her eligibility date.

If the employee does not elect initial dependent coverage within 31 days of his or her eligibility date, his or her 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, the employee 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 the employee elects to enroll his or her initial dependents outside of the group open enrollment period, he or she must provide Proof of Insurability by answering health questions, or wait until the next group enrollment period.

If Proof of Insurability is required, the employee's initial dependents will not be covered by this Plan until we approve that Proof of Insurability in writing and notify the employee of his or her initial dependents effective date of coverage.

In the case of a newly acquired dependent, other than the first newborn child, the employee may elect to enroll a newly acquired dependent within 31 days. If the employee does not elect to enroll a newly acquired dependent within 31 days of his or her eligibility date, the newly acquired dependent(s) may have to answer health questions, or wait until the next scheduled group enrollment period to enroll.

If the employee's dependent coverage ends for any reason, including failure to make the required payments, the employee's dependent(s) will not be covered by this Plan again until he or she gives 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 the employee's dependent coverage to start, he or she must already be covered for employee coverage, or enroll for employee and dependent coverage at the same time.

If the employee enrolls his or her dependent(s) on or before his or her eligibility date, the dependent's coverage is scheduled to start on the later of the employee's eligibility date and the date he or she becomes covered for employee coverage.

If the employee does this within the group enrollment period, the coverage is scheduled to start on the date he or she becomes covered for employee coverage.

If the employee does this after the group enrollment period ends, his or her dependent coverage may be subject to Proof of Insurability and will not start until we approve that Proof of Insurability in writing.

Once the employee has dependent child coverage for initial dependent child(ren) any newly acquired dependent children will be covered as of the date he or she is first eligible.

Whether the employee must pay all or part of the cost this coverage, he or she must elect to enroll and agree to make the required payments before his or her coverage will start. If the employee does this on or before his or her eligibility date, his or her coverage is scheduled to start on his or her eligibility date. If the employee

does this within 31 days after his or her eligibility date, his or her coverage is scheduled to start on the eligibility date. If the employee elects to enroll and agree to make the required payments more than 31 days after his or her eligibility date, his or her coverage will not be scheduled to start until he or she sends us Proof of Insurability or until he or she enrolls during the next group enrollment period. If Proof of Insurability is required, the employee will not be covered by this Plan until we approve that Proof of Insurability in writing and notify the employee of his or her 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 the employee gives 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 the employee's application.

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

**The Guardian** Life Insurance Company of America

A handwritten signature in black ink, appearing to read "Raymond J. Manna". The signature is written in a cursive style with a large initial 'R'.

Senior Vice President, Group and Worksite Markets

P477.0431



**All Options**

**ATTACHED TO AND MADE PART OF GROUP INSURANCE POLICY NO. G -00551834-**  
issued by

**The Guardian** Life Insurance Company of America  
(herein called the Insurance Company)

to

**UPLIFT EDUCATION**  
(herein called the Policyholder)

Effective on the later of (i) the original effective date of Cancer Insurance; or (ii) the effective date of any applicable amendment requested by the Policyholder and approved by the Insurance Company, this rider amends this plan by the addition of the following:

**Initial Diagnosis Benefit**

We pay a one-time benefit when a *covered person* is *diagnosed* for the first time as having *internal cancer*, other than carcinomas in-situ. The first *diagnosis* must occur while the *covered person* is covered by this *plan*.

The benefit is \$5,000.00 for *employees*, \$5,000.00 for spouse and \$5,000.00 for child.

We pay this benefit once per *covered person* in a *covered person's* lifetime.

We don't pay this benefit for a *diagnosis* of skin cancer.

We don't pay the benefit if the *diagnosis* occurred prior to the *covered person's* effective date under this *plan*.

We don't pay this benefit for a recurrence, extension or metastatic spread of an *internal cancer* that was diagnosed: (a) prior to a *covered person's* effective date under this *plan*; or (b) during this *plan's* *benefit waiting period*.

We don't pay this benefit if the diagnosis was made solely outside of the United States or Canada.

**Benefit Waiting Period:** This plan has a *benefit waiting period*. It is 30 days. This period starts on the date a *covered person* is first covered by this *plan*. We do not pay an initial *diagnosis* benefit for *cancer* that is *diagnosed* during the *benefit waiting period*.

If this *plan* replaces a similar plan the *employer* had with some other insurer, the *benefit waiting period* under this plan will be waived if for any *covered person* who was covered under the *employer's* old plan on the day before this *plan* starts and is covered by this *plan* on the day it starts.

As used in this rider, *benefit waiting period* means the period of time a *covered person* must be covered under this *plan* before we pay an Initial Diagnosis Benefit.

As used in this rider, carcinomas in-situ means *cancer* that is confined to the site of origin, without having invaded neighboring tissue. 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*.

Dated at \_\_\_\_\_ This \_\_\_\_\_ Day of \_\_\_\_\_, \_\_\_\_\_

UPLIFT EDUCATION  
Full or Corporate Name of Policyholder

\_\_\_\_\_  
Witness BY: \_\_\_\_\_  
Signature and Title

**The Guardian** Life Insurance Company of America

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

GP-1-A-CAN-IDB-12

P477.0036

**Options A and B**

**ATTACHED TO AND MADE PART OF GROUP INSURANCE POLICY NO. G -00551834-**  
issued by

**The Guardian** Life Insurance Company of America  
(herein called the Insurance Company)

to

**UPLIFT EDUCATION**  
(herein called the Policyholder)

Effective on the later of (i) the original effective date of Cancer Insurance; or (ii) the effective date of any applicable amendment requested by the Policyholder and approved by the Insurance Company.

This rider amends the certificate Schedule of Insurance for *internal cancer* or a *specified disease*. We pay the amount shown below per *covered person* for *internal cancer*. Terms that are not defined specifically in this rider are defined in the certificate or in the *specified disease* rider.

**Blood, Plasma and Platelets:** Actual costs up to \$10,000.00 per 12 month period.

**Radiation Therapy and Chemotherapy:** Actual costs up to \$10,000.00 per 12 month period.

This rider also amends the **Benefits** section of the certificate as follows:

**Blood, Plasma and Platelets:** We pay Actual costs, up to the limit stated above, for:

- blood, plasma and platelets (including transfusions and administration charges);
- processing and procurement costs; and
- cross-matching

received by a *covered person* in conjunction with *internal cancer* or *specified disease* treatment. We limit what we pay in the 12 months which starts on the date of the first treatment to the amount shown in this rider.

We don't pay blood, plasma and/or platelets for any other reason, including replacement of blood during surgery or for blood replaced by donors.

**Radiation Therapy and Chemotherapy:** We pay Actual costs, up to the limit shown above for radiation therapy and chemotherapy received by a *covered person* as part of a treatment for *internal cancer* or *specified disease*.

We only pay this benefit for *internal cancer* treatment consisting of:

- cancericidal chemical substances for the purpose of modification or destruction of *internal cancer* or a *specified disease*; and
- X-ray radiation; and
- radium and cesium implants; and
- cobalt

We limit what we pay in the 12 months which starts on the date of the first treatment to the amount shown in this rider.

Administration of radiation therapy or chemotherapy other than by medical personnel in a *doctor's* office or *hospital*, including medications dispensed by a pump, will be limited to the costs of the drugs only, subject to the maximum amount payable per 12 month period explained above.

This benefit does not pay for:

- treatment planning;
- treatment consultation;
- treatment management;
- design and construction of treatment devices;
- basic radiation dosimetry calculation;
- any type of laboratory tests, X-ray or other imaging used for diagnosis or disease monitoring;
- diagnostic tests related to these treatments.

This benefit also does not pay for any devices or supplies including intravenous solutions and needles related to these treatments.

For these benefits paid based on Actual Costs up to a specified maximum amount, if specific costs are not obtainable as proof of loss, we will pay 50% of the applicable maximum for benefits payable.

Actual Costs means the amount actually paid by, or on behalf of, the *covered person* and accepted by the provider as full payment for the particular treatment of services provided.

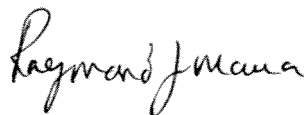
This rider is part of this *plan*. Except as stated in this rider, nothing contained in this rider changes or affects any other terms of this *plan*.

Dated at \_\_\_\_\_ This \_\_\_\_\_ Day of \_\_\_\_\_, \_\_\_\_\_

UPLIFT EDUCATION  
Full or Corporate Name of Policyholder

\_\_\_\_\_  
Witness BY: \_\_\_\_\_  
Signature and Title

**The Guardian** Life Insurance Company of America



Raymond Marra, Senior Vice President, Group and Worksite Markets

**Option C**

**ATTACHED TO AND MADE PART OF GROUP INSURANCE POLICY NO. G -00551834-**  
issued by

**The Guardian** Life Insurance Company of America  
(herein called the Insurance Company)

to

**UPLIFT EDUCATION**  
(herein called the Policyholder)

Effective on the later of (i) the original effective date of Cancer Insurance; or (ii) the effective date of any applicable amendment requested by the Policyholder and approved by the Insurance Company.

This rider amends the certificate Schedule of Insurance for *internal cancer* or a *specified disease*. We pay the amount shown below per *covered person* for *internal cancer*. Terms that are not defined specifically in this rider are defined in the certificate or in the *specified disease* rider.

**Blood, Plasma and Platelets:** Actual costs up to \$15,000.00 per 12 month period.

**Radiation Therapy and Chemotherapy:** Actual costs up to \$15,000.00 per 12 month period.

This rider also amends the **Benefits** section of the certificate as follows:

**Blood, Plasma and Platelets:** We pay Actual costs, up to the limit stated above, for:

- blood, plasma and platelets (including transfusions and administration charges);
- processing and procurement costs; and
- cross-matching

received by a *covered person* in conjunction with *internal cancer* or *specified disease* treatment. We limit what we pay in the 12 months which starts on the date of the first treatment to the amount shown in this rider.

We don't pay blood, plasma and/or platelets for any other reason, including replacement of blood during surgery or for blood replaced by donors.

**Radiation Therapy and Chemotherapy:** We pay Actual costs, up to the limit shown above for radiation therapy and chemotherapy received by a *covered person* as part of a treatment for *internal cancer* or *specified disease*.

We only pay this benefit for *internal cancer* treatment consisting of:

- cancericidal chemical substances for the purpose of modification or destruction of *internal cancer* or a *specified disease*; and
- X-ray radiation; and
- radium and cesium implants; and
- cobalt

We limit what we pay in the 12 months which starts on the date of the first treatment to the amount shown in this rider.

Administration of radiation therapy or chemotherapy other than by medical personnel in a *doctor's* office or *hospital*, including medications dispensed by a pump, will be limited to the costs of the drugs only, subject to the maximum amount payable per 12 month period explained above.

This benefit does not pay for:

- treatment planning;
- treatment consultation;
- treatment management;
- design and construction of treatment devices;
- basic radiation dosimetry calculation;
- any type of laboratory tests, X-ray or other imaging used for diagnosis or disease monitoring;
- diagnostic tests related to these treatments.

This benefit also does not pay for any devices or supplies including intravenous solutions and needles related to these treatments.

For these benefits paid based on Actual Costs up to a specified maximum amount, if specific costs are not obtainable as proof of loss, we will pay 50% of the applicable maximum for benefits payable.

Actual Costs means the amount actually paid by, or on behalf of, the *covered person* and accepted by the provider as full payment for the particular treatment of services provided.

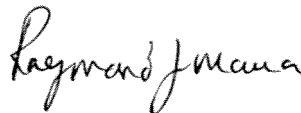
This rider is part of this *plan*. Except as stated in this rider, nothing contained in this rider changes or affects any other terms of this *plan*.

Dated at \_\_\_\_\_ This \_\_\_\_\_ Day of \_\_\_\_\_ , \_\_\_\_\_

UPLIFT EDUCATION  
Full or Corporate Name of Policyholder

\_\_\_\_\_  
Witness BY: \_\_\_\_\_  
Signature and Title

**The Guardian** Life Insurance Company of America



Raymond Marra, Senior Vice President, Group and Worksite Markets

**All Options**

**ATTACHED TO AND MADE PART OF GROUP INSURANCE POLICY NO. G -00551834-**  
issued by

**The Guardian** Life Insurance Company of America  
(herein called the Insurance Company)

to

**UPLIFT EDUCATION**  
(herein called the Policyholder)

Effective on the later of (i) the original effective date of Cancer Insurance; or (ii) the effective date of any applicable amendment requested by the Policyholder and approved by the Insurance Company.

This rider amends this *plan* so that the benefits for the treatment of *cancer* are deemed to also include benefits for treatment of a *specified disease* as defined below. Limitations and Exclusions that apply to *cancer* also apply to *specified disease*. Terms in italics that are not specifically defined in this rider are defined in the certificate.

*Diagnosis of specified disease* must be made by a *doctor* while the *covered person* is insured under the *plan*.

We limit what we pay to the treatment of one *specified disease* in each *covered person's* lifetime.

**Specified Disease:** This term means one of the following; only one *specified disease* for this list may be claimed under this *plan*:

- Addison's Disease
- Amyotrophic Lateral Sclerosis (Lou Gehrig's Disease)
- Brucellosis
- Cerebrospinal Meningitis (bacterial)
- Cystic Fibrosis
- Diphtheria
- Encephalitis
- Hansen's Disease
- Hepatitis (Chronic B or Chronic C with liver failure or hepatoma)
- Legionnaire's Disease (confirmation by culture or sputum)
- Lyme Disease
- Multiple Sclerosis
- Muscular Dystrophy
- Myasthenia Gravis
- Osteomyelitis
- Poliomyelitis
- Primary Biliary Cirrhosis
- Primary Sclerosing Cholangitis (Walter Payton's Liver Disease)
- Rabies

- Reye's Syndrome
- Rocky Mountain Spotted Fever
- Scarlet Fever
- Sickle Cell Anemia
- Systemic Lupus Erythematosus
- Tetanus
- Thalassemia
- Tuberculosis
- Tularemia
- Typhoid Fever

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*.

Dated at \_\_\_\_\_ This \_\_\_\_\_ Day of \_\_\_\_\_

UPLIFT EDUCATION  
Full or Corporate Name of Policyholder

\_\_\_\_\_  
Witness BY: \_\_\_\_\_  
Signature and Title

**The Guardian** Life  
Insurance Company of America



Raymond Marra, Senior Vice President, Group and  
Worksite Markets

GP-1-A-CAN-SD-16

P477.0369



## **All Options**

### **STATEMENT OF ERISA RIGHTS**

As a participant, an employee is 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 The 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 the employer, an employee's union, or any other person may fire the employee or otherwise discriminate against an employee in any way to prevent then employee from obtaining a welfare benefit or exercising his or her rights under ERISA.

#### **Enforcement Of An Employee's Rights**

If an employee's claim for a welfare benefit is denied or ignored, in whole or in part, he or she has 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 an employee can take to enforce the above rights. For instance, if an employee requests a copy of plan documents or the latest annual report from the plan and does not receive them within 30 days, he or she 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 the employee up to \$110.00 a day until he or she receives the material, unless the materials were not sent because of reasons beyond the control of the administrator. If an employee has a claim for benefits which is denied or ignored, in whole or in part, he or she may file suit in a federal court. If it should happen that plan fiduciaries misuse the plan's money or if an employee is discriminated against for asserting his or her rights, the employee may seek assistance from the U.S. Department of Labor, or he or she may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If an employee is successful, the court may order the person he or she sued to pay these costs and fees. If the employee loses, the court may order him or her to pay these costs and fees, for example, if it finds that the employee's claim is frivolous.

#### **Assistance with Questions**

If an employee has questions about the plan, he or she should contact the plan administrator. If an employee has questions about this statement or about his or her rights under ERISA, or if the employee needs assistance in obtaining documents from the plan administrator, he or she should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor listed in the telephone directory or the Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington D.C. 20210. An employee may also obtain certain publications about his or her rights and

responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

P800.0065

***All Options***

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

P800.0038

## DISABILITY AND GROUP HEALTH BENEFITS CLAIMS PROCEDURE

If an employee seeks benefits under the plan he or she should complete, execute and submit a claim form. Claim forms and instructions for filing claims may be obtained from the Plan Administrator.

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

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

### Definitions

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

"Group Health Benefits" means any accident, cancer or critical illness 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 day 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 claimants 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 th 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 plans 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 persons 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 persons 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.

P560.0087

**The Guardian** Life Insurance Company of America

A Mutual Company - Incorporated 1860 by the State of New York  
7 Hanover Square, New York, New York 10004

**POLICYHOLDER:** UPLIFT EDUCATION

<b>GROUP POLICY NUMBER</b>	<b>DELIVERED IN</b>	<b>POLICY DATE</b>
G-00551834	Texas	September 1, 2018

**POLICY ANNIVERSARIES:** September 1st of each year, beginning in 2019

**IMPORTANT NOTICE TO PERSONS ON MEDICARE  
THIS INSURANCE DUPLICATES SOME MEDICARE BENEFITS**

**THIS IS NOT MEDICARE SUPPLEMENT INSURANCE**

This insurance pays a fixed amount, regardless of your expenses, if you meet the policy conditions, for one of the specific disease or health conditions named in the policy. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

*This insurance duplicates Medicare benefits because Medicare generally pays for most of the expenses for the diagnosis and treatment of the specific conditions or diagnoses named in the policy.*

*Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include: hospitalization; physician services; hospice; and other approved items and services.*

**BEFORE YOU BUY THIS INSURANCE**

- Check the coverage in *all* health insurance policies you already have.
- For more information about Medicare and Medicare Supplement insurance, review the *Guide to Health Insurance for People with Medicare*, available from the insurance company.
- For help in understanding your health insurance, contact you state insurance department or state senior insurance counseling program.

**GUARDIAN AGREES** to pay benefits in accordance with, and subject to, the terms of this Policy. This promise is based on the Policyholder's Application and payment of the required premiums.

This Policy is delivered in the jurisdiction shown above and is governed by its laws.

This Policy takes effect on the Policy Date shown above.

IN WITNESS OF WHICH, GUARDIAN has caused this Policy to be executed as of August 20, 2018 which is its date of issue.



Raymond Marra, Senior Vice President, Group Products and Marketing

**GROUP INSURANCE POLICY**  
**Providing**  
**Hospital Indemnity Insurance**

Dividends Apportioned Annually

Please read this Policy carefully. If any error or omission is found, send full details with the number of the Policy to Guardian.

P020.1813

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*All Options*

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**GENERAL PROVISIONS**

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**Definitions**

The terms shown below have the meanings shown below.

**Covered Person:** This term means an Employee or Dependent insured by this Policy.

**Employee:** This term means a person: (1) who works for You or an associated company at Your or such company's place of business; and (2) whose income is reported for tax purposes using a W-2 or 1099 form.

**Employer:** This term means the entity that purchased the Plan.

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

**Hospital Indemnity Insurance:** This term means Hospital Indemnity Insurance provided by the Plan.

**Policy:** This term means the Guardian group Hospital Indemnity Insurance Policy purchased by You.

**You and Your:** As used in this Policy, these terms mean the Policyholder who purchased this group Policy. As used in the Certificate(s) attached to this Policy, these terms mean an insured Employee.

P020.1815

*All Options*

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***Incontestability***

This Policy will be incontestable after two years from its Policy Date, except for non-payment of premiums.

This Policy may replace the group policy of another insurer. In that case, We may rescind this Policy based on misrepresentations made in Your or a Covered Person's signed application for up to two years from the Policy Date.

No statement in any application, except a fraudulent statement, made by a Covered Person will be used to contest the validity of his or her insurance or to deny a claim for a loss incurred after his or her insurance has been in force for two years during his or her lifetime.

In the event a Covered Person's insurance is rescinded due to a fraudulent statement made in his or her application We will refund premiums paid for the periods such insurance is void. The premium paid by the Covered Person will be sent to his or her last known address on file with You or Us. If You pay all or part of the cost of a Covered Person's insurance Your part of the premium will be paid to You.

P020.1816

*All Options*

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**Associated Companies**

An associated company is a business entity affiliated with You through common ownership of stock or assets.

If You ask Us in writing to include such a company under this Policy, We will treat Employees of that company like Your Employees. We must give Our written approval. Our approval will show the starting date of the company's coverage under this Policy. Each Eligible employee of that company must still meet all of the terms and conditions of this Policy before he or she will be insured.



You must notify Us in writing when a company ceases to be an associated company. On the date a company ceases to be such a company, this Policy will end for all of that company's Employees, except those covered by You or another associated company as Employees on such date.

P020.0034

**All Options**

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**Premiums**

Premiums are payable by You as follows: (1) the first premium is due on the Policy Date; and (2) later premiums are, during the time this Policy remains in force, due the 1st of each month.

Premiums due under this Policy must be paid by You: (1) at a Guardian office; or (2) to a representative that We have authorized. The premiums must be paid as shown above, unless by agreement between You and Us, the interval of payment is changed. In that event, adjustment will be made for payment annually, semi-annually, or quarterly.

The premium due under this Policy on each due date will be the sum of the premium charges for the insurance provided under this Policy. The premium charges are based on the rates set forth in the Schedule of Premium Rates.

We may change such rates: (1) on the first day of any Policy month; (2) on any date the extent or terms of coverage for You are changed by amendment of this Policy; or (3) on any date Our obligation under this Policy with respect to You is changed because of statutory or other regulatory requirements.

We must give You 60 days written notice of the rate change. Such change will apply to any premium due on and after the effective date of the change stated in such notice.

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**Adjustment Of Premiums Payable  
Other Than Monthly Or Quarterly**

A premium rate may be changed after an annual or semi-annual premium became payable with respect to insurance on and after the date of such change. In that case, the premium will be adjusted by a pro rata change for the rest of the period for which the premium became payable. If the adjustment results in a decrease, the amount of the decrease will be paid to You by Us. If the adjustment results in an increase, the amount of the increase will be considered a premium due on the date of the rate change. This Policy's grace period will apply to any such premium due.

---

**Grace In Payment Of Premiums - Termination Of Policy**

A grace period of 60 days, without interest charge, will be allowed for each premium payment except the first. If You give Us advance written notice of an earlier termination date during the grace period, this Policy will end as of such earlier date.

If this Policy ends during or at the end of the grace period, You will still owe Us premium for all the time this Policy was in force during the grace period.

This Policy ends on any date when a coverage under this Policy ends and, as a result, no benefits remain in effect under this Policy.

P020.1820

**All Options**

### **Term of Policy - Renewal Privilege**

This Policy is issued for a term of one year from the Policy Date shown on face page. All policy years and policy months will be calculated from the Policy Date. All periods of insurance will begin and end at 12:01 A.M. Standard Time at Your place of business.

You may renew this Policy for a further term of one year on the first and each subsequent Policy Anniversary. All renewals are subject to the payment of premiums then due, computed as shown in Premiums.

We have the right to decline to renew this Policy, or any coverage under it, on any Policy Anniversary or premium due date, if, on that date the number of Employees is below Our minimum group size requirements.

You may cancel this Policy at any time by giving us 31 days advance written notice. This notice must be sent to our Home Office. You will owe Us all unpaid premiums for the period this Policy is in force. We may cancel this Policy by giving You 31 days advance written notice.

### **The Contract**

The entire contract between You and Us consists of: (1) this Policy; (2) the Schedule of Premium Rates; (3) the Certificate(s) which describe(s) the insurance for which the Covered Persons are insured; (4) any attached riders, schedule of benefits or amendments; and (5) Your application, a copy of which is attached. In the event of a conflict, the Policy shall reign.

We can amend this Policy at any time, without the consent of the insured Employee or any other person having a beneficial interest in it: (1) upon written request made by You and agreed to by Us; (2) on any date Our obligation under this Policy with respect to You is changed because of statutory or other regulatory requirements; or (3) on any date on which Our contractual relationship with any vendor supplying services or supplies with respect to this Policy changes.

If We amend this Policy, except upon request made by You, We must give You written notice of such change.

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 Guardian, has the authority to act for Us to: (1) determine whether any contract, policy or certificate is to be issued; (2) waive or alter any provisions of any contract or policy, or any of Our requirements; (3) bind Us by any statement or promise relating to the contract issued or to be issued; or (4) accept any information or representation which is not in a signed application.

P020.1821

### ***All Options***

### **Clerical Error - Misstatements Of Age**

Neither clerical error by You or Us in keeping any records on the insurance under this Policy, nor delays in making entries, will invalidate insurance otherwise validly in force or continue insurance otherwise validly terminated. On discovery of such error or delay, an equitable adjustment of premiums will be made.

Premium adjustments involving return of unearned premium to You will be limited to the period of 60 days before the date of Our receipt of satisfactory evidence that such adjustments should be made.

The age of an Employee, or any other relevant facts, may be found to have been misstated. If premiums are affected due to this, an equitable adjustment of premiums will be made. If such misstatement involves whether or not an insurance risk would have been accepted by Us, or the amount of insurance, the true facts will be used to determine whether insurance is in force under the terms of this Policy, and in what amount.

---

## **Statements**

No statement will void the insurance under this Policy, or be used in defense of a claim unless: (1) in Your case, it is contained in the application signed by You; or (2) in the case of a Covered Person, it is contained in a written instrument signed by him or her.

All statements will be deemed representations and not warranties.

P020.1824

### **All Options**

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## **Assignment**

For Hospital Indemnity Insurance, the Employee's Certificate and his or her right to benefits under this Policy are not assignable.

Assignment or transfer of Your interest under this Policy will not bind Us without Our written consent.

P020.1757

### **All Options**

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## **Dividends**

The portion, if any, of the divisible surplus of the Guardian allocable to this Policy at each Policy Anniversary will be determined annually by Our Board of Directors. It will be credited to this Policy as a dividend on such anniversary, provided this Policy is continued in force by the payment of all premiums to such anniversary.

Any such dividend will be: (1) paid to You in cash; or (2) at Your option it may be applied to the reduction of the premiums then due.

If the Employees contribute toward the cost of the insurance under any other group policy issued to You by Us and the aggregate dividends under this Policy and any other such group policy or policies are in excess of Your share of the aggregate cost, such excess will be applied by You for the sole benefit of the Employees.

Payment of any dividend to You will completely discharge Our liability with respect to the dividend so paid.

P020.0053

### **All Options**

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## **Employees Certificate**

We will issue to You, for delivery to each insured Employee, a certificate of insurance. It will state the essential features of the insurance to which the employee is entitled and to whom the benefits are payable. In the event this Policy is amended, and such amendment affects the material contained in the certificate, a rider or revised certificate reflecting such amendment will be issued to You for delivery to affected Employees.

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## **Employee Notice**

From time to time We may provide You with notices that are needed due to state or federal requirements. You must deliver copies of these notices to each of Your Employees.

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## **Claims Of Creditors**

Except when prohibited by the laws of the jurisdiction in which this Policy was issued, the insurance and other benefits under this Policy will be exempt from execution, garnishment, attachment, or other legal or equitable process, for the debts or liabilities of the Covered Persons or their beneficiaries.

---

### **Records - Information To Be Furnished**

You must keep a record of the insured Employees containing, for each Employee, the essential details of the insurance which apply to him or her. You must periodically forward to Us, on Our forms, such information concerning the Employees in the classes eligible for insurance under this Policy as may reasonably be considered to have a bearing: (1) on the administration of the insurance under this Policy; and (2) on the determination of the premium rates. For benefits which are based on an Employee's salary, changes in his or her salary must promptly be reported to Us. Your payroll and other such records which have a bearing on the insurance must be furnished to Us at our request at any reasonable time.

P020.0054

***All Options***

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### **Examination and Autopsy**

We have the right to have a doctor of Our choice to conduct a physical examination of the person for whom a claim is being made under this Policy as often as We reasonably require. We 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.

P020.1825

***All Options***

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### **Conformity With Law**

If the provisions of this Policy do not conform to the requirements of any state or federal law or regulation that applies, any such provision is changed to conform with Our interpretation of the requirements of that law or regulation.

P020.0058

***All Options***

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### **New Entrants**

Eligible new Employees may be added to the group originally insured in accordance with the terms of this Policy. Eligible new Dependents may be added to the group originally insured in accordance with the terms of this Policy.

P020.0060

***All Options***

## **Hospital Indemnity Claims Provisions**

An Employee's right to make a claim for any Hospital Indemnity benefits provided by this Policy is governed as follows:

**Notice:** The Employee 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 his or her name and Policy number. If the claim is being made for any other Covered Person, his or her name should also be shown.

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

**Proof of Loss:** The Employee must send written proof of loss to Our designated office. This proof must be sent within 90 days of the end of each period for which We are liable.

Failure to provide proof within the specified time frame does not reduce or invalidate a claim if it was not reasonably possible to give such proof and the proof was provided as soon as reasonably possible.

**Late Notice or Proof:** We will not void or reduce the Employee claim if he or she cannot send Us notice and proof of loss within the required time. In that case, the Employee must send Us notice and proof as soon as reasonably possible.

**Payment of Benefits:** The Employee must submit periodic written proof of loss as shown above. Any balance remaining unpaid at the end of Our liability will be paid as soon as We receive written proof.

We will pay all Hospital Indemnity benefits as soon as We receive written proof of loss.

Unless otherwise required by law or regulation or You have made a written assignment, We pay all Hospital Indemnity benefits to the Employee if he or she is living. If he or she is not living, We have the right to pay all Hospital Indemnity benefits to one of the following, the Employee's: (1) estate; (2) spouse; (3) parents; (4) children; or (5) brothers and sisters. See the section in the applicable Certificate describing Hospital Indemnity benefits for how Hospital Indemnity benefits are paid.

All benefits payable under this Plan will be paid not later than 60 days after the proof of loss is received by Us.

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

**Workers' Compensation:** The Hospital Indemnity benefits provided by this Policy are not in place of and do not affect requirements for coverage by Worker's Compensation.

P020.1826

### **All Options**

## **When An Employee's Active Service Ends**

"You may not continue an Employee's Hospital Indemnity insurance after his or he active service with You ends."

P020.1759

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## **SCHEDULE OF OPTION PACKAGES**

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This Policy's classes are shown below. The benefit option packages which are available to Covered Persons who are members of each class are shown below.

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### **Class Description**

***Class 0001*** ALL ELIGIBLE EMPLOYEES

P020.0087

## **Benefit Option Packages**

Employees may choose from the benefit packages available to members of their class. Coverage for a benefit will not become effective until the Covered Person satisfies the eligibility requirements. Coverage for a benefit that requires payment from the Employee will not become effective until the Employee: (1) elects it in a form acceptable by Us; and (2) agrees to make any required payments. The benefits are described in the applicable Certificate(s) attached to and made a part of this Policy.

P020.0089

Members of Class 0001 may choose from benefits in option package(s) A, B and C.

P020.0090

### ***All Options***

- Hospital Indemnity insurance

P020.1760

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## **ATTACHED CERTIFICATES**

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The Certificate(s) shown below are added to and made part of this policy.

P024.0662

Class 0001 Option(s) A, B and C

P024.0663

The Certificate(s) describe the Hospital Indemnity Insurance benefits for which each class of Employees is eligible.

Each Employee's eligibility, effective date of insurance, plan of insurance, and termination date is determined by the option he or she has elected on his or her enrollment form, or other suitable documents approved by Guardian, and the provisions of the Certificate that apply to that option.

Certificate(s) will include any changes made by rider or amendments to this Policy.

P020.1761



**All Options**

**The Guardian Life Insurance Company of America**  
**Schedule of Premium Rates**  
**Hospital Indemnity Insurance**

The monthly premium rates, in U.S. dollars, for the benefits provided under the Policy are listed below. Guardian has the right to change any premiums rates(s) set forth below at the times and in the manner set forth in the Premiums section of the Policy.

P020.1770

**All Options**

**Premium Rates**  
**Hospital Indemnity Coverage**

P020.1771

<b>All Options</b>	<b>All Classes</b>			
	<b>Rate per Employee</b>	<b>per Employee and Insured Spouse with no Insured Child</b>	<b>per Employee and Insured Child(ren) with no Insured Spouse</b>	<b>per Employee and Insured Family</b>
	\$ 21.94	\$ 39.35	\$ 34.86	\$ 52.58

P020.1775



\*END OF POLICY DOCUMENT\*

