



GUARDIANSM

**YOUR GROUP INSURANCE
PLAN BENEFITS**

THE KINGS ACADEMY
ANCILLARY COVERAGES FOR THOSE ELECTING THE MDG
PLAN

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.

CERTIFICATE OF COVERAGE

The Guardian
7 Hanover Square
New York, New York 10004

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.



Vice President, Group Products

CGP-3-R-STK-90-3

B110.0023

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COMPLAINT NOTICE

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

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

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

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

Consumer Hotline: 1-800-927-4357

CGP-3-CADISC-91

B120.0011

GENERAL PROVISIONS

As used in this booklet:

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

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

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

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

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

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

CGP-3-R-GENPRO-90

B160.0002

Limitation of Authority

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

CGP-3-R-LOA-90

B160.0004

Incontestability

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

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

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

CGP-3-R-INCY-96

B160.0061

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. If the claim is being made for one of your *covered dependents*, his or her name should also be noted.

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

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

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

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

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.

Accident and Health Claims Provisions (Cont.)

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

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

CGP-3-R-AHC-90

B160.0005

Coordination Between Continuation Sections

A covered person may be eligible to continue his group health benefits under this plan's "Federal Continuation Rights" section and under other continuation sections of this plan at the same time. If he chooses to continue his group health benefits under more than one section, the continuations: (a) start at the same time; (b) run concurrently; and (c) end independently, on their own terms.

A covered person covered under more than one of this plan's continuation sections: (a) will not be entitled to duplicate benefits; and (b) will not be subject to the premium requirements of more than one section at the same time.

CGP-3-R-COC-87

B240.0044

An Important Notice About Continuation Rights

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

CGP-3-R-NCC-87

B240.0064

YOUR CONTINUATION RIGHTS

Federal Continuation Rights

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

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

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

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

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

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

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

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

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

Federal Continuation Rights (Cont.)

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

CGP-3-R-COBRA-96-1

B235.0164

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

CGP-3-R-COBRA-96-2

B235.0075

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

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

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

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

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

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

Federal Continuation Rights (Cont.)

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

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

CGP-3-R-COBRA-96-3

B235.0178

Your Employer's Responsibilities

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

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

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

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

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

Your Employer's Liability

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

Federal Continuation Rights (Cont.)

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

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

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

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

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

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

- (1) with respect to continuation upon your termination of employment or reduction of work hours, the end of the 18 month period which starts on the date the group health benefits would otherwise end;
- (2) with respect to a qualified continuee who has an additional 11 months of continuation due to disability, the earlier of: (a) the end of the 29 month period which starts on the date the group health benefits would otherwise end; or (b) the first day of the month which coincides with or next follows the date which is 30 days after the date on which a final determination is made that the disabled qualified continuee is no longer disabled under Title II or Title XVI of the Social Security Act;
- (3) with respect to continuation upon your death, your legal divorce, or legal separation, or the end of an insured dependent's eligibility, the end of the 36 month period which starts on the date the group health benefits would otherwise end;
- (4) the date the employer ceases to provide any group health plan to any employee;

Federal Continuation Rights (Cont.)

- (5) the end of the period for which the last premium payment is made;
- (6) the date, after the date of election, he or she becomes covered under any other group health plan which does not contain any pre-existing condition exclusion or limitation affecting him or her; or
- (7) the date, after the date of election, he or she becomes entitled to Medicare.

CGP-3-R-COBRA-96-4

B235.0198

Uniformed Services Continuation Rights

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

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

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

CGP-3-R-COBRA-96-4

B235.0195

ELIGIBILITY FOR LIFE AND DISMEMBERMENT COVERAGES

B264.0003

Employee Coverage

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

Other Conditions

You must:

- (a) be legally working in the United States.
- (b) be regularly working at least the number of hours in the normal work week set by your *employer* (but not less than 30 hours per week), at:
 - (i) your *employer's* place of business;
 - (ii) some place where your *employer's* business requires you to travel; or
 - (iii) any other place you and your *employer* have agreed upon for performance of occupational duties.

Note: If you are working outside the United States on a temporary assignment and you meet all other conditions of eligibility, you will be covered by this *plan*, provided that: you are on an assignment, not exceeding one year, in a country or region that is not under a travel warning issued by the US Department of State. Coverage may be available when you are: (1) on a longer temporary assignment; or (2) assigned in a region that is under a travel warning; however, coverage must be approved in writing.

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

CGP-3-EC-90-1.0

B264.0900

When Your Coverage Starts Employee benefits that don't require *proof* that you are insurable are scheduled to start on the effective date shown on the sticker attached to the inside front cover of this booklet.

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

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

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

CGP-3-EC-90-2.0

B264.0690

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.

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

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

CGP-3-EC-90-3.0

B264.0703

Your Right To Continue Group Life Insurance During A Family Leave Of Absence

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

Continuation of Coverage Life and Accidental Death and Dismemberment insurance may be continued at your employer's option. You must contact your employer to find out if you may continue this insurance.

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

When Continuation Ends 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 insurance would have ended had you not been on leave.
- The end of the period for which the premium has been paid.

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

- **Active Duty:** This term means duty under a call or order to active duty in the Armed Forces of the United States.
- **Contingency Operation:** This term means a military operation that: (a) is designated by the Secretary of Defense as an operation in which members of the armed forces are or may become involved in military actions, operations, or hostilities against an enemy of the United States or against an opposing military force; or (b) results in the call or order to, or retention on, active duty of members of the uniformed services under any provision of law during a war or during a national emergency declared by the President or Congress.
- **Covered Servicemember:** This term means a member of the Armed Forces, including a member of the National Guard or Reserves, who for a serious injury or illness: (a), is undergoing medical treatment, recuperation, or therapy; (b) is otherwise in outpatient status; or (c) is otherwise on the temporary disability retired list.
- **Next Of Kin:** This term means the nearest blood relative of the *employee*.

- **Outpatient Status:** This term means, with respect to a covered servicemember, that he or she is assigned to: (a) a military medical treatment facility as an outpatient; or (b) a unit established for the purpose of providing command and control of members of the Armed Forces receiving medical care as outpatients.
- **Serious Injury Or Illness:** This term means, in the case of a covered servicemember, an injury or illness incurred by him or her in line of duty on active duty in the Armed Forces that may render him or her medically unfit to perform the duties of his or her office, grade, rank, or rating.

CGP-3-EC-90-3.0

B264.1183

GROUP TERM LIFE INSURANCE SCHEDULE

Employee Basic Term Life Insurance

Your Basic Term Life Insurance Amount Insurance Amount \$15,000.00

Reduction of Basic Life Insurance Amount Based on Age If an employee is less than age 65 when his or her insurance under this plan starts, his or her insurance amount is reduced, on the date he or she reaches age 65, by 35% of the amount which otherwise applies to his or her classification and/or option. But in no case will such reduced amount be less than \$1,000.00.

The preceding reduction also applies to an employee's initial insurance amount if his or her insurance starts after he or she reaches age 65 but before he or she reaches age 70.

If an employee is less than age 70 when his or her insurance under this plan starts, the employee's basic life insurance amount is reduced, when he or she reaches age 70, by 50% of the amount which otherwise applies to his or her classification and/or option. But in no case will such reduced amount be less than \$1,000.00.

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

Limitations For Future Entrants However, regardless of any of the above reductions, we limit the amount of insurance for which you are eligible if your insurance under this plan starts both: (a) after this plan's effective date; and (b) after you reach age 70.

If you provide us with proof of insurability, and we approve it in writing, the amount of your insurance will be 50% of the amount which otherwise applies to your classification and/or option. But in no event will this reduced amount be less than \$1,000.00.

If we do not approve the proof, your insurance amount will be \$1,000.00.

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

Your Basic AD&D Insurance Amount Insurance Amount \$15,000.00

Spousal Education and Retraining Benefit

Lifetime Maximum Benefit \$20,000

Maximum Number Of Benefit Payments Full-Time Post Secondary Education 8
Part-Time Post Secondary Education 4

Dependent Child Education Benefit

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

Lifetime Maximum Benefit	\$20,000.00 per eligible dependent
Maximum Number Of Benefit Payments	8 per lifetime per eligible dependent
Maximum Benefit Period	6 years from the date the first education benefit is made; per eligible dependent.
Reduction of Basic AD&D Amount Based on Age	<p>If an employee is less than age 65 when his or her insurance under this plan starts, his or her insurance amount is reduced, on the date he or she reaches age 65, by 35% of the amount which otherwise applies to his or her classification and/or option. But in no case will such reduced amount be less than \$1,000.00.</p> <p>The preceding reduction also applies to an employee's initial insurance amount if his or her insurance starts after he or she reaches age 65 but before he or she reaches age 70.</p> <p>If an employee is less than age 70 when his or her insurance under this plan starts, the employee's insurance amount is reduced, when he or she reaches age 70, by 50% of the amount which otherwise applies to his or her classification and/or option. But in no case will such reduced amount be less than \$1,000.00.</p> <p>The preceding reduction also applies to an employee's initial insurance amount if his or her insurance starts after he or she reaches age 70.</p>
Limitations For Future Entrants	<p>However, regardless of any of the above reductions, we limit the amount of insurance for which you are eligible if your insurance under this plan starts both: (a) after this plan's effective date; and (b) after you reach age 70.</p> <p>If you provide us with proof of insurability, and we approve it in writing, the amount of your insurance will be 50% of the amount which otherwise applies to your classification and/or option. But in no event will this reduced amount be less than \$1,000.00.</p> <p>If we do not approve the proof, your insurance amount will be \$1,000.00.</p>

Your Group Term Life Insurance

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

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

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

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

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

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

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

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

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

Portability Privilege

- Applicability** This provision applies only to this plan's employee Basic group term life insurance. It does not apply to supplemental life insurance, if any is included in this plan. And it does not apply to Accidental Death and Dismemberment with Catastrophic Loss Insurance.
- Important Restriction** You must provide proof of insurability satisfactory to us.
- Portability Of Basic Group Term Life Insurance** You may elect to continue all or part of your employee Basic group term life insurance, by choosing a portable certificate of coverage, subject to the following terms.
- You may port your coverage if coverage under this plan ends because you: (a) have terminated employment; or (b) stop being a member of an eligible class of employees.
- You may not port your coverage, if you: (a) have reached your 70th birthday on the day coverage under this plan ends; or (b) are eligible for this plan's Basic Group Term Life Insurance Extended Life Benefit.
- You may not port your coverage if coverage under this plan ends due to: (a) failure to pay any required premium; or (b) the end of this group plan.
- You may port: (a) the full amount(s) of your Basic term life insurance as of the day your coverage under this plan ends, or (b) 50% of such amount, if such amount under this plan is at least \$50,000.00.
- The Portable Certificate Of Coverage** You can port to a portable certificate of coverage. The certificate provides group term insurance. It does not provide any: (a) accidental death and dismemberment benefits; (b) income replacement benefits; or (c) extended life benefits or waiver of premium privileges. The benefits provided by the portable certificate of coverage may not be the same as the benefits of this group plan.
- The premium for the portable certificate of coverage will be based on: (a) your rate class under this plan; and (b) your age bracket as shown in the Basic Life Portability Coverage Premium Notice.
- How To Port** To get a portable certificate of coverage, you must: (a) apply to us in writing; and (b) pay the required premium. You have 31 days from the date your coverage under this plan ends to do this. We require proof of insurability satisfactory to us.
- Defined Term** As used in this provision, the term "port" means to choose a portable certificate of coverage which provides group term life insurance.

CGP-3-R-LP-00

B270.0389

Information About Conversion and Portability

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

CGP-3-R-LPN-95

B270.0326

THE FOLLOWING PROVISION APPLIES TO YOUR BASIC TERM LIFE INSURANCE:

Converting This Group Term Life Insurance

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

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

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

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

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

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

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

Converting This Group Term Life Insurance (Cont.)

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

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

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

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

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

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

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

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

CGP-3-R-LCONV-99-CA

B275.0217

Your Extended Life Benefit With Waiver Of Premium

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

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

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

- (a) not able to perform any work for wages or profit; and
- (b) you are receiving regular doctor's care appropriate to the cause of disability.

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

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

- (a) become totally disabled before you reach age 60 and while insured by the group plan; and
- (b) remain totally disabled for nine continuous months.

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

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

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

Until You've Been Approved For This Extended Life Benefit Your life insurance under the group plan may end after you've become totally disabled, but before we've approved you for this extension. During this time period, you may either:

- (a) continue group premium payments, including any portion which would have been paid by the employer until you are approved or declined for this extended life benefit; or
- (b) convert to an individual permanent or term policy. Please read the section labeled "Converting This Group Term Life Insurance" for details on how to convert.

Your Extended Life Benefit With Waiver Of Premium (Cont.)

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

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

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

- (a) nine continuous months from the date active full-time service ends due to total disability; or
- (b) the date we approve you for this benefit.

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B275.0056

When This Extension Ends Your extension will end on the earliest of:

- (a) the date you are no longer disabled;
- (b) the date we ask you to be examined by our doctor, and you refuse;
- (c) the date you do not give us the proof of disability we require;
- (d) the date you are no longer receiving regular doctor's care appropriate to the cause of disability; or
- (e) the day before the date you reach age 65.

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

If You Die While Covered By This Extension If you die while covered by this extension we'll pay your beneficiary the amount for which you were covered as of your last day of active full-time work, subject to all reductions which would have applied had you stayed an active employee.

Proof Of Death We'll pay as soon as we receive

- (a) written proof of your death, that is acceptable to us; and
- (b) medical proof that you were continuously disabled until your death. This must be sent within one year of your death.

CGP-3-R-LW-TD-99-2

B275.0059

Your Basic Accidental Death And Dismemberment With Catastrophic Loss Benefits

The Benefit We'll pay the benefits described below if you suffer an irreversible covered loss due to an accident that occurs while you are insured. The loss must be a direct result of the accident, independent of all other causes. And, it must occur within 90 days of the date of the accident.

Your Basic Accidental Death And Dismemberment With Catastrophic Loss Benefits (Cont.)

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

ACCIDENTAL DEATH AND DISMEMBERMENT

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

CATASTROPHIC LOSS BENEFITS

Covered Loss	Benefit
Quadriplegia (total paralysis of upper and lower limbs, bilaterally)	100% of Insurance Amount
Loss of speech and hearing (both ears)	100% of Insurance Amount
Loss of cognitive function	100% of Insurance Amount
Comatose state, in excess of one month	100% of Insurance Amount
Hemiplegia (total paralysis of upper and lower limbs, unilaterally)	50% of Insurance Amount
Paraplegia (total paralysis of both lower limbs)	50% of Insurance Amount
Loss of speech or hearing (both ears)	50% of Insurance Amount

For covered multiple losses due to the same accident, we will pay 100% of the Insurance Amount. We won't pay more than 100% of the Insurance Amount for all losses due to the same accident, except under the Common Carrier, Seatbelt and Airbag Benefit, and Repatriation Benefit provisions.

Loss of:

- (a) cognitive function means a significant decline or loss in intellectual aptitude. Such loss must result from an accidental injury. It must be supported by clinical proof or standardized tests that precisely measure decline in the areas of: (i) short term memory; (ii) orientation to time, place and person; (iii) deductive or abstract reasoning; and (iv) judgement as it relates to awareness of safety.

Your Basic Accidental Death And Dismemberment With Catastrophic Loss Benefits (Cont.)

- (b) a hand or foot means it is completely cut off at or above the wrist or ankle.
- (c) sight means the total and permanent loss of sight.
- (d) speech or hearing means that speech or hearing is lost entirely.

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

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

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

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B310.0397

Seatbelt And Airbag Benefits If you die as a direct result of a motor vehicle accident while properly wearing a seatbelt, we will increase your benefit by \$10,000.00. And if you die as a direct result of a motor vehicle accident while both: (a) properly wearing a seatbelt; and (b) sitting in a seat equipped with an airbag; we'll increase your benefit by another \$5,000.00, for a total increase of \$15,000.00. This benefit will be applied after the Common Carrier provision.

Common Carrier If your loss is due to an accident which occurs while you are riding in a public conveyance, we increase the benefit payable. We pay two times the amount which otherwise applies to such loss. But, you must have been a fare-paying passenger.

Repatriation Benefit For covered loss of life due to an accident which occurs at least 75 miles from your home, we pay an extra sum. We pay up to \$5,000.00 for costs to prepare and transport your body to a mortuary chosen by you or an authorized agent.

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

- by willful self-injury, suicide, or attempted suicide;
- by sickness, disease, mental infirmity, medical or surgical treatment;
- by your taking part in a riot or other civil disorder; or in the commission of or attempt to commit a felony;
- by travel on any type of aircraft if you are an instructor or crew member; or have any duties at all on that aircraft;
- by declared or undeclared war or act of war or armed aggression;
- while you are a member of any armed force;
- while you are a driver in a motor vehicle accident, if you do not hold a current and valid driver's license;
- by your legal intoxication; this includes, but is not limited to, your operation of a motor vehicle; or

Your Basic Accidental Death And Dismemberment With Catastrophic Loss Benefits (Cont.)

- by your voluntary use of a controlled substance, unless: (1) it was prescribed for you by a doctor; and (2) it was used as prescribed. A controlled substance is anything called a controlled substance in Title II of the Comprehensive Drug Abuse Prevention and Control Act of 1970, as amended from time to time.

CGP-3-R-ADCL2-00

B310.0404

SPOUSAL EDUCATION AND RETRAINING BENEFIT

If you suffer a specified loss due to an accidental bodily injury, we will pay a spousal education and retraining benefit subject to all the terms below.

When And How The Spousal Education And Retraining Benefit Begins

We will pay a spousal education and retraining benefit when all of the following conditions are met:

- (a) a benefit is payable under this plan's Employee Basic Accidental Death and Dismemberment with Catastrophic Loss (ADDCL) Benefit, due to a specified loss; and
- (b) on the date of the accidental injury which results in the specified loss, you and your spouse share the same place of residence;
- (c) we receive proof of the spouse's enrollment in an institute of higher learning. The spouse must: (i) be enrolled on the date of the accidental injury which results in the specified loss; or (ii) enroll within 12 months of this date.

Specified Loss means: (1) death; (2) a comatose state which lasts for a period in excess of one month; (3) spinal cord injury, resulting in: (a) quadriplegia; (b) paraplegia; or (c) hemiplegia; or (4) severe head injury resulting in loss of cognitive function. Loss of cognitive function means a significant decline or loss in intellectual aptitude. It must be supported by clinical proof or standardized tests that precisely measure decline in the areas of: (i) short term memory; (ii) orientation to time, place and person; (iii) deductive or abstract reasoning; and (iv) judgement as it relates to awareness of safety.

Institute of Higher Learning includes, but is not limited to: (a) universities; (b) colleges; (c) trade schools; and (d) professional schools. It does not include graduate level programs.

What We Pay

Subject to all the terms of this plan, the Spousal Education and Retraining Benefit per academic term is equal to the lesser of: (i) the spouse's net tuition expense for the term; (ii) 5% of the Employee Basic ADDCL Benefit paid as a result of the specified loss; and (iii) \$2,500.00.

Tuition Expense means charges incurred for courses or lab fees. It does not include: (a) cost of books; (b) other related course materials; (c) student activity fees; or (d) room and board.

Net Tuition Expense means tuition expense less any scholarships or grants to which the spouse is entitled.

We pay this benefit to the person who has primary responsibility for these expenses.

Your Basic Accidental Death And Dismemberment With Catastrophic Loss Benefits (Cont.)

This benefit is paid per academic term. Benefit duration is based on whether the spouse is enrolled in a part-time or full-time course of study. See the Employee Basic Accidental Death and Dismemberment Insurance Schedule.

Continued Eligibility For The Spousal Education And Retraining Benefit We require periodic proof of the spouse's continued enrollment in an institute of higher learning. The spouse must maintain a grade point average of at least 2.0 on a 4.0 scale, or the equivalent. We also require proof, per academic term, of: (a) the spouse's tuition expenses; and (b) any scholarships and grants the spouse is entitled to.

When The Spousal Education And Retraining Benefit Ends The spousal education and retraining benefit ends on the earliest of the following dates:

- (a) the date the spouse is no longer enrolled in an institute of higher learning;
- (b) the date the spouse fails to maintain a minimum grade point average as required above;
- (c) the date the spouse fails to furnish proof as required above;
- (d) the date the lifetime maximum benefit amount, shown in the schedule, is reached; and
- (e) the date the maximum number of benefit payments, shown in the schedule, is reached.

CGP-3-R-ESED-00

B310.0407

DAY CARE EXPENSE BENEFIT

If you suffer a specified loss due to an accidental bodily injury, we will pay a Day Care Expense Benefit subject to all the terms below.

Eligibility For The Day Care Expense Benefit This plan provides a day care expense benefit when all of the following conditions are met:

- (a) a benefit is payable under this plan's Employee Basic Accidental Death and Dismemberment with Catastrophic Loss Benefit (ADDCL), due to a specified loss; and
- (b) we receive proof of a qualified dependent's enrollment in a qualified day care program. Such enrollment must commence within 12 months of the date of the specified loss.

Specified Loss means: (1) death; (2) a comatose state which lasts for a period in excess of one month; (3) spinal cord injury, resulting in: (a) quadriplegia; (b) paraplegia; or (c) hemiplegia; or (4) severe head injury resulting in loss of cognitive function. Loss of cognitive function means a significant decline or loss in intellectual aptitude. It must be supported by clinical proof or standardized tests that precisely measure decline in the areas of: (i) short term memory; (ii) orientation to time, place and person; (iii) deductive or abstract reasoning; and (iv) judgement as it relates to awareness of safety.

Your Basic Accidental Death And Dismemberment With Catastrophic Loss Benefits (Cont.)

Qualified Dependent: For purposes of the Day Care Expense Benefit a qualified dependent is: (a) your: (i) biological child; (ii) lawfully adopted child; (iii) stepchild; or (iv) any other child who is living with you in a regular parent-child relationship; (b) dependent upon you for main support and maintenance; and (c) under the age of seven on the date of the accidental injury which results in the specified loss.

Qualified Day Care Program: means a program of child care which: (i) is provided in a facility that is licensed as a day care center; or (ii) is operated by a licensed day care provider; and (iii) charges a fee for the care of children. A qualified day care program does not include child care provided by a parent, step-parent, grandparent, sibling, aunt or uncle.

What We Pay Subject to all the terms of this plan, the Day Care Expense Benefit is equal to the lesser of: (i) \$10,000 annually; or (ii) the actual annual day care expenses for all of your qualified dependents.

We pay this benefit quarterly, in arrears, upon receipt of proof of qualified day care expenses. Proof should be submitted within 30 days following the end of each calendar year quarter.

Payment will be made to the person who has primary responsibility for these expenses.

Continued Eligibility For The Day Care Expense Benefit We require periodic proof that a qualified dependent remains enrolled in a qualified day care program. We require periodic proof of the qualified dependent's day care expenses.

When The Day Care Expense Benefit Ends This plan's Day Care Expense Benefits end on the earliest of the following dates:

- (a) the date the dependent is no longer qualified, as defined above;
- (b) the date the dependent is no longer enrolled in a qualified day care program;
- (c) the date we do not receive proof of qualified day care expenses, as required by this plan; and
- (d) four years from the date the first day care expense benefit is paid.

CGP-3-R-EDCXB-00

B310.0412

DEPENDENT CHILD EDUCATION BENEFIT

If you suffer a specified loss due to an accidental bodily injury, we will pay an education benefit on behalf of a qualified dependent, subject to all the terms below.

When And How The Dependent Child Education Benefit Begins We will pay a Dependent Child Education Benefit when all of the following conditions are met:

- (a) A benefit is payable under this plan's Employee Basic Accidental Death and Dismemberment with Catastrophic Loss Benefit (ADDCL), due to a specified loss;

Your Basic Accidental Death And Dismemberment With Catastrophic Loss Benefits (Cont.)

- (b) We receive proof of a qualified dependent's enrollment in an institute of higher learning. The dependent must be a full-time student, as defined by the institute.

Specified Loss means: (1) death; (2) a comatose state which lasts for a period in excess of one month; (3) spinal cord injury which results in: (a) quadriplegia; (b) paraplegia; or (c) hemiplegia; or (4) severe head injury which results in loss of cognitive function. Loss of cognitive function means a significant decline or loss in intellectual aptitude. It must be supported by clinical proof or standardized tests that precisely measure decline in the areas of: (i) short term memory; (ii) orientation to time, place and person; (iii) deductive or abstract reasoning; and (iv) judgement as it relates to awareness of safety.

Qualified Dependent: To be qualified for the Dependent Child Education Benefit, a dependent must meet the following conditions. The dependent must be: (a) your: (i) biological child; (ii) lawfully adopted child; (iii) stepchild; or (iv) any other child who is living with you in a regular parent-child relationship; (b) unmarried; and (c) dependent upon you for main support and maintenance. On the date of the accidental injury which results in the specified loss, the dependent must be: (a) 22 years of age or younger; and (b) enrolled as a full-time student in an institute of higher learning; or (c) in the 12th grade, and enroll as a full-time student in an institute of higher learning within 12 months of this date. The dependent must maintain a grade point average of at least 2.0 on a 4.0 scale, or the equivalent.

Institute of Higher Learning includes, but is not limited to: (a) universities; (b) colleges; (c) trade schools; and (d) professional schools. It does not include graduate level programs.

What We Pay Subject to all the terms of this plan, the Dependent Child Education Benefit per academic term is equal to the lesser of: (i) the qualified dependent's net tuition expense for the term; (ii) 5% of the Basic ADDCL Benefit paid as a result of the specified loss; or (iii) \$2,500.00.

Tuition Expense means charges incurred for credit courses or lab fees. It does not include: (a) cost of books; (b) other related course materials; (c) student activity fees; or (d) room and board.

Net Tuition Expense means tuition expense less any scholarships or grants to which the dependent is entitled.

We pay this benefit per academic term for each qualified dependent.

We pay this benefit to the person who has primary responsibility for these expenses.

Continued Eligibility For Dependent Education Benefit We require periodic proof that a dependent remains a qualified dependent, as defined above. We also require proof, per academic term, of: (a) the qualified dependent's tuition expenses; and (b) any scholarships and grants the dependent is entitled to.

Your Basic Accidental Death And Dismemberment With Catastrophic Loss Benefits (Cont.)

**When The
Dependent Child
Education Benefit
Ends**

A qualified dependent's Dependent Child Education Benefit ends on the earliest of the following dates:

- (a) the date the dependent child is no longer a qualified dependent, as defined above;
- (b) the date the dependent fails to furnish proof as required above;
- (c) the date the lifetime maximum benefit amount, shown in the schedule, is reached;
- (d) the date the maximum number of benefit payments, shown in the schedule, is reached; and
- (e) the date the maximum benefit period, shown in the schedule, is reached.

CGP-3-R-EDCED-00

B310.0419

ELIGIBILITY FOR VISION CARE EXPENSE COVERAGE

B505.0152

Employee Vision Care Expense Coverage

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

Other Conditions You must enroll and agree to make required payments within 31 days of your *eligibility date*. If you fail to do so, you can't enroll until this *plan's* next vision open enrollment period.

This *plan's* vision open enrollment period occurs from September 1st to September 30th of each year.

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

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

CGP-3-EC-90-1.0

B505.0060

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

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

CGP-3-EC-90-2.0

B505.0075

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

Your coverage ends on the date you die.

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

Employee Vision Care Expense Coverage (Cont.)

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

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

CGP-3-EC-90-3.0

B505.0083

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

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

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

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

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

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

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

CGP-3-EC-90-3.0

B449.0727

Dependent Vision Care Expense Coverage

CGP-3-DEP-90-1.0

B505.0099

Eligible Dependents For Dependent Vision Care Benefits

Your *eligible dependents* are: (a) your legal spouse; (b) your unmarried dependent children who are under age 20; and (c) your unmarried dependent children from age 20 until their 26 birthday, who are enrolled as full-time students at accredited schools.

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

CGP-3-DEP-90-2.0

B505.0782

Adopted Children And Step-Children

Your "unmarried dependent children" include your legally adopted children and, if they depend on you for most of their support and maintenance, your step-children.

Dependent Coverage (Cont.)

We treat a child as legally adopted from the time the child is placed in your physical custody for the purpose of adoption. We treat such a child this way whether or not a final adoption order is ever issued. We cover your adopted child from the moment of his or her placement if you are already covered for dependent child coverage when the child is placed for adoption. If you do not have dependent coverage when the child is placed for adoption, we cover the child for the first 31 days from the moment of his or her placement. To continue the child's coverage past the 31 days, you must enroll the child and agree to make any required premium payments within 31 days of the date of placement. If you fail to do this, the child's coverage will end at the end of the 31 days, and the child cannot be enrolled for this coverage until the plan's next open enrollment period.

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

CGP-3-DEP-90-3.1

B505.0537

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

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

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

The child's coverage ends when yours does.

CGP-3-DEP-90-4.0

B505.0119

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

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

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

Dependent Vision Care Expense Coverage (Cont.)

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

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

CGP-3-DEP-90-6.0

B505.0130

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

CGP-3-DEP-90-7.0

B505.0132

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

CGP-3-DEP-90-8.0

B505.0538

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

If a surviving dependent elects to continue his dependent vision care benefits under this *plan's* "Federal Continuation Rights" provision, or under any other continuation provision of this *plan*, if any, this free continuation period will be provided as the first six months of such continuation. Premiums required to be paid by, or on behalf of a surviving dependent will be waived for the first six months of continuation, subject to restrictions (a), (b) and (c) above. After the first six months of continuation, the remainder of the continuation period, if any, will be subject to the premium requirements, and all of the terms of the "Federal Continuation Rights" or other continuation provisions.

Dependent Vision Care Expense Coverage (Cont.)

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

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

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

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

CGP-3-DEP-90-9.0

B505.0139

CERTIFICATE AMENDMENT

Effective October 1, 2008, this rider amends the dependent coverage provisions as follows:

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

To qualify for such coverage, you and your domestic partner must be registered domestic partners.

As used here:

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

Your registered domestic partner will be eligible for vision coverage under this plan.

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

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

A registered domestic partner will have all of the rights of a spouse under this plan except that the continuation of vision coverage as explained under the "Federal Continuation Rights" section is available to a registered domestic partner and his or her children only if you are also eligible for and elect continuation.

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

The Guardian Life Insurance Company of America



Vice President, Group Products

VISION CARE HIGHLIGHTS

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

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

CGP-3-VSN-96-BEN3

B505.0004

VISION CARE EXPENSE INSURANCE

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

CGP-3-VSN-96-VIS

B505.0007

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

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

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

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

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

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

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

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

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

Vision Service Plan

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

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

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

CGP-3-VSN-96-PPOA

B505.0009

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

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

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

CGP-3-VSN-96-PTR2

B505.0014

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

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

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

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

Vision Service Plan

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

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

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

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

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

CGP-3-VSN-96-APP

B505.0015

How This Plan Works

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

Services or Supplies From a Preferred Provider

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

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

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

Services or Supplies From a Preferred Provider (Cont.)

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

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

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

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

For covered charges 100%

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

The discounts are:

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

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

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

If a *covered person* receives a vision examination, and lenses or frames from a *preferred provider*, he or she will receive a discount on the cost of purchasing an unlimited number of additional prescription glasses and non-prescription sunglasses from the same *preferred provider* on the same day.

The discounts are:

For Prescription Glasses 30% off of the *preferred provider's*
usual and customary fee

For Non-Prescription Sunglasses 30% off of the *preferred provider's*
usual and customary fee

Services or Supplies From a Non-Preferred Provider

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

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

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

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

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

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

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

For covered charges 100%

CGP-3-VSN-96-BEN2

B505.0021

Covered Charges

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

Covered Services and Supplies

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

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

Covered Services and Supplies (Cont.)

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

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

We don't cover more than one vision examination in any 12 month period.

And if a *covered person* uses a *non-preferred provider*, we limit what we pay for each vision examination to \$46.00.

CGP-3-VSN-96-LIST1

B505.0025

Standard Lenses We cover charges for single vision, bifocal, trifocal or *lenticular lenses*. We cover glass, plastic or for dependent children to age 20, polycarbonate lenses.

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

- \$47.00 for each pair of single vision lenses
- \$66.00 for each pair of bifocal lenses
- \$85.00 for each pair of trifocal lenses and
- \$125.00 for each pair of *lenticular lenses*.

B505.0453

We do not cover charges for more than one set of *standard lenses* in any 24 month period.

B505.0455

CGP-3-VSN-05-SL

B505.0461

Standard Frames We cover charges for standard frames.

If a *covered person* uses a preferred provider, we cover charges up to a retail frame allowance of \$120.00, plus 20% of any amount over the allowance.

If a *covered person* uses a non-preferred provider, we limit what we pay for each set of standard frames to \$47.00.

We don't cover charges for more than one set of standard frames in any 24 month period.

Covered Services and Supplies (Cont.)

If the covered person chooses elective contact lenses, we do not cover standard frames for 24 months from the date the elective contacts are purchased.

CGP-3-VSN-05-SF

B505.1261

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

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

We don't cover charges for more than one pair of Necessary Contact Lenses in any 24 month period.

If a *covered person* receives Necessary Contact Lenses from a *preferred provider*, we pay 100% of covered charges. If he or she receives Necessary Contact Lenses from a *non-preferred provider*, we limit what we pay to \$210.00 in any 24 month period.

CGP-3-VSN-96-LIST7

B505.0028

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

If we cover charges for elective contact lenses, we will not cover charges for standard lenses for 24 months and standard frames for at least 24 months.

We limit what we pay for elective contact lenses to \$120.00 once every 24 months.

CGP-3-VSN-05-ECL

B505.0427

Special Limitations

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

CGP-3-VSN-96-SL1

B505.0031

Exclusions

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

CGP-3-VSN-96-EXC1

B505.0034

- We will not pay for plano lenses (lenses with less than a .38 diopter power).
- We will not pay for two sets of glasses in lieu of bifocals.
- We will not pay for replacement of lenses and frames furnished under this plan which are lost or broken, except at normal intervals when services are otherwise available.
- We will not pay for blended lenses.
- We will not pay for oversized lenses.
- We will not pay for the laminating of the lens or lenses.
- We will not pay for a frame that costs more than the plan allowance.
- We will not pay for UV (ultraviolet protected lenses).
- We will not pay for cosmetic lenses or any cosmetic process, unless specifically shown as covered in the "Covered Services and Supplies" section.
- We will not pay for progressive multifocal lenses.
- We will not pay for the coating of the lens or lenses.
- We will not pay for photochromic lenses and tinted lenses, except for pink #1 and pink #2.

CGP-3-VSN-05-EXC

B505.0428

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

CGP-3-VSN-96-EXC17

B505.0037

CERTIFICATE AMENDMENT

We cover charges for Primary Eye Care (PEC) treatment from a preferred provider in excess of a \$20 copay for each office visit.

PEC is designed for the detection, treatment and management of ocular conditions and systemic conditions, which produce ocular or visual symptoms which left untreated may result in vision loss.

We cover services performed by a preferred provider only if such service is within the scope of his or her optometric license.

Covered persons may call for an appointment or be seen immediately if the preferred provider determines urgent care is necessary.

Under this provision, we do not cover charges for

- PEC treatment or services from a non-preferred provider;
- Pre- and post- operative services
- Laser surgery
- A and B scans
- Lab tests, including surgical pathology and microbiology services, which should be coordinated with a covered person's medical primary care physician; or
- Services provided for refractive diagnoses that are part of the covered person's routine vision care coverage.

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



Vice President, Group Products

GLOSSARY

	This Glossary defines the italicized terms appearing in your booklet.	
	CGP-3-GLOSS-90	B900.0118
Anisometropia	means a condition of unequal refractive state for the two eyes, one eye requiring different lens correction than the other.	
	CGP-3-VSN-96-DEF1	B750.0457
Benefit Period	with respect to Vision Care Insurance, means the time period beginning when a covered service is received and extending to the date on which, according to the time limitations contained in this <i>plan</i> , the covered service is again available to a <i>covered person</i> .	
	CGP-3-VSN-96-DEF3	B750.0458
Blended Lenses	mean bifocals which do not have a visible dividing line.	
	CGP-3-VSN-96-DEF3	B750.0459
Coated Lenses	means substance added to a finished lens on one or both surfaces.	
	CGP-3-VSN-96-DEF3	B750.0460
Copayment	with respect to Vision Care Insurance, means a charge, expressed as a fixed dollar amount, required to be paid by or on behalf of a <i>covered person</i> to a <i>preferred provider</i> at the time covered vision services are received.	
	CGP-3-VSN-96-DEF3	B750.0461
Covered Person	with respect to Vision Care Insurance, means an <i>employee</i> or eligible dependent who meets this <i>plan's</i> eligibility criteria and who is covered under this <i>plan</i> .	
	CGP-3-VSN-96-DEF3	B750.0462
Customary	with respect to Vision Care Insurance, means, when referring to a covered charge, that the charge for the covered vision condition isn't more than the <i>usual</i> charge made by most other doctors with similar training and experience in the same geographic area.	
	CGP-3-VSN-96-DEF3	B750.0484
Deductible	with respect to Vision Care Insurance, means any amount which a <i>covered person</i> must pay before he or she is reimbursed for covered services provided by a <i>non-preferred provider</i> .	
	CGP-3-VSN-96-DEF3	B750.0483
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

Glossary (Cont.)

Employee	means a person who works for the <i>employer</i> at the <i>employer's</i> place of business, and whose income is reported for tax purposes using a W-2 form.	CGP-3-GLOSS-90	B750.0006
Employer	means THE KINGS ACADEMY .	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 <i>employee</i> regularly works at least the number of hours in the normal work week set by the <i>employer</i> (but not less than 30 hours per week), at his <i>employer's</i> place of business.	CGP-3-GLOSS-90	B750.0229
Incurred, Or Incurred Date	with respect to Vision Care Insurance, means the placing of an order for lenses, frames or contact lenses, or the date on which such an order was placed.	CGP-3-VSN-96-DEF3	B750.0466
Initial Dependents	means those <i>eligible dependents</i> you have at the time you first become eligible for <i>employee</i> coverage. If at this time you do not have any <i>eligible dependents</i> , but you later acquire them, the first <i>eligible dependents</i> you acquire are your <i>initial dependents</i> .	CGP-3-GLOSS-90	B900.0006
Keratoconus	means a development or dystrophic deformity of the cornea in which it becomes coneshaped due to a thinning and stretching of the tissue in its central area.	CGP-3-VSN-96-DEF11	B750.0467
Lenticular Lenses	mean high-powered lenses with the desired prescription power found only in the central portion. The outer carrier portion has a front surface with a changing radius of curvature.	CGP-3-VSN-96-DEF11	B750.0485
Newly Acquired Dependent	means an <i>eligible dependent</i> you acquire after you already have coverage in force for <i>initial dependents</i> .	CGP-3-GLOSS-90	B900.0008
Non-Preferred Provider	with respect to Vision Care Insurance, means any optometrist, optician, ophthalmologist, or other licensed and qualified vision care provider who has not contracted with the <i>plan</i> to provide vision care services and/or vision care materials to <i>covered persons</i> of the <i>plan</i> .	CGP-3-VSN-96-DEF14	B750.0487

Glossary (Cont.)

Orthoptics	means the teaching and training process for the improvement of visual perception and coordination of two eyes for efficient and comfortable binocular vision.	CGP-3-VSN-96-DEF16	B750.0472
Oversize lenses	mean larger than a <i>standard lens</i> blank, to accommodate prescriptions.	CGP-3-VSN-96-DEF17	B750.0489
Photochromic Lenses	mean lenses which change color with the intensity of sunlight.	CGP-3-VSN-96-DEF17	B750.0490
Plan	means the <i>Guardian</i> group <i>plan</i> purchased by your <i>employer</i> , 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
Plan Benefits	with respect to Vision Care Insurance, mean the vision care services and vision care materials which a <i>covered person</i> is entitled to receive by virtue of coverage under this <i>plan</i> .	CGP-3-VSN-96-DEF17	B750.0492
Plano Lenses	mean lenses which have no refractive power (lenses with less than a +/- .38 diopter power).	CGP-3-VSN-96-DEF17	B750.0491
Preferred Provider	with respect to Vision Care Insurance, means an optometrist, ophthalmologist or optician or other licensed and qualified vision care provider who has contracted with the <i>plan</i> to provide vision care services and/or vision care materials on behalf of <i>covered persons</i> of the <i>plan</i> .	CGP-3-VSN-96-DEF14	B750.0488
Proof or Proof of Insurability	means an application for insurance showing that a person is insurable.	CGP-3-GLOSS-90	B900.0010
Standard Frames	mean frames valued up to the limit published by VSP which is given to <i>preferred providers</i> .	CGP-3-VSN-96-DEF17	B750.0478
Standard Lenses	mean regular glass or plastic lenses. See the "Special Limitations" section for what we limit or exclude.	CGP-3-VSN-96-DEF17	B750.0479

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

CGP-3-VSN-96-DEF17

B750.0480

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

CGP-3-VSN-96-DEF17

B750.0481

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

CGP-3-VSN-96-DEF17

B750.0482

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.

Continue Group Health Plan Coverage

Continue health care coverage for yourself, spouse or dependents if there is a loss of coverage under the plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. You should review this summary plan description and the documents governing the plan on the rules governing your COBRA continuation coverage rights.

Prudent Actions By Plan Fiduciaries

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

Enforcement Of Your Rights

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

Statement of Erisa Rights (Cont.)

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

Assistance with Questions

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

Qualified Medical Child Support Order

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

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

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

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

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

B800.0094

The Guardian's Responsibilities

B800.0048

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

B800.0055

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

B800.0049

Group Health Benefits Claims Procedure

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

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

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

Definitions "Adverse determination" means any denial, reduction or termination of a benefit or failure to provide or make payment (in whole or in part) for a benefit. A failure to cover an item or service: (a) due to the application of any utilization review; or (b) because the item or service is determined to be experimental or investigational, or not medically necessary or appropriate, is also considered an adverse determination.

"Group Health Benefits" means any dental, out-of-network point-of-service medical, major medical, vision care or prescription drug coverages which are a part of this plan.

"Pre-service claim" means a claim for a medical care benefit with respect to which the plan conditions receipt of the benefit, in whole or in part, on approval of the benefit in advance of receipt of care.

"Post-service claim" means a claim for payment for medical care that already has been provided.

"Urgent care claim" means a claim for medical care or treatment where making a non-urgent care decision: (a) could seriously jeopardize the life or health of the claimant or the ability of the claimant to regain maximum function, as determined by an individual acting on behalf of the plan applying the judgment of a prudent layperson who possesses an average knowledge of health and medicine; or (b) in the opinion of a physician with knowledge of the claimant's medical condition, would subject the claimant to severe pain that cannot be adequately managed without the care.

Note: Any claim that a physician with knowledge of the claimant's medical condition determines is a claim involving urgent care will be treated as an urgent care claim for purposes of this section.

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

Urgent Care Claims. Guardian will make a benefit determination within 72 hours after receipt of an urgent care claim.

Group Health Benefits Claims Procedure (Cont.)

If a claimant fails to provide all information needed to make a benefit determination, Guardian will notify the claimant of the specific information that is needed as soon as possible but no later than 24 hours after receipt of the claim. The claimant will be given not less than 48 hours to provide the specified information.

Guardian will notify the claimant of the benefit determination as soon as possible but not later than the earlier of:

- the date the requested information is received; or
- the end of the period given to the claimant to provide the specified additional information.

The required notice may be provided to the claimant orally within the required time frame provided that a written or electronic notification is furnished to the claimant not later than 3 days after the oral notification.

Pre-Service Claims. Guardian will provide a benefit determination not later than 15 days after receipt of a pre-service claim. If a claimant fails to provide all information needed to make a benefit determination, Guardian will notify the claimant of the specific information that is needed as soon as possible but no later than 5 days after receipt of the claim. A notification of a failure to follow proper procedures for pre-service claims may be oral, unless a written notification is requested by the claimant.

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

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

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

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

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

Group Health Benefits Claims Procedure (Cont.)

Concurrent Care Decisions. A reduction or termination of an approved ongoing course of treatment (other than by plan amendment or termination) will be regarded as an adverse benefit determination. This is true whether the treatment is to be provided(a) over a period of time; (b) for a certain number of treatments; or (c) without a finite end date. Guardian will notify a claimant at a time sufficiently in advance of the reduction or termination to allow the claimant to appeal.

In the case of a request by a claimant to extend an ongoing course of treatment involving urgent care, Guardian will make a benefit determination as soon as possible but no later than 24 hours after receipt of the claim.

Adverse Benefit Determination

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

- the specific reason(s) for the adverse determination;
- reference to the specific plan provision(s) on which the determination is based;
- a description of any additional material or information necessary to make the claim valid and an explanation of why such material or information is needed;
- a description of the plan's claim review procedures and the time limits applicable to such procedures, including a statement indicating that the claimant has the right to bring a civil action under ERISA Section 502(a) following an adverse benefit determination;
- identification and description of any specific internal rule, guideline or protocol that was relied upon in making an adverse benefit determination, or a statement that a copy of such information will be provided to the claimant free of charge upon request;
- in the case of an adverse benefit determination based on medical necessity or experimental treatment, notice will either include an explanation of the scientific or clinical basis for the determination, or a statement that such explanation will be provided free of charge upon request; and
- in the case of an urgent care adverse determination, a description of the expedited review process.

Appeal of Adverse Benefit Determinations

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

A request for an appeal of an adverse benefit determination involving an urgent care claim may be submitted orally or in writing. Necessary information and communication regarding an urgent care claim may be sent to Guardian by telephone, facsimile or similar expeditious manner.

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

- the opportunity to submit written comments, documents, records and other information relating to the claim;

Group Health Benefits Claims Procedure (Cont.)

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

In reviewing an appeal, Guardian will:

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

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

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

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

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

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

B800.0076

Termination of This Group Plan

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

Life And Accidental Death And Dismemberment Insurance Claims Procedure

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.

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")

- (a) If a claim is wholly or partially denied, the claimant will be notified of the decision within 90 days after Guardian received the claim.
- (b) If special circumstances require an extension of time for processing the claim, written notice of the extension shall be furnished to the claimant prior to the termination of the initial 90-day period. In no event shall such extension exceed a period of 90 days from the end of such initial period. The extension notice shall indicate the special circumstances requiring an extension of time and the date by which The Guardian expects to render the final decision.
- (c) If a claim is denied, Guardian will provide a notice that will set forth:
 - (1) the specific reason(s) the claim was denied;
 - (2) specific references to the pertinent plan provision on which the denial is based;
 - (3) a description of any additional material or information needed to make the claim valid, and an explanation of why the material or information is needed;
 - (4) an explanation of the plan's claim review procedure. A claimant must file a request for review of a denied claim within 60 days after receipt of written notification of denial of a claim.
- (d) Guardian will notify the claimant of its decision within 60 days of receipt of the request for review. If special circumstances require an extension of time for processing, The Guardian will render a decision as soon as possible, but no later than 120 days after receiving the request. The Guardian will notify the claimant about the extension.

B800.0079

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 or convert your insurance coverage. Your rights upon termination of the *plan* are explained in this booklet.

B800.0007

YOUR BENEFITS INFORMATION - ANYTIME, ANYWHERE

www.GuardianAnytime.com

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

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

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

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

To register, go to www.GuardianAnytime.com



GUARDIANSM

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