YOUR GROUP INSURANCE PLAN BENEFITS

UPLIFT EDUCATION

CLASS 0001

CRITICAL ILLNESS, ACCIDENT BENEFITS, CANCER BENEFITS, HOSPITAL INDEMNITY COVERAGE

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

Have a complaint or need help?

If You have a problem with a claim or Your premium, call Your insurance company first. If You can't work out the issue, the Texas Department of Insurance may be able to help.

Even if You file a complaint with the Texas Department of Insurance, You should also file a complaint or appeal through Your insurance company. If You don't, You may lose Your right to appeal.

The Guardian Life Insurance Company of America and/or Managed DentalGuard (for DHMO coverage only)

To get information or to file a complaint with your insurance company or HMO:

Call: (toll-free) 1-888-GUARDIAN (1-888-482-7342)
Online: www.guardiananytime.com/contact-us
Email: corporate_inquiries@glic.com
Mail: Corporate Complaints, 10 Hudson Yards, New York, NY 10001

The Texas Department of Insurance

To get help with an insurance question or file a complaint with the state:

Call: 1-800-252-3439
Online: www.tdi.texas.gov
E-mail: ConsumerProtection@tdi.texas.gov
Mail: MC 111-1A, P.O. Box 149091, Austin, TX 78714

Tiene una queja o necesita ayuda?

Si tiene un problema con una reclamacion o con su prima de seguro, llame primero a su compania de seguros. Si no puede resolver el problema, es posible que el Departamento de Seguros de Texas (Texas Department of Insurance, por su nombre en ingles) pueda ayudar.

Aun si usted presenta una queja ante el Departamento de Seguros de Texas, tambien debe presentar una queja a traves del proceso de quejas o de apelaciones de su compania de seguros. Si no lo hace, podria perder su derecho para apelar.

The Guardian Life Insurance Company of America and/or Managed DentalGuard (for DHMO coverage only)

Para obtener informacion o para presentar una queja ante su compania de seguros:

Llame: (telefono gratuito) 1-888-GUARDIAN (1-888-482-7342)
En linea: www.guardiananytime.com/contact-us
Correo electronico: corporate_inquiries@glic.com
Direccion postal: Corporate Complaints, 10 Hudson Yards, New York, NY 10001

El Departamento de Seguros de Texas

Para obtener ayuda con una pregunta relacionada con los seguros o para presentar una queja ante el estado:
Llame: 1-800-252-3439
En linea: www.tdi.texas.gov
Correo electronico: ConsumerProtection@tdi.texas.gov
Direccion postal: MC 111-1A, P.O. Box 149091, Austin, TX 78714

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

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

New Mexico Residents
Consumer Complaint Notice

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

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

CCN-2019-NM B999.0042

CERTIFICATE OF COVERAGE

The Guardian
10 Hudson Yards
New York, New York 10001

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

Group Policy No.	Certificate No.	Effective Date
Issued To		

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

The Guardian Life Insurance Company of America

Michael Prestileo, Senior Vice President

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IMPORTANT NOTICE

The insurance policy under which this certificate is issued is not a policy of Workers' Compensation insurance. You should consult your employer to determine whether your employer is a subscriber to the Workers' Compensation system.

CGP-3-R-COMP-TX-92 B120.0015

GENERAL PROVISIONS

As used in this booklet:

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

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

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

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

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

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

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

Limitation of Authority

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

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

Incontestability

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

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

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

CGP-3-R-INCY-90 B160.0003

Examination and Autopsy

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

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

Accident and Health Claims Provisions

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

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

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

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

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

Payment of Benefits We'll pay benefits for loss of income once every 30 days for as long as we're liable, provided you submit periodic written proof of loss as stated above. We'll pay all other *accident and health* benefits to which you're entitled within 60 days after we receive written proof of loss.

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

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

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

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

CGP-3-R-AHC-90-TX B160.0035

ELIGIBILITY FOR CANCER INSURANCE

Employee Coverage

Eligible Employees

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

Other Conditions

If *you* must pay all or part of the cost of *employee* coverage, *we* won't insure *you* until *you* enroll and agree to make the required payments.

We require that *you* answer insurability questions. The answers to these questions will determine whether or not *you* will be covered by this *plan.*

We require that *you* answer insurability questions again to change to a richer plan of benefits, if offered by *your employer.* The answers to these questions will determine whether or not *you* will be covered for the richer benefits.

CGP-3-EC-90-1.0 B477.0054

When Your Coverage Starts

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

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

CGP-3-EC-90-2.0 B476.3878

When Your Coverage Ends

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

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

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

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

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

Group Cancer Insurance Coverage During a Family Leave of Absence

This section may not apply to an employer's *plan. You* must contact *your* employer to find out if:

- the employer must allow for a leave of absence under Federal law, in which case;
- the section applies to *you.*

Group Cancer Insurance may normally end for *you* because *you* cease work due to an approved leave of absence. But, *you* may continue *your* coverage if the leave of absence has been granted: (a) to allow the *you* to care for a seriously injured or ill spouse, child, or parent; (b) after the birth or adoption of a child; (c) due to *your* own serious health condition; or (d) because of any serious injury or illness arising out of the fact that *your* spouse, child, parent, or next of kin, who is a covered service member, is on active duty(or has been notified of an impending call or order to active duty) in the Armed Forces in support of a contingency operation. *You* will be required to pay the same share of the premium as *you* paid before the leave of absence.

Group Cancer Insurance may continue until the earliest of the following:

- The date *you* return to active work.
- The end of a total leave period of 26 weeks in one 12 month period, in the case of an *employee* who cares for a covered servicemember. This 26 week total leave period applies to all leaves granted to the *employee* under this section for all reasons.
- The end of a total leave period of 12 weeks in: (a) any 12 Month period, in the case of any other *employee;* or (b) any later 12 month period in the case of an *employee* who cares for a covered servicemember.
- The date on which *your* coverage would have ended had *you* not been on leave.
- The end of the period for which the premium has been paid.

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

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

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

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

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

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

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

CGP-3-DEP-90-1.0 B473.0009

Eligible Dependents For Dependent Cancer Coverage

Your eligible dependents are: (1) *your* legal spouse; And (2) *your* unmarried dependent children from birth until they reach age 26.

CGP-3-DEP-90-2.0 B477.0070

Adopted Children And Step-Children

Your "unmarried dependent children" include: (a) *your* legally adopted children; and (b) if they depend on *you* for most of their support and maintenance, *your* step-children.

We treat a child as legally adopted from the time the child is placed in *your* home for the purpose of adoption. *We* treat such a child this way whether or not a final adoption order is ever issued.

Dependents Not Eligible

We exclude any dependent who is insured by this *plan* as an *employee.* And, *we* exclude any dependent who is on active duty in any armed force. Upon notice of entry into service, pro rata unearned premiums will be refunded.

A child may be an eligible dependent of more than one *employee* who is insured under this *plan.* In that case, the child may be insured for dependent cancer benefits by only one *employee* at a time.

CGP-3-DEP-90-3.0 B477.0071

Handicapped Children

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

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

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

The child's coverage ends when *your* coverage does.

CGP-3-DEP-90-4.0 B477.0073

Proof of Insurability

We require that *you* answer insurability questions with respect to *your* dependents. The answers to these questions will determine whether or not *your* dependents will be covered by this *plan.*

CGP-3-DEP-90-5.0 B477.0075

When Dependent Coverage Starts

In order for *your* dependent coverage to start, *you* must: (a) already be insured for *employee* coverage; or (b) enroll for *employee* and dependent coverage at the same time.

Subject to all of the terms of this *plan,* the date *your* dependent coverage is scheduled to start depends on when *you* elect to enroll *your* initial dependents and agree to make the required payments.

If *you* do this on or before *your* eligibility date, the dependent coverage is scheduled to start on the later of: (a) *your* eligibility date; and (b) the date *you* become insured for *employee* coverage.

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

Once *you* have dependent child coverage for *your* initial dependent child(ren), any *newly acquired dependent* children will be covered as of the date they are eligible.

CGP-3-DEP-90-6.0 B477.0074

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

CGP-3-DEP-90-7.0 B477.0076

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

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

An individual dependent's coverage ends when he or she stops being an eligible dependent. This happens to a child on the last day of the month in which the child attains this Plan's age limit, the date he or she marries, or the date 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, the date he or she marries or is no longer dependent on the employee for support and maintenance. It happens to a spouse on the date a marriage ends in legal divorce or annulment.

CGP-3-DEP-90-9.0 B477.0644

SCHEDULE OF INSURANCE

Cancer Benefit

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

Intensive Care Unit Confinement:	$600.00 for first 30 days per confinement. $800.00 for 31st day and thereafter confinement.
Inpatient Special Nursing:	$150.00 per day. Limited to 30 days per *benefit year.*
Medical Imaging:	$200.00 per image. Limited to 2 images per *benefit year.*
Outpatient and Family Member Lodging:	$100.00 per day. Limited to 90 days per *benefit year.*
Outpatient or Ambulatory Surgical Center:	$350.00 per day. Limited to 3 days per procedure.
Physical or Speech Therapy:	$50.00 per visit. Limited to 4 visits per month. Limited to $1,000.00 per lifetime.
Surgically Implanted Prosthetic Devices:	$3,000.00 per device. Limited to $6,000.00 per lifetime.
Non-Surgically Implanted Prosthetic Devices:	$300.00 per device. Limited to $600.00 per lifetime.

Reconstructive Surgery:

Breast TRAM flap	$3,000.00
Breast reconstruction	$700.00
Breast symmetry	$350.00
Facial reconstruction	$700.00

Reproductive Benefits:	$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.
Second Surgical Opinion:	$300.00 Limited to one per surgical procedure.

Skin Cancer:

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

Surgical Benefits:

Surgery	**Surgical Benefit**
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 (bilaterial)	$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
Transportation/Companion Transportation:	$0.50 per mile. Limited to $1,500 per round trip.

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.

CGP-3-CAN-IC-12-TX B477.0365

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.

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 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

DEFINITIONS

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 *you* have 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 myelodyplastic 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 *you,* if *you* are covered under this *plan* and *your* covered dependents.

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 *your* 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 *inpatients,* diagnostic services and therapeutic services for diagnosis, treatment and care of sick or injured persons;

(2) has organized departments of medicine and major surgery;

(3) has a requirement that every patient must be under the care of a *doctor* or *dentist;*

(4) provides 24 hour nursing service by or under the supervision of a registered professional nurse (R.N.);

(5) is duly licensed by the agency responsible for licensing such *hospitals;* and

(6) is not, other than incidentally: (a) a place of rest; (b) a place primarily for the treatment of tuberculosis; (c) a place for the aged; (d) a place for drug addicts or alcoholics; or (e) a place for convalescent, custodial, educational or rehabilitative care.

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 this certificate.

Pre-Existing Condition 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.*

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) you are *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.

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.

CGP-3-CAN-EXC-12 B477.0030

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.*

CGP-3-CAN-WP-12 B477.0031

PORTABILITY

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.

- *You* may port *your* coverage or coverage for any of *your* dependents if coverage under this *plan* ends because *you:* (a) have terminated employment; (2) stop being a member of an eligible class of employees; or (3) this *plan* ends.
- *You* may not Port *your* coverage or coverage for any of *your* dependents if(1) coverage under this *plan* ends due to *your* failure to pay any required premium; or (2) you have reached age 70 on or before *your* coverage under this *plan* ends.

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

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

If *you* die while covered for dependent *cancer* coverage, *your* spouse may port *your* dependent Cancer coverage as described above. *your* spouse and dependent children must be covered under this *plan* on the date of *your* death. But this option is not available if(1) there is no surviving spouse; or (2) the surviving spouse has reached age 70 on the date *you* die.

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: *your* rate class under this *plan;* and (2)*you* or *your* surviving spouse's age bracket as shown in the Cancer Portability Coverage Premium Notice.

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

We will not ask for *proof* that *you* or *your* surviving spouse are in good health.

CERTIFICATE AMENDMENT - ELIGIBILITY FOR CANCER COVERAGE

The Guardian Life Insurance Company of America
DOMICILED IN NEW YORK
10 Hudson Yards, New York, New York 10001

Effective on the latter of (i) the original effective date of the Certificate; 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 of *your* insurance amounts may be subject to Proof of Insurability. *You* and *your* dependents will not be covered for any amount that requires such Proof of Insurability until *you* give the Proof of Insurability to *us* and *we* approve that Proof of Insurability in writing.

If *you* elect to enroll within 31 days after *your eligibility date,* coverage is scheduled to start on *your eligibility date.*

If *you* do not elect this coverage within 31 days of *your eligibility date, you* must answer health questions, or wait until the next scheduled group enrollment period. Once each year, during the group enrollment period, *you* may elect to enroll in this coverage as offered by the *employer.* As used here, "group enrollment period" means an annual open enrollment period set by the *employer* and agreed to by *us.* If *you* elect to enroll outside of the group open enrollment period, *you* must provide Proof of Insurability by answering health questions, or wait until the next group enrollment period.

If Proof of Insurability is required, *you* and *your* dependents will not be covered by this *plan* until *we* approve that Proof of Insurability in writing and notify *you* of *your* effective date of coverage.

When Employee Coverage Starts

Your eligibility date is the date *you* have met all of the conditions of eligibility.

Whether *you* must pay all or part of the cost of *your* coverage, *you* must elect to enroll and agree to make the required payments before *your* coverage will start. If *you* do this on or before *your eligibility date, your* coverage is scheduled to start on *your eligibility date.* If *you* do this within 31 days after *your eligibility date, your* coverage is scheduled to start on *your eligibility date.* If *you* elect to enroll and agree to make the required payments more than 31 days after *your eligibility date, your* coverage will not be scheduled to start until *you* send *us* Proof of Insurability or until You enroll during the next group enrollment period. If Proof of Insurability is required, *you* will not be covered by this *plan* until *we* approve that Proof of Insurability in writing and notify *you* of *your* effective date of coverage.

If *your* active service ends before *you* meet any Proof of Insurability requirements that apply, *you* will still have to meet those requirements if *you* are later re-employed by the *employer* or an associated company.

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

DEPENDENT COVERAGE

Proof of Insurability

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

If *you* elect to enroll *your initial dependents* within 31 days after *your eligibility date,* coverage is scheduled to start on *your eligibility date.*

If *you* do not elect *initial dependent* coverage within 31 days of *your eligibility date, your initial dependents* must answer health questions, or wait until the next scheduled group enrollment period to enroll. Once each year, during the group enrollment period, *you* may elect to enroll *initial dependents* in this coverage as offered by the *employer.* As used here, "group enrollment period" means an annual open enrollment period set by the *employer* and agreed to by *us.* If *you* elect to enroll *your initial dependents* outside of the group open enrollment period, *you* must provide Proof of Insurability by answering health questions, or wait until the next group enrollment period.

If Proof of Insurability is required, *your initial dependents* will not be covered by this *plan* until *we* approve that Proof of Insurability in writing and notify *you* of *your initial dependent's* effective date of coverage.

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

If *your* dependent coverage ends for any reason, including failure to make the required payments, *your* dependent will not be covered by this *plan* again until *you* give *us* new Proof of Insurability that they are insurable and *we* approve that Proof of Insurability in writing, or wait until the next group enrollment period.

When Dependent Coverage Starts

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

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

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

If *you* do this after the group enrollment period ends, *your* dependent coverage may be subject to Proof of Insurability and will not start until *we* approve that Proof of Insurability in writing.

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

Whether *you* must pay all or part of the cost of *your* coverage, *you* must elect to enroll and agree to make the required payments before *your* coverage will start. If *you* do this on or before *your eligibility date, your* coverage is scheduled to start on *your eligibility date.* If *you* do this within 31 days after *your eligibility date, your* coverage is scheduled to start on *your eligibility date.* If *you* elect to enroll and agree to make the required payments more than 31 days after *your eligibility date, your* coverage will not be scheduled to start until *you* send *us* Proof of Insurability or until you enroll during the next group enrollment period. If Proof of Insurability is required, *you* will not be covered by this *plan* until *we* approve that Proof of Insurability in writing and notify *you* of *your* effective date of coverage.

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

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

Michael Prestileo, Senior Vice President

B477.0479

CGP-1-A

CERTIFICATE AMENDMENT

The certificate is amended to add the following:

Initial Diagnosis Benefit

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

The benefit is $5,000.00 for *you,* $5,000.00 for *your* spouse and $5,000.00 for *your* 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 certificate. Except as stated in this rider, nothing contained in this rider changes or affects any other terms of this certificate.

The Guardian Life Insurance Company of America

Michael Prestileo, Senior Vice President

CGP-3-A-CAN-IDB-12 B477.0036

CERTIFICATE AMENDMENT

(To be attached to certificates issued to employees)

The certificate is amended to add the following:

This rider amends the certificate Schedule of Insurance for *internal cancer.* *We* pay the amount shown below per *covered person* for *internal cancer* or a *specified disease.* 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 a *specified disease* .

We only pay this benefit for *internal cancer* or a *specified disease* 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.

In addition to the exclusions listed in *your* certificate, *we* do not pay a benefit under this rider 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.*

The Guardian Life Insurance Company of America

Michael Prestileo, Senior Vice President

CGP-3-A-CAN-RC-16 B477.0387

CERTIFICATE AMENDMENT

(To be attached to certificates issued to employees)

The certificate is amended to add the following: Terms that are not defined specifically in this rider are defined in the certificate.

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 italic 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 Anermia
- Systemic Lupus Erythematosus
- Tetanus
- Thallasemia
- 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.*

The Guardian Life Insurance Company of America

Michael Prestileo, Senior Vice President

CGP-3-A-CAN-SD-16 B477.0390

GLOSSARY

This Glossary defines the italicized terms appearing in your booklet.

CGP-3-GLOSS-90 B900.0118

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

CGP-3-GLOSS-90 B900.0003

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

CGP-3-GLOSS-90 B750.0015

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

CGP-3-GLOSS-90 B750.0006

Employer means UPLIFT EDUCATION .

CGP-3-GLOSS-90 B900.0051

Enrollment Period with respect to dependent coverage, means the 31 day period which starts on the date that you first become eligible for dependent coverage.

CGP-3-GLOSS-90 B900.0004

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

CGP-3-GLOSS-90 B750.0229

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

CGP-3-GLOSS-90 B900.0006

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

CGP-3-GLOSS-90 B900.0008

Plan means the *Guardian* group *plan* purchased by your *employer,* except in the provision entitled "Coordination of Benefits" where "plan" has a special meaning. See that provision for details.

CGP-3-GLOSS-90 B900.0039

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

STATEMENT OF ERISA RIGHTS

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

Receive Information About Your Plan and Benefits

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

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

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

Prudent Actions By Plan Fiduciaries

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

Enforcement Of Your Rights

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

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

Assistance with Questions

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

B800.0093

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

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

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

Definitions

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

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

Timing For Initial Benefit Determination

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

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

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

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

Adverse Benefit Determination

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

- the specific reason(s) for the adverse determination;
- reference to the specific plan provision(s) on which the determination is based;
- a description of any additional material or information necessary to make the claim valid and an explanation of why such material or information is needed;

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

Appeal of Adverse Benefit Determinations

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

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

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

In reviewing an appeal, Guardian will:

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

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

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

Alternative Dispute Options

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

B752.0052

Termination of This Group Plan

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

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

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

B800.0086

CERTIFICATE OF COVERAGE

The Guardian
10 Hudson Yards
New York, New York 10001

The group Critical Illness coverage described in this Certificate Is attached to the group Policy effective September 1, 2021. This Certificate replaces any Certificate previously issued under this Plan or under any other plan providing similar or identical benefits issued to the planholder by Guardian.

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

THIS IS NOT MEDICARE SUPPLEMENT INSURANCE

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

GROUP CRITICAL ILLNESS COVERAGE

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

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

Policyholder: UPLIFT EDUCATION

Group Policy Number: 00551834

Michael Prestileo, Senior Vice President

B045.0006

GC-CI-14-TX

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DEFINITIONS

This section defines certain terms appearing in Your Certificate.

B045.0009

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

B045.0010

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

B045.0012

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

B045.0013

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

B045.0015

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

B045.0016

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

B045.0017

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

B045.0019

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

B045.0021

Employer: This term means UPLIFT EDUCATION .

B045.0022

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

B045.0023

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

B045.0024

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

B045.0026

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

B045.0027

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

(1) medically appropriate;

(2) needed to Diagnose or treat a Sickness or Injury;

(3) consistent in type, frequency, and length of treatment with scientifically based guidelines of national medical research or health care coverage organizations or government agencies;

(4) needed for reasons other than comfort or convenience of the Covered Person or Doctor;

(5) of proven medical value; and

(6) done with the appropriate level of service or supply needed to provide safe and adequate care.

B045.0028

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

B045.0029

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

B045.0031

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

B045.0032

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

B045.0033

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

B010.0624

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

Your or Your: These terms mean the insured Employee.

B045.0035

GENERAL PROVISIONS

B045.0036

Applicable Benefits

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

B045.0037

Limitation of Authority

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

B045.0038

Incontestability

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

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

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

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

B045.0039

Examination and Autopsy

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

B045.0041

Critical Illness Claims Provisions

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

Notice

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

Claim Forms

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

Proof Of Loss

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

Late Notice Of Proof

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

Payment Of Benefits

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

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

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

Legal Actions

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

Workers' Compensation

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

B045.0042

ELIGIBILITY FOR CRITICAL ILLNESS - EMPLOYEE COVERAGE

Eligible Employees

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

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

Conditions of Eligibility

You are eligible for Critical Illness coverage if You are;

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

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

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

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

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

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

B045.0043

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

B045.0045

Multiple Employment If You work for both the Employer and a covered associated company, or for more than one covered associated company, We will treat You as if only one firm employs You. You will not have multiple Critical Illness coverages under this plan.

B045.0046

When Employee Coverage Starts

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

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

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

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

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

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

Any Critical Illness benefit payable will be the lesser of:

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

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

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

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

1. the date You are fully capable of performing the major duties of Your regular occupation for Your Employer on a full-time basis;
2. the date insurance terminates for one of the reasons stated in When Employee Coverage Ends;

3. the last day of a period of 12 consecutive months which begins on the Policy effective date; or

4. the last day You would have been covered under the prior insurer's group critical illness policy, had the prior plan not terminated.

B045.0050

When Employee Coverage Ends

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

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

B045.0653

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

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

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

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

- The date You return to Active Work.

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

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

- **Active Duty:** This term means duty under a call or order to active duty in the Armed Forces of the United States.
- **Contingency Operation:** This term means a military operation that: (1) is designated by the Secretary of Defense as an operation in which members of the Armed Forces are or may become involved in military actions, operations or hostilities against an enemy of the United States or against an opposing military force; or (2) results in the call or order to, or retention on, active duty of members of the uniformed services under any provision of law or during a national emergency declared by the President or Congress.
- **Covered Service member:** This term means a member of the Armed Forces, including a member of the National Guard or Reserves, who for a serious injury or illness is: (1) undergoing medical treatment, recuperation or therapy; (2) otherwise in outpatient status; or (3) otherwise on the temporary disability retired list.
- **Next Of Kin:** This term means Your nearest blood relative.
- **Outpatient Status:** This term means, in the case of a covered service member, that he or she is assigned to: (1) a military medical treatment facility as an outpatient; or (2) a unit established for the purpose of providing command and control of members of the Armed Forces receiving medical care as outpatients.
- **Serious Injury Or Illness:** This term means, in the case of a covered service member, an Injury or illness incurred by him or her in line of duty on active duty in the Armed Forces that may render him or her medically unfit to perform the duties of his or her: (1) office; (2) grade; (3) rank; or (4) rating.

B045.0053

ELIGIBILITY FOR CRITICAL ILLNESS COVERAGE
DEPENDENT COVERAGE

B045.0054

Eligible Dependents for Dependent Critical Illness Coverage

B045.0055

Eligible Dependents for Voluntary Dependent Critical Illness

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

B045.0057

Adopted Children, Grandchildren and Step-Children

Your "unmarried dependent children" include (a) Your legally adopted children; (b) Your grandchildren who are dependents for federal income tax puroposes at the time application for coverage of the grandchildren is made; (c) Your step-children; and (d) a child for whom a medical support order has been issued. We treat a child as legally adopted from the time You are a party to a suit in which the adoption of such child is sought. We treat such a child this way whether or not a final adoption order is ever issued.

B045.0058

Dependents Not Eligible

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

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

B045.0059

Handicapped Children

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

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

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

B045.0061

Proof of Insurability

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

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

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

B045.0063

When Dependent Coverage Starts

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

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

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

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

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

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

B045.0064

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

B045.0065

When Dependent Coverage Ends

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

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

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

B045.0070

CRITICAL ILLNESS COVERAGE

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

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

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

B045.0073

Critical Illness Benefits

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

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

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

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

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

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

B045.0074

Covered Critical Illnesses

B045.0076

Cancer Related Conditions

B045.0077

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

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

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

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

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

B045.0078

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

We do not pay a benefit under this provision for:

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

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

We deem Carcinoma in Situ to occur on the date a Doctor of appropriate specialty makes a Diagnosis.

"TNM classification" means the classification standards for cancer developed by the American Joint Committee on Cancer.

B045.0079

Invasive Cancer We pay a benefit if a Covered Person is Diagnosed with Invasive Cancer, which means a malignant tumor which is characterized by the uncontrolled growth and spread of malignant cells and the invasion of neighboring tissue.

Invasive Cancer also includes leukemia and lymphoma.

Invasive Cancer must be supported by pathological diagnosis.

We do not pay a benefit under this provision for:

- Pre-malignant growths or lesions, such as dysplasia or intraepithelial neoplasia;
- Any benign tumor or polyp;
- Any condition that is Carcinoma in Situ.
- Any skin cancer, including carcinoma in situ of the skin, unless there is metastasis.

Diagnosis of Invasive Cancer must be based on microscopic (histologic) exam of: (a) fixed tissues; or (b) preparations of blood or bone marrow. Such exam must be documented in a written report by a Doctor.

We deem Invasive Cancer to occur on the date a Doctor of appropriate specialty makes a Diagnosis.

B045.0080

Skin Cancer We pay a benefit if a Covered Person is Diagnosed with the types of Skin Cancer known as either basal cell carcinoma or squamous cell carcinoma. We don't pay a benefit under this provision for any other type of skin cancer. We deem Skin Cancer to occur on the date a Doctor of appropriate specialty makes a Diagnosis.

We limit what we pay to one benefit in a Covered Person's lifetime.

B045.0081

Vascular Conditions

B045.0082

Arteriosclerosis We pay a benefit if a Covered Person is diagnosed with Arteriosclerosis, which means blockage of a coronary artery of sufficient severity to require one or more coronary artery bypass graft(s).

Diagnosis must include demonstrated need for intervention.

We deem Arteriosclerosis to occur on the date a Doctor of appropriate specialty makes a Diagnosis of Arteriosclerosis of sufficient severity to warrant one or more coronary artery bypass graft(s).

B045.0083

Heart Attack We pay a benefit if a Covered Person is Diagnosed with a Heart Attack, which means death of heart muscle due to inadequate blood supply. Symptoms of cardiac ischemia must be present, as well as two or more of the following criteria for acute myocardial infarction:

(1) typical clinical symptoms such as central chest pain;

(2) diagnostic increase of specific cardiac markers;

(3) new electrocardiographic changes indicative of new ischemia (new ST-T changes or new left bundle branch block (LBBB);

(4) development of pathological Q waves in the ECG; or

(5) imaging evidence of new loss of viable myocardium or new regional wall motion abnormality.

Proof of Heart Attack requires submission of medical records. We deem a heart attack to occur on the date a Doctor of appropriate specialty makes a Diagnosis. A Heart Attack that results in death will be covered under this provision.

We don't pay a benefit for a Heart Attack that occurs during a medical procedure, including, but not limited to, surgery.

B045.0084

Heart Failure We pay a benefit if a Covered Person is Diagnosed with Heart Failure. By Heart Failure we mean the irreversible failure of the heart, which requires a human to human heart, heart/lung or heart combined with any other organ transplant determined to be Medically Necessary by a Doctor of the appropriate specialty.

We deem Heart Failure to occur on the date the Covered Person is accepted onto the transplant waiting list of a recognized transplant program in the United States. We pay the benefit whether or not the transplant is ever performed. If the Covered Person is too ill for a transplant, but otherwise meets the criteria for being on the waiting list of a recognized transplant program, the waiting list requirement will be waived. In this instance we deem Heart Failure to occur on the date a Doctor of appropriate specialty deems the Covered Person is too ill for a transplant, but otherwise meets the criteria for being on a waiting list of a recognized transplant program in the United States.

B045.0085

Stroke We pay a benefit if a Covered Person is diagnosed with a Stroke, which means death of brain tissue due to an acute cerebrovascular event. All of the following criteria must be satisfied: (1) clinical evidence of infarction of brain tissue, or intracranial or subarachnoid hemorrhage; (2) clear evidence on a CT, MRI or similar imaging techniques that a stroke has occurred; and (3) permanent neurologic deficit measured 30 days or more after the event that results in functional impairment rated at a score of two or higher on the Modified Rankin Scale for stroke outcome. The term does not mean symptoms due to: (a) transient ischemic attack; (b) migraine; (c) hypoxia; (d) traumatic injury to brain tissue or blood vessels; and (e) vascular disease affecting the eye, optic nerve or vestibular functions.

Diagnosis of Stroke must be:

(1) confirmed in writing by a Doctor of the appropriate specialty; and

(2) based on medical records. These records must show objective evidence of significant neurological impairment.

Such impairment must be documented by meeting all of the following criteria:

(a) clinical evidence of infarction of brain tissue, or intracranial or subarachnoid hemorrhage;

(b) clear evidence on a CT, MRI or similar imaging techniques that a stroke has occurred; and

(c) permanent neurologic deficit measured 30 days or more after the event that results in a score of two or higher on the Modified Rankin Scale for stroke outcome.

We deem the Stroke to occur on the date of the event. In the event of death, an autopsy confirmation and/or death certificate identifying Stroke as the cause of death will be accepted.

B045.0086

Neurological Conditions

B045.0087

Alzheimer's Disease

We pay a benefit if a Covered Person is Diagnosed with Alzheimer's Disease, which means a progressive degenerative disease of the brain that is Diagnosed by a psychiatrist or neurologist as Alzheimer's Disease. The Diagnosis must be supported by medical evidence that the Covered Person exhibits the loss of intellectual capacity resulting in impairment of memory and judgment as documented and demonstrated by cognitive testing and supported by neuroradiological tests (e.g., CT Scan, MRI, PET of the brain). This impairment must result in a significant reduction in mental and social functioning, resulting in the Covered Person's inability to permanently perform two or more of the Activities of Daily Living without the continuing assistance of another person. No other dementing organic brain disorders or psychiatric illnesses are included in this definition.

Activities of Daily Living include:

- Bathing: wash in a tub or shower; or take a sponge bath; and towel dry.
- Dressing: put on and take off all clothes; and those medically necessary braces or prosthetic limbs usually worn; and fasten or unfasten them.
- Toileting: get to and from and on and off the toilet; to maintain personal hygiene; and care for clothes.
- Transferring: move in and out of a chair or bed.
- Continence: control bowel and bladder function; or, in the event of incontinence, maintain personal hygiene.
- Eating: get food into the body by any means once it has been prepared and made available.

Diagnosis must be based on clinical and/or diagnostic findings as supported by the Covered Person's medical records. We deem Alzheimer's Disease to occur on the date a Doctor of appropriate specialty makes a Diagnosis. The Diagnosis must occur while the Covered Person is insured under this Plan.

B045.0088

Amyotrophic Lateral Sclerosis (also known as ALS or Lou Gehrig's Disease

We pay a benefit if a Covered Person is Diagnosed with Amyotrophic Lateral Sclerosis (ALS), which means motor neuron disease, marked by muscular weakness and atrophy with spasticity and hyperreflexia due to a loss of motor neurons of the spinal cord, medulla and cortex.

We deem ALS to occur on the date a Doctor of appropriate specialty makes a Diagnosis.

B045.0089

Huntington's Disease

We pay a benefit if a Covered Person is Diagnosed with Huntington's Disease, which is a neurodegenerative genetic disorder that affects muscle coordination and leads to cognitive decline and psychiatric problems.

Diagnosis must document symptoms and verify the presence of the gene via genetic testing. We don't pay a benefit for the presence of the Huntington's Disease gene in absence of symptoms.

Symptoms include

- Personality changes, mood swings and depression;
- Forgetfulness and impaired judgment;
- Unsteady gait and involuntary movements;
- Slurred speech and difficulty in swallowing.

We deem Huntington's Disease to occur on the date a Doctor of appropriate specialty makes a Diagnosis.

The Diagnosis must occur while the Covered Person is insured under this Plan.

B045.0090

Multiple Sclerosis (MS)

We pay a benefit if a Covered Person is diagnosed with Multiple Sclerosis (MS), which means demonstrated neurological deficits that have been present for 6 months or more. Diagnosis must be made on the basis of:

(1) neurological examination demonstrating functional impairments;

(2) imaging studies of the brain or spine demonstrating lesions consistent with MS; and

(3) analysis of cerebrospinal fluid consistent with the diagnosis.

We deem MS to occur on the date a Doctor of appropriate specialty makes a Diagnosis. Diagnosis must occur while the Covered Person is insured under this Plan.

B045.0091

Advanced Parkinson's Disease

We pay a benefit if a Covered Person is Diagnosed with Advanced Parkinson's Disease, which means Parkinson's Disease that has progressed to Stage 4, as Diagnosed by a neurologist based on abnormal findings from neurological examination, cognitive testing, and results of imaging studies.

We deem Advanced Parkinson's Disease to occur on the date a Doctor of appropriate specialty makes a Diagnosis that the person has progressed to Stage 4. The Diagnosis must occur while the Covered Person is covered under this Plan.

B045.0092

Childhood Conditions

B045.0093

Cerebral Palsy We pay a benefit if a Covered Dependent Child is Diagnosed with Cerebral Palsy, which means a group of disorders of the development of movement and posture causing activity limitation that are attributed to progressive disturbances that occurred in the developing fetal or infant brain. The motor disorders of cerebral palsy are often accompanied by disturbances of sensation, cognition, communication, perception and/or behavior and/or a seizure disorder. Other similar conditions such as degenerative nerve disorders, genetic diseases, muscle diseases, metabolic disorders, nervous system tumors, coagulation disorders, or other injuries or disorders which delay early development, but can be outgrown, are not included in this definition.

We deem Cerebral Palsy to occur on the first date after live birth where a Doctor of appropriate specialty makes a Diagnosis.

B045.0094

Cleft Lip or Palate We pay a benefit if a Covered Dependent Child is Diagnosed with Cleft Lip or Cleft Palate. A Cleft Lip appears as a narrow opening or gap in the skin of the upper lip that extends all the way to the base of the nose. A Cleft Palate is an opening between the roof of the mouth and the nasal cavity, including clefts that occur on one side of the mouth or both sides.

We pay a benefit for either a Cleft Lip or Cleft Palate, but not both.

We deem Cleft Lip or Cleft Palate to occur on the first date after live birth where a Doctor of appropriate specialty makes a definite clinical Diagnosis of a cleft lip or palate.

B045.0095

Clubfoot We pay a benefit if a Covered Dependent Child is Diagnosed with Clubfoot, which means a congenital deformity of the foot.

We pay the benefit only once even if Clubfoot is present in both of the child's feet.

We deem Clubfoot to occur on the first day after live birth where a Doctor of appropriate specialty makes a definite Diagnosis of Clubfoot.

B045.0096

Cystic Fibrosis We pay a benefit if a Covered Dependent Child is Diagnosed with Cystic Fibrosis, which means chronic lung disease and pancreatic insufficiency. The Diagnosis of Cystic Fibrosis made via sweat test is based upon sweat chloride concentrations greater than 60 mmol/L.

We deem Cystic Fibrosis to occur on the first date after live birth where Cystic Fibrosis has been definitively Diagnosed by a Doctor of appropriate specialty via sweat test.

B045.0097

Down Syndrome We pay a benefit if a Covered Dependent Child is Diagnosed with Down Syndrome, which means a Diagnosis of Down Syndrome through study of the 21st chromosome. Down Syndrome includes:

- Trisomy - an individual has three instead of two number 21 chromosomes;

- Translocation - an extra part of the 21st chromosome is attached to another chromosome;
- Mosaicism - the individual has an extra 21st chromosome in only some of the cells but not all of them. The other cells have the usual pair of 21st chromosomes.

We deem Down Syndrome to occur on the first date after live birth where a Doctor of appropriate specialty completes a chromosome test that positively reveals Down Syndrome.

B045.0098

Muscular Dystrophy We pay a benefit if a Covered Dependent Child is Diagnosed with Muscular Dystrophy, which means a hereditary condition that is marked by progressive weakening and wasting of muscles. The Covered Dependent Child must have well defined neurological abnormalities, confirmed by electromyography and muscle biopsy.

We deem Muscular Dystrophy to occur on the first date after live birth where a Doctor of appropriate specialty makes a Diagnosis.

B045.0099

Spina Bifida We pay a benefit if a Covered Dependent Child is Diagnosed with Spina Bifida, which means either of the following types of Spina Bifida:

(1) Meningocele - the protective coatings (meninges) come through the open part of the spine like a sac that is pushed out. Cerebrospinal fluid is in the sac and there is usually no nerve damage.

(2) Myelomeningocele - This occurs when the meninges (protective covering of the spinal cord) and spinal nerves come through the open part of the spine.

We pay no benefits for spina bifida occulta.

We deem Spina Bifida to occur on the first date after live birth where a Doctor of appropriate specialty makes a Diagnosis

B045.0100

Type 1 Diabetes We pay a benefit if a Covered Dependent Child is Diagnosed with Type 1 Diabetes, which means the child has a total insulin deficiency and a continuous dependence on exogenous insulin for survival. Dependence on insulin must persist for a continuous period of at least 3 months.

We deem Type 1 Diabetes to occur on the date a Doctor of appropriate specialty makes a Diagnosis.

B045.0101

Other Critical Illnesses

B045.0102

Addison's Disease We pay a benefit if a Covered Person is Diagnosed with Addison's disease, which means an endocrine or hormonal disorder resulting in the adrenal glands not producing sufficient cortisol.

Diagnosis must be made by laboratory tests designed to show insufficient levels of cortisol.

We deem Addison's Disease to occur on the date a Doctor of appropriate specialty makes a Diagnosis.

B045.0103

Coma We pay a benefit if a Covered Person is Diagnosed with a Coma, which means a state of complete mental unresponsiveness with no evidence of appropriate responses to stimulation, lasting for a period of 7 or more consecutive days and characterized by the absence of eye opening, verbal response and motor response. The condition must require intubation for respiratory assistance. This benefit is not payable for a medically induced Coma.

We deem a Coma to occur on the date a Doctor of appropriate specialty makes a Diagnosis.

B045.0104

Kidney Failure We pay a benefit if a Covered Person is Diagnosed with Kidney Failure, which means chronic irreversible failure of both kidneys to function, as a result of which either weekly or bi-weekly renal or peritoneal dialysis is started, or renal transplant is performed.

Proof of Kidney Failure requires submission of medical records. Diagnosis of Kidney Failure will be deemed to occur on the earlier of the date: (a) renal or peritoneal dialysis is started; or (b) the date the Covered Person is accepted onto the kidney transplant waiting list of a recognized transplant program in the United States. If the Covered Person is too ill for a transplant, but otherwise meets the criteria for being on the waiting list of a recognized transplant program, the waiting list requirement will be waived. In this instance we deem Kidney Failure to occur on the date a Doctor of appropriate specialty deems the Covered Person is too ill for a transplant, but otherwise meets the criteria for being on a waiting list of a recognized transplant program in the United States.

B045.0105

Loss of Hearing We pay a benefit if a Covered Person is Diagnosed with Loss of Hearing, which means clinically-proven irreversible loss of hearing in both ears, with an auditory threshold of more than 90 decibels, as a result of illness or injury that has continued without interruption for at least 6 consecutive months after Diagnosis.

No benefit will be paid if, in general medical opinion, surgery, a hearing aid, device, or implant could result in the partial or total restoration of hearing.

The Diagnosis must be made by physical examination by an licensed audiologist.

A Covered Dependent Child must be at least 3 years old on the date of Diagnosis in order to receive a benefit. However, if a Covered Dependent Child is Diagnosed prior to age 3, we will pay a benefit if the initial diagnosis occurred while insured by this Plan, and the Diagnosis is confirmed on or after the child reaches age 3 and remains insured by this Plan.

We deem Loss of Hearing to occur on the date on which a licensed audiologist physically examines the Covered Person and certifies that the Covered Person meets the definition above.

B045.0106

Loss of Sight We pay a benefit if a Covered Person is diagnosed with Loss of Sight, based on best corrected visual acuity of 20/400 or less or visual field of 20 degrees or less in the better eye. No benefit will be paid if, in general medical opinion, surgery, device, or implant could result in the partial or total restoration of sight.

A Covered Dependent Child must be at least 3 years old on the date of Diagnosis in order to receive a benefit. However, if a Covered Dependent Child is Diagnosed prior to age 3, we will pay a benefit if the initial diagnosis occurred while insured by this Plan, and the Diagnosis is confirmed on or after the child reaches age 3 and remains insured by this Plan.

We deem Loss of Sight to occur on the date on which a licensed ophthalmologist physically examines the Covered Person and certifies that the Covered Person has best corrected visual acuity of 20/400 or less or visual field of 20 degrees or less in the better eye.

B045.0107

Loss of Speech We pay a benefit if a Covered Person is Diagnosed with Loss of Speech, which means the clinically proven total, permanent and irreversible loss of the ability to speak as a result of sickness or injury that has continued without interruption for a period of at least 6 consecutive months.

No benefit will be payable if, in general medical opinion, surgery, a device or implant could result in the partial or total restoration of speech.

The Diagnosis must be made by physical examination by a speech pathologist.

A Covered Dependent Child must be at least 3 years old on the date of Diagnosis in order to receive a benefit. However, if a Covered Dependent Child is Diagnosed prior to age 3, we will pay a benefit if the initial diagnosis occurred while insured by this Plan, and the Diagnosis is confirmed on or after the child reaches age 3 and remains insured by this Plan.

We deem Loss of Speech to occur on the date on which a Doctor of appropriate specialty physically examines the Covered Person and certifies that the Covered Person meets the definition above.

B045.0108

Major Organ Failure We pay a benefit if a Covered Person is Diagnosed with Major Organ Failure. By Major Organ Failure we mean the irreversible failure of both lungs, liver, pancreas, or bone marrow, which requires a human to human transplant determined to be Medically Necessary by a Doctor of the appropriate specialty.

We deem Major Organ Failure to occur on the date the Covered Person is accepted onto the transplant waiting list of a recognized transplant program in the United States. We pay the benefit whether or not the transplant is ever performed. If the Covered Person is too ill for a transplant, but otherwise meets the criteria for being on the waiting list of a recognized transplant program, the waiting list requirement will be waived. In this instance we deem Major Organ Failure to occur on the date a Doctor of appropriate specialty deems the Covered Person is too ill for a transplant, but otherwise meets the criteria for being on a waiting list of a recognized transplant program in the United States.

We don't pay a benefit under both this provision and the Heart Failure provision at the same time.

We pay no benefits for autologous bone marrow transplants.

B045.0109

Permanent Paralysis We pay a benefit if a Covered Person is Diagnosed with Permanent Paralysis, which means a complete and irreversible condition marked by loss of muscle function in any combination of arms and legs. Permanent Paralysis must be the direct result of a Sickness or Injury, other than a Stroke.

We pay 100% of the benefit amount for the Permanent Paralysis of two or more limbs. We pay 50% of the benefit amount for the Permanent Paralysis of one limb.

We deem Permanent Paralysis to occur on the date a Doctor of appropriate specialty makes a Diagnosis.

B045.0110

Severe Burns We pay a benefit if a Covered Person is Diagnosed with Severe Burns, which means full-thickness or third-degree burn, as determined by a Doctor covering at least 25% of the body. A full-thickness or third-degree burn is the destruction of the skin through the entire thickness or depth of the dermis and possible into underlying tissues, with loss of fluid and sometimes shock, by means of exposure to fire, heat, caustics, electricity or radiation.

We deem Severe Burns to occur on the date of the Injury.

B045.0111

B045.0114

Proof Of Insurability The Covered Person's benefit amount, part of it, or increases in it, may not become effective until he or she submits Proof of Insurability to Us. We must approve such Proof of Insurability in writing. These requirements are shown in the Schedule of Benefits.

B045.0117

Pre-Existing Conditions A pre-existing condition is a Sickness or Injury, for which in the 3 months before a person becomes covered by this Plan he or she: (1) sought medical advice, treatment or care; or (2) received other medical care or treatment, including consultation with a Doctor. This Plan will not pay benefits for a Critical Illness that is caused by, or results from, a Pre-Existing Condition until the earlier of: (a) the first 6 months that the person is insured by this Plan during which the person does not receive medical advice or treatment in connection with the disease or physical condition; or (b) the 12 month period commencing on the effective date of the persons coverage.

This Plan also limits the Covered Person's benefits under this Plan if a Critical Illness that is caused by, or results from, a Pre-Existing Condition occurs after: (a) a change which provides for an increase in the benefits payable by this Plan; or (b) a change in Your benefit election which increased the benefit payable by this Plan, In this case, Your benefit will be limited to the amount that would have been payable had the change not taken place. This limit does not apply if the Critical Illness occurs after the Covered Person completes at least one full day of active work after the change has been in force for 12 months in a row.

B045.0121

If This Plan Replaces Another Plan This Plan may be replacing a similar plan that the Employer had with some other carrier. In that case, the Pre-Existing Condition limitation will not apply to any Covered Person who: (1) was covered under the Employer's old plan on the day before this Plan started; and (2) has met the requirements of any Pre-Existing Condition or limitation of the old plan; and (3) in Your case, are Actively At Work on a Full-Time basis on the effective date of this Plan.

This Plan will credit any time used to meet the old plan's Pre-Existing Condition provision toward meeting this Plan's Pre-Existing Condition provision, if the Covered Person: (1) was covered under the old plan when it ended; (2) enrolls for coverage under this Plan on or before this Plan's effective date; and (3) is Actively Working on the effective date of this Plan; but (4) has not fulfilled the requirements of any Pre-Existing Condition provision of the old plan.

But, this Plan limits a Covered Person's benefit under this Plan if: (1) it is more than the Critical Illness benefit for which he or she was covered under the old plan; (2) the illness is due to a Pre-Existing Condition; and (3) this Plan pays benefits because this Plan credits time as explained above. In this case, this Plan limits the benefit to the amount the Covered Person to which he or she would have been entitled under the old plan.

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

B045.0122

Exclusions

1) This Plan will not pay benefits for any Critical Illness:

- That is not listed as a Critical Illness in the section entitled Covered Critical Illnesses.
- Caused by, contributed to by, or resulting from: (1) participating in a felony, riot or insurrection; (2) intentionally causing a self-inflicted Injury; (3) committing or attempting to commit suicide while sane or insane; (4) engaging in any illegal activity; or (5) serving in the armed forces or any auxiliary unit of the armed forces of any country.
- Caused by, contributed to by, or resulting from voluntary use of any poison, chemical, prescription or non-prescription drug or controlled substance unless: (1) it was prescribed for the Covered Person by a Doctor, and (2) it was used as prescribed. In the case of a non-prescription drug, this Plan does not pay for any Critical Illness resulting from or contributed to by use in a manner inconsistent with package instructions. "Controlled substance" means an abusable volatile chemical, as defined by Section 485.001, Health and Safety Code, or a substance designated as a controlled substance under Chapter 481, Health and Safety Code.
- Arising from war or act of war, even if war is not declared.
- For which Diagnosis is made outside the United States, unless the Diagnosis is confirmed in the United States. In that case, the Critical Illness will be deemed to occur on the date the Diagnosis was made outside the United States.
- That is Diagnosed while the person is not covered by this Plan.
- For which Diagnosis is made by a Doctor who is the Covered Person, his or her spouse, child, parent, sibling or business associate.

2) This Plan will not pay benefits for the First Occurrence of a Critical Illness if it occurs less than 3 months after the First Occurrence of a related Critical Illness for which this Plan paid benefits. By related we mean either: (a) both Critical Illnesses are contained within the Cancer Related Conditions category; or (b) both Critical Illnesses are contained within the Vascular Conditions category; or (c) both Critical Illnesses are contained within the Childhood Conditions category.

3) This Plan will not pay benefits for a Recurrence of a Critical Illness unless the Covered Person has not received care or treatment for that Critical Illness for at least 12 months in a row prior to the Recurrence. For purposes of this exclusion, care or treatment does not include: (1) preventive medications in the absence of disease; and (2) routine scheduled follow-up visits to a Doctor.

4) This Plan will not pay benefits for more than one Recurrence of any Critical Illness.

B045.0126

SCHEDULE OF BENEFITS

CRITICAL ILLNESS COVERAGE

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

B005.0141

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

You may request to switch to another Plan at any time. But, We will require Proof of Insurability before You switch to another Plan which provides greater benefits if You do this outside of the group enrollment period (See Conditions of Eligibility for more information). You must notify the Employer of any desired switch and pay the required premium.

B005.0762

Annual Election After You are initially covered under this Plan You may increase Your coverage by selecting the next higher Critical Illness Benefit Amount, up to this Plan's guaranteed issue amount, without submitting Proof of Insurability. This option is available during Your open enrollment period specified by Your Employer. (See Conditions of Eligibility for more information).

If the next available option is greater than the guaranteed issue amount You will need to supply Proof of Insurability. If Proof of Insurability is required and has been declined, You will not be eligible for additional increases. Also, any increase in dependent coverage due to Your annual election will require Proof of Insurability.

B005.0763

Benefit Levels	Critical Illness	% of Benefit Amount for First Occurrence	% of Benefit Amount for Recurrence
Cancer Related Conditions:			
	Benign Brain Tumor	75%	Not Covered
	Carcinoma in Situ	30%	Not Covered
	Invasive Cancer	100%	100%
	Skin Cancer	$250.00	Not Covered
Vascular Conditions:			
	Arteriosclerosis	30%	Not Covered
	Heart Attack	100%	100%
	Heart Failure	100%	100%
	Stroke	100%	100%

Neurological Conditions:			
	Alzheimer's Disease for Covered Person	50%	Not Covered
	ALS (Lou Gehrigs's Disease)	100%	Not Covered
	Huntington's Disease	30%	Not Covered
	Multiple Sclerosis	30%	Not Covered
	Advanced Parkinson's Disease	100%	Not Covered
Childhood Conditions: **(applies only to covered dependent children)**			
	Cerebral Palsy	100%	Not Covered
	Cleft lip/cleft palate	100%	Not Covered
	Club Foot	100%	Not Covered
	Cystic Fibrosis	100%	Not Covered
	Down's Syndrome	100%	Not Covered
	Muscular Dystrophy	100%	Not Covered
	Spina Bifida	100%	Not Covered
	Type 1 Diabetes	100%	Not Covered
Other Conditions:			
	Addison's Disease	30%	Not Covered
	Coma	100%	Not Covered
	Kidney Failure	100%	100%
	Loss of Hearing	100%	Not Covered
	Loss of Sight	100%	Not Covered
	Loss of Speech	100%	Not Covered
	Major Organ Failure	100%	100%
	Permanent Paralysis	100% for 2 or more limbs; 50% for 1 limb	Not Covered
	Severe Burns	100%	Not Covered

EMPLOYEE VOLUNTARY CRITICAL ILLNESS COVERAGE

Critical Illness Insurance Amount

Plan A

You may elect amounts of critical illness insurance in increments of $5,000.00, but the amount may not be less than $10,000.00 and may not exceed $50,000.00.

B005.0317

GC-SCH-CI-18-TX

Proof of Insurability Requirements

Proof of Insurability requirements may apply to this coverage. Such requirements may apply to the full benefit amount, or just part of it. When Proof of Insurability requirements apply, it means You must submit to Us, Proof of Insurability, and We must approve the Proof of Insurability in writing before the coverage, or the specified part becomes effective.

We require Proof of Insurability as follows:

We require Proof of Insurability before We will cover You if You enroll for Critical Illness coverage after 31 days from Your Eligibility Date or outside of the group enrollment period specified by Your Employer. (See Conditions of Eligibility for more information).

We require Proof of Insurability when You switch from Your current Plan of Critical Illness coverage to a Plan with a higher benefit amount if You elect a higher Plan outside of the group enrollment period specified by Your Employer. (See Conditions of Eligibility for more information).

You must provide Proof of Insurability for amounts of Critical Illness coverage in excess of $50,000.00.

B005.0768

DEPENDENT VOLUNTARY CRITICAL ILLNESS COVERAGE

Dependent Spouse Critical Illness Benefit Amount

An amount up to 50% of Your Critical Illness Benefit Amount, but not more than $25,000.00.

B005.0404

Dependent Child Critical Illness Benefit Amount

$12,500.00 not to exceed 25% of Your Critical Illness Benefit Amount.

B005.0427

Dependent Spouse Proof of Insurability Requirements

Proof of Insurability requirements may apply to this coverage. Such requirements may apply to the full benefit amount, or just part of it. When Proof of Insurability requirements apply, it means You must submit to Us, Proof of Insurability for Your dependent spouse, and We must approve the Proof of Insurability in writing before the coverage, or the specified part becomes effective.

We require Proof of Insurability as follows:

We require Proof of Insurability before We will cover Your Spouse if You enroll him or her for Critical Illness coverage after 31 days from Your Eligibility Date or outside of the group enrollment period specified by Your Employer. (See Conditions of Eligibility for more information).

We require Proof of Insurability for Your Spouse when You switch from Your current plan of dependent Spouse Critical Illness coverage to a plan with a higher benefit amount if You elect a higher Plan outside of the group enrollment period specified by Your Employer. (See Conditions of Eligibility for more information).

Your Spouse must provide Proof of Insurability for amounts of dependent Spouse Critical Illness coverage in excess of $25,000.00.

B005.0774

Changes To Coverage

Changes in Coverage Amounts

If You are not Actively At Work on a Full-Time basis, any change in Your amount of coverage or the amount of coverage on a covered dependent will not become effective prior to the date You return to Active Work on a Full-Time basis.

Changes in Insurance Classification

If Your classification changes, coverage will not be changed to the new amount until the first day on which You are: (1) Actively At Work on a Full-Time basis; and (2) make a contribution, if required, for the new classification.

If a contribution is required for the new classification for which a larger amount of coverage is provided, You must make the required contribution for the new amount within 31 days of the change. If You do not make the required contribution within 31 days of the change or within 31 days of becoming Actively At Work on a Full-Time basis, if You are not Actively At Work on a Full-Time basis, when Your classification changes, no increase will be allowed due to such change or any later change. In that case, in order to become covered for the larger amount, You must: (1) make the required contribution for the new amount; and (2) furnish Proof of Insurability to Us, which We approve in writing.

If the coverage amount was previously reduced because of age or retirement, it will be retained at the reduced amount.

B005.0450

CERTIFICATE RIDER - Portability Privilege

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

PORTABILITY PRIVILEGE

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

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

- You may port if Your coverage under this Plan ends because: (1) You have terminated employment; (2) You stop being a member of an eligible class of Employees; or (3) this Plan ends.
- You may **not** port Your coverage if You have reached Your 70th birthday on the date coverage under this Plan ends.
- You may **not** port coverage for any of Your dependents if he or she has reached his or her 70th birthday on the date coverage under this Plan ends.
- You may **not** port if coverage under this Plan ends due to Your failure to pay any required premium.

Portability Options: You may port Your Critical Illness coverage, subject to any benefit amount reductions based on age, less the amount of any Critical Illness benefits paid by this Plan.

You may port Your dependent's Critical Illness coverage, subject to any benefit amount reductions based on Your age, less the amount of any Critical Illness benefits paid by this Plan.

You may port: (1) Your coverage only; (2) Your coverage and coverage of Your covered Spouse; (3) Your coverage and the coverage of all of Your covered dependents; or (4) if You are a single parent, Your coverage and the coverage of all of Your covered dependent children. No other combinations will be allowed.

A dependent must be covered as of the date Your coverage under this Plan ends in order to be eligible for portability.

If You die while covered for dependent Critical Illness coverage, Your Spouse may port Your dependent Critical Illness coverage as described above. Your Spouse and dependent children must be covered under this Plan on the date of Your death. But, this option is not available if: (1) there is no surviving Spouse; or (2) Your surviving Spouse has reached his or her 70th birthday on the date of Your death.

The Portable Certificate of Coverage: The portable certificate of coverage provides group Critical Illness. The benefits provided by the portable certificate of coverage are the same as the benefits provided by this Plan. The portable certificate provides seamless coverage. Benefit limits, maximums and timeframes do not reset when someone becomes covered under the portable certificate. The premium for the portable certificate of coverage will be based on: (1) the Covered Person's rate class under this Plan; and (2) Your surviving Spouse's age bracket as shown in the Critical Illness Portability Coverage Premium Notice.

How to Port: You or Your surviving Spouse must: (1) apply to Us in writing; and (2) pay the required premium. You or Your surviving Spouse must do this within 31 days from the date Your coverage under this Plan ends. We will not ask for proof that You or Your surviving Spouse are in good health.

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

The Guardian Life Insurance Company of America

Michael Prestileo, Senior Vice President

B005.0240

GC-R-CI-PORT-14

CERTIFICATE RIDER - Wellness Benefit

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

Wellness Benefit

This Plan will pay a benefit if a Covered Person has one of the following wellness tests or procedures performed.

We limit what we pay to $50.00 per day of wellness tests or procedures. We limit what we pay to one day per Covered Person per Benefit Year.

By Benefit Year, we mean a 12 month period which starts on January 1st and ends on December 31st of each year.

By Covered Person, we mean You, as the Employee insured under this Plan and Your dependent Spouse and Covered Dependent Child(ren).

This Plan pays this benefit regardless of the results of the test or procedure.

Wellness tests or procedures are limited to:

- Blood test for triglycerides
- Bone marrow testing
- Breast ultrasound
- Cancer genetic mutation test
- CA 15-3 (blood test for breast cancer)
- CA125 (blood test for ovarian cancer)
- CEA (blood test for colon cancer)
- Chest x-ray
- Colonoscopy
- Completion of a smoking cessation program
- Completion of a weight reduction program
- Fasting blood glucose test
- Flexible Sigmoidoscopy
- Hemoccult stool analysis
- Mammography
- Pap smear
- PSA (blood test for prostate cancer)
- Serum cholesterol test to determine level of
- HDL and LDL
- Serum Protein Electrophoresis (blood test for myeloma)
- Stress test on a bicycle or treadmill
- Thermography
- ThinPrep pap test
- Virtual colonoscopy

The Covered Person must submit proof of the test or procedure.

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

The Guardian Life Insurance Company of America

Michael Prestileo, Senior Vice President

B005.0462

GC-R-CI-WELL-14

CERTIFICATE RIDER - Infectious or Contagious Disease Benefit

This Rider amends the Certificate as follows and is effective on the Policy Date. If this Rider is effective after the Policy Date, the Rider becomes effective on its issue date.

INFECTIOUS OR CONTAGIOUS DISEASE BENEFIT RIDER

COVERAGE PROVIDED BY THIS RIDER

We pay the benefit stated in this Rider as a part of the Certificate to which it is attached, subject to any limitations and exclusions in this Rider or the Certificate. This Rider ONLY provides coverage for Infectious or Contagious Diseases, and does not provide coverage for basic hospital, basic medical-surgical or major medical expenses.

Infectious or Contagious Disease Benefit: This benefit is payable when a Covered Person is:

- Diagnosed with an Infectious or Contagious Disease by a Doctor. The Date of the Diagnosis must be after this Rider is in effect; and
- Hospital Confined due to that Infectious or Contagious Disease for 5 or more consecutive days. If the Covered Person is Hospital Confined but dies before completing 5 consecutive day(s) of Hospital Confinement, We will pay this benefit so long as all other terms of this Rider are satisfied.

What We Pay:

We will pay 30% of the Critical Illness Benefit Amount shown in the Schedule of Benefits for the first occurrence of the Infectious or Contagious Disease.

This Rider will pay one benefit per person, per lifetime.

LIMITATIONS & EXCLUSIONS

We do not pay this benefit for:

- Any disease or illness that is not specifically listed in the definition of Infectious or Contagious Disease.

DEFINITIONS

This section defines certain terms appearing in this Rider. Any terms not listed here, are defined in the Critical Illness Insurance Certificate to which this Rider is attached.

Date of Diagnosis: This term means the earliest of:

1) The date the specimen used to Diagnose a condition was taken;
2) The date any test was done that was used to establish the Diagnosis of a condition; or
3) The date a condition was positively Diagnosed by a Doctor.

For a Diagnosis made by a Doctor outside of the United States, the Date of Diagnosis is the date such Diagnosis is confirmed by a Doctor practicing within the United States or its territories.

Diagnosis, Diagnose or Diagnosed: This term means the definitive establishment of a specified condition through the use of clinical and/or laboratory findings. The Diagnosis must be made by a Doctor who is acting within the scope of his or her license within the United States or be confirmed by a Doctor within the United States or its territories. Diagnosis of any condition will be considered to have been made before the effective date of this Rider if medical advice or treatment received before the effective date results in a Diagnosis of that condition.

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

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

- Is licensed, accredited or certified by the state in which it operates;
- Is primarily engaged in providing diagnostic and therapeutic services for the diagnosis, treatment and care of sick or injured inpatients under the continuous supervision of Doctors;
- Has organized departments of medicine and major surgery; and
- Provides 24-hour nursing service by or under the supervision of a registered professional nurse.

A hospital does not include a facility, wing, ward, floor or unit that is primarily engaged in providing one or more of the following:

- Long-term care, skilled nursing care, convalescent care, custodial care or rest care;
- Extended care or rehabilitative care;
- Hospice care;
- Treatment for mental, emotional or nervous disorders; or
- Treatment for substance abuse.

Hospital Confined or Confinement: This term means the period of time a Covered Person is assigned as an Inpatient in a Hospital, upon the advice of, and supervision of, a Doctor.

Infectious or Contagious Disease: This term means one of the following diseases or illnesses that is specifically covered by this Rider:

- Antibiotic resistant bacteria (including MRSA)
- Coronavirus
- Diphtheria
- Encephalitis
- Legionnaire’s Disease

- Lyme Disease
- Malaria
- Meningitis
- Necrotizing fasciitis (flesh eating bacteria)
- Osteomyelitis
- Rabies
- Tuberculosis

Inpatient: This term means a patient who is assigned to a bed within a Hospital and charged for room and board for at least one day.

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

The Guardian Life Insurance Company of America

Michael Prestileo, Senior Vice President

B045.0815

GC-R-CI-ICD-20-TX

CERTIFICATE AMENDMENT - ELIGIBILITY FOR CRITICAL ILLNESS COVERAGE

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

Conditions of Eligibility

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

If You elect to enroll within 31 days after Your Eligibility Date, coverage is scheduled to start on Your Eligibility Date.

If You do not elect this coverage within 31 days of Your Eligibility Date, You must answer health questions, or wait until the next scheduled group enrollment period. Once each year, during the group enrollment period, You may elect to enroll in this coverage as offered by the Employer. As used here, "group enrollment period" means an annual open enrollment period set by the Employer and agreed to by Us. If You elect to enroll outside of the group open enrollment period, You must provide Proof of Insurability by answering health questions, or wait until the next group enrollment period.

If Proof of Insurability is required, You will not be covered by this Plan until We approve that Proof of Insurability in writing and notify You of Your effective date of coverage.

When Employee Coverage Starts

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

Whether You must pay all or part of the cost of Your coverage, You must elect to enroll and agree to make the required payments before Your coverage will start. If You do this on or before Your Eligibility Date, Your coverage is scheduled to start on Your Eligibility Date. If You do this within 31 days after Your Eligibility Date, Your coverage is scheduled to start on Your Eligibility Date. If You elect to enroll and agree to make the required payments more than 31 days after Your Eligibility Date, Your coverage will not be scheduled to start until You send Us Proof of Insurability or until You enroll during the next group enrollment period. If Proof of Insurability is required, You will not be covered by this Plan until We approve that Proof of Insurability in writing and notify You of Your effective date of coverage.

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

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

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

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

Any Critical Illness benefit payable will be the lesser of:

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

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

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

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

1. the date You are fully capable of performing the major duties of Your regular occupation for Your Employer on a full-time basis;
2. the date insurance terminates for one of the reasons stated in When Employee Coverage Ends;
3. the last day of a period of 12 consecutive months which begins on the Policy effective date; or

4. the last day You would have been covered under the prior insurer's group critical illness policy, had the prior plan not terminated.

DEPENDENT COVERAGE

Proof of Insurability

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

If You elect to enroll Your Initial Dependents within 31 days after Your Eligibility Date, coverage is scheduled to start on Your Eligibility Date.

If You do not elect Initial Dependent coverage within 31 days of Your Eligibility Date, Your Initial Dependents must answer health questions, or wait until the next scheduled group enrollment period to enroll. Once each year, during the group enrollment period, You may elect to enroll Initial Dependents in this coverage as offered by the Employer. As used here, "group enrollment period" means an annual open enrollment period set by the Employer and agreed to by Us. If You elect to enroll Your Initial Dependents outside of the group open enrollment period, You must provide Proof of Insurability by answering health questions, or wait until the next group enrollment period.

If Proof of Insurability is required, Your Initial Dependents will not be covered by this Plan until We approve that Proof of Insurability in writing and notify You of Your Initial Dependent's effective date of coverage.

In the case of a Newly Acquired Dependent, other than the first newborn child, You may elect to enroll a Newly Acquired Dependent within 31 days. If You do not elect to enroll a Newly Acquired Dependent within 31 days of his or her Eligibility Date, Your Newly Acquired Dependent(s) may have to answer health questions, or wait until the next scheduled group enrollment period to enroll.

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

When Dependent Coverage Starts

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

If You enroll Your dependents on or before Your Eligibility Date, the dependent's coverage is scheduled to start on the later of the 1st day of the month which coincides with or next follows Your Eligibility Date and the date You become covered for Employee coverage.

If You do this within the group enrollment period, the coverage is scheduled to start on the later of the 1st day of the month which coincides with or next follows the date You sign the enrollment form and the date You become covered for Employee coverage.

If You do this after the group enrollment period ends, Your dependent coverage may be subject to Proof of Insurability and will not start until We approve that Proof of Insurability in writing.

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

Whether You must pay all or part of the cost of Your coverage, You must elect to enroll and agree to make the required payments before Your coverage will start. If You do this on or before Your Eligibility Date, Your coverage is scheduled to start on Your Eligibility Date. If You do this within 31 days after Your Eligibility Date, Your coverage is scheduled to start on Your Eligibility Date. If You elect to enroll and agree to make the required payments more than 31 days after Your Eligibility Date, Your coverage will not be scheduled to start until You send Us Proof of Insurability or until You enroll during the next group enrollment period. If Proof of Insurability is required, You will not be covered by this Plan until We approve that Proof of Insurability in writing and notify You of Your effective date of coverage.

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

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

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

The Guardian Life Insurance Company of America

Michael Prestileo, Senior Vice President

B045.0640

GC-A-CI-GI-18-TX

CERTIFICATE AMENDATORY RIDER - Dependent Termination

This Rider amends the Certificate as follows and is effective on the Policy Date. If this Rider is effective after the Policy Date, the Rider becomes effective on its issue date.

The **When Dependent Coverage Ends** provision is replaced in its entirety with the following:

When Dependent Coverage Ends

Dependent coverage ends for all of Your dependent(s) as follows:

- When Your Employee coverage ends;
- When You stop being a member of a class of Employees eligible for such coverage;
- When this Certificate ends, or dependent coverage is discontinued for a class of Employees to which You belong;
- On the last day of the period, including any applicable grace period, for which required payments are made for Your dependent(s);
- For Your natural or adopted child, grandchild, or stepchild, on the last day of the month in which he or she attains the age limit or no longer qualifies under Continuing Coverage For Dependent Children Past the Age Limit.
- It also happens at 12:01 A.M. on the date in which Your child marries.
- For Your Spouse, at 12:01 A.M. on the date Your marriage is lawfully terminated.
- On the date Your dependent dies.

The **Handicapped Children** provision is replaced in its entirety with the following:

Continuing Coverage For Dependent Children Past the Age Limit

An unmarried child that meets all of the conditions below may continue coverage past the child age limit:

- The child must be incapable of living independently due to a mental, physical, or developmental disability;
- The child must be primarily dependent upon You for support and maintenance;
- The child's mental, physical, or developmental disability must have begun before he or she reached the age limit; and
- The child must have been covered by this Certificate, or the prior carrier's group plan that it replaced, before he or she reached the age limit, and remained continuously covered until he or she reached the age limit.

You will have to send us documentation that your child meets these requirements within 31 days of the date the age limit was reached.

After two years has passed from the date the age limit was reached, we may periodically ask for documentation that your child continues to meet these requirements. We won't ask for this more than once a year.

Any coverage provided under this section ends when Your coverage ends, or your child no longer meets the conditions above.

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

The Guardian Life Insurance Company of America

Michael Prestileo, Senior Vice President

B045.0793

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

STATEMENT OF ERISA RIGHTS

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

Receive Information About Your Plan and Benefits

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

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

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

Prudent Actions By Plan Fiduciaries

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

Enforcement Of Your Rights

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

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

Assistance with Questions

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

B800.0093

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

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

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

Definitions

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

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

Timing For Initial Benefit Determination

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

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

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

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

Adverse Benefit Determination

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

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

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

Appeal of Adverse Benefit Determinations

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

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

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

In reviewing an appeal, Guardian will:

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

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

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

Alternative Dispute Options

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

B055.0061

Termination of This Group Plan

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

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

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

B800.0086

CERTIFICATE OF COVERAGE

The Guardian
10 Hudson Yards
New York, New York 10001
www.GuardianAnytime.com

The Group Accident coverage described in this Certificate is attached to the group Policy effective September 1, 2021. This Certificate replaces any Certificate previously issued under the Policy or under any other plan providing similar or identical benefits issued to the Policyholder by Guardian.

GROUP ACCIDENT COVERAGE

THIS IS AN ACCIDENT ONLY CERTIFICATE. THIS CERTIFICATE PROVIDES LIMITED BENEFITS. BENEFITS PROVIDED ARE SUPPLEMENTAL AND ARE NOT INTENDED TO COVER ALL MEDICAL EXPENSES. READ YOUR CERTIFICATE CAREFULLY.

THIS IS A SUPPLEMENT TO HEALTH INSURANCE AND IS NOT A SUBSTITUTE FOR MAJOR MEDICAL COVERAGE.

THE INSURANCE POLICY UNDER WHICH THIS CERTIFICATE IS ISSUED IS NOT A POLICY OF WORKERS' COMPENSATION INSURANCE. YOU SHOULD CONSULT YOUR EMPLOYER TO DETERMINE WHETHER YOUR EMPLOYER IS A SUBSCRIBER TO THE WORKERS' COMPENSATION SYSTEM.

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

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

Policyholder: UPLIFT EDUCATION

Group Policy Number: 00551834

The Guardian Life Insurance Company of America

Harris Oliner, Senior Vice President,
Corporate Secretary

Michael Prestileo,
Senior Vice President

B401.3063

GC-ACC-18-TX

Please read this Certificate carefully. If You are not satisfied for any reason, You may return this Certificate to Us within 30 days from the date You receive it. If You return it within the 30 day period, this Certificate will be void from the beginning. We will refund any premium paid.

B442.0005

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GENERAL PROVISIONS

Applicable Benefits

This Certificate may include multiple benefit options and types of benefits.

- They were previously selected in an acceptable manner, such as an enrollment form or other required form; and
- We have received any required premium.

Limitation Of Authority

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

- Determine whether any Policy or Certificate is to be issued;
- Waive or alter any Policy or Certificate provisions, or any of Our requirements;
- Bind Us by any statement or promise relating to the Policy or Certificate issued, or to be issued; or
- Accept any information, or representation, which is not in a signed application.

Agents and brokers do not have the authority to change the Policy or Certificate, or waive any of its provisions.

Incontestability

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

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 absence of fraud, a statement may not be used to contest the validity of his or her insurance or to deny a claim for a loss incurred unless the statement is contained in a written instrument signed by the Covered Person.

In the event Your insurance is rescinded, We will refund premiums paid for the periods such insurance is void.

Examination and Autopsy

We have the right to have a Doctor of Our choice conduct a physical examination of the person for whom a claim is being made under the Certificate as often as We reasonably require. We also have the right to have an autopsy performed in the case of death where allowed by law. We will pay for all such examinations and autopsies.

Overpayment Recovery

We will recover any benefit payments made if We overpaid a Covered Person. The Covered Person must repay Us in full. We have the right to recover an overpayment from any future benefits payable.

Statements

No material statement will void the insurance under this Certificate, or be used in defense of a claim unless:

- in the case of the Policyholder, it is contained in the application signed by the Policyholder; or
- in the case of a Covered Person, it is contained in a written instrument signed by him or her. A copy of the instrument containing the statement will be furnished to the Covered Person.

All statements will be deemed representations and not warranties. No written statement made by any person insured shall be used in any contest unless a copy of the statement is furnished to the person or to his or her beneficiary or personal representative if the person dies or becomes incapacitated.

EXTENSION OF BENEFITS

If a Covered Person is disabled or confined in a hospital on the date the Certificate ends, an extension of benefits will be provided until the earliest of:

- 90 days after the date the Certificate ends;
- The date the Covered Person ceases to be Disabled;
- The date the Covered Person's confinement ends; or
- The date the maximum benefits are paid.

This extension of benefits is not applicable if the Certificate is replaced by another carrier providing substantially similar or greater benefits.

B401.3065

ELIGIBILITY FOR ACCIDENT COVERAGE - EMPLOYEE COVERAGE

Conditions of Eligibility

You are eligible for Accident coverage if You are:

- In an eligible class of Employees;
- An active Full-Time Employee;
- Legally working in the United States or working outside of the United States for a United States based Employer in a country or region approved by Us; and
- Working at least the minimum number of hours of an Employee in Your eligible class at:
  - o The Employer's place of business;
  - o Some place where the Employer's business requires You to travel; or
  - o Any other place You and the Employer have agreed upon for the performance of Your occupational duties.

You are **not** eligible for Accident coverage if You are

- A temporary or seasonal Employee.

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

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

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

B442.0009

Whether You must pay all or part of the cost of Your coverage, You must elect to enroll and agree to make the required payments before Your coverage will start. If You do this on or before Your Eligibility Date, Your coverage is scheduled to start on Your Eligibility Date. If You do this within 31 days after Your Eligibility Date, Your coverage is scheduled to start on Your Eligibility Date.

If You do not elect this coverage within 31 days of Your Eligibility Date, You must wait until the next scheduled group enrollment period. Once each year, during the group enrollment period, You may elect to enroll in this coverage as offered by Your Employer. As used here, "group enrollment period" means an annual open enrollment period set by Your Employer and agreed to by Us. During this period, You can choose the Group Accident coverage Your Employer offers. A group enrollment period is usually held once a year and often lasts for 30 days.

B442.0014

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

B401.3066

Exception to When Employee Coverage Starts

Transfer Business Exception: If due to Injury, You are not Actively At Work and not working the minimum number of hours of an Employee in Your eligible class, on Your scheduled Eligibility Date, You will be insured for this Group Accident insurance if:

- You were insured under the Employer's prior group accident plan at the time the prior insurer's group accident plan ended and this Group Accident Plan became effective with Us, with no break in coverage;
- You were a member of an eligible class under the Employer's prior group accident plan and are eligible under this Certificate;
- Premiums for You were paid up to date for the Employer's prior group accident plan and this Certificate; You are not receiving or eligible to receive benefits under the Employer's prior group accident plan.
- You are not receiving or eligible to receive benefits under the Employer's prior group accident plan.

B401.3068

When Employee Coverage Ends

When Employee Coverage Ends

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

- The date Your Active Work ends for any reason.
- The date You stop being an eligible Employee under this Certificate.
- The date You are no longer working in the United States, or no longer working outside the United States for a United States based Employer in a country or region approved by Us. Any incidental business or personal travel outside of the United States or outside of a country or region approved by Us, is covered. Such travel will be considered incidental if it is for a period not to exceed 30 consecutive days.
- The date the group Certificate ends, or is discontinued for a class of Employees to which You belong.
- The last day of the period for which required payments are made for You, subject to the grace period.
- The date you die.

You may have the right to continue certain group benefits for a limited time after Your coverage would otherwise end. Contact Your Employer regarding any continuation options available.

B401.3070

CONTINUATION OF COVERAGE

Coverage During Temporary Layoff or Leave of Absence

If Your Active Work ends because of a temporary layoff or leave of absence, You and Your Employer may agree to continue Your insurance, subject to continued payment of all required premium, until the earliest of:

- The end of the temporary layoff or leave of absence; or
- The end of the month of the leave or layoff plus 3 month(s) following the date the leave or layoff begins.
- The end of the time period covered under a severance agreement not to exceed 3 month(s).

Your Employer must notify Us of the date your Active Work ends and the date You return to Active Work. If You do not return to Active Work at the end of the approved layoff or leave of absence, Your coverage will end. See When Employee Coverage Ends for further explanation.

See Portability Privilege for continuing coverage when You are no longer covered under this Policy and Certificate.

B442.0022

Coverage During Family Leave of Absence

Important Notice

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

If Your Coverage Would End

Your Accident coverage would normally end because You cease work due to an approved leave of absence. But, You may continue Your coverage if the leave has been granted to: (1) allow You to care for a seriously injured or ill spouse, child or parent; (2) after the birth or adoption of a child; (3) due to Your own serious health condition; or (4) because of a serious injury or illness arising out of the fact that Your spouse, child, parent or Next of Kin who is a Covered Service Member is on Active Duty, or has been notified of an impending call or order to active duty, in the Armed Forces in support of a contingency operation. To continue Your coverage, You will be required to pay the same share of the premium as You paid before the leave of absence.

When Continuation Ends

Continued coverage will end on the earliest of the following:

- The date You return to Active Work.

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

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

- **Active Duty:** This term means duty under a call or order to active duty in the Armed Forces of the United States.
- **Contingency Operation:** This term means a military operation that: (1) is designated by the Secretary of Defense as an operation in which members of the Armed Forces are or may become involved in military actions, operations or hostilities against an enemy of the United States or against an opposing military force; or (2) results in the call or order to, or retention on, active duty of members of the uniformed services under any provision of law or during a national emergency declared by the President or Congress.
- **Covered Service Member:** This term means a member of the Armed Forces, including a member of the National Guard or Reserves, who for a serious injury or illness is: (1) undergoing medical treatment, recuperation or therapy; (2) otherwise in outpatient status; or (3) otherwise on the temporary disability retired list.
- **Next Of Kin:** This term means Your nearest blood relative.
- **Outpatient Status:** This term means, in the case of a Covered Service Member, that he or she is assigned to: (1) a military medical treatment facility as an outpatient; or (2) a unit established for the purpose of providing command and control of members of the Armed Forces receiving medical care as outpatients.
- **Serious Injury:** This term means, in the case of a Covered Service Member, an Injury incurred by him or her in line of duty on Active Duty in the Armed Forces that may render him or her medically unfit to perform the duties of his or her: (1) office; (2) grade; (3) rank; or (4) rating.

See Portability Privilege for continuing coverage when You are no longer covered under this Policy and Certificate.

Rehire

If You were previously covered under this Certificate and Your coverage ended, You will be eligible for insurance under this Certificate on the date You return to Active Work, provided You:

- Return to Active Work within 6 month(s) of the date Your coverage ended;
- Were covered for Group Accident under this Certificate on the day before Your coverage ended; and
- Enroll for coverage within 31 days of the date You return to Active Work.

Upon return to Active Work, a new Eligibility Date will be established according to the When Coverage Starts rules above.

Upon returning to Active Work, subject to the limitations noted under the Rehire provision of this Certificate, Your coverage under this Certificate will be reinstated at the amount of coverage in place prior to the coverage ending due to temporary layoff or leave of absence. Coverage will be re-established on the date You return to Active Work if all of the required conditions are satisfied. Employee coverage under this Certificate that is reinstated will not be subject to the waiting period established by the Employer, if any.

See Portability Privilege for continuing coverage when You are no longer covered under this Policy and Certificate.

B401.3071

ELIGIBILITY FOR ACCIDENT COVERAGE - DEPENDENT COVERAGE

Conditions of Eligibility

Your eligible dependents are Your spouse; and

- Unmarried dependent child, including:
  - o A newborn child from the moment of birth, natural child, an adopted child or any child to whom You or Your Spouse are a party to a suit to adopt the child, stepchild, a natural or adopted child of Your Spouse, grandchild(ren) who are dependents for federal income tax purposes at the time of application, a child for whom a medical support order has been issued or a child placed with You for foster care who is under age 25; and
  - o A child who is incapable of self-support because of a physical or mental incapacity. See Continuing Coverage For Dependent Children Past the Limiting Age to remain an eligible dependent child.

Eligible dependent does not include anyone who is insured under this Certificate as the Employee.

Dependents Not Eligible

We exclude:

- A dependent who is on Active Duty in any armed force;
- A dependent who is covered by this Certificate as a/an Employee.

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

B401.3073

When Dependent Coverage Starts

When Dependent Coverage Starts

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

Subject to all of the other terms of this Certificate, the date Your dependent coverage starts depends on when You elect to enroll Your dependents and agree to make any required payments.

When You enroll Your dependents, coverage begins on the later of Your Eligibility Date and the date You become covered for Employee coverage.

B442.0028

When Dependent Coverage Ends

When Dependent Coverage Ends

Dependent coverage ends for all of Your dependents as follows:

- Your Employee coverage ends;
- You stop being a member of a class of Employees eligible for such coverage;
- This Certificate ends, or dependent coverage is discontinued for a class of Employees to which You belong;
- The last day of the period for which required payments are made for Your dependent(s), subject to the grace period;
- For Your Spouse, at 12:01 A.M. on the date Your marriage ends in legal divorce or annulment;
- The date Your dependent dies.

B401.3082

When Dependent Coverage Ends

When Dependent Coverage Ends

Dependent coverage ends for all of Your dependents as follows:

- Your Employee coverage ends;
- You stop being a member of a class of Employees eligible for such coverage;
- This Certificate ends, or dependent coverage is discontinued for a class of Employees to which You belong;
- The last day of the period for which required payments are made for Your dependent(s), subject to the grace period;
- For Your child, this happens on the last day of the month in which the child attains this Certificate's age limit;
- The date Your dependent dies.

Continuing Coverage For Dependent Children Past the Limiting Age

Continuing Coverage For Dependent Children Past the Limiting Age

If You have an unmarried child:

- Incapable of independent living by reason of a mental, physical, or developmental disability; and
- Primarily dependent upon You for support and maintenance;

Then, the child or children may remain eligible for dependent benefits past the age limit provided all the conditions shown below are satisfied. Each such child:

- Must have a mental, physical, or developmental disability that began before he or she reached the dependent age limit;
- Became covered by this Certificate, or the prior carrier's group accident plan that it replaced, before he or she reached the dependent age limit, and remained continuously covered until he or she reached the age limit;
- Is unmarried and remains:
    - o Incapable of independent living; and
    - o Dependent upon You for most of his or her support and maintenance.

You must send Us written proof, and we approve such proof, of the child's disability and dependence within 31 days from the date he or she reaches the dependent age limit. After the two year period following the child's attainment of the age limit, We can ask for periodic proof that the child's condition continues, but We cannot ask for this proof more than once a year.

Any coverage provided under this section ends when Your coverage ends.

B401.3084

ACCIDENT BENEFITS

This Certificate will pay the benefits described below if a Covered Person sustains an Injury, or incurs a loss, as a result of a Covered Accident. The Covered Accident and/or treatment must occur on or after the date the Covered Person becomes insured by this Certificate. This Certificate pays no benefits other than what is specifically listed below.

We pay no benefits for any Accident that occurs before a person is a Covered Person under this Certificate.

Subject to a Covered Person's right to port this coverage, if a Covered Person's coverage under this Certificate ends for any reason other than non-payment of premium, We will pay benefits for the Covered Accident that occurs while a Covered Person is insured by this Certificate. The treatment must be performed within 90 days of the date the Covered Person's coverage ends.

B442.0038

Accidental Death We pay the amount shown in the Schedule of Benefits if the Covered Person sustains an Injury in a Covered Accident that causes the Covered Person's death. The Injury must cause the Covered Person's death within 90 days of the Covered Accident. If We pay this benefit, We will not pay the Accidental Death Common Carrier benefit.

If an Accidental Death and Accidental Dismemberment result from the same Covered Accident, We will pay the higher amount. This benefit is payable once per Covered Person per Covered Accident.

Accidental Death Common Carrier: We pay the amount shown in the Schedule of Benefits if the Covered Person's Accidental Death is due to a Covered Accident which occurs while riding as a fare-paying passenger in a Common Carrier. If We pay this benefit, We will not pay the Accidental Death benefit. This benefit is payable once per Covered Person per Covered Accident.

Accidental Death Common Disaster: We pay the increased amount shown in the Schedule of Benefits if both You and Your covered Spouse die in a Covered Accident or separate Covered Accidents within the same 24 hour period. The benefit increase applies to Your covered Spouse's benefit. This benefit is payable once per Covered Person per Covered Accident.

Accidental Dismemberment: We pay the amount shown in the Schedule of Benefits if a loss listed below is sustained by a Covered Person due to Injuries caused by a Covered Accident:

- "Loss of a hand" means the hand is completely severed at or above the wrist.
- "Loss of a foot" means the foot is completely severed at or above the ankle.
- "Loss of sight" means total and permanent loss of all sight in both eyes that is irrecoverable by natural, surgical or artificial means.

- "Loss of thumb and index finger of same hand" or "Loss of four fingers of same hand" means complete severance through or above the metacarpophalangeal joints of the same hand. This benefit is not payable if benefits have been paid for "Loss of a hand".
- "Loss of all toes on same foot" means complete severance at the metatarsophalangeal joint. This benefit is not payable if benefits have been paid for "Loss of a foot".

We will not pay more than $50,000.00 for all losses due to the same Covered Accident.

If an Accidental Death and Accidental Dismemberment result from the same Covered Accident, We will pay the higher amount. This benefit is payable once per Covered Person per Covered Accident.

Accidental Death Seatbelt and Airbag: We pay the seatbelt amount shown in the Schedule of Benefits if a Covered Person dies due to Injuries sustained in a Covered Accident while properly wearing a seatbelt. We will pay the Seatbelt & Airbag amount shown in the Schedule of Benefits if a Covered Person dies as a direct result of an automobile Accident while both properly wearing a seatbelt and sitting in a seat equipped with an airbag. We will not pay both the Seatbelt, and Seatbelt and Airbag benefit, for the same Covered Accident.

B442.0039

Air Ambulance We pay the amount shown in the Schedule of Benefits if a Covered Person is transported by Air Ambulance to or from a Hospital or between medical facilities for treatment of Injuries sustained as the result of a Covered Accident within 48 hours of a Covered Accident. This benefit is payable once per Covered Person per Covered Accident.

B442.0041

Ambulance: We pay the amount shown in the Schedule of Benefits if a licensed ambulance company transports a Covered Person by ground, to or from a Hospital, or between medical facilities, for treatment of Injuries sustained as a result of a Covered Accident, within 90 days of a Covered Accident. This benefit is payable once per Covered Person per Covered Accident.

B442.0049

Blood / Plasma / Platelets We pay the amount shown in the Schedule of Benefits if, as the result of a Covered Accident, a Covered Person receives a transfusion, administration, cross matching, typing and processing of Blood/Plasma/Platelets, within 90 days of the Covered Accident. This benefit is payable once per Covered Person per Covered Accident.

B442.0042

Burn We pay the amount shown in the Schedule of Benefits if a Covered Person suffers one or more burns as a result of a Covered Accident, and is treated by a Doctor within 72 hours of the Covered Accident. If the burn(s) sustained by the Covered Person meets more than one of the burn classifications, We pay the higher amount. This benefit is payable once per Covered Person per Covered Accident.

Burn - Skin Graft We pay the amount shown in the Schedule of Benefits when grafting of the skin is necessary, as determined by a medical professional, for a burn that was payable under the Burn benefit. This benefit is payable once per Covered Person per Covered Accident.

B442.0043

Catastrophic Loss We pay the amount shown in the Schedule of Benefits if a Covered Person suffers a Catastrophic Loss within 365 days of a Covered Accident, due to Injuries sustained in a Covered Accident. This benefit is payable once per Covered Person per Covered Accident. If a Catastrophic Loss benefit is paid, an Accidental Dismemberment benefit will not be paid for the same, or attached body part.

B442.0044

Child Organized Sport We pay the additional amount shown in the Schedule of Benefits if the Covered Accident occurred while Your covered dependent child is participating in an Organized Sport. The child must be insured by this Certificate on the date the Covered Accident occurred. The covered dependent child must be 18 years of age or younger.

B442.0045

Chiropractic Visits We pay the amount shown in the Schedule of Benefits if, as the result of a Covered Accident, a Covered Person suffers a structural imbalance and receives Chiropractic Care Services by a chiropractor in a chiropractors office. Treatment must begin within 60 days after a Covered Accident and be completed within 180 days of the Covered Accident. We will pay a benefit for up to 6 visits per Covered Person per Covered Accident, but no more than 12 visits per calendar year.

B442.0046

Coma We pay the amount shown in the Schedule of Benefits if, as the result of a Covered Accident, a Covered Person is in a Coma lasting at least 7 consecutive days characterized by the absence of eye opening, verbal response, and motor response. The condition must require intubation for respiratory assistance, and be diagnosed or treated by a Doctor within 90 days of the Covered Accident. This benefit is not payable for a medically-induced Coma. If a Coma and Traumatic Brain Injury result from the same Covered Accident, We will pay the higher amount.

B442.0047

Concussions We pay the amount shown in the Schedule of Benefits if a Covered Person sustains a concussion as the result of a Covered Accident, and is diagnosed within 72 hours of the Covered Accident. This benefit is payable once per Covered Person per Covered Accident.

B442.0048

Concussion Baseline Study We pay the amount shown in the Schedule of Benefits if a covered dependent child 18 years of age or younger completes a baseline concussion test.

As a preventive measure, these baseline tests are typically taken prior to a sport season when an athlete has not yet had exposure to training and/or competition. In the event a concussion is sustained during the season, the same test ("post-injury") is taken again by the athlete, yielding comparative scores from before and after the Injury.

These baseline tests and post-injury tests are computerized assessments that measure reaction time, memory capacity, speed of mental processing, and executive functioning of the brain. They also record baseline concussion symptoms and provide extensive information about the athlete's history with concussions.

This benefit is payable once per covered dependent child per year. We do not pay a benefit for "post-injury" tests.

B442.0053

Dislocations We pay the amount shown in the Schedule of Benefits if a Covered Person is Injured and suffers a Dislocation as a result of a Covered Accident. A Dislocation must be diagnosed by a Doctor within 90 days of the Covered Accident. The Dislocation must be corrected by open (surgical) or closed (non-surgical) reduction.

For multiple Dislocations due to the same Covered Accident, We will pay no more than 2 times the benefit amount for the joint involved with the highest benefit amount.

For partial Dislocation, We will pay 25% of the benefit shown in the Schedule of Benefits for a closed reduction.

We will pay this benefit only for the first Dislocation of a joint per Covered Person per Covered Accident; subsequent Dislocations of the same joint will not be covered for the same Covered Accident.

B442.0050

Diagnostic Exam (Major) We pay the amount shown in the Schedule of Benefits if a Covered Person receives one of the following imaging studies due to a Covered Accident: Computerized Tomography (CT scan), computerized axial tomography (CAT), magnetic resonance imaging (MRI or electroencephalography (EEG). The imaging study must be prescribed by a Doctor and performed in a Doctor's office or Hospital within 90 days of the Covered Accident, on an Inpatient or outpatient basis. This benefit is payable once per Covered Person per Covered Accident.

B442.0051

Doctor Follow-Up Visit We pay the amount shown in the Schedule of Benefits if a Covered Person requires additional follow up treatments (not including Outpatient Therapies) after initial Emergency Room treatment or Initial Doctor's Office/Urgent Care Facility Treatment. This benefit is payable to a Covered Person for up to 6 treatments per Covered Accident. The follow-up treatment must be provided by a Doctor in a Doctor's office or in a Hospital on an outpatient basis. Treatment must begin within 60 days from initial treatment from a Covered Accident and be completed within 365 days.

B442.0052

Emergency Dental Work

We pay the amount shown in the Schedule of Benefits if a Covered Person suffers a broken tooth as the result of a Covered Accident, and it is repaired by a Dentist using a dental crown and/or dental extraction. The dental services must begin within 60 days of the Covered Accident. One dental crown and one dental extraction is payable once per Covered Person per Covered Accident.

B442.0054

Emergency Room Treatment

We pay the amount shown in the Schedule of Benefits if a Covered Person is examined or treated by a Doctor in a Hospital Emergency Room for the initial treatment of Injuries sustained in a Covered Accident within 72 hours after the Covered Accident. This benefit is payable once per Covered Person per Covered Accident. We will not pay the Emergency Room Treatment benefit and the Initial Doctor's Office/Urgent Care Facility benefit for the same Covered Accident.

B442.0055

Epidural Anesthesia Pain Management

We pay the amount shown in the Schedule of Benefits if a Covered Person is prescribed and receives an epidural administered for pain management as a result of a Covered Accident. The epidural must be administered in a Hospital or Doctor's office and is payable twice per Covered Person per Covered Accident. This benefit is not payable for an epidural administered during a surgical procedure.

B442.0056

Eye Injury

We pay the amount shown in the Schedule of Benefits if a Covered Person suffers an Eye Injury as the result of a Covered Accident. The Eye Injury must require surgery or the removal of a foreign object by a Doctor within 90 days of a Covered Accident. This benefit is payable once per Covered Person per Covered Accident.

B442.0057

Fracture (Bone)

We pay the amount shown in the Schedule of Benefits if a Covered Person suffers a Fracture as a result of a Covered Accident and it is diagnosed within 90 days of the Covered Accident. The Fracture must require open (surgical) or closed (non-surgical) reduction by a Doctor. This benefit is payable for up to 2 Fracture(s) per Covered Person per Covered Accident. If there are more than 2 Fractures, We will pay the highest two benefit amounts per Covered Accident. We pay 25% of the amount shown in the Schedule of Benefits for the closed reduction of a bone with a chip Fracture that was a result of a Covered Accident.

B442.0059

Hospital Admission We pay the amount shown in the Schedule of Benefits if a Covered Person is admitted to a Hospital within 180 days of a Covered Accident. This benefit is payable once per Covered Person per Covered Accident. If the Covered Person is admitted to a Hospital or a Hospital Intensive Care Unit for the same Covered Accident within 30 days of an Admission for which a benefit was payable, We will treat this later Admission as a continuation of the previous Admission and no additional benefit will be paid. If more than 30 days have passed between the periods of Hospital or Hospital Intensive Care Unit Admission, We will treat this later Admission as a new and separate Hospital or Hospital Intensive Care Unit Admission. This benefit is not payable for Emergency Room treatment, Outpatient Treatment, or a Hospital stay less than 20 hours in an observation unit, or when a charge for room and board is not made. We will not pay the Hospital Admission and Hospital Intensive Care Unit Admission benefits for the same Covered Accident. We will pay the higher of the Hospital Admission or the Hospital Intensive Care Unit Admission benefit if both occur on the same day for the same Covered Accident.

B442.0061

Hospital Confinement We pay the amount shown in the Schedule of Benefits if a Covered Person is confined to a bed in a Hospital as an Inpatient within 180 days of a Covered Accident. This benefit is payable up to 365 days per Covered Person per Covered Accident. This benefit is not payable for a Hospital stay less than 20 hours. We do not pay the Hospital Confinement or Hospital Intensive Care Unit Confinement benefit on the same day as the Hospital Admission or Hospital Intensive Care Unit Admission. We will pay the higher of the Hospital Confinement or Intensive Care Unit Confinement benefit if both occur on the same day.

B442.0062

Hospital Intensive Care Unit Admission We pay the amount shown in the Schedule of Benefits if a Covered Person is admitted directly to a Hospital Intensive Care Unit within 30 days of a Covered Accident. This benefit is payable once per Covered Person per Covered Accident. If the Covered Person is admitted to a Hospital or a Hospital Intensive Care Unit for the same Covered Accident within 30 days of an Admission for which a benefit was payable, We will treat this later Admission as a continuation of the previous Admission and no additional benefit will be paid. If more than 30 days have passed between the periods of Hospital or Hospital Intensive Care Unit Admission, We will treat this later Admission as a new and separate Hospital or Hospital Intensive Care Unit Admission. This benefit is not payable for Emergency Room treatment, Outpatient Treatment, or a Hospital stay less than 20 hours in an observation unit, or when a charge for room and board is not made. We will not pay the Hospital Admission and Hospital Intensive Care Unit Admission benefits for the same Covered Accident. We will pay the higher of the Hospital Admission or the Hospital Intensive Care Unit Admission benefit if both occur on the same day for the same Covered Accident.

B442.0063

Hospital Intensive Care Unit Confinement

We pay the amount shown in the Schedule of Benefits if a Covered Person is confined to a Hospital Intensive Care Unit within 30 days of a Covered Accident. This benefit is payable up to 15 days per Covered Person per Covered Accident. This benefit is not payable for a Hospital Intensive Care Unit stay less than 20 hours. We do not pay the Hospital Confinement or Hospital Intensive Care Unit Confinement benefit on the same day as the Hospital Admission or Hospital Intensive Care Unit Admission.

We will pay the higher of the Hospital Confinement or Intensive Care Unit Confinement benefit if both occur on the same day.

B442.0064

Initial Doctor's Office/Urgent Care Facility Treatment

We pay the amount shown in the Schedule of Benefits if a Covered Person is examined or treated by a Doctor in a Doctor's office or Urgent Care Facility for the initial treatment from a Covered Accident. The initial treatment must begin within 30 days after the Covered Accident. This benefit is payable once per Covered Person per Covered Accident. We will not pay the Emergency Room Treatment benefit and the Initial Doctor's Office/Urgent Care Facility benefit for the same Covered Accident.

B442.0065

Knee Cartilage

We pay the amount shown in the Schedule of Benefits if a Covered Person tears, ruptures or severs knee cartilage (meniscus) as the direct result of a Covered Accident and requires surgical repair. Treatment by a Doctor must begin within 60 days after the Covered Accident and be repaired through surgery within 365 days. This benefit is payable only once per Covered Person per Covered Accident.

B442.0067

Laceration

We pay the amount shown in the Schedule of Benefits if a Covered Person sustains a Laceration as a result of a Covered Accident, and it is repaired by a Doctor within 72 hours of the Covered Accident. The amount We pay will be based on the total length of all Lacerations received in any one Covered Accident which require repair. This benefit is payable once per Covered Person per Covered Accident for a Laceration:

- With no sutures; and
- Which requires sutures.

B442.0068

Lodging

We pay the amount shown in the Schedule of Benefits for a Companion's hotel/motel stay during the period of time a Covered Person is confined to the Hospital as the direct result of a Covered Accident. This benefit is payable up to 30 days per Covered Person per Covered Accident and is only payable while the Covered Person is confined to the Hospital. The Hospital must be more than 50 miles from the residence of the Covered Person.

B442.0069

Medical Appliance

We pay the amount shown in the Schedule of Benefits if a Doctor requires and prescribes an appliance for a Covered Person as a direct result of a Covered Accident.

An appliance includes wheelchairs; a brace for back, leg or neck; cane, crutches, walkers, and walking boots that extend above the ankle. We will not pay for casts, splints, slings or an arm/hand/wrist brace. The medical prescription for the appliance must begin within 90 days of a Covered Accident.

We limit what We pay for all Medical Appliances combined, per Covered Person per Covered Accident, to the amount shown in the Schedule of Benefits.

B442.0070

Outpatient Therapy

We pay the amount shown in the Schedule of Benefits if a Covered Person requires Cognitive Behavioral, Occupational, Physical, Respiratory, Speech or Vocational therapy due to a Covered Accident. Therapy must begin within the later of: (a) 60 days from the Covered Accident; or (b) 60 days from any required surgery. Therapy must be completed within 6 month(s), and be performed by a licensed Cognitive Behavioral, Occupational, Physical, Respiratory, Speech or Vocational Therapist. This benefit is payable up to 10 treatment(s) per Covered Person per Covered Accident.

B442.0071

Post-Traumatic Stress Disorder

We pay the amount shown in the Schedule of Benefits if a Covered Person is diagnosed with Post-Traumatic Stress Disorder (PTSD) that is triggered by a Covered Accident for which We paid a benefit. PTSD is a mental health condition, and for this benefit to be payable, it must meet the diagnostic criteria for PTSD, stipulated in the Diagnostic and Statistical Manual of Mental disorders IV (DSM IV-TR), or the most current version, and a Covered Person must be under the active care of either a psychiatrist or Ph.D.-level psychologist.

This benefit is payable only once per Covered Person per Covered Accident.

B442.0072

Prosthetic Device/Artificial Limb

We pay the amount shown in the Schedule of Benefits if a Covered Person receives one or more Prosthetic Devices/Artificial Limbs as prescribed by a Doctor for functional use due to the loss of a limb, hand, or foot as a direct result of a Covered Accident. The device or limb must be prescribed within 365 days of the Covered Accident and is payable once per Covered Person per Covered Accident. This benefit is not payable for hearing aids, dental aids (including false teeth), eyeglasses, or cosmetic prostheses such as hair wigs.

B442.0073

Reasonable Accommodation to Home or Vehicle

We pay the amount shown in the Schedule of Benefits if a Covered Person requires modification to his or her place of residence or vehicle if he or she suffers an Accidental Dismemberment or Catastrophic Loss due to a Covered Accident. The modification must be made within 2 year(s) of the Covered Accident and is payable once per Covered Person per Covered Accident.

B442.0074

Rehabilitation Facility Confinement

We pay the amount shown in the Schedule of Benefits if a Covered Person is confined to a Rehabilitation Facility due to a Covered Accident. This benefit is payable up to 15 days per Covered Person per Covered Accident but cannot exceed 30 days per calendar year. We will not pay the Rehabilitation Facility Confinement and the Hospital Confinement benefits for the same day.

B442.0075

Ruptured Disc with Surgical Repair

We pay the amount shown in the Schedule of Benefits if a Covered Person suffers a ruptured disc in his or her spine as a direct result of a Covered Accident. The ruptured disc must be treated by a Doctor within 60 days of the Covered Accident and be surgically repaired within 365 days of the Covered Accident. This benefit is payable once per Covered Person per Covered Accident.

B442.0076

Surgery (cranial, open-abdominal, thoracic, hernia)

We pay the amount shown in the Schedule of Benefits if a Covered Person undergoes cranial, open-abdominal, thoracic, or hernia surgery as a direct result of a Covered Accident. Cranial, open-abdominal, and thoracic surgery must be performed within 72 hours from the initial treatment from the Covered Accident. Hernia surgery must be diagnosed within 30 days of Covered Accident and surgery must be performed within 60 days from the initial treatment from the Covered Accident. If more than one surgery is performed, We pay the benefit with the highest dollar amount. Surgeries can be performed in a Hospital, Emergency Room, Doctor's Office or an appropriate outpatient facility. This benefit is payable once per Covered Person per Covered Accident.

B442.0077

Surgery (Exploratory and Arthroscopic)

We pay the amount shown in the Schedule of Benefits if a Covered Person undergoes exploratory or arthroscopic surgery as a direct result of a Covered Accident. The surgery must take place within 60 days from the initial treatment from the Covered Accident. Surgeries can be performed in a Hospital, Emergency Room, Doctor's Office or an appropriately licensed outpatient facility. Hernia repair is not covered under this benefit. This benefit is not payable if the Surgery or Tendon/Ligament/Rotator Cuff benefits are payable for the same surgery. This benefit is payable once per Covered Person per Covered Accident.

B442.0078

Tendon / Ligament / Rotator Cuff

We pay the amount shown in the Schedule of Benefits if a Covered Person sustains a torn, ruptured or severed tendon, ligament, or rotator cuff as the direct result of a Covered Accident. Treatment must be initiated within 60 days of the Covered Accident and the condition must be repaired through surgery within 365 days of the Covered Accident. Surgery can be performed in a Hospital, Emergency Room, Doctor's Office or an appropriate outpatient facility. This benefit is payable once per Covered Person per Covered Accident.

B442.0079

Transportation We pay the amount shown in the Schedule of Benefits if a Covered Person must travel more than 50 miles one way to receive special treatment at a Hospital or free standing treatment facility as a direct result of a Covered Accident. The treatment must be prescribed by a Doctor and not available locally. This benefit is payable 3 times per Covered Person per Covered Accident and is not payable if Transportation is provided by Ambulance or Air Ambulance.

B442.0080

Traumatic Brain Injury We pay the amount shown in the Schedule of Benefit if a Covered Person is diagnosed with a Traumatic Brain Injury which is a direct result of a Covered Accident.

A Traumatic Brain Injury is a nondegenerative, non-congenital injury to the brain from an external non-biological force, requiring Hospital Confinement for 48 hours or more, and resulting in a permanent neurological deficit with significant loss of muscle function and persistent clinical symptoms. Traumatic Brain Injury must be positively diagnosed by a Doctor based upon documented neurological deficits and confirmatory neuroimaging studies.

A Concussion is not a Traumatic Brain Injury.

If a Coma and Traumatic Brain Injury result from the same Covered Accident, We will pay the higher amount.

This benefit is payable once per Covered Person per Covered Accident.

B442.0081

X-Ray We pay the amount shown in the Schedule of Benefits if a Covered Person receives a series of X-Rays as the direct result of a Covered Accident. The X-rays must be prescribed by a Doctor and performed in a Doctor’s office or a Hospital or an Urgent Care Facility on an Inpatient or outpatient basis and performed within 90 days of the Covered Accident. This benefit is payable once per Covered Person per Covered Accident. By "series", we mean one or more X-rays performed within a 24-hour period.

B442.0082

ACCIDENT CLAIM PROVISIONS

The Covered Person's right to make a claim for Group Accident Insurance Benefits provided by this Certificate is governed as follows:

Administration: We have the responsibility to fairly, thoroughly, objectively and timely investigate, evaluate and determine a Covered Person's eligibility for benefits under this Certificate.

We will:

- Obtain only such information that is necessary to evaluate a claim for benefits. This information will be obtained as set forth herein with respect to Notice and Proof of Loss.
- Consider and interpret the terms of this Certificate and all information obtained by Us and submitted that relates to a claim for benefits and make a determination based on that information and in accordance with the terms of this Certificate and applicable state law.
- If a claim is approved, review the determination as often as is reasonably necessary to determine continued eligibility for benefits.
- If a claim is denied, provide the claimant, within a reasonable period of time, a written notification of an adverse determination. Such notification will include the specific reason(s) for the adverse determination.

Notice: Written Notice of intent to file a claim under this Certificate must be sent to Us within 30 days of the date of the loss. This Notice should include the name of the Covered Person and the Policy number. For details, the Covered Person can call Us at 1-800-268-2525. We will not void or reduce a claim if We do not receive Notice within the required time. Notice must be sent as soon as reasonably possible.

Proof of Loss: The Covered Person must send written Proof of Loss to Our designated office within 90 days of the loss. We will not void or reduce a claim if We do not receive Proof of Loss within the required time. Proof of Loss must be sent as soon as reasonably possible and in no event, except in the absence of legal capacity, later than one year from the time proof is otherwise required.

Claim Forms: We will furnish forms within 15 days for filing Proof of Loss or Proof of death. If the Covered Person does not receive such forms before the expiration of 15 days after We receive Notice of claim under this Certificate, the Covered Person shall be deemed to comply with the requirements of the Certificate. We will accept a written Notice and adequate Proof of Loss or Proof of death that is the basis of the claim. The Covered Person must detail the nature and extent of the loss for which the claim is being made.

Proof of Loss and other claim data should be submitted to:

The Guardian Life Insurance Company of America
Group Accident Claims Department
P.O. Box 14315
Lexington, KY 40512

GC-ACC-18-TX

Payment Of Benefits: We will pay Accident 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 Accident benefits to the Covered Person if living.

If the Covered Person is not living, We have the right to pay all Accident benefits to one of the following: estate; Spouse; parent; child; or brother or sister of the Covered Person.

All benefits payable under this Certificate will be paid not later than 60 days after the Proof of Loss is received by Us.

Change of Beneficiary: If the Covered Person has named a beneficiary, the beneficiary designation should be maintained by Your Employer. The Covered Person has the right to change the beneficiary.

Legal Actions: No legal action against Guardian related to this Certificate may be brought until 60 days from the date Proof of Loss has been given as shown above. No legal action may be brought against Guardian related to claims for benefits under this Certificate after 3 years from the date on which written Proof of Loss is required to be filed.

Workers' Compensation: The Accident benefits provided by this Certificate are not in place of and do not affect requirements for coverage by Workers' Compensation.

B401.3086

EXCLUSIONS

This Certificate will not pay benefits for any Injury or Accident caused by, or related directly or indirectly to:

- Disease, mental infirmity or medical or surgical treatment.
- Voluntary use of any poison, chemical, prescription or non-prescription drug or controlled substance unless:
  - (1) it was prescribed for a Covered Person by a Doctor, and
  - (2) it was used as prescribed. In the case of a non-prescription drug, this Certificate does not pay for any Accident resulting from or contributed to or by use in a manner inconsistent with package instructions. "Controlled substance" means anything called a controlled substance in Title II of the Comprehensive Drug Abuse Prevention and Control Act of 1970, as amended from time to time.
- The Covered Person being legally intoxicated.
- Declared or undeclared war, act of war, or armed aggression.
- Service in the armed forces, National Guard, or military reserves of any state or country.
- Taking part in a riot or insurrection.
- Participation in the commission of a felony.
- Intentional self-inflicted Injury.
- Suicide or attempted suicide.
- Travel or flight in any kind of aircraft, including any aircraft owned by, or for the, Covered Person, except as a fare-paying passenger on a Common Carrier.
- Participation in any kind of sporting activity for compensation or profit, including coaching or officiating.
- Riding in, or driving any motor-driven vehicle in a race, stunt show or speed test.
- Participation in hang gliding, bungee jumping, sail gliding, parasailing, parakiting, ballooning, parachuting, zorbing or skydiving.
- An Accident that occurs before the Covered Person is covered by this Certificate.
- Injuries to a dependent child received during birth.

B401.3226

DEFINITIONS

This section defines certain terms appearing in Your Certificate.

B442.0088

Accident: This term means an event or occurrence that was not reasonably foreseeable, or that could not have been reasonably expected or anticipated. The term Accident does not include a sickness.

B401.3089

Accidental Death: This term means death caused by an Accident independent of bodily infirmity, or any other cause and which is not excluded under the Exclusions section.

B401.3090

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

B442.0091

Catastrophic Loss: This term means the aggregate impact of loss or loss from, but not limited to, the following: a loss of cognitive function, loss of speech and hearing (both ears), a quadriplegia, hemiplegia or paraplegia.

B442.0093

Certificate: This term means the Guardian group Accident insurance plan that covers You and Your dependents, if insured.

B442.0094

Chiropractic Care Services: This term means spinal manipulation by a licensed chiropractor to correct a structural imbalance caused by a Covered Accident. This does not include services for massage therapy or treatment of chronic conditions or other Injuries not related to structural imbalance.

B442.0096

Cognitive Behavioral Therapist: This term means a person who: 1) has a Masters or Doctoral degree in psychology, counseling, social work, psychiatry, or related field; 2) is certified by The National Association of Cognitive-Behavioral Therapists; 3) performs services which are allowed by his or her certificate; and 4) performs services for which benefits are provided by this Certificate.

B401.3104

Cognitive Behavioral Therapy (CBT): This term means a type of psychotherapy. CBT helps one become aware of inaccurate or negative thinking in order to view challenging situations, such as recovering from an Accident, more clearly and respond to them in a more effective way.

B442.0098

Coma: This term means a state of complete mental unresponsiveness, due to Injury, with no evidence of appropriate responses to stimulation, as diagnosed by a Doctor.

B442.0099

Common Carrier: This term means any land, air or water conveyance operated under a license to transport passengers for hire.

B442.0100

Companion: This term means a Spouse, domestic partner, civil union partner, sibling, child, parent, grandparent, or any primary caregiver.

B442.0101

Covered Accident: This term means an Accident that:

- Occurs while a Covered Person's coverage under this Certificate is in effect;
- Results in a bodily Injury; and
- Is not otherwise excluded under the terms of this Certificate.

B442.0102

Covered Person: This term means the Employee or dependent insured by this Certificate.

B442.0134

Dentist: This term means a licensed Dentist, operating within the scope of his or her license, in the state in which he or she is licensed.

B442.0104

Dislocation: This term means a completely separated joint due to an Injury. A partial Dislocation means the joint is misaligned but not completely dislocated, as diagnosed by a Doctor.

B442.0105

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

B442.0106

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

B442.0135

Emergency Room: This term means a department of the Hospital that is designated for emergency care. This area must be staffed and equipped to handle trauma, be supervised and provide treatment by Doctors, and provide care seven days per week, 24 hours per day.

B442.0109

Employee: This term means a person who works for the Employer and whose income is reported to the United States Internal Revenue Service, and/or a state, for tax purposes.

B442.0110

Employer: This term means the entity that purchased the Policy.

B442.0111

Epidural Anesthesia: This term means a form of regional anesthesia involving injection of drugs through a catheter placed into the epidural space. The epidural must be administered due to a Covered Accident and does not include treatment for childbirth or diseases.

B442.0112

Fracture: This term means a partial or complete break of a bone that can be determined by a diagnostic exam. A chip Fracture is a Fracture in which a piece of the bone is broken off near a joint at a place where a ligament is usually attached.

B442.0113

Full-Time: This term means You regularly work at least the number of hours in the normal work week set by the Employer for Full-Time work at: (1) Your Employer's place of business: (2) some place where the Employer's business requires You to travel; or (3) any other place You and Your Employer have agreed upon for the performance of occupational duties.

B442.0114

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

- Is primarily engaged in providing, by or under the continuous supervision of Doctors, to Inpatients diagnostic services and therapeutic services for diagnosis, treatment and care of sick or injured persons;
- Has organized departments of medicine and major surgery;
- Has a requirement that every patient must be under the care of a Doctor or Dentist;
- Provides 24 hour nursing service by or under the supervision of a registered professional nurse (R.N.);
- Is duly licensed by the agency responsible for licensing such Hospitals; and
- Is not, other than incidentally: (a) a place of rest; (b) a place primarily for the treatment of tuberculosis; (c) a place for the aged; (d) a place for drug addicts or alcoholics; or (e) a place for convalescent, custodial, educational or rehabilitative care.

B442.0115

Hospital Intensive Care Unit: This term means a designated area of a Hospital that:

- Provides the highest quality of medical care and is restricted to patients who are critically ill or injured and who require intensive comprehensive observation and care;
- Is separate and apart from the surgical recovery room and from rooms, beds, wards, and units customarily used for patient confinement;
- Is permanently equipped with special lifesaving equipment for the care of the critically ill or injured;

Is under continuous observation by a specially trained nursing staff assigned exclusively to the intensive care unit on a 24 hour basis and is assigned a Doctor on a full-time basis.

B442.0116

Injury: This term means unintentional physical damage or harm caused directly by an Accident and not due to disease or any other causes. The Injury must occur while a Covered Person is insured under this Certificate.

B401.3105

Inpatient: This term means a patient who is admitted to a Hospital.

B442.0118

Occupational Therapist: This term means a person who: 1) possesses the designation "Occupational Therapist, Registered (OTR)"; 2) is licensed by the state to practice Occupational Therapy; 3) performs services which are allowed by his or her license; and 4) performs services for which benefits are provided by this Certificate.

B401.3106

Occupational Therapy: This term means the treatment of a person by means of constructive activities designed and adapted to promote the restoration of a Covered Person’s ability to satisfactorily accomplish the ordinary tasks of daily living, and those tasks required by a Covered Person’s particular occupational role. Occupational Therapy does not include diversional, recreational, vocational therapies (i.e. hobbies, arts and crafts).

B442.0120

Organized Sport This term means a sport activity that is governed by an organization and requires formal registration to participate. Proof of registration will be required at claim time.

B442.0121

Outpatient Treatment: This term means medical services that a Covered Person receives when not confined as an Inpatient in a Hospital.

B442.0122

Physical Therapist: This term means a person who: 1) is licensed by the state to practice Physical Therapy; 2) performs services which are allowed by his or her license; 3) performs services for which benefits are provided by this Certificate and 4) practices according to the code of ethics of the American Physical Therapy Association.

B401.3108

Physical Therapy: This term means treatment by physical means, hydrotherapy, heat, or similar modalities, physical agents, bio-mechanical and neuro-physiological principles and devices. Such therapy is given to relieve pain, restore function, and to prevent disability following Injury or loss of a body part.

B442.0125

Policy: This term means the Guardian Group Accident Insurance Policy purchased by the Policyholder.

B442.0126

Rehabilitation Facility: This term means an appropriately licensed facility or separate section of a Hospital that provides rehabilitation care services on an Inpatient basis and is designated, staffed and equipped to provide restorative services under the supervision of a trained and experienced rehabilitation Doctor. A Rehabilitation Unit is not: a nursing home; an extended care facility; a skilled nursing facility; a rest home or home for the aged; a hospice care facility; a place for alcoholics or drug addicts; or an assisted living facility.

B442.0127

Respiratory Therapist: This term means a person who: 1) is a specialized healthcare practitioner trained in pulmonary medicine in order to work therapeutically with people suffering from pulmonary disease; 2) has graduated from a technical college with a certification in Respiratory Therapy; 3) has passed a national board certifying examination and performs services which are allowed by his or her certification; and 4) performs services which are covered by this Certificate. The NBRC (National Board for Respiratory Care) is the not for profit organization responsible for credentialing the seven areas of Respiratory Therapy.

B401.3107

Respiratory Therapy: This term means exercises and treatments that help patients recover lung function, such as after surgery.

B442.0136

Spouse: This term means the person to whom You are legally married, as recognized and allowed by federal law, or state law in Your state of residence or the state in which the marriage was recorded.

B442.0137

Urgent Care Facility: This term means a health care facility that is organizationally separate from a Hospital and whose primary purpose is the offering and provision of immediate, short-term medical care, without appointment, for urgent care.

B442.0131

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

B442.0132

You or Your: These terms mean the insured Employee.

B442.0133

SCHEDULE OF BENEFITS

EMPLOYEE ACCIDENT COVERAGE

This Schedule of Benefits is attached to the Certificate and is effective the later of: 1) the Policy Effective Date or; 2) the Effective Date of any amendment. This Schedule of Benefits replaces any previously issued Schedule of Benefits.

For more details regarding limitations and the number of benefit payments per Covered Accident please refer to the ACCIDENT BENEFITS section of the Certificate.

Accident Benefit	**Benefit Levels**
Accidental Death	Yourself: $50,000.00 Your Spouse: $20,000.00 Your Children: $10,000.00
Accidental Death Common Carrier	200% of the Accidental Death benefit amount
Accidental Death Common Disaster	200% of the Spouse Accidental Death benefit amount
Accidental Dismemberment	Loss of a hand, foot or sight: 50% of Accidental Death benefit. **Multiple Losses of hand, foot or sight:** For more than one covered loss due to the same Accident, We will pay 100% of the Accidental Death benefit. Loss of thumb and index finger of same hand, or loss of four fingers of same hand: 25% of Accidental Death benefit. Loss of all toes of same foot: 25% of Accidental Death benefit. We will not pay more than $50,000.00 for all losses due to the same Covered Accident.
Accidental Death Seatbelt and Airbag benefit	Seatbelt: $10,000.00 Seatbelt and Airbag: $15,000.00
Air Ambulance	$1,000.00
Ambulance	$200.00
Blood/Plasma/Platelets	$500.00
Burn	**2nd Degree** From 18 sq inches up to 34 sq inches: $1,250.00 35 sq inches and over: $3,750.00

	3rd Degree From 9 sq inches to 17 sq inches: $2,500.00 From 18 sq inches to 34 sq inches: $5,000.00 35 sq inches and over: $15,000.00
Burn-Skin Graft	50% of burn benefit
Catastrophic Loss	Quadriplegia: 100% of Accidental Death benefit Loss of speech and hearing (both ears): 100% of Accidental Death benefit Loss of cognitive function: 100% of Accidental Death benefit Hemiplegia: 50% of Accidental Death benefit Paraplegia: 50% of Accidental Death benefit
Child Organized Sport (applies only to covered dependent children age 18 or younger)	Additional 25% of payable benefits
Chiropractic Visits	$50.00 per visit
Coma	$12,500.00
Concussions	$200.00
Concussion Baseline Study (applies only to covered dependent children age 18 or younger	$25.00
Dislocations	**Closed/Open**
● Hip	$4,000.00/$8,000.00
● Knee	$2,600.00/$5,200.00
● Shoulder	$2,000.00/$4,000.00
● Collar bone (sternoclavicular)	$800.00/$1,600.00
● Collar bone (acromioclavicular and separation)	$160.00/$320.00
● Ankle or Foot	$1,600.00/$3,200.00
● Lower jaw	$1,200.00/$2,400.00
● Wrist or elbow	$1,000.00/$2,000.00
● Toe or finger	$320.00/$640.00
● Bones of the hand	$1,400.00/$2,800.00
Diagnostic Exam (Major)	$200.00
Doctor Follow-Up Visit	$100.00

Emergency Dental Work	Crown: $300.00 Extraction: $75.00
Emergency Room Treatment	$200.00
Epidural Anesthesia Pain Management	$100.00
Eye Injury	$400.00

Fractures	**Closed/Open**
● Skull (depressed)	$3,750.00/$7,500.00
● Skull (non-depressed)	$1,750.00/$3,500.00
● Hip, Thigh (femur)	$5,000.00/$10,000.00
● Vertebrae, body of (excluding vertebrae processes)	$3,600.00/$7,200.00
● Pelvis	$4,000.00/$8,000.00
● Leg	$3,000.00/$6,000.00
● Bones of the face or nose	$1,500.00/$3,000.00
● Upper jaw, maxilla	$1,750.00/$3,500.00
● Upper arm (humerus)	$1,750.00/$3,500.00
● Lower jaw, mandible	$2,000.00/$4,000.00
● Shoulder blade	$2,000.00/$4,000.00
● Vertebral process	$1,000.00/$2,000.00
● Forearm	$2,500.00/$5,000.00
● Kneecap	$2,000.00/$4,000.00
● Foot (except toes)	$2,000.00/$4,000.00
● Ankle	$2,000.00/$4,000.00
● Rib	$400.00/$800.00
● Coccyx	$400.00/$800.00
● Finger, toe	$400.00/$800.00
Hospital Admission	$2,000.00
Hospital Confinement	$400.00 per day
Hospital ICU Admission	$4,000.00
Hospital ICU Confinement	$800.00 per day
Initial Doctor's Office/Urgent Care Facility Treatment	$100.00
Knee Cartilage	$1,000.00
Laceration	No sutures required: $80.00

	Lacerations 4cm or less: $120.00 Lacerations 5cm up to 14 cm: $400.00 Lacerations 15cm or more: $800.00
Lodging	$200.00 per day
Medical Appliance	**Limit for all Medical Appliances combined, per Covered Person, per Covered Accident is $600.00**
● Brace for back, leg or neck	$100.00
● Cane	$50.00
● Crutches	$50.00
● Walker	$200.00
● Walking Boot	$100.00
● Wheel Chair or Motorized Scooter	$250.00
● Other medical device used for mobility	$50.00
Outpatient Therapy	$50.00 per day
Post-Traumatic Stress Disorder	$500.00
Prosthetic Device/Artificial Limb	One: $1,000.00 Two or more: $2,000.00
Reasonable Accommodation to Home or Vehicle	$2,500.00
Rehabilitation Facility Confinement	$150.00 per day
Ruptured Disc With Surgical Repair	$750.00
Surgery - cranial, open abdominal, thoracic hernia	Cranial, open abdominal, thoracic: $2,000.00 Hernia: $400.00
Surgery - Exploratory or Arthroscopic	$200.00
Tendon/Ligament/Rotator Cuff	One: $750.00 Two or more: $1,500.00
Transportation	$.50 per mile, limited to $600.00 per round trip
Traumatic Brain Injury	$2,500.00
X-ray	$30.00

Changes To Coverage

Changes in Coverage Amounts

If You are not Actively At Work on a Full-Time basis, any change in Your amount of coverage or the amount of coverage on a covered dependent will not become effective prior to the date You return to Active Work on a Full-Time basis.

Changes in Insurance Classification

If Your classification changes, coverage will not be changed to the new amount until the first day on which You are: (1) Actively At Work on a Full-Time basis; and (2) make a contribution, if required, for the new classification.

If a contribution is required for the new classification for which a larger amount of coverage is provided, You must make the required contribution for the new amount within 31 days of the change.

B442.0489

CERTIFICATE RIDER - Wellness Benefit

This Rider is effective as of the effective date of the Employee's Certificate. If this Rider is added to an inforce Certificate, the Rider becomes effective on its issue date. This Rider amends the Certificate By the addition of the following:

This Rider will pay a benefit if a Covered Person has one of the following wellness tests or procedures performed while the Accident coverage is in force. This Rider pays this benefit regardless of the results of the test or procedure. Wellness tests or procedures are limited to:

- Abdominal aortic aneurysm ultrasonography
- Blood test for triglycerides
- Bone marrow testing
- Bone density screening
- Breast ultrasound
- CA 15-3(blood test for breast cancer)
- CA125(blood test for ovarian cancer)
- Cancer genetic mutation test
- Carotid ultrasound
- CEA (blood test for colon cancer)
- Chest x-ray
- Colonoscopy
- Completion of a smoking cessation program
- Completion of a weight reduction program
- Double contrast barium enema
- EKG
- Fasting blood glucose test
- Flexible sigmoidoscopy
- Hemoccult stool analysis
- Immunizations
- Lymphocyte Genome Sensitivity test (LGS)
- Mammography
- Pap smear
- PSA (blood test for prostate cancer)
- Registration of a covered dependent child age 18 or younger for an organized sport

- Routine/annual physical
- Serum cholesterol test to determine level of HDL and LDL
- Serum Protein Electrophoresis (blood test for myeloma)
- Skin cancer biopsy
- Stress test on a bicycle or treadmill
- Thermography
- ThinPrep pap test
- Virtual colonoscopy

The Wellness Benefit is $50.00.

The Covered Person must submit proof of the test, procedure or registration.

We limit what We pay to 1 Wellness Benefit(s) per Covered Person per calendar year.

The calendar year limits above apply inclusively to any combination of Accident, Critical Illness or Hospital Indemnity Wellness/Health Screening benefit provided by Us for which each Covered Person is insured.

The Wellness Benefit does not qualify for additional limits or payments under this Certificate's Rainy Day Fund, if this Rider is also included with this Certificate.

A Covered Person is an Employee or any of his or her covered dependents.

If You port Your Accident coverage, and the Wellness Benefit was already paid in the same calendar year under this Rider, the Wellness Benefit will not be paid again in that calendar year under the ported certificate.

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

The Guardian Life Insurance Company of America

Michael Prestileo, Senior Vice President

B442.0565

GC-R-ACC-WELL-18

CERTIFICATE RIDER - Rainy Day Fund

This Rider is effective as of the effective date of the Employee's Certificate. If this Rider is added to an inforce Certificate, the Rider becomes effective on its issue date. This Rider amends the Certificate by the addition of the following:

Rainy Day Fund

The "Rainy Day Fund" provides a Covered Person with additional benefits when he or she has exhausted a benefit frequency limitation, which applies to a particular benefit, as shown in the Certificate's Schedule of Benefits and/or the Accident Benefits section of the Certificate.

Each Benefit Year, the Rainy Day Fund is available to extend a benefit which the Covered Person has exhausted due to a frequency limitation in that Benefit Year.

We will pay from the Rainy Day Fund, the amounts shown in the Certificate's Schedule of Benefits, for each covered benefit or service. However, We limit what We pay to the amount remaining in the Covered Person's Rainy Day Fund.

Benefit Amounts

Initial Rainy Day Fund Amount: $500.00

Rainy Day Rollover Maximum: $250.00

Rainy Day Fund Maximum: $1,000.00

Each Covered Person starts each Benefit Year with at least the Initial Rainy Day Fund Amount in their Rainy Day Fund. Each Benefit Year, we will use the fund to pay claims until it's exhausted. If, at the end of a Benefit Year, all available funds are not used to pay claims, the remaining amount is rolled over to the next Benefit Year, subject to the Rainy Day Rollover Maximum. The amount rolled over is added to the greater of the next Benefit Year's Initial Rainy Day Fund Amount or the remaining amount at the end of the Benefit Year. However, we limit the amount in each Covered Person's Rainy Day Fund to the Rainy Day Fund Maximum.

By Covered Person, We mean You, as an Employee covered under this Rider or Your covered dependent Spouse or child.

Benefit Year means a 12 month calendar year.

The Rainy Day Fund does not apply to the following benefits, if these benefits are shown in this Certificate, including any Riders:

- Burn;
- Burn Skin Graft;
- Coma;
- Concussion;

- Concussion Baseline Study;
- Disability;
- Dislocations;
- Emergency Room Treatment;
- Hospital Admission/Hospital ICU Admission;
- Hospitalization for Sickness;
- Initial Doctor's Office/Urgent Care visit;
- Laceration;
- Medical Appliance;
- Post-Traumatic Stress Disorder;
- Prosthetic Device;
- Tendon/Ligament/Rotator Cuff;
- Traumatic Brain Injury;
- Wellness.

If a Covered Person ports Accident coverage, his or her Rainy Day Fund balance under this Rider is transferred to the ported certificate.

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

The Guardian Life Insurance Company of America

Michael Prestileo, Senior Vice President

B442.2100

GC-R-ACC-RDF-20

CERTIFICATE RIDER - Portability Privilege

This Rider is effective as of the effective date of the Employee's Certificate. If this Rider is added to an inforce Certificate, the Rider becomes effective on its issue date. This Rider amends the Certificate by the addition of the following:

Portability Privilege

As used in this Rider, the terms "Port" and "to Port" mean to choose a Portable Certificate of Coverage which provides Group Accident coverage. Portability is subject to all the conditions described below.

- You may Port Your own coverage, and coverage for any of Your dependents, if coverage under this Policy and Certificate ends because You:
  - Have terminated employment;
  - Stop being a member of an eligible class of Employees; or
  - Have terminated or lost coverage under the Group Accident Policy and Certificate.
- You may not Port Your coverage, or coverage for any of Your dependents, if coverage under this Policy and Certificate ends due to failure to pay any required premium.

Portability Options

You may Port:

- Your coverage only;
- Your coverage and the coverage of your Spouse;
- Your coverage and the coverage of all of Your dependents;
- Your coverage and the coverage of all of Your dependent child(ren), if You are a single parent;

No other combinations will be allowed.

A dependent must be covered as of the date Your coverage under this Policy and Certificate ends in order to be eligible to Port.

If You die while covered for Group Accident coverage, Your Spouse may Port the dependent coverage on behalf of himself or herself, and the dependent child(ren). The Spouse and dependent child(ren) must be covered under this Policy and Certificate on the date of Your death. This option is not available if there is no surviving Spouse.

How to Port Coverage

You or Your surviving Spouse or dependent child(ren) must:

- Apply to Us in writing; and
- Pay the required premium.

You or Your surviving Spouse or dependent child(ren) must do this within 31 days from the date Your coverage under this Policy and Certificate ends.

We will not ask for proof that You or Your surviving Spouse or dependent child(ren) are in good health.

The Portable Certificate of Coverage

The Portable Certificate of Coverage provides Group Accident coverage. The premium for the Portable Certificate of Coverage will be based on Your rate class under this Policy and Certificate or Your surviving Spouse's rate shown in the Accident Portability Coverage Premium Notice.

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

The Guardian Life Insurance Company of America

Michael Prestileo, Senior Vice President

B401.3102

GC-R-ACC-PORT-18-TX

CERTIFICATE AMENDATORY RIDER - Telemed

This Rider is effective as of the effective date of the Employee's Certificate. If this Rider is added to an inforce Certificate, the Rider becomes effective on its issue date.

This Rider amends the Certificate by replacing the **Doctor Follow-Up Visit** provision in the **Accident Benefits** section as shown below.

Doctor Follow-Up Visit: We pay the amount shown in the Schedule of Benefits if a Covered Person requires additional follow up treatments (not including Outpatient Therapies) after initial Emergency Room treatment or Initial Doctor's Office/Urgent Care Facility Treatment. This benefit is payable to a Covered Person for up to 6 treatments per Covered Accident. The follow-up treatment must be provided by a Doctor in a Doctor's office, through Telemedicine Services, or in a Hospital on an outpatient basis. Treatment must begin within 60 days from initial treatment from a Covered Accident and be completed within 365 days.

This Rider also amends the **Definitions** section of the Certificate by adding the definition shown below.

Telemedicine Services: A medical inquiry with a Doctor via the use of telecommunication and information technologies (including, but not limited to, audio or video communications) for the Covered Person's evaluation, diagnosis, or treatment as would be practiced in person. This does not include requests for prescription refills, test results or medical records.

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

The Guardian Life Insurance Company of America

Michael Prestileo, Senior Vice President

B442.2096

GC-A-TELEMED2.0-20

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

STATEMENT OF ERISA RIGHTS

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

Your group accident insurance benefits may be covered by the Employee Retirement Income Security Act of 1974 (ERISA). If so, you are entitled to certain rights and protections under ERISA.

ERISA provides that all plan participants shall be entitled to:

Receive Information about Your Plan and Benefits

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

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

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

Prudent Actions by Plan Fiduciaries

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

Enforcement of Your Rights

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

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

Assistance with Questions

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

B442.0581

Accident Insurance Claims Procedure

If you seek benefits under the plan you should complete, execute and submit a request for claim. Instructions for filing claims may be obtained from The Guardian Life Insurance Company of America (hereinafter referenced as Guardian.)

Guardian is the Claims Fiduciary with the authority to interpret and construe the terms of the Policy, the Certificate, the Schedule of Benefits, and any riders, or other documents or forms that may be attached to the Certificate or the Policy, and any other plan documents. Guardian has the authority to determine eligibility for benefits and coverage under those documents. Guardian has the right to secure independent professional healthcare advice and to require such other evidence as needed to decide your claim.

In addition to the basic claim procedure explained in your Certificate, Guardian will also observe the procedures listed below. These procedures are the minimum requirements for benefit claims procedures of employee benefit plans covered by Title 1 of ERISA.

Definitions

"Adverse determination" means a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit, including any such denial, reduction, termination, or failure to provide or make payment that is based on a determination of a participants or beneficiarys eligibility to participate in a plan.

Timing for Initial Benefit Determination of Accident Insurance Claims

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

Guardian will provide a benefit determination not later than 90 days from the date of receipt of a claim. This period may be extended by up to 90 days if Guardian determines that an extension is necessary due to special circumstances, and so notifies the claimant before the end of the initial 90-day period. Such notification will include the reason for the special circumstances requiring the extension and a date by which the determination is expected to be made.

A notification of an extension to the time period in which a benefit determination will be made will include an explanation of the standards upon which entitlement to a benefit is based, any unresolved issues that prevent a decision of the claim, and the additional information needed to resolve those issues.

Adverse Benefit Determination of Accident Insurance Claims

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

- The specific reason(s) for the adverse determination;
- References to the specific provisions in the Policy, Certificate, plan or other documents, on which the determination is based;
- A description of any additional material or information needed to perfect the claim, and an explanation of why such material or information is necessary;
- A description of the plan’s claim review procedures which a claimant may follow to have a claim for benefits reviewed and the time limits applicable to such procedures; and
- A description of the plan’s review procedures and the time limits applicable to such procedures, including a statement of the claimant’s right to bring a civil action under ERISA Section 502(a) following an adverse benefit determination on review.

B442.0582

Appeals of Adverse Determinations of Accident Insurance Claims

If a claim is wholly or partially denied, you will have up to 60 days to make an appeal. Guardian will conduct a full and fair review of an appeal which includes providing to claimants the following:

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

In reviewing an appeal, Guardian will notify the claimant of its decision not later than 60 days after receipt of the request for review of the adverse determination. This period may be extended by an additional period of up to 60 days if Guardian determines that special circumstances require an extension of the time period for processing and so notifies the claimant before the end of the initial 60-day period.

A notification with respect to an extension will indicate the special circumstances requiring an extension of the time period for review, and the date by which the final determination will be made. In the event Guardian denies the appeal of an adverse benefit determination, it will:

- Provide the specific reason or reasons why the appeal was denied;
- Refer to the specific provisions in the Policy, Certificate, plan, or other documents on which the benefit determination is based;
- Provide a statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of all documents, records, and other information relevant to the claimants claim for benefits.

Alternative Dispute Options

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

B442.0583

CERTIFICATE RIDER

This Rider amends this plan to provide additional services as described below.

ADDITIONAL NON-INSURANCE SERVICES

Guardian has arranged to make available, at the policyholder's option, selected services for eligible Guardian policyholders and/or covered persons to receive certain services from third party vendors in addition to the insurance coverage.

The services identified below, and agreed to by the providers of these services, are not provided by Guardian. Guardian receives no fee from the respective vendors to make available the selected services. Further, Guardian will not be liable for the negligent provision of services by third party vendors.

Policyholders and/or covered persons will be provided with complete details about available services and a telephone number to call with questions about the service.

The policyholder and covered Persons will be provided the following service(s):

- Travel Services - provides an emergency response network of global resources which includes medical centers, specialized security resources and approved air ambulances for when a person travels overseas. There is no additional charge above the premium to the covered person for these services.

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

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

Guardian reserves the right to terminate, modify or replace any program at any time. We will give You 60 days advance notice of any service discontinuation.

The Guardian Life Insurance Company of America

Michael Prestileo, Senior Vice President

B601.0137

CGP-3-A-VAP-AH-17-TX

CERTIFICATE OF COVERAGE

The Guardian
10 Hudson Yards
New York, New York 10001

The group Hospital Indemnity coverage described in this Certificate is attached to the group Policy effective September 1, 2018. This Certificate replaces any Certificate previously issued under this Plan or under any other Plan providing similar or identical benefits issued to the Policyholder by Guardian.

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 diseases 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 your state insurance department or state senior insurance counseling program.

This is a limited plan of Hospital Indemnity insurance. It is a supplement to health insurance. It is not a substitute for hospital or medical expense insurance, a health maintenance organization (HMO) contract, or major medical expense insurance. Please read this Plan carefully to fully understand what it covers, limits, and excludes. This Certificate does not meet the Federal requirement for health care coverage under the Affordable Care Act.

GROUP HOSPITAL INDEMNITY COVERAGE

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

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

Policyholder: UPLIFT EDUCATION

Group Policy Number: 00551834

The Guardian Life Insurance Company of America

Michael Prestileo, Senior Vice President

B045.0399

GC-HI-15-TX-ER

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DEFINITIONS

The terms shown below have the meaning given in this section. Whenever used throughout this Certificate, they will be capitalized. Additional terms may be defined within the provision to which they apply.

B005.0526

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

B045.0405

Benefit Year: This term means a 12 month period which starts on September 1st and ends on August 31st.

B005.0695

Complications of Pregnancy: This term means:

(1) Conditions requiring Confinement to a Hospital or treatment in an Outpatient Surgery facility (when the pregnancy is not terminated) whose diagnoses are distinct from pregnancy, but are adversely affected by, or caused by, pregnancy, including but not limited to: non-scheduled cesarean section, acute nephritis, nephrosis, cardiac decompensation, hyperemesis gravidarum, pre-eclampsia, missed abortion, and similar medical and surgical conditions of comparable severity.

(2) Termination of ectopic pregnancy and spontaneous termination of pregnancy occurring during a time that a viable birth is not possible.

Complications of Pregnancy does not mean: false labor, occasional spotting, Doctor-prescribed rest during the period of pregnancy, morning sickness, scheduled cesarean section, and similar conditions associated with the management of a difficult pregnancy.

B005.0529

Confined/ Confinement: This term means the admission to, and subsequent continued stay in, a Hospital as an overnight bed patient and a charge for room and board is made. **If** death occurs before a Covered Person completes one overnight stay, that person will be deemed to have been Confined for one day.

B005.0530

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

B005.0531

Covered Family: This term means You, and all of Your covered dependents.

B005.0532

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

B005.0535

Covered Sickness: This term means an illness or disease, including Complications of Pregnancy, which occurs on or after the Covered Person's effective date of this coverage and while this Plan is in force; and is not excluded by name or specific description in the Plan. All related conditions and recurring symptoms of Sickness to the same person will be considered one Sickness.

B005.0537

Diagnosis/ Diagnose: This term means the establishment of the presence or existence of a Covered Sickness or Injury by a Doctor through the use of clinical and/or lab findings, as described in the Covered Benefits section of this Plan.

B005.0539

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

B005.0540

Elective Surgery: This term means surgery that:

(1) is not Medically Necessary;

(2) does not promote the proper function of the Covered Person's body or prevent or treat Sickness; or

(3) is directed at improving appearance; unless such surgery is needed to correct a deformity resulting from: (a) a congenital abnormality; or (b) a disfiguring Sickness, physical disease or Injury.

Laser correction or other surgery to correct vision or hearing will be deemed Elective Surgery when similar results could be provided by use of eyeglasses, contact lenses, hearing aid or other device. Medically Necessary surgery for glaucoma, cataracts or other Sickness or Injury is not considered Elective Surgery.

B005.0542

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

B005.0543

Emergency Room: This term means a department of the Hospital that is designated for emergency care. This area must be staffed and equipped to handle trauma, be supervised and provide treatment by Doctors, and provide care seven days per week, 24 hours per day.

B005.0545

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

Employer: This term means UPLIFT EDUCATION .

B045.0422

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

B045.0607

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

(1) is primarily engaged in providing, by or under the continuous supervision of Doctors, to Inpatients, Diagnostic services and therapeutic services, for Diagnosis, treatment and care of sick or injured persons;

(2) has organized departments of medicine and major surgery;

(3) has a requirement that every patient must be under the care of a Doctor or dentist;

(4) provides 24 hour Nursing service by or under the supervision of a registered professional Nurse (R.N.);

(5) is duly licensed by the agency responsible for licensing such Hospitals; and

(6) is not, other than incidentally: (a) a place of rest; (b) a place primarily for the treatment of tuberculosis; (c) a place for the aged; (d) a place for drug addicts or alcoholics; or (e) a place for convalescent, custodial, educational or rehabilitative care.

B005.0550

Hospital Intensive Care Unit: This term means a designated area of a Hospital that:

(1) provides the highest quality of medical care and is restricted to patients who are critically ill and who require intensive comprehensive observation and care;

(2) is separate and apart from the surgical recovery room and from rooms, beds, wards, and units customarily used for patient Confinement;

(3) is permanently equipped with special lifesaving equipment for the care of the critically ill;

(4) is under continuous observation by a specially trained Nursing staff assigned exclusively to the Intensive Care Unit on a 24 hour basis and is assigned a Doctor on a full-time basis.

B005.0551

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

B005.0552

Injury: This term means unintentional physical damage or harm caused directly to the Covered Person's body; not due to Sickness or disease. The Injury must occur while You or Your covered dependents are insured under this Plan.

B005.0553

Inpatient: This term means a patient who is admitted to a Hospital, as an overnight bed patient with a charge for room and board for a Covered Sickness or Injury.

B005.0555

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

(1) medically appropriate;

(2) needed to Diagnose or treat a Covered Sickness or Injury;

(3) consistent in type, frequency, and length of treatment with scientifically based guidelines of national medical research or health care coverage organizations or government agencies;

(4) needed for reasons other than comfort or convenience of the Covered Person or Doctor;

(5) of proven medical value; and

(6) done with the appropriate level of service or supply needed to provide safe and adequate care.

B005.0557

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

B005.0558

Nurse: This term means either a professional, licensed, graduate registered Nurse (R.N.) or a professional, licensed practical Nurse (L.P.N.).

B005.0559

Observation Unit: This term means a specified area within a Hospital, apart from the Emergency Room, where a patient can be monitored following Outpatient Surgery or treatment in the Emergency Room by a Doctor, and that fully meets each of the following requirements:

(1) It is under the direct supervision of a Doctor or registered Nurse.

(2) It is staffed by Nurses assigned specifically to that unit.

(3) It provides care seven days per week, 24 hours per day.

B005.0560

Outpatient Treatment: This term means medical services that a Covered Person receives when not Confined as an Inpatient in a Hospital.

B005.0562

Plan: This term means the group Hospital Indemnity coverage described in the policy and this Certificate.

B005.0564

Rehabilitation Unit Confinement: This term means an appropriately licensed facility or separate section of a Hospital that provides rehabilitation care services on an Inpatient basis and is designated, staffed and equipped to provide restorative services under the supervision of a trained and experienced rehabilitation Doctor. A Rehabilitation Unit is not: a nursing home; an extended care facility; a skilled nursing facility; a rest home or home for the aged; a hospice care facility; a place for alcoholics or drug addicts; or an assisted living facility.

B005.0565

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

B010.0624

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

You or Your: These terms mean the covered Employee.

B005.0570

GENERAL PROVISIONS

B005.0033

Applicable Benefits

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

B005.0034

Limitation of Authority

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

B005.0573

Incontestability

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

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

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

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

B045.0449

Examination and Autopsy

We have the right to have a Doctor of Our choice conduct a physical examination of the person for whom a claim is being made under the Plan as often as we reasonably require. We also have the right to have an autopsy performed in the case of death where allowed by law. We will pay for all such examinations and autopsies.

B045.0451

Hospital Indemnity Claim Provisions

Your right to make a claim for Hospital Indemnity benefits provided by this Plan is governed as follows:

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

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

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

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

Payment Of Benefits We will pay Hospital Indemnity benefits as soon as We receive written proof of loss.

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

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

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

B045.0453

ELIGIBILITY FOR HOSPITAL INDEMNITY COVERAGE - EMPLOYEE

Eligible Employees

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

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

Conditions of Eligibility

You are eligible for Hospital Indemnity coverage if You are:

- Legally working in the United States, or working outside of the United States for a United States based Employer in a country or region approved by Us; and
- Regularly working at least the number of hours in the normal work week set by the Employer (but not less than 30 hours per week) at: (1) the Employer' place of business; (2) some place where the Employer's business requires You to travel; or (3) any other place You and the Employer have agreed upon for the performance of occupational duties.
- Age 69 or below at the time of Your enrollment.

You are **not** eligible for Hospital Indemnity coverage if You are:

- A temporary or seasonal Employee ;
- Age 70 or older at the time of Your enrollment

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

B045.0456

The Service Waiting Period If You are in an eligible class, You are eligible for Hospital Indemnity coverage under this Plan after You complete the Service Waiting Period, if any, established by the Employer.

B045.0458

Multiple Employment

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

B045.0465

Coverage During Temporary Layoff or Leave of Absence:

If Your active Full-Time service ends because You were laid off or go on a leave of absence approved by Your Employer, You may continue Your insurance, subject to continued payment of premium, until the earlier of: (a) the end of the temporary layoff or Employer approved leave of absence; and (b) 3 months following the date the temporary layoff or approved leave of absence begins. If You become Disabled under this Plan while Your coverage is being continued during a temporary layoff or leave of absence, Your eligibility for benefits will be governed by all the term of this Plan.

B045.0464

When Employee Coverage Starts

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

Whether You must pay all or part of the cost of Your coverage, You must elect to enroll and agree to make the required payments before Your coverage will start. If You do this on or before Your Eligibility Date, Your coverage is scheduled to start on Your Eligibility Date. If You do this within 31 days after Your Eligibility Date, Your coverage is scheduled to start on Your Eligibility Date. If You do not elect this coverage within 31 days of Your Eligibility Date, You must wait until the next scheduled group enrollment period. Once each year, during the group enrollment period You may elect to enroll in this coverage as offered by Your Employer. As used here, "group enrollment period" means an annual open enrollment period set by Your Employer and agreed to by Us. During this period, You can choose the Hospital Indemnity coverage Your Employer offers. An open enrollment period is usually held once a year and usually lasts for 30 days.

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

Exception to When Employee Coverage Starts:

If You are not capable of performing the major duties of Your regular occupation for Your Employer on a Full-Time basis on the date Your coverage is scheduled to start, You will be insured for Hospital Indemnity insurance if:

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

Any Hospital Indemnity benefit payable will be the lesser of:

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

B045.0460

When Employee Coverage Ends

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

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

B045.0610

Your Right to Continue Hospital Indemnity Coverage During a Family Leave of Absence

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

If Your Coverage Would End: Your Hospital Indemnity coverage would normally end because You cease work due to an approved leave of absence. But, You may continue Your coverage if the leave has been granted to: (1) allow You to care for a seriously injured or ill Spouse, child or parent; (2) after the birth or adoption of a child; (3) due to Your own serious health condition; or (4) because of a Serious Injury or Illness arising out of the fact that Your Spouse, child, parent or Next of Kin who is a Covered Service Member is on Active Duty, or has been notified of an impending call or order to Active Duty, in the Armed Forces in support of a Contingency Operation. To continue Your coverage, You will be required to pay the same share of the premium as You paid before the leave of absence.

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

- The date You return to Active Work.
- In the case of a leave granted to You to care for a Covered Service Member, the end of a total leave period of 26 weeks in one 12 month period. This 26 week total leave period applies to all leaves granted to You under this section for all reasons. If You take an additional leave of absence in a subsequent 12 month period, continued coverage will cease at the end of a total leave period of 12 weeks.
- In any other case, the end of a total leave period of 12 weeks in any 12 month period.

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

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

- **Active Duty:** This term means duty under a call or order to Active Duty in the Armed Forces of the United States.
- **Contingency Operation:** This term means a military operation that: (1) is designated by the Secretary of Defense as an operation in which members of the Armed Forces are or may become involved in military actions, operations or hostilities against an enemy of the United States or against an opposing military force; or (2) results in the call or order to, or retention on, Active Duty of members of the uniformed services under any provision of law or during a national emergency declared by the President or Congress.
- **Covered Service Member:** This term means a member of the Armed Forces, including a member of the National Guard or Reserves, who for a Serious Injury or Illness is: (1) undergoing medical treatment, recuperation or therapy; (2) otherwise in Outpatient Status; or (3) otherwise on the temporary disability retired list.
- **Next Of Kin:** This term means Your nearest blood relative.
- **Outpatient Status:** This term means, in the case of a Covered Service Member, that he or she is assigned to: (1) a military medical treatment facility as an outpatient; or (2) a unit established for the purpose of providing command and control of members of the Armed Forces receiving medical care as outpatients.
- **Serious Injury Or Illness:** This term means, in the case of a Covered Service Member, an Injury or illness incurred by him or her in line of duty on Active Duty in the Armed Forces that may render him or her medically unfit to perform the duties of his or her: (1) office; (2) grade; (3) rank; or (4) rating.

B045.0470

ELIGIBILITY FOR HOSPITAL INDEMNITY COVERAGE - DEPENDENT

Eligible Dependents

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

B045.0473

Adopted Children, Grandchildren and Step-Children

Your unmarried dependent children include (a) Your legally adopted children; (b) Your grandchildren who are dependents for federal income tax purposes at the time application for coverage of the grandchildren is made, (c) Your step-children; and (d) a child for whom a medical support order has been issued. We treat a child as legally adopted from the time You are a party to a suit in which the adoption of such child is sought. We treat such a child this way whether or not final adoption order is ever issued.

B045.0474

Handicapped Children

You may have an unmarried child (a) with a mental or physical handicap or developmental disability and (b) chiefly dependent upon You for support and maintenance. In that case such a child may remain eligible for dependent benefits past the age limit subject to the conditions shown below.

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

The child's coverage ends when Your coverage ends.

B005.0599

Dependents Not Eligible

We exclude:

- A dependent who is on Active Duty in any armed force;
- A dependent who is covered by this Plan as an Employee.

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

B005.0601

When Dependent Coverage Starts

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

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

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

If You do this within 31 days of Your Eligibility Date, the coverage is scheduled to start on the later of Your Eligibility Date and the date You become covered for Employee coverage.

If You do not elect dependent coverage within 31 days of Your Eligibility Date, You must wait until the next scheduled group enrollment period to add dependent coverage. Once each year, during the group enrollment period You may elect to enroll dependents in this coverage as offered by Your Employer. As used here, "group enrollment period" means an annual open enrollment period set by Your Employer and agreed to by Us. During this period, You can choose the dependent Hospital Indemnity coverage Your Employer offers. An open enrollment period is usually held once a year and usually lasts for 30 days.

You may enroll Your dependents outside of the group enrollment period only as follows:

- You may enroll a new Spouse within 31 days of marriage;
- You may enroll for dependent child coverage within 31 days of the birth or adoption of Your first eligible child.

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

Exception: We will postpone the effective date of a dependent's, other than a newborn child's, coverage if, on that date, he or she is: (1) Confined to a Hospital or other health care facility or (2) home confined. In that case, We will postpone the effective date of his or her coverage until the day after the date: (a) of his or her discharge from such facility or (b) his or her home confinement ends. If a dependent was covered under a prior plan at transfer, this language will not apply to the amount of coverage that was in force with the prior plan.

B045.0477

When Dependent Coverage Ends

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

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

Your dependent's coverage ends when he or she stops being an eligible dependent. This happens to a child at 12:01 A.M. on the date the child attains this Plan's age limit, when he or she marries, or when a step-child is no longer dependent on You for support and maintenance or for Your handicapped child who has reached the age limit, when he or she marries or is no longer dependent on You for support and maintenance. It happens to a Spouse when a marriage ends in legal divorce or annulment or a Domestic Partnership ends or no longer qualifies as a Domestic Partnership.

B005.0605

HOSPITAL INDEMNITY COVERAGE

This Certificate includes the Schedule of Benefits. Your class and benefit options are shown in the Schedule of Benefits that applies to You. Subject to all of this Plan's terms, We will pay the benefits described below if a Covered Person receives care or treatment for a Covered Sickness or Injury. The care or treatment must occur while the Covered Person is insured by this Plan. This Plan pays no benefits for the treatment of a Covered Sickness or Injury other than those listed below in Covered Benefits.

B005.0607

Covered Benefits

B005.0608

Health Screening: We will pay the amount in the Schedule of Benefits if You provide proof that a Covered Person received at least one of the following tests:

- Stress test on a bicycle or treadmill
- Fasting blood glucose test
- Blood test for triglycerides
- Serum Cholesterol test to determine level of HDL and LDL Arteriogram
- Bone marrow testing
- Breast ultrasound
- CA 15-3 (blood test for breast cancer)
- CA 125 (blood test for ovarian cancer)
- CEA (blood test for colon cancer)
- Chest x-ray (preventative screening, not diagnostic)
- Colonoscopy (blood test for colon cancer)
- Flexible sigmoidoscopy
- Bone density screening
- Double contrast barium enema
- Immunizations
- Skin cancer screening/biopsy
- Hemoccult stool analysis
- Mammography
- Pap smear
- PSA (blood test for prostate cancer)
- Serum protein electrophoresis (blood test for myeloma)
- Thermography
- ThinPrep pap test
- Virtual colonoscopy
- Lymphocyte Genome Sensitivity test (LGS)
- Cancer genetic mutation test
- Completion of a smoking cessation program
- Completion of a weight reduction program
- Carotid ultrasound
- EKG
- Routine/annual physicals

We limit what We cover to 1 day(s) of benefits per Covered Person per Benefit Year.

B005.0896

Hospital Admission or Intensive Care Unit Admission: We pay the amount shown in the Schedule of Benefits if a Covered Person is admitted to a Hospital as a result of a Covered Sickness or Injury. We limit what We cover to 1 day(s) of benefits per Covered Person per Benefit Year for either Hospital Admission or Intensive Care Unit Admission. If a Covered Person is admitted to the Hospital or the Intensive Care Unit for the same or related condition within 30 day(s) of an Admission for which this Plan has paid a benefit, We will treat this later Admission as a continuation of the previous Admission and no additional benefit will be paid. If more than 30 day(s) have passed between the periods of Hospital or Intensive Care Unit Admission, We will treat this later Admission as a new and separate Hospital or Intensive Care Unit Admission. This benefit is not payable for Emergency Room treatment, Outpatient Surgery or Treatment, or a Hospital stay of less than 20 hours in an Observation Unit, or when a charge for room and board is not made. We will pay the higher of the Hospital Admission or Intensive Care Unit Admission benefit if both occur on the same day or same Benefit Year. Hospital Admission or Intensive Care Unit Admission does not include Hospice Care in a Hospice facility. The admission must be within 180 day(s) of an Injury.

B005.0627

Hospital Confinement or Intensive Care Unit Confinement We will pay the amount shown in the Schedule of Benefits for days of Hospital Confinement or Intensive Care Unit Confinement following a Hospital Admission or Intensive Care Unit Admission, if a Covered Person is Confined in a Hospital or Intensive Care Unit for the treatment of a Covered Sickness or Injury. We limit what We cover to 15 day(s) of benefits per Covered Person per Benefit Year. We do not pay the Hospital Confinement or Intensive Care Unit Confinement benefit on the same day as the Hospital Admission or Intensive Care Unit Admission.

We will pay the higher of the Hospital Confinement or Intensive Care Unit Confinement benefit if both occur on the same day. Hospital Confinement or Intensive Care Unit Confinement does not include Hospice Care in a Hospice facility.

B005.0631

Exclusions

This Plan will not pay benefits for the treatment of any Covered Sickness or Injury caused by, or resulting from any of the following:

- Suicide or any intentionally self-inflicted Injury;
- Participation in a riot or insurrection;
- Declared or undeclared war, or act of war;
- Commission of, or attempt to commit, a felony, or participating in an illegal occupation;
- Commission of, or attempt to commit, an act of terrorism

And this Plan will not pay benefits for:

- Elective Surgery;
- Dental care, dental x-rays, or dental treatment;

- Gastric or intestinal bypass services including lap banding, gastric stapling, and other similar procedures to facilitate weight loss; the reversal, or revision of such procedures; or services required for the treatment of complications from such procedures. This exclusion does not apply to completion of a weight reduction program that may be payable under the Health Screening benefit;
- Rest cures or custodial care, or treatment of sleep disorders;
- Treatment of a Covered Dependent Child's child(ren);
- Cosmetic surgery. This Exclusion does not apply to reconstructive surgery:

(a) on an injured part of the body following infection or disease of the involved part;

(b) of a congenital disease or anomaly of a covered dependent newborn or adopted infant; or

(c) on a non-diseased breast to restore and achieve symmetry between two breasts following a covered mastectomy;

- Treatment or removal of warts, moles, boils, skin blemishes or birthmarks, bunions, acne, corns, calluses, the cutting and trimming of toenails, care for flat feet, fallen arches or chronic foot strain;
- Service, treatment or loss related to alcoholism or drug addiction, except for drugs prescribed by the Covered Person's Doctor and taken as prescribed;
- Care or treatment for mental or nervous disorders;
- Services, treatment or loss rendered in any Veterans Administration or Federal Hospital, except if there is a legal obligation to pay;
- Services or treatment provided by a Doctor, Nurse or any other person who is employed or retained by a Covered Person or who is a Covered Person's Spouse, parent, brother, sister, child, Domestic Partner, or partner in a civil union;
- Sickness or Injury sustained while on Active Duty in the armed forces of any country. This does not include Reserve or National Guard duty for training;
- Surgery and treatment, procedures, products or services that are Experimental or Investigative. "Experimental or Investigative" means a drug, device or medical treatment or procedure that:

(a) Cannot lawfully be marketed without approval of the United States Food and Drug Administration and approval for marketing has not been given at the time of being furnished;

(b) Has Reliable Evidence indicating it is the subject of ongoing clinical trials or is under study to determine its maximum tolerated dose, toxicity, safety, efficacy, or its efficacy as compared with the standard means of treatments or Diagnosis; or

(c) Has Reliable Evidence indicating that the consensus of opinion among experts is that further studies or clinical trials are necessary to determine its maximum tolerated dose, toxicity, efficacy, or its efficacy as compared with the standard means of treatment or Diagnosis.

"Reliable Evidence" means (i) published reports and articles in authoritative medical and scientific literature; (ii) the written protocol(s) of the treating facility or the protocols of another facility studying substantially the same drug, device, medical treatment or procedure; or (iii) the written informed consent used by the treating facility or by another facility studying substantially the same drug, device, or medical treatment or procedure.

B005.0808

Waiver of Premium Benefit

After the Covered Person has been Confined to a Hospital due to a Covered Sickness or Injury for more than 30 continuous days while this Plan is in force, We will waive the premium for the Plan for as long as the Covered Person remains Confined to a Hospital or Rehabilitation Unit.

The Covered Person must pay all premiums to keep the Plan in force until he or she has been Confined to a Hospital for more than 30 continuous days and the waiver becomes effective.

The Waiver of Premium Benefit does not apply to any period that the Covered Person is Confined to a Hospital or Rehabilitation Unit due to a Sickness or Injury which is excluded by name or specific description in this Plan. This benefit does not apply to the Hospital Confinement of a Spouse or Covered Dependent Child. We will waive the premium only if the Covered Person insured is Confined to a Hospital for more than 30 continuous days, and the premium will be waived for the entire Plan, including the premium for any covered Spouse or Covered Dependent Child if insured under the Plan.

B005.0694

SCHEDULE OF BENEFITS

HOSPITAL INDEMNITY

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

B005.0703

Covered Benefits

Health Screening: $50.00 per day

Limited to 1 days per Benefit Year.

Hospital Admission: $1,000.00 per day

Limited to 1 days per Benefit Year combined with Hospital ICU Admission.

Hospital Confinement: $200.00 per day

for first 15 days Hospital Confinement combined with Hospital ICU Confinement.

Hospital ICU Admission: $1,000.00 per day

Limited to 1 days per Benefit Year combined with Hospital Admission.

Hospital ICU Confinement: $200.00 per day

for first 15 days Hospital ICU Confinement combined with Hospital Confinement.

Initial Election

When You first become eligible for this Plan You must choose to be covered for a Plan Option as described below. You may only be covered under one plan at a time. You must notify Your Employer of Your election and pay the required premium.

B045.0591

EMPLOYEE VOLUNTARY HOSPITAL INDEMNITY COVERAGE

Election of Hospital Indemnity Plan Option Based on Age

If You are less than age 70 you may elect Hospital Indemnity coverage. If you are age 70 or above, you may not elect Hospital Indemnity coverage.

B005.0732

DEPENDENT VOLUNTARY HOSPITAL INDEMNITY COVERAGE

Election of Hospital Indemnity Plan Option Based on Age

If You, as the Employee, are less than age 70, You may elect Hospital Indemnity coverage for Your Dependent(s). If You as the Employee are age 70 or above, You may not elect Hospital Indemnity coverage for Your Dependent(s).

Changes To Coverage

Changes in Coverage Amounts

If You are not Actively At Work on a Full-Time basis, any change in Your coverage or the coverage on a covered dependent will not become effective prior to the date You return to Active Work on a Full-Time basis.

Changes In Insurance Classification

If Your classification changes, coverage will not be changed to the new amount until the first day on which You are: (1) Actively At Work on a Full-Time basis; and (2) make a contribution, if required, for the new classification.

If a contribution is required for the new classification for which greater coverage is provided, You must make the required contribution for the new coverage within 31 days of the change. If You do not make the required contribution within 31 days of the change or within 31 days of becoming Actively At Work on a Full-Time basis, if You are not Actively At Work on a Full-Time basis, when Your classification changes, no increase will be allowed due to such change or any later change. In that case, in order to become covered for the greater coverage, You must: (1) make the required contribution for the greater coverage; and (2) furnish Proof of Insurability to Us, which We approve in writing.

B045.0603

CERTIFICATE RIDER

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

PORTABILITY PRIVILEGE

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

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

- You may port if Your coverage under this Plan ends because: (1) You have terminated employment; (2) You stop being a member of an eligible class of Employees; or (3) this Plan ends.
- You may **not** port Your coverage if You have reached Your 70th birthday on the date coverage under this Plan ends.
- You may **not** port coverage for any of Your dependents if he or she has reached his or her 70th birthday on the date coverage under this Plan ends.
- You may **not** port if coverage under this Plan ends due to Your failure to pay any required premium.

Portability Options: You may port Your Hospital Indemnity coverage, subject to any benefit amount reductions based on age, less the amount of any Hospital Indemnity benefits paid by this Plan.

You may port Your dependent's Hospital Indemnity coverage, less the amount of any Hospital Indemnity benefits paid by this Plan.

You may port: (1) Your coverage only; (2) Your coverage and coverage of Your covered Spouse; (3) Your coverage and the coverage of all of Your covered dependents; or (4) if You are a single parent, Your coverage and the coverage of all of Your covered dependent children. No other combinations will be allowed.

A dependent must be covered as of the date Your coverage under this Plan ends in order to be eligible for portability.

If You die while covered for dependent Hospital Indemnity coverage, Your Spouse may port Your dependent Hospital Indemnity coverage as described above. Your Spouse and dependent children must be covered under this Plan on the date of Your death. But, this option is not available if: (1) there is no surviving Spouse; or (2) Your surviving Spouse has reached his or her 70th birthday on the date of Your death.

The Portable Certificate of Coverage: The portable certificate of coverage provides group Hospital Indemnity. The benefits provided by the portable certificate of coverage are the same as the benefits provided by this Plan. The portable certificate provides seamless coverage. Benefit limits, maximums and timeframes do not reset when someone becomes covered under the portable certificate. The premium for the portable certificate of coverage will be based on: (1) the Covered Person's rate class under this Plan; and (2) Your or Your surviving Spouse's age bracket as shown in the Hospital Indemnity Portability Coverage Premium Notice.

How to Port: You or Your surviving Spouse must: (1) apply to Us in writing; and (2) pay the required premium. You or Your surviving Spouse must do this within 31 days from the date Your coverage under this Plan ends. We will not ask for proof that You or Your surviving Spouse are in good health.

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

The Guardian Life Insurance Company of America

Michael Prestileo, Senior Vice President

GC-R-HI-PORT-15 B005.0740

GC-R-HI-PORT-15

CERTIFICATE AMENDATORY RIDER

This Rider amends the Certificate as follows and is effective on the Policy Date. If this Rider is effective after the Policy Date, the Rider becomes effective on its issue date.

The **Hospital Admission or Intensive Care Unit Admission** benefit is replaced with the following:

Hospital Admission or Intensive Care Unit Admission: We pay the amount shown in the Schedule of Benefits if a Covered Person is admitted to a Hospital as a result of a Covered Sickness or Injury. We limit what We cover to 1 day(s) of benefits per Covered Person per Benefit Year for either Hospital Admission or Intensive Care Unit Admission. A Covered Person includes a newborn with a Covered Sickness or Injury that incurs a separate Hospital Admission or Intensive Care Unit Admission charge (N.I.C.U.). If a Covered Person is admitted to the Hospital or the Intensive Care Unit for the same or related condition within 30 day(s) of an Admission for which this Plan has paid a benefit, We will treat this later Admission as a continuation of the previous Admission and no additional benefit will be paid. If more than 30 day(s) have passed between the periods of Hospital or Intensive Care Unit Admission, We will treat this later Admission as a new and separate Hospital or Intensive Care Unit Admission. This benefit is payable for a Hospital stay of 20 hours or more. We will pay the higher of the Hospital Admission or Intensive Care Unit Admission benefit if both occur on the same day or same Benefit Year. Hospital Admission or Intensive Care Unit Admission does not include Hospice Care in a Hospice facility. The admission must be within 180 day(s) of an Injury.

B005.0878

The **Hospital Confinement or Intensive Care Unit Confinement** benefit is replaced with the following:

Hospital Confinement or Intensive Care Unit Confinement We will pay the amount shown in the Schedule of Benefits for days of Hospital Confinement or Intensive Care Unit Confinement following a Hospital Admission or Intensive Care Unit Admission, if a Covered Person is Confined in a Hospital or Intensive Care Unit for the treatment of a Covered Sickness or Injury. A Covered Person includes a newborn with a Covered Sickness or Injury that incurs a separate Hospital Confinement or Intensive Care Unit Confinement charge (N.I.C.U.). We limit what We cover to 15 day(s) of benefits per Covered Person per Benefit Year. We do not pay the Hospital Confinement or Intensive Care Unit Confinement benefit on the same day as the Hospital Admission or Intensive Care Unit Admission.

We will pay the higher of the Hospital Confinement or Intensive Care Unit Confinement benefit if both occur on the same day. Hospital Confinement or Intensive Care Unit Confinement does not include Hospice Care in a Hospice facility.

B005.0882

GC-A-HI-BEN-20

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

The Guardian Life Insurance Company of America

Michael Prestileo, Senior Vice President

B005.0888

GC-A-HI-BEN-20

CERTIFICATE AMENDATORY RIDER - Dependent Termination

This Rider amends the Certificate as follows and is effective on the Policy Date. If this Rider is effective after the Policy Date, the Rider becomes effective on its issue date.

The **When Dependent Coverage Ends** provision is replaced in its entirety with the following:

When Dependent Coverage Ends

Dependent coverage ends for all of Your dependent(s) as follows:

- When Your Employee coverage ends;
- When You stop being a member of a class of Employees eligible for such coverage;
- When this Certificate ends, or dependent coverage is discontinued for a class of Employees to which You belong;
- On the last day of the period, including any applicable grace period, for which required payments are made for Your dependent(s);
- For Your natural or adopted child, grandchild or stepchild, on the last day of the month in which he or she attains the age limit or no longer qualifies under Continuing Coverage For Dependent Children Past the Age Limit.
- It also happens at 12:01 A.M. on the date in which Your child marries.
- For Your Spouse, at 12:01 A.M. on the date Your marriage is lawfully terminated.
- On the date Your dependent dies.

The **Handicapped Children** provision is replaced in its entirety with the following:

Continuing Coverage For Dependent Children Past the Age Limit

An unmarried child that meets all of the conditions below may continue coverage past the child age limit:

- The child must be incapable of living independently due to a mental, physical, or developmental disability;
- The child must be primarily dependent upon You for support and maintenance;
- The child's mental, physical, or developmental disability must have begun before he or she reached the age limit; and
- The child must have been covered by this Certificate, or the prior carrier's group plan that it replaced, before he or she reached the age limit, and remained continuously covered until he or she reached the age limit.

You will have to send us documentation that your child meets these requirements within 31 days of the date the age limit was reached.

After two years has passed from the date the age limit was reached, we may periodically ask for documentation that your child continues to meet these requirements. We won't ask for this more than once a year.

Any coverage provided under this section ends when Your coverage ends, or your child no longer meets the conditions above.

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

The Guardian Life Insurance Company of America

Michael Prestileo, Senior Vice President

B045.0809

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

STATEMENT OF ERISA RIGHTS

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

Receive Information About Your Plan and Benefits

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

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

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

Prudent Actions By Plan Fiduciaries

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

Enforcement Of Your Rights

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

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

Assistance with Questions

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

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

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

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

Definitions

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

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

Timing For Initial Benefit Determination

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

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

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

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

Adverse Benefit Determination

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

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

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

Appeal of Adverse Benefit Determinations

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

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

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

In reviewing an appeal, Guardian will:

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

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

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

Alternative Dispute Options

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

B055.0061

Termination of This Group Plan

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

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

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

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

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