YOUR GROUP INSURANCE PLAN BENEFITS

THE EVERGREENE COMPANIES

CLASS 0001

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

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

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

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

New Mexico Residents
Consumer Complaint Notice

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

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

CCN-2019-NM

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

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

CERTIFICATE OF COVERAGE

The Guardian
10 Hudson Yards
New York, New York 10001

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

Group Policy No.	Certificate No.	Effective Date
Issued To		

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

The Guardian Life Insurance Company of America

Michael Prestileo, Senior Vice President

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IMPORTANT INFORMATION REGARDING YOUR INSURANCE

In the event you need to contact someone about this insurance for any reason please contact your agent. If no agent was involved in the sale of this insurance, or if you have additional questions you may contact the insurance company issuing this insurance at the following address and telephone number:

The Guardian Sales Office
Maple Lawn Office Three
8161 Maple Lawn Boulevard
Suite 100
Maple Lawn, Maryland 20759 Telephone: (301) 957-7320
Fax: (301) 957-7339

If you have been unable to contact or obtain satisfaction from the company or the agent, you may contact:

Virginia State Corporation Commission
Bureau of Insurance
P.O. Box 1157
Richmond, VA 23218
Telephone: (800) 552-7945

Written correspondence is preferable so that a record of your inquiry is maintained. When contacting your agent, company or the Bureau of Insurance, have you policy number available.

If you have a complaint pertaining to the availability, delivery, or quality of health care services including adverse decisions, claims payments, the handling or reimbursement for such service(s), or any other matter, you may contact:

Office of Licensure and Certification
Virginia Department of Health
9960 Maryland Drive - Suite 401
Richmond, VA 23233-1463

Telephone: (804) 367-2106 (Richmond Metro Area)
(800) 955-1819

Fax: (804) 527-4503
E-mail: mchip@vdh.virginia.gov

You have the right to file a complaint and will not be penalized for exercising these rights.

CGP-3-R-VADISC-97 B120.0070

NOTICE OF PROTECTION PROVIDED BY VIRGINIA LIFE, ACCIDENT AND SICKNESS INSURANCE GUARANTY ASSOCIATION

This notice provides a **brief summary**of the Virginia Life, Accident and Sickness Insurance Guaranty Association ("the Association") and the protection it provides for policyholders. This safety net was created under Virginia law, which determines who and what is covered and the amounts of coverage.

The Association was established to provide protection in the unlikely event that a life, annuity or health insurance company licensed in the Commonwealth of Virginia becomes financially unable to meet its obligations and is taken over by its Insurance Department. If this should happen, the Association will typically arrange to continue coverage and pay claims, in accordance with Virginia law, with funding from assessments paid by other life and health insurance companies licensed in the Commonwealth of Virginia.

The basic protections provided by the Association are:

- Life Insurance

- $300,000 in death benefits
- $100,000 in cash surrender or withdrawal values

- Health Insurance

- $500,000 in hospital, medical and surgical insurance benefits
- $300,000 in disability income insurance benefits
- $300,000 in long-term care insurance benefits
- $100,000 in other types of health insurance benefits

- Annuities

- $250,000 in withdrawal and cash values

The maximum amount of protection for each individual, regardless of the number of policies or contracts, is $350,000, except for hospital, medical and surgical insurance benefits, for which the limit is increased to $500,000.

Note: Certain policies and contracts may not be covered or fully covered. For example, coverage does not extend to any portion(s) of a policy or contract that the insurer does not guarantee, such as certain investment additions to the account value of a variable life insurance policy or a variable annuity contract. There are also various residency requirements and other limitations under Virginia law.

To learn more about the above protections, please visit the Association's website at www.valifega.org or contact:

VIRGINIA LIFE, ACCIDENT AND SICKNESS
INSURANCE GUARANTY ASSOCIATION
c/o APM Management Services, Inc.
8001 Franklin Farms Drive, Suite 235
Henrico, VA 23229
804-282-2240

STATE CORPORATION COMMISSION
Bureau of Insurance
P. O. Box 1157
Richmond, VA 23218
804-371-9741
Toll Free Virginia only: 1-800-552-7945
http://www.scc.virginia.gov/division/boi/index.htm

Insurance companies and agents are not allowed by Virginia law to use the existence of the Association or its coverage to encourage you to purchase any form of insurance. When selecting an insurance company, you should not rely on Association coverage. If there is any inconsistency between this notice and Virginia law, then Virginia law will control.

CGP-3-R-VADISC-11 B120.0075

All Options

GENERAL PROVISIONS

As used in this booklet:

"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 B160.0012

All Options

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

All Options

Incontestability

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

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

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

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

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 Loss *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 are 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. But *we* can't tell you that a particular provider must provide such care. And you may not assign your right to take legal action under this *plan* to such provider.

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

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

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 notice contains important information about the right to continue group dental coverage. In addition to the continuation rights described below, other health coverage alternatives may be available through states' Health Insurance Marketplaces. Please read the information contained in this notice very carefully.

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".

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 B235.0631

All Options

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

All Options

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.

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.

All Options

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.

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;

(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.

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

All Options

ELIGIBILITY FOR DENTAL COVERAGE

B489.0002

All Options

Employee Coverage

Eligible Employees

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

Other Conditions

If you must pay all or part of the cost of *employee* coverage, we won't insure you until you enroll and agree to make the required payments. If you do this: (a) more than 31 days after you first become eligible; or (b) after you previously had coverage which ended because you failed to make a required payment, we consider you to be a late entrant.

If you initially waived dental coverage under this *plan* because you were covered under another group *plan,* and you now elect to enroll in the dental coverage under this *plan*, the Penalty for Late Entrants provision will not apply to you with regard to dental coverage provided your coverage under the other *plan* ends 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 the dental coverage under this *plan* within 30 days of the date that any of the events described above occur.

CGP-3-EC-90-1.0 B489.0122

All Options

When Your Coverage Starts

Employee benefits are scheduled to start on your effective date.

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

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

CGP-3-EC-90-2.0 B489.0070

All Options

When Your Coverage Ends

Your coverage ends on the last day of the month in which your active *full-time* service ends for any reason, other than disability. Such reasons include 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.

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

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

CGP-3-EC-90-3.0 B489.0075

All Options

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.
- **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

All Options

Dependent Coverage

B200.0271

All Options

Eligible Dependents For Dependent Dental Benefits Your *eligible dependents* are: (a) your legal spouse; and (b) your dependent children who are under age 26.

CGP-3-DEP-90-2.0 B489.0506

All Options

Adopted Children And Step-Children

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

Dependents Not Eligible

We exclude any dependent who is insured by this *plan* as an *employee*. And we exclude any dependent who is on active duty in any armed force.

CGP-3-DEP-90-3.0 B489.0509

All Options

Handicapped Children

You may have a child who is: (i) incapable of self-sustaining employment by reason of intellectual disability or physical handicap; and (ii) chiefly dependent on you for support and maintenance. Subject to all of the terms of this coverage and the plan, such a child may stay eligible for dependent benefits past this coverage's age limit. The child will stay eligible as long as he or she is unable to support himself or herself, if: (a) his or her conditions started before he or she reached this coverage's age limit; (b) he or she became insured by this coverage before he or she reached the age limit, and stayed continuously insured until he or she reached such limit; and (c) he or she depends on you for most of his or her support and maintenance. But, for the child to stay eligible, you must send us written proof that the child is handicapped and depends on you for most of his or her support and maintenance. You have 31 days from the date 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-VA B449.0860

All Options

Waiver Of Dental Late Entrants Penalty

If you initially waived dental coverage for your spouse or eligible dependent children under this plan because they were covered under another group plan, and you now elect to enroll them in the dental coverage under this plan, the Penalty for Late Entrants provision will not apply to them with regard to dental coverage provided their coverage under the other plan ends 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 your spouse or eligible dependent children in the dental coverage under this plan within 30 days of the date that any of the events described above occur.

In addition, the Penalty for Late Entrants provision for dental coverage will not apply to your spouse or eligible dependent children if: (a) you are under legal obligation to provide dental coverage due to a court-order; and (b) you enroll them in the dental coverage under this plan within 30 days of the issuance of the court-order.

CGP-3-DEP-90-5.0 B200.0749

All Options

When Dependent Coverage Starts

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

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

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

If you do this after the *enrollment period* ends, each of your *initial dependents* is a late entrant and is subject to any applicable late entrant penalties. The dependent's coverage is scheduled to start on the first of the month which coincides with or next follows the date you sign the enrollment form.

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

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 first becomes eligible. If you fail to notify us on time, the *newly acquired dependent*, when enrolled, is a late entrant and is subject to any applicable late entrant penalties. The late entrant's coverage is scheduled to start on the date you sign the enrollment form.

CGP-3-DEP-90-6.0 B489.0254

All Options

Exception

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

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

All Options

Newborn Children

We cover your newborn child for dependent benefits, from the moment of birth if: (a) you are already covered for dependent child coverage when the child is born; or (b) you 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, once the child is enrolled, the child is a late entrant, is subject to any applicable late entrant penalties, and will be covered as of the date you sign the enrollment form.

CGP-3-DEP-90-8.0 B489.0019

All Options

When Dependent Coverage Ends

Dependent coverage ends for all of an employee's dependents when his or her employee coverage ends. But, if an employee dies while insured, we'll automatically continue dependent benefits for those of his or her dependents who were insured when he or she died. 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 or her dependent 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 coverage also ends for all of an employee's dependents when the employee stops being a member of a class of employees eligible for such coverage. And, it ends when this plan ends, or when dependent coverage is dropped from this plan for all employees or for an employee's class.

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

An individual dependent's coverage ends when he or she stops being an eligible dependent. This happens to a child on the last day of the month in which the child attains this coverage's age limit. It happens to a spouse on the last day of the month in which 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 certain group benefits for a limited time.

All Options

DENTAL HIGHLIGHTS

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

- **Benefit Year Cash Deductible for Non-Orthodontic Services**

  For Group I Services . . . . . None
  For Group II and III Services $50.00
  for each covered person

CGP-3-DENT-HL-90 B497.0507

All Options

- **Payment Rates:**

  For Group I Services 100%
  For Group II Services 80%
  For Group III Services 50%
  For Group IV Services 50%

CGP-3-DENT-HL-90 B497.0086

All Options

- **Benefit Year Payment Limit for Non-Orthodontic Services**

  For Group I, II and III Services . . . . . Up to $1,500.00

- **Lifetime Payment Limit for Orthodontic Treatment**

  For Group IV Services . . . . . Up to $2,000.00

Note: A covered person may be eligible for a rollover of a portion of his or her unused Benefit Year Payment Limit for Non-Orthodontic Services. See "Rollover of Benefit Year Payment Limit for Non-Orthodontic Services" for details.

CGP-3-DENT-HL-90 B497.1432

All Options

Group Enrollment Period

A group enrollment period is held each year. The group enrollment period is a time period agreed to by your employer and us. During this period, you may elect to enroll in dental insurance under this *plan*. Coverage starts on the first day of the month that next follows the date of enrollment. You and your *eligible dependents* are not subject to late entrant penalties if you enroll during the group enrollment period.

CGP-3-DENT-HLTS B497.2407

All Options

DENTAL EXPENSE INSURANCE

This insurance will pay many of a *covered person's* dental expenses. *We* pay benefits for covered charges incurred by a *covered person*. What *we* pay and terms for payment are explained below.

CGP-3-DG2000 B498.0007

All Options

DentalGuard Preferred - This Plan's Dental Preferred Provider Organization

This *plan* is designed to provide high quality dental care while controlling the cost of such care. To do this, the *plan* encourages a *covered person* to seek dental care from *dentists* and dental care facilities that are under contract with *Guardian's dental preferred provider organization (PPO),* which is called DentalGuard Preferred.

The dental PPO is made up of *preferred providers* in a covered person's geographic area. Use of the dental PPO is voluntary. A *covered person* may receive dental treatment from any dental provider he or she chooses. And he or she is free to change providers anytime.

This *plan* usually pays a higher level of benefits for covered treatment furnished by a *preferred provider*. Conversely, it usually pays less for covered treatment furnished by a *non-preferred provider*.

When an *employee* enrolls in this *plan,* he or she and his or her dependents receive a dental plan ID card and information about current *preferred providers*.

A *covered person* must present his or her ID card when he or she uses a *preferred provider*. Most *preferred providers* prepare necessary claim forms for the *covered person,* and submit the forms to *us*. We send the *covered person* an explanation of this *plan's* benefit payments, but any benefit payable by us is sent directly to the *preferred provider*.

What *we* pay is based on all of the terms of this *plan*. Please read this *plan* carefully for specific benefit levels, deductibles, *payment rates* and *payment limits*.

A *covered person* may call the Guardian at the number shown on his or her ID card should he or she have any questions about this *plan*.

CGP-3-DGY2K-PPO B498.0151

Covered Charges

Whether a *covered person* uses the services of a *preferred provider* or a *non-preferred provider,* covered charges are the charges listed in the fee schedule the *preferred provider* has agreed to accept as payment in full, for the dental services listed in this *plan's* List of Covered Dental Services.

To be covered by this *plan,* a service must be: (a) necessary; (b) appropriate for a given condition; and (c) included in the List of Covered Dental Services.

We may use the professional review of a *dentist* to determine the appropriate benefit for a dental procedure or course of treatment.

When certain comprehensive dental procedures are performed, other less extensive procedures may be performed prior to, at the same time or at a later date. For benefit purposes under this *plan,* these less extensive procedures are considered to be part of the more comprehensive procedure. Even if the *dentist* submits separate bills, the total benefit payable for all related charges will be limited to the maximum benefit payable for the more comprehensive procedure. For example, osseous surgery includes the procedure scaling and root planing. If the scaling and root planing is performed one or two weeks prior to the osseous surgery, we may only pay benefits for the osseous surgery.

We only pay benefits for covered charges incurred by a *covered person* while he or she is insured by this *plan.* A covered charge for a crown, bridge or cast restoration is incurred on the date the tooth is initially prepared. A covered charge for any other *dental prosthesis* is incurred on the date the first master impression is made. A covered charge for root canal treatment is incurred on the date the pulp chamber is opened. A covered charge for *orthodontic treatment* is incurred on the date the *active orthodontic appliance* is first placed. All other covered charges are incurred on the date the services are furnished. If a service is started while a *covered person* is insured, *we'll* only pay benefits for services which are completed within 31 days of the date his or her coverage under this *plan* ends.

COMPLAINT & APPEAL PROCESS

Definitions As used in this section:

"Adverse Determination" means a determination by the *utilization review entity* that based upon information provided, a request for a benefit upon application of any utilization review technique does not meet the managed care health insurance plan's requirements for medical necessity, appropriateness, health care setting, level of care, or effectiveness or is determined to be experimental or investigational and the requested benefit is therefore denied, reduced or terminated or payment is not provided or made, in whole or in part, for the benefit.

"Appeal" means a formal request by a covered person or a provider on behalf of a covered person for reconsideration of a determination such as a utilization review recommendation, a benefit payment, an administrative action, or a quality-of-care or service issue.

"Appellant" means: (i) the covered person; (ii) the covered person's parent, guardian, legal custodian, or other individual authorized by law to act on behalf of the covered person, if the covered person is a minor; (iii) the covered person's spouse, parent, committee, legal guardian, or other individual authorized by law to act on behalf of the covered person if the covered person is not a minor but is incompetent or incapacitated; or (iv) the covered person's treating health care provider acting with the consent of the covered person, the covered person's parent, guardian, legal custodian, or other individual authorized by law to act on behalf of the covered person, if the covered person is a minor, or the covered person's spouse, parent, committee, legal guardian, or other individual authorized by law to act on behalf of the covered person, if the covered person is not a minor but is incompetent or incapacitated.

"Complaint" means a written communication primarily expressing a grievance. A complaint may pertain to the availability, delivery, or quality of health care services including *adverse determinations,* claims payments, the handling or reimbursement for such service(s), or any other matter pertaining to the covered person's contractual relationship with the *Managed Care Health Insurance Plan (MCHIP).*

"Concurrent review" means *utilization review* conducted during a patient's stay or course of treatment in a facility, the office of a health care professional, or other inpatient or outpatient health care setting.

"Final adverse determination" means an *adverse determination* involving a covered benefit that has been upheld by a managed care health insurance plan, or it's designee *utilization review entity,* at the completion of the managed care health insurance plan's internal appeal process.

"Independent review organization" means an organization selected by the Bureau of Insurance that conducts external reviews of *adverse determinations* and *final adverse determinations.*

"Managed care health insurance plan" or *"MCHIP"* means an arrangement for the delivery of health care in which Guardian undertakes to provide, arrange for, pay for, or reimburse any of the costs of health care services for a covered person on a prepaid or insured basis which: i) contains one or more incentive arrangements, including any credentialing requirements intended to influence the cost or level of health care services between the health carrier and one or more providers with respect to the delivery of health care services; and ii) requires or creates benefit payment differential incentives for covered persons to use providers that are directly or indirectly managed, owned, under contract with or employed by the health carrier. For the purposes of this definition, the prohibition of balance billing by a provider shall not be deemed a benefit payment differential incentive for covered persons to use providers who are directly or indirectly manage, owned, under contract with or employed by the health carrier. A single managed care health insurance plan may encompass multiple types of benefit payment differentials; however, a single managed care health insurance plan shall encompass only one provider network or set of provider networks.

"Medically necessary" means appropriate and necessary health care services which are rendered for any condition which, according to generally accepted principles of good medical practice, requires the diagnosis or direct care and treatment of an illness, injury, or pregnancy- related condition, and are not provided only as a convenience.

"Peer of the treating health care provider" means a physician or other health care professional who holds a non-restricted license in the Commonwealth of Virginia or under a comparable licensing law of a state of the United States and in the same or similar specialty as typically manages the medical condition, procedure or treatment under review.

"Physician advisor" means a physician licensed to practice medicine in the Commonwealth of Virginia or under a comparable licensing law of a state of the United States who provides medical advice or information to a private review agent or a *utilization review entity* in connection with its *utilization review* activities.

"Prospective review" means *utilization review* conducted prior to an admission or a course of treatment.

"Retrospective review" means a review of medical necessity conducted after services have been provided to a patient, but does not include the review of a claim that is limited to an evaluation of reimbursement levels, veracity of documentation, accuracy of coding, or adjustment for payment.

"Timely" means the provision of services so as not to impair or jeopardize the integrity of the covered person's diagnosis or outcomes of illness.

"Treating health care provider" or *"Provider"* means:

a) a licensed health care provider who renders or proposes to render health care services to a covered person; and

b) for purposes of this provision, is acting on behalf of the covered person.

All Options

"Urgent Care Appeal" means an *appeal* for medical care or treatment with respect to which the application of the time periods for making non-urgent care determinations (i) could seriously jeopardize the life or health of the covered person or the ability of the covered person to regain maximum function; or (ii) in the opinion of the treating health care professional with knowledge of the covered person's medical condition, would subject the covered person to severe pain that cannot be adequately managed without the care or treatment that is the subject of the *appeal*. An *urgent care appeal* shall not be available for any post-service claim or retrospective adverse determination.

"Utilization Review" means a system for reviewing the necessity, appropriateness and efficiency of hospital, medical or other health care services rendered or proposed to be rendered to a covered person for the purpose of determining whether such services should be covered. Utilization review includes, but is not limited to, preadmission, concurrent and retrospective *medical necessity* determination, and review related to the appropriateness of the site at which services were or are to be delivered. Utilization review also includes determinations of medical necessity based upon contractual limitations regarding "experimental" or "investigational" procedures, by whatever terms designated in the evidence of coverage. Utilization review does not include any: (i) denial of benefits for a procedure which is explicitly excluded pursuant to the terms of the contract or evidence of coverage; (ii) review of issues concerning contractual restrictions on facilities to be used for the provision of services; or (iii) determination by an insurer as to the reasonableness and necessity of services for the treatment and care of an injury suffered by an insured for which reimbursement is claimed under a contract of insurance covering any other classes of insurance.

"Utilization review entity" or *"entity"* means an insurer or managed care health insurance plan licensee that performs utilization review or upon whose behalf utilization review is performed with regard to the health care or proposed health care that is the subject of the final adverse determination.

All Options

Internal Appeal Procedures

Complaint Process If a covered person has concerns regarding a quality of care issue, he or she may file a *complaint* as follows:

In Writing: Center for Quality Health Care Services and Consumer Protection
Virginia Department of Health
9960 Mayland Drive, Suite 401
Henrico, Virginia 23233

Telephone: 804-367-2104 (Richmond Metro Area)
800-955-1819

Fax: 804-367-2149

E-mail: mchip@vdh.state.va.us

If a covered person or his or her *treating health care provider* does not agree with a *utilization review* determination, his or her provider may file, within 180 days of receipt of the *determination*, a *complaint* to request reconsideration of the *adverse determination*.

A *complaint* for reconsideration of a *utilization review* determination made by Guardian should be made to:

For Dental Claims

Guardian
Group Quality Assurance-WRO
P.O. Box 981573
El Paso, TX 79998-1573

The *provider's* written *complaint* requesting reconsideration should provide the *utilization review entity* with any added information which: (a) relates to the case; and (b) may impact on the first determination. A determination on reconsideration will be made by a *physician advisor, peer of the treating health care provider,* or a panel of other appropriate health care providers with at least one *physician advisor* or *peer of the treating health care provider* on the panel.

Resolution of the *complaint,* and written notification of such determination will be provided to the covered person and the *treating health care provider* no later than ten (10) working days after receipt of the *complaint*.

The written notification of such determination will include the criteria used and the clinical reason for the *adverse determination,* and, if any, the alternate length of treatment of the alternate treatment setting(s) that the *utilization review entity* deems to be appropriate.

If the reconsideration results in a *final adverse determination,* the covered person, his or her *provider,* or a representative of the covered person may *appeal* the *final adverse determination*.

Appeals of Adverse Determinations

Except as explained below for an urgent care appeal, a covered person, his or her *treating health care provider,* or a representative of the covered person may make a written request for an *appeal* of an *adverse determination* or a *final adverse determination* made by the *utilization review entity*.

An *appeal* for reconsideration of a determination made by Guardian should be made to:

For Dental Claims

Guardian
Group Quality Assurance-WRO
P.O. Box 981573
El Paso, TX 79998-1573

The request for *appeal* of a determination should provide the *utilization review entity* with any additional evidence for consideration (e.g., pertinent medical records of the covered person's *provider,* the pertinent records of any facility in which health care is provided to the covered person, etc.).

Any information provided to the *utilization review entity* to support an *appeal* will be reviewed by a *physician advisor* or a *peer of the treating health care provider.* With the exception of expedited *appeals,* a *physician advisor* must be:

a) a *peer of the treating health care provider* who proposes the care under review or who was primarily responsible for the care under review;

b) board certified; and

c) specialized in a discipline pertinent to the issue under review.

A *physician advisor* or *peer of the treating health care provider* who renders a decision on *appeal* must:

a) not have participated in the *adverse decision* or any prior reconsideration thereof;

b) not be employed by or be a director of the *utilization review entity;* and

c) be licensed to practice in Virginia, or under a comparable licensing law of a state of the United States, as a *peer of the treating health care provider.*

In the *appeals* process, consideration will be given to the availability or non-availability of alternative health care services proposed by the *utilization review entity.*

Except for *urgent care appeals,* written notification of the results of the *appeal* process will be provided to the covered person, his or her *treating health care provider,* or the representative of the covered person who filed the *appeal.* Notification for *prospective reviews* will be provided no later than thirty (30) working days after receiving all required documentation. Notification for *retrospective reviews* will be no later than sixty (60) working days after receiving all required documentation. Notification for *concurrent care reviews* will be provided sufficiently in advance of a reduction or termination of a benefit after receipt of the claim to allow the *appellant* to *appeal* and obtain a determination on review before the benefit is reduced or terminated but in no case will this be less than thirty (30) working days after receiving all required documentation. The notification of all decisions will state the criteria used and the clinical reason for the decision.

All Options

Urgent Care Appeals of Adverse Determinations

When the *treating health care provider* believes that an *adverse determination* or adverse reconsideration warrants an immediate *appeal,* the *treating health care provider* shall have the opportunity to *appeal* on an urgent care basis.

An *urgent care appeal* may be requested only when the regular reconsideration and *appeals* process would delay the rendering of health care in a manner that would be detrimental to the health of the covered person. Both the *utilization review entity* and the *treating health care provider* must attempt to share the maximum information by telephone, facsimile machine, or otherwise to resolve the *urgent care appeal* in a satisfactory manner.

A written or oral *appeal* for *urgent care* reconsideration of an *adverse determination* or a *final adverse determination* made by Guardian should be made to:

For Dental Claims

Guardian
Group Quality Assurance-WRO
P.O. Box 981573
El Paso, TX 79998-1573

Phone: 1-800-541-7846
Fax: 1-509-468-6399

If additional information is needed to make a determination, the *appellant* will be notified of the specified information needed as soon as possible but not later than twenty-four (24) hours after receipt of the request for appeal. Such notice will be provided orally or, if requested by the *appellant,* it shall be provided in writing and shall state what specified information is needed. The *appellant* must provide the requested information within forty-eight (48) hours.

Any decision of an *urgent care appeal* must be made by a *physician advisor, peer of the treating health care provider,* or a panel of other appropriate health care providers with at least one *physician advisor* on the panel. A decision on a prospective *urgent care appeal* will be made by the *utilization review entity* no later than seventy- two (72) hours after receipt by the *utilization review entity* of all information necessary to make such a determination. A decision on an concurrent *urgent care appeal* will be made by the *utilization review entity* no later than seventy-two (72) hours after receipt by the *utilization review entity* of all information necessary to make such a determination, but the request to continue treatment must be received at least twenty-four (24) hours prior to the expiration of the prescribed period of time or number of treatments.

An *urgent care appeal* determination may be further appealed through the *utilization review entity's* standard *appeal* process If:

a) all material information and documentation was not reasonably available to the provider and to the *utilization review entity* at the time of the *expedited review appeal;*

b) the *physician advisor* reviewing the case under an *urgent care review appeal:* i) was not a *peer of the treating health care provider;* and ii) was not board certified or board eligible, and specialized in a discipline pertinent to the issue under review

If the review of an *urgent care appeal* by a *utilization review entity* results in a *final adverse determination,* the *utilization review entity* will immediately notify the person who requested the *urgent care appeal* of the *final adverse determination.*

CGP-3-C&A.2-VA-02 B497.2460

All Options

Consumer Assistance

If you have any questions regarding an appeal or grievance concerning the health care services that you have been provided that have not been satisfactorily addressed by your plan, you may contact the Office of the Managed Care Ombudsman for assistance.

The Office of the Managed Care Ombudsman is charged with protecting the interests of *covered persons* under *MCHIP's* in the Commonwealth of Virginia. For purposes of this plan, the Office of The Managed Care Ombudsman must:

1) assist *covered persons* in understanding their rights and the processes available to them according to their *managed care health insurance plan;*

2) answer inquiries from *covered persons,* their *treating health care providers,* and any representative of the *covered person* received via telephone, mail, electronic mail or in person;

3) provide to *covered persons,* their *treating health care providers,* and any representative of the *covered person* information concerning *managed health care insurance plans* and other *utilization review entities* upon request;

4) upon request, assist *covered persons* in using the procedures and processes available to them from their *managed care health insurance plan,* including all *utilization review appeals.* Such assistance may require the review of insurance and health care records of a *covered person,* which shall be done only with the express written consent of the *covered person.* The confidentiality of all such information shall be maintained in accordance with the laws of the Commonwealth of Virginia.

5) ensure that *covered persons* have access to the services provided through the Office and that the *covered persons* receive timely responses from the representatives of the Office to the inquiries.

The address, telephone number, or E-mail address shown below should be used in order to obtain assistance with any questions regarding an *appeal* or *complaint* concerning the health care services provided which have not been satisfactorily addressed by the *utilization review entity*.

Address: Office of the Managed Care Ombudsman
Bureau of Insurance
P.O. Box 1157
Richmond, Virginia 23218

Telephone: 1-877-310-6560 toll-free
1-804-371-9032 in the Richmond Metropolitan Area

Ombudsman E-mail: ombudsman@scc.virginia.gov

Bureau of Insurance Website: www.scc.virginia.gov

CGP-3-C&A.3-VA-14 B490.0253

All Options

Alternate Treatment

If more than one type of service can be used to treat a dental condition, *we* have the right to base benefits on the least expensive service which is within the range of professionally accepted standards of dental practice as determined by *us*. For example, in the case of bilateral multiple adjacent teeth, or multiple missing teeth in both quadrants of an arch, the benefit will be based on a removable partial denture. In the case of a composite filling on a *posterior tooth*, the benefit will be based on the corresponding amalgam filling benefit.

Proof Of Claim

So that *we* may pay benefits accurately, the *covered person* or his or her *dentist* must provide *us* with information that is acceptable to *us*. This information may, at *our* discretion, consist of radiographs, study models, periodontal charting, narratives or other diagnostic materials that document *proof of claim* and support the necessity of the proposed treatment. If *we* don't receive the necessary information, *we* may pay no benefits, or minimum benefits. However, if *we* receive the necessary information within 15 months of the date of service, *we* will redetermine the *covered person's* benefits based on the new information.

CGP-3-DGY2K-AT B498.0002

Pre-Treatment Review

When the expected cost of a proposed course of treatment is $300.00 or more, the *covered person's dentist* should send us a treatment plan before he or she starts. This must be done on a form acceptable to *Guardian*. The treatment plan must include: (a) a list of the services to be done, using the American Dental Association Nomenclature and codes; (b) the itemized cost of each service; and (c) the estimated length of treatment. In order to evaluate the treatment plan, dental radiographs, study models and whatever else will document the necessity of the proposed course of treatment, must be sent to *us*.

A treatment plan should always be sent to us before orthodontic treatment starts.

We review the treatment plan and estimate what we will pay. We will send the estimate to the covered person and/or the covered person's dentist. If the treatment plan is not consistent with accepted standards of dental practice, or if one is not sent to us, we have the right to base our benefit payments on treatment appropriate to the covered person's condition using accepted standards of dental practice.

The covered person and his or her dentist have the opportunity to have services or a treatment plan reviewed before treatment begins. Pre-treatment review is not a guarantee of what we will pay. It tells the covered person, and his or her dentist, in advance, what we would pay for the covered dental services listed in the treatment plan. But, payment is conditioned on: (a) the services being performed as proposed and while the covered person is insured; and (b) the deductible, payment rate and payment limits provisions, and all of the other terms of this plan.

Emergency treatment, oral examinations, evaluations, dental radiographs and teeth cleaning are part of a course of treatment, but may be done before the pre-treatment review is made.

We won't deny or reduce benefits if pre-treatment review is not done. But what we pay will be based on the availability and submission of proof of claim.

CGP-3-DGY2K-PTR B498.0003

Benefits From Other Sources

Other plans may furnish benefits similar to the benefits provided by this *plan*. For instance, you may be covered by this *plan* and a similar plan through your spouse's employer. You may also be covered by this *plan* and a medical plan. In such instances, we coordinate *our* benefits with the benefits from that other plan. *We* do this so that no one gets more in benefits than the charges he or she incurs. Read "Coordination of Benefits" to see how this works.

CGP-3-DGY2K-OS B498.0005

The Benefit Provision - Qualifying For Benefits

CGP-3-DGY2K-BEN B498.0072

All Options

Penalty For Late Entrants

During the first 6 months that a late entrant is covered by this *plan*, *we* won't pay for the following services:

- All Group II Services.

During the first 12 months a late entrant is covered by this *plan*, *we* won't pay for the following services:

- All Group III Services.

During the first 24 months a late entrant is covered by this *plan*, *we* won't pay for the following services:

- All Group IV Services.

Charges for the services we don't cover under this provision are not considered to be covered charges under this *plan*, and therefore can't be used to meet this *plan's* deductibles.

We don't apply a late entrant penalty to covered charges incurred for services needed solely due to an *injury* suffered by a *covered person* while insured by this *plan*.

A late entrant is a person who: (a) becomes covered by this dental *plan* more than 31 days after he or she is eligible; or (b) becomes covered again, after his or her coverage lapsed because he or she did not make required payments.

CGP-3-DGY2K-LE B498.0231

All Options

How We Pay Benefits For Group I, II And III Non-Orthodontic Services

There is no deductible for Group I services. *We* pay for Group I covered charges at the applicable *payment rate*.

A *benefit year* deductible of $50.00 applies to Group II and III services. Each *covered person* must have covered charges from these service groups which exceed the deductible before *we* pay him or her any benefits for such charges. These charges must be incurred while the *covered person* is insured.

Once a *covered person* meets the deductible, *we* pay for his or her Group II and III covered charges above that amount at the applicable *payment rate* for the rest of that *benefit year*.

CGP-3-DGY2K-BP-07 B498.3653

All Options

All covered charges must be incurred while insured. We limit what we pay each benefit year to $1,500.00. What we pay for Group I Services is not subject to, nor applied toward, the *benefit year payment limit* shown in the schedule but subject to all of the other terms of this plan.

CGP-3-DGY2K-BP-07 B498.3477

All Options

The Benefit Provision - Qualifying For Benefits

A *covered person* may be eligible for a rollover of a portion of his or her unused *benefit year* payment limit for Group I, II and III Non-Orthodontic Services. See "Rollover of Benefit Year Payment Limit for Group I, II and III Services" for details.

CGP-3-DG-ROLL-04-2.1 B498.2041

All Options

Rollover of Benefit Year Payment Limit for Group I, II and III Non-Orthodontic Services

A *covered person* may be eligible for a rollover of a portion of his or her unused *benefit year* payment limit for Group I, II and III Non-Orthodontic Services, as follows:

If a *covered person* submits at least one claim for covered charges during a *benefit year* and, in that *benefit year,* receives benefits that are in excess of any deductible or co-pay fees, and that, in total, do not exceed the *Rollover Threshold*, he or she may be entitled to a Reward.

Note: If all of the benefits that a *covered person* receives in a *benefit year* are for services provided by a *preferred provider,* he or she may be entitled to a greater *Reward* than if any of the benefits are for services of a *non-preferred provider.*

Rewards can accrue and are stored in the *covered person's Bank.* If a *covered person* reaches his or her *benefit year* payment limit for Group I, II and III Non-Orthodontic Services, we pay benefits up to the amount stored in the *covered person's Bank.* The amount of *Reward* stored in the *Bank* may not be greater than the *Bank Maximum.*

A *covered person's Bank* may be eliminated, and the accrued *Reward* lost, if he or she has a break in coverage of any length of time, for any reason.

The amounts of this *plan's Rollover Threshold, Reward,* and *Bank Maximum* are:

- *Rollover Threshold* $700.00
- *Reward* (if all benefits are for services provided by a *preferred provider)* $500.00
- *Reward* (if any benefits are for services provided by a *non-preferred provider)* $350.00

- *Bank Maximum* $1,250.00

If this *plan's* dental coverage first becomes effective in October, November or December, this rollover provision will not apply until January 1 of the first full *benefit year.* And, if the effective date of a *covered person's* dental coverage is in October, November or December, this rollover provision will not apply to the covered person until January 1 of the next full *benefit year.* In either case:

- only claims incurred on or after January 1 will count toward the *Rollover Threshold;* and
- *Rewards* will not be applied to a *covered person's Bank* until the *benefit year* that starts one year from the date the rollover provision first applies.

If charges for any dental services are not payable for a *covered person* for a period set forth in the provision of this *plan* called Penalty for Late Entrants, this rollover provision will not apply to the *covered person* until the end of such period. And, if such period ends within the three months prior to the start of this plan's next *benefit year,* this rollover provision will not apply to the *covered person* until the next *benefit year,* and:

- only claims incurred on or after the start of the next *benefit year* will count toward the *Rollover Threshold;* and
- *Rewards* will not be applied to a *covered person's Bank* until the *benefit year* that starts one year from the date the rollover provision first applies.

Definitions of terms used in this provision:

"Bank" means the amount of a *covered person's* accrued *Reward* .

"Bank Maximum" means the maximum amount of *Reward* that a *covered person* can store in his or her *Bank.*

"Reward" means the dollar amount which may be added to a *covered person's Bank* when he or she receives benefits in a *benefit year* that do not exceed the *Rollover Threshold.*

"Rollover Threshold" means the maximum amount of benefits that a *covered person* can receive during a *benefit year* and still be entitled to receive a *Reward.*

CGP-3-DG-ROLL-04-2 B498.9137

How We Pay Benefits For Group IV Orthodontic Services

This *plan* provides benefits for Group IV orthodontic services.

We pay for Group IV covered charges at the applicable *payment rate*. There may be different *payment rates* which apply to covered charges for services from a *preferred provider* and a *non-preferred provider*.

Using the *covered person's* original treatment *plan, we* calculate the total benefit *we* will pay. *We* divide the benefit into equal payments, which *we* will spread out over the shorter of: (a) the proposed length of treatment; or (b) two years.

We make the initial payment when the *active orthodontic appliance* is first placed. *We* make further payments at the end of each subsequent three month period, upon receipt of verification of ongoing treatment. But, treatment must continue and the *covered person* must remain covered by this *plan*. *We* limit what *we* pay for orthodontic services to the lifetime payment of $2,000.00. What *we* pay is based on all of the terms of this *plan*.

We don't pay for orthodontic charges incurred by a *covered person* prior to being covered by this *plan*. *We* limit what *we* pay for *orthodontic treatment* started prior to a *covered person* being covered by this *plan* to charges determined to be incurred by the *covered person* while covered by this *plan*. Based on the original treatment *plan*, *we* determine the portion of charges incurred by the *covered person* prior to being covered by this *plan,* and deduct them from the total charges. What *we* pay is based on the remaining charges. *We* limit what *we* consider of the proposed treatment *plan* to the shorter of the proposed length of treatment, or two years from the date the *orthodontic treatment* started.

The benefits *we* pay for *orthodontic treatment* won't be charged against a *covered person's benefit year* payment limits that apply to all other services.

The negotiated discounted fees for orthodontics performed by a *preferred provider* include: (a) treatment *plan* and records, including initial, interim and final records; (b) orthodontic retention, including any and all necessary fixed and removable *appliances* and related visits; and (c) limited, interceptive and comprehensive *orthodontic treatment,* with associated: (i) fabrication and insertion of any and all fixed *appliances;* and (ii) periodic visits.

There is a separate negotiated discounted fee for *orthodontic treatment* which extends beyond 24 consecutive months.

The negotiated discounted fee for orthodontics performed by a *preferred provider* does not include: (a) any incremental charges for orthodontic *appliances* made with clear, ceramic, white lingual brackets or other optional material; (b) procedures, *appliances* or devices to guide minor tooth movement or to correct harmful habits; (c) retreatment of orthodontic cases, or changes in *orthodontic treatment* necessitated by any kind of accident; (d) replacement or repair of orthodontic *appliances* damaged due to the neglect of the patient; (e) orthognathic surgery and associated incremental charges; (f) extractions performed solely to facilitate orthodontic treatment; and (g) *orthodontic treatment* started before the member was eligible for orthodontic benefits under this *plan*.

Whether or not a charge is based on a discounted fee, it will be counted toward a *covered person's* orthodontic lifetime payment limit under this *plan*.

All Options

Non-Orthodontic Family Deductible Limit

A *covered family* must meet no more than three individual *benefit year* deductibles in any *benefit year*. Once this happens, *we* pay benefits for covered charges incurred by any *covered person* in that *covered family*, at the applicable *payment rate* for the rest of that *benefit year*. The charges must be incurred while the person is insured. What *we* pay is based on this *plan's payment limits* and to all of the terms of this *plan*.

CGP-3-DGY2K-FL B498.0073

All Options

Payment Rates

Benefits for covered charges are paid at the following *payment rates:*

- Benefits for Group I Services performed by a *preferred provider* 100%
- Benefits for Group I Services performed by a *non-preferred provider* 100%
- Benefits for Group II Services performed by a *preferred provider* 80%
- Benefits for Group II Services performed by a *non-preferred provider* 80%
- Benefits for Group III Services performed by a *preferred provider* 50%
- Benefits for Group III Services performed by a *non-preferred provider* 50%
- Benefits for Group IV Services performed by a *preferred provider* 50%
- Benefits for Group IV Services performed by a *non-preferred provider* 50%

CGP-3-DGY2K-PR B498.0080

All Options

After This Insurance Ends

We don't pay for charges incurred after a *covered person's* insurance ends. But, subject to all of the other terms of this *plan, we'll* pay for the following if the procedure is finished in the 31 days after a *covered person's* insurance under this *plan* ends: (a) a bridge or cast restoration, if the tooth or teeth are prepared before the *covered person's* insurance ends; (b) any other *dental prosthesis,* if the master impression is made before the *covered person's* insurance ends; and (c) root canal treatment, if the pulp chamber is opened before the *covered person's* insurance ends.

We pay benefits for *orthodontic treatment* to the end of the month in which the *covered person's* insurance ends.

CGP-3-DGY2K-END B498.0233

All Options

Special Limitations

CGP-3-DGY2K-LMT B498.0138

All Options

Teeth Lost, Extracted Or Missing Before A Covered Person Becomes Covered By This Plan

A *covered person* may have one or more congenitally missing teeth or may have had one or more teeth lost or extracted before he or she became covered by this *plan. We* won't pay for a *dental prosthesis* which replaces such teeth unless the *dental prosthesis* also replaces one or more eligible natural teeth lost or extracted after the *covered person* became covered by this *plan.*

CGP-3-DGY2K-TL B498.0133

If This Plan Replaces The Prior Plan

This *plan* may be replacing the *prior plan* you had with another insurer. If a *covered person* was insured by the *prior plan* and is covered by this *plan* on its effective date, the following provisions apply to such *covered person*.

- **Teeth Extracted While Insured By The Prior Plan** - The "Teeth Lost, Extracted or Missing Before A Covered Person Becomes Covered By This Plan" provision above, does not apply to a *covered person's dental prosthesis* which replaces teeth: (a) that were extracted while the *covered person* was insured by the *prior plan;* and (b) for which extraction benefits were paid by the *prior plan*.
- **Deductible Credit** - In the first *benefit year* of this *plan,* we reduce a *covered person's* deductibles required under this *plan,* by the amount of covered charges applied against the *prior plan's* deductible. The *covered person* must give us proof of the amount of the *prior plan's* deductible which he or she has satisfied.
- ***Benefit Year* Non-Orthodontic Payment Limit Credit** - In the first *benefit year* of this *plan,* we reduce a *covered person's benefit year payment limits* by the amounts paid or payable under the *prior plan*. The *covered person* must give us proof of the amounts applied toward the *prior plan's* payment limits.
- **Orthodontic Payment Limit Credit** - We reduce a *covered person's* orthodontic *payment limits* by the amounts paid or payable under the *prior plan*. The *covered person* must give us proof of the amounts applied toward the *prior plan's* payment limits.

Exclusions

We will not pay for:

- Any service or supply which is not specifically listed in this *plan's* List of Covered Dental Services.
- Any procedure performed in conjunction with, as part of, or related to a procedure which is not covered by this *plan*.
- Educational services, including, but not limited to, oral hygiene instruction, plaque control, tobacco counseling or diet instruction.
- Precision attachments and the replacement of part of a precision attachment, magnetic retention or overdenture attachments.
- Overdentures and related services, including root canal therapy on teeth supporting an overdenture.
- Any restoration, procedure, *appliance* or *prosthetic device* used solely to: (1) alter vertical dimension; (2) restore or maintain occlusion, except to the extent that this *plan* covers *orthodontic treatment;* (3) treat a condition necessitated by attrition or abrasion; or (4) splint or stabilize teeth for periodontal reasons.

- The use of general anesthesia, intramuscular sedation, intravenous sedation, non-intravenous sedation or inhalation sedation, including but not limited to nitrous oxide, except when administered in conjunction with covered periodontal surgery, surgical extractions, the surgical removal of impacted teeth, apicoectomies, root amputations and services listed under the "Other Oral Surgical Procedures" section of this *plan*.
- The use of local anesthetic.
- Cephalometric radiographs, oral/facial images, including traditional photographs and images obtained by intraoral camera, except when performed as part of the *orthodontic treatment* plan and records for a covered course of *orthodontic treatment*.
- Replacement of a lost, missing or stolen *appliance* or *dental prosthesis* or the fabrication of a spare *appliance* or *dental prosthesis*.
- Prescription medication.
- Desensitizing medicaments and desensitizing resins for cervical and/or root surface.
- Duplication of radiographs, the completion of claim forms, OSHA or other infection control charges.
- Pulp vitality tests or caries susceptibility tests.
- Bite registration or bite analysis.
- Gingival curettage.
- The localized delivery of chemotherapeutic agents.
- Tooth transplants.
- Maxillofacial prosthetics that repair or replace facial and skeletal anomalies, maxillofacial surgery, orthognathic surgery or any oral surgery requiring the setting of a fracture or dislocation.
- Temporary or provisional *dental prosthesis* or *appliances* except interim partial dentures/stayplates to replace *anterior teeth* extracted while insured under this *plan*.
- Any service or procedure associated with the placement, prosthodontic restoration or maintenance of a dental implant and any incremental charges to other covered services as a result of the presence of a dental implant.
- Any service furnished solely for cosmetic reasons. This includes, but is not limited to: (1) characterization and personalization of a *dental prosthesis;* (2) facings on a *dental prosthesis* for any teeth posterior to the second bicuspid; (3) bleaching of discolored teeth; and (4) odontoplasty.
- Replacing an existing *appliance* or *dental prosthesis* with a like or un-like *appliance* or *dental prosthesis;* unless (1) it is at least 5 years old and is no longer usable; or (2) it is damaged while in the *covered person's* mouth in an *injury* suffered while insured, and can't be made serviceable.

- A fixed bridge replacing the extracted portion of a hemisected tooth or the placement of more than one unit of crown and/or bridge per tooth.
- The replacement of extracted or missing third molars/wisdom teeth.
- Treatment of congenital or developmental malformations, or the replacement of congenitally missing teeth.
- Any endodontic, periodontal, crown or bridge abutment procedure or *appliance* performed for a tooth or teeth with a guarded, questionable or poor prognosis.
- Any procedure or treatment method which does not meet professionally recognized standards of dental practice or which is considered to be experimental in nature.
- Any procedure, *appliance, dental prosthesis,* modality or surgical procedure intended to treat or diagnose disturbances of the temporomandibular joint (TMJ).
- Treatment needed due to: (1) an on-the-job or job-related *injury;* or (2) a condition for which benefits are payable by Worker's Compensation or similar laws.
- Treatment for which no charge is made. This usually means treatment furnished by: (1) the *covered person's* employer, labor union or similar group, in its dental or medical department or clinic; (2) a facility owned or run by any governmental body; and (3) any public program, except Medicaid, paid for or sponsored by any governmental body.
- Evaluations and consultations for non-covered services; detailed and extensive oral evaluations.
- The repair of an orthodontic appliance.
- The replacement of a lost or broken orthodontic retainer.

CGP-3-DGY2K-EXC B498.0031

All Options

List of Covered Dental Services

The services covered by this *plan* are named in this list. Each service on this list has been placed in one of four groups. A separate payment rate applies to each group. Group I is made up of preventive services. Group II is made up of basic services. Group III is made up of major services. Group IV is made up of orthodontic services.

All covered dental services must be furnished by or under the direct supervision of a *dentist.* And they must be usual and necessary treatment for a dental condition.

CGP-3-DNTL-90-13 B490.0048

Group I - Preventive Dental Services
(Non-Orthodontic)

Prophylaxis And Fluorides

Prophylaxis - limited to a total of 2 prophylaxis or periodontal maintenance procedure (considered under "Periodontal Services") in any 12 consecutive month period. Allowance includes scaling and polishing procedures to remove coronal plaque, calculus, and stains.

- Adult prophylaxis covered age 12 and older.

Additional prophylaxis when needed as a result of a medical (i.e., a non-dental) condition - covered once in 12 months, and only when the additional prophylaxis is recommended by the dentist and is a result of a medical condition as verified in writing by the patient's medical physician. This does not include a condition which could be resolved by proper oral hygiene or that is the result of patient neglect.

Fluoride treatment, topical application - limited to *covered persons* under age 19 and limited to 2 treatment(s) in any 12 consecutive month period.

Office Visits, Evaluations And Examination

Office visits, oral evaluations, examinations or limited problem focused re-evaluations - limited to a total of 2 in any 12 consecutive month period.

Emergency or problem focused oral evaluation - limited to a total of 1 in a 6 consecutive month period. Covered if no other treatment, other than radiographs, is performed in the same visit.

After hours office visit or emergency palliative treatment and other non-routine, unscheduled visits. Limited to a total of 1 in a 6 consecutive month period. Covered only when no other treatment, other than radiographs, is performed during the same visit.

CGP-3-DNTL-90-14 B498.4802

All Options

Space Maintainers

Space Maintainers - limited to *covered persons* under age 16 and limited to initial *appliance* only. Covered only when necessary to replace prematurely lost or extracted deciduous teeth. Allowance includes all adjustments in the first six months after insertion, limited to a maximum of one bilateral per arch or one unilateral per quadrant, per lifetime.

- Fixed - unilateral
- Fixed - bilateral
- Removable - bilateral
- Removable - unilateral

Recementation of space maintainer performed more than 12 months after the initial insertion

Fixed And Removable Appliances

Fixed and Removable Appliances To Inhibit Thumbsucking - limited to *covered persons* under age 14 and limited to initial *appliance* only. Allowance includes all adjustments in the first 6 months after insertion.

CGP-3-DNTL-90-14 B498.0164

All Options

Radiographs Allowance includes evaluation and diagnosis.
Full mouth, complete series or panoramic radiograph - Either, but not both, of the following procedures, limited to one in any 36 consecutive month period.

Full mouth series, of at least 14 films including bitewings
Panoramic film, maxilla and mandible, with or without bitewing radiographs.

Other diagnostic radiographs:

Bitewing films - limited to either a maximum of 4 bitewing films or a set (7-8 films) of vertical bitewings, in one visit, once in any 12 consecutive month period.

Intraoral periapical or occlusal films - single films

CGP-3-DNTL-90-14 B498.0165

All Options

Diagnostic Services Adjunctive pre-diagnostic test that aids in detection of mucosal abnormalities including premalignant and malignant lesions, not to include cytology or biopsy procedures - limited to one test in any 24 consecutive month period for covered persons age 40 and older.

CGP-3-DNTL-90-17 B498.3461

All Options

Dental Sealants Dental Sealants - permanent molar teeth only - Topical application of sealants is limited to the unrestored, permanent molar teeth of *covered persons* under age 16 and limited to one treatment, per tooth, in any 36 consecutive month period.

CGP-3-DNTL-90-14 B498.0163

All Options

Group II - Basic Dental Services
(Non-Orthodontic)

Diagnostic Services Allowance includes examination and diagnosis.

Consultations - Diagnostic consultation with a dentist other than the one providing treatment, limited to one consultation for each *covered dental specialty* in any 12 consecutive month period. Covered only when no other treatment, other than radiographs, is performed during the visit.

Diagnostic Services: Allowance includes examination and diagnosis.

Diagnostic casts - when needed to prepare a treatment plan for three or more of the following performed at the same time in more than one arch: dentures, crowns, bridges, inlays or onlays.

Histopathologic examinations when performed in conjunction with a tooth related biopsy.

Restorative Services Multiple restorations on one surface will be considered one restoration. Benefits for the replacement of existing amalgam and resin restorations will only be considered for payment if at least 12 months have passed since the previous restoration was placed if the *covered person* is under age 19, and 36 months if the *covered person* is age 19 and older. Also see the "Major Restorative Services" section.

Amalgam restorations - Allowance includes bonding agents, liners, bases, polishing and local anesthetic.

Resin restorations - limited to *anterior teeth* only. Coverage for resins on *posterior teeth* is limited to the corresponding amalgam benefit. Allowance includes light curing, acid etching, adhesives, including resin bonding agents and local anesthetic.

Silicate cement, per restoration
Composite resin

Stainless steel crown, prefabricated resin crown, and resin based composite crown - limited to once per tooth in any 24 consecutive month period. Stainless steel crowns, prefabricated resin crowns and resin based composite crowns are considered to be a temporary or provisional procedure when done within 24 months of a permanent crown. Temporary and provisional crowns are considered to be part of the permanent restoration.

Pin retention, per tooth, covered only in conjunction with a permanent amalgam or composite restoration, exclusive of restorative material.

CGP-3-DNTL-90-15 B498.2780

All Options

Endodontic Services

Allowance includes diagnostic, treatment and final radiographs, cultures and tests, local anesthetic and routine follow-up care, but excludes final restoration.

Pulp capping, limited to permanent teeth and limited to one pulp cap per tooth, per lifetime.
- Pulp capping, direct
- Pulp capping, indirect - includes sedative filling.

Vital pulpotomy, only when root canal therapy is not the definitive treatment

Gross pulpal debridement

Pulpal therapy, limited to primary teeth only

Root Canal Treatment
- Root canal therapy
- Root canal retreatment, limited to once per tooth, per lifetime
- Treatment of root canal obstruction, no-surgical access
- Incomplete endodontic therapy, inoperable or fractured tooth
- Internal root repair of perforation defects

Other Endodontic Services
- Apexification, limited to a maximum of three visits
- Apicoectomy, limited to once per root, per lifetime
- Root amputation, limited to once per root, per lifetime
- Retrograde filling, limited to once per root, per lifetime
- Hemisection, including any root removal, once per tooth

All Options

Periodontal Services

Allowance includes the treatment plan, local anesthetic and post-treatment care. Requires documentation of periodontal disease confirmed by both radiographs and pocket depth probings of each tooth involved.

Periodontal maintenance procedure - limited to a total of 2 prophylaxis or periodontal maintenance procedure(s) in any 12 consecutive month period. Allowance includes periodontal pocket charting, scaling and polishing. (Also see Prophylaxis under "Preventive Services") Coverage for periodontal maintenance is considered upon evidence of completed active periodontal therapy (periodontal scaling and root planing or periodontal surgery).

Scaling and root planing, per quadrant - limited to once per quadrant in any 24 consecutive month period. Covered when there is radiographic and pocket charting evidence of bone loss.

Full mouth debridement - limited to once in any 36 consecutive month period. Considered only when no diagnostic, preventive, periodontal service or periodontal surgery procedure has been performed in the previous 36 consecutive month period.

Periodontal Surgery Allowance includes the treatment plan, local anesthetic and post-surgical care. Requires documentation of periodontal disease confirmed by both radiographs and pocket depth probings of each tooth involved.

The following treatment is limited to a total of one of the following, once per tooth in any 12 consecutive months.

Gingivectomy, per tooth (less than 3 teeth)
Crown lengthening - hard tissue

The following treatment is limited to a total of one of the following once per quadrant, in any 36 consecutive months.

Gingivectomy or gingivoplasty, per quadrant
Osseous surgery, including scaling and root planing, flap entry and closure, per quadrant
Gingival flap procedure, including scaling and root planing, per quadrant
Distal or proximal wedge, not in conjunction with osseous surgery
Surgical revision procedure, per tooth

The following treatment is limited to a total of one of the following, once per quadrant in any 36 consecutive months.

Pedicle or free soft tissue grafts, including donor site, or subepithelial connective tissue graft procedure, when the tooth is present, or when dentally necessary as part of a covered surgical placement of an implant.

The following treatment is limited to a total of one of the following, once per area or tooth, per lifetime.

Guided tissue regeneration, resorbable barrier or nonresorbable barrier
Bone replacement grafts, when the tooth is present

Periodontal surgery related

Limited occlusal adjustment - limited to a total of two visits, covered only when done within a 6 consecutive month period after covered scaling and root planing or osseous surgery. Must have radiographic evidence of vertical defect or widened periodontal ligament space.

Occlusal guards, covered only when done within a 6 consecutive month period after osseous surgery, and limited to one per lifetime

All Options

Non-Surgical Extractions

Allowance includes the treatment plan, local anesthetic and post-treatment care.

Uncomplicated extraction, one or more teeth
Root removal non-surgical extraction of exposed roots

Surgical Extractions

Allowance includes the treatment plan, local anesthetic and post-surgical care. Services listed in this category and related services, may be covered by your medical plan.

Surgical removal of erupted teeth, involving tissue flap and bone removal
Surgical removal of residual tooth roots
Surgical removal of impacted teeth

Other Oral Surgical Procedures

Allowance includes diagnostic and treatment radiographs, the treatment plan, local anesthetic and post-surgical care. Services listed in this category and related services, may be covered by your medical plan.

Alveoloplasty, per quadrant
Removal of exostosis, per site
Incision and drainage of abscess
Frenulectomy, Frenectomy, Frenotomy
Biopsy and examination of tooth related oral tissue
Surgical exposure of impacted or unerupted tooth to aid eruption
Excision of tooth related tumors, cysts and neoplasms
Excision or destruction of tooth related lesion(s)
Excision of hyperplastic tissue
Excision of pericoronal gingiva, per tooth
Oroantral fistula closure
Sialolithotomy
Sialodochoplasty
Closure of salivary fistula
Excision of salivary gland
Maxillary sinusotomy for removal of tooth fragment or foreign body
Vestibuloplasty

CGP-3-DNTL-90-15.0 B498.1124

All Options

Other Services

General anesthesia, intramuscular sedation, intravenous sedation, non-intravenous sedation or inhalation sedation, including nitrous oxide, when administered in connection with covered periodontal surgery, surgical extractions, the surgical removal of impacted teeth, apicoectomies, root amputations, surgical placement of an implant and services listed under the "Other Oral Surgical Procedures" section of this *plan*.

Injectable antibiotics needed solely for treatment of a dental condition.

CGP-3-DNTL-90-15 B498.0206

Group III - Major Dental Services
(Non-Orthodontic)

Major Restorative Services

Crowns, inlays, onlays, labial veneers, and crown buildups are covered only when needed because of decay or *injury,* and only when the tooth cannot be restored with amalgam or composite filling material. Post and cores are covered only when needed due to decay or *injury*. Allowance includes insulating bases, temporary or provisional restorations and associated gingival involvement. Limited to permanent teeth only. Also see the "Basic Restorative Services" section.

Single Crowns
- Resin with metal
- Porcelain
- Porcelain with metal
- Full cast metal (other than stainless steel)
- 3/4 cast metal crowns
- 3/4 porcelain crowns

Inlays
Onlays, including inlay
Labial veneers
Posts and buildups - only when done in conjunction with a covered unit of crown or bridge and only when necessitated by substantial loss of natural tooth structure.

- Cast post and core in addition to a unit of crown or bridge, per tooth
- Prefabricated post and composite or amalgam core in addition to a unit of crown or bridge, per tooth
- Crown or core buildup, including pins

Implant supported prosthetics - Allowance includes the treatment plan and local anesthetic.
- Abutment supported crown
- Implant supported crown
- Abutment supported retainer for fixed partial denture
- Implant supported retainer for fixed partial denture
- Implant/abutment supported fixed denture for completely edentulous arch
- Implant/abutment supported fixed denture for partially edentulous arch

Prosthodontic Services

Specialized techniques and characterizations are not covered. Allowance includes insulating bases, temporary or provisional restorations and associated gingival involvement. Limited to permanent teeth only.

Fixed bridges - Each abutment and each pontic makes up a unit in a bridge

Bridge abutments - See inlays, onlays and crowns under "Major Restorative Services"

Bridge Pontics
Resin with metal
Porcelain
Porcelain with metal
Full cast metal

Dentures - Allowance includes all adjustments and repairs done by the *dentist* furnishing the denture in the first 6 consecutive months after installation and all temporary or provisional dentures. Temporary or provisional dentures, stayplates and interim dentures older than one year are considered to be a permanent *appliance*.

Complete or Immediate dentures, upper or lower

Partial dentures - Allowance includes base, clasps, rests and teeth

Upper, resin base, including any conventional clasps, rests and teeth

Upper, cast metal framework with resin denture base, including any conventional clasps, rests and teeth

Lower, resin base, including any conventional clasps, rests and teeth

Lower, cast metal framework with resin denture base, including any conventional clasps, rests and teeth

Interim partial denture (stayplate), upper or lower, covered on *anterior teeth* only

Removable unilateral partial, one piece cast metal, including clasps and teeth

Simple stress breakers, per unit

All Options

Crown And Prosthodontic Restorative Services

Also see the "Major Restorative Services" section.

Crown and bridge repairs - allowance based on the extent and nature of damage and the type of material involved.

Recementation, limited to recementations performed more than 12 months after the initial insertion.

Inlay or onlay
Crown
Bridge

Adding teeth to partial dentures to replace extracted natural teeth

Denture repairs - Allowance based on the extent and nature of damage and on the type of materials involved.

Denture repairs, metal
Denture repairs, acrylic
Denture repair, no teeth damaged
Denture repair, replace one or more broken teeth
Replacing one or more broken teeth, no other damage

Denture rebase, full or partial denture - limited to once per denture in any 24 consecutive month period. Denture rebases done within 12 months are considered to be part of the denture placement when the rebase is done by the *dentist* who furnished the denture. Limited to rebase done more than 12 consecutive months after the insertion of the denture.

Denture reline, full or partial denture - limited to once per denture in any 24 consecutive month period. Denture relines done within 12 months are considered to be part of the denture placement when the reline is done by the *dentist* who furnished the denture. Limited to reline done more than 12 consecutive months after a denture rebase or the insertion of the denture.

Denture adjustments - Denture adjustments done within 12 months are considered to be part of the denture placement when the adjustment is done by the *dentist* who furnished the denture. Limited to adjustments that are done more than 6 consecutive months after a denture rebase, denture reline or the initial insertion of the denture.

Tissue conditioning - Tissue conditioning done within 12 months is considered to be part of the denture placement when the tissue conditioning is done by the *dentist* who furnished the denture. Limited to a maximum of 1 treatment, per arch, in any 12 consecutive month period.

All Options

Group IV - Orthodontic Services

Orthodontic Services

Any covered Group I, II or III service in connection with *orthodontic treatment.*

Transseptal fiberotomy

Surgical exposure of impacted or unerupted teeth in connection with *orthodontic treatment* - Allowance includes treatment and final radiographs, local anesthetics and post-surgical care.

Treatment *plan* and records, including initial, interim and final records.

Limited *orthodontic treatment,* Interceptive *orthodontic treatment* or Comprehensive *orthodontic treatment,* including fabrication and insertion of any and all fixed *appliances* and periodic visits.

Orthodontic retention, including any and all necessary fixed and removable *appliances* and related visits - limited to initial *appliance(s)* only.

CGP-3-DNTL-90-8 B498.0071

CERTIFICATE AMENDMENT

This rider amends this plan's dental expense Appeals section to include the following:

Any case under appeal must be reviewed by a peer of the treating health care provider who proposes the care under review or who was primarily responsible for the care under review. With the exception of expedited appeals, a physician advisor who reviews cases under appeal must be: (a) a peer of the treating health care provider; (b) board certified in the same or similar specialty as the treating health care provider; and (c) specialized in a discipline pertinent to the issue under review.

A physician advisor or peer of the treating health care provider who renders a decision on appeal must: (a) not have participated in the adverse decision or any prior reconsideration concerning it; (b) not be employed by or a director of the health care review organization (HCRO); and (c) be licensed to practice in Virginia, or under a comparable licensing law of a state of the United States, as a peer of the treating health care provider.

Except as stated in this rider, nothing contained in this rider changes or affects any other terms of this certificate.

The Guardian Life Insurance Company of America

Michael Prestileo, Senior Vice President

CGP-3-A-AP-VA-10 B500.0042

CERTIFICATE AMENDMENT

Effective on the latter of (i) the original effective date of the Policy; or (ii) the effective date of any applicable amendment requested by the Policyholder and approved by the Insurance Company, this rider amends the Dental Expense Insurance provisions of the Group Policy as follows:

The Alternate Treatment provision is changed to read as follows when titanium or high noble metal (gold) is used in a *dental prosthesis*.

If more than one type of service can be used to treat a dental condition, we have the right to base benefits on the least expensive service which is within the range of professionally accepted standards of dental practice as determined by us. For example, in the case of bilateral multiple adjacent missing teeth, or multiple missing teeth in both quadrants of an arch the benefit will be based on a removable partial denture. In the case of titanium or high noble metal (gold) used in a *dental prosthesis*, the benefit will be based on the noble metal benefit. In the case of a composite filling on a posterior tooth, the benefit will be based on the corresponding covered amalgam filling benefit.

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

The Guardian Life Insurance Company of America

Michael Prestileo, Senior Vice President

CGP-3-A-DGOPT-10 B531.0029

COORDINATION OF BENEFITS

Important Notice This section applies to all group health benefits under this plan; except prescription drug coverage, if any. It does not apply to any death, dismemberment, or loss of income benefits that may be provided under this plan.

Purpose When a covered person has health care coverage under more than one plan, this section allows this plan to coordinate what it pays with what other plans pay. This is done so that the covered person does not collect more in benefits than he or she incurs in charges.

Definitions

Allowable Expense This term means any necessary, reasonable, and customary item of health care expense that is covered, at least in part, by any of the plans which cover the person. This includes: (a) deductibles; (b) coinsurance; and (c) copayments. When a plan provides benefits in the form of services, the reasonable cash value of each service will be considered an allowable expense and a benefit paid.

An expense or service that is not covered by any of the plans is **not** an allowable expense. Examples of other expenses or services that are **not** allowable expenses are:

(1) If a person is confined in a private hospital room, the difference between the cost of a semi-private room in the hospital and the private room is **not** an allowable expense. This does not apply if: (a) the stay in the private room is medically necessary in terms of generally accepted medical practice; or (b) one of the plans routinely provides coverage for private hospital rooms.

(2) The amount a benefit is reduced by the primary plan because a person does not comply with the plan's provisions is **not** an allowable expense. Examples of these provisions are: (a) precertification of admissions and procedures; (b) continued stay reviews; and (c) preferred provider arrangements.

(3) If a person is covered by two or more plans that compute their benefit payments on the basis of reasonable and customary charges, any amount in excess of the primary plan's reasonable and customary charges for a specific benefit is **not** an allowable expense.

(4) If a person is covered by two or more plans that provide benefits or services on the basis of negotiated fees, an amount in excess of the primary plan's negotiated fees for a specific benefit is **not** an allowable expense.

If a person is covered by one plan that computes its benefits or services on the basis of reasonable and customary charges and another plan that provides its benefits or services on the basis of negotiated fees, the primary plan's payment arrangements will be the allowable expense for all plans. However, if the provider has contracted with the secondary plan to provide the benefit or service for a specific negotiated fee or payment amount that is different than the primary plan's payment arrangement and if the provider's contract permits, the negotiated fee or payment shall be the allowable expense used by the secondary plan to determine its benefit.

Claim This term means a request that benefits of a plan be provided or paid.

Claim Determination Period This term means a calendar year. It does not include any part of a year during which a person has no coverage under this plan, or before the date this section takes effect.

Closed Panel Plan This term means a health maintenance organization (HMO), preferred provider organization (PPO), exclusive provider organization (EPO), or other plan that provides health benefits to covered persons primarily in the form of services through a panel of providers that have contracted with or are employed by the plan; and that limits or excludes benefits for services provided by other providers, except in cases of emergency or referral by a panel member.

Coordination Of Benefits This term means a provision which determines an order in which plans pay their benefits, and which permits secondary plans to reduce their benefits so that the combined benefits of all plans do not exceed total allowable expenses.

Custodial Parent This term means a parent awarded custody by a court decree. In the absence of a court decree, it is the parent with whom the child resides more than one half of the calendar year without regard to any temporary visitation.

Group-Type Contracts This term means contracts: (a) which are not available to the general public; and (b) can be obtained and maintained only because of membership in or connection with a particular organization or group. This includes, but is not limited to, blanket coverage.

Hospital Indemnity Benefits This term means benefits that are not related to expenses incurred. This term does not include reimbursement-type benefits even if they are designed or administered to give the insured the right to elect indemnity-type benefits at the time of claim.

Plan This term means any of the following that provides benefits or services for health care or treatment: (1) group insurance; (2) closed panel or other forms of group or group-type coverage, whether insured or uninsured; (3) group-type contracts; (4) amounts of group or group-type hospital indemnity benefits in excess of $200.00 per day; (5) medical components of group long-term care contracts such as skilled nursing care; and (6) governmental benefits, except Medicare, as permitted by law.

This term does not include: (a) individual or family insurance; (b) closed panel or other individual coverage; (c) amounts of group or group-type hospital indemnity benefits of $200.00 or less per day; (d) school accident type coverage; (e) benefits for non-medical components of group long-term care policies; (f) medical expense or medical payments insurance provided in conjunction with liability coverage; or (g) Medicare, Medicare supplement policies, Medicaid, and coverage under other governmental plans, unless permitted by law.

This term also does not include any plan that this plan supplements. Plans that this plan supplements are named in the benefit description.

Each type of coverage listed above is treated separately. If a plan has two parts and coordination of benefits applies only to one of the two, each of the parts is treated separately.

Primary Plan This term means a plan that pays first without regard that another plan may cover some expenses. A plan is a primary plan if either of the following is true: (1) the plan either has no order of benefit determination rules, or its rules differ from those explained in this section; or (2) all plans that cover the person use the order of benefit determination rules explained in this section, and under those rules the plan pays its benefits first.

Secondary Plan This term means a plan that is not a primary plan.

This Plan This term means the group health benefits, except prescription drug coverage, if any, provided under this group plan.

All Options

Order Of Benefit Determination

The primary plan pays or provides its benefits as if the secondary plan or plans did not exist.

A plan may consider the benefits paid or provided by another plan to determine its benefits only when it is secondary to that other plan. If a person is covered by more than one secondary plan, the rules explained below decide the order in which secondary plan benefits are determined in relation to each other.

A plan that does not contain a coordination of benefits provision is always primary.

When all plans have coordination of benefits provisions, the rules to determine the order of payment are listed below. The first of the rules that applies is the rule to use.

Non-Dependent Or Dependent The plan that covers the person other than as a dependent (for example, as an employee, member, subscriber, or retiree) is primary. The plan that covers the person as a dependent is secondary.

But, if the person is a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the plan that covers the person as a dependent; and primary to the plan that covers the person other than as a dependent (for example, as a retiree); then the order of payment between the two plans is reversed. In that case, the plan that covers the person as an employee, member, subscriber, or retiree is secondary and the other plan is primary.

Child Covered Under More Than One Plan

The order of benefit determination when a child is covered by more than one plan is:

(1) If the parents are married, or are not separated (whether or not they ever have been married), or a court decree awards joint custody without specifying that one party must provide health care coverage, the plan of the parent whose birthday is earlier in the year is primary. If both parents have the same birthday, the plan that covered either of the parents longer is primary. If a plan does not have this birthday rule, then that plan's coordination of benefits provision will determine which plan is primary.

(2) If the specific terms of a court decree state that one of the parents must provide health care coverage and the plan of the parent has actual knowledge of those terms, that plan is primary. This rule applies to claim determination periods that start after the plan is given notice of the court decree.

(3) In the absence of a court decree, if the parents are not married, or are separated (whether or not they ever have been married), or are divorced, the order of benefit determination is: (a) the plan of the custodial parent; (b) the plan of the spouse of the custodial parent; (c) the plan of the noncustodial parent; and (d) the plan of the spouse of the noncustodial parent.

Active Or Inactive Employee

The plan that covers a person as an active employee, or as that person's dependent, is primary. An active employee is one who is neither laid off nor retired. The plan that covers a person as a laid off or retired employee, or as that person's dependent, is secondary. If a plan does not have this rule and as a result the plans do not agree on the order of benefit determination, this rule is ignored.

Continuation Coverage

The plan that covers a person as an active employee, member, subscriber, or retired employee, or as that person's dependent, is primary. The plan that covers a person under a right of continuation provided by federal or state law is secondary. If a plan does not have this rule and as a result the plans do not agree on the order of benefit determination, this rule is ignored.

Length Of Coverage

The plan that covered the person longer is primary.

Other

If the above rules do not determine the primary plan, the allowable expenses will be shared equally between the plans that meet the definition of plan under this section. But, this plan will not pay more than it would have had it been the primary plan.

Effect On The Benefits Of This Plan

When This Plan Is Primary When this plan is primary, its benefits are determined before those of any other plan and without considering any other plan's benefits.

When This Plan Is Secondary When this plan is secondary, it may reduce its benefits so that the total benefits paid or provided by all plans during a claim determination period are not more than 100% of total allowable expenses.

Closed Panel Plans If the primary plan is a closed panel plan and the secondary plan is not a closed panel plan, the secondary plan will pay or provide benefits as if it were primary when a covered person uses a non-panel provider; except for emergency services or authorized referrals that are paid or provided by the primary plan.

A person may be covered by two or more closed panel plans. If, for any reason including the provision of service by a non-panel provider, benefits are not payable by one closed panel plan, coordination of benefits will not apply between that plan and other closed panel plans.

Right To Receive And Release Needed Information

Certain facts about health care coverage and services are needed to apply these rules and to determine benefits payable under this plan and other plans. This plan may get the facts it needs from, or give them to, other organizations or persons to apply these rules and determine benefits payable under this plan and other plans which cover the person claiming benefits. This plan need not tell, or get the consent of, any person to do this. Each person claiming benefits under this plan must provide any facts it needs to apply these rules and determine benefits payable.

Facility Of Payment

A payment made under another plan may include an amount that should have been paid by this plan. If it does, this plan may pay that amount to the organization that made the payment. That amount will then be treated as though it were a benefit paid by this plan. This plan will not have to pay that amount again.

As used here, the term "payment made" includes the reasonable cash value of any benefits provided in the form of services.

If the amount of the payments made by this plan is more than it should have paid under this section, it may recover the excess: (a) from one or more of the persons it has paid or for whom it has paid; or (b) from any other person or organization that may be responsible for benefits or services provided for the covered person.

As used here, the term "amount of the payments made" includes the reasonable cash value of any benefits provided in the form of services.

CGP-3-R-COB-05 B555.0260

All Options

GLOSSARY

This Glossary defines the italicized terms appearing in your booklet.

CGP-3-GLOSS-90 B900.0118

All Options

Active Orthodontic means an *appliance,* like a fixed or removable appliance, braces or a functional orthotic used for orthodontic treatment to move teeth or reposition the jaw.

CGP-3-GLOSS-90 B750.0663

All Options

Anterior Teeth means the incisor and cuspid teeth. The teeth are located in front of the bicuspids (pre-molars).

CGP-3-GLOSS-90 B750.0664

All Options

Appliance means any dental device other than a *dental prosthesis.*

CGP-3-GLOSS-90 B750.0665

All Options

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

CGP-3-GLOSS-90 B750.0666

All Options

Covered Dental Specialty means any group of procedures which falls under one of the following categories, whether performed by a specialist *dentist* or a general *dentist:* restorative/prosthodontic services; endodontic services, periodontic services, oral surgery and pedodontics.

CGP-3-GLOSS-90 B750.0667

All Options

Covered Family means an employee and those of his or her dependents who are covered by this *plan.*

CGP-3-GLOSS-90 B750.0668

All Options

Covered Person means an employee or any of his or her covered dependents.

CGP-3-GLOSS-90 B750.0669

All Options

Dental Prosthesis means a restorative service which is used to replace one or more missing or lost teeth and associated tooth structures. It includes all types of abutment crowns, inlays and onlays, bridge pontics, complete and immediate dentures, partial dentures and unilateral partials. It also includes all types of crowns, veneers, inlays, onlays, implants and posts and cores.

CGP-3-GLOSS-90 B750.0670

All Options

Dentist means any dental or medical practitioner we are required by law to recognize who: (a) is properly licensed or certified under the laws of the state where he or she practices; and (b) provides services which are within the scope of his or her license or certificate and covered by this *plan*.

CGP-3-GLOSS-90 B750.0671

All Options

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

CGP-3-GLOSS-90 B900.0003

All Options

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

CGP-3-GLOSS-90 B750.0015

All Options

Emergency Treatment means bona fide emergency services which: (a) are reasonably necessary to relieve the sudden onset of severe pain, fever, swelling, serious bleeding, severe discomfort, or to prevent the imminent loss of teeth; and (b) are covered by this *plan*.

CGP-3-GLOSS-90 B750.0672

All Options

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

CGP-3-GLOSS-90 B750.0005

All Options

Employer means THE EVERGREENE COMPANIES .

CGP-3-GLOSS-90 B900.0051

All Options

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

CGP-3-GLOSS-90 B900.0004

All Options

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

CGP-3-GLOSS-90 B750.0229

All Options

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

CGP-3-GLOSS-90 B900.0006

All Options

Injury means all damage to a *covered person's* mouth due to an accident which occurred while he or she is covered by this *plan,* and all complications arising from that damage. But the term *injury* does not include damage to teeth, *appliances* or *dental prostheses* which results solely from chewing or biting food or other substances.

CGP-3-GLOSS-90 B750.0673

All Options

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

CGP-3-GLOSS-90 B900.0008

All Options

Non-Preferred Provider means a *dentist* or dental care facility that is not under contract with DentalGuard Preferred as a *preferred provider.*

CGP-3-GLOSS-90 B750.0674

All Options

Orthodontic Treatment means the movement of one or more teeth by the use of *active appliances*. it includes: (a) treatment plan and records, including initial, interim and final records; (b) periodic visits, limited orthodontic treatment, interceptive orthodontic treatment and comprehensive orthodontic treatment, including fabrication and insertion of any and all fixed appliances; (c) orthodontic retention, including any and all necessary fixed and removable appliances and related visits.

CGP-3-GLOSS-90 B750.0675

All Options

Payment Limit means the maximum amount this *plan* pays for covered services during either a *benefit year* or a *covered person's* lifetime, as applicable.

CGP-3-GLOSS-90 B750.0676

All Options

Payment Rate means the percentage rate that this *plan* pays for covered services.

CGP-3-GLOSS-90 B750.0677

All Options

Posterior Teeth means the bicuspid (pre-molars) and molar teeth. These are the teeth located behind the cuspids.

CGP-3-GLOSS-90 B750.0679

All Options

Plan means the Guardian group dental plan purchased by the planholder.

CGP-3-GLOSS-90 B750.0678

All Options

Preferred Provider means a *dentist* or dental care facility that is under contract with DentalGuard Preferred as a preferred provider.

CGP-3-GLOSS-90 B750.0680

All Options

Prior Plan means the planholder's plan or policy of group dental insurance which was in force immediately prior to this *plan*. To be considered a prior plan, this *plan* must start immediately after the prior coverage ends.

CGP-3-GLOSS-90 B750.0681

All Options

Proof Of Claim means dental radiographs, study models, periodontal charting, written narrative or any documentation that may validate the necessity of the proposed treatment.

CGP-3-GLOSS-90 B750.0682

All Options

We, Us, Our And Guardian mean The Guardian Life Insurance Company of America.

CGP-3-GLOSS-90 B750.0683

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

STATEMENT OF ERISA RIGHTS

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

Receive Information About Your Plan and Benefits

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

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

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

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.

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

All Options

The Guardian's Responsibilities

B800.0048

All Options

The dental 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.

B800.0053

All Options

The Guardian is located at 10 Hudson Yards, New York, New York 10001.

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.

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.

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;

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

B800.0007

All Options

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.

Effective: 5/01/2016

This Notice of Privacy Practices describes how Guardian and its subsidiaries may use and disclose your Protected Health Information (PHI) in order to carry out treatment, payment and health care operations and for other purposes permitted or required by law.

Guardian is required by law to maintain the privacy of PHI and to provide you with notice of our legal duties and privacy practices concerning PHI. We are required to abide by the terms of this Notice so long as it remains in effect. We reserve the right to change the terms of this Notice of Privacy Practices as necessary and to make the new Notice effective for all PHI maintained by us. If we make material changes to our privacy practices, copies of revised notices will be made available on request and circulated as required by law. Copies of our current Notice may be obtained by contacting Guardian (using the information supplied below), or on our Web site at: www.guardianlife.com/privacy-policy.

What is Protected Health Information (PHI):

PHI is individually identifiable information (including demographic information) relating to your health, to the health care provided to you or to payment for health care. PHI refers particularly to information acquired or maintained by us as a result of your having health coverage (including medical, dental, vision and long term care coverage).

In What Ways may Guardian Use and Disclose your Protected Health Information (PHI):

Guardian has the right to use or disclose your PHI without your written authorization to assist in your treatment, to facilitate payment and for health care operations purposes. There are certain circumstances where we are required by law to use or disclose your PHI. And there are other purposes, listed below, where we are permitted to use or disclose your PHI without further authorization from you. Please note that examples are provided for illustrative purposes only and are not intended to indicate every use or disclosure that may be made for a particular purpose.

Guardian has the right to use or disclose your PHI for the following purposes :

Treatment.Guardian may use and disclose your PHI to assist your health care providers in your diagnosis and treatment. For example, we may disclose your PHI to providers to supply information about alternative treatments.

Payment.Guardian may use and disclose your PHI in order to pay for the services and resources you may receive. For example, we may disclose your PHI for payment purposes to a health care provider or a health plan. Such purposes may include: ascertaining your range of benefits; certifying that you received treatment; requesting details regarding your treatment to determine if your benefits will cover, or pay for, your treatment.

Health Care Operations.Guardian may use and disclose your PHI to perform health care operations, such as administrative or business functions. For example, we may use your PHI for underwriting and premium rating purposes. However, we will not use or disclose your genetic information for underwriting purposes and are prohibited by law from doing so.

Appointment Reminders.Guardian may use and disclose your PHI to contact you and remind you of appointments.

Health Related Benefits and Services.Guardian may use and disclose PHI to inform you of health related benefits or services that may be of interest to you.

Plan Sponsors.Guardian may use or disclose PHI to the plan sponsor of your group health plan to permit the plan sponsor to perform plan administration functions. For example, a plan may contact us regarding benefits, service or coverage issues. We may also disclose summary health information about the enrollees in your group health plan to the plan sponsor so that the sponsor can obtain premium bids for health insurance coverage, or to decide whether to modify, amend or terminate your group health plan.

All Options

Guardian is required to use or disclose your PHI :

- To you or your personal representative (someone with the legal right to make health care decisions for you);
- To the Secretary of the Department of Health and Human Services, when conducting a compliance investigation, review or enforcement action related to health information privacy or security; and
- Where otherwise required by law.

Guardian is Required to Notify You of any Breaches of Your Unsecured PHI.

Although Guardian takes reasonable, industry-standard measures to protect your PHI, should a breach occur, Guardian is required by law to notify affected individuals. Under federal medical privacy law, a breach means the acquisition, access, use, or disclosure of unsecured PHI in a manner not permitted by law that compromises the security or privacy of the PHI.

Other Uses and Disclosures .

Guardian may also use and disclose your PHI for the following purposes without your authorization:

- We may disclose your PHI to persons involved in your care or payment for care, such as a family member or close personal friend, when you are present and do not object, when you incapacitated, under certain circumstances during an emergency or when otherwise permitted by law.
- We may use or disclose your PHI for public health activities, such as reporting of disease, injury, birth and death, and for public health investigations.
- We may use or disclose your PHI in an emergency, directly to or through a disaster relief entity, to find and tell those close to you of your location or condition
- We may disclose your PHI to the proper authorities if we suspect child abuse or neglect; we may also disclose your PHI if we believe you to be a victim of abuse, neglect, or domestic violence.
- We may disclose your PHI to a government oversight agency authorized by law to conducting audits, investigations, or civil or criminal proceedings.
- We may use or disclose your PHI in the course of a judicial or administrative proceeding (e.g., to respond to a subpoena or discovery request).
- We may disclose your PHI to the proper authorities for law enforcement purposes.

- We may disclose your PHI to coroners, medical examiners, and/or funeral directors consistent with law.
- We may use or disclose your PHI for organ or tissue donation.
- We may use or disclose your PHI for research purposes, but only as permitted by law.
- We may use or disclose PHI to avert a serious threat to health or safety.
- We may use or disclose your PHI if you are a member of the military as required by armed forces services.
- We may use disclose your PHI to comply with workers' compensation and other similar programs.

- We may disclose your PHI to third party business associates that perform services for us, or on our behalf (e.g. vendors).
- We may use and disclose your PHI to federal officials for intelligence and national security activities authorized by law. We also may disclose your PHI to authorized federal officials in order to protect the President, other officials or foreign heads of state, or to conduct investigations authorized by law.
- We may disclose your PHI to correctional institutions or law enforcement officials if you are an inmate or under the custody of a law enforcement official (e.g., for the institution to provide you with health care services, for the safety and security of the institution, and/or to protect your health and safety or the health and safety of other individuals).
- We may use or disclose your PHI to your employer under limited circumstances related primarily to workplace injury or illness or medical surveillance.

B998.0052

All Options

We generally will not sell your PHI, or use or disclose PHI about you for marketing purposes without your authorization unless otherwise permitted by law.

Your Rights with Regard to Your Protected Health Information (PHI):

Your Authorization for Other Uses and Disclosures. Other than for the purposes described above, or as otherwise permitted by law, Guardian must obtain your written authorization to use or disclosure your PHI. You have the right to revoke that authorization in writing except to the extent that: (i) we have taken action in reliance upon the authorization prior to your written revocation, or (ii) you were required to give us your authorization as a condition of obtaining coverage, and we have the right, under other law, to contest a claim under the coverage or the coverage itself.

Under federal and state law, certain kinds of PHI will require enhanced privacy protections. These forms of PHI include information pertaining to:

- HIV/AIDS testing, diagnosis or treatment
- Venereal and /or communicable Disease(s)
- Genetic Testing
- Alcohol and drug abuse prevention, treatment and referral
- Psychotherapy notes

We will only disclose these types of delineated information when permitted or required by law or upon your prior written authorization.

Your Right to an Accounting of Disclosures . An 'accounting of disclosures' is a list of certain disclosures we have made, if any, of your PHI. You have the right to receive an accounting of certain disclosures of your PHI that were made by us. This right applies to disclosures for purposes other than those made to carry out treatment, payment and health care operations as described in this notice. It excludes disclosures made to you, or those made for notification purposes.

We ask that you submit your request in writing by completing our form. Your request may state a requested time period not more than six years prior to the date when you make your request. Your request should indicate in what form you want the list (e.g., paper, electronically). Our form for Account of Disclosure requests is available at www.guardianlife.com/privacy-policy.

Your Right to Obtain a Paper Copy of This Notice . You have a right to request a paper copy of this notice even if you have previously agreed to accept this notice electronically. You may obtain a paper copy of this notice by sending a request to the contact information listed at the end of this notice.

Your Right to File a Complaint . If you believe your privacy rights have been violated, you may file a complaint with Guardian or the Secretary of U.S. Department of Health and Human Services. If you wish to file a complaint with Guardian, you may do so using the contact information below. You will not be penalized for filing a complaint.

Please submit any exercise of the Rights designated below to Guardian in writing using the contact information listed below. For some requests, Guardian may charge for reasonable costs associated with complying with your requests; in such a case, we will notify you of the cost involved and provide you the opportunity to modify your request before any costs are incurred.

Your Right to Request Restrictions . You have the right to request a restriction on the PHI we use or disclose about you for treatment, payment or health care operations as described in this notice. You also have the right to request a restriction on the medical information we disclose about you to someone who is involved in your care or the payment for your care.

Guardian is not required to agree to your request; however, if we do agree, we will comply with your request until we receive notice from you that you no longer want the restriction to apply (except as required by law or in emergency situations). Your request must describe in a clear and concise manner: (a) the information you wish restricted; (b) whether you are requesting to limit Guardian's use, disclosure or both; and (c) to whom you want the limits to apply.

Your Right to Request Confidential Communications . You have the right to request that Guardian communicate with you about your PHI be in a particular manner or at a certain location. For example, you may ask that we contact you at work rather than at home. We are required to accommodate all reasonable requests made in writing, when such requests clearly state that your life could be endangered by the disclosure of all or part of your PHI.

B998.0053

All Options

Your Right to Amend Your PHI . If you feel that any PHI about you, which is maintained by Guardian, is inaccurate or incomplete, you have the right to request that such PHI be amended or corrected. Within your written request, you must provide a reason in support of your request. Guardian reserves the right to deny your request if: (i) the PHI was not created by Guardian, unless the person or entity that created the information is no longer available to amend it (ii) if we do not maintain the PHI at issue (iii) if you would not be permitted to inspect and copy the PHI at issue or (iv) if the PHI we maintain about you is accurate and complete. If we deny your request, you may submit a written statement of your disagreement to us, and we will record it with your health information.

Your Right to Access to Your PHI. You have the right to inspect and obtain a copy of your PHI that we maintain in designated record sets. Under certain circumstances, we may deny your request to inspect and copy your PHI. In an instance where you are denied access and have a right to have that determination reviewed, a licensed health care professional chosen by Guardian will review your request and the denial. The person conducting the review will not be the person who denied your request. Guardian promises to comply with the outcome of the review.

How to Contact Us:

If you have any questions about this Notice or need further information about matters covered in this Notice, please call the toll-free number on the back of your Guardian ID card. If you are a broker please call 800-627-4200. All others please contact us at 800-541-7846. You can also write to us with your questions, or to exercise any of your rights, at the address below:

Attention:
Guardian Corporate Privacy Officer
National Operations

Address:
The Guardian Life Insurance Company of America
Group Quality Assurance - Northeast
P.O. Box 981573
El Paso, TX 79998-1573

B998.0055

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

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

CERTIFICATE OF COVERAGE

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

The Group Term Life Insurance described in this Certificate is attached to the group Policy effective January 1, 2020. This Certificate replaces any Certificate previously issued under this Policy or under any other plan providing similar or identical benefits issued to the Policyholder by Guardian.

GROUP TERM LIFE INSURANCE

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

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

Policyholder: THE EVERGREENE COMPANIES
Group Policy Number: 00571412

The Guardian Life Insurance Company of America

Michael Prestileo, Senior Vice President

BENEFICIARY DESIGNATION MAY NOT APPLY IN THE EVENT OF ANNULMENT OR DIVORCE

Under Virginia law (Virginia Code Section 20-111.1), a revocable beneficiary designation in a policy owned by one spouse that names the other spouse as beneficiary becomes void upon the entry of a decree of annulment or divorce, and the death benefit prevented from passing to a former spouse will be paid as if the former spouse had predeceased the decedent. In the event of annulment or divorce proceedings, and if it is the intent of the parties that the beneficiary designation of the former spouse is to continue, you are advised to make certain that one of the following courses of action is taken prior to the entry of a decree of annulment or divorce: (i) change the beneficiary designation to make it irrevoc able; (ii) change the ownership of the policy or contract; (iii) execute a separate written agreement stating the intention of both parties that the beneficiary designation is to remain in effect beyond the date of entry of the decree of annulment or divorce; or (iv) make certain that the decree of annulment or divorce contains a provision stating that the beneficiary designation is not to be revoked pursuant to Section 20-111.1

B438.0131

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All Options

IMPORTANT INFORMATION REGARDING YOUR INSURANCE

In the event you need to contact someone about this insurance for any reason, please contact your agent. If no agent was involved in the sale of this insurance, or if you have additional questions, you may contact the insurance company issuing this insurance at the following address and telephone number:

The Guardian Life Insurance Company of America
7 Hanover Square
New York, NY 10004
(212) 598- 8000

If you have been unable to contact or obtain satisfaction from the company or the agent, you may contact the Virginia State Corporation Commission's Bureau of Insurance at:

Bureau of Insurance
Tyler Building, 1300 E. Main St.
Richmond, VA 23219
Local (804) 371-9691
National Toll Free (877) 310-6560
VA only Toll Free (800) 552-7945

Written correspondence is preferable so that a record of your inquiry is maintained. When contacting your agent, company or the Bureau of Insurance, have your policy number available.

GENERAL PROVISIONS

Applicable Benefits

This Certificate may include multiple benefit options and types of benefits. You will only be covered for benefits if:

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

If Proof of Insurability is required, You will not be covered unless You satisfy the Proof of Insurability requirements stated in the Certificate and Schedule of Benefits.

Limitation Of Authority

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

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

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

Incontestability

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

No statement in any application made by You, or any dependent, will be used to contest the validity of Your insurance or to deny a claim for a loss incurred, or for a disability which starts, after such insurance has been in force for two years during Your lifetime.

No statement made by any person insured under the policy relating to his or her insurability of his or her insured dependents shall be used in contesting the validity of the insurance with respect to which such statement was made: (1) after the insurance has been in force, prior to the contest, for a period of two years during the lifetime of the person about whom the statement was made; and (2) unless the statement is contained in a written instrument signed by him or her.

If this Certificate replaces a plan Your Employer had with another insurer, We may rescind this Certificate based on misrepresentations or omissions made by Your Employer or You in a signed application for up to two years from the Effective Date of the Policy.

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

Examination And Autopsy

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

Overpayment Recovery

If We overpay benefits, all such benefits must be repaid in full. We have the right to reduce the benefit or reduce any other benefits payable under this Certificate, toward recovery of any overpayment.

B438.0132

ELIGIBILITY FOR GROUP TERM LIFE COVERAGE - EMPLOYEE COVERAGE

Conditions Of Eligibility

Subject to the conditions of eligibility set forth below, and to all of the other conditions of this Certificate, You are eligible for Group Term Life coverage if You are:

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

You are **not** eligible for Group Term Life coverage if You are:

- A temporary or seasonal Employee.

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

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

The Waiting Period If You are in an eligible class, You are eligible for Group Term Life insurance under this Certificate after You complete the service waiting period, if any, established by the Employer.

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

When Coverage Starts

For coverage to start, You must be fully capable of performing the major duties of Your regular occupation for the Employer and working the minimum required number of hours of an Employee in Your eligible class at 12:01 A.M. Standard Time for Your place of residence on Your scheduled Eligibility Date. And, for coverage to start, You must satisfy all of the Conditions of Eligibility described above, and the conditions shown below which apply to You. If You are not fully capable of performing the major duties of Your regular occupation on Your scheduled Eligibility Date, We will postpone the start of Your coverage until You are so capable and working the minimum required number of hours of an Employee in Your eligible class for one full day, with the capacity to do so for one full week.

Whether You must pay all or part of the cost of Your coverage, You must elect to enroll and agree to make the required payments before Your coverage starts. If You do this on or before Your Eligibility Date, Your coverage is scheduled to start on Your Eligibility Date. If You do this within 31 days after Your Eligibility Date, Your coverage is scheduled to start on Your Eligibility Date. If You elect to enroll and agree to make the required payments more than 31 days after Your Eligibility Date, Your coverage will not start until You send Us Proof Of Insurability. Once We approve such Proof Of Insurability, Your coverage will start on the date we approve such coverage.

B400.3129

All Options

Exception to When Coverage Starts

Sometimes a scheduled Eligibility Date is not a regularly scheduled work day. If the scheduled Eligibility Date falls on:

- A holiday;
- A vacation day;
- A non-scheduled work day;
- A day during an approved leave of absence not due to Sickness or Injury, of 90 days or less; or
- A day during a period of absence that is less than 7 days in duration;

and if:

- You are fully capable of performing the major duties of Your regular occupation for Your Employer for the minimum number of hours of an Employee in Your eligible class at 12:01 AM Standard Time for Your place of residence on the scheduled Eligibility Date; and

- You were performing the major duties of Your regular occupation and working the minimum number of hours of an Employee in Your eligible class on Your last regularly scheduled work day;

Your coverage will start on the scheduled Eligibility 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, layoff or absence and such coverage or part of coverage was not previously in force for You under a prior plan which this Certificate replaced.

Any part of Your coverage which is subject to Proof Of Insurability will not start unless You send such proof to Us, and We approve it in writing. Once We have approved it, that part of Your coverage is scheduled to start on Your approved Eligibility Date.

B400.3131

All Options

Delayed Eligibility Date For Employee Voluntary Term Life Insurance

If due to sickness or injury, You are not Actively at Work and working the minimum required number of hours of an Employee in Your eligible class, on the date Your Voluntary Term Life coverage is scheduled to start, We will postpone coverage for an otherwise covered loss for any condition that prevents you from meeting the Actively at Work requirement. We will postpone such coverage until You:

- Complete one full day of Active Work, working the minimum number of hours of an Employee in Your eligible class, with the capacity to do so for one full week; and,
- Do not miss a day of work due to the same condition.

Coverage for an otherwise covered loss due to all other conditions will start on the date You:

- Return to Active Work working the minimum number of hours of an Employee in Your eligible class and;
- Are performing the regular duties of your occupation.

B400.3132

All Options

The Delayed Eligibility Date provision will not apply if You are covered under the Transfer Business Exception as stated below.

Transfer Business Exception

If due to sickness or injury You are not Actively at Work and not working the minimum number of hours of an Employee in Your eligible class, on Your scheduled Eligibility Date, You will be insured for this Group Term Life insurance if:

- You were insured under the Employer's prior insurer's group term life plan at the time the prior insurer's group term life plan ended and the group term life plan became effective with Us, with no break in group coverage;
- You were a member of an eligible class under the Employer's prior insurer's group term life plan and are eligible under this Certificate;

- Premiums for You were paid up to date for the Employer's prior insurer's group term life plan and this Certificate;
- Premiums are not currently being waived under the Waiver of Premium Rider, or You were not eligible, under the terms of the Employer's prior insurer's group term life plan, to have premiums waived under the Waiver of Premium provision; and
- You are not receiving or eligible to receive benefits under the Employer's prior insurer's group term life plan.

Any Group Term Life benefit payable will be the lesser of:

- The Group Term Life benefit payable under this Certificate; or
- The group term life benefit payable under the Employer's prior insurer's group term life plan had it remained in force; reduced by any amount paid by the prior insurer's group term life plan.

If You are covered under the Exception to When Coverage Starts, You will not be eligible for the Waiver of Premium Benefit provision under this Certificate until such a time You are Actively At Work as defined by this Certificate.

If You meet the conditions stated above, You will remain insured under this provision until the first of the following to occur:

- The date You are fully capable of performing the major duties of Your regular occupation for the Employer, and capable of doing so for the minimum number of hours of an Employee in Your eligible class;
- The date insurance terminates for one of the reasons stated in When Employee Coverage Ends;
- The last day of a period of 12 consecutive months which begins on this Certificate's Effective Date;
- The date You become eligible for the Waiver of Premium Benefit provision under the prior insurer's group life policy; or
- The last day You would have been covered under the prior insurer's group term life plan, had the prior plan not terminated.

B400.3133

All Options

When Coverage Ends

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

- The date Your Active Work ends for any reason, except as noted below under Coverage During Leave of Absence. Such reasons include:
  - Disability;
  - Death;

- Retirement;
- Layoff;
- Leave of absence;
- The end of employment; and
- Expiration of the employment contract.

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

You may have the right to continue certain group benefits for a limited time after Your coverage would otherwise end. And, You may have the right to replace certain group benefits with converted policies. The Employer will notify you of any conversion options available.

B400.3135

CONTINUATION OF COVERAGE

Coverage During Disability

If Your Active Work ends because You are Totally Disabled, You and Your Employer may agree to continue Your insurance for the amount of basic and voluntary term life insurance for which You are insured on Your last day of Active Work, subject to continued payment of all required premiums, until the earlier of:

- The date you are no longer Totally Disabled, as defined by this Certificate;
- 12 months; from the date Your Total Disability began;
- The date you are approved for any Waiver of Premium Benefit for which you are eligible; or
- The date of Your 99th birthday.

We may require written Proof of Loss that You remain Totally Disabled and are receiving regular Doctor's care to maintain this benefit. This Proof of Loss must be given to Us within 30 days of the date We request it. Your eligibility for benefits will be governed by all the terms of this Certificate.

Coverage During Temporary Layoff

If Your Active Work ends because You are temporarily laid off, You and Your Employer may agree to continue Your insurance, subject to continued payment of all required premium, until the earlier of:

- The end of the temporary layoff; or
- The end of the month in which You are laid off plus 1 months.
- The end of the time period covered under a severance agreement not to exceed 1 months.

If You die or become Disabled under this Certificate while Your coverage is being continued during a temporary layoff, Your eligibility for benefits will be governed by all the terms of this Certificate.

Coverage During Temporary Leave of Absence

If Your Active Work ends because You go on a leave of absence that has been approved by Your Employer, You and Your Employer may agree to continue Your insurance, subject to continued payment of all required premiums, until the earlier of:

- The end of the Employer approved leave of absence; or

- The end of the month in which Your leave begins plus 1 months.

If You become Disabled under this Certificate while Your coverage is being continued during a leave of absence, Your eligibility for benefits will be governed by all the terms of this Certificate.

B400.3138

ELIGIBILITY FOR GROUP TERM LIFE COVERAGE
DEPENDENT COVERAGE

B400.3143

All Options

Eligible Dependents For Dependent Voluntary Term Life Insurance

Your eligible dependents are Your:

- Spouse who is under age 70; and
- dependent children from birth until they reach age 25.

B438.1099

All Options

Adopted Children And Step-Children

Your dependent children include Your legally adopted children and Your step-children. However, to qualify as a dependent, each person must depend on You for at least 50% of their support and maintenance. We treat a child as legally adopted from the time the child is placed in Your home for the purpose of adoption. We treat such a child this way whether or not a final adoption order is ever issued.

B400.3200

All Options

Dependents Not Eligible

We exclude:

- A dependent who is on Active Duty in any armed force.

B400.3201

All Options

Continuing Coverage For Dependent Children Past the Limiting Age

If You have a child or children who:

- Is/are incapable of independent living by reason of an intellectual disability or a physical handicap; and

- Is/are primarily dependent upon You for support and maintenance,

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

Each such child:

- Must have an intellectual disability or a physical handicap that began before he or she reached the dependent age limit;
- Became covered by this Certificate, or the prior carrier's group life policy that it replaced, before he or she reached the dependent age limit, and remained continuously covered until he or she reached the age limit;
- Remains:
  - Incapable of independent living; and
  - Dependent upon You for most of his or her support and maintenance; and

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

Irrespective of this provision, any coverage provided under this section ends when Your coverage ends.

B438.0134

All Options

Proof Of Insurability

Part or all of Your dependent insurance amounts may be subject to proof that they are insurable. The Schedule of Benefits explains if and when We require Proof of Insurability. Your dependents will not be covered for any amount that requires Proof of Insurability until You provide that proof to Us and We approve that proof in writing.

B400.3203

All Options

When Dependent Coverage Starts

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

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

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Initial Dependents

If You enroll Your Initial Dependents on or before Your Eligibility Date, the dependents' coverage begins on the later of Your Eligibility Date and the date You become covered for Employee coverage.

If You enroll Your Initial Dependents within the Enrollment Period, their coverage begins on the later of Your Eligibility Date and the date You become covered for Employee coverage.

If You do not enroll Your Initial Dependents when they are first eligible, and enroll those Initial Dependents after the Enrollment Period ends, You must supply Proof Of Insurability and coverage will not start until We approve that proof in writing.

If an Initial Dependent becomes eligible after this Certificate's Effective Date, his or her coverage will start on the date We approve him or her for coverage.

If Dependent Proof of Insurability is required

Subject to the Exception shown below, if Proof Of Insurability is required for dependent benefits, You must send Us the proof We require, and We must approve that proof in writing. Those benefits will then begin on the approved Eligibility Date.

If You must pay part of the cost of dependent coverage, We will not cover You for such coverage until You enroll each of Your dependents, agree to make the required payments, submit Proof Of Insurability and We approve that proof in writing.

Newly Acquired Dependents

If You do not pay any part of the cost of dependent coverage, a Newly Acquired Dependent is covered from the date he or she first becomes eligible.

If You must pay part of the cost of dependent coverage, and are already enrolled for dependent child coverage for Your Initial Dependent children, any Newly Acquired Dependent children will be covered as of the date he or she is first eligible.

However, if You were previously eligible to enroll for dependent child coverage and waived coverage or failed to enroll, We will not cover any of Your dependent children until You submit Proof of Insurability and we approve that proof in writing and you make any additional required payments.

B400.3204

All Options

Exception

We will postpone the Eligibility Date of a dependent's, other than a newborn child's, coverage if, on that date, he or she is unable to perform two or more Activities of Daily Living (ADLs).

In that case, We will postpone the Eligibility Date of his or her coverage until the day after the date he or she no longer requires assistance with two or more Activities of Daily Living.

If a dependent was covered under a prior plan at transfer, this language will not apply to the amount of coverage that was in force with the prior plan.

B400.3206

When Dependent Coverage Ends

Dependent coverage ends for all of Your dependents when:

- Your Employee coverage ends;
- You stop being a member of a class of Employees eligible for such coverage;
- This Certificate ends; or
- Dependent coverage is discontinued from this Certificate for all Employees or for Your 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 or she stops being an eligible dependent. For dependent children the coverage ends at 12:01 A.M. Standard Time for Your place of residence on the date the child attains this Certificate's age limit, or when a step-child is no longer dependent on You for at least 50% of their support and maintenance, or for Your disabled or handicapped child who has reached the age limit, when he or she is no longer eligible under the Continuing Coverage for Dependent Children Past the Limiting Age provision.

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

B438.1060

EMPLOYEE TERM LIFE INSURANCE

B400.3211

All Options

Basic Term Life Insurance

If You die while covered for Group Term Life insurance, We will pay Your beneficiary the amount shown in the Schedule Of Benefits.

Payment Of Benefits

We will pay this insurance as soon as We receive written Proof of Loss as shown in the Claims Provisions section of this Certificate.

The Beneficiary

You decide who receives this benefit when You die. Your beneficiary designation should be provided in a means acceptable by Us.

You can change Your beneficiary at any time by providing written notice; unless You have assigned this insurance. But, the change will not take effect until We or the Employer records the change.

We will not be liable for any amounts paid before receiving notice of a beneficiary change.

In no event may a beneficiary be changed by a Power of Attorney.

If You named more than one person as a primary beneficiary, but You do not specify what shares each such primary beneficiary is entitled to receive, We will divide the benefits equally among all such named primary beneficiaries who survive You. If someone You named as a primary beneficiary dies before You, that person's share will be divided equally by the primary beneficiaries still alive; unless You have specified otherwise.

If You have named a contingent beneficiary or contingent beneficiaries, We will pay Your contingent beneficiary or contingent beneficiaries, if no primary beneficiary survives You. If there is more than one contingent beneficiary who is eligible for benefits, We will divide the benefits equally among all such named contingent beneficiaries who survive You; unless You have specified otherwise.

If there is no primary or contingent beneficiary or beneficiaries eligible for benefits when You die, We will pay this benefit as follows:

- To Your Spouse or Domestic Partner;
- If Your Spouse or Domestic Partner does not survive You, then to Your children who survive You in equal shares;
- If no Spouse or Domestic Partner or children survive You, then to Your parents who survive You in equal shares;
- If no Spouse or Domestic Partner, children, or parents survive You, then to Your brothers and sisters in equal shares;

- If none of the above parties survive You, then to Your executors or administrators of Your estate.

Assigning This Life Insurance

If You assign this insurance, You permanently transfer all Your rights under this insurance to the assignee.

We will recognize an assignee as the owner of the rights assigned only if:

- The assignment is in writing and signed by You; and
- A signed or certified copy of the written assignment has been received and approved by Us in writing.

Unless otherwise specified by You, the assignment shall take effect on the date the notice of assignment is signed by You, subject to any payments made or actions taken by Us prior to receipt of the notice.

We are not responsible for any legal, tax, or other effects of any assignment, or for any benefits We pay under this Certificate before We receive and approve any assignment.

We suggest You speak to Your lawyer before You make any assignment.

Payment Of Funeral Expenses

We have the option of paying up to $500 of this benefit to any person who incurred expenses for Your funeral.

Repatriation Benefit

We will pay an extra sum for covered loss of life which occurs at least 75 miles from Your home. In that case, We will reimburse up to $2,000 to any person who incurred expenses to prepare and transport Your body to a mortuary chosen by You or an authorized agent. The total repatriation benefit payable under Your life and Accidental Death & Dismemberment contracts will not exceed $2,000.

B438.0147

All Options

Voluntary Term Life Insurance

Subject to the limitations and exclusions shown below, if You die while covered for this Group Term Life insurance, We will pay Your beneficiary the amount shown in the Schedule Of Benefits for the plan of voluntary term life insurance You have elected. The voluntary term life insurance amount may be subject to reductions. These reductions are also shown in the Schedule Of Benefits. Your voluntary term life insurance amount, a part of it, or increases in such amount may not become effective until You submit Proof Of Insurability to Us, and We approve it in writing. These requirements are also shown in the Schedule Of Benefits.

Payment Of Benefits

Subject to all of the terms of this Certificate, We will pay this insurance as soon as We receive written Proof of Loss as shown in the Claims Provisions section of this Certificate.

B400.3213

All Options

Suicide Exclusion We pay no voluntary term life insurance benefits if Your death is due to suicide, and if such death occurs within 2 years from Your voluntary term life insurance effective date under this Certificate. And, We pay no increased voluntary term life insurance benefit amount if Your death is due to suicide, and if such death occurs within 2 years from the effective date of the increase. In the event of death by suicide during the 2 year Suicide Exclusion period, a refund of premiums will be made.

If this Certificate replaces another voluntary Group Term Life insurance plan Your Employer had with another insurer, You will be given credit for the amount of time covered under the prior plan's Suicide Exclusion if:

- You were covered under the prior plan when it ended;
- You Enrolled for voluntary Group Term Life insurance under this Certificate on or before this Certificate's effective date; and
- You are Actively At Work on the effective date of this Certificate.

If You satisfy these conditions We will credit any time covered under the prior term life plan toward meeting this Certificate's 2 year Suicide Exclusion requirement.

However, We limit Your voluntary term life insurance benefit under this Certificate if it is more than the benefit for which You were insured under the prior term life plan. In this case, We limit the benefit to the amount You would have been entitled to under the prior term life plan.

The Beneficiary You decide who receives this benefit when You die. The name of the beneficiary appears in the enrollment or similar form unless changed by You. Your beneficiary designation should be provided in a means acceptable by Us.

You can change Your beneficiary at any time by providing written notice; unless You have assigned this insurance. But, the change will not take effect until We or the Employer records the change.

We will not be liable for any amounts paid before receiving notice of a beneficiary change.

If You named more than one person as a primary beneficiary, but You do not specify what shares each such primary beneficiary is entitled to receive, We will divide the benefits equally among all such named primary beneficiaries who survive You. If someone You named as a primary beneficiary dies before You, that person's share will be divided equally by the primary beneficiaries still alive; unless You have specified otherwise.

If You have named a contingent beneficiary or contingent beneficiaries, We will pay Your contingent beneficiary or contingent beneficiaries, if no primary beneficiary survives You. If there is more than one contingent beneficiary who is eligible for benefits, We will divide the benefits equally among all such named contingent beneficiaries who survive You; unless You have specified otherwise.

If there is no primary or contingent beneficiary or beneficiaries eligible for benefits when You die, We will pay this benefit as follows:

- To Your Spouse or Domestic Partner;
- If Your Spouse or Domestic Partner does not survive You, then to Your children who survive You in equal shares;
- If no Spouse or Domestic Partner or children survive You, then to Your parents who survive You in equal shares;
- If no Spouse or Domestic Partner, children, or parents survive You, then to Your brothers and sisters in equal shares;
- If none of the above parties survive You, then to Your executors or administrators of Your estate.

Assigning This 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:

- Your Spouse or Domestic Partner;
- One of Your parents or grandparents;
- One of Your children or grandchildren;
- One of Your brothers or sisters; or
- The trustee(s) of a trust set up for the benefit of one or more of these relatives.

We will recognize an assignee as the owner of the rights assigned only if:

- The assignment is in writing and signed by You; and
- A signed or certified copy of the written assignment has been received and approved by Us in writing.

We are not responsible for any legal, tax, or other effects of any assignment, or for any benefits We pay under this Certificate before We receive and approve any assignment.

We suggest You speak to Your lawyer before You make any assignment.

Payment Of Funeral Expenses

We have the option of paying up to $500 of this benefit to any person who incurred expenses for Your funeral.

Repatriation Benefit

We will pay an extra sum for covered loss of life which occurs at least 75 miles from Your home. In that case, We reimburse up to $2,000 to any person who incurred expenses to prepare and transport Your body to a mortuary chosen by You or an authorized agent. The total repatriation benefit payable under Your life and Accidental Death & Dismemberment contracts will not exceed $2,000.

B438.0148

CONVERTING THIS EMPLOYEE BASIC AND VOLUNTARY TERM LIFE INSURANCE

If Employment Or Eligibility Ends

Your group life insurance ends on the date:

- Your active Full-Time employment ends; or
- You stop being a member of an eligible class or Your class is no longer eligible under this Certificate.

If Your group life insurance ends, Your Employer is responsible for providing You Notice of Your Right to Convert.

If You are not Totally Disabled, You can apply to convert Your Employee group basic and voluntary life insurance to a permanent life insurance policy.

You can apply to convert up to the full amount of basic and voluntary life insurance for which You were insured under this Certificate on the date Your insurance ended, less any group life insurance for which You become eligible in the 31 days after Your insurance under this Certificate ends.

If This Certificate Ends Or Group Life Insurance Policy Is Discontinued

Your group life insurance also ends:

- If this Certificate ends; or
- Life insurance is discontinued from the Group Policy for all Employees or for Your class.

If Your group life insurance ends for either of these reasons, You may apply to convert Your Employee group basic and voluntary life insurance to a Converted Policy.

You can apply to convert to a permanent life insurance policy, if

- You are not Totally Disabled; and
- You have been insured by a Guardian group life insurance plan or a group plan it replaces for at least five consecutive years prior to the termination date.

However, the amount of life insurance that You can convert in either scenario is limited to the lesser of:

- $10,000, or
- The amount of Your basic and voluntary life insurance under this Certificate, less any group life insurance for which You become eligible in the 31 days after Your insurance under this Certificate ends.

If You Are Totally Disabled

Your group life insurance ends on the date:

- Your active Full-Time employment ends;
- You stop being a member of an eligible class;

- This Certificate ends; or
- Life insurance is discontinued from this Certificate for all Employees or for Your class;

and

- You are Totally Disabled; and
- You are eligible for Waiver of Premium Benefits pursuant to the Waiver of Premium Benefit Rider, but You have not yet been approved for the Waiver of Premium of Benefit,

You can apply to convert Your group term life insurance to:

- A permanent life insurance policy; or
- Interim term life insurance coverage.

You can apply to convert up to the full amount of basic and voluntary life insurance for which You are insured under this Certificate on the date Your insurance ends, less any group life insurance for which You become eligible in the 31 days after Your insurance under this Certificate ends.

However, if You have coverage under this Certificate's Exception to When Employee Coverage Starts, You may not convert if You are eligible or could become eligible under the prior plan's waiver of premium provision.

If You have converted and are later approved for this Certificate's Waiver of Premium Benefit, the Converted Policy will be cancelled as of the date You are approved for the Waiver of Premium Benefit. In this instance, Your coverage under this Certificate will continue subject to its terms, provided You remain eligible for the Waiver of Premium Benefit.

Interim Term Life Insurance

You may choose to apply to convert to interim term life insurance coverage if:

- You are Totally Disabled; and
- You may be eligible for Waiver of Premium Benefits based upon Your age, but You have not yet been approved for the Waiver of Premium Benefit.

If interim term life insurance coverage is issued to You, it can remain in force for up to one year from the date the interim term life insurance coverage goes into force and effect.

If You are approved for this Certificate's basic and voluntary Waiver of Premium Benefit during this year, the interim term life insurance coverage will be cancelled as of the date that You are approved for the Waiver of Premium Benefit. In this instance, Your coverage under this Certificate will continue subject to its terms, provided You remain eligible for the Waiver of Premium Benefit. If You have not been approved for this Certificate's basic and voluntary Waiver of Premium Benefit, the interim term life insurance coverage will end exactly one year from the first day said coverage goes into force and effect, and Your life insurance will be converted to a permanent life insurance policy. Premiums for the permanent life insurance policy will be based on Your age as of the date You convert from the interim term life insurance coverage.

If You are Totally Disabled, but You are not eligible for the Waiver of Premium Benefit based on Your age, You can apply to convert to a permanent life insurance policy.

How and When to Convert

To obtain a Converted Policy, We must receive a written application fully completed by You, and all required premiums within the Conversion Period. Your Employer is responsible for providing You with Notice of Your Right to Convert within 15 days of the date Your group life insurance ends. We will not ask for proof that You are insurable. In order to obtain a Converted Policy, You must satisfy all conditions required to convert within the Conversion Period.

Coverage will begin under the Converted Policy when We receive:

- A written application fully completed by You; and
- All required premiums during the Conversion Period.

Death During The Conversion Period

We will pay a death benefit equal to the amount of life insurance that could have been converted if:

- You die within the Conversion Period; and
- Before Your death, You would have been entitled to purchase a Converted Policy; and
- We receive Proof of Loss.

Any benefit payable under the group Certificate will be paid to the beneficiary You designate under the group Certificate. However, if the Converted Policy has already taken effect, any benefit payable under the Converted Policy will be paid to the beneficiary You designated for the individual life insurance on the application for conversion. Under no circumstances will a benefit be paid under both the group Certificate and the Converted Policy.

B438.0171

All Options

Portability And Conversion

If You choose to convert, this Certificate's portability privilege will not be available. In the event that a person would be eligible to both convert and to port, only one of these privileges may be chosen. Coverage under both a Conversion Policy and a portable certificate of coverage at the same time is not permitted. You should read the entire Certificate, as well as any related materials carefully before making a choice.

B400.3234

DEPENDENT TERM LIFE INSURANCE

B400.3235

All Options

Voluntary Term Life Insurance

A Subject to the limitations and exclusions shown below, If Your dependent dies while insured for this benefit, We will pay You the amount shown in the Schedule Of Benefits. If You are not living when Your dependent dies, We will pay this benefit as follows:

If the dependent was Your Spouse or Domestic Partner, We will pay this benefit to the Spouse's or Domestic Partner's estate. If there is no established estate, We will pay this benefit in equal shares to the first eligible party or parties in the following order:

- To Your Spouse's or Domestic Partner's children in equal shares;
- If no children survive him or her, then to his or her parents in equal shares;
- If no children, or parents survive him or her, then to then to his or her brothers and sisters in equal shares;
- If none of the above parties survive Your Spouse or Domestic Partner, then to the executors or administrators of Your estate.

If the dependent was Your child, we will pay this benefit in equal shares to the first eligible party or parties in the following order:

- Your child's custodial parent(s);
- If no custodial parent survives him or her, then to Your parents;
- If no custodial parent or Your parents survive him or her, then to Your child's estate;
- If none of the above parties survive him or her and no estate exists, then to the executors or administrators of Your estate;
- If none of the above parties survive him or her, and no estates exist, then to Your child's siblings.

We have the option of paying up to $500 of this benefit to any person who incurred expenses for your dependent's funeral.

Payment Of Benefits Subject to all of the terms of this Certificate, We will pay this insurance as soon as We receive written Proof of Loss which is acceptable to Us. This should be sent to Us as soon as possible. We will pay this benefit in a lump sum.

B438.0175

All Options

The Choices: You may elect coverage of any of the plans of dependent Spouse or Domestic Partner voluntary term life insurance and any of the plans of dependent child voluntary term life insurance offered by the Employer. These plans are shown in the Schedule Of Benefits. But, You can only be covered for one Spouse or Domestic Partner plan and one child plan at a time. You must notify the Employer of Your election and pay the required premium.

You may switch to another Spouse or Domestic Partner and child plan during the dependent voluntary life enrollment period shown in the Schedule Of Benefits. Subject to any of this Certificate's Proof Of Insurability requirements, You will be covered for the new plan as of the transfer date shown in the Schedule of Benefits. You must notify the Employer of any desired switch.

B438.0179

All Options

Suicide Exclusion We pay no voluntary term life insurance benefits if Your dependent's death is due to suicide, if such death occurs within 2 years from his or her voluntary term life insurance effective date under this Certificate. And, We pay no increased voluntary term life insurance benefit amount if Your dependent's death is due to suicide, if such death occurs within 2 years from the effective date of the increase. In the event of death by suicide during the 2 year suicide exclusion period, a refund of premiums will be made to the Employer for all premiums paid by the Employer and a refund of premiums will be made to You for all premiums paid by You.

If this Certificate replaces another voluntary term life insurance plan Your Employer had with another insurer, your dependent may be given credit for the amount of time covered. If your dependent was:

- Covered under the prior plan when it ended;
- Enrolled for insurance under this Certificate on or before this Certificate's effective date; and
- You were actively working on the effective date of this Certificate;

We credit any time covered under the prior plan toward meeting this Certificate's 2 year Suicide Exclusion requirement.

However, We limit Your dependent voluntary term life insurance benefit under this Certificate if it is more than the benefit for which Your dependents were insured under the prior plan. In this case, We limit the benefit to the amount Your dependents would have been entitled to under the prior plan.

B438.0184

CONVERTING THIS DEPENDENT TERM LIFE INSURANCE

If A Dependent's Life Insurance Ends

Dependent term life insurance ends for all of Your dependents when Your group life insurance eligibility ends. Your group life insurance eligibility ends if:

- Your active Full-Time employment ends;
- You stop being a member of an eligible class or Your class is no longer eligible under this Certificate; or
- Your group life insurance is continued under the Waiver of Premium Benefit provision; or
- You die.

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

If Dependent Life Insurance ends for any of the above reasons any dependent who was insured under this Certificate may apply to convert the amount equal to the amount of terminated group life insurance less the amount of any group life insurance that the dependent is or becomes eligible for within 31 days of termination. Your Employer is responsible for notifying You or Your dependents of any conversion options available.

Your dependent may apply to convert the voluntary life insurance for which he or she was insured under this Certificate on the date his or her insurance ended to a permanent life insurance policy.

If This Certificate Ends Or Group Life Insurance Policy Is Discontinued

Dependent term life insurance also ends for all of Your dependents:

- If this Certificate ends; or
- Dependent life insurance is discontinued from the Group Policy for all Employees or for Your class.

If Your Spouse's or Domestic Partner's term life insurance ends for either of these reasons, and Your Spouse or Domestic Partner has been insured by a Guardian Group plan, or a group plan it replaces, for at least five consecutive years, Your Spouse or Domestic Partner may apply to convert to a permanent life insurance policy.

However the amount that Your Spouse or Domestic Partner can convert in either scenario is limited to the lesser of:

- $10,000; or
- The amount of Your Spouse's or Domestic Partner's life insurance under this Certificate, less any group life insurance for which Your dependent becomes eligible in the 31 days after dependent life insurance under this Certificate ends.

If Your dependent child's term life insurance ends for either of these reasons, You may apply to convert Your child's coverage to a permanent life insurance policy, without proof of insurability. The amount available for conversion will be equal to Your dependent child's life insurance under this Certificate, less any group life insurance for which Your dependent child becomes eligible in the 31 days after dependent child's life insurance under this Certificate ends.

If A Dependent Stops Being Eligible

A dependent's term life insurance ends when he or she stops being an eligible dependent.

A Spouse is no longer an eligible dependent when:

- A marriage is lawfully terminated; or
- He or she reaches age 70.

A Domestic Partner is no longer an eligible dependent when:

- The relationship ends or no longer qualifies as a Domestic Partnership; or
- He or she reaches age 70.

A child is no longer an eligible dependent when he or she:

- Reaches the limiting age.

If a dependent stops being eligible, he or she may convert the amount equal to the amount of terminated group life insurance less the amount of any group life insurance that the dependent is or becomes eligible for within 31 days of termination.

B438.0194

All Options

How And When to Convert

To obtain a Converted Policy, We must receive a written application fully completed by You or Your dependent, and all required premiums within the Conversion Period. Your Employer is responsible for providing You and Your dependents with written Notice of Your Right to Convert within 15 days of the date Your group life insurance ends. You will have 31 days after Your dependent group voluntary life insurance ends to convert. We will not ask for proof that he or she is insurable. If the dependent is a minor or incompetent, the person who cares for and supports the dependent may apply for him or her.

Death During The Conversion Period

We will pay a death benefit equal to the amount of dependent life insurance that could have been converted if:

- Your dependent dies within the Conversion Period; and

- Before his or her death, Your dependent would have been entitled to purchase a Converted Policy; and
- We receive Proof of Loss.

Any benefit payable under the group Certificate will be paid to you. However, if the Converted Policy has already taken effect, any benefit payable under the Converted Policy will be paid to the beneficiary You or Your dependent designated for the individual life insurance on the application for conversion. Under no circumstances will a benefit be paid under both the group Certificate and the Converted Policy.

B438.0216

CLAIM PROVISIONS

Your right to make a claim for Group Term Life insurance benefits provided by this Certificate is governed as follows:

Authority We have discretionary authority to:

- Interpret the terms of this Certificate; and
- Determine Your eligibility for coverage and benefits under this Certificate.

All such determinations are conclusive and binding, except that they may be modified or reversed by a court or regulatory agency with appropriate jurisdiction.

Notice Written notice of intent to file a claim under this Certificate must be sent to Us within 20 days of the date of the loss. This Notice should include the name of the insured and the Policy number. If the claim is being made for any other Covered Person, his or her name should also be shown. For details, You can call Us at 1-800-525-4542.

Claim Forms We will furnish forms for filing proof of death within 15 days of receipt of Notice. If we do not furnish the forms on time, We will accept a written Notice and adequate proof of death that is the basis of the claim as Proof of Loss.

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

Late Notice and Proof of Loss We will not void or reduce Your claim if we do not receive Notice and Proof of Loss within the required time. In that case, Notice and Proof of Loss must be sent as soon as reasonably possible.

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

The Guardian Life Insurance Company of America
Group Life Claims Department
P.O. Box 14334
Lexington, KY 40512

Payment of Benefits We will pay the Group Term Life insurance benefit as soon as We receive written Proof of Loss.

Legal Actions No legal action against Guardian related to this Certificate may be brought until 60 days from the date Proof of Loss has been given as shown above. No legal action may be brought against Guardian related to claims for benefits under this Certificate after three years from the date of the final benefit determination.

B400.3502

All Options

DEFINITIONS

This section defines certain terms appearing in this Certificate.

B400.3503

All Options

Active Work or Actively At Work These terms mean You are able to perform, and are performing, all of the regular duties of Your work for the Employer, on a Full-Time basis at:

- One of the Employer's usual places of business;
- Some place where the Employer's business requires You to travel; or
- Any other place You and the Employer have agreed on for Your work.

B400.3504

All Options

Activities Of Daily Living This term means the ability to independently perform the following, with or without equipment or adaptive devices:

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

B400.3505

All Options

Certificate This term means this Certificate of Coverage, including any riders and enrollment forms that may be attached to this Certificate.

B400.3506

All Options

Conversion Period This term means the consecutive 31 day period beginning on the date Your Employee and dependent group basic and voluntary life insurance ends.

B400.3512

All Options

Converted Policy This term means a policy which provides individual life insurance, on an interim term or permanent basis, resulting from the option to convert provided in the Policy. The Converted Policy will not provide any:

- Benefits for accidental death;
- Waiver of Premium Benefits; or
- Other supplemental benefits.

The benefits provided by the Converted Policy may not be the same as the benefits provided by this Certificate.

The premium for the Converted Policy will be based on

- Your risk and rate class under this Certificate; and
- Your age on the date the Converted Policy goes into effect.

B400.3513

All Options

Covered Person This term means the Employee and dependents who are insured by this Certificate.

B400.3514

All Options

Disabled This term means the Covered Person is:

- Not able to perform any work for wage or profit; and
- Receiving Regular and Appropriate Care for the cause of Disability.

B400.3516

All Options

Doctor Any medical practitioner We are required by law to recognize. He or she must:

- Be properly licensed or certified by the laws of the state where he or she practices; and
- Provide services that are within the lawful scope of his or her practice.

B400.3517

All Options

Effective Date This term means the date the Certificate goes into force and effect as stated on the cover page of the Certificate of Coverage, or any change to the Certificate as requested by the Policyholder and approved by Us and in force and effect as stated on the cover page of the Certificate of Coverage.

B400.3518

All Options

Eligibility Date This term means the earliest date a Covered Person is eligible for coverage under this Certificate, and he or she has satisfied all requirements for coverage to begin, as required by this Certificate.

- For Employee coverage, this term means the earliest date You are eligible for coverage under this Certificate.
- For an Employee in Active Work who has completed any waiting period required by the Employer as of the Effective Date of this Certificate, the Eligibility Date means the Effective Date of this Certificate.
- For an Employee in Active Work as of the Effective Date of this Certificate who has not completed any waiting period required by the Employer, the Eligibility Date will be the date following the completion of the required waiting period.
- For an Employee hired on or after the Effective Date of this Certificate, the Eligibility Date will be the later of the Employee's date of hire or the first date after the end of any waiting period required by the Employer.

If this plan requires Employees to elect coverage under this Certificate, the Eligibility Date will be the later of:

- The Employee's date of hire;
- The first date after any waiting period required by the Employer; or
- The approval by Us in writing of any coverage for which You were required to provide Proof of Insurability.

For dependent coverage, this term means the earliest date on which:

- You have Initial Dependents; and
- Are eligible for dependent coverage.

B400.3519

All Options

Employee This term means a person who works for the Employer at the Employer's place of business and whose income is reported to the United States Internal Revenue Service, and/or a state, for tax purposes. Partners and proprietors will also be treated as employees if the Conditions of Eligibility requirements are met.

B400.3521

All Options

Employer This term means THE EVERGREENE COMPANIES .

B400.3522

All Options

Enrollment Period This term means the 31 day period which starts on the date the Covered Person first becomes eligible for coverage.

B400.3523

All Options

Full-Time This term means You are not a part time Employee as defined by Your Employer and the average number of hours You worked for the 6 months prior to the last full day worked was at least 30 hours per week at:

- Your Employer's place of business;
- Some place where the Employer's business requires You to travel; or
- Any other place You and Your Employer have agreed upon for the performance of occupational duties.

B400.3525

All Options

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

B438.0220

All Options

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

B400.3526

All Options

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

B400.3538

All Options

Notice of Right to Convert This term means the written notice presented to You by the Employer, delivered to Your last known address.

B400.3539

All Options

Policy or Plan This term means the Group Term Life insurance coverage described in the Policy and this Certificate.

B400.3541

All Options

Proof Of Insurability This term means the completion of an evidence of insurability requirement as defined in the Schedule of Benefits.

B400.3542

All Options

Proof of Loss This term means the documents that are deemed acceptable for purposes of substantiating a claim. Acceptable Proof of Loss includes:

- An original certified finalized death certificate;
- The beneficiary designation in effect at the time of death;
- Enrollment information documenting that the insured was properly enrolled for the amount of coverage claimed; and
- A fully completed claim form; and
- Any additional information deemed necessary during the course of Our claim investigation.

B438.0222

All Options

Reasonable Accommodation This term means any modification or adjustment that the Employer willingly provides to:

- A job;
- An employment practice;
- A work process; or
- The work place.

The modification or adjustment must make it possible for a Disabled person to:

- Reach the same level of performance as a similarly situated non-disabled person; or
- Enjoy equal benefits and privileges of employment as are available to a similarly situated non-disabled person.

The modification or adjustment must not place an undue hardship on the Employer.

B400.3545

All Options

Regular and Appropriate Care

This term means, with respect to Your disabling condition(s) and any other condition(s) which, if left untreated, would adversely affect Your disabling condition, You:

- Visit a Doctor as frequently as medically required, according to generally accepted medical standards, to effectively manage these conditions; and
- Are receiving the most appropriate treatment, according to generally accepted medical standards, designed to achieve maximum medical improvement in these conditions.

Treatment must be provided by a Doctor or Doctors whose specialty is most appropriate according to generally accepted medical standards for Your:

- Disability; and
- Any other conditions which left untreated would adversely affect Your disabling condition.

Generally accepted medical standards are those supported by nationally recognized authorities in the health care field including:

- The American Medical Association (AMA);
- The AMA Board of Medical Specialties;
- The Food and Drug Administration;
- The Centers for Disease Control;
- The National Cancer Institute;
- The National Institutes of Health;
- The Department of Health and Human Services; and
- Any other agency of similar repute.

B400.3546

All Options

Spouse

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

B400.3547

All Options

Total Disability and Totally Disabled

This term means that, due to sickness or injury, the Covered Person is:

- Not able to perform any work for wages or profit; and
- Receiving Regular and Appropriate Care for the cause of disability.

B400.3548

All Options

You or Your These terms mean the insured Employee.

B400.3551

All Options

GROUP TERM LIFE SCHEDULE OF BENEFITS

B400.4199

All Options

Employee Basic Term Life Insurance Schedule

B400.4200

All Options

Basic Term Life Insurance Amount

Insurance Amount $25,000.00

B400.4213

All Options

Reduction of Basic Life Insurance Amount Based on Age

If You are less than age 65 when Your insurance under this Policy starts, Your insurance amount is reduced at 12:01 A.M Standard Time for Your place of residence on the date You reach age 65, by 35% of the amount which otherwise applies to Your classification. But in no case will such reduced amount be less than $1,000.00. This reduction also applies to Your initial insurance amount if Your insurance starts after You reach age 65 but before You reach age 70.

If You are less than age 70 when Your insurance under this Policy starts, Your basic life insurance amount is reduced at 12:01 A.M Standard Time for Your place of residence on the date You reach age 70, by 50% of the amount which otherwise applies to Your classification. But in no case will such reduced amount be less than $1,000.00. This reduction also applies to Your initial insurance amount if Your insurance starts after You reach age 70.

With respect to any of the reductions described above, the reduced insurance amount is in place of the amount which otherwise applies to Your classification.

B400.4361

All Options

Proof of Insurability

Depending on the coverage selected, or as otherwise required in this Certificate, You, Your Spouse or Domestic Partner and/or Dependents may be required to supply proof that the person applying for coverage is insurable for the amount and type of coverage selected. This requirement is called Proof of Insurability. For purposes of this section, any person applying for coverage requiring Proof of Insurability is referred to as "Applicant."

To determine if the Applicant is required to submit Proof of Insurability for the type and amount of coverage sought, please see below.

Any applicant required to submit Proof of Insurability is required to complete and submit to Us an Enrollment/Change form. We may also require the completion of additional forms so that We may determine whether the Applicant is insurable, according to Our underwriting standards for the amount and type of coverage applied for. To determine if the Applicant is insurable, We may also need to obtain and review the Applicant's

- Health and medical history;
- Prescription history;
- Records relating to treatment, diagnostic testing, hospitalization, and
- Records pertaining to Applicant's driving and motor vehicle history.

No coverage requiring Proof of Insurability will become effective unless and until it is approved by Us in writing. Our receipt of any premiums associated with coverage requiring Proof of Insurability does not waive or modify any requirement that must be satisfied for coverage to begin, including but not limited to the requirement that the Applicant submit Proof of Insurability. In the event that any premiums are overpaid, Our only obligation is to return the amount of overpaid premiums.

The Policyholder, or its designee, must give Us complete and accurate information so that we may determine:

- Who is insured;
- The type and amount of coverage for which someone is insured; and
- Any other information required so that Guardian may meet its obligations under the Policy.

Proof Of Insurability Requirements

Proof Of Insurability requirements apply to Basic Term Life Insurance. Such requirements may apply to the full insurance amount, or just part of it, as outlined below. When Proof Of Insurability requirements apply, it means You must submit to Us Proof that You are insurable, and We must approve the Proof in writing before the insurance, or the specified part becomes effective.

We require Proof of Insurability as follows:

If You:

- Do not meet this Policy's enrollment requirement within 30 days after You first become eligible; or
- Enroll after You previously had coverage which ended because You failed to make a required payment,

We will require that You provide Proof Of Insurability. And, You will not be covered until We approve that proof in writing.

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

B438.0402

All Options

Employee Voluntary Term Life Insurance Schedule

B400.4492

All Options

Initial Election You may choose to be insured under the plan of Voluntary Term Life Insurance shown below. You must notify the Employer of Your election and pay the required premium.

B400.4493

All Options

Changing Election You may switch to another plan of Voluntary Term Life Insurance during the Voluntary life enrollment period. Each year, the Voluntary life enrollment period starts on December 1st and ends on December 31st. You must notify the Employer of any desired switch. We may require Proof Of Insurability before You become insured under the new plan of benefits. See below For details. If We do not require Proof, You will become insured under the new plan of benefits as of the January 1st which coincides with or next follows the end of the Voluntary life enrollment period.

B400.4495

All Options

Voluntary Term Life Insurance Amount

Plan A

You may elect amounts of voluntary term life insurance in increments of $5,000.00, but the amount may not be less than $10,000.00 and may not exceed $100,000.00.

B400.4510

All Options

Annual Election After You first enroll for Employee Voluntary Term Life Insurance, You may choose to increase Your amount of Voluntary Term Life Insurance by an amount not to exceed an increase of $50,000 as shown above. This option is available once annually during the Voluntary life enrollment period described above. Proof Of Insurability will not be required unless the insurance amount exceeds the amount of Voluntary Term Life Insurance for which Proof Of Insurability is required as shown below.

If Proof Of Insurability is required and has been submitted and approved by Us, Proof of Insurability for additional increases will be required on the second anniversary of the date we approve such coverage.

If Proof Of Insurability is required and has been declined, You will not be eligible for additional annual increases without submitting Proof Of Insurability for them, and then if such increases are approved by Us in writing.

B400.4698

All Options

Family Status Change

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

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

- Marriage or divorce;
- Death of a Spouse or Domestic Partner or child;
- Birth or adoption of a child;
- Your Spouse's or Domestic Partner's termination of employment or a change in Your Spouse's or Domestic Partner's employment that results in the loss of group coverage.

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

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

Proof Of Insurability is not required for the change to Voluntary Term Life Insurance due to Family Status Change as long as the change to Your Voluntary Term Life Insurance does not exceed the Proof of Insurability requirements as shown in the Schedule of Benefits. Refer to When Coverage Begins and When Dependent Coverage Begins in the Eligibility section of Your Certificate for information regarding when this coverage is effective.

B438.0403

All Options

Reduction of Voluntary Life Insurance Amount Based on Age

If You are less than age 65 when Your insurance under this Policy starts, Your insurance amount is reduced at 12:01 A. M. Standard Time for your place of residence on the date You reach age 65, by 35% of the amount which otherwise applies to Your classification. But in no case will such reduced amount be less than $1,000.00. The reduced amount is in place of the amount which otherwise applies to Your classification. This reduction also applies to Your initial insurance amount if Your insurance starts after You reach age 65, but before You reach age 70.

If You are less than age 70 when Your insurance under this Policy starts, Your insurance amount is reduced at 12:01 A. M. Standard Time for your place of residence on the date You reach age 70, by 50% of the amount which otherwise applies to Your classification. But in no case will such reduced amount be less than $1,000.00. The reduced amount is in place of the amount which otherwise applies to Your classification. This reduction also applies to Your initial insurance amount if Your insurance starts after You reach age 70.

B400.4734

All Options

Proof Of Insurability Requirements

Depending on the coverage selected, or as otherwise required in this Certificate, You may be required to supply proof that the person applying for coverage is insurable for the amount and type of coverage selected. This requirement is called Proof of Insurability. For purposes of this section, any person applying for coverage requiring Proof of Insurability is referred to as "Applicant."

To determine if the coverage requires an applicant to submit Proof of Insurability, please see below.

Any applicant required to submit Proof of Insurability is required to complete and submit to Us an Enrollment/Change form. We may also require the completion of additional forms so that We may determine whether the Applicant is insurable, according to Our underwriting standards for the amount and type of coverage applied for. To determine if the Applicant is insurable, We may also need to obtain and review the Applicants:

- Health and medical history;
- Prescription history;
- Records relating to treatment, diagnostic testing, hospitalization; and
- Records pertaining to an Applicants driving and motor vehicle history.

No coverage requiring Proof of Insurability will become effective unless and until it is approved by Us in writing. Our receipt of any premiums associated with coverage requiring Proof of Insurability does not waive or modify any condition that must be satisfied for coverage to begin, including but not limited to the requirement that the applicant submit Proof of Insurability. In the event that any premiums are overpaid, Our only obligation is to return the amount of overpaid premiums.

The Policyholder, or its designee, must give Us complete and accurate information so that we may determine:

- Who is insured;
- The type and amount of coverage for which someone is insured; and

Any other information required so that Guardian may meet its obligations under the Policy.

Proof Of Insurability Requirements

Proof of Insurability requirements apply to Voluntary Term Life Insurance. Such requirements may apply to the full insurance amount, or just part of it, as outlined below. When Proof of Insurability requirements apply, it means You must submit to Us Proof that You are insurable, and We must approve the Proof of Insurability in writing before the insurance, or the specified amount of insurance becomes effective.

We require Proof of Insurability as follows:

B400.4903

All Options

Except as provided for annual election, We require Proof of Insurability before You switch from Your current increment of Voluntary Term Life Insurance to an increment which provides a greater amount of insurance.

B400.5270

All Options

We require Proof of Insurability before We will insure You if You enroll for Voluntary Term Life Insurance after the time allowed for enrolling as specified in this Policy.

B400.4903

All Options

We require Proof for amounts of Voluntary Term Life Insurance which exceed of $50,000.00, if Your scheduled Voluntary term life effective date is after You reach age 65.

B400.4915

All Options

We require Proof for amounts of Voluntary Term Life Insurance which exceed of $10,000.00, if Your scheduled Voluntary term life effective date is after You reach age 70.

B400.4915

All Options

Dependent Voluntary Term Life Insurance Schedule

B400.5473

All Options

Initial Election You may choose the plan of dependent Spouse or Domestic Partner Voluntary Term Life Insurance and the plan of dependent child Voluntary life insurance shown below. You must notify the Employer of Your election and pay the required premium.

B438.0411

All Options

Voluntary Dependent Spouse or Domestic Partner Term Life Insurance Amount

Plan A

You may elect amounts of voluntary dependent Spouse or Domestic Partner term life insurance in increments of $5,000.00, but the amount may not be less than $5,000.00 and may not exceed $50,000.00.

B438.0414

All Options

Voluntary Dependent Child Insurance Amount

Plan A

You may elect amounts of voluntary dependent child Term Life Insurance in increments of $2,000.00, but the amount may not be less than $2,000.00 and may not exceed $10,000.00.

B400.5716

All Options

In no event may the insurance amount of a dependent Spouse or Domestic Partner exceed 50% of Your insurance amount.

B438.0489

All Options

In no event may the insurance amount of a dependent child exceed 100% of Your insurance amount.

B400.6004

All Options

Reduction of Dependent Voluntary Life Insurance Amount Based on Age

An employee's dependent benefits are reduced in the same manner as his or her employee benefits. The dependent reductions are based on the employee's age.

B400.5474

All Options

Proof Of Insurability Requirements

Depending on the coverage selected, or as otherwise required in this Certificate, Your Spouse or Domestic Partner may be required to supply proof that the person applying for coverage is insurable for the amount and type of coverage selected. This requirement is called Proof of Insurability. For purposes of this section, any person apply for coverage requiring Proof of Insurability is referred to as "Applicant."

To determine if the Applicant is required to submit Proof of Insurability for the type and amount of coverage sought, please see below.

Any applicant required to submit Proof of Insurability is required to complete and submit to Us an Enrollment/Change form. We may also require the completion of additional forms so that we may determine whether the Applicant is insurable according to our underwriting standards for the amount and type of coverage applied for. To determine if the Applicant is insurable, We may also need to obtain and review the Applicant's:

- Health and medical history;
- Prescription history;
- Records relating to treatment, diagnostic testing, hospitalization; and
- Records pertaining to the Applicant's driving and motor vehicle history.

No coverage requiring Proof of Insurability will become effective unless and until it is approved by Us in writing. Our receipt of any premiums associated with coverage requiring Proof of Insurability does not waive or modify any requirement that must be satisfied for coverage to begin, including but not limited to the requirement that the Applicant provide Proof of Insurability. In the event that any premiums are overpaid, Our only obligation is to return the amount of overpaid premiums.

The Policyholder, or its designee, must give Us complete and accurate information so that We may determine:

- Who is insured;
- The type and amount of coverage for which someone is insured; and
- Any other information required so that Guardian may meet its obligations under the Policy.

We require Proof of Insurability as follows:

B438.0492

All Options

We require Proof Of Insurability that a dependent is insurable if You:

- Enroll a dependent, submit the dependent's signed health statement, and agree to make the required payments after the end of the Enrollment Period;
- In the case of a Newly Acquired Dependent, other than the first newborn child, have other eligible dependents who You have not elected to enroll; or
- In the case of a Newly Acquired Dependent, have other eligible dependents whose coverage previously ended because You failed to make the required contributions, or otherwise chose to end such coverage.

B400.6018

All Options

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

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

B400.6019

All Options

We require Proof of Insurability before We will insure any dependent Spouse or Domestic Partner who is enrolled for dependent Spouse or Domestic Partner Voluntary Term Life Insurance after the time allowed for enrolling as specified in this Policy.

B438.0508

All Options

We require Proof of Insurability for any amount of dependent Voluntary Term Life Insurance In excess of $10,000.00 with respect to a dependent Spouse or Domestic Partner, if the dependent Spouse's or Domestic Partner's scheduled dependent Voluntary term life effective date is after he or she reaches age 65.

B438.0525

All Options

We require Proof of Insurability before We will insure any dependent child who is enrolled for dependent child Voluntary Term Life Insurance after the time allowed for enrolling as specified in this Policy.

B400.6060

All Options

Changes to Insurance

B400.6068

All Options

Changes In Insurance Amounts

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

B400.6069

All Options

Changes In Insurance Classification

If Your classification changes, insurance will not be changed to the new amount until the first day on which You are:

- Actively At Work on a Full-Time basis; and
- Make a contribution, if required, for the new classification.

If a contribution is required for the new classification for which a larger amount of insurance is provided, You must make the required contribution for the new amount within 31 days of the change. If You do not make the required contribution within 31 days of the change or within 31 days of becoming Actively At Work on a Full-Time basis, if You are not Actively At Work on a Full-Time basis, when Your classification changes, no increase will be allowed due to such change or any later change. In that case, in order to become insured for the larger amount, You must:

- Make the required contribution for the new amount; and
- Furnish Proof Of Insurability to Us, which We approve in writing.

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

B400.6072

SUPPLEMENTAL RIDER - Accelerated Life Benefit

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

Note: This benefit is not available for retirees.

Employee Accelerated Basic Life Benefit

IMPORTANT NOTICE: USE OF THIS BENEFIT MAY HAVE TAX IMPLICATIONS. IT MAY ALSO AFFECT GOVERNMENT BENEFITS OR CLAIMS OF CREDITORS. YOU SHOULD CONSULT YOUR TAX OR FINANCIAL ADVISOR BEFORE YOU APPLY FOR THIS BENEFIT.

THE AMOUNT OF YOUR GROUP TERM LIFE INSURANCE IS PERMANENTLY REDUCED BY THE GROSS AMOUNT OF THE ACCELERATED LIFE BENEFIT.

Accelerated Life Benefit

You may be eligible for an Accelerated Life Benefit if you meet the following conditions:

- You have a Terminal Condition;
- You supply the required written proof of Your Terminal Condition (see "How To Apply");
- You apply for this benefit in writing while living and before You attain age 60.

This benefit is a payment of part of Your Group Term Life Insurance made to You before death. You may use this benefit in any way You choose, subject to the restrictions stated below.

If You qualify for the Accelerated Life Benefit, We will subtract the Gross Amount paid to You as an Accelerated Life Benefit from the amount of Your Group Term Life Insurance under the Certificate. The remaining amount of Group Term Life Insurance is permanently reduced by the Gross Amount of this benefit.

You may only receive one Employee Accelerated Life Benefit during Your lifetime. This benefit does not have to be repaid, even if You:

- Live longer than 6 months from the date We receive Your application for this benefit; or
- Recover from the Terminal Condition.

However, the amount of this benefit will not be restored to Your remaining Group Term Life Insurance. And, You may not receive another Accelerated Life Benefit under any circumstances and even if You:

- Have a relapse; or

- You are subsequently diagnosed as having another Terminal Condition.

Benefit Amount For The Accelerated Life Benefit

The amount of the Accelerated Life Benefit for which You may apply is based on the amount of group term life insurance for which You are insured on the day before You apply for the benefit subject to the following minimum and maximum amounts.

The minimum benefit amount is the lesser of: (1) $10,000.00; or (2) 75% of Your amount of Group Term Life Insurance.

The maximum benefit amount is the lesser of: (1) $500,000.00; or (2) 75% of Your amount of Group Term Life Insurance.

Discount

The amount of the Accelerated Life Benefit which is available to You is discounted to the present value in 6 months from the date this benefit is paid. The interest discount rate shall be no greater than the greater of the current yield on 90 day treasury bills or the current maximum statutory adjustable policy loan interest rate.

A detailed statement of the method of computing the amount of the Accelerated Life Benefit is available from Us on request.

Payment Of The Accelerated Life Benefit

If We approve Your application for this benefit, We pay the amount You have elected, less the present value discount. We pay this benefit to You in one lump sum. This payment is subject to all of the other terms of the Certificate.

How To Apply

You must send Us written proof from a Doctor who is operating within the scope of his or her license that You have a Terminal Condition. We must approve such proof in writing before this benefit is paid.

We may have You examined by a Doctor of Our choice to determine whether the Terminal Condition exists. We will pay the cost of such exam.

If We approve Your application to receive this benefit, We will provide You with a statement along with Your benefit payment which shows:

- The amount of the Accelerated Life Benefit You requested;
- The amount of the present value discount;
- The amount of Your Accelerated Life Benefit check; and
- The remaining amount of Your Basic Life Insurance coverage.

Even if You have been approved for a waiver of premium benefit under this Certificate, You may still apply for an Accelerated Life Benefit. But, if You convert Your Group Term Life Insurance, the terms of the converted life policy will apply. Any amount to which You could otherwise convert is permanently reduced by the gross amount of Your Accelerated Life Benefit.

If You Have Assigned Your Group Term Life Insurance

If You have already assigned Your Group Term Life Insurance, or any portion thereof, You cannot apply for an Accelerated Life Benefit.

If You Are Legally Incompetent

If You are not legally competent, Your lawful guardian, conservator, legal representative, or any person or fiduciary with the lawful authority to act on Your behalf or handle Your affairs may apply for the Accelerated Life Benefit on Your behalf.

Your Remaining Group Term Life Insurance

The remaining amount of Your Group Term Life Insurance after You receive an Accelerated Life Benefit payment is subject to any increases or reductions that would otherwise apply to Your insurance. Applicable reductions are applied to the amount of Group Term Life Insurance for which You were insured on the day before the date You applied for the Accelerated Life Benefit.

If Your Life Benefit is scheduled to reduce within 6 months of the date You apply for the Accelerated Life Benefit, any applicable reduction will also be applied to Your Accelerated Benefit amount.

The premium cost of Your remaining insurance is based on the amount of Group Term Life Insurance for which You were insured on the day before the date You applied for the Accelerated Life Benefit.

The total amount of Group Term Life Insurance Your beneficiary would otherwise receive on Your death is reduced by the Gross Amount of the Accelerated Life Benefit.

If You die after applying, and were eligible, for the Accelerated Life Benefit, but before We send You the benefit, Your beneficiary will receive the full amount of Group Term Life Insurance for which You were insured on the day before the date You applied for the Accelerated Life Benefit.

Restrictions

We will not pay an Accelerated Life Benefit if:

- Your coverage under the Certificate ends for any reason after You apply for the Accelerated Life Benefit, but before We pay such benefit;
- You are required by law to use the proceeds of the Group Term Life Insurance from the Certificate to meet the claims of creditors, whether or not You are in bankruptcy;
- You are required by court order to pay all or part of the proceeds of the Group Term Life Insurance from the Certificate to another person; or
- You are required by a government agency to use the payment to apply for, receive or maintain a governmental benefit or entitlement.

Definitions

This section defines certain terms appearing in this Rider. Additional terms, not listed here, are defined in the Certificate.

- **Doctor:** Any medical practitioner We are required by law to recognize. He or she must:
  - Be properly licensed or certified by the laws of the state where he or she practices; and
  - Provide services that are within the lawful scope of his or her practice.
- **Gross Amount:** This term means the amount of the Accelerated Life Benefit elected by You before subtraction of the discount.

- **Group Term Life Insurance:** This term means the amount of Employee Basic Group Term Life Insurance for which You are insured under the Certificate. The term does not include any:
  - Accidental death benefits; or
  - Scheduled increase in the amount of Employee Basic Group term life insurance that is due within the 6 month period after the date You apply for the Accelerated Life Benefit.
- **Terminal Condition:** This term means a medical condition that is expected to result in death within 6 months from the date You apply for the Accelerated Life Benefit.

The Guardian Life Insurance Company of America

Michael Prestileo, Senior Vice President

B438.0307

GC-R-ALB-15-VA

SUPPLEMENTAL RIDER - Accelerated Life Benefit

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

Note: This benefit is not available for retirees.

Employee Accelerated Voluntary Life Benefit

IMPORTANT NOTICE: USE OF THIS BENEFIT MAY HAVE TAX IMPLICATIONS. IT MAY ALSO AFFECT GOVERNMENT BENEFITS OR CLAIMS OF CREDITORS. YOU SHOULD CONSULT YOUR TAX OR FINANCIAL ADVISOR BEFORE YOU APPLY FOR THIS BENEFIT.

THE AMOUNT OF YOUR GROUP TERM LIFE INSURANCE IS PERMANENTLY REDUCED BY THE GROSS AMOUNT OF THE ACCELERATED LIFE BENEFIT.

Accelerated Life Benefit

You may be eligible for an Accelerated Life Benefit if you meet the following conditions:

- You have a Terminal Condition;
- You supply the required written proof of Your Terminal Condition (see "How To Apply");
- You apply for this benefit in writing while living and before You attain age 60.

This benefit is a payment of part of Your Group Term Life Insurance made to You before death. You may use this benefit in any way You choose, subject to the restrictions stated below.

If You qualify for the Accelerated Life Benefit, We will subtract the Gross Amount paid to You as an Accelerated Life Benefit from the amount of Your Group Term Life Insurance under the Certificate. The remaining amount of Group Term Life Insurance is permanently reduced by the Gross Amount of this benefit.

You may only receive one Employee Accelerated Life Benefit during Your lifetime. This benefit does not have to be repaid, even if You:

- Live longer than 6 months from the date We receive Your application for this benefit; or
- Recover from the Terminal Condition.

However, the amount of this benefit will not be restored to Your remaining Group Term Life Insurance. And, You may not receive another Accelerated Life Benefit under any circumstances and even if You:

- Have a relapse; or

- You are subsequently diagnosed as having another Terminal Condition.

Benefit Amount For The Accelerated Life Benefit

The amount of the Accelerated Life Benefit for which You may apply is based on the amount of group term life insurance for which You are insured on the day before You apply for the benefit subject to the following minimum and maximum amounts.

The minimum benefit amount is the lesser of: (1) $10,000.00; or (2) 50% of Your amount of Group Term Life Insurance.

The maximum benefit amount is the lesser of: (1) $250,000.00; or (2) 50% of Your amount of Group Term Life Insurance.

Discount

The amount of the Accelerated Life Benefit which is available to You is discounted to the present value in 6 months from the date this benefit is paid. The interest discount rate shall be no greater than the greater of the current yield on 90 day treasury bills or the current maximum statutory adjustable policy loan interest rate.

A detailed statement of the method of computing the amount of the Accelerated Life Benefit is available from Us on request.

Payment Of The Accelerated Life Benefit

If We approve Your application for this benefit, We pay the amount You have elected, less the present value discount. We pay this benefit to You in one lump sum. This payment is subject to all of the other terms of the Certificate.

How To Apply

You must send Us written proof from a Doctor who is operating within the scope of his or her license that You have a Terminal Condition. We must approve such proof in writing before this benefit is paid.

We may have You examined by a Doctor of Our choice to determine whether the Terminal Condition exists. We will pay the cost of such exam.

If We approve Your application to receive this benefit, We will provide You with a statement along with Your benefit payment which shows:

- The amount of the Accelerated Life Benefit You requested;
- The amount of the present value discount;
- The amount of Your Accelerated Life Benefit check; and
- The remaining amount of Your Voluntary Life Insurance coverage.

Even if You have been approved for a waiver of premium benefit under this Certificate, You may still apply for an Accelerated Life Benefit. But, if You convert Your Group Term Life Insurance, the terms of the converted life policy will apply. Any amount to which You could otherwise convert is permanently reduced by the gross amount of Your Accelerated Life Benefit.

If You Have Assigned Your Group Term Life Insurance

If You have already assigned Your Group Term Life Insurance, or any portion thereof, You cannot apply for an Accelerated Life Benefit.

If You Are Legally Incompetent

If You are not legally competent, Your lawful guardian, conservator, legal representative, or any person or fiduciary with the lawful authority to act on Your behalf or handle Your affairs may apply for the Accelerated Life Benefit on Your behalf.

Your Remaining Group Term Life Insurance

The remaining amount of Your Group Term Life Insurance after You receive an Accelerated Life Benefit payment is subject to any increases or reductions that would otherwise apply to Your insurance. Applicable reductions are applied to the amount of Group Term Life Insurance for which You were insured on the day before the date You applied for the Accelerated Life Benefit.

If Your Life Benefit is scheduled to reduce within 6 months of the date You apply for the Accelerated Life Benefit, any applicable reduction will also be applied to Your Accelerated Benefit amount.

The premium cost of Your remaining insurance is based on the amount of Group Term Life Insurance for which You were insured on the day before the date You applied for the Accelerated Life Benefit.

The total amount of Group Term Life Insurance Your beneficiary would otherwise receive on Your death is reduced by the Gross Amount of the Accelerated Life Benefit.

If You die after applying, and were eligible, for the Accelerated Life Benefit, but before We send You the benefit, Your beneficiary will receive the full amount of Group Term Life Insurance for which You were insured on the day before the date You applied for the Accelerated Life Benefit.

Restrictions

We will not pay an Accelerated Life Benefit if:

- Your coverage under the Certificate ends for any reason after You apply for the Accelerated Life Benefit, but before We pay such benefit;
- You are required by law to use the proceeds of the Group Term Life Insurance from the Certificate to meet the claims of creditors, whether or not You are in bankruptcy;
- You are required by court order to pay all or part of the proceeds of the Group Term Life Insurance from the Certificate to another person; or
- You are required by a government agency to use the payment to apply for, receive or maintain a governmental benefit or entitlement.

Definitions

This section defines certain terms appearing in this Rider. Additional terms, not listed here, are defined in the Certificate.

- **Doctor:** Any medical practitioner We are required by law to recognize. He or she must:
  - Be properly licensed or certified by the laws of the state where he or she practices; and
  - Provide services that are within the lawful scope of his or her practice.
- **Gross Amount:** This term means the amount of the Accelerated Life Benefit elected by You before subtraction of the discount.

- **Group Term Life Insurance:** This term means the amount of Employee Voluntary Group Term Life Insurance for which You are insured under the Certificate. The term does not include any:
  - Accidental death benefits; or
  - Scheduled increase in the amount of Employee Voluntary group term life insurance that is due within the 6 month period after the date You apply for the Accelerated Life Benefit.
- **Terminal Condition:** This term means a medical condition that is expected to result in death within 6 months from the date You apply for the Accelerated Life Benefit.

The Guardian Life Insurance Company of America

Michael Prestileo, Senior Vice President

B438.0503

GC-R-ALB-15-VA

SUPPLEMENTAL RIDER - Seatbelt and Airbag Benefit

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

Terms not specifically defined within this Rider are defined in the Certificate.

Employee Basic and Voluntary Term Life Insurance and Dependent Voluntary Term Life Insurance Seatbelt and Airbag Benefit

This rider applies to Your Basic and Voluntary term life insurance and dependent Voluntary term life insurance.

Seatbelt And Airbag Benefits

If You die as a direct result of an automobile accident while properly wearing a seatbelt, We will increase Your term life benefit amount by $10,000. And, if You die as a direct result of an automobile accident while both properly wearing a seatbelt, and sitting in a seat equipped with an airbag, We will increase Your term life benefit amount by an additional $5,000, for a total increase of $15,000.

Proof that You were properly wearing a seatbelt must be provided. A law enforcement official investigating the accident must certify that the seatbelt was properly fastened and that the automobile in which the deceased was traveling was equipped with airbags. A copy of such certification must be submitted to Us with the claim for benefits.

If We cannot determine that You were wearing a seatbelt at the time of the Accident, We will increase Your term life benefit amount by $1,000.

If We determine that a seatbelt was not worn at the time of the automobile accident directly resulting in Your death, or if the required official report is not provided, no Seatbelt or Airbag benefit will be paid.

The total amount payable for the Seatbelt and Airbag Benefit under Your Basic and Voluntary term life insurance and Basic and Voluntary Accidental Death and Dismemberment insurance may not exceed $30,000.

Exclusions

This Policy does not pay a Seatbelt or Airbag Benefit for loss of life caused by, or related to an accident occurring:

- While You are the driver in an automobile Accident, if Your driver's license has been suspended or revoked or if You are unlicensed;
- While You are legally intoxicated; or
- While You are voluntarily using a controlled substance, unless:
  - It was prescribed for You by a doctor; and
  - 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.

- While You were intentionally or voluntarily inhaling or ingesting a gas, chemical, solvent, poison or other substances not intended for internal consumption;
- During Your commission of, or attempt to commit a felony as defined per the laws in the jurisdiction in which the felony was committed or attempted, or as defined under federal law if the offense charged was a federal offense;
- During Your participation in any sport for compensation or profit; or
- During Your racing an automobile in an organized event or street race.

Dependent Seatbelt and Airbag Benefit

Seatbelt And Airbag Benefits

If Your dependent dies as a direct result of an automobile accident while properly wearing a seatbelt, We will increase his or her Voluntary term life benefit amount by $5,000. And, if Your dependent dies as a direct result of an automobile accident while both properly wearing a seatbelt, and sitting in a seat equipped with an airbag, We will increase his or her Voluntary term life benefit amount by an additional $2,500, for a total increase of $7,500.

You are responsible for providing proof that Your dependent was properly wearing a seatbelt. A law enforcement official investigating the Accident must certify that the seatbelt was properly fastened and that the automobile in which the deceased was traveling was equipped with airbags. A copy of such certification must be submitted to Us with the claim for benefits.

If We cannot determine that Your dependent was wearing a seatbelt at the time of the automobile accident directly resulting in his or her death, We will increase Your dependent term life benefit amount by $1,000.

If We determine that a seatbelt was not worn at the time of the automobile accident directly resulting in Your dependent's death, or if the required official report is not provided, no Seatbelt or Airbag Benefit will be paid.

The total amount payable for the Seatbelt and Airbag Benefit under Your Dependent Voluntary term life insurance and Dependent Voluntary Accidental Death and Dismemberment insurance may not exceed $15,000.

Exclusions

This Policy does not pay a Seatbelt or Airbag Benefit for loss of life caused by, or related to an accident occurring:

- While Your dependent is the driver in an automobile Accident, if his or her driver's license is suspended or revoked or if the driver is unlicensed;
- While Your dependent is legally intoxicated; or
- While Your dependent is voluntarily using a controlled substance, unless:
  - It was prescribed for the dependent by a doctor; and
  - 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.

- While Your dependent intentionally or voluntarily inhales or ingests a gas, chemical, solvent, poison or other substances not intended for internal consumption;
- During Your dependent's commission of, or attempt to commit a felony as defined per the laws in the jurisdiction in which the felony was committed or attempted, or as defined under federal law if the offense charged was a federal offense;
- During Your dependent's participation in any sport for compensation or profit; or
- During Your dependent's racing an automobile in an organized event or street race.

The Guardian Life Insurance Company of America

Michael Prestileo, Senior Vice President

B400.7271

SUPPLEMENTAL RIDER - Waiver of Premium Benefit

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

Employee Basic and Voluntary Term Life Insurance
Waiver Of Premium Benefit

Important Notice This rider applies to Your Basic and Voluntary term life insurance. It does not apply to any of Your dependent life insurance under the Certificate. To continue dependent life insurance, You must convert Your dependent coverage. See "Converting This Dependent Term Life Insurance" in Your Certificate for details.

If You Are Disabled If You are Totally Disabled, and meet the requirements in "How And When To Apply," We will extend Your Basic and Voluntary life insurance without payment of premiums from You or the Employer in an amount equal to the amount of Basic and Voluntary life insurance for which You are insured on Your last day of Active Work.

How And When To Apply To apply for this benefit, You must submit, while living, written medical proof of Your Total Disability satisfactory to Us within one year of the start of that disability. Any claim filed after one year from the start of Total Disability will be denied, unless We receive written proof that:

- You lacked the legal capacity to file the claim; or
- It was not reasonably possible for You to file the claim within the required period of time.

To be approved for this benefit, You must:

- Become Totally Disabled before You reach age 60 and while insured by the Certificate; and
- While insured by the Certificate remain Totally Disabled for at least 9 months in a row.

You should apply for this benefit immediately at the start of Your Total Disability.

If You are Totally Disabled, but You are not eligible for the Waiver of Premium Benefit based on Your age, You can apply to convert to a permanent life insurance policy. See "Converting This Employee Basic and Voluntary Term Life Insurance" in Your Certificate for details on how We do this.

Continued Proof For Waiver of Premium Benefit We may require written proof that You remain Totally Disabled and receive regular Doctor's care to maintain this benefit. This proof must be given to Us within 30 days of the date We request it.

We can also require that You take part in a medical assessment by a medical professional of Our choice as often as We feel is reasonably necessary during the first 2 years We have waived Your life insurance premiums pursuant to the Rider. After 2 years, We cannot have You examined more than once a year.

Until You Have Been Approved For This Benefit

If Your life insurance under the Certificate ends after You have become Totally Disabled and applied for Waiver of Premium Benefits, but before We have approved You for this benefit, You may:

- Continue to pay your group premium payments, including any part which would have been paid by the Employer, until You are approved or declined for this benefit; or
- Apply to convert to an individual permanent or term life insurance policy.

Please read "Converting This Employee Basic and Voluntary Term Life Insurance" in Your Certificate for details on how to convert.

NOTICE: The interim term life insurance coverage will end exactly one year from the first day said coverage goes into force and effect. If You have not yet received approval for Your Waiver of Premium application at the end of that one-year period, Your life insurance will be converted to a permanent life insurance policy if you wish to continue coverage. Premiums for the permanent life insurance policy will be based on Your age as of the date You convert from the interim term life insurance coverage to the permanent life insurance. As such, the premium may be higher than if You converted to a permanent life insurance policy initially.

Converting Your life insurance does not stop You from claiming Your rights under this section. But, if You apply to convert and obtain a policy, and We later approve You for this benefit, We will cancel the converted policy on the date We approve You for this Benefit. See "Converting This Employee Basic and Voluntary Term Life Insurance" for details on how We do this. Once You are approved for this benefit, Your insurance under the Certificate will be reinstated at no further cost to You or the Employer.

If You are declined for the Waiver of Premium benefit, You will have the option to apply to convert to an individual permanent or term life insurance policy. If You do not convert within 31 days of the date You are declined for the Waiver of Premium benefit, and You have not returned to Active Work, Your coverage will end.

If the Certificate terminates before You are approved

If this group Certificate terminates and You are Totally Disabled and eligible, but not yet approved, for this Waiver of Premium benefit, You must apply to convert to an individual permanent or term policy, and remain insured under such policy until You are approved by Us for the Waiver of Premium benefit.

When This Waiver Begins

Once approved by Us, Your Waiver of Premium benefit will be effective on the date following the day You have been Totally Disabled for 9 months in a row.

When This Waiver Ends

Your Waiver of Premium benefit will end on the earliest of:

- The date You are no longer Totally Disabled;

- The date We ask You to be examined by Our Doctor, and You refuse;
- The date You do not give Us the proof of Total Disability We require;
- the date you have been out of the United States and/or Canada or a country or region approved by Us for more than 2 months in a 12 month period;
- The date You are no longer receiving regular Doctor's care appropriate to the cause of Your claimed Total Disability;
- The day before the date You reach age 65.

If Your Waiver of Premium Benefit ends and You do not return to Active Work, You will have the option to convert the Employee Basic and Voluntary life insurance that was in effect on the date the Waiver of Premium Benefit ends.

Please read "Converting This Employee Basic and Voluntary Term Life Insurance" for details on how to convert.

If You Die While Covered By This Waiver of Premium Benefit

If You die while covered for this benefit, We will pay Your beneficiary the amount of Basic and Voluntary life insurance for which You were insured as of Your last day of Active Full-Time Work. This payment is subject to all the terms of the Certificate and all reductions which would have applied had You remained an Active at Work Employee.

If You Die Prior to Approval for This Waiver of Premium Benefit

If You die prior to being approved for the Waiver of Premium Benefit and within 12 months of the onset date of Total Disability 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 provided You:

- Were Totally Disabled, as defined by this Rider, through the date of death,
- Became Totally Disabled prior to age 60; and
- Became Totally Disabled while insured; and
- We received the required premiums for this coverage.

Proof Of Death

We will pay the term life insurance benefit as soon as We receive:

- Written proof of Your death; and
- Medical proof that You were continuously Totally Disabled until Your death.

This proof must be sent to Us within one year of Your date of death.

B438.0350

All Options

Definitions

This section defines certain terms appearing in this Rider. Additional terms, not listed here, are defined in the Certificate.

Reasonable Accommodation: This term means any modification or adjustment that the Employer willingly provides to:

- A job;
- An employment practice;
- A work process; or
- The work place.

The modification or adjustment must make it possible for a Disabled person to:

- Reach the same level of performance as a similarly situated non-disabled person; or
- Enjoy equal benefits and privileges of employment as are available to a similarly situated non-disabled person.

The modification or adjustment must not place an undue hardship on the Employer.

Regular and Appropriate Care: This term means, with respect to Your disabling condition(s) and any other condition(s) which, if left untreated, would adversely affect Your disabling condition, You:

- Visit a Doctor as frequently as medically required, according to generally accepted medical standards, to effectively manage these conditions; and
- Are receiving the most appropriate treatment, according to generally accepted medical standards, designed to achieve maximum medical improvement in these conditions.

Treatment must be provided by a Doctor or Doctors whose specialty is most appropriate according to generally accepted medical standards for Your:

- Disability; and
- Any other conditions which left untreated would adversely affect Your disabling condition.

Generally accepted medical standards are those supported by nationally recognized authorities in the health care field including:

- The American Medical Association(AMA);
- The AMA Board of Medical Specialties;
- The Food and Drug Administration;
- The Centers for Disease Control;
- The National Cancer Institute;
- The National Institutes of Health;
- The Department of Health and Human Services; and
- Any other agency of similar repute.

"Total Disability" and **"Totally Disabled":** This term means that, due to sickness or injury, You are:

- Not able to perform any work for wages or profit; and
- Receiving Regular and Appropriate Care for the cause of Your Total Disability.

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

The Guardian Life Insurance Company of America

Michael Prestileo, Senior Vice President

B438.0372

GC-R-WOP-15-VA

SUPPLEMENTAL RIDER - Portability Privilege

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

PORTABILITY PRIVILEGE

This rider applies only to Your Employee Basic and Employee and Dependent Voluntary term life insurance.

Portability Conditions

Portability is subject to all of the conditions described below.

- You may Port if Your coverage under the Certificate if coverage ends because:
  - You are no longer employed by the Employer; or
  - You are no longer a member of an eligible class of Employees
- You may **not** Port unless You have been covered by the Certificate, or the plan it replaced, for Employee Basic and Voluntary term life insurance for at least three months in a row prior to the date Your coverage under the Certificate ends.
- You may **not** Port if You have reached age 70 on the date coverage under the Certificate ends.
- You may **not** Port if You are eligible for the Certificate's Waiver of Premium Benefit.
- You may **not** Port if coverage under the Certificate ends due to:
  - Failure to pay any required premium; or
  - Termination of the Certificate

Portability Options

You may Port the full amount of Your Basic and Voluntary term life insurance in force as of the date Your coverage under the Certificate ends. If You do not wish to Port the full amount, You may choose to Port 50% of such amount, if such amount under the Certificate is at least $50,000 and does not exceed $1,000,000.

You may Port the full amount of Your dependent's Voluntary term life insurance in force as of the date Your coverage under the Certificate ends. If You do not wish to Port the full amount, You may choose to Port 50% of such amount if:

- Your dependent Spouse or Domestic Partner amount under the Certificate is at least $10,000; and
- Your dependent child amount under the Certificate is at least $2,000 .

You may Port:

- Your insurance only;
- Your insurance and insurance of Your covered Spouse or Domestic Partner; or
- Your insurance and the insurance of all of Your covered dependents.

If You Port the full amount of Your insurance and You choose to Port Your dependent's insurance, You must Port the full amount of Your dependent's insurance. If You Port 50% of Your insurance and You choose to Port Your dependent's insurance, You must Port 50% of Your dependent's insurance.

A dependent must be insured as of the date Your coverage under the Certificate ends in order to be eligible for Portability.

If You die while insured for dependent Voluntary term life insurance, Your Spouse or Domestic Partner may Port Your dependent Voluntary term life insurance as described above. Your Spouse or Domestic Partner and dependent children must be insured under the Certificate on the date of Your death. But, this option is not available if:

- There is no surviving Spouse or Domestic Partner; or
- Your surviving Spouse or Domestic Partner has reached age 70 on the date of Your death.

The Portable Certificate Of Coverage

If You Port, You will obtain a new Certificate of coverage, which will be issued under the Portable group policy and will describe the benefits provided. The Portable group policy has been established specifically for, and limited to, providing portability coverage for Employees and their dependents whose coverage ends under an Employer's plan. The benefits provided by the Portable certificate of coverage may not be the same as the benefits provided by the Certificate provided by your Employer. The group term life insurance provided by the Portable Certificate of coverage will not provide any of the following benefits or types of coverage:

- Accidental death or dismemberment;
- Income replacement;
- Or Waiver of Premium benefits.

The premium for the Portable certificate of coverage will be based on:

- the covered person's rate class under the Ported Policy; and
- Your surviving Spouse's or Domestic Partner's age bracket as shown in the Life Portability Coverage Premium Notice.

The Portable Certificate of Coverage ends at age 70.

How To Port

You or Your surviving Spouse or Domestic Partner must:

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

You or Your surviving Spouse or Domestic Partner must do this within 31 days from the date Your coverage under the Certificate ends. In order to Port Your Basic and Voluntary term life insurance, We will not ask for proof that You or Your surviving Spouse or Domestic Partner is insurable.

Portability And Conversion

If You or Your surviving Spouse or Domestic Partner choose to Port, the Certificate's conversion privilege will not be available. In the event that a person would be eligible to both convert and to Port, only one of these privileges may be chosen. Coverage under both a converted policy and a Portable certificate of coverage at the same time is not permitted. You or Your surviving Spouse or Domestic Partner should read the entire Certificate, as well as any related materials carefully before making a choice.

Definitions

This section defines certain terms appearing in this Rider. Additional terms, not listed here, are defined in the Certificate.

- **Port or "To Port"**:these terms mean to choose a Portable certificate of coverage which provides group term life insurance.

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

The Guardian Life Insurance Company of America

Michael Prestileo, Senior Vice President

B438.0638

GC-R-LIFPORT-15-VA

STATEMENT OF ERISA RIGHTS

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

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

Language contained in this notice regarding your potential rights under ERISA may be required under Department of Labor regulations. This language is not subject to approval or disapproval by the state insurance department in which the contract is issued for delivery. Please consult with the Department of Labor if you have questions regarding these notices.

ERISA provides that all plan participants shall be entitled to:

Receive Information about Your Plan and Benefits

- Examine, without charge, at the plan administrator's office and at other specified locations, such as worksites and union halls, all documents governing the plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the plan with the U. S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.
- Obtain, upon written request to the plan administrator, copies of documents governing the operation of the plan, including insurance contracts, collective bargaining agreements and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The administrator may make a reasonable charge for the copies.
- Receive a summary of the plan's annual financial report. The plan administrator is required by law to furnish each participant with a copy of this summary annual report.

Prudent Actions by Plan Fiduciaries

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

Enforcement of Your Rights

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

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

Assistance with Questions

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

Life Insurance Claims Procedure

If you seek benefits under the plan you should complete, execute and submit a claim form. Claim forms and instructions for filing claims may be obtained from the Guardian Life Insurance Company of America (hereinafter referenced as Guardian.)

Guardian is the Claims Fiduciary with discretionary authority to interpret and construe the terms of the Policy, the Certificate, the Schedule of Benefits, and any riders, or other documents or forms that may be attached to the Certificate or the Policy, and any other plan documents. Guardian has discretionary authority to determine eligibility for benefits and coverage under those documents. Guardian has the right to secure independent professional healthcare advice and to require such other evidence as needed to decide your claim.

In addition to the basic claim procedure explained in your certificate, Guardian will also observe the procedures listed below. These procedures are the minimum requirements for benefit claims procedures of employee benefit plans covered by Title 1 of ERISA.

Definitions

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

Timing for Initial Benefit Determination of Life Insurance Claims

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

Guardian will provide a benefit determination not later than 90 days from the date of receipt of a claim. This period may be extended by up to 90 days if Guardian determines that an extension is necessary due to special circumstances, and so notifies the claimant before the end of the initial 90-day period. Such notification will include the reason for the special circumstances requiring the extension and a date by which the determination l is expected to be made.

A notification of an extension to the time period in which a benefit determination will be made will include an explanation of the standards upon which entitlement to a benefit is based, any unresolved issues that prevent a decision of the claim, and the additional information needed to resolve those issues.

Adverse Benefit Determination of Life Insurance Claims

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

- The specific reason(s) for the adverse determination;
- References to the specific provisions in the Policy, Certificate, plan or other documents, on which the determination is based;
- A description of any additional material or information needed to perfect the claim, and an explanation of why such material or information is necessary;
- A description of the plan's claim review procedures which a claimant may follow to have a claim for benefits reviewed and the time limits applicable to such procedures; and
- A description of the plan's review procedures and the time limits applicable to such procedures, including a statement of the claimant's right to bring a civil action under ERISA Section 502(a) following an adverse benefit determination.

B997.0403

All Options

Appeals of Adverse Determinations of Life Insurance Claims

If a claim is wholly or partially denied, you will have up to 60 days to make an appeal. Guardian will conduct a full and fair review of an appeal which includes providing to claimants the following:

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

Guardian will notify the claimant of its decision not later than 60 days after receipt of the request for review of the adverse determination. This period may be extended by an additional period of up to 60 days if Guardian determines that special circumstances require an extension of the time period for processing and so notifies the claimant before the end of the initial 60-day period.

A notification with respect to an extension will indicate the special circumstances requiring an extension of the time period for review, and the date by which the final determination will be made.

In the event Guardian denies the appeal of an adverse benefit determination, it will:

- Provide the specific reason or reasons why the appeal was denied;
- Refer to the specific provisions in the Policy, Certificate, plan, or other documents on which the benefit determination is based;
- Provide a statement that the claimant is entitled to receive, upon request and free of charge, reasonably access to, and copies of all documents, records, and other information relevant to the claimant's claim for benefits; and
- Provide a statement describing any voluntary appeal procedures offered by the Plan, the claimant's right to obtain information about such procedures, and a statement that the claimant's right to bring an action under ERISA section 502(a).

Waiver of Premium

If you apply for an extension of life insurance benefits due to Total Disability under the Waiver of Premium benefit under this plan, these claim procedures will apply to such request:

Timing For Initial Benefit Determination for Waiver of Premium

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

Guardian will make a determination of whether the claimant meets the plan's standard for total disability not later than 45 days from the date of receipt of a claim. This period may be extended by up to 30 days if Guardian determines that an extension is necessary due to matters beyond the control of the plan, and so notifies the claimant before the end of the initial 45-day period. Such notification will include the reason for the extension and a date by which the determination will be made. If prior to the end of the 30-day period Guardian determines that an additional extension is necessary due to matters beyond the control of the plan, and so notifies the claimant, the time period for making a benefit determination may be extended for up to an additional period of up to 30 days. Such notification will include the special circumstances requiring the extension and a date by which the final determination will be made.

A notification of an extension to the time period in which a benefit determination will be made will include an explanation of the standards upon which entitlement to a benefit is based, any unresolved issues that prevent a decision of the claim, and the additional information needed to resolve those issues.

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

Adverse Benefit Determination

If a claim for an extension of benefits is denied, Guardian will provide a notice that will set forth:

- The specific reason(s) for the adverse determination;
- References to the specific provisions in the Policy, Certificate, plan or other documents, on which the determination is based;
- A description of any additional material or information needed to perfect the claim, and an explanation of why such material or information is necessary;
- A description of the plan's claim review procedures which a claimant may follow to have a claim for benefits reviewed and the time limits applicable to such procedures;
- A description of the plan's review procedures and the time limits applicable to such procedures, including a statement of the claimant's right to bring a civil action under ERISA Section 502(a) following an adverse benefit determination; and
- In the case of adverse benefit determination based on medical necessity or experimental treatment, notice will either include an explanation of the scientific or clinical basis for the determination, or a statement that such explanation will be provided free of charge upon request.

B997.0404

All Options

Appeals of Adverse Determinations for Waiver of Premium

If a claim for Waiver of Premium is denied, the claimant will have up to 180 days to make an appeal. Guardian will conduct a full and fair review of an appeal which includes providing to claimants the following:

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

In reviewing an appeal, Guardian will:

- Provide for a review conducted by a named fiduciary who is neither the person who made the initial adverse determination nor that person's subordinate;

- In deciding an appeal based upon a medical judgment, consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment;
- Identify medical or vocational experts whose advice was obtained in connection with an adverse benefit determination; and
- Ensure that a health care professional engaged for consultation regarding an appeal based upon a medical judgment shall be neither the person who was consulted in connection with the adverse benefit determination, nor that person's subordinate.

Guardian will notify the claimant of its decision not later than 45 days after receipt of the request for review of the adverse determination. This period may be extended by an additional period of up to 45 days if Guardian determines that special circumstances require an extension of the time period for processing and so notifies the claimant before the end of the initial 45-day period.

A notification with respect to an extension will indicate the special circumstances requiring an extension of the time period for review, and the date by which the final determination will be made.

In the event Guardian denies the appeal of an adverse benefit determination, it will:

- Provide the specific reason or reasons why the appeal was denied;
- Refer to the specific provisions in the Policy, Certificate, plan, or other documents on which the benefit determination is based;
- Provide a statement that the claimant is entitled to receive, upon request and free of charge, reasonably access to, and copies of all documents, records, and other information relevant to the claimant's claim for benefits;
- Provide a statement disclosing any internal rule, guideline, protocol or similar criterion relied on in making the adverse benefit determination (or a statement that such information will be provided free of charge upon request); or a statement that no internal rule, guideline, protocol or similar criterion was relied upon in making the adverse benefit determination;
- If applicable, provide an explanation of the basis of disagreement with or not following the views presented by you, of health care professionals who treated you, and vocational professionals who evaluated you;
- If applicable, provide an explanation of the basis for disagreeing with or not following the views of any medical or vocational expert whose advice was obtained on our behalf in connection with the adverse benefit determination, without regard to whether the advice was relied upon in making the determination;
- If applicable, provide an explanation of the basis for disagreeing with or not following a disability determination made by the Social Security Administration that you present to us;

- Provide a statement describing the claimant s right to bring a civil suit under Section 502(a) of the Employee Retirement Income Security Act of 1974 which shall also describe any applicable contractual limitations period that applies the claimant's right to bring such an action, including the calendar date on which the contractual limitations period expires for the claim, and;
- In the event the adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, provide either an explanation of the scientific or clinical judgment for the determination, applying the terms of the plan to the claimant's medical circumstances, or a statement that such explanation will be provided free of charge upon request.

Alternative Dispute Options

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

In addition to any legal rights you may have under section 502(a), if you believe that we have violated ERISA's procedural requirements, you may request that we review any claimed violation(s) and we will respond to you within ten days.

B997.0405

CERTIFICATE OF COVERAGE

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

The Group Accidental Death and Dismemberment Coverage described in this Certificate is attached to the group Policy effective January 1, 2020. This Certificate replaces any Certificate previously issued under this Policy or under any other plan providing similar or identical benefits issued to the Policyholder by Guardian. This Certificate is part of the Policy.

GROUP ACCIDENTAL DEATH AND DISMEMBERMENT COVERAGE

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

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

Policyholder: THE EVERGREENE COMPANIES
Group Policy Number: 00571412

The Guardian Life Insurance Company of America

Michael Prestileo, Senior Vice President

B401.1529

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All Options

IMPORTANT INFORMATION REGARDING YOUR INSURANCE

In the event you need to contact someone about this insurance for any reason, please contact your agent. If no agent was involved in the sale of this insurance, or if you have additional questions, you may contact the insurance company issuing this insurance at the following address and telephone number:

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

If you have been unable to contact or obtain satisfaction from the company or the agent, you may contact the Virginia State Corporation Commission's Bureau of Insurance at:

Bureau of Insurance
Tyler Building, 1300 E. Main St.
Richmond, VA 23219
Local (804) 371-9691
National Toll Free (877) 310-6560
VA only Toll Free (800) 552-7945

Written correspondence is preferable so that a record of your inquiry is maintained. When contacting your agent, company or the Bureau of Insurance, have your policy number available.

B401.1530

GENERAL PROVISIONS

Applicable Benefits

This Certificate may include multiple benefit options and types of benefits. You will only be covered for benefits if:

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

Limitation Of Authority

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

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

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

Incontestability

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

No statement in any application, made by You, or any dependent, will be used to contest the validity of Your insurance or to deny a claim for a loss incurred, or for a disability which starts, after such insurance has been in force for two years during Your lifetime (excluding any period during which the Insured is disabled).

No statement made by any person insured under the policy relating to his or her insurability of his or her insured dependents shall be used in contesting the validity of the insurance with respect to which such statement was made: (1) after the insurance has been in force, prior to the contest, for a period of two years during the lifetime of the person about whom the statement was made; and (2) unless the statement is contained in a written instrument signed by him or her.

If this Certificate replaces a plan Your Employer had with another insurer, We may rescind this Certificate based on misrepresentations or omissions made by Your Employer or You in a signed application for up to two years from the Effective Date of the Policy. If the Policy or Certificate will be rescinded, a written notice will be delivered to You at least 30 days prior to termination.

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

Statements

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

Examination And Autopsy

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

Overpayment Recovery

If We overpay benefits, all such benefits must be repaid in full. We have the right to reduce the benefit, or reduce any other benefits payable under this Certificate, toward recovery of any overpayment.

B401.1531

ELIGIBILITY FOR ACCIDENTAL DEATH AND DISMEMBERMENT COVERAGE EMPLOYEE COVERAGE

Conditions Of Eligibility

Subject to the conditions of eligibility set forth below, and to all of the other conditions of this Certificate, You are eligible for Accidental Death and Dismemberment coverage if You are

- In an eligible class of Employees;
- Are an active Full time Employee;
- Legally working in the United States and/or Canada or working outside of the United States for a United States based Employer in a country or region approved by Us;

  and

- Working at least the minimum number of hours of an Employee in Your eligible class at:
  - The Employer's place of business;
  - Some place where the Employer's business requires You to travel; or
  - Any other place You and the Employer have agreed upon for the performance of your occupational duties.

You are **not** eligible for Accidental Death and Dismemberment coverage if You are

- A temporary or seasonal Employee.

The Waiting Period If You are in an eligible class, You are eligible for Accidental Death and Dismemberment coverage under this Certificate after You complete the service waiting period, if any, established by the Employer and as stated in the Schedule of Benefits.

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

B400.6098

When Coverage Starts

For coverage to start, You must be fully capable of performing the major duties of Your regular occupation for the Employer and working the minimum required number of hours of an Employee in Your eligible class at 12:01 A.M. Standard Time for Your place of residence on Your scheduled Eligibility Date. And, for coverage to start, You must satisfy all of the Conditions of Eligibility described above, and the conditions shown below which apply to You. If You are not fully capable of performing the major duties of Your regular occupation on Your scheduled Eligibility Date, We will postpone the start of Your coverage until You are so capable and working the minimum required number of hours of an Employee in Your eligible class for one full day, with the capacity to do so for one full week.

Whether You must pay all or part of the cost of Your coverage, You must elect to enroll and agree to make the required payments before Your coverage will start. If You do this on or before Your Eligibility Date, Your coverage is scheduled to start on Your Eligibility Date. If You do this within 31 days after Your Eligibility Date, Your coverage is scheduled to start on Your Eligibility Date. If You elect to enroll and agree to make the required payments more than 31 days after Your Eligibility Date, Your coverage will not start until You send Us Proof Of Insurability. Once We approve such Proof Of Insurability, Your coverage will start on the date we approve such coverage.

B400.6103

All Options

Exception to When Coverage Starts

Sometimes a scheduled Eligibility Date is not a regularly scheduled work day. If the scheduled Eligibility Date falls on:

- A holiday;
- A vacation day;
- A non-scheduled work day;
- A day during an approved leave of absence not due to sickness or injury, of 90 days or less; or
- A day during a period of absence that is less than 7 days in duration;

and if:

- You are fully capable of performing the major duties of Your regular occupation for Your Employer for the minimum number of hours of an Employee in Your eligible class at 12:01 AM Standard Time for Your place of residence on the scheduled Eligibility Date ; and
- You were performing the major duties of Your regular occupation and working the minimum number of hours of an Employee in Your eligible class on Your last regularly scheduled work day;

Your coverage will start on the scheduled Eligibility Date. However, in no event will any coverage or part of coverage for which You must elect and pay all or part of the cost, start if You are on an approved leave, layoff or absence and such coverage or part of coverage was not previously in force for You under a prior plan which this Certificate replaced.

B400.6106

All Options

Delayed Eligibility Date For Employee Voluntary Accidental Death and Dismemberment Insurance

If due to sickness or injury, You are not Actively At Work and working the minimum number of hours of an Employee in Your eligible class on the date Your Voluntary Accidental Death and Dismemberment coverage is scheduled to start, We will postpone coverage for an otherwise Covered Loss for any condition(s) that prevent you from meeting the Actively at Work requirement. We will postpone such coverage until You:

- Complete one full day of Active Work, working the minimum number of hours of an Employee in Your eligible class, with the capacity to do so for one full week; and,
- Do not miss a day of work due to the same condition.

Coverage for an otherwise Covered Loss due to all other conditions will start on the date You:

- Return to Active Work working the minimum number of hours of an Employee in Your eligible class and;
- Are performing the regular duties of your occupation.

B400.6107

All Options

The Delayed Eligibility Date provision will not apply if You are covered under the Transfer Business Exception as stated below.

Transfer Business Exception

If due to sickness or injury, You are not Actively At Work and not working the minimum number of hours of an Employee in Your eligible class, on Your scheduled Eligibility Date, You will be insured for this Accidental Death and Dismemberment insurance if:

- You were insured under the Employer's prior insurer's group accidental death and dismemberment plan at the time the prior insurer's group accidental death and dismemberment plan ended and the group accidental death and dismemberment plan became effective with Us, with no break in group coverage;

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- You were a member of an eligible class under the Employer's prior insurer's group accidental death and dismemberment plan and are eligible under this Certificate;
- Premiums for You were paid up to date for the Employer's prior insurer's group plan and this Certificate;
- Premiums are not currently being waived under the Waiver of Premium Rider, or You were not eligible, under the terms of the Employer's prior insurer's group accidental death and dismemberment plan, to have premiums waived under the Waiver of Premium provision; and
- You are not receiving or eligible to receive benefits under the Employer's prior insurer's group accidental death and dismemberment plan.

Any Accidental Death and Dismemberment benefit payable will be the lesser of:

- The Accidental Death and Dismemberment benefit payable under this Certificate; or
- The accidental death and dismemberment benefit payable under the Employer's prior insurer's group accidental death and dismemberment plan had it remained in force; reduced by any amount paid by the prior insurer's group accidental death and dismemberment plan.

If You are covered under the Exception to When Coverage Starts, You will not be eligible for the Waiver of Premium Benefit provision under this Certificate until such a time You are Actively At Work as defined by this Certificate.

If You meet the conditions stated above, You will remain insured under this provision until the first to occur of:

- The date You are fully capable of performing the major duties of Your occupation for the Employer, and capable of doing so for the minimum number of hours of an Employee in Your eligible class;
- The date insurance terminates for one of the reasons stated in When Employee Coverage Ends;
- The last day of a period of 12 consecutive months which begins on this Certificate's Effective Date;
- The date You become eligible for the Waiver of Premium Benefit provision under the prior insurer's group accidental death and dismemberment plan; or
- The last day You would have been covered under the prior insurer's group accidental death and dismemberment plan, had the prior plan not terminated.

B400.8108

When Coverage Ends

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

- The date Your Active Work ends for any reason, except as noted below under Coverage During Leave of Absence. Such reasons include:
  - Disability;
  - Death;
  - Retirement;
  - Layoff;
  - Leave of absence;
  - The end of employment; and
  - Expiration of the employment contract.
- The date You stop being an eligible Employee under this Certificate.
- The date You are no longer working in the United States and/or Canada, or no longer working outside the United States for a United States based Employer in a country or region approved by Us. Any incidental business or personal travel outside of the United States and/or Canada, or outside of a country or region approved by Us, is covered. Such travel will be considered incidental if it is for a period not to exceed 30 consecutive days.
- The date the group Certificate ends, or is discontinued for a class of Employees to which You belong.
- The last day of the period for which required payments are made for You subject to the Grace Period.

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

B401.1534

CONTINUATION OF COVERAGE

Coverage During Disability

If Your Active Work ends because You are Totally Disabled, You and Your Employer may agree to continue Your insurance, subject to continued payment of all required premiums, until the earlier of:

- The date you are no longer Totally Disabled, as defined by this Certificate;
- 12 months; from the date Your Total Disability began;
- The date you are approved for any Waiver of Premium Benefit for which you are eligible; or
- The date of Your 99th birthday.

We may require written Proof of Loss that You remain Totally Disabled and receiving regular Doctor's care to maintain this benefit. This Proof of Loss must be given to Us within 30 days of the date we request it.

Your eligibility for benefits will be governed by all the terms of this Certificate.

Coverage During Temporary Layoff

If Your Active Work ends because You are temporarily laid off, You and Your Employer may agree to continue Your insurance, subject to continued payment of all required premium, until the earlier of:

- The end of the temporary layoff; or
- The end of the month in which You are laid off plus 1 months following the date the temporary layoff begins.
- The end of the time period covered under a severance agreement not to exceed 1 months.

If You die or become Disabled under this Certificate while Your coverage is being continued during a temporary layoff, Your eligibility for benefits will be governed by all the terms of this Certificate.

Coverage During Temporary Leave of Absence

If Your Active Work ends because You go on a leave of absence that has been approved by Your Employer, You and Your Employer may agree to continue Your insurance, subject to continued payment of all required premiums, until the earlier of:

- The end of the Employer approved leave of absence; or

- The end of the month in which Your leave begins plus 1 months following the date the approved leave of absence begins.

If You become disabled under this Certificate while Your coverage is being continued during a leave of absence, Your eligibility for benefits will be governed by all the terms of this Certificate.

B400.6111

All Options

DEPENDENT COVERAGE

B400.6116

All Options

Eligible Dependents For Dependent Voluntary Accidental Death and Dismemberment Insurance

Your eligible dependents are Your:

- Spouse who is under age 70; and
- Your dependent children who are under age 25.

B400.6120

All Options

Adopted Children And Step-Children

Your dependent children include Your legally adopted children and Your step-children. However, to qualify as a dependent, each person must depend on You for at least 50% of their support and maintenance. We treat a child as legally adopted from the time the child is placed in Your home for the purpose of adoption. We treat such a child this way whether or not a final adoption order is ever issued.

B400.6127

All Options

Dependents Not Eligible

We exclude:

- A dependent who is on Active Duty in any armed force.

B400.6128

All Options

Continuing Coverage For Dependent Children Past the Limiting Age

If You have a child or children who:

- Is/are incapable of independent living by reason of an intellectual disability or a physical handicap; and
- Is/are primarily dependent upon You for support and maintenance;

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

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Each such child:

- Must have an intellectual disability or a physical handicap that began before he or she reached the dependent age limit;
- Became covered by this Certificate, or the prior carrier s group accidental death and dismemberment plan that it replaced, before he or she reached the dependent age limit, and remained continuously covered until he or she reached the age limit;
- and remains:
  - Incapable of independent living; and
  - Dependent upon You for most of his or her support and maintenance; and

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

Irrespective of this provision, any coverage provided under this section ends when Your coverage ends.

B401.1535

All Options

When Dependent Coverage Starts

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

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

Initial Dependents

If You enroll Your Initial Dependents on or before Your Eligibility Date, the dependents' coverage begins on the later of Your Eligibility Date and the date You become covered for Employee coverage.

If You enroll Your Initial Dependents within the Enrollment Period, their coverage begins on the later of Your Eligibility Date and the date You become covered for Employee coverage.

If You do not enroll Your Initial Dependents when they are first eligible, and enroll those Initial Dependents after the Enrollment Period ends, You must supply Proof Of Insurability and coverage will not start until We approve that proof in writing.

If an Initial Dependent becomes eligible after this Certificate's Effective Date, his or her coverage will start on the date We approve him or her for coverage.

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If Dependent Proof of Insurability is required

Subject to the Exception shown below, if Proof Of Insurability is required for dependent benefits, You must send Us the proof We require, and We must approve that proof in writing. Those benefits will then begin on the approved Eligibility Date.

If You must pay part of the cost of dependent coverage, We will not cover You for such coverage until You enroll each of Your dependents, agree to make the required payments, submit Proof Of Insurability and We approve that proof in writing.

Newly Acquired Dependents

If You do not pay any part of the cost of dependent coverage, a Newly Acquired Dependent is covered from the date he or she first becomes eligible.

If You must pay part of the cost of dependent coverage, and are already enrolled for dependent child coverage for Your Initial Dependent children, any Newly Acquired Dependent children will be covered as of the date he or she is first eligible.

However, if You were previously eligible to enroll for dependent child coverage and waived coverage or failed to enroll, We will not cover any of Your dependent children until You submit Proof of Insurability and we approve that proof in writing and you make any additional required payments.

B400.8130

All Options

Exception

We will postpone the Eligibility Date of a dependent's, other than a newborn child's, coverage if, on that date, he or she is Unable to perform two or more Activities of Daily Living (ADLs).

In that case, We will postpone the Eligibility Date of his or her coverage until the day after the date he or she no longer requires assistance with two or more Activities of Daily Living.

If a dependent was covered under a prior plan at transfer, this language will not apply to the amount of coverage that was in force with the prior plan.

B400.8131

All Options

When Dependent Coverage Ends

Dependent coverage ends for all of Your dependents when:

- Your Employee coverage ends;
- You stop being a member of a class of Employees eligible for such coverage;
- This Certificate ends, or
- Dependent coverage is discontinued from this Certificate for all Employees or for Your 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 subject to the Grace Period, unless coverage ends earlier for other reasons.

An individual dependent's coverage ends when he or she stops being an eligible dependent. For dependent children the coverage ends at 12:01 A.M. Standard Time for Your place of residence on the date the child attains this Certificate's age limit, or when a step-child is no longer dependent on You for at least 50% of their support and maintenance, or for Your disabled child who has reached the age limit, when he or she is no longer eligible under the Continuing Coverage for Dependent Children Past the Limiting Age provision.

Coverage ends for a Spouse when a marriage is lawfully terminated, and with respect to Voluntary Accidental Death and Dismemberment coverage, it happens at 12:01 A.M. on the date the Spouse reaches age 70 .

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

B401.1536

EMPLOYEE ACCIDENTAL DEATH AND DISMEMBERMENT (AD&D) INSURANCE

B400.6134

All Options

Basic and Voluntary Accidental Death and Dismemberment Insurance

B400.6137

We will pay the benefits described below if You suffer an irreversible loss due to an Accident and the Accident occurs while You are insured by this Certificate. The loss also must:

- Be a direct result of the Accident;
- Be independent of all other causes; and
- Occur within 365 days of the date of the Accident.

Payment Of Benefits We will pay this insurance as soon as We receive written Proof of Loss as shown in the Claims Provisions section of this Certificate.

Payment Of Benefits For Covered Loss of life, We pay the beneficiary of Your Accidental Death and Dismemberment Insurance under the Employer's Policy with Us.

For all other Covered Losses, We pay You if You are living. If You are not living, We pay the beneficiary of Your Term Life coverage under the Employer's Plan with Us.

Subject to all the terms of this Certificate, We pay all benefits in a lump sum as soon as We receive written proof of Covered Loss and proof of claim which is acceptable to Us. This should be sent to Us as soon as possible.

The Beneficiary You decide who receives this benefit when You die. Your beneficiary designation should be provided in a means acceptable by Us.

You can change Your beneficiary at any time by providing written notice. But, the change will not take effect until We or the Employer records the change.

We will not be liable for any amounts paid before receiving notice of a beneficiary change.

In no event may a beneficiary be changed by a Power of Attorney.

If You named more than one person as a primary beneficiary, but You do not specify what shares each such primary beneficiary is entitled to receive, We will divide the benefits equally among all such named primary beneficiaries who survive You. If someone You named as a primary beneficiary dies before You, that person's share will be divided equally by the primary beneficiaries still alive; unless You have specified otherwise.

If You have named a contingent beneficiary or contingent beneficiaries, We will pay Your contingent beneficiary or contingent beneficiaries, if no primary beneficiary survives You. If there is more than one contingent beneficiary who is eligible for benefits, We will divide the benefits equally among all such named contingent beneficiaries who survive You; unless You have specified otherwise.

If there is no primary or contingent beneficiary or beneficiaries eligible for benefits when You die, We will pay this benefit as follows:

- To Your Spouse;
- If Your Spouse does not survive You, then to Your children who survive You in equal shares;
- If no Spouse or children survive You, then to Your parents who survive You in equal shares;
- If no Spouse, children, or parents survive You, then to then to Your brothers and sisters in equal shares;
- If none of the above parties survive You, then to Your executors or administrators of Your estate.

Payment Of Funeral Expenses We have the option of paying up to $500 of this benefit to any person who incurred expenses for Your funeral.

B400.6141

All Options

Covered Losses Benefits will be paid only for losses listed in the Table of Covered Losses shown below. Your insurance amount is shown in the Accidental Death and Dismemberment Schedule Of Benefits.

B400.6147

All Options

ACCIDENTAL DEATH AND DISMEMBERMENT

Table Of Covered Losses

Covered Loss	Benefit
Loss of life	100% of Your AD&D insurance amount.
Disappearance	100% of Your AD&D insurance amount.
Loss of a hand	50% of Your AD&D insurance amount. No benefit will be paid if benefits have been paid for "loss of one arm".

Loss of a foot	50% of Your AD&D insurance amount. No benefit will be paid if benefits have been paid for "loss of one leg".
Loss of sight in one eye	50% of Your AD&D insurance amount.
Loss of thumb and index finger of same hand	25% of Your AD&D insurance amount. No benefit will be paid if benefits have been paid for "Loss of a hand" or "loss of one arm".
Loss of four fingers of same hand	25% of Your AD&D insurance amount. No benefit will be paid if benefits have been paid for "Loss of a hand" or "loss of one arm".
Loss of all toes of same foot	25% of Your AD&D insurance amount. No benefit will be paid if benefits have been paid for "Loss of a foot" or "loss of one leg".
Loss of the great toe (hallux)	15% of Your AD&D insurance amount. No benefit will be paid if benefits have been paid for "Loss of a foot" or "loss of one leg".

B400.6143

All Options

As used here:

- "Loss of a hand" means the hand is completely severed at or above the wrist.
- "Loss of a foot" means the foot is completely severed at or above the ankle.
- "Loss of sight" means total and permanent loss of sight.
- "Loss of thumb and index finger of same hand" or "Loss of four fingers of same hand" means complete severance at the metacarpophalangeal joints of the same hand.
- "Loss of all toes of same foot" means complete severance at the metatarsalphalangeal joint.
- "Loss of the great toe (hallux)" means complete severance at the metatarsalphalangeal joint.

B400.6149

GC-ADD-15-VA

All Options

Multiple Losses For more than one Covered Loss due to the same Accident, We will pay up to 100% of Your Accidental Death and Dismemberment Insurance amount. We will not pay more than 100% of Your Accidental Death and Dismemberment Insurance amount for all losses due to the same Accident, except as shown under the Common Carrier Benefit, Seatbelt And Airbag Benefits and Repatriation Benefit.

B400.6151

All Options

Exclusions Conditions that are not considered Covered Losses and that are not covered under the terms of this Certificate can be found in the definition of "Accident". Please refer to the Definitions section of this Certificate.

B400.6153

All Options

Repatriation Benefit We pay an extra sum for Covered Loss of life due to an Accident which occurs at least 75 miles from Your home. In that case, We pay up to $5,000 for costs to prepare and transport Your body to a mortuary chosen by You or an authorized agent. In the event that a Repatriation Benefit is paid under Your Group Term Life Insurance Certificate, no additional benefit will be paid under this Accidental Death and Dismemberment Certificate.

B400.6155

All Options

Exposure If You suffer a Covered Loss shown in the Table of Covered Losses due to an Accidental bodily injury caused by being unavoidably exposed to the elements, We will pay the amount which otherwise applies to the loss. If Covered Loss benefits are deemed payable under Exposure, the Covered Loss benefit is only paid once, not in addition to the Exposure payments.

B400.6156

All Options

Disappearance You will have a presumed Covered Loss due to an Accident if:

- You are riding in a public conveyance that is involved in an Accident;
- As a result of the Accident, the public conveyance is wrecked, sinks, is stranded or disappears;
- Your body is not found within 365 days of the day the Accident; and
- The Accident occurs while You are covered by this Certificate.

If Covered Loss benefits are deemed payable under Disappearance, the Covered Loss benefit is only paid once, not in addition to the Disappearance payments.

B400.6157

GC-ADD-15-VA

DEPENDENT ACCIDENTAL DEATH AND DISMEMBERMENT (AD&D) INSURANCE

B400.6177

All Options

Dependent Voluntary Accidental Death and Dismemberment Insurance

B400.6178

All Options

We will pay the benefits described below if a covered dependent suffers an irreversible loss due to an Accident that occurs while he or she is insured under this Certificate. The loss must: (1) be a direct result of the Accident; (2) be independent of all other causes; and (3) occur within 365 days of the date of the Accident.

B400.6180

All Options

Payment Of Benefits

For all Covered Losses, We pay You, if You are living. If You are not living, We will pay this benefit as follows:

If the dependent was Your Spouse, We will pay this benefit in equal shares to the first eligible party or parties in the following order:

- To Your Spouses estate;
- To Your Spouses children in equal shares;
- If no children survive him or her, then to his or her parents in equal shares;
- If no children, or parents survive him or her, then to then to his or her brothers and sisters in equal shares;
- If none of the above parties survive Your Spouse, then to the executors or administrators of Your estate.

If the dependent was Your child, we will pay this benefit in equal shares to the first eligible party or parties in the following order:

- Your childs custodial parent(s);
- If no custodial parent survives him or her, then to Your parents;
- If no custodial parent or Your parents survive him or her, then to Your childs estate;

- If none of the above parties survive him or her and no estate exists, then to the executors or administrators of Your estate;
- If none of the above parties survive him or her, and no estates exist, then to Your childs siblings.

Payment of Funeral Expenses We have the option of paying up to $500 of this benefit to any person who incurred expenses for your dependents funeral.

B400.6184

All Options

ACCIDENTAL DEATH AND DISMEMBERMENT

Covered Losses Benefits will be paid only for losses listed in the Table of Covered Losses shown below. Your covered dependent's insurance amount is shown in the Accidental Death and Dismemberment Schedule Of Benefits.

Table Of Covered Losses

Covered Loss	Benefit
Loss of life	100% of the Voluntary AD&D insurance amount.
Disappearance	100% of the Voluntary AD&D insurance amount.
Loss of a hand	50% of the Voluntary AD&D insurance amount. No benefit will be paid if benefits have been paid for "loss of one arm".
Loss of a foot	50% of the Voluntary AD&D insurance amount. No benefit will be paid if benefits have been paid for "loss of one leg".

GC-ADD-15-VA

Loss of sight in one eye	50% of the Voluntary AD&D insurance amount.
Loss of thumb and index finger of same hand	25% of the Voluntary AD&D insurance amount. No benefit will be paid if benefits have been paid for "Loss of a hand" or "loss of one arm".
Loss of four fingers of same hand	25% of the Voluntary AD&D insurance amount. No benefit will be paid if benefits have been paid for "Loss of a hand" or "loss of one arm".
Loss of all toes of same foot	25% of the Voluntary AD&D insurance amount. No benefit will be paid if benefits have been paid for "Loss of a foot" or "loss of one leg".
Loss of the great toe (hallux)	15% of the Voluntary AD&D insurance amount. No benefit will be paid if benefits have been paid for "Loss of a foot" or "loss of one leg".

B400.6185

All Options

As used here:

- "Loss of a hand" means the hand is completely severed at or above the wrist.
- "Loss of a foot" means the foot is completely severed at or above the ankle.
- Loss of all toes of same foot means complete severance at the metatarsalphalangeal joint.
- Loss of the great toe (hallux) means complete severance at the metatarsalphalangeal joint.
- "Loss of sight" means total and permanent loss of sight.
- Loss of thumb and index finger of same hand or Loss of four fingers of same hand means complete severance at the metacarpophalangeal joints of the same hand.
- Loss of all toes of same foot means complete severance at the metatarsalphalangeal joint.

B400.6187

All Options

Multiple Losses For more than one Covered Loss due to the same Accident, We will pay up to 100% of the covered dependent's Voluntary Accidental Death and Dismemberment Insurance amount. We will not pay more than 100% of his or her Voluntary Accidental Death and Dismemberment Insurance amount for all losses due to the same Accident, except as shown under the Common Carrier Benefit, Seatbelt And Airbag Benefits and Repatriation Benefit.

B400.6189

All Options

Repatriation Benefit We pay an extra sum for Covered Loss of life due to an Accident which occurs at least 75 miles from the covered dependent's home. In that case, We pay up to $5,000 for costs to prepare and transport his or her body to a mortuary chosen by You.

B400.7168

All Options

Exposure If the covered dependent suffers a Covered Loss shown in the Table of Covered Losses due to an Accidental bodily injury caused by being unavoidably exposed to the elements, We will pay the amount which otherwise applies to the loss.

If Covered Loss benefits are deemed payable under Exposure, the Covered Loss benefit is only paid once, not in addition to the Exposure payment.

B400.7169

All Options

Disappearance The covered dependent will have a presumed Accidental bodily injury due to an Accident if:

- The covered dependent is riding in a public conveyance that is involved in an Accident;
- As a result of the Accident, the public conveyance is wrecked, sinks, is stranded or disappears;
- The covered dependent's body is not found within 365 days of the day the Accident; and
- The Accident occurs while the covered dependent is covered by this policy.

If Covered Loss benefits are deemed payable under Disappearance, the Covered Loss benefit is only paid once, not in addition to the Disappearance payment.

B400.7170

CLAIM PROVISIONS

Your right to make a claim for Group Accidental Death and Dismemberment Insurance Benefits provided by this Certificate is governed as follows:

Authority We have discretionary authority to:

- Interpret the terms of this Certificate; and
- Determine Your eligibility for coverage and benefits under this Certificate.

All such determinations are conclusive and binding, except that they may be modified or reversed by a court or regulatory agency with appropriate jurisdiction.

Notice Written notice of intent to file a claim under this Certificate must be sent to Us within 20 days of the date of the loss. This Notice should include the name of the insured and the Policy number. If the claim is being made for any other Covered Person, his or her name should also be shown. For details, You can call Us at 1-800-525-4542.

Claim Forms We will furnish forms for filing proof of death within 15 days of receipt of Notice. If we do not furnish the forms on time, We will accept a written Notice and adequate proof of death that is the basis of the claim as Proof of Loss.

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

Late Notice and Proof of Loss We will not void or reduce Your claim if we do not receive Notice and Proof of Loss within the required time. In that case, Notice and Proof of Loss must be sent as soon as reasonably possible.

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

The Guardian Life Insurance Company of America
Group Life Claims Department
P.O. Box 14334
Lexington, KY 40512

Payment of Benefits We will pay the Group Accidental Death & Dismemberment Insurance Benefit as soon as We receive written Proof of Loss.

Legal Actions No legal action against Guardian related to this Certificate may be brought until 60 days from the date Proof of Loss has been given as shown above. No legal action may be brought against Guardian related to claims for benefits under this Certificate after three years from the time that proof of loss was required to be filed.

B401.1538

DEFINITIONS

This section defines certain terms appearing in Your Certificate.

B400.7183

All Options

Accident This term means an event or occurrence, resulting in bodily injury or death, independent of all other causes, while a Covered Person is insured by this Certificate. Accident does not include:

- Willful self-injury, suicide, or attempted suicide while sane or insane;
- Sickness, disease, mental infirmity, or result of any medical or surgical treatment;
- Infection, except pyogenic infections which result from a bodily injury or bacterial infections which result from the unintentional ingestion of contaminated substances;
- The intentional or voluntary inhalation or ingestion of gas, chemical, solvent, poison or other substances not intended for internal consumption;
- An injury the Covered Person suffers while taking part in a riot or other civil disorder; or in the commission of or attempt to commit a felony, as defined per the laws in the jurisdiction in which the felony was committed or attempted, or as defined under federal law if the offense charged was a federal offense;
- Injury suffered while travelling on any type of aircraft if the Covered Person is an instructor or crew member; or has any duties at all on that aircraft;
- Injury suffered in declared or undeclared war or act of war or armed aggression;
- Injury suffered while the Covered Person is a member of any armed force;
- Injury suffered while the Covered Person is a driver in a motor vehicle Accident, if his or her driver's license has been suspended, revoked or has been expired for more than 90 days, or if the driver is unlicensed;
- Injury suffered while the Covered Person is legally intoxicated; or
- Injury suffered while the Covered Person is voluntarily using a controlled substance, unless:

- It was prescribed for the Covered Person by a doctor; and
- 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.

B400.7184

All Options

Active Work or Actively At Work These terms mean You are able to perform, and are performing, all of the regular duties of Your work for the Employer at:

- One of the Employer's usual places of business;
- Some place where the Employer's business requires You to travel; or
- Any other place You and the Employer have agreed on for Your work.

B400.7186

All Options

Activities Of Daily Living This term means the ability to independently perform the following, with or without equipment or adaptive devices:

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

B400.7187

All Options

Certificate This term means this Certificate of Coverage, including any riders and enrollment forms that may be attached to this Certificate.

B400.7188

All Options

Covered Loss This term means loss due to an Accident while a Covered Person is insured by this Certificate and as outlined in the Table of Covered Losses.

B400.7189

All Options

Covered Person This term means the Employee and dependents who are insured by this Certificate.

B400.7190

All Options

Effective Date The date the Certificate goes into force and effect as stated on the cover page of the Certificate of Coverage, or any change to the Certificate as requested by the Policyholder and approved by Us and in force and effect as stated on the cover page of the Certificate of Coverage.

B400.7192

All Options

Eligibility Date This term means the earliest date a Covered Person is eligible for coverage under this Certificate, and he or she has satisfied all requirements for coverage to begin, as required by this Certificate.

- For Employee coverage, this term means the earliestdate You are eligible for coverage under this Certificate.
- For an Employee in Active Work who had completed any waiting period required by the Employer as of the Effective Date of this Certificate, the Eligibility Date means the Effective Date of this Certificate.
- For an Employee in Active Work as of the Effective Date of this Certificate who has not completed any waiting period required by the Employer , the Eligibility Date will be the first date following the completion of the required waiting period.
- For an Employee hired on or after the Effective Date of this Certificate, the Eligibility Date will be the later of the Employee's date of hire, or the first date following the completion of any waiting period required by the Employer.

If this plan requires Employees to elect coverage under this Certificate, the Eligibility date will be the later of:

- The Employee's date of hire;
- The first date following the completion of any waiting period required by the Employer; or
- The approval by Us in writing of any coverage for which You were required to provide Proof of Insurability.

For dependent coverage, this term means the earliest date on which:

- You have Initial Dependents; and
- Are eligible for dependent coverage.

B400.7193

All Options

Employee This term means a person who works for the Employer at the Employer's place of business and whose income is reported to the United States Internal Revenue Service, and/or a state, for tax purposes. Partners and proprietors will also be treated as Employees if the eligibility requirements are met.

B400.7195

All Options

Employer This term means THE EVERGREENE COMPANIES .

B400.7196

All Options

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

B400.7197

All Options

Full-Time This term means You are not a part time Employee as defined by Your Employer and the average number of hours You worked for the six months prior to the last full day worked was at least 30 hours per week at:

- Your Employer's place of business;
- Some place where the Employer's business requires You to travel; or
- Any other place You and Your Employer have agreed upon for the performance of occupational duties.

B401.3005

All Options

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

B400.7199

All Options

Legally Intoxicated "Intoxicated" means that the Covered Person's blood alcohol content meets or exceeds the percentage or amount of blood alcohol content that creates a legal presumption of intoxication under the laws of the state or territory in which the loss occurred for operating a motor vehicle under the influence, regardless of whether the Covered Person was operating a motor vehicle at the time the loss occurred.

B400.7219

All Options

Month or Months or Monthly These terms mean a consecutive 30 day period.

B400.7220

All Options

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

B400.7221

All Options

Policy or Plan This term means the Group Accidental Death and Dismemberment Coverage described in the Policy and in this Certificate.

B400.7223

All Options

Proof Of Insurability This terms means the completion of an evidence of insurability form, acceptable to Us, which shows that a person is insurable.

B400.7224

All Options

Proof of Loss This term means the documents that are deemed acceptable for purposes of substantiating a life claim. Acceptable Proof of Loss includes:

- An original certified finalized death certificate;
- The beneficiary designation in effect at the time of death;
- Enrollment information documenting that the insured was properly enrolled for the amount of coverage claimed;
- A fully completed claim form; and
- Any additional information deemed necessary during the course of Our claim investigation. This may include, but is not limited to, an autopsy report, investigative reports, toxicology reports and medical records.

B400.7225

All Options

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

B400.7228

All Options

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

B400.7229

All Options

You or Your These terms mean the insured Employee.

B400.7230

GROUP ACCIDENTAL DEATH AND DISMEMBERMENT SCHEDULE OF BENEFITS

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

B401.1601

All Options

Employee Basic Accidental Death And Dismemberment (AD&D) Insurance Schedule

B400.7859

All Options

Basic AD&D Insurance Amount

The Insurance Amount is $25,000.00

B400.7860

All Options

Reduction of Basic AD&D Insurance Amount Based on Age

If You are less than age 65 when Your insurance under this Policy starts, Your insurance amount will be reduced at 12:01 A.M. Standard Time for Your place of residence on the date You reach age 65, by 35% of the amount which otherwise applies to Your classification. But in no case will such reduced amount be less than $1,000.00. This reduction also applies to Your initial insurance amount if Your insurance starts after You reach age 65, but before You reach age 70.

If You are less than age 70 when Your insurance under this Policy starts, Your insurance amount will be reduced at 12:01 A.M. Standard Time for Your place of residence on the date You reach age 70, by 50% of the amount which otherwise applies to Your classification. But in no case will such reduced amount be less than $1,000.00. This reduction also applies to Your initial insurance amount if Your insurance starts after You reach age 70.

The reduced amount is in place of the amount which otherwise applies to Your classification.

B400.7899

All Options

Proof of Insurability

Depending on the coverage selected, or as otherwise required in this Certificate, You, Your Spouse and/or Dependents may be required to supply proof that the person applying for coverage is insurable for the amount and type of coverage selected. This requirement is called Proof of Insurability. For purposes of this section, any person applying for coverage requiring Proof of Insurability is referred to as "Applicant."

To determine if the Applicant is required to submit Proof of Insurability for the type and amount of coverage sought, please see below.

Any applicant required to submit Proof of Insurability is required to complete and submit to Us an Enrollment/Change form. We may also require the completion of additional forms so that We may determine whether the Applicant is insurable, according to Our underwriting standards for the amount and type of coverage applied for. To determine if the Applicant is insurable, We may also need to obtain and review the Applicant's health and medical history; prescription history; records relating to treatment, diagnostic testing, hospitalization and the like; and records pertaining to Applicant's driving and motor vehicle history.

No coverage requiring Proof of Insurability will become effective unless and until it is approved by Us in writing. Our receipt of any premiums associated with coverage requiring Proof of Insurability does not waive or modify any requirement that must be satisfied for coverage to begin, including but not limited to the requirement that the Applicant submit Proof of Insurability. In the event that any premiums are overpaid, Our only obligation is to return the amount of overpaid premiums.

The Policyholder, or its designee, must give Us complete and accurate information so that we may determine:

- Who is insured;
- The type and amount of coverage for which someone is insured; and
- Any other information required so that Guardian may meet its obligations under the Policy.

Proof Of Insurability Requirements

Proof Of Insurability requirements apply to Basic Accidental Death and Dismemberment Insurance. Such requirements may apply to the full insurance amount, or just part of it, as outlined below. When Proof Of Insurability requirements apply, it means You must submit to Us Proof that You are insurable, and We must approve the Proof in writing before the insurance, or the specified part becomes effective.

We require Proof of Insurability as follows:

If You:

- Do not meet this Policy's enrollment requirement within 30 days after You first become eligible; or

- Enroll after You previously had coverage which ended because You failed to make a required payment,

We will require that You provide Proof Of Insurability. And, You will not be covered until We approve that proof in writing.

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

B400.8032

All Options

Employee Voluntary Accidental Death And Dismemberment (AD&D) Insurance Schedule

B400.8097

All Options

Initial Election You will be insured under one of the plans of Voluntary Accidental Death and Dismemberment Insurance which is equal to 100% of the Voluntary Term Life amount not to exceed $100,000.00. You may only be insured under one plan at a time. You must notify the Employer of your election and pay the required premium.

B400.8100

All Options

Changing Election You may switch to another benefit any time the Voluntary Term Life amount is changed. You must notify the Employer of the switch and the amount must be 100% of the Voluntary Term Life amount.

B400.8104

All Options

Voluntary AD&D Insurance Amount

Plan A

You may elect amounts of Voluntary Accidental Death and Dismemberment Insurance in increments of $5,000.00, but your amount may not be less than $10,000.00 and may not exceed $100,000.00.

B400.8127

All Options

Annual Election After You first enroll for Employee Voluntary Accidental Death and Dismemberment Insurance, You may choose to increase Your amount of Voluntary Accidental Death and Dismemberment Insurance by an amount not to exceed an increase of $50,000 as shown above. This option is available during the Voluntary Accidental Death and Dismemberment enrollment period described above. Proof Of Insurability will not be required unless the insurance amount exceeds the amount of Voluntary Accidental Death and Dismemberment Insurance for which Proof Of Insurability is required as shown below.

If Proof Of Insurability is required and has been submitted and approved by Us, Proof of Insurability for additional increases will be required on the second anniversary of the date we approve such coverage.

If Proof Of Insurability is required and has been declined, You will not be eligible for additional annual increases without submitting Proof Of Insurability for them, and then if such increases are approved by Us in writing.

B400.9092

All Options

Family Status Change You may request a change to your Voluntary Accidental Death and Dismemberment Insurance coverage if you have experienced a Family Status Change.

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

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

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

Domestic Partner: This term means an opposite or same sex partner who has met all of the following requirements for at least 12 months: (1) resides with the Covered Person; (2) shares financial assets and obligations with the Covered Person; (3) is not related by blood to the Covered Person to a degree of closeness that would prohibit a legal marriage; (4) is at least the age of consent in the state in which they reside; and (5) neither the Covered Person or Domestic Partner is married to anyone else, nor has any other Domestic Partner. The Company requires proof of the Domestic Partner relationship in the form of a signed and completed Affidavit of Domestic Partnership.

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

B401.1602

All Options

Reduction of Voluntary AD&D Insurance Amount Based on Age

If You are less than age 65 when Your insurance under this Plan starts, Your insurance amount is reduced at 12:01 A.M. Standard Time for Your place of residence on the date You reach age 65, by 35% of the amount which otherwise applies to Your classification. But in no case will such reduced amount be less than $1,000.00. This reduction also applies to Your initial insurance amount if Your insurance starts after You reach age 65, but before You reach age 70.

If You are less than age 70 when Your insurance under this Plan starts, Your insurance amount is reduced at 12:01 A.M. Standard Time for Your place of residence on the date You reach age 70, by 50% of the amount which otherwise applies to Your classification. But in no case will such reduced amount be less than $1,000.00. This reduction also applies to Your initial insurance amount if Your insurance starts after You reach age 70.

The reduced amount is in place of the amount which otherwise applies to Your classification.

B400.9128

All Options

Proof of Insurability

Depending on the coverage selected, or as otherwise required in this Certificate, You, Your Spouse and/or Dependents may be required to supply proof that the person applying for coverage is insurable for the amount and type of coverage selected. This requirement is called Proof of Insurability. For purposes of this section, any person applying for coverage requiring Proof of Insurability is referred to as "Applicant."

To determine if the Applicant is required to submit Proof of Insurability for the type and amount of coverage sought, please see below.

Any applicant required to submit Proof of Insurability is required to complete and submit to Us an Enrollment/Change form. We may also require the completion of additional forms so that We may determine whether the Applicant is insurable, according to Our underwriting standards for the amount and type of coverage applied for. To determine if the Applicant is insurable, We may also need to obtain and review the Applicant's health and medical history; prescription history; records relating to treatment, diagnostic testing, hospitalization and the like; and records pertaining to Applicant's driving and motor vehicle history.

No coverage requiring Proof of Insurability will become effective unless and until it is approved by Us in writing. Our receipt of any premiums associated with coverage requiring Proof of Insurability does not waive or modify any requirement that must be satisfied for coverage to begin, including but not limited to the requirement that the Applicant submit Proof of Insurability. In the event that any premiums are overpaid, Our only obligation is to return the amount of overpaid premiums.

The Policyholder, or its designee, must give Us complete and accurate information so that we may determine:

- Who is insured;
- The type and amount of coverage for which someone is insured; and
- Any other information required so that Guardian may meet its obligations under the Policy.

Proof Of Insurability Requirements

Proof Of Insurability requirements apply to Voluntary Accidental Death and Dismemberment Insurance. Such requirements may apply to the full insurance amount, or just part of it, as outlined below. When Proof Of Insurability requirements apply, it means You must submit to Us Proof that You are insurable, and We must approve the Proof in writing before the insurance, or the specified part becomes effective.

We require Proof of Insurability as follows:

B400.9141

All Options

Except as provided for annual election, We require Proof of Insurability before You switch from Your current increment of Voluntary Accidental Death and Dismemberment Insurance to an increment which provides a greater amount of insurance.

B400.9179

All Options

We require Proof of Insurability before We will insure You if You enroll for Voluntary Accidental Death and Dismemberment Insurance after the time allowed for enrolling as specified in this Certificate.

B400.9184

All Options

We require Proof of Insurability for all amounts of Voluntary Accidental Death and Dismemberment Insurance which exceed $50,000.00, if Your scheduled Voluntary Accidental Death and Dismemberment Insurance effective date is after You reach age 65.

B400.9191

All Options

We require Proof of Insurability for all amounts of Voluntary Accidental Death and Dismemberment Insurance which exceed $10,000.00, if Your scheduled Voluntary Accidental Death and Dismemberment Insurance effective date is after You reach age 70.

B400.9191

All Options

Dependent Voluntary Accidental Death and Dismemberment Schedule

B400.9308

All Options

Initial Election You may choose the plan of dependent Spouse Voluntary Accidental Death and Dismemberment Insurance and the plan of dependent child Voluntary Accidental Death and Dismemberment Insurance shown below. You must notify the Employer of Your election and pay the required premium.

B400.9309

All Options

Voluntary Dependent Spouse Insurance Amount

Plan A

You may elect amounts of Voluntary dependent spouse Accidental Death and Dismemberment Insurance in increments of $5,000.00, but the amount may not be less than $5,000.00 and may not exceed $50,000.00.

B400.9318

All Options

Dependent Child Voluntary AD&D Insurance Amount

Plan A

Child's Age At Death	Insurance Amount
From birth to 14 days	$500.00
At least 14 days but less than 25 years	an amount not less than $2,000.00, and not more than $10,000.00, increments of $2,000.00

B401.2802

All Options

In no event may the insurance amount of a dependent Spouse exceed 50% of Your insurance amount.

B401.2814

All Options

In no event may the insurance amount of a dependent child exceed 100% of Your insurance amount.

B400.9343

All Options

Reduction of Dependent Voluntary Accidental Death and Dismemberment Insurance Amount based on Age

Your dependent benefits are reduced in the same manner as Your benefits. The dependent reductions are based on Your age.

B400.9363

All Options

Proof Of Insurability Requirements

Depending on the coverage selected, or as otherwise required in this Certificate, Your Spouse and Dependent Children may be required to supply proof that the person applying for coverage is insurable for the amount and type of coverage selected. This requirement is called Proof of Insurability. For purposes of this section, any person apply for coverage requiring Proof of Insurability is referred to as "Applicant."

To determine if the Applicant is required to submit Proof of Insurability for the type and amount of coverage sought, please see below.

Any applicant required to submit Proof of Insurability is required to complete and submit to Us an Enrollment/Change form. We may also require the completion of additional forms so that we may determine whether the Applicant is insurable according to our underwriting standards for the amount and type of coverage applied for. To determine if the Applicant is insurable, We may also need to obtain and review the Applicant's:

- Health and medical history;
- Prescription history;
- Records relating to treatment, diagnostic testing, hospitalization; and
- Records pertaining to the Applicant's driving and motor vehicle history.

No coverage requiring Proof of Insurability will become effective unless and until it is approved by Us in writing. Our receipt of any premiums associated with coverage requiring Proof of Insurability does not waive or modify any requirement that must be satisfied for coverage to begin, including but not limited to the requirement that the Applicant provide Proof of Insurability. In the event that any premiums are overpaid, Our only obligation is to return the amount of overpaid premiums.

The Policyholder, or its designee, must give Us complete and accurate information so that We may determine:

- Who is insured;
- The type and amount of coverage for which someone is insured; and
- Any other information required so that Guardian may meet its obligations under the Policy.

We require Proof of Insurability as follows:

B400.9364

All Options

We require Proof Of Insurability that a dependent is insurable if You:

- Enroll a dependent, submit the dependent's signed health statement, and agree to make the required payments after the end of the Enrollment Period;
- In the case of a Newly Acquired Dependent, other than the first newborn child, have other eligible dependents who You have not elected to enroll; or
- In the case of a Newly Acquired Dependent, have other eligible dependents whose coverage previously ended because You failed to make the required contributions, or otherwise chose to end such coverage.

B400.9367

All Options

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

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

B400.9368

All Options

We require Proof of Insurability before We will insure any dependent Spouse who is enrolled for dependent Spouse Voluntary Accidental Death and Dismemberment Insurance after the time allowed for enrolling as specified in this Policy.

B400.9373

All Options

We require Proof of Insurability for any amount of dependent Voluntary Accidental Death and Dismemberment Insurance In excess of $10,000.00 with respect to a dependent Spouse, if the dependent Spouse's scheduled dependent Voluntary Accidental Death and Dismemberment effective date is after he or she reaches age 65.

B400.9375

All Options

We require Proof of Insurability before We will insure any dependent child who is enrolled for dependent child Voluntary Accidental Death and Dismemberment Insurance after the time allowed for enrolling as specified in this Policy.

B400.9481

All Options

Changes to Insurance

B400.9564

All Options

Changes In Insurance Amounts

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

B400.9568

Changes In Insurance Classification

If Your classification changes, insurance will not be changed to the new amount until the first day on which You are:

- Actively At Work on a Full-Time basis; and
- Make a contribution, if required, for the new classification.

If a contribution is required for the new classification for which a larger amount of insurance is provided, You must make the required contribution for the new amount within 31 days of the change. If You do not make the required contribution within 31 days of the change or within 31 days of becoming Actively At Work on a Full-Time basis, if You are not Actively At Work on a Full-Time basis, when Your classification changes, no increase will be allowed due to such change or any later change. In that case, in order to become insured for the larger amount, You must:

- Make the required contribution for the new amount; and
- Furnish Proof Of Insurability to Us, which We approve in writing.

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

B400.9570

CERTIFICATE RIDER - Seatbelt and Airbag Benefit

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

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

Terms not specifically defined within this Rider are defined in the Certificate.

Employee Basic and Voluntary Accidental Death and Dismemberment Insurance and Dependent Voluntary Accidental Death and Dismemberment Insurance Seatbelt and Airbag Benefit

This rider applies to Your Basic and Voluntary Accidental Death and Dismemberment Insurance and dependent Voluntary Accidental Death and Dismemberment Insurance.

Seatbelt And Airbag Benefits

If You die as a direct result of an automobile Accident while properly wearing a seatbelt, We will increase Your Accidental Death and Dismemberment Benefit amount by $10,000. And, if You die as a direct result of an automobile Accident while both properly wearing a seatbelt, and sitting in a seat equipped with an airbag, We will increase Your Accidental Death and Dismemberment Benefit amount by an additional $5,000, for a total increase of $15,000.

Proof that You were properly wearing a seatbelt must be provided. A law enforcement official investigating the Accident must certify that the seatbelt was properly fastened and that the automobile in which the deceased was traveling was equipped with airbags. A copy of such certification must be submitted to Us with the claim for benefits.

If We cannot determine that You were wearing a seatbelt at the time of the Accident, We will increase Your Accidental Death and Dismemberment Benefit amount by $1,000.

If We determine that a seatbelt was not worn at the time of the automobile Accident directly resulting in Your death, or if the required official report is not provided, no Seatbelt or Airbag Benefit will be paid.

The total amount payable for the Seatbelt and Airbag Benefit under Your Basic and Voluntary Accidental Death and Dismemberment Insurance and Basic and Voluntary Group Term Life Insurance and may not exceed $30,000.

Exclusions This Certificate Rider does not pay a Seatbelt or Airbag Benefit for loss of life caused by, or related to an Accident occurring:

- While You are the driver in an automobile Accident, if Your driver's license has been suspended or revoked or if You are unlicensed;
- While You are Legally Intoxicated;
- While You are voluntarily using a controlled substance, unless:
  - It was prescribed for You by a Doctor; and
  - 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.
- While You were intentionally or voluntarily inhaling or ingesting a gas, chemical, solvent, poison or other substances not intended for internal consumption;
- During Your commission of, or attempt to commit a felony as defined per the laws in the jurisdiction in which the felony was committed or attempted, or as defined under federal law if the offense charged was a federal offense;
- During Your participation in any sport for compensation or profit; or
- During Your racing an automobile in an organized event or street race.

Dependent Seatbelt and Airbag Benefit

Seatbelt And Airbag Benefits If Your dependent dies as a direct result of an automobile Accident while properly wearing a seatbelt, We will increase his or her Voluntary Accidental Death and Dismemberment Benefit amount by $5,000. And, if Your dependent dies as a direct result of an automobile Accident while both properly wearing a seatbelt, and sitting in a seat equipped with an airbag, We will increase his or her Voluntary Accidental Death and Dismemberment Benefit amount by an additional $2,500, for a total increase of $7,500.

You are responsible for providing proof that Your dependent was properly wearing a seatbelt. A law enforcement official investigating the Accident must certify that the seatbelt was properly fastened and that the automobile in which the deceased was traveling was equipped with airbags. A copy of such certification must be submitted to Us with the claim for benefits.

If We cannot determine that Your dependent was wearing a seatbelt at the time of the automobile Accident directly resulting in his or her death, We will increase Your dependent Accidental Death and Dismemberment Benefit amount by $1,000.

If We determine that a seatbelt was not worn at the time of the automobile Accident directly resulting in Your dependent's death, or if the required official report is not provided, no Seatbelt or Airbag Benefit will be paid.

The total amount payable for the Seatbelt and Airbag Benefit under Your dependent Voluntary Accidental Death and Dismemberment Insurance and Voluntary Group Term Life Insurance may not exceed $15,000 for each covered dependent.

Exclusions This Policy does not pay a Seatbelt or Airbag Benefit for loss of life caused by, or related to an Accident occurring:

- While Your dependent is the driver in an automobile Accident, if his or her driver's license is suspended or revoked or if the driver is unlicensed;
- While Your dependent is Legally Intoxicated;
- While Your dependent is voluntarily using a controlled substance, unless:
  - It was prescribed for the dependent by a doctor; and
  - 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.
- While Your dependent intentionally or voluntarily inhales or ingests a gas, chemical, solvent, poison or other substances not intended for internal consumption;
- During Your dependent's commission of, or attempt to commit a felony as defined per the laws in the jurisdiction in which the felony was committed or attempted, or as defined under federal law if the offense charged was a federal offense;
- During Your dependent's participation in any sport for compensation or profit;
- During Your dependent's racing an automobile in an organized event or street race.

The Guardian Life Insurance Company of America

Michael Prestileo, Senior Vice President

B401.1552

GC-R-ADD-SBA-15-VA

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

STATEMENT OF ERISA RIGHTS

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

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

ERISA provides that all plan participants shall be entitled to:

Receive Information about Your Plan and Benefits

- Examine, without charge, at the plan administrator's office and at other specified locations, such as worksites and union halls, all documents governing the plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the plan with the U. S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.
- Obtain, upon written request to the plan administrator, copies of documents governing the operation of the plan, including insurance contracts, collective bargaining agreements and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The administrator may make a reasonable charge for the copies.
- Receive a summary of the plan's annual financial report. The plan administrator is required by law to furnish each participant with a copy of this summary annual report.

Prudent Actions by Plan Fiduciaries

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

Enforcement of Your Rights

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

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

Assistance with Questions

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

Accidental Death and Dismemberment Insurance Claims Procedure

If you seek benefits under the plan you should complete, execute and submit a claim form. Claim forms and instructions for filing claims may be obtained from the Guardian Life Insurance Company of America (hereinafter referenced as Guardian.)

Guardian is the Claims Fiduciary with discretionary authority to interpret and construe the terms of the Policy, the Certificate, the Schedule of Benefits, and any riders, or other documents or forms that may be attached to the Certificate or the Policy, and any other plan documents. Guardian has discretionary authority to determine eligibility for benefits and coverage under those documents. Guardian has the right to secure independent professional healthcare advice and to require such other evidence as needed to decide your claim.

In addition to the basic claim procedure explained in your certificate, Guardian will also observe the procedures listed below. These procedures are the minimum requirements for benefit claims procedures of employee benefit plans covered by Title 1 of ERISA.

Definitions

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

Timing for Initial Benefit Determination of Accidental Death and Dismemberment Insurance Claims

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

Guardian will provide a benefit determination not later than 90 days from the date of receipt of a claim. This period may be extended by up to 90 days if Guardian determines that an extension is necessary due to special circumstances, and so notifies the claimant before the end of the initial 90-day period. Such notification will include the reason for the special circumstances requiring the extension and a date by which the determination is expected to be made.

A notification of an extension to the time period in which a benefit determination will be made will include an explanation of the standards upon which entitlement to a benefit is based, any unresolved issues that prevent a decision of the claim, and the additional information needed to resolve those issues.

Adverse Benefit Determination of Accidental Death and Dismemberment Insurance Claims

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

- The specific reason(s) for the adverse determination;
- References to the specific provisions in the Policy, Certificate, plan or other documents, on which the determination is based;
- A description of any additional material or information needed to perfect the claim, and an explanation of why such material or information is necessary;
- A description of the plan's claim review procedures which a claimant may follow to have a claim for benefits reviewed and the time limits applicable to such procedures;
- Identification and description of any specific internal rule, guideline or protocol that was relied upon in making an adverse benefit determination, or a statement, that a copy of such information will be provided to the claimant free of charge upon request;
- A description of the plan's review procedures and the time limits applicable to such procedures, including a statement of the claimant's right to bring a civil action under ERISA Section 502(a) following an adverse benefit determination; and
- In the case of adverse benefit determination based on medical necessity or experimental treatment, notice will either include an explanation of the scientific or clinical basis for the determination, or a statement that such explanation will be provided free of charge upon request.

B997.0367

Appeals of Adverse Determinations of Accidental Death and Dismemberment Insurance Claims

If a claim is wholly or partially denied, you will have up to 60 days to make an appeal. Guardian will conduct a full and fair review of an appeal which includes providing to claimants the following:

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

In reviewing an appeal, Guardian will:

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

Guardian will notify the claimant of its decision not later than 60 days after receipt of the request for review of the adverse determination. This period may be extended by an additional period of up to 60 days if Guardian determines that special circumstances require an extension of the time period for processing and so notifies the claimant before the end of the initial 60-day period.

A notification with respect to an extension will indicate the special circumstances requiring an extension of the time period for review, and the date by which the final determination will be made.

In the event Guardian denies the appeal of an adverse benefit determination, it will:

- Provide the specific reason or reasons why the appeal was denied;
- Refer to the specific provisions in the Policy, Certificate, plan, or other documents on which the benefit determination is based;
- Provide a statement that the claimant is entitled to receive, upon request and free of charge, reasonably access to, and copies of all documents, records, and other information relevant to the claimant's claim for benefits;

- In the event the adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, provide either an explanation of the scientific or clinical judgment for the determination, applying the terms of the plan to the claimant's medical circumstances, or a statement that such explanation will be provided free of charge upon request.

Waiver of Premium

If you apply for an extension of accidental death and dismemberment insurance benefits due to Total Disability under the Waiver of Premium benefit under this plan, these claim procedures will apply to such request:

Timing For Initial Benefit Determination for Waiver of Premium

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

Guardian will make a determination of whether the claimant meets the plan's standard for total disability not later than 45 days from the date of receipt of a claim. This period may be extended by up to 30 days if Guardian determines that an extension is necessary due to matters beyond the control of the plan, and so notifies the claimant before the end of the initial 45-day period. Such notification will include the reason for the extension and a date by which the determination will be made. If prior to the end of the 30-day period Guardian determines that an additional extension is necessary due to matters beyond the control of the plan, and so notifies the claimant, the time period for making a benefit determination may be extended for up to an additional period of up to 30 days. Such notification will include the special circumstances requiring the extension and a date by which the final determination will be made.

A notification of an extension to the time period in which a benefit determination will be made will include an explanation of the standards upon which entitlement to a benefit is based, any unresolved issues that prevent a decision on the claim, and the additional information needed to resolve those issues.

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

Adverse Benefit Determination

If a claim for an extension of benefits is denied, Guardian will provide a notice that will set forth:

- The specific reason(s) for the adverse determination;
- References to the specific provisions in the Policy, Certificate, plan or other documents, on which the determination is based;
- A description of any additional material or information needed to perfect the claim, and an explanation of why such material or information is necessary;
- A description of the plan's claim review procedures which a claimant may follow to have a claim for benefits reviewed and the time limits applicable to such procedures;

- A statement disclosing any internal rule, guideline, protocol or similar criterion relied on in making the adverse benefit determination (or a statement that such information will be provided free of charge upon request); or a statement that no internal rule, guideline, protocol or similar criterion was relied upon in making the adverse benefit determination;
- If applicable, an explanation of the basis of disagreement with or not following the views presented by you, of health care professionals who treated you and vocational professionals who evaluated you;
- If applicable, an explanation of the basis for disagreeing with or not following the views of any medical or vocational expert whose advice was obtained on our behalf in connection with the adverse benefit determination, without regard to whether the advice was relied upon in making the determination;
- If applicable, an explanation of the basis for disagreeing with or not following a disability determination made by the Social Security Administration that you present to us;
- A description of the plan's review procedures and the time limits applicable to such procedures, including a statement of the claimant's right to bring a civil action under ERISA Section 502(a) following an adverse benefit determination; and
- In the case of adverse benefit determination based on medical necessity or experimental treatment, notice will either include an explanation of the scientific or clinical basis for the determination, or a statement that such explanation will be provided free of charge upon request.

B997.0368

All Options

Appeals of Adverse Determinations for Waiver of Premium

If a claim for Waiver of Premium is denied, the claimant will have up to 180 days to make an appeal. Guardian will conduct a full and fair review of an appeal which includes providing to claimants the following:

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

In reviewing an appeal, Guardian will:

- Provide for a review conducted by a named fiduciary who is neither the person who made the initial adverse determination nor that person's subordinate;

- In deciding an appeal based upon a medical judgment, consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment;
- Identify medical or vocational experts whose advice was obtained in connection with an adverse benefit determination; and
- Ensure that a health care professional engaged for consultation regarding an appeal based upon a medical judgment shall be neither the person who was consulted in connection with the adverse benefit determination, nor that person's subordinate.

Guardian will notify the claimant of its decision not later than 45 days after receipt of the request for review of the adverse determination. This period may be extended by an additional period of up to 45 days if Guardian determines that special circumstances require an extension of the time period for processing and so notifies the claimant before the end of the initial 45-day period.

A notification with respect to an extension will indicate the special circumstances requiring an extension of the time period for review, and the date by which the final determination will be made.

In the event Guardian denies the appeal of an adverse benefit determination, it will:

- Provide the specific reason or reasons why the appeal was denied;
- Refer to the specific provisions in the Policy, Certificate, plan, or other documents on which the benefit determination is based;
- Provide a statement that the claimant is entitled to receive, upon request and free of charge, reasonably access to, and copies of all documents, records, and other information relevant to the claimant's claim for benefits;
- Provide a statement disclosing any internal rule, guideline, protocol or similar criterion relied on in making the adverse benefit determination (or a statement that such information will be provided free of charge upon request); or a statement that no internal rule, guideline, protocol or similar criterion was relied upon in making the adverse benefit determination;
- If applicable, provide an explanation of the basis of disagreement with or not following the views presented by you, of health care professionals who treated you, and vocational professionals who evaluated you;
- If applicable, provide an explanation of the basis for disagreeing with or not following the views of any medical or vocational expert whose advice was obtained on our behalf in connection with the adverse benefit determination, without regard to whether the advice was relied upon in making the determination;
- If applicable, provide an explanation of the basis for disagreeing with or not following a disability determination made by the Social Security Administration that you present to us;

- Provide a statement describing the claimant s right to bring a civil suit under Section 502(a) of the Employee Retirement Income Security Act of 1974 which shall also describe any applicable contractual limitations period that applies the claimant's right to bring such an action, including the calendar date on which the contractual limitations period expires for the claim, and;
- In the event the adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, provide either an explanation of the scientific or clinical judgment for the determination, applying the terms of the plan to the claimant's medical circumstances, or a statement that such explanation will be provided free of charge upon request.

Alternative Dispute Options

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

In addition to any legal rights you may have under section 502(a), if you believe that we have violated ERISA's procedural requirements, you may request that we review any claimed violation(s) and we will respond to you within ten days.

B997.0369

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

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

CERTIFICATE OF COVERAGE

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

The group Short Term Disability income coverage described in this Certificate is attached to the group Policy effective January 1, 2020. This Certificate replaces any Certificate previously issued under this Policy or under any other plan providing similar or identical benefits issued to the Policyholder by Guardian. Please note that this Certificate is part of the Policy.

GROUP SHORT TERM DISABILITY INCOME COVERAGE

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

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

Policyholder: THE EVERGREENE COMPANIES
Group Policy Number: 00571412

The Guardian Life Insurance Company of America

Michael Prestileo, Senior Vice President

B400.2730

IMPORTANT INFORMATION REGARDING YOUR INSURANCE

In the event You need to contact someone about this insurance for any reason, please contact Your agent. If no agent was involved in the sale of this insurance, or if You have additional questions, You may contact the insurance company issuing this insurance at the following address and telephone number:

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

If You have been unable to contact or obtain satisfaction from the company or the agent, You may contact the Virginia State Corporation Commission's Bureau of Insurance at:

Bureau of Insurance
Tyler Building, 1300 E. Main St.
Richmond, VA 23219
Local (804) 371-9691
National Toll Free (877) 310-6560
VA only Toll Free (800) 552-7945

Written correspondence is preferable so that a record of Your inquiry is maintained. When contacting Your agent, company, or the Bureau of Insurance, have Your policy number available.

B400.2731

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GENERAL PROVISIONS

Applicable Benefits

This Certificate may include multiple benefit options and types of benefits. You will only be covered for benefits if:

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

B400.0048

Limitation of Authority

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

- Determine whether any contract, Policy or certificate is to be issued;
- Waive or alter any contract or Policy provisions, or any of Our requirements; or
- Accept any information or representation which is not in a signed application.

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

B400.2732

Incontestability

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

No statement in any application made by You will be used to contest the validity of Your insurance or to deny a claim for a loss incurred, or for a disability which starts, after such insurance has been in force for two years during Your lifetime.

No statement made by any person insured under the policy relating to his or her insurability or his or her insured dependents shall be used in contesting the validity of the insurance with respect to which such statement was made:

- After the insurance has been in force, prior to the contest, for a period of two years during the lifetime of the person about whom the statement was made; and
- Unless the statement is contained in a written instrument signed by him or her.

If this Certificate replaces a plan Your Employer had with another insurer, We may rescind this Certificate based on misrepresentations or omissions made by the Employer or You in a signed application for up to two years from the Effective Date of the Policy.

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

B400.2733

Examination

We have the right to have a Doctor(s) of Our choice examine the person for whom a claim is being made under this Certificate as often as We feel necessary. We will pay for all such examinations.

B400.0052

All Options

ELIGIBILITY FOR SHORT TERM DISABILITY INCOME COVERAGE

Conditions of Eligibility

You are eligible for Short Term Disability if You are:

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

B400.0054

All Options

You are **not** eligible for Short Term Disability if You are:

- A temporary or seasonal Employee.

B400.0057

All Options

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

B400.0059

All Options

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

B400.0060

All Options

The Waiting Period: If You are in an eligible class, You are eligible for Short Term Disability under this Certificate after you complete the service waiting period, if any, established by the Employer.

B400.0061

All Options

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

B400.0062

All Options

When Coverage Starts

For coverage to start, You must be fully capable of performing the major duties of Your Own Job for the Employer working the minimum required number of hours of an Employee in Your eligible class at 12:01 A.M. Standard Time for Your place of residence on Your scheduled Eligibility Date. And, for coverage to start, You must meet all of the Conditions of Eligibility described above and the conditions shown below which apply to You. If You are not fully capable of performing the major duties of Your Own Job on Your scheduled Eligibility Date, We will postpone the start of Your coverage while this Certificate is in force. We will postpone coverage until You are so capable and working the minimum required number of hours of an Employee in Your eligible class for one full day, with the capacity to do so for one full week.

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

B400.0064

Exception to When Coverage Starts

Sometimes a scheduled Eligibility Date is not a regularly scheduled work day. If the scheduled Eligibility Date falls on:

- A holiday;
- A vacation day;
- A non-scheduled work day;
- A day during an approved leave of absence not due to Sickness or Injury, of 90 days or less; or
- A day during a period of absence that is less than 7 days in duration;

and if:

- You were fully capable of performing the major duties of Your Own Job for the Employer for the minimum number of hours of an Employee in Your eligible class at 12:01 AM Standard Time for Your place of residence on the scheduled Eligibility Date; and
- You were performing the major duties of Your Own Job and working the minimum number of hours of an Employee in Your eligible class on Your last regularly scheduled work day.

Your coverage will start on the scheduled Eligibility 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 Certificate replaced.

Any part of Your coverage which is subject to Proof of Insurability will not start unless You send such proof to Us, and We approve it in writing. Once We have approved it, that part of Your coverage is scheduled to start on Your approved Eligibility Date.

B400.0066

All Options

Delayed Effective Date For Short Term Disability Income Coverage: If, due to Sickness or Injury, You are not Actively At Work and working the minimum required number of hours of an Employee in Your eligible class, on Your scheduled Eligibility Date for Short Term Disability, We will postpone coverage for any condition(s) that prevent you from meeting the Active Work requirement. We will postpone such coverage until You complete one full day of Active Work working Your regular number of hours, with the capacity to do so for one full week, and without missing a work day due to the same condition(s). Coverage for an otherwise covered loss due to all other conditions will start on the date You return to Active Work working the minimum required number of hours of Your eligible class and performing the regular duties of Your job.

B400.0067

When Coverage Ends

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

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

You may have the right to continue certain group benefits for a limited time after Your coverage would otherwise end. Read this Certificate carefully for details and discuss with your Employer or administrator. Any provisions that allow continuation of such group benefits must be offered and administered on a fair and equitable basis.

B400.3087

CONTINUATION OF COVERAGE

Coverage During Disability

You may be Disabled when Your Active Full-Time Work ends due to a non-job related Injury or Sickness for which benefits are not payable. In that case, Your coverage will remain in force during the:

- Elimination Period, subject to payment of required premiums; and
- The period of time for which benefits are payable by this Certificate.

But, in order for Your coverage to continue, the Disability:

- Must be covered by this Certificate;
- And benefits must not be excluded due to this Certificate's Pre-Existing Conditions provision, or any other exclusion.

If You're Disabled when Your Active Full-Time Work ends due to a job-related Injury or Sickness for which benefits are not payable, Your coverage will remain in force until the earlier of the date:

- You are terminated from employment with the Employer; or
- You have been Disabled for 6 Months.

B440.0065

SHORT TERM DISABILITY INCOME COVERAGE

This coverage replaces part of Your income if You become Disabled due to a covered Sickness or Injury. What We pay is governed by all the terms of this Policy. This Certificate includes the Short Term Disability Schedule of Benefits. Your class and benefit options are shown in the Schedule of Benefits that applies to You.

Terms with special meanings are defined, and are capitalized. See the Definitions section of this Certificate. Other terms with special meanings are defined where they are used.

Benefit Provisions

How Payments Start: To start getting payments from this Certificate, You must meet all of the conditions listed below and elsewhere in this Certificate.

- You must:
  - Become Disabled while covered by this Certificate; and
  - Remain Disabled and covered for this Certificate's Elimination Period.
- You must provide Proof of Loss, as described in Claim Provisions.

Benefits accrue as of the first day after the end of the Elimination Period, subject to all Certificate terms.

You can satisfy the Elimination Period while working, provided You are Disabled.

Waiver Of Premium: We waive Your premiums for this coverage while You are entitled to receive a Weekly Benefit payment from this Certificate.

When Payments End: Your benefits from this Certificate will end on the earliest of the dates shown below:

- The date You are no longer Disabled.
- The date You fail to provide Proof of Loss as required by this Certificate.
- The date You earn, or are able to earn, the maximum earnings allowed while Disabled under this Certificate.
- The date You are able to perform the major duties of Your Own Job on a Full-Time basis with Reasonable Accommodation.
- The date You die.
- The end of the Maximum Payment Period.
- The date no further benefits are payable under any provision in this Certificate that limits the Maximum Payment Period.

- The date You are no longer receiving Regular and Appropriate Care from a Doctor.
- The date payments end in accordance with a Rehabilitation Agreement.
- The date You refuse to take part in a Rehabilitation Program.

B400.0127

All Options

Maximum Payment Period: The Maximum Payment Period is shown in the Schedule Of Benefits. But, it may be less than that shown due to:

- The date You were first treated for the cause of Your Disability; and
- The length of time You have been covered by this Certificate. See Pre-Existing Conditions.

Benefits payable during the Maximum Payment Period will not be affected by the termination of the Certificate, subject to all the terms and conditions of the Certificate that were in effect on the first date of Your Disability. Any change to the Certificate with an Effective Date after the first date of Your Disability will not apply to benefits payable during the Maximum Payment Period.

B400.0144

All Options

Recurring Disability: Benefits from this Certificate end if You cease to be Disabled. But, a later Disability may be treated as a Recurring Disability, if all of the conditions listed below are met:

- You must return to Active Work right after Your benefits end.
- The Disability must recur less than two weeks after You were last entitled to benefits.
- The later Disability must be due to the same or related cause of Your earlier Disability.
- This Certificate must not end during Your return to Active Work.
- You must not become covered under any other similar group income replacement plan during the time You return to Active Work.
- When You return to Active Work after being disabled, You must be covered by this Certificate and all required premium must be paid.
- A subsequent Disability will not be considered a Recurring Disability if Your benefits for the prior Disability ended because Your prior Disability had been paid for the Maximum Payment Period.

If the later Disability is a Recurring Disability, You will not need to satisfy a new Elimination Period. The Recurring Disability will be subject to all the terms of this Certificate in effect on the date the earlier Disability began.

If all of the conditions listed above are not met, the later Disability will be treated as a new period of Disability. You will be required to satisfy a new Elimination Period. The new period of Disability will be subject to all the terms of this Certificate in effect on the date the new period of Disability starts.

B400.0146

Calculation of Weekly Benefit: Your benefit is governed by the terms of this Certificate in effect on the date Disability starts. Any changes to this Certificate that take place as follows are inapplicable to, and will not affect, Your benefit:

- While You are Disabled; or
- During a period of Active Work that occurs between an initial period of Disability and a Recurring Disability.

We calculate Your Gross Weekly Benefit according to the Schedule of Benefits.

From Your Gross Weekly Benefit, subtract the amount of any income listed in Other Income Benefits that You receive or are entitled to receive. The result is Your Weekly Benefit.

B400.0148

All Options

Redetermination: This Certificate redetermines Your Insured Earnings on each January 1st , the Employer must report current Insured Earnings for all Employees under this Certificate. Changes to Your Insured Earnings are subject to any Proof of Insurability requirements that may apply to this Certificate. As of this Certificate s redetermination date, We use Your Insured Earnings on record with Us to:

- Set rates;
- Project benefit amounts and limits; and
- Calculate premium payable under this Certificate.

You must be Actively at Work on a Full-Time basis on that date. If You are not, We do not do this until the date You return to Active Work on a Full-Time basis. But, changes in earnings will not apply to a Recurring Disability.

B400.0157

All Options

Other Income Benefits: You may receive, or be entitled to receive, income shown in the list below. We will reduce Your Gross Weekly Benefit by such other income benefits to determine Your Weekly Benefit from this Certificate.

- Commissions or monies received, payable but not deferred, or paid after Disability benefits start.

  This includes:

  - Vested and nonvested renewal commissions;

- Bonuses;
- Royalties; and
- Other distributions.

- Disability benefits from any mandated benefit act or law. This includes all temporary disability or state disability benefits required by law.
- Disability benefits from all group policies or plans of the Employer. This includes payments made by a group life insurance plan due to Your Disability. This does not include payments made from a group life insurance plan's:
  - Accelerated death benefit; or
  - Like provision that allows payment of such plan's proceeds due to terminal illness.
- Disability benefits from any other group policy or plan; but, if the other group plan was in force prior to this Certificate, and the other group plan also deducts for Disability benefits from any other group plan, We will not deduct these other group Disability benefits.
- Income received from partnership distributions but only to the extent that such income plus the amount of Your Gross Weekly Benefit is more than 100% of Your Insured Earnings.
- Benefits from: The United States Social Security Act; The Railroad Retirement Act; or any other like U.S. or Canadian plan or act.

  This includes:

  (a) All Disability benefits for which: (i) You are entitled; and (ii) Your Spouse and children are entitled due to Your Disability;

  (b) All unreduced retirement benefits for which: (i) You are entitled and awarded; and (ii) Your Spouse and children are entitled and awarded due to Your entitlement; and

  (c) All reduced retirement benefits paid to: (i) You; and (ii) Your Spouse and children due to Your receipt of such benefits.

  We do not reduce Your Gross Weekly Benefit by the retirement benefits described in (b) and (c) above, to the extent that You and Your dependents were entitled and awarded to receive such income prior to the start of Disability. We will reduce the Gross Weekly Benefit by marginal increases in such income You and Your dependents were entitled and awarded after Disability begins.

We will reduce Your Gross Weekly Benefit by Your dependent's benefits described in (a), (b) and (c) above if: (i) the dependent's benefits are provided to You by the Social Security Administration; (ii) at the time that the Social Security Administration makes its first payment of the dependent benefits described in (a), (b), and (c) above, the dependent child remains a minor dependent or an adult Disabled dependent; and (iii) the dependent benefits You are entitled to are greater than any dependent benefit being received by another person. Under these circumstances, We will reduce Your Gross Weekly Benefit by the difference between the amount the dependent was awarded under the prior recipient and the amount awarded the dependent under Your benefits.

We do not reduce Your Gross Weekly Benefit by the benefits to which You are entitled, as described in (a), (b), and (c) above unless such benefits are greater than any widow/widower benefit You are receiving. And then We reduce Your Gross Weekly Benefit by the difference.

- Income of the type that is included in Your Insured Earnings for purposes of determining Your Gross Weekly Benefit under this Certificate.
- That portion of Retirement Plan retirement benefits which the Employer funds.
- That portion of Retirement Plan Disability benefits which the Employer funds.
- Retirement benefits or Retirement Plan disability benefits, due to Your Disability, from any Government Plan other than those shown above.
- Payment or settlement, with or without admission of liability, from: A Workers' Compensation law; an occupational disease law; or any other act or law of like intent.

  This includes:

  - The Jones' Act;
  - The Longshoreman's and Harbor Workers' Compensation Act; or
  - Any Maritime doctrine of Maintenance, Wages or Cure.

  If You receive a payment net of attorney fees approved by the Workers' Compensation Board or similar authority, We reduce Our benefit by the net payment.
- Unemployment compensation benefits.

- Payment from Your Employer as part of a termination or severance agreement.

We reduce Your Gross Weekly Benefit with income shown above that You are entitled to receive without regard to the reason You are entitled to receive it.

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

B400.2741

All Options

Other Income Not Subject to Deduction: We will not reduce Your Gross Weekly Benefit by any income You receive or are entitled to receive from the list below.

- Deferred compensation arrangements such as 401(k), 403(b) or 457 plans;
- Profit sharing plans;
- Thrift plans;
- Tax sheltered annuities;
- Stock ownership plans;
- Individual Retirement Accounts (IRA);
- Individual disability income policies;
- Credit disability insurance;
- Non qualified plans of deferred compensation;
- Pension plans for partners;
- Retirement plans of another Employer not affiliated with this Certificate;
- Military pension and disability plans;
- Income from a sick leave, salary continuance, or paid time off plan;
- Critical Illness insurance, unless the benefit is paid out as a wage replacement benefit;
- Accident insurance, unless the benefit is paid out as a wage replacement benefit;
- Specified Disease insurance, unless the benefit is paid out as a wage replacement benefit;
- Cancer insurance, unless the benefit is paid out as a wage replacement benefit.

B400.0172

Lump Sum Payments Of Other Income: Income with which We integrate may be paid in a lump sum. In this case, We take the equivalent weekly rate stated in the award into account when We determine Your Weekly Benefit. If no weekly rate is given, We divide the lump sum payment by the number of calendar days in the period for which it was awarded. This will determine the daily rate. Then, multiply the daily rate by 7. The result is the prorated weekly rate.

Cost of Living Freeze: You may receive a cost of living increase in other income with which We integrate. In this case, We do not further reduce Your Weekly Benefit by the amount of such increase.

Application For Other Income: You must apply for other income benefits to which You may be entitled. If these benefits are denied, You must appeal until:

- All reasonable appeals have been made; or
- We notify You that no further appeals are required.

If We determine that You are entitled to receive such other income benefits, We will estimate the amount due to You and Your Spouse and children. We will take this estimated amount into account when We determine Your Weekly Benefit. But, We will not estimate the amount due to You if You and We agree in writing in an agreement provided to You by Us that You will:

- Apply for any benefits for which You may be eligible;
- Appeal any denial of such benefits until all reasonable appeals have been made; and
- Repay any amount We overpaid due to an award of such benefits.

If We do reduce Your Gross Weekly Benefit by an estimated amount, We will adjust Your Weekly Benefit when We receive written proof:

- Of the amount awarded; or
- That the other income benefits have been denied, and no further appeals are possible.

If We underpay You, We will pay the full amount of the underpayment in a lump sum.

We will assist You in applying for other income benefits.

B400.0173

All Options

Adjustment Of Weekly Benefit For Disability Earnings: We adjust the Weekly Benefit for Disability Earnings as follows:

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

Method 1:

- If your Disability Earnings are less than 20% of Your Insured Earnings, We do not reduce your Weekly Benefit.

- If your Disability Earnings are 20% or more of Your Insured Earnings, We reduce Your Weekly Benefit by 50% of Your Disability Earnings.

Method 2:

(1) Subtract Your Disability Earnings from Your Insured Earnings.

(2) Divide the result in (1) above by Your Insured Earnings.

(3) Multiply the result in (2) above by Your Weekly Benefit. This is the amount We pay.

If Your Disability Earnings fluctuate widely from week to week, We may adjust Your Weekly Benefit using an average Disability Earnings amount. The average Disability Earnings amount will be computed using Your most current week's Disability Earnings and the prior two weeks Disability Earnings.

B400.0199

All Options

Maximum Allowable Disability Earnings: This Certificate limits the amount of income You may earn, or may be able to earn, and still be considered Disabled.

If Your Disability Earnings are more than 80% of Your Insured Earnings, payments from this Certificate will end. Payments from this Certificate will also end if You are able to earn more than 80% of Your Insured Earnings.

B400.0200

All Options

Limitations And Exclusions

Pre-Existing Conditions: A pre-existing condition is an Injury or Sickness, whether diagnosed or misdiagnosed, and any symptoms of it, for which, in the "look back period", You:

- Receive advice or treatment from a Doctor;
- Underwent diagnostic procedures other than routine screening in the absence of symptoms or suspicion of disease process by a Doctor;
- Were prescribed or took prescription drugs; or
- Receive other medical care or treatment, including consultation with a Doctor.

The "look back period" is the 3 Months before the latest of:

- Your Eligibility Date for coverage under this Certificate;
- The Effective Date of a change that increases the benefits payable by this Certificate; and
- The Eligibility Date of a change in Your benefit election that increases the benefit payable by this Certificate.

For any Disability caused by, contributed to, by, or resulting from a Pre-Existing Condition, We limit the Maximum Payment Period to 2 weeks, unless the Disability starts after You complete at least one full day of Active Work after the date You have been covered under this Certificate for 12 Months in a row.

Your Disability caused by, contributed to, by, or resulting from a Pre- Existing Condition may begin after:

- A change which provides for an increase in the benefits payable by this Certificate; or
- A change in Your benefit election which increases the benefit payable by this Certificate.

In this case, Your benefit will be limited to the amount that would have been payable had the change not taken place. But, this limit does not apply if Your Disability starts after You complete at least one full day of Active Work after the date the change has been in force for 12 Months in a row.

We do not cover any Disability that starts before Your coverage under this Certificate.

B400.0206

All Options

Prior Coverage Credit: If this Certificate replaces a similar Disability income replacement plan the Employer had with another insurer, the Pre-Existing Condition provision may not apply to You, if coverage under this Certificate starts immediately after the termination of coverage under the prior Disability income replacement plan.

This Certificate must start right after the prior plan ends.

The Pre-Existing Condition provision will be waived for You if You:

- Are Actively Working on Your Eligibility Date for coverage under this Certificate; and
- Have fulfilled the requirements of any Pre-Existing Condition provision of the prior plan provided by the Employer.

You may have been covered under the prior plan when it ended, but have not met the requirements of any Pre-Existing Condition provision of the prior plan. In that case, We credit any time used to meet the prior plan's Pre-Existing Condition provision toward meeting this Certificate's Pre-Existing Condition provision. You must:

- Enroll for coverage under this Certificate on or before this Certificate's Effective Date; and
- Be Actively Working on Your Eligibility Date for coverage under this Certificate.

But, We limit Your maximum Weekly Benefit under this Certificate if:

- It is more than the maximum Weekly Benefit for which You were covered under the prior plan provided by the Employer;

- You become Disabled due to a Pre-Existing Condition; and
- This Certificate pays benefits for such Disability because We credit time as explained above.

In this case, We limit the maximum Weekly Benefit to the amount to which You would have been entitled under the prior plan.

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

B400.0207

All Options

Exclusions

This Certificate does not pay benefits for Disability caused by, or related to:

- Declared or undeclared war, act of war, or armed aggression;
- Service in the armed forces, National Guard, or military reserves of any state or country;
- Your taking part in a riot or civil disorder;
- Your commission of, or attempt to commit, a felony. A felony means either:
  - A crime as defined as such under the laws in the jurisdiction in which the crime was committed or attempted; or
  - In states where the law does not define crimes in terms of felonies and misdemeanors, felony means any crime punishable for a minimum of a one year term of incarceration in a jail or prison, as determined by the law of the jurisdiction where the crime was committed or attempted; or
  - A crime as defined as such under federal law;
- The intentional or voluntary inhalation or ingestion of gas, chemical, solvent, poison or other substances not intended for internal consumption, irrespective of any pre-existing or co-morbid condition;
- Intentional self-inflicted injuries while sane or insane;
- An Injury that occurs while, or a Sickness that develops from, performing an occupational duty except for those Employees who are not eligible to participate in Workers' Compensation, occupational disease law, or any other law of like intent; or for an Injury that occurs while, or a Sickness that develops from, performing an occupational duty while working for another employer;

This Certificate does not pay any benefits for any period of Disability:

- During which You are confined to a facility as a result of Your conviction of a crime;

- During which You are receiving medical treatment or care outside the United States or Canada unless expressly authorized by Us;
- Which starts before You are covered by this Certificate;
- After the date You have been outside the United States and/or Canada or a country or region approved by Us for more than 2 Months in a 12 Month period. If You return to the United States and/or Canada or a country or region approved by Us within 6 Months of the end of payments, payments may be resumed, provided You have remained continuously Disabled, subject to all the terms and conditions of this Certificate; or
- During which Your loss of earnings is not solely due to Your Disability.

This Certificate does not pay benefits due solely to a risk of relapse or exacerbation of a prior Injury or illness in the absence of current impairment and Disability.

B400.0208

All Options

Services

Rehabilitation And Case Management: We will review Your Disability to see if certain services are likely to help You return to Gainful Work. If needed, We may ask for more medical or vocational information.

When Our review is complete, We may offer You a Rehabilitation Program. We have the right to suspend or end Your Weekly Benefit if You do not accept it.

The Rehabilitation Program will start when a written Rehabilitation Agreement is signed by:

- You;
- Us; and
- Your Employer, if needed.

The program may include, but is not limited to:

- Vocational assessment of Your work potential;
- Coordination and transition planning with an Employer for Your return to work;
- Consulting with Your Doctor on Your return to work and need for accommodations;
- Training in job seeking skills and resume preparation; and
- Retraining.

We have the right to determine which services are appropriate.

If You accept the Rehabilitation Agreement, We will pay an enhanced benefit. The enhanced benefit will be 110% of the Weekly Benefit that would otherwise be paid. This enhanced benefit will be payable as of the first Weekly Benefit after the Rehabilitation Program starts.

We stop paying the enhanced benefit on the earliest of:

- The date Your benefits from this Certificate end;
- The date You violate the terms of the Rehabilitation Agreement;
- The date You end the Rehabilitation Program; or
- The date the Rehabilitation Agreement ends.

If You end a Rehabilitation Program without Our consent, You must repay any enhanced benefits paid.

Dependent Care Expenses: While You are participating in a Rehabilitation Program, We will pay a dependent care expense benefit, when all of the following conditions are met:

- You incur expense to provide care for a qualified dependent; and
- The care is provided by a licensed provider other than a family member by blood or marriage.

The dependent care expense benefit will be the lesser of:

- $100.00 per week per qualified dependent; not to exceed $300.00 per week for all qualified dependents combined; and
- The actual weekly day care expense incurred by You.

We will stop paying the dependent care expense benefit on the earlier of the date You are no longer:

- Incurring dependent care expenses for a qualified dependent;
- Participating in a Rehabilitation Program; or
- Entitled to receive a Weekly Benefit from this Certificate.

As used here, "qualified dependent" means a person who is:

- Dependent upon You for main support and maintenance; and
- Under the age of 14; and
- Your biological child, lawfully adopted child, stepchild or any other child who is living with You in a regular parent-child relationship.

The term also means a family member, related by blood or marriage, age 14 or over who is physically or mentally incapable of caring for him or herself and is dependent upon You for main support and maintenance.

B400.0210

Worksite Modification: In order to accommodate Your Disability, an Employer may incur a cost to modify his or her worksite. We may reimburse the Employer, up to $2,500.00 for the cost of the worksite modification. We make this payment if We agree that the modification will enable You to:

- Return to work; or
- Remain at work.

B400.0212

Authority: We have discretionary authority to:

- Interpret the terms of this Certificate; and
- Determine Your eligibility for coverage and benefits under this Certificate.

All such determinations are conclusive and binding, except that they may be modified or reversed by a court or regulatory agency with appropriate jurisdiction.

Notice: You must send Us written notice of Your intent to file a claim under this Certificate within 20 days of the date the Injury occurs or the Sickness starts. This notice should include Your name and the Policy number. For details, You can call Us at 1-800-268-2525.

Proof Of Loss: When We receive Your Notice, We will provide You with a claim form within 15 days for filing Proof of Loss. This form requires data from the Employer, You, and the Doctor(s) treating Your Sickness or Injury. Proof of Loss must be given to Us within 90 days of the loss. If You do not receive a claim form within 15 days of the date You sent Your Notice, You should send Us written Proof of Loss without waiting for the form. We will not void or reduce Your claim if You cannot send Us Notice of claim and Proof of Loss within the required time. In that case, You must send Us Notice of claim and Proof of Loss as soon as reasonably possible. However, under no circumstances will We pay benefits if written Proof of Loss is delayed for more than one year, unless your inability to provide Proof of Loss is because you are not legally competent or You lack legal capacity.

You are required to cooperate with Guardian in its evaluation of any claim for benefits. You must provide Proof of Loss at Your expense, consisting of the following listed below. Failure to provide this information may prevent, delay, suspend, reduce or terminate Your eligibility for benefits.

- The date Disability began.
- Your last day of Active Work.
- The cause of Disability.
- The extent of Disability, including limitations and restrictions preventing You from performing the major duties of Your Own Job.
- If Your occupation requires that You carry liability or malpractice insurance, information including, but not limited to: the policy, any applications for such coverage, and any changes to the terms and conditions of such policies prior to or after the first date of Disability.
- Objective Medical Evidence in support of Your limitations and restrictions, beginning with the date Disability began.

- Objective Proof of Your Restrictions and Limitations, beginning with the date Disability began.
- The prognosis of Disability.
- The name and address of all Doctors, hospitals and health care facilities where You have been treated for Your Disability since the date Disability began.
- Proof that You are currently receiving Regular and Appropriate Care from a Doctor.
- Proof that You have been receiving Regular and Appropriate Care from a Doctor, from the date Disability began.
- Proof of Insured Earnings.
- Proof of Disability Earnings.
- Payroll or absence data from the Employer for the three months prior to the date Disability began, or other period We specify.
- Proof of application for all other sources of income to which You may be entitled, that may affect Your payment from this Certificate.
- Proof of receipt of other income that may affect Your payment from this Certificate.
- Proof of identity and residency, including, but not limited to, a current government issued photo identification.
- Documentation of travel outside the United States.
- Any other information We may reasonably require to determine if You are Disabled and eligible for benefits and coverage under this Certificate.

You must provide Objective Medical Evidence from a Doctor who is not Yourself, or a relative by blood or marriage, or who is a business associate.

Proof of Insured Earnings and Disability Earnings may consist of:

- Copies of Your W-2 forms;
- Payroll records from Your Employer(s);
- Copies of Your U.S. individual income tax returns;
- Copies of the U.S. income tax returns from any business in which You hold an ownership or shareholder interest;
- A statement from a certified public accountant;
- Copies of any income records accepted or required by the IRS; or
- Any other records We deem necessary.

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

The Guardian Life Insurance Company of America
Group Short Term Disability Claims Department

P.O. Box 14331
Lexington, KY 40512.

Authorization Required: You must provide Us with written, unaltered authorizations in a form provided by Us to obtain medical, financial, vocational, occupational, and governmental information required to determine Our liability under this Certificate. We may agree to obtain such authorization by use of voice or other electronic means. You must provide Us with such authorizations as often as We may require, in order that they remain current. Failure to provide such authorizations may prevent, delay, suspend or terminate Your eligibility for benefits.

Right To Request Medical, Financial Or Vocational Assessment: We may ask You to take part in a medical, financial, vocational or other assessment that We feel is necessary to determine whether the terms of this Certificate are met.

Medical assessment may include, but not be limited to:

- Independent medical examination (IMEs),
- Functional capacity examinations (FCEs) or
- Neuropsychological evaluations.

We may require medical, financial or vocational assessment(s) as often as We feel is reasonably necessary. We will pay for all such assessments. But, if You postpone a scheduled assessment without Our approval, You will be responsible for any rescheduling fees. If You do not take part in or cooperate with the assessment, We have the right to stop or suspend Your payments under this Certificate.

Ongoing Proof Of Loss: To continue to receive payments from this Certificate, You must give Us current Proof of Loss as often as We may reasonably require. Ongoing Proof of Loss must be provided to Us within 30 days of the date We request it.

Payment Of Benefits: We pay benefits to You, if You are legally competent. If You are not, We pay benefits to your lawful guardian, conservator, legal representative, or any person or fiduciary with the lawful authority to act on Your behalf or handle Your affairs. Benefits are paid in United States currency.

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

No benefits are payable for this Certificate s Elimination Period.

Benefits to which You are entitled may remain unpaid at Your death. Such benefits may be paid at Our discretion to:

- Your estate; or
- Your Spouse, parents, children, or brothers and sisters.

Partial Week Payment: You may be Disabled for only part of a week. In this case, We compute Your payment as 1/7th of the benefit to which You would be entitled for the full week times the number of days You are Disabled.

Overpayment Recovery: If We overpaid You, You must repay Us in full. We have the right to reduce Your payment or apply any benefits payable, including the minimum payment, toward recovery of the overpayment.

Legal Actions: No legal action against Guardian related to claim for benefits under this Certificate may be brought until 60 days from the date Proof of Loss has been given as shown above. No legal action may be brought against Guardian related to claims for benefits under this Certificate after three years from the date of the final benefit determination.

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

B400.0213

DEFINITIONS

Active Work, Actively At Work or Actively Working: These terms mean You are able to perform, and are performing, all of the regular duties of Your work for the Employer, on a Full-Time basis at:

- One of the Employer's usual places of business;
- Some place where the Employer's business requires You to travel; or
- Any other place You and the Employer have agreed on for Your work.

B400.0225

All Options

Certificate: This term means this Certificate of Coverage, including the Schedule of Benefits and any riders and enrollment forms that may be attached to this Certificate.

B400.0336

All Options

Disability or Disabled: These terms mean that a current Sickness or Injury causes impairment to such a degree that You are:

- Not able to perform, on a Full-Time basis, the major duties of Your Own Job; and
- Not able to earn more than this Plan's maximum allowed Disability Earnings.

If, prior to your Disability, You are required to work more than 40 hours per week, on average, You will not be considered Disabled if You can work for 40 hours per week.

Neither loss of a professional or occupational license due to misconduct or unlawful activity, nor receipt of, or entitlement to, Social Security Disability benefits in and of themselves constitute Disability under this Certificate.

B400.0227

All Options

Disability Earnings: This term means the weekly income You earn from Working While Disabled. It includes salaries, wages, commissions, bonuses and any other compensation earned or accrued while working including pension, profit sharing contributions, sick pay, paid time off, holiday and vacation pay. When You have an ownership interest in the business, Disability Earnings also includes business profits, attributable to You, whether received or not. It includes any income You earn while Disabled and return to the Employer, partnership, or any other similar business arrangement to cover any business or overhead expenses. If You have the ability to work on a Part-Time or Full-Time basis, Disability earnings also includes Maximum Capacity Earnings beginning with the earlier of the date You have been:

- Terminated from employment with the Employer;
- Disabled for four weeks in a row; or
- Offered a job or workplace modification by the Employer and You do not return to work.

You may have held a job with an employer other than Your Employer, immediately prior to the start of Your Disability. While benefits are payable while Working While Disabled, Disability Earnings will not include earnings from a job with an employer other than Your Employer, if such job was held immediately prior to the start of Your Disability. If Working While Disabled and the income from the job with the other employer exceeds Your average amount of earnings for that other employer for the six months immediately prior to the start of Your Disability, We will include such excess as Disability Earnings.

B400.0234

All Options

Doctor: Any medical practitioner We are required by law to recognize. He or she must:

- Be properly licensed or certified by the laws of the state where he or she practices; and
- Provide services that are within the lawful scope of his or her practice.

B400.0235

All Options

Effective Date: The date the Policy goes into force and effect as stated on the cover page of the Certificate of Coverage, or any change to the Policy as requested by the Policyholder and approved by Us and in force and effect as stated on cover page of the Certificate of Coverage.

B400.0236

All Options

Eligibility Date: This term means the earliest date You are eligible for coverage under this Certificate, and you have satisfied all requirements for coverage to begin, as required by this Certificate.

- For an Employee in Active Work who has completed any waiting period required by the Employer as of the Effective Date of this Certificate, the Eligibility Date will be the Effective Date of this Certificate.
- For an Employee in Active Work as of the Effective Date of this Certificate who has not completed any waiting period required by the Employer, the Eligibility Date will be the first date following the completion of the required waiting period.
- For an Employee hired on or after the Effective Date of this Certificate, the Eligibility Date will be the later of the Employee's date of hire, or the first date following the completion of any waiting period required by the Employer.
- If this Certificate requires Employees to elect coverage under this Certificate, the Eligibility Date will be the later of:
  - The Employee's date of hire;
  - The first date following the completion of any waiting period required by the Employer; or
  - The date We approve in writing Your application for any coverage for which You are required to supply Proof of Insurability.

B400.0238

All Options

Elimination Period: This term means the period of time, as shown in the Schedule of Benefits, You must be Disabled, due to a covered Disability, before this Certificate's benefits are payable.

Any days during which You return to work earning more than 80% of Your Insured Earnings will not count toward the Elimination Period, but You will continue to accumulate days of Disability for days for which You return to work earning less than 80% during the Elimination Period as long You meet the definition of Disability each Week during the Elimination Period. If You are or become eligible under any other similar group income replacement plan while You are working during the Elimination Period, You will not be entitled to benefits from this Certificate.

We do not require You to complete an Elimination Period if:

- You were covered under a similar income replacement plan the Employer had with another carrier on the day before this Certificate starts; and
- Your Disability would have been a Recurring Disability under the prior plan had it remained in effect.

B400.0239

All Options

Employee: This term means a person who works for the Employer at the Employer's place of business and whose income is reported to the United States Internal Revenue Service, and/or a state for tax purposes. Partners and proprietors will also be treated as Employees if the Conditions of Eligibility requirements are met.

B400.0241

All Options

Employer: This term means THE EVERGREENE COMPANIES

B400.0243

All Options

Full-Time: This term means:

You are not a Part-time Employee as defined by Your Employer and the average number of hours You worked for the six Months prior to the last full day worked was at least 30 hours per week at:

- Your Employer's place of business;
- Some place where the Employer's business requires You to travel; or
- Any other place You and Your Employer have agreed upon for the performance of Your job.

B400.0244

All Options

Gainful Occupation or **Gainful Work:** These terms mean work for which You are, or may become, qualified by:

- Training;
- Education; or
- Experience.

When You are able to perform such work, You can be expected to earn at least 80% of Your Insured Earnings, within 12 months of returning to work.

B400.0245

All Options

Government Plan: This term means any of the following:

- The United States Social Security Act;
- The Railroad Retirement Act;
- The Canadian Pension Plan; or
- Any other plan provided under the laws of a state, province or any other political subdivision.

It also includes:

- Any public employee Retirement Plan; or
- Any plan provided in place of the above named plan or acts.

It does not include:

- Any Workers' Compensation Act or similar law;
- The Jones' Act;
- The Longshoreman's and Harbor Workers' Compensation Act; or
- The Maritime Doctrine of Maintenance, Wages, or Cure.

B400.0246

All Options

Gross Weekly Benefit: This term means this Certificate's Weekly Benefit before it is integrated with other income and earnings.

B400.0247

All Options

Injury: This term means a bodily Injury due to an accident that occurs while You are covered by this Certificate. Subject to all other requirements, We will cover a Disability caused by an Injury when the Disability starts within 90 days of the date of such Injury.

B400.0248

All Options

Insured Earnings: Only Your earnings from the Employer will be included as Insured Earnings.

We calculate benefit amounts and limits based on the amount of Your Insured Earnings as of the Redetermination date immediately prior to the start of Your Disability. See the Redetermination section of this Certificate.

B400.0250

All Options

- **For Partners And S Corporation Shareholders:** Insured Earnings means the sum of the amounts listed below, divided by 104.
  - Your compensation as an Employee or S Corporation shareholder, or guaranteed payments as a Partner, as reported on Your Federal Income Tax Return(s), Form 1040, for the prior two calendar years, less the gross total of unadjusted Employee business expenses as included on the corresponding Schedule A-Itemized Deductions.
  - Your non-passive income (loss) from trade of business as reported on Schedule E - Part II of Your Federal Income Tax Return(s), Form 1040, for the prior two calendar years, less any expenses incurred and reported elsewhere on Your Return; and

- Your contributions during the prior calendar years, deposited into a:
    - Cash or deferred compensation plan, or salary reduction plan, qualified under IRC section 401(k), 403(b), 457 or similar plan; and
    - Elective Employee pre-tax deferrals to a Section 125 plan or flexible spending account.

  You may not have been a partner or S Corporation shareholder for the full prior two calendar years. In that case, Your earnings are based on the weekly average of the sum of the listed amounts averaged for the full number of weeks that You were a partner or S Corporation shareholder during that prior calendar years.

- **For Sole Proprietors:** Insured Earnings means the sum of the amounts listed below.
    - Your average weekly net profit as determined from Schedule C - Part II of Your Federal Income Tax Return(s), Form 1040 for the prior two calendar years.
    - Your average weekly contribution during the prior calendar year deposited into a:
        - Cash or deferred compensation plan, or salary reduction plan, qualified under IRC section 401(k), 403(b), 457 or similar plan; and
        - Elective Employee pre-tax deferrals to a Section 125 plan or flexible spending account.

  Weekly net profit is calculated as gross income less total expenses.

  You may not have been a sole proprietor for the prior calendar years. In that case, We calculate average weekly net profit and average weekly contributions using the full number of weeks that You were a sole proprietor during such time.

- **For Any Other Employee Whose Compensation Includes Commissions And Bonuses**: Insured Earnings means:
    - Your base weekly salary from the Employer; plus
    - The average of Your commissions and bonuses from the Employer for the previous 104 weeks, or length of employment if less.

  Your base weekly salary will include shift differential.

  The term also includes Your contributions deposited into a:
    - Cash or deferred compensation plan, or salary reduction plan, qualified under IRC section 401(k), 403(b), 457 or similar plan; and
    - Elective Employee pre-tax deferrals to a Section 125 plan or flexible spending account.

Earnings based on excluded income and Employer contributions deposited into such 401(k), 403(b), 457 or similar plan are not included.

The term also does not include:

- Overtime pay;
- Expense accounts;
- Stock options; and
- Any other extra compensation.

If You are paid hourly, We calculate weekly earnings based on actual hours worked or billed in the eight weeks before the start of Your Disability. We do not include pay for hours worked or billed over 40 per week.

- **For Employees Who Are Compensated On Less Than A 12 Month Basis:** Insured Earnings means Your average rate of weekly earnings determined from Your annual contract salary. If You do not have an annual contract salary, Insured Earnings means Your prior calendar year salary divided by twelve. Your annual contract or prior calendar year salary will include shift differential.

  The term also includes Your contributions deposited into a:

  - Cash or deferred compensation plan, or salary reduction plan, qualified under IRC section 401(k), 403(b), 457 or similar plan; and
  - Elective Employee pre-tax deferrals to a Section 125 plan or flexible spending account.

  Earnings based on excluded income and Employer contributions deposited into such 401(k), 403(b), 457 or similar plan are not included.

  The term also does not include:

  - Overtime pay;
  - Expense accounts;
  - Stock options; and
  - Any other extra compensation.

  If You are paid hourly, We calculate weekly earnings based on actual hours worked or billed in the eight weeks before the start of Your Disability. We do not include pay for hours worked or billed over 40 per week.

- **For Employees Whose Income Is Reported On A IRS Form 1099:** Insured Earnings means Your average rate of weekly earnings as figured from the 1099 form(s) received from the Employer for the prior calendar years. Earnings are calculated as Your earned income as reported on the 1099 form(s) minus business expenses as reported on Schedule C - Part II of Your Federal Income Tax Return(s), Form 1040. Your average rate of weekly earnings is calculated as such earnings divided by 104 or the number of weeks You worked for the Employer during such calendar year, if less than 104.

  The term also includes Your contributions deposited into a:

  - Cash or deferred compensation plan, or salary reduction plan, qualified under IRC section 401(k), 403(b), 457 or similar plan; and
  - Elective Employee pre-tax deferrals to a Section 125 plan or flexible spending account.

B400.0254

All Options

Maximum Capacity Earnings: This term means the income You could earn if working to the fullest extent to which You are able in Your Own Job. We decide the fullest extent of work You are able to do based on objective data provided by any or all of the following sources:

- Your treating Doctor;
- Impartial medical or vocational exams;
- Peer review specialists;
- Functional capacities exams; and
- Other medical and vocational specialists whose area of expertise is appropriate to Your Disability.

B400.0261

All Options

Maximum Payment Period: This term means the longest time that benefits are paid by this Certificate, subject to all terms, limitations and exclusions.

B400.0262

All Options

Month or Months or Monthly: These terms mean a consecutive 30 day period.

B400.0264

All Options

Objective Medical Evidence: This term includes, but is not Limited to:

- Diagnostic testing;
- Laboratory reports; and
- Medical records of a Doctor's exam documenting clinical signs, presence of symptoms and test results consistent with generally accepted medical standards supported by nationally recognized authorities in the health care field.

B400.0266

All Options

Objective Proof of Your Restrictions and Limitations: During the Own Job period this term means objective proof of Your inability to perform the duties of Your Own Job, and including all restrictions and limitations relating to Your inability to work.

B400.0267

All Options

Own Job: This term means Your job for the Employer. We use the job description provided by the Employer to determine the duties and requirements of Your Own Job.

B400.0268

All Options

Part-Time: This term means:

- With respect to eligibility for benefits, the ability to work and earn between 40% and 80% of Insured Earnings.

B400.0270

All Options

Policy: This term means the group Short Term Disability income coverage described in the Policy and this Certificate.

B400.0272

All Options

Reasonable Accommodation: This term means any modification or adjustment that the Employer willingly provides to:

- A job;
- An employment practice;
- A work process; or the work place.

The modification or adjustment must make it possible for a Disabled person to:

- Reach the same level of performance as a similarly situated non-disabled person; or
- Enjoy equal benefits and privileges of employment as are available to a similarly situated non-disabled person.

The modification or adjustment must not place an undue hardship on the Employer.

B400.0274

All Options

Recurring Disability: This term means a later Disability that:

- Is related to an earlier Disability for which this Certificate paid benefits; and
- Meets the conditions described in the Recurring Disability section of this Certificate.

B400.0275

All Options

Regular and Appropriate Care: This term means, with respect to Your disabling condition(s) and any other condition(s) which, if left untreated, would adversely affect Your disabling condition, You:

- Visit a Doctor as frequently as medically required, according to generally accepted medical standards, to effectively manage these conditions; and
- Are receiving the most appropriate treatment, according to generally accepted medical standards, designed to achieve maximum medical improvement in these conditions.

Treatment must be provided by a Doctor or Doctors whose specialty is most appropriate according to generally accepted medical standards for Your:

- Disability; and
- Any other conditions which left untreated would adversely affect Your disabling condition.

Generally accepted medical standards are those supported by nationally recognized authorities in the health care field including:

- The American Medical Association (AMA);
- The AMA Board of Medical Specialties;
- The Food and Drug Administration;
- The Centers for Disease Control;
- The National Cancer Institute;

- The National Institutes of Health;
- The Department of Health and Human Services; and
- Any other agency of similar repute.

B400.0276

All Options

Rehabilitation Agreement: This term means a formal agreement between:

- You;
- Us; and
- Your Employer, if needed.

It outlines the Rehabilitation Program in which You agree to take part.

B400.0277

All Options

Rehabilitation Program: This term means a program of work or job-related training for You that We approve in writing. Its aim is to restore Your wage earning abilities.

B400.0278

All Options

Retirement Plan: This term means a defined benefit or defined contribution plan funded wholly or in part by the Employer's deposits for Your benefit. The term does not include:

- Profit sharing plans;
- Thrift plans;
- Non-qualified deferred compensation plans;
- Individual retirement accounts;
- Tax sheltered annuities;
- 401(k), 403(b), 457 or similar plans; or
- Stock ownership plans.

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

B400.0282

All Options

Short Term Disability: This term means the Short Term Disability income coverage described in the Policy and this Certificate.

B400.0283

All Options

Sickness: This term means an illness or disease. Pregnancy is treated as a Sickness under this Certificate.

B400.0284

All Options

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

B400.0492

All Options

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

B400.0286

All Options

Week: This term means, during the Elimination Period, a consecutive 7 day period.

B400.0287

All Options

Weekly Benefit: This term means this Certificate's Gross Weekly Benefit reduced by other income. If You are Working While Disabled, Your Weekly Benefit will be further reduced based on the amount of Your Disability Earnings.

B400.0288

All Options

Working While Disabled: This term means You are working and earning a gross monthly income of 20% or more of Insured Earnings.

B400.0290

All Options

You or **Your:** These terms mean the covered Employee.

B400.0291

All Options

SHORT TERM DISABILITY INCOME COVERAGE SCHEDULE OF BENEFITS

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

Effective January 1, 2020 this Schedule of Benefits is attached to the Certificate. This Schedule of Benefits replaces any previously issued Schedule of Benefits.

B400.0630

All Options

Elimination Period During Disability

For Disability due to Injury . . . . . 7 days

For Disability due to Sickness . . . . . 7 days

B400.0632

All Options

Maximum Payment Period For Each Disability

For Disability due to Injury . . . . . 12 weeks

For Disability due to Sickness . . . . . 12 weeks

The Maximum Payment Period for a pre-existing condition will be limited to a maximum of 2 weeks.

B400.0636

All Options

Gross Weekly Benefit

60% of Your Insured Earnings to a maximum benefit of $1,000.00.

The benefit will be rounded to the nearest $1.00, if not already a multiple of that amount.

Note: We integrate Your Gross Weekly Benefit with certain other income You may receive. Read all of the terms of this Certificate to see:

- The other income with which We integrate; and
- How We integrate.

B400.0639

All Options

Proof of Insurability Requirements

Depending on the coverage sought, You may be required to supply proof that the person applying for coverage is insurable for the type and amount of coverage selected. This requirement is called Proof of Insurability. For purposes of this section, any person applying for coverage requiring Proof of Insurability is referred to as an "applicant."

To determine if the applicant is required to submit Proof of Insurability for the type and amount of coverage sought, please see below.

Any applicant required to submit Proof of Insurability must complete and submit to Us an acceptable Enrollment/Change form. We may also require the completion of additional forms so that we may determine whether the applicant is insurable, according to Our underwriting standards for the type and amount of insurance for which the applicant applied. To determine if the applicant is insurable, We may also need to obtain and review the applicant's:

- Health and medical history;
- Prescription history;
- Records relating to treatment;
- Diagnostic testing;
- Hospitalization and the like; and
- Records pertaining to the applicant's driving and motor vehicle history.

No coverage requiring Proof of Insurability will become effective unless and until it is approved by Us in writing. Our receipt of any premiums associated with coverage requiring Proof of Insurability does not waive or modify any requirement that must be satisfied for coverage to begin, including but not limited to the requirement that the applicant submit Proof of Insurability. In the event that any premiums are overpaid, Our only obligation is to return the amount of overpaid premiums.

The Employer, or its designee, must give Us complete and accurate information so that we may determine:

- Who is insured;
- The type and amount of coverage for which someone is insured; and
- Any other information required so that Guardian may meet its obligations under the Certificate.

We require Proof of Insurability as follows:

If You:

- Do not meet this Certificate's enrollment requirement within 30 days after You first become eligible; or
- Enroll after You previously had coverage which ended because You failed to make a required payment.

We will require Proof of Insurability. And, You will not be covered until We approve that proof in writing.

If Your active Full-Time work ends before You meet any Proof of Insurability requirements that apply, You will still have to meet those requirements if You are later re-employed by the Employer or an associated company within 30 days.

If You request to change Your plan election to a higher level of coverage, Proof of Insurability is required. You will not be covered for the higher level of coverage until We approve that proof in writing.

Any level of coverage that requires Proof of Insurability takes effect on the date We approve that proof in writing. But, You must be Actively At Work on a Full-Time basis on that date. If You are not, the new level of coverage will take effect on the date You return to Active Work on a Full- Time basis. In any case, the new level of coverage will not apply to a Recurring Disability.

B440.1017

All Options

Changes To Coverage

Changes In Coverage Amounts

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

Changes In Insurance Classification

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

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

- Make the required contribution for the new amount; and
- Furnish Proof of Insurability to Us, which We approve in writing.

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

B400.0661

CERTIFICATE AMENDATORY RIDER

This Rider is effective on the Policy Date. If this Rider is added after the Policy Date, the Rider becomes effective on its issue date.

This Rider amends the Certificate by the replacement of the following Benefit Provisions:

Other Income Benefits: You may receive, or be entitled to receive, income shown in the list below. We will reduce Your Gross Weekly Benefit by such other income benefits to determine Your Weekly Benefit from this Certificate.

- Commissions or monies received, payable but not deferred, or paid after Disability benefits start.

  This includes:

  - Vested and nonvested renewal commissions;
  - Bonuses;
  - Royalties; and
  - Other distributions.

- Disability benefits from any mandated benefit act or law. This includes all temporary disability or state disability benefits required by law.

- Disability benefits from all group policies or plans of the Employer. This includes payments made by a group life insurance plan due to Your Disability. This does not include payments made from a group life insurance plan's:

  - Accelerated death benefit; or
  - Like provision that allows payment of such plan's proceeds due to terminal illness.

- Disability benefits from any other group policy or plan; but, if the other group plan was in force prior to this Certificate, and the other group plan also deducts for Disability benefits from any other group plan, We will not deduct these other group Disability benefits.

- Income received from partnership distributions but only to the extent that such income plus the amount of Your Gross Weekly Benefit is more than 100% of Your Insured Earnings.

- Benefits from: The United States Social Security Act; The Railroad Retirement Act; or any other like U.S. or Canadian plan or act.

  This includes:

  (a) All Disability benefits for which: (i) You are entitled; and (ii) Your spouse or domestic partner and children are entitled due to Your Disability;

(b) All unreduced retirement benefits for which: (i) You are entitled and awarded; and (ii) Your spouse or domestic partner and children are entitled and awarded due to Your entitlement; and

(c) All reduced retirement benefits paid to: (i) You; and (ii) Your spouse or domestic partner and children due to Your receipt of such benefits.

We do not reduce Your Gross Weekly Benefit by the retirement benefits described in (b) and (c) above, to the extent that You and Your dependents were entitled and awarded to receive such income prior to the start of Disability. We will reduce the Gross Weekly Benefit by marginal increases in such income You and Your dependents were entitled and awarded after Disability begins.

We will reduce Your Gross Weekly Benefit by Your dependent s benefits described in (a), (b) and (c) above if: (i) the dependent s benefits are provided to You by the Social Security Administration; (ii) at the time that the Social Security Administration makes its first payment of the dependent benefits described in (a), (b), and (c) above, the dependent child remains a minor dependent or an adult Disabled dependent; and (iii) the dependent benefits You are entitled to are greater than any dependent benefit being received by another person. Under these circumstances, We will reduce Your Gross Weekly Benefit by the difference between the amount the dependent was awarded under the prior recipient and the amount awarded the dependent under Your benefits.

We do not reduce Your Gross Weekly Benefit by the benefits to which You are entitled, as described in (a), (b), and (c) above unless such benefits are greater than any widow/widower benefit You are receiving. And then We reduce Your Gross Weekly Benefit by the difference.

- Income of the type that is included in Your Insured Earnings for purposes of determining Your Gross Weekly Benefit under this Certificate.
- That portion of Retirement Plan retirement benefits which the Employer funds.
- That portion of Retirement Plan Disability benefits which the Employer funds.
- Retirement benefits or Retirement Plan disability benefits, due to Your Disability, from any Government Plan other than those shown above.
- Payment or settlement, with or without admission of liability, from: A Workers' Compensation law; an occupational disease law; or any other act or law of like intent.

  This includes:

  - The Jones' Act;
  - The Longshoreman's and Harbor Workers' Compensation Act; or

- Any Maritime doctrine of Maintenance, Wages or Cure.

If You receive a payment net of attorney fees approved by the Workers' Compensation Board or similar authority, We reduce Our benefit by the net payment.

- Unemployment compensation benefits.
- Payment from Your Employer as part of a termination or severance agreement.
- Payments from a paid leave, or a similar plan that pays for an approved leave, but only to the extent that such income plus the amount of Your Gross Weekly Benefit is more than 100% of Your Insured Earnings.

We reduce Your Gross Weekly Benefit with income shown above that You are entitled to receive without regard to the reason You are entitled to receive it.

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

B440.0454

All Options

Other Income Not Subject to Deduction: We will not reduce Your Gross Weekly Benefit by any income You receive or are entitled to receive from the list below.

- Deferred compensation arrangements such as 401(k), 403(b) or 457 plans;
- Profit sharing plans;
- Thrift plans;
- Tax sheltered annuities;
- Stock ownership plans;
- Individual Retirement Accounts (IRA);
- Individual disability income policies;
- Credit disability insurance;
- Non-qualified plans of deferred compensation;
- Pension plans for partners;
- Retirement plans of another Employer not affiliated with this Certificate;
- Military pension and disability plans;
- Income from a sick leave, salary continuance, or paid time off plan;
- Critical Illness insurance, unless the benefit is paid out as a wage replacement benefit;
- Accident insurance, unless the benefit is paid out as a wage replacement benefit;

- Specified Disease insurance, unless the benefit is paid out as a wage replacement benefit;
- Cancer insurance, unless the benefit is paid out as a wage replacement benefit.

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

The Guardian Life Insurance Company of America

Michael Prestileo, Senior Vice President

B440.0459

GC-A-STD-OI-19-VA

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

STATEMENT OF ERISA RIGHTS

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

Your group Short Term and/or Long Term Disability Income benefits may be covered by the Employee Retirement Income Security Act of 1974 (ERISA). If so, you are entitled to certain rights and protections under ERISA.

ERISA provides that all plan participants shall be entitled to:

Receive Information about Your Plan and Benefits

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

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

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

Prudent Actions by Plan Fiduciaries

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

Enforcement of Your Rights

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

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

Assistance with Questions

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

Disability Benefits Claims Procedure

If you seek benefits under the plan you should complete, execute and submit a claim form. Claim forms and instructions for filing claims may be obtained from The Guardian Life Insurance Company of America (hereinafter referenced as Guardian).

Guardian is the Claims Fiduciary with discretionary authority to interpret and construe the terms of the Policy, the Certificate, the Schedule of Benefits, and any riders, or other documents or forms that may be attached to the Certificate or the Policy, and any other plan documents. Guardian has discretionary authority to determine eligibility for benefits and coverage under those documents. Guardian has the right to secure independent professional healthcare advice and to require such other evidence as needed to decide your claim.

In addition to the basic claim procedure explained in your certificate, Guardian will also observe the procedures listed below. These procedures are the minimum requirements for benefit claims procedures of employee benefit plans covered by Title 1 of ERISA.

Definitions

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

Timing for Initial Benefit Determination

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

Guardian will provide a benefit determination not later than 45 days from the date of receipt of a claim. This period may be extended by up to 30 days if Guardian determines that an extension is necessary due to matters beyond the control of the plan, and so notifies the claimant before the end of the initial 45-day period. Such notification will include the reason for the extension and a date by which the determination will be made. If prior to the end of the 30-day period Guardian determines that an additional extension is necessary due to matters beyond the control of the plan, and so notifies the claimant, the time period for making a benefit determination may be extended for up to an additional period of up to 30 days. Such notification will include the special circumstances requiring the extension and a date by which the final determination will be made.

A notification of an extension to the time period in which a benefit determination will be made will include an explanation of the standards upon which entitlement to a benefit is based, any unresolved issues that prevent a decision of the claim, and the additional information needed to resolve those issues.

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

B997.0370

Adverse Benefit Determination

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

- The specific reason(s) for the adverse determination;
- References to the specific provisions in the Policy, Certificate, plan or other documents, on which the determination is based;
- A description of any additional material or information necessary to perfect the claim and an explanation of why such material or information is necessary;
- A description of the plan's claim review procedures which a claimant may follow to have a claim for benefits reviewed and the time limits applicable to such procedures;
- A statement disclosing any internal rule, guideline, protocol or similar criterion relied on in making the adverse benefit determination (or a statement that such information will be provided free of charge upon request); or a statement that no internal rule, guideline, protocol or similar criterion was relied upon in making the adverse benefit determination;
- If applicable, an explanation of the basis of disagreement with or not following the views presented by you, of health care professionals who treated you and vocational professionals who evaluated you;
- If applicable, an explanation of the basis for disagreeing with or not following the views of any medical or vocational expert whose advice was obtained on our behalf in connection with the adverse benefit determination, without regard to whether the advice was relied upon in making the determination;

- If applicable, an explanation of the basis for disagreeing with or not following a disability determination made by the Social Security Administration that you present to us;
- A description of the plan's review procedures and the time limits applicable to such procedures, including a statement of the claimant's right to bring a civil action under ERISA Section 502(a) following an adverse benefit determination on appeal, and;
- In the case of an adverse benefit determination based on medical necessity or experimental treatment, notice will either include an explanation of the scientific or clinical basis for the determination, or a statement that such explanation will be provided free of charge upon request.

Appeal of Adverse Benefit Determinations

If a claim is wholly or partially denied, the claimant will have up to 180 days to make an appeal. Guardian will conduct a full and fair review of an appeal which includes providing to claimants the following:

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

In reviewing an appeal, Guardian will:

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

Guardian will notify the claimant of its decision not later than 45 days after receipt of the request for review of the adverse determination. This period may be extended by an additional period of up to 45 days if Guardian determines that special circumstances require an extension of the time period for processing and so notifies the claimant before the end of the initial 45-day period.

A notification with respect to an extension will indicate the special circumstances requiring an extension of the time period for review, and the date by which the final determination will be made.

In the event Guardian denies the appeal of an adverse benefit determination, it will:

- Provide the specific reason or reasons why the appeal was denied;
- Refer to the specific provisions in the Policy, Certificate, plan, or other documents on which the benefit determination is based;
- Provide a statement that the claimant is entitled to receive, upon request and free of charge, reasonably access to, and copies of all documents, records, and other information relevant to the claimant's claim for benefits;
- Provide a statement disclosing any internal rule, guideline, protocol or similar criterion relied on in making the adverse benefit determination (or a statement that such information will be provided free of charge upon request); or a statement that no internal rule, guideline, protocol or similar criterion was relied upon in making the adverse benefit determination;
- If applicable, provide an explanation of the basis of disagreement with or not following the views presented by you, of health care professionals who treated you, and vocational professionals who evaluated you;
- If applicable, provide an explanation of the basis for disagreeing with or not following the views of any medical or vocational expert whose advice was obtained on our behalf in connection with the adverse benefit determination, without regard to whether the advice was relied upon in making the determination;
- If applicable, provide an explanation of the basis for disagreeing with or not following a disability determination made by the Social Security Administration that you present to us;
- Provide a statement describing the claimant's right to bring a civil suit under Section 502(a) of the Employee Retirement Income Security Act of 1974 which shall also describe any applicable contractual limitations period that applies the claimant's right to bring such an action, including the calendar date on which the contractual limitations period expires for the claim, and;

- In the event the adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, provide either an explanation of the scientific or clinical judgment for the determination, applying the terms of the plan to the claimant's medical circumstances, or a statement that such explanation will be provided free of charge upon request.

Alternative Dispute Options

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

In addition to any legal rights you may have under section 502(a), if you believe that we have violated ERISA's procedural requirements, you may request that we review any claimed violation(s) and we will respond to you within ten days.

B997.0371

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

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

CERTIFICATE OF COVERAGE

The Guardian
10 Hudson Yards
New York, New York 10001
(212) 598-8000

The group Long Term Disability Income Coverage described in this Certificate is attached to the group Policy effective January 1, 2020. This Certificate replaces any Certificate previously issued under this Plan or under any other plan providing similar or identical benefits issued to the planholder by Guardian. Please note that this Certificate is part of the Policy.

GROUP LONG TERM DISABILITY INCOME COVERAGE

Guardian certifies that the Employee to whom this Certificate is issued is eligible for the coverage, and in the amount described herein. In order to be eligible for coverage, the Employee must: (a) satisfy all of this Certificate's eligibility and Effective Date requirements; (b) be listed in Our and/or the Policyholder's records as a validly covered Employee under this Certificate; (c) all required premium payments must have been made by or on behalf of the Employee; and (d) satisfy any necessary Proof of Insurability requirements.
The Employee is not covered by any part of this Plan for which he or she has waived coverage. Such a waiver of coverage is shown in Our and/or the Policyholder's records.

Policyholder: THE EVERGREENE COMPANIES
Group Policy Number: 00571412

The Guardian Life Insurance Company of America

Michael Prestileo, Senior Vice President

B400.2548

IMPORTANT INFORMATION REGARDING YOUR INSURANCE

In the event you need to contact someone about this insurance for any reason, please contact your agent. If no agent was involved in the sale of this insurance, or if you have additional questions, you may contact the insurance company issuing this insurance at the following address and telephone number:

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

If you have been unable to contact or obtain satisfaction from the company or the agent, you may contact the Virginia State Corporation Commission's Bureau of Insurance at:

Bureau of Insurance
Tyler Building, 1300 E. Main St.
Richmond, VA 23219
Local (804) 371-9691
National Toll Free (877) 310-6560
VA only Toll Free (800) 552-7945

Written correspondence is preferable so that a record of your inquiry is maintained. When contacting your agent, company or the Bureau of Insurance, have your policy number available.

B400.2549

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All Options

GENERAL PROVISIONS

Applicable Benefits

This Certificate may include multiple benefit options and types of benefits. You will only be covered for benefits if:

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

B400.0343

All Options

Limitation of Authority

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

- Determine whether any contract, Policy or Certificate is to be issued;
- Waive or alter any contract or Policy provisions, or any of Our requirements; or
- Accept any information or representation which is not in a signed application.

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

B400.2550

All Options

Incontestability

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

No statement in any application, made by You will be used to contest the validity of Your insurance or to deny a claim for a loss incurred, or for a disability which starts, after such insurance has been in force for two years during Your lifetime.

No statement made by any person insured under the policy relating to his or her insurability or his or her insured dependents shall be used in contesting the validity of the insurance with respect to which such statement was made:

- After the insurance has been in force, prior to the contest, for a period of two years during the lifetime of the person about whom the statement was made; and
- Unless the statement is contained in a written instrument signed by him or her.

If this Certificate replaces a plan Your Employer had with another insurer, We may rescind this Certificate based on misrepresentations or omissions made by the Employer or You in a signed application for up to two years from the Effective Date of the Policy.

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

B400.2551

All Options

Examination

We have the right to have a Doctor(s) of Our choice examine the person for whom a claim is being made under this Certificate as often as We feel necessary. We will pay for all such examinations.

B400.0347

All Options

ELIGIBILITY FOR LONG TERM DISABILITY INCOME COVERAGE

Conditions Of Eligibility

You are eligible for Long Term Disability if You are:

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

B400.0349

All Options

You are **not** eligible for Long Term Disability if You are:

- A temporary or seasonal Employee.

B400.0352

All Options

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

B400.0354

All Options

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

B400.0355

All Options

The Waiting Period: If You are in an eligible class, You are eligible for Long Term Disability under this Certificate after You complete the service waiting period, if any, established by the Employer.

B400.0356

All Options

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

B400.0357

All Options

When Coverage Starts

For coverage to start, You must be fully capable of performing the major duties of Your Own Occupation for the Employer and working the minimum required number of hours of an Employee in Your eligible class at 12:01 A.M. Standard Time for Your place of residence on Your scheduled Eligibility Date. And, for coverage to start, You must meet all of the Conditions of Eligibility described above and the conditions shown below which apply to You. If You are not fully capable of performing the major duties of Your Own Occupation on Your scheduled Eligibility Date, We will postpone the start of Your coverage until You are so capable and working the minimum required number of hours of an Employee in Your eligible class for one full day, with the capacity to do so for one full week.

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

B400.0359

Exception to When Coverage Starts

Sometimes a scheduled Eligibility Date is not a regularly scheduled work day. If the scheduled Eligibility Date falls on:

- A holiday;
- A vacation day;
- A non-scheduled work day;
- A day during an approved leave of absence not due to Sickness or Injury, of 90 days or less; or
- A day during a period of absence that is less than 7 days in duration;

and if:

- You are fully capable of performing the major duties of Your Own Occupation for the Employer for the minimum number of hours of an Employee in Your eligible class at 12:01 AM Standard Time for Your place of residence on the scheduled Eligibility Date; and
- You were performing the major duties of Your Own Occupation and working the minimum number of hours of an Employee in Your eligible class on Your last regularly scheduled work day.

Your coverage will start on the scheduled Eligibility 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, layoff or absence and such coverage or part of coverage was not previously in force for You under a prior plan which this Certificate replaced.

Any part of Your coverage which is subject to Proof of Insurability will not start unless You send such proof to Us, and We approve it in writing. Once We have approved it, that part of Your coverage is scheduled to start on Your approved Eligibility Date.

B400.0364

All Options

Delayed Eligibility Date For Long Term Disability Income Coverage: If due to Sickness or Injury, You are not Actively At Work and working the minimum required number of hours of an Employee in Your eligible class, on Your scheduled Eligibility Date for Long Term Disability, We will postpone coverage for an otherwise covered loss for any condition(s) that prevent you from meeting the Active Work requirement. We will postpone such coverage until You complete one full day of Active Work, working the minimum required number of hours of an eligible class, with the capacity to do so for one full week without missing a work day due to the same condition(s). Coverage for an otherwise covered loss due to all other conditions will start on the date You return to Active Work working the minimum required number of hours of Your eligible class and performing the regular duties of Your Occupation.

B400.0365

All Options

When Coverage Ends

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

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

You may have the right to continue certain group benefits for a limited time after Your coverage would otherwise end. Read this Certificate carefully for details and discuss with your Employer or administrator. Any provisions that allow continuation of such group benefits must be offered and administered on a fair and equitable basis.

B400.2556

CONTINUATION OF COVERAGE

Coverage During Disability

You may be Disabled when Your Active Full-Time Work ends In that case, Your coverage will remain in force during the:

- Elimination Period, subject to payment of required premiums; and
- The period of time for which benefits are payable by this Certificate.

But, in order for Your coverage to continue, the Disability:

- Must be covered by this Certificate;
- And benefits must not be excluded due to this Certificate's Pre-Existing Conditions provision, or any other exclusion.

If You're Disabled when Your Active Full-Time Work ends due to a job-related Injury or Sickness for which benefits are not payable Your coverage will remain in force until the earlier of the date:

- You are terminated from employment with the Employer; or
- You have been Disabled for 6 Months.

B400.0378

LONG TERM DISABILITY INCOME COVERAGE

This coverage replaces part of Your income if You become Disabled due to a covered Sickness or Injury. What We pay is governed by all the terms of this Policy.

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

Terms with special meanings are defined, and are capitalized. See the definitions section of this Certificate. Other terms with special meanings are defined where they are used.

Benefit Provisions

How Payments Start: To start getting payments from this Certificate, You must meet all of the conditions listed below and elsewhere in this Certificate.

- You must:
  - Become Disabled while covered by this Plan; and
  - Remain Disabled and covered for this Plan's Elimination Period.
- You must provide Proof of Loss, as described in Claim Provisions.

Benefits accrue as of the first day after the end of the Elimination Period, subject to all Certificate terms.

You can satisfy the Elimination Period while working, provided You are Disabled.

Waiver Of Premium: We waive Your premiums for this coverage and for short term disability income coverage while You are entitled to receive a Monthly Benefit payment from this Certificate.

When Payments End: Your benefits from this Certificate will end on the earliest of the dates shown below:

- The date You are no longer Disabled.
- The date You fail to provide Proof of Loss as required by this Certificate.
- The date You earn, or are able to earn, the maximum earnings allowed while Disabled under this Certificate.
- The date You are able to perform the major duties of Your Own Occupation on a Full-Time basis with Reasonable Accommodation.
- After the Own Occupation period, the date You are able to perform the major duties of any Gainful Work on a Full-Time basis with Reasonable Accommodation.

- The date You die.
- The end of the Maximum Payment Period.
- The date no further benefits are payable under any provision in this Certificate that limits the Maximum Payment Period.
- The date You are no longer receiving Regular and Appropriate Care from a Doctor.
- The date payments end in accordance with a Rehabilitation Agreement.
- The date You refuse to take part in a Rehabilitation Program.

B400.0402

All Options

Maximum Payment Period: The Maximum Payment Period is shown in the Schedule Of Benefits. But, it may be less than that shown due to:

- The nature of Your Disability;
- The date You were first treated for the cause of Your Disability; and
- The length of time You have been covered by this Certificate.

See Disabilities With A Limited Maximum Payment Period and Pre-Existing Conditions.

Benefits payable during the Maximum Payment Period will not be affected by the termination of the Certificate, subject to all the terms and conditions of the Certificate that were in effect on the first date of Your Disability. Any change to the Certificate with an Effective Date after the first date of Your Disability will not apply to benefits payable during the Maximum Payment Period.

B400.0446

All Options

Recurring Disability: Benefits from this Certificate end if You cease to be Disabled. But, a later Disability may be treated as a Recurring Disability, if all of the conditions listed below are met:

- You must return to Active Work right after Your benefits end.
- The Disability recurs less than six Months after You were last entitled to benefits.
- The later Disability must be due to the same or related cause of Your earlier Disability.
- This Certificate must not end during Your return to Active Work.
- You must not become covered under any other similar group income replacement plan during the time You return to Active Work.

- When You return to Active Work after being Disabled, You must be covered by this Certificate and all required premium must be paid.
- A subsequent Disability will not be considered a Recurrent Disability if Your benefits for the prior Disability ended because Your prior Disability had been paid for the Maximum Payment Period.

If the later Disability is a Recurring Disability, You will not need to satisfy a new Elimination Period. The Recurring Disability will be subject to all the terms of this Certificate in effect on the date the earlier Disability began.

If all of the conditions listed above are not met, the later Disability will be treated as a new period of Disability. You will be required to satisfy a new Elimination Period. The new period of Disability will be subject to all the terms of this Certificate in effect on the date the new period of Disability starts.

B400.0453

All Options

Calculation of Monthly Benefit: Your benefit is governed by the terms of this Certificate in effect on the date Disability starts. Any changes to this Certificate that take place as follows are inapplicable to, and will not affect, Your benefit:

- While You are Disabled; or
- During a period of Active Work that occurs between an initial period of Disability and a Recurring Disability.

We calculate Your Gross Monthly Benefit according to the Schedule of Benefits.

From Your Gross Monthly Benefit, subtract the amount of any income listed in Other Income Benefits that You receive or are entitled to receive. The result is Your Monthly Benefit.

B400.0455

All Options

Redetermination: This Certificate redetermines Your Insured Earnings on each January 1st , the Employer must report current Insured Earnings for all Employees under this Certificate. Changes to Your Insured Earnings are subject to any Proof of Insurability requirements that may apply to this Certificate. As of this Certificate's redetermination date, We use Your Insured Earnings on record with Us to:

- set rates;

- project benefit amounts and limits; and
- calculate premium payable under this Certificate.

You must be actively-at-work on a Full-Time basis on that date. If You are not, We do not do this until the date You return to Active Work on a Full-Time basis. But, changes in earnings will not apply to a Recurring Disability.

B400.0474

All Options

Other Income Benefits: You may receive, or be entitled to receive, income shown in the list below.

We will reduce Your Gross Monthly Benefit by such other income benefits to determine Your Monthly Benefit from this Certificate.

- Commissions or monies received, payable but deferred, or paid after Disability benefits start.

  This includes:

  - Vested and nonvested renewal commissions;
  - Bonuses;
  - Royalties; and
  - Other distributions.

- Disability benefits from any mandated benefit act or law. This includes all temporary disability or state disability benefits required by law.
- Disability benefits from all group policies or plans of the Employer. This includes payments made by a group life insurance plan due to Your Disability. This does not include payments made from a group life insurance plan's:
  - Accelerated death benefit; or
  - Like provision that allows payment of such plan's proceeds due to terminal illness.
- Disability benefits from any other group policy or plan; but, if the other group plan was in force prior to this Certificate, and the other group plan also deducts for disability benefits from any other group plan, We will not deduct these other group disability benefits.
- Income from sick leave, salary continuance or paid time off, exclusive of vacation time accrued prior to Disability, but only to the extent that such income plus the amount of Your Gross Monthly Benefit is more than 100% of Your Indexed Insured Earnings. This applies whether such benefits are sponsored on a formal or informal basis. This includes:
  - Donated;
  - Lump sum; and

- Recurrent payments of accrued sick leave benefits.

  But, if You are working while Disabled, We will account for such income as described in Adjustment of Monthly Benefit for Disability Earnings.

- Income received from partnership distributions but only to the extent that such income plus the amount of Your Gross Monthly Benefit is more than 100% of Your Indexed Insured Earnings.

- Benefits from: The United States Social Security Act; The Railroad Retirement Act; or any other like U.S. or Canadian plan or act.

  This includes:

  (a) All disability benefits for which: (i) You are entitled; and (ii) Your spouse and children are entitled due to Your Disability;

  (b) All unreduced retirement benefits for which: (i) You are entitled and awarded; and (ii) Your spouse and children are entitled and awarded due to Your entitlement; and

  (c) All reduced retirement benefits paid to: (i) You; and (ii) Your spouse and children due to Your receipt of such benefits.

  We do not reduce Your Gross Monthly Benefit by the retirement benefits described in (b) and (c) above, to the extent that You and Your dependents were entitled and awarded such income prior to the start of Disability. We will reduce the Gross Monthly Benefit by marginal increases in such income You and Your dependents were entitled and awarded after Disability begins.

  We will reduce Your Gross Monthly Benefit by Your dependents' benefits described in (a), (b) and (c) above if: (i) the dependents' benefits are provided to You by the Social Security Administration; (ii) at the time that the Social Security Administration makes its first payment of the dependent benefits described in (a), (b), and (c) above, the dependent child remains a minor dependent or an adult Disabled dependent, and (iii) the dependent benefits You are entitled to are greater than any dependent benefit being received by another person. Under these circumstances, We will reduce Your Gross Monthly Benefit by the difference between the amount the dependent was awarded under the prior recipient and the amount awarded the dependent under Your benefits.

  We do not reduce Your Gross Monthly Benefit by the benefits to which You are entitled, as described in (a), (b), and (c) above unless such benefits are greater than any widow/widower benefit You are receiving. And then We reduce Your Gross Monthly Benefit by the difference.

- Income of the type that is included in Your Insured Earnings for purposes of determining Your Gross Monthly Benefit under this Certificate.

- That portion of Retirement Plan retirement benefits which the Employer funds.

- That portion of Retirement Plan disability benefits which the Employer funds.

- Retirement benefits or Retirement Plan disability benefits, due to Your Disability, from any Government Plan other than those shown above.
- Payment or settlement, with or without admission of liability, from: A Workers' Compensation law; an occupational disease law; or any other act or law of like intent.

  This includes:

  - The Jones' Act;
  - The Longshoreman's and Harbor Workers' Compensation Act; or
  - Any Maritime doctrine of Maintenance, Wages or Cure.

  If You receive a payment net of attorney fees approved by the Workers' Compensation Board or similar authority, We reduce Our benefit by the net payment.
- Unemployment compensation benefits.
- Payment from Your Employer as part of a termination or severance agreement.

We reduce Your Gross Monthly Benefit with income shown above that You are entitled to receive without regard to the reason You are entitled to receive it.

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

B400.2557

All Options

Other Income Not Subject To Deduction: We will not reduce Your Gross Monthly Benefit by any income You receive or are entitled to receive from the list below.

- Deferred compensation arrangements such as 401(k), 403(b) or 457 plans;
- Profit sharing plans;
- Thrift plans;
- Tax sheltered annuities;
- Stock ownership plans;
- Individual Retirement Accounts (IRA);
- Individual disability income policies;
- Credit disability insurance;
- Non qualified plans of deferred compensation;
- Pension plans for partners;

- Retirement plans of another Employer not affiliated with this Certificate;
- Military pension and disability plans;
- Critical Illness insurance, unless the benefit is paid out as a wage replacement benefit;
- Accident Insurance, unless the benefit is paid out as a wage replacement benefit;
- Specified Disease insurance, unless the benefit is paid out as a wage replacement benefit;
- Cancer insurance, unless the benefit is paid out as a wage replacement benefit.

B400.0484

All Options

Lump Sum Payments of Other Income: Income with which We integrate may be paid in a lump sum. In this case, We take the equivalent Monthly rate stated in the award into account when We determine Your Monthly Benefit.

If no Monthly rate is given, We pro-rate the lump sum over the lesser of:

- 60 months; or
- The expected remaining number of Months for which You would be entitled to benefits from this Certificate based on the proof of loss submitted to Us.

B400.0486

All Options

Cost of Living Freeze: You may receive a cost of living increase in other income with which We integrate. In this case, We do not further reduce Your Monthly Benefit by the amount of such increase.

B400.0487

All Options

Application For Other Income: You must apply for other income benefits to which You may be entitled. If these benefits are denied, You must appeal until:

- All reasonable appeals have been made; or
- We notify You that no further appeals are required.

If We determine that You are entitled to receive such other income benefits, We will estimate the amount due to You and Your spouse and children. We will take this estimated amount into account when We determine Your Monthly Benefit.

But, We will not estimate the amount due to You if You and We agree in writing in an agreement provided to You by Us that You will:

- Apply for any benefits for which You may be eligible;
- Appeal any denial of such benefits until all reasonable appeals have been made; and
- Repay any amount We overpaid due to an award of such benefits.

If We do reduce Your Gross Monthly Benefit by an estimated amount, We will adjust Your Monthly Benefit when We receive written proof:

- Of the amount awarded; or
- That the other income benefits have been denied; and no further appeals are possible.

If We underpay You, We will pay the full amount of the underpayment in a lump sum.

We will assist You in applying for other income benefits.

B400.0488

All Options

Adjustment of Monthly Benefit For Disability Earnings: We adjust the Monthly Benefit for Disability Earnings as follows:

For each of the first 12 Months after the date You first have Disability Earnings, add Your Gross Monthly Benefit and Your Disability Earnings.

- If the sum is not more than 100% of Your Indexed Insured Earnings, We do not reduce Your Monthly Benefit.
- If the sum is more than 100% of Your Indexed Insured Earnings, We reduce Your Monthly Benefit by the amount over 100% of Your Indexed Insured Earnings.

For each Month after that, We pay the greater of the amount calculated under Method 1 or Method 2.

Method 1:

- If Your Disability Earnings are less than 20% of Your Indexed Insured Earnings, We do not reduce Your Monthly Benefit.
- If Your Disability Earnings are 20% or more of Your Indexed Insured Earnings, We reduce Your Monthly Benefit by 50% of Your Disability Earnings.

Method 2:

(1) Subtract Your Disability Earnings from Your Indexed Insured Earnings.

(2) Divide the result in (1) above by Your Indexed Insured Earnings.

(3) Multiply the result in (2) above by Your Monthly Benefit. This is the amount We pay.

If Your Disability Earnings fluctuate widely from Month to Month, We may adjust Your Monthly Benefit using an average Disability Earnings amount. The average Disability Earnings amount will be computed using Your most current Month's Disability Earnings and the prior two Months Disability Earnings.

B400.0491

All Options

Maximum Allowable Disability Earnings: This Certificate limits the amount of income You may earn, or may be able to earn, and still be considered Disabled.

If Your Disability Earnings are more than the limit shown below, payments from this Certificate will end. Payments from this Certificate will also end if You are able to earn more than the limit shown below:

- During the Own Occupation period, the limit is 80% of Your Indexed Insured Earnings.
- After this Certificate has paid benefits for 24 Months in a row, the limit is 80% of Your Indexed Insured Earnings if You are Working While Disabled, or 60% of Your Indexed Insured Earnings if You are not Working While Disabled.

B400.0495

All Options

Indexing: We apply an indexing factor to Your Insured Earnings on the date You have received 12 Monthly payments in a row and each anniversary after that. This factor increases the amount of income You may earn and still be considered Disabled. This adjustment does not increase Your Gross Monthly Benefit, Monthly Benefit, or any other benefit under this Certificate.

To make the first adjustment, We multiply Your Insured Earnings by the indexing factor for that year. To make adjustments in each later year, We multiply the amount of Your last indexed Insured Earnings by the indexing factor.

The indexing factor is the lesser of:

- 10%; or
- One-half of the average CPI-W from the prior calendar year.

B400.0497

All Options

Minimum Payment: The minimum Monthly payment for Disability under this Certificate is the larger of: (1) 10% of Your Gross Monthly Benefit; or (b) $100.00.

B400.0503

Limitations And Exclusions

Disabilities With A Limited Maximum Payment Period: We limit the Maximum Payment Period, if You are Disabled due to: a Mental Illness; drug or alcohol abuse. If You have a coexistent condition(s), which is not subject to the limits in this section, and constitutes a Disability in and of itself, We will not limit benefits as described below.

The Maximum Payment Period for all periods of Disability due to: a Mental Illness; drug or alcohol abuse; is 24 Months. This is a combined lifetime maximum for all such conditions and all periods of Disability.

No benefits will be paid for Disability due to a Mental Illness or drug or alcohol abuse if You are not receiving treatment for the cause of the Disability from a provider, or a facility that is:

- Licensed by the state to provide treatment for such condition; and
- Accredited or approved by the Joint Commission on the Accreditation of Health Care Facilities or Medicare.

If payments under this Certificate would otherwise end due to the limits in this section, We may extend such payments if You meet all of the following conditions:

- You must be Disabled due to a condition named above;
- You must be an inpatient in a qualified institution because of Your Disability; and
- You must have been treated as an inpatient for at least 14 days in a row.

In such case, We will extend payments, if You are Disabled and otherwise remain entitled to payments under the Certificate, until the earliest of:

- 90 days from the date of Your discharge, following the date benefits would otherwise have ended;
- The end of this Certificate's Maximum Payment Period; or
- The date Your Disability ends.

As used here, "qualified institution" means a legally operated hospital or other public or private facility licensed to provide inpatient medical care and treatment for the cause of Your Disability.

B400.0512

Pre-Existing Conditions: A Pre-Existing Condition is an Injury or Sickness, whether diagnosed or misdiagnosed, and any symptoms of it, for which, in the "look back period", You:

- Receive advice or treatment from a Doctor;

- Underwent diagnostic procedures other than routine screening in the absence of symptoms or suspicion of disease process by a Doctor;
- Were prescribed or took prescription drugs; or
- Received other medical care or treatment, including consulting with a Doctor.

The "look back period" is the three Months before the latest of:

- Your Eligibility Date for coverage under this Certificate;
- The Effective Date of a change that increases the benefits payable by this Certificate; or
- The Eligibility Date of a change in Your benefit election that increases the benefit payable by this Certificate.

No benefits are payable for Disability caused by, contributed to, by, or resulting from a Pre-Existing Condition; unless the Disability starts after You complete at least one full day of Active Work after the date You have been covered under this Certificate for 12 Months in a row.

Your Disability caused by, contributed to by or resulting from; a Pre- Existing Condition may begin after:

- A change which provides for an increase in the benefits payable by this Certificate; or
- A change in Your benefit election which increases the benefit payable by this Certificate.

In this case, Your benefit will be limited to the amount that would have been payable had the change not taken place. But, this limit does not apply if Your Disability starts after You complete at least one full day of Active Work after the date the change has been in force for 12 Months in a row.

We do not cover any Disability that starts before Your Eligibility Date for coverage under this Certificate.

B400.0518

All Options

Prior Coverage Credit: If this Certificate replaces a similar disability income replacement plan the Employer had with another insurer, the Pre-Existing Condition provision may not apply to You, if coverage under this Certificate starts immediately after the termination of coverage under the prior disability income replacement plan. This Certificate must start right after the prior plan ends.

The Pre-Existing Condition provision will be waived for You if You:

- Are Actively Working on the Your Eligibility Date for coverage under this Certificate; and
- Have fulfilled the requirements of any Pre-Existing Condition provision of the prior plan provided by the Employer.

You may have been covered under the prior plan when it ended, but have not met the requirements of any Pre-Existing Condition provision of the prior plan. In that case, We credit any time used to meet the prior plan's Pre-Existing Condition provision toward meeting this Certificate's Pre-Existing Conditions provision. You must:

- Enroll for coverage under this Certificate on or before this Certificate's Effective Date; and
- Be Actively Working on Your Eligibility Date for coverage under this Certificate.

But, We limit Your maximum Monthly Benefit under this Certificate if:

- It is more than the maximum Monthly Benefit for which You were covered under the prior plan provided by the Employer;
- You become Disabled due to a Pre-Existing Condition; and
- This Certificate pays benefits for such Disability because We credit time as explained above.

In this case, We limit the maximum Monthly Benefit to the amount to which You would have been entitled under the prior plan.

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

B400.0520

All Options

Exclusions: This Certificate does not pay benefits for Disability caused by, or related to:

- Declared or undeclared war, act of war, or armed aggression;
- Service in the armed forces, National Guard, or military reserves of any state or country;
- Your taking part in a riot or civil disorder;
- Your commission of, or attempt to commit a felony. A felony means either:
  - A crime as defined as such under the laws in the jurisdiction in which the crime was committed or attempted; or
  - In states where the law does not define crimes in terms of felonies and misdemeanors, felony means any crime punishable for a minimum of one year term of incarceration in a jail or prison, as determined by the law of the jurisdiction where the crime was committed or attempted; or
  - A crime as defined as such under federal law;
- The intentional or voluntary inhalation or ingestion of gas, chemical, solvent, poison or other substances not intended for internal consumption, irrespective of any pre-existing or co-morbid condition;

- Intentional self-inflicted injuries while sane or insane;

This Certificate does not pay any benefits for any period of Disability:

- During which You are confined to a jail, prison or other facility as a result of Your conviction of a crime;
- During which You are receiving medical treatment or care outside the United States or Canada unless expressly authorized by Us;
- Which starts before You are covered by this Certificate;
- After the date You have been outside the United States and/or Canada and/or a country or region approved by Us for more than 2 Months in a 12 Month period. If You return to the United States and/or a country or region approved by Us within 6 Months of the end of payments, payments may be resumed, provided You have remained continuously Disabled, subject to all the terms and conditions of this Certificate; or
- During which Your loss of earnings is not solely due to Your Disability.

This Certificate does not pay benefits due solely to a risk of relapse or exacerbation of a prior injury or illness in the absence of a current impairment and Disability.

B400.0522

Services

Social Security Assistance: If You are Disabled, We require You to apply for Social Security benefits. See Application for Other Income. If We believe You are eligible for such benefits, We may offer to assist You in applying for them. Receiving Social Security benefits will protect Your earnings record for retirement and enable You to qualify for Medicare coverage after 24 Months.

Services We can provide include:

- Help in completing Your application for such benefits, and any related forms;
- Assistance finding suitable legal counsel; and
- Copies of medical and vocational data needed to file Your claim.

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

You must apply for all income benefits for which You may be eligible, whether or not You use Our help. Using Our help does not cancel Your duties shown in Application for Other Income.

Rehabilitation And Case Management: We will review Your Disability to see if certain services are likely to help You return to Gainful Work. If needed, We may ask for more medical or vocational information.

When Our review is complete, We may offer You a Rehabilitation Program. We have the right to suspend or end Your Monthly Benefit if You do not accept it.

The Rehabilitation Program will start when a written Rehabilitation Agreement is signed by:

- You;
- Us; and
- Your Employer, if needed.

The program may include, but is not limited to:

- Vocational assessment of Your work potential;
- Coordination and transition planning with an Employer for Your return to work;
- Consulting with Your Doctor on Your return to work and need for accommodations;
- Training in job seeking skills and resume preparation; and
- Retraining.

We have the right to determine which services are appropriate.

If You accept the Rehabilitation Agreement, We will pay an enhanced benefit. The enhanced benefit will be 110% of the Monthly Benefit that would otherwise be paid. This enhanced benefit will be payable as of the first Monthly Benefit after the Rehabilitation Program starts.

We stop paying the enhanced benefit on the earliest of:

- The date Your benefits from this Certificate end;
- The date You violate the terms of the Rehabilitation Agreement;
- The date You end the Rehabilitation Program; or
- The date the Rehabilitation Agreement ends.

If You end a Rehabilitation Program without Our consent, You must repay any enhanced benefits paid.

Dependent Care Expenses: While You are participating in a Rehabilitation Program, We will pay a dependent care expense benefit, when all of the following conditions are met:

- You incur expense to provide care for a qualified dependent; and
- The care is provided by a licensed provider other than a family member by blood or marriage.

The dependent care expense benefit will be the lesser of:

- $350.00 per Month per qualified dependent; not to exceed $1,000.00 per Month for all qualified dependents combined; and
- The actual Monthly day care expense incurred by You.

We will stop paying the dependent care expense benefit on the earlier of the date You are no longer:

- Incurring dependent care expenses for a qualified dependent;
- Participating in a Rehabilitation Program; or
- Entitled to receive a Monthly Benefit from this Certificate.

As used here, "qualified dependent" means a person who is:

- Dependent upon You for main support and maintenance; and
- Under the age of 14; and
- Your biological child, lawfully adopted child, stepchild or any other child who is living with You in a regular parent-child relationship.

The term also means a family member, related by blood or marriage, age 14 or over who is physically or mentally incapable of caring for him or herself and is dependent upon You for main support and maintenance.

B400.0523

All Options

Worksite Modification: In order to accommodate Your Disability, an Employer may incur a cost to modify his or her worksite. We may reimburse the Employer, up to $2,500.00 for the cost of the worksite modification. We make this payment if We agree that the modification will enable You to:

- Return to work; or
- Remain at work.

B400.0553

All Options

Early Intervention Services: This Certificate includes early intervention services as part of Our disability management program. The intent of these services is to:

- Assist Disabled persons in achieving higher levels of functionality; and
- Support the Employer's absence management goals by promoting stay-at work and return-to work agendas where possible.

When You are Disabled from one of the conditions listed below, a Long Term Disability claim form should be completed as soon as possible following the date of Disability. To facilitate an immediate intervention, the form should be submitted to Us within one week of the date Your Disability begins.

- Chronic fatigue conditions, including Epstein-Barr syndrome.
- Mental Illness.
- Repetitive motion syndromes or injuries.
- Fibromyalgia.
- Back pain or strain.
- Neck pain or strain.
- Chronic pain.
- Diabetes.
- Cardiovascular conditions.

On receipt of the completed claim form, We will determine whether the claim is appropriate for early intervention services. You will be notified of Our decision. Examples of services, which We may provide, at Our discretion, include, but are not limited to:

- Job accommodation;
- Ergonomic adjustments to workstations; or
- Proactive case management consultations with Your Doctor or other providers of medical care.

B400.0555

Claim Provisions

Authority: We have discretionary authority to:

- Interpret the terms of this Certificate; and
- Determine Your eligibility for coverage and benefits under this Certificate.

All such determinations are conclusive and binding, except that they may be modified or reversed by a court or regulatory agency with appropriate jurisdiction.

Notice: You must send Us written notice of Your intent to file a claim under this Certificate within 20 days of the date the Injury occurs or the Sickness starts. This Notice should include Your name and the Policy number. For details, You can call Us at 1-800-538-4583.

Proof Of Loss: When We receive Your Notice, We will provide You with a claim form within 15 days for filing Proof of Loss. This form requires data from the Employer, You, and the Doctor(s) treating Your Sickness or Injury. Proof of Loss must be given to Us within 90 days of the loss. If You do not receive a claim form within 15 days of the date You sent Your Notice, You should send Us written Proof of Loss without waiting for the form. We will not void or reduce Your claim if You cannot send Us Notice of claim and Proof of Loss within the required time. In that case, You must send Us Notice of claim and Proof of Loss as soon as reasonably possible. However, under no circumstances will We pay benefits if written Proof of Loss is delayed for more than one year, unless your inability to provide Proof of Loss is because you are not legally competent or You lack legal capacity.

You are required to cooperate with Guardian in its evaluation of any claim for benefits. You must provide Proof of Loss at Your expense, consisting of the following listed below. Failure to provide this information may prevent, delay, suspend, reduce or terminate Your eligibility for benefits.

- The date Disability began.
- Your last day of Active Work.
- The cause of Disability.
- The extent of Disability, including limitations and restrictions preventing You from performing the major duties of Your Own Occupation and any Gainful Occupation.
- If Your occupation requires that You carry liability or malpractice insurance, information including, but not limited to: the policy, any applications for such coverage, and any changes to the terms and conditions of such policies prior to or after the first date of Disability.
- Objective Medical Evidence in support of Your limitations and restrictions, beginning with the date Disability began.

- Objective Proof of Your Restrictions and Limitations, beginning with the date Disability began.
- The prognosis of Disability.
- The name and address of all Doctors, hospitals and health care facilities where You have been treated for Your Disability since the date Disability began.
- Proof that You are currently receiving Regular and Appropriate Care from a Doctor.
- Proof that You have been receiving Regular and Appropriate Care from a Doctor, from the date Disability began.
- Proof of Insured Earnings.
- Proof of Disability Earnings.
- Payroll or absence data from the Employer for the three Months prior to the date Disability began, or other period We specify.
- Proof of application for all other sources of income to which You may be entitled, that may affect Your payment from this Certificate.
- Proof of receipt of other income that may affect Your payment from this Certificate.
- Proof of identity and residency, including, but not limited to, a current government issued photo identification.
- Documentation of travel outside the United States.
- Any other information We may reasonably require to determine if You are Disabled and eligible for benefits and coverage under this Certificate.

You must provide Objective Medical Evidence from a Doctor who is not Yourself, or a relative by blood or marriage, or who is a business associate.

Proof of Insured Earnings and Disability Earnings may consist of:

- Copies of Your W-2 forms;
- Payroll records from Your Employer(s);
- Copies of Your U.S. individual income tax returns;
- Copies of the U.S. income tax returns from any business in which You hold an ownership or shareholder interest;
- A statement from a certified public accountant;
- Copies of any income records accepted or required by the IRS; or
- Any other records We deem necessary.

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

The Guardian Life Insurance Company of America
Group Long Term Disability Claims Department

P.O. Box 14333
Lexington, KY 40512.

Authorization Required: You must provide Us with written, unaltered authorizations in a form provided by Us to obtain medical, financial, vocational, occupational, and governmental information required to determine Our liability under this Certificate. We may agree to obtain such authorization by use of voice or other electronic means. You must provide Us with such authorizations as often as We may require, in order that they remain current. Failure to provide such authorizations may prevent, delay, suspend or terminate Your eligibility for benefits.

Right To Request Medical, Financial Or Vocational Assessment: We may ask You to take part in a medical, financial, vocational or other assessment that We feel is necessary to determine whether the terms of this Certificate are met.

Medical assessment may include, but not be limited to:

- Independent medical examination (IMEs),
- Functional capacity examinations (FCEs) or
- Neuropsychological evaluations.

We may require medical, financial or vocational assessment(s) as often as We feel is reasonably necessary. We will pay for all such assessments. But, if You postpone a scheduled assessment without Our approval, You will be responsible for any rescheduling fees. If You do not take part in or cooperate with the assessment, We have the right to stop or suspend Your payments under this Certificate.

Ongoing Proof of Loss: To continue to receive payments from this Certificate, You must give Us current Proof of Loss as often as We may reasonably require. Ongoing Proof of Loss must be provided to Us within 30 days of the date We request it.

Payment of Benefits: We pay benefits to You, if You are legally competent. If You are not, We pay benefits to your lawful guardian, conservator, legal representative, or any person or fiduciary with the lawful authority to act on Your behalf or handle Your affairs. Benefits are paid in United States currency.

We pay benefits once each Month at the end of the period for which they are payable.

No benefits are payable for this Certificate's Elimination Period.

Benefits to which You are entitled may remain unpaid at Your death. Such benefits may be paid at Our discretion to:

- Your estate; or
- Your spouse, parents, children, or brothers and sisters.

Partial Month Payment: You may be Disabled for only part of a Month. In this case, We compute Your payment as 1/30th of the benefit to which You would be entitled for the full Month times the number of days You are Disabled. Payment will not be made for more than 30 days in any Month.

Overpayment Recovery: If We overpaid You, You must repay Us in full. We have the right to reduce Your payment or apply any benefits payable, including the minimum payment, toward recovery of the overpayment.

Legal Actions: No legal action against Guardian related to claim for benefits under this Certificate may be brought until 60 days from the date Proof of Loss has been given as shown above. No legal action may be brought against Guardian related to claims for benefits under this Certificate after three years from the date of the final benefit determination.

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

B400.0559

DEFINITIONS

This section defines certain terms appearing in Your Certificate.

Active Work or **Actively At Work** or **Actively Working:** These terms mean You are able to perform, and are performing, all of the regular duties of Your work for the Employer, on a Full-Time basis at:

- One of the Employer's usual places of business;
- Some place where the Employer's business requires You to travel; or
- Any other place You and the Employer have agreed on for Your work.

B400.0563

All Options

Certificate: This term means this Certificate of Coverage, including the Schedule of Benefits and any riders and enrollment forms that may be attached to this Certificate.

B400.0565

All Options

CPI-W: This term means that part of the United States Department of Labor Consumer Price Index that measures the relative value of the cost of a typical urban wage earner's purchase of certain goods and services. If the Department of Labor stops publishing the CPI-W, We have the right to use some other similar standard.

B400.0567

All Options

Disability or Disabled:

These terms mean that a current Sickness or Injury causes impairment to such a degree that You are:

- Not able to perform, on a Full-Time basis, the major duties of Your Own Occupation during the Elimination Period and the Own Occupation period.
- Not able to perform, on a Full-Time basis, the major duties of any Gainful Work after the end of the Own Occupation period.

You are not Disabled if You earn, or are able to earn, more than this Certificate's maximum allowed Disability Earnings.

If, prior to Your Disability, You are required to work more than 40 hours per week on average, You will not be considered Disabled if You can work for 40 hours per week.

Neither loss of a professional or occupational license due to misconduct or unlawful activity, nor receipt of, or entitlement to, Social Security disability benefits in and of themselves constitutes Disability under this Certificate.

B400.0593

All Options

Disability Earnings: This term means the Monthly income You earn from Working While Disabled. It includes salaries, wages, commissions, bonuses and any other compensation earned or accrued while working including pension, profit sharing contributions, sick pay, paid time off, holiday and vacation pay. When You have an ownership interest in the business, Disability Earnings also includes business profits, attributable to You, whether received or not. It includes any income You earn while Disabled and return to the Employer, partnership, or any other similar business arrangement to cover any business or overhead expenses. If You have the ability to work on a Part-Time or Full-Time basis, Disability Earnings also includes Maximum Capacity Earnings beginning with the earlier of the date You:

- Have been terminated from employment with the Employer;
- Have been Disabled for 12 Months in a row; or
- Have been offered a job or workplace modification by the Employer and You do not return to work.

You may have held a job with an employer other than Your Employer, immediately prior to the start of Your Disability. While benefits are payable during the Own Occupation period and Working While Disabled, Disability Earnings will not include earnings from a job with an employer other than Your Employer, if such job was held immediately prior to the start of Your Disability. If Working While Disabled and the income from the job with the other employer exceeds Your average amount of earnings for that other employer for the six months immediately prior to the start of Your Disability, We will include such excess as Disability Earnings.

B400.0605

All Options

Doctor: Any medical practitioner We are required by law to recognize. He or she must:

- Be properly licensed or certified by the laws of the state where he or she practices; and
- Provide services that are within the lawful scope of his or her practice.

B400.0606

All Options

Effective Date: The date the Certificate goes into force and effect as stated on the cover page of the Certificate of Coverage, or any change to the Policy as requested by the Policyholder and approved by Us and in force and effect as stated on cover page of the Certificate of Coverage.

B400.0607

All Options

Eligibility Date: This term means the earliest date You are eligible for coverage under this Certificate, and you have satisfied all requirements for coverage to begin, as required by this Certificate.

- For an Employee in Active Work who has completed any waiting period required by the Employer as of the Effective Date of this Certificate, the Eligibility Date means the Effective Date of this Certificate.
- For an Employee in Active Work as of the Effective Date of this Certificate who has not completed any waiting period required by the Employer, the Eligibility Date will be the first date following the completion of the required waiting period.
- For an Employee hired on or after the Effective Date of this Certificate, the Eligibility Date will be the later of the Employee's date of hire, or the first date following the completion of any waiting period required by the Employer.
- If this Certificate requires Employees to elect coverage under this Certificate, the Eligibility Date will be the later of:
  - The Employee's date of hire;
  - The first date following the completion of any waiting period required by the Employer; or
  - The date We approve in writing Your application for any coverage for which You are required to supply Proof of Insurability.

B400.0608

All Options

Elimination Period: This term means the period of time, as shown in the Schedule of Benefits, You must be Disabled, due to a covered Disability, before this Certificate's benefits are payable.

Any days during which You return to work on a Full-Time basis performing the major duties of Your Own Occupation, will not count toward the Elimination Period.

But You will continue to accumulate days of Disability for days for which You are working on less than a Full-Time basis during the Elimination Period as long as You meet the definition of Disability each Month during the Elimination Period.

If You are or become eligible under any other similar group income replacement plan while You are working during the Elimination Period, You will not be entitled to benefits from this Certificate.

If, at the end of the Elimination Period, You are not able to perform, on a Full-Time basis, the major duties of Your Own Occupation, but You earn or are able to earn 80% or more of Your Indexed Insured Earnings, the Elimination Period will be extended until the earlier of:

- Six Months from the date benefits otherwise would have commenced; or
- Until You are unable to earn 80% or more of Your Indexed Insured Earnings.

If at the end of this time period, You earn or are able to earn 80% or more of Your Indexed Insured Earnings, You must start a new Elimination Period.

We do not require You to complete an Elimination Period if:

- You were covered under a similar income replacement plan the Employer had with another carrier on the day before this Certificate starts; and
- Your Disability would have been a Recurring Disability under the prior plan had it remained in effect.

B400.0609

All Options

Employee: This term means a person who works for the Employer at the Employer's place of business and whose income is reported to the United States Internal Revenue Service, and/or a state for tax purposes. Partners and proprietors will also be treated as employees if the Conditions of Eligibility requirements are met.

B400.0611

All Options

Employer: This term means THE EVERGREENE COMPANIES

B400.0612

All Options

Full-Time: This term means:

You are not a Part-time Employee as defined by Your Employer and the average number of hours You worked for the six Months prior to the last full day worked was at least 30 hours per week at:

- Your Employer's place of business;
- Some place where the Employer's business requires You to travel; or
- Any other place You and Your Employer have agreed upon for the performance of occupational duties.

B400.0613

All Options

Gainful Occupation or **Gainful Work:** These terms mean work for which You are, or may become, qualified by:

- Training;
- Education; or
- Experience.

When You are able to perform such work, You can be expected to earn at least 80% of Your Indexed Insured Earnings while Working While Disabled or 60% of Your Indexed Insured Earnings if You are not Working While Disabled, within 12 Months of returning to work.

B400.0615

All Options

Government Plan: This term means any of the following:

- The United States Social Security Act;
- The Railroad Retirement Act;
- The Canadian Pension Plan; or
- Any other plan provided under the laws of a state, province or any other political subdivision.

It also includes:

- Any public employee Retirement Plan; or
- Any plan provided in place of the above named plan or acts.

It does not include:

- Any Workers' Compensation Act or similar law;
- The Jones' Act;
- The Longshoreman's and Harbor Workers' Compensation Act; or
- The Maritime Doctrine of Maintenance, Wages, or Cure.

B400.0616

All Options

Gross Monthly Benefit: This term means this Certificate's Monthly Benefit before it is integrated with other income and earnings.

B400.0617

All Options

Injury: This term means a bodily Injury due to an accident that occurs while You are covered by this Certificate. Subject to all other requirements, We will cover a Disability caused by an Injury when the Disability starts within 90 days of the date of such Injury.

B400.0618

All Options

Insured Earnings: Only Your earnings from the Employer will be included as Insured Earnings.

We calculate benefit amounts and limits based on the amount of Your Insured Earnings as of the Redetermination date immediately prior to the start of Your Disability. See the "Redetermination" section of this Certificate.

B400.0620

All Options

- **For Partners And S Corporation Shareholders:** Insured Earnings means the sum of the amounts listed below, divided by 24.
    - Your compensation as an Employee or S Corporation shareholder, or guaranteed payments as a Partner, as reported on Your Federal Income Tax Return(s), Form 1040, for the prior calendar year, less the gross total of unadjusted Employee business expenses as included on the corresponding Schedule A- Itemized Deductions.
    - Your non-passive income (loss) from trade of business as reported on Schedule E - Part II of Your Federal Income Tax Return(s), Form 1040, for prior two calendar years, less any expenses incurred and reported elsewhere on Your Return; and
    - Your contributions during the prior 2 calendar years, deposited into a:
        - Cash or deferred compensation plan, or salary reduction plan, qualified under IRC section 401(k), 403(b), 457 or similar plan; and
        - Elective Employee pre-tax deferrals to a Section 125 plan or flexible spending account.

    You may not have been a partner or S Corporation shareholder for the full prior two calendar years. In that case, Your earnings are based on the Monthly average of the sum of the listed amounts averaged for the full number of Months that You were a partner or S Corporation shareholder during that calendar year.

- **For Sole Proprietors:** Insured Earnings means the sum of the amounts listed below.

    - Your average Monthly net profit as determined from Schedule C - Part II of Your Federal Income Tax Return(s), Form 1040 for the prior two calendar years.

    - Your average Monthly contribution during the prior two calendar years deposited into a:

        - Cash or deferred compensation plan, or salary reduction plan, qualified under IRC section 401(k), 403(b), 457 or similar plan; and

        - Elective Employee pre-tax deferrals to a Section 125 plan or flexible spending account.

    Monthly net profit is calculated as gross income less total expenses.

    You may not have been a sole proprietor for the prior two calendar years. In that case, We calculate average Monthly net profit and average monthly contributions using the full number of Months that You were a sole proprietor during such time.

- **For Any Other Employee Whose Compensation Includes Commissions And Bonuses:** Insured Earnings means:

    - Your base Monthly salary from the Employer; plus

    - The average of Your commissions and bonuses from the Employer for the previous 24 Months, or length of employment if less.

    Your base Monthly salary will include shift differential.

    The term also includes Your contributions deposited into a:

    - Cash or deferred compensation plan, or salary reduction plan, qualified under IRC section 401(k), 403(b), 457 or similar plan; and

    - Elective Employee pre-tax deferrals to a Section 125 plan or flexible spending account.

    Earnings based on excluded income and Employer contributions deposited into such 401(k), 403(b), 457 or similar plan are not included.

    The term also does not include:

    - Overtime pay;

    - Expense accounts;

    - Stock options; and

    - Any other extra compensation.

    If You are paid hourly, We calculate Monthly earnings based on actual hours worked or billed in the two Months before the start of Your Disability. We do not include pay for hours worked or billed over 40 per week.

- **For Employees Who Are Compensated On Less Than A 12 Month Basis**: Insured Earnings means Your average rate of Monthly earnings determined from Your annual contract salary. If You do not have an annual contract salary, Insured Earnings means Your prior calendar year salary divided by twelve. Your annual contract salary will include shift differential.

  The term also includes Your contributions deposited into a:

  - Cash or deferred compensation plan, or salary reduction plan, qualified under IRC section 401(k), 403(b), 457 or similar plan; and
  - Elective Employee pre-tax deferrals to a Section 125 plan or flexible spending account.

  Earnings based on excluded income and Employer contributions deposited into such 401(k), 403(b), 457 or similar plan are not included.

  The term also does not include:

  - Overtime pay;
  - Expense accounts;
  - Stock options; and
  - Any other extra compensation.

  If You are paid hourly, We calculate monthly earnings based on actual hours worked or billed in the eight weeks before the start of Your Disability. We do not include pay for hours worked or billed over 40 per week.

- **For Employees Whose Income Is Reported On An IRS Form 1099:** Insured Earnings means Your average rate of Monthly earnings as figured from the 1099 form(s) received from the Employer for the prior two calendar years. Earnings are calculated as Your earned income as reported on the 1099 form(s) minus business expenses as reported on Schedule C - Part II of Your Federal Income Tax Return(s), Form 1040. Your average rate of monthly earnings is calculated as such earnings divided by 24 or the number of Months You worked for the Employer during such calendar years, if less than 24. The term also includes Your contributions deposited into a:

  - Cash or deferred compensation plan, or salary reduction plan, qualified under IRC section 401(k), 403(b), 457 or similar plan; and
  - Elective Employee pre-tax deferrals to a Section 125 plan or flexible spending account.

B400.0622

All Options

Long Term Disability: This term means the Long Term Disability Income Coverage described in the Policy and this Certificate.

B400.0662

All Options

Maximum Capacity Earnings: This term means the income You could earn if working to the fullest extent to which You are able in Your Own Occupation if during the Own Occupation period or after the Own Occupation period, the income You could earn if working to the fullest extent to which You are able in any Gainful Occupation.

We decide the fullest extent of work You are able to do based on objective data provided by any or all of the following sources:

- Your treating Doctor;
- Impartial medical or vocational exams;
- Peer review specialists;
- Functional capacities exams; and
- Other medical and vocational specialists whose area of expertise is appropriate to Your Disability.

B400.0663

All Options

Maximum Payment Period: This term means the longest time that benefits are paid by this Certificate, subject to all terms, limitations and exclusions.

B400.0666

All Options

Mental Illness: This term means any mental disorder, regardless of cause, listed in the Diagnostic and Statistical Manual of Mental Disorders (DSM) currently in use by the American Psychiatric Association (APA). If the APA stops publishing the DSM, We will use another similar source. A Mental Illness may be caused or contributed to, by or result in, physical, biological or chemical factors or symptoms.

For purposes of this Certificate, Mental Illness does not include:

- Irreversible dementia caused by Alzheimer's disease, stroke, trauma or viral infection; or
- Any other condition not typically treated by a psychiatrist, clinical psychologist or other qualified mental health professional.

B400.0667

All Options

Month or Months or Monthly: These terms mean a consecutive 30 day period.

B400.0668

All Options

Monthly Benefit: This term means this Certificate's Gross Monthly Benefit reduced by other income. If You are Working While Disabled, Your Monthly Benefit will be further reduced based on the amount of Your Disability Earnings.

B400.0669

All Options

Objective Medical Evidence: This term includes, but is not limited to:

- Diagnostic testing;
- Laboratory reports; and
- Medical records of a Doctor's exam documenting clinical signs, presence of symptoms and test results consistent with generally accepted medical standards supported by nationally recognized authorities in the health care field.

B400.0671

All Options

Objective Proof of Your Restrictions and Limitations: During the Own Occupation period this term means objective proof of Your inability to perform the duties of Your Own Occupation, and including all restrictions and limitations relating to Your inability to work. After the Own Occupation period, this term means objective proof of Your inability to perform the duties of any Gainful Work and including all restrictions and limitations relating to Your inability to work.

B400.0672

All Options

Own Occupation: This term means:

- The occupation(s) You are routinely performing for Your Employer immediately prior to the first date of Disability, and is further defined as follows. Own Occupation:
  - Includes any employment, trade, or profession that is substantially similar in terms of tasks, functions, skills, abilities, knowledge, training and experience, required by Employers from those engaged in a particular occupation in the general labor market in the national economy; and
  - Is not defined with reference to a specific Employer or specific location or particular work environment; and
  - Only includes the occupation or occupations for which You are covered under this Certificate, and
  - Generates the Insured Earnings covered by this Certificate.

B400.0675

All Options

Part-Time: This term means:

With respect to eligibility for benefits, the ability to work and earn between 40% and 80% of Indexed Insured Earnings during the Own Occupation period, and between 40% and 60% of Indexed Insured Earnings after the Own Occupation period.

B400.0681

All Options

Policy: This term means the group Long Term Disability Income Coverage described in the Policy and this Certificate.

B400.0683

All Options

Reasonable Accommodation: This term means any modification or adjustment that the Employer willingly provides to:

- A job;
- An employment practice;
- A work process; or
- The work place.

The modification or adjustment must make it possible for a Disabled person to:

- Reach the same level of performance as a similarly situated non-disabled person; or
- Enjoy equal benefits and privileges of employment as are available to a similarly situated non-disabled person.

The modification or adjustment must not place an undue hardship on the Employer.

B400.0685

All Options

Recurring Disability: This term means a later Disability that:

- Is related to an earlier Disability for which this Certificate paid benefits; and
- Meets the conditions described in the Recurring Disability section of this Certificate.

B400.0686

All Options

Regular and Appropriate Care: This term means, with respect to Your disabling condition(s) and any other condition(s) which, if left untreated, would adversely affect Your disabling condition, You:

- Visit a Doctor as frequently as medically required, according to generally accepted medical standards, to effectively manage these conditions; and
- Are receiving the most appropriate treatment, according to generally accepted medical standards, designed to achieve maximum medical improvement in these conditions.

Treatment must be provided by a Doctor or Doctors whose specialty is most appropriate according to generally accepted medical standards for Your:

- Disability; and
- Any other conditions which left untreated would adversely affect Your disabling condition.

Generally accepted medical standards are those supported by nationally recognized authorities in the health care field including:

- The American Medical Association (AMA);
- The AMA Board of Medical Specialties;
- The Food and Drug Administration;
- The Centers for Disease Control;
- The National Cancer Institute;
- The National Institutes of Health;
- The Department of Health and Human Services; and
- Any other agency of similar repute.

B400.0687

All Options

Rehabilitation Agreement: This term means a formal agreement between:

- You;
- Us; and
- Your Employer, if needed

It outlines the Rehabilitation Program in which You agree to take part.

B400.0688

All Options

Rehabilitation Program: This term means a program of work or job-related training for You that We approve in writing. Its aim is to restore Your wage earning abilities.

B400.0689

All Options

Retirement Plan: This term means a defined benefit or defined contribution plan funded wholly or in part by the Employer's deposits for Your benefit. The term does not include:

- Profit sharing plans;
- Thrift plans;
- Non-qualified deferred compensation plans;
- Individual retirement accounts;
- Tax sheltered annuities;
- 401(k), 403(b), 457 or similar plans; or
- Stock ownership plans.

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

B400.0690

All Options

Sickness: This term means an illness or disease. Pregnancy is treated as a Sickness under this Certificate.

B400.0691

All Options

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

B400.2560

All Options

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

B400.0696

All Options

Working While Disabled: This term means You are working and earning a gross Monthly income of 20% or more of Indexed Insured Earnings.

B400.0697

All Options

You or **Your:** These terms mean the Employee.

B400.0698

All Options

LONG TERM DISABILITY INCOME COVERAGE SCHEDULE OF BENEFITS

Effective January 1, 2020, this Schedule of Benefits is attached to the Certificate. This Schedule of Benefits replaces any previously issued Schedule of Benefits.

B400.0709

All Options

Plan ID A

Own Occupation Period The first 24 months of benefit payments from this Plan.

B400.0789

All Options

Plan ID A

Elimination Period

For Disability due to Injury . . . . . the later of: (1) the end of the maximum period for which benefits are payable under the Employer's Short Term Disability Income Coverage plan; or (2) 90 days.

For Disability due to Sickness . . . . . the later of: (1) the end of the maximum period for which benefits are payable under the Employer's Short Term Disability Income Coverage plan; or (2) 90 days.

B400.0813

All Options

Plan ID A

Maximum Payment Period Social Security Normal Retirement Age Table

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

GC-SCH-LTD-19-VA

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

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

But, if Your Disability starts after age 60, and reach the end of the Maximum Payment Period shown in the table, and You have not reached your Social Security Normal Retirement Age, we will extend Your Maximum Payment Period until You reach Social Security Normal Retirement Age.

B400.0827

All Options

Plan ID A

Gross Monthly Benefit

60% of Your Insured Earnings to a maximum benefit of $6,000.00.

The benefit will be rounded to the nearest $1.00, if not already a multiple of that amount.

Note: We integrate Your Gross Monthly Benefit with certain other income You may receive. Read all of the terms of this Certificate to see:

- The other income with which We integrate; and
- How We integrate.

B400.0847

All Options

Changes To Coverage

Changes In Coverage Amounts

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

Changes In Insurance Classification

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

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

- Make the required contribution for the new amount; and
- Furnish Proof of Insurability to Us, which We approve in writing.

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

B400.0955

SUPPLEMENTAL RIDERS

B400.1169

CERTIFICATE RIDER

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

Income Recovery Benefit Rider

This Rider may pay an Income Recovery Benefit, if Monthly Benefits cease because You are no longer Disabled.

To be eligible for the Income Recovery Benefit, You must be:

- Able to perform the major duties of Your Own Occupation or, if the Certificate has paid all benefits for the Own Occupation period, able to perform the major duties of any Gainful Occupation;
- Working in Your Own Occupation or, if the Certificate has paid all benefits for the Own Occupation period, Your Gainful Occupation, the same number of hours as You did prior to Disability;
- Unable to earn the Certificate's maximum allowable Disability Earnings, due to the Sickness or Injury which caused the prior Disability.

We pay this benefit Monthly, in arrears. We determine the amount We pay in two steps.

In step one, We compute the following: (1) Your Gross Monthly Benefit as of the last month You were Disabled under the terms of the Certificate; less (2) Other Income Benefits.

In step two, We make a current earnings adjustment.

We add:

- Your Gross Monthly Benefit as of the last month You were Disabled under the terms of the Certificate; and
- Your current Disability Earnings.

If such sum exceeds 100% of Your Insured Earnings, We pay the amount in step one less the excess over 100%. If such sum does not exceed 100%, We pay the amount in step one.

We stop paying this benefit on the earliest of:

- The date You are able to earn the Certificate's maximum allowable Disability Earnings;
- The date You become Disabled;
- The date You stop working;
- The date 12 months in a row after the first Income Recovery Benefit is paid; or

- The end of the Maximum Payment Period.

We will not pay more than 12 monthly Income Recovery Benefit payments following any one period of Disability, including any Recurring Disability.

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

The Guardian Life Insurance Company of America

Michael Prestileo, Senior Vice President

B400.2626

GC-R-LTD-INC-15-VA

CERTIFICATE RIDER

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

Survivor Benefit Rider

This Rider may pay a Survivor Benefit, according to the terms below.

What We Pay: We pay a Survivor Benefit if You die after You:

- Had been Disabled for at least six months in a row; and
- Were entitled to receive at least one full Monthly Benefit prior to Your death.

When We receive proof of Your death, We pay Your Eligible Survivor a lump sum benefit.

But, We first apply such benefit to reduce any overpayment You may owe Us.

If You have no Eligible Survivor, We pay the Survivor Benefit to Your estate.

Accelerated Survivor Benefit

If You have a terminal illness, We may accelerate payment of this Rider's Survivor Benefit.

For purposes of the accelerated Survivor Benefit, a terminal illness means a medical condition that is expected to result in Your death within 6 months.

To receive an accelerated Survivor Benefit, You must:

- Be entitled to receive a Monthly Benefit from the Certificate;
- Request this benefit in writing; and
- Provide written proof of terminal illness from a Doctor.

But, We will not pay an accelerated Survivor Benefit if there are less than 6 months remaining in the maximum benefit period.

If You choose to receive an accelerated Survivor Benefit, no Survivor Benefit is payable on Your death.

Definitions

This section defines certain terms appearing in this Rider. Additional terms, not listed here, are defined in the Certificate.

Eligible Survivor: This term means Your Spouse, if living. If Your Spouse is not living, Your Eligible Survivor is Your:

- Unmarried child under age 20; and

- Unmarried child under age 26 who is enrolled as a full-time student at an accredited school.

If there is more than one such child when You die, this benefit will be paid to each child in equal shares.

Survivor Benefit: This term means an amount equal to 3 times the amount of Your last Monthly Benefit after it is reduced by Disability Earnings.

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

The Guardian Life Insurance Company of America

Michael Prestileo, Senior Vice President

B400.2672

GC-R-LTD-SUR-15-VA

CERTIFICATE AMENDATORY RIDER

This Rider is effective on the Policy Date. If this Rider is added after the Policy Date, the Rider becomes effective on its issue date.

This Rider amends the Certificate by the replacement of the following Benefit Provisions:

Other Income Benefits: You may receive, or be entitled to receive, income shown in the list below.

We will reduce Your Gross Monthly Benefit by such other income benefits to determine Your Monthly Benefit from this Certificate.

- Commissions or monies received, payable but deferred, or paid after Disability benefits start.

  This includes:

  - Vested and nonvested renewal commissions;
  - Bonuses;
  - Royalties; and
  - Other distributions.

- Disability benefits from any mandated benefit act or law. This includes all temporary disability or state disability benefits required by law.

- Disability benefits from all group policies or plans of the Employer. This includes payments made by a group life insurance plan due to Your Disability. This does not include payments made from a group life insurance plan's:

  - Accelerated death benefit; or
  - Like provision that allows payment of such plan's proceeds due to terminal illness.

- Disability benefits from any other group policy or plan; but, if the other group plan was in force prior to this Certificate, and the other group plan also deducts for disability benefits from any other group plan, We will not deduct these other group disability benefits.

- Income from sick leave, salary continuance or paid time off, exclusive of vacation time accrued prior to Disability, but only to the extent that such income plus the amount of Your Gross Monthly Benefit is more than 100% of Your Indexed Insured Earnings. This applies whether such benefits are sponsored on a formal or informal basis. This includes:

  - Donated;
  - Lump sum; and

- Recurrent payments of accrued sick leave benefits.

  But, if You are working while Disabled, We will account for such income as described in Adjustment of Monthly Benefit for Disability Earnings.

- Income received from partnership distributions but only to the extent that such income plus the amount of Your Gross Monthly Benefit is more than 100% of Your Indexed Insured Earnings.

- Benefits from: The United States Social Security Act; The Railroad Retirement Act; or any other like U.S. or Canadian plan or act.

  This includes:

  (a) All disability benefits for which: (i) You are entitled; and (ii) Your spouse or domestic partner and children are entitled due to Your Disability;

  (b) All unreduced retirement benefits for which: (i) You are entitled and awarded; and (ii) Your spouse or domestic partner and children are entitled and awarded due to Your entitlement; and

  (c) All reduced retirement benefits paid to: (i) You; and (ii) Your spouse or domestic partner and children due to Your receipt of such benefits.

  We do not reduce Your Gross Monthly Benefit by the retirement benefits described in (b) and (c) above, to the extent that You and Your dependents were entitled and awarded such income prior to the start of Disability. We will reduce the Gross Monthly Benefit by marginal increases in such income You and Your dependents were entitled and awarded after Disability begins.

  We will reduce Your Gross Monthly Benefit by Your dependents' benefits described in (a), (b) and (c) above if: (i) the dependents' benefits are provided to You by the Social Security Administration; (ii) at the time that the Social Security Administration makes its first payment of the dependent benefits described in (a), (b), and (c) above, the dependent child remains a minor dependent or an adult Disabled dependent, and (iii) the dependent benefits You are entitled to are greater than any dependent benefit being received by another person. Under these circumstances, We will reduce Your Gross Monthly Benefit by the difference between the amount the dependent was awarded under the prior recipient and the amount awarded the dependent under Your benefits.

  We do not reduce Your Gross Monthly Benefit by the benefits to which You are entitled, as described in (a), (b), and (c) above unless such benefits are greater than any widow/widower benefit You are receiving. And then We reduce Your Gross Monthly Benefit by the difference.

- Income of the type that is included in Your Insured Earnings for purposes of determining Your Gross Monthly Benefit under this Certificate.

- That portion of Retirement Plan retirement benefits which the Employer funds.

- That portion of Retirement Plan disability benefits which the Employer funds.
- Retirement benefits or Retirement Plan disability benefits, due to Your Disability, from any Government Plan other than those shown above.
- Payment or settlement, with or without admission of liability, from: A Workers' Compensation law; an occupational disease law; or any other act or law of like intent.

  This includes:

  - The Jones' Act;
  - The Longshoreman's and Harbor Workers' Compensation Act; or
  - Any Maritime doctrine of Maintenance, Wages or Cure.

  If You receive a payment net of attorney fees approved by the Workers' Compensation Board or similar authority, We reduce Our benefit by the net payment.
- Unemployment compensation benefits.
- Payment from Your Employer as part of a termination or severance agreement.
- Payments from a paid leave, or a similar plan that pays for an approved leave, but only to the extent that such income plus the amount of Your Gross Monthly Benefit is more than 100% of Your Insured Earnings.

We reduce Your Gross Monthly Benefit with income shown above that You are entitled to receive without regard to the reason You are entitled to receive it.

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

B441.0419

All Options

Other Income Not Subject To Deduction: We will not reduce Your Gross Monthly Benefit by any income You receive or are entitled to receive from the list below.

- Deferred compensation arrangements such as 401(k), 403(b) or 457 plans;
- Profit sharing plans;
- Thrift plans;
- Tax sheltered annuities;
- Stock ownership plans;
- Individual Retirement Accounts (IRA);
- Individual disability income policies;

- Credit disability insurance;
- Non qualified plans of deferred compensation;
- Pension plans for partners;
- Retirement plans of another Employer not affiliated with this Certificate;
- Military pension and disability plans;
- Critical Illness insurance, unless the benefit is paid out as a wage replacement benefit;
- Accident Insurance, unless the benefit is paid out as a wage replacement benefit;
- Specified Disease insurance, unless the benefit is paid out as a wage replacement benefit;
- Cancer insurance, unless the benefit is paid out as a wage replacement benefit.

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

The Guardian Life Insurance Company of America

Michael Prestileo, Senior Vice President

B441.0421

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

STATEMENT OF ERISA RIGHTS

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

Your group Short Term and/or Long Term Disability Income benefits may be covered by the Employee Retirement Income Security Act of 1974 (ERISA). If so, you are entitled to certain rights and protections under ERISA.

ERISA provides that all plan participants shall be entitled to:

Receive Information about Your Plan and Benefits

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

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

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

Prudent Actions by Plan Fiduciaries

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

Enforcement of Your Rights

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

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

Assistance with Questions

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

Disability Benefits Claims Procedure

If you seek benefits under the plan you should complete, execute and submit a claim form. Claim forms and instructions for filing claims may be obtained from The Guardian Life Insurance Company of America (hereinafter referenced as Guardian).

Guardian is the Claims Fiduciary with discretionary authority to interpret and construe the terms of the Policy, the Certificate, the Schedule of Benefits, and any riders, or other documents or forms that may be attached to the Certificate or the Policy, and any other plan documents. Guardian has discretionary authority to determine eligibility for benefits and coverage under those documents. Guardian has the right to secure independent professional healthcare advice and to require such other evidence as needed to decide your claim.

In addition to the basic claim procedure explained in your certificate, Guardian will also observe the procedures listed below. These procedures are the minimum requirements for benefit claims procedures of employee benefit plans covered by Title 1 of ERISA.

Definitions

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

Timing for Initial Benefit Determination

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

Guardian will provide a benefit determination not later than 45 days from the date of receipt of a claim. This period may be extended by up to 30 days if Guardian determines that an extension is necessary due to matters beyond the control of the plan, and so notifies the claimant before the end of the initial 45-day period. Such notification will include the reason for the extension and a date by which the determination will be made. If prior to the end of the 30-day period Guardian determines that an additional extension is necessary due to matters beyond the control of the plan, and so notifies the claimant, the time period for making a benefit determination may be extended for up to an additional period of up to 30 days. Such notification will include the special circumstances requiring the extension and a date by which the final determination will be made.

A notification of an extension to the time period in which a benefit determination will be made will include an explanation of the standards upon which entitlement to a benefit is based, any unresolved issues that prevent a decision of the claim, and the additional information needed to resolve those issues.

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

B997.0370

Adverse Benefit Determination

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

- The specific reason(s) for the adverse determination;
- References to the specific provisions in the Policy, Certificate, plan or other documents, on which the determination is based;
- A description of any additional material or information necessary to perfect the claim and an explanation of why such material or information is necessary;
- A description of the plan's claim review procedures which a claimant may follow to have a claim for benefits reviewed and the time limits applicable to such procedures;
- A statement disclosing any internal rule, guideline, protocol or similar criterion relied on in making the adverse benefit determination (or a statement that such information will be provided free of charge upon request); or a statement that no internal rule, guideline, protocol or similar criterion was relied upon in making the adverse benefit determination;
- If applicable, an explanation of the basis of disagreement with or not following the views presented by you, of health care professionals who treated you and vocational professionals who evaluated you;
- If applicable, an explanation of the basis for disagreeing with or not following the views of any medical or vocational expert whose advice was obtained on our behalf in connection with the adverse benefit determination, without regard to whether the advice was relied upon in making the determination;

- If applicable, an explanation of the basis for disagreeing with or not following a disability determination made by the Social Security Administration that you present to us;
- A description of the plan's review procedures and the time limits applicable to such procedures, including a statement of the claimant's right to bring a civil action under ERISA Section 502(a) following an adverse benefit determination on appeal, and;
- In the case of an adverse benefit determination based on medical necessity or experimental treatment, notice will either include an explanation of the scientific or clinical basis for the determination, or a statement that such explanation will be provided free of charge upon request.

Appeal of Adverse Benefit Determinations

If a claim is wholly or partially denied, the claimant will have up to 180 days to make an appeal. Guardian will conduct a full and fair review of an appeal which includes providing to claimants the following:

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

In reviewing an appeal, Guardian will:

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

Guardian will notify the claimant of its decision not later than 45 days after receipt of the request for review of the adverse determination. This period may be extended by an additional period of up to 45 days if Guardian determines that special circumstances require an extension of the time period for processing and so notifies the claimant before the end of the initial 45-day period.

A notification with respect to an extension will indicate the special circumstances requiring an extension of the time period for review, and the date by which the final determination will be made.

In the event Guardian denies the appeal of an adverse benefit determination, it will:

- Provide the specific reason or reasons why the appeal was denied;
- Refer to the specific provisions in the Policy, Certificate, plan, or other documents on which the benefit determination is based;
- Provide a statement that the claimant is entitled to receive, upon request and free of charge, reasonably access to, and copies of all documents, records, and other information relevant to the claimant's claim for benefits;
- Provide a statement disclosing any internal rule, guideline, protocol or similar criterion relied on in making the adverse benefit determination (or a statement that such information will be provided free of charge upon request); or a statement that no internal rule, guideline, protocol or similar criterion was relied upon in making the adverse benefit determination;
- If applicable, provide an explanation of the basis of disagreement with or not following the views presented by you, of health care professionals who treated you, and vocational professionals who evaluated you;
- If applicable, provide an explanation of the basis for disagreeing with or not following the views of any medical or vocational expert whose advice was obtained on our behalf in connection with the adverse benefit determination, without regard to whether the advice was relied upon in making the determination;
- If applicable, provide an explanation of the basis for disagreeing with or not following a disability determination made by the Social Security Administration that you present to us;
- Provide a statement describing the claimant's right to bring a civil suit under Section 502(a) of the Employee Retirement Income Security Act of 1974 which shall also describe any applicable contractual limitations period that applies the claimant's right to bring such an action, including the calendar date on which the contractual limitations period expires for the claim, and;

- In the event the adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, provide either an explanation of the scientific or clinical judgment for the determination, applying the terms of the plan to the claimant's medical circumstances, or a statement that such explanation will be provided free of charge upon request.

Alternative Dispute Options

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

In addition to any legal rights you may have under section 502(a), if you believe that we have violated ERISA's procedural requirements, you may request that we review any claimed violation(s) and we will respond to you within ten days.

B997.0371

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

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

CERTIFICATE OF COVERAGE

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

The Group Vision Insurance Coverage described in this Certificate is attached to and part of the group Policy effective January 1, 2022. This Certificate replaces any Certificate previously issued under the Policy or under any other plan providing similar or identical benefits issued to the Employer by Guardian.

GROUP VISION INSURANCE COVERAGE

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

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

Employer: THE EVERGREENE COMPANIES

Group Policy Number: 00571412

Effective Date: January 1, 2022

Michael Prestileo,
Senior Vice President

Harris Oliner, Senior Vice President
and Corporate Secretary

B435.2347

GC-GVSN-19-VA

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IMPORTANT INFORMATION REGARDING YOUR INSURANCE

In the event You need to contact someone about this insurance for any reason please contact Your agent. If no agent was involved in the sale of this insurance, or if You have additional questions You may contact the insurance company issuing this insurance at the following address and telephone number:

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

If You have been unable to contact or obtain satisfaction from the company or the agent, You may contact:

Virginia State Corporation Commission
Bureau of Insurance
P.O. Box 1157
Richmond, VA 23218

Telephone Numbers
National Toll-Free Number: (877) 310-6560
Toll-Free Number: (800) 552-7945
Local Number: (804) 371-9691

Written correspondence is preferable so that a record of Your inquiry is maintained. When contacting Your agent, company or the Bureau of Insurance, have Your Policy number available. If You have a complaint pertaining to the availability, delivery, or quality of health care services including adverse decisions, claims payments, the handling or reimbursement for such service(s), or any other matter, You may contact:

Office of Licensure and Certification
Virginia Department of Health
9960 Mayland Drive - Suite 401
Richmond, VA 23233-1463
Telephone: (804) 367-2106 (Richmond Metro Area)
(800) 955-1819
Fax: (804) 527-4503
E-mail: mchip@vdh.virginia.gov

You have the right to file a complaint and will not be penalized for exercising these rights.

B435.2348

GENERAL PROVISIONS

Applicable Benefits

This Certificate may include multiple benefit options and types of benefits. You will only be covered for benefits if:

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

Limitation of Authority

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

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

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

Incontestability

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

No statement made by any Covered Person relating to his or her insurability of his or her insured dependents shall be used in contesting the validity of the insurance with respect to which such statement was made: (1) after the insurance has been in force, prior to the contest, for a period of two years during the lifetime of the person about whom the statement was made; and (2) unless the statement is contained in a written instrument signed by him or her.

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

If the Policy or Certificate will be rescinded, a written notice will be delivered to You at least 30 days prior to termination.

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

B435.2349

CONDITIONS OF ELIGIBILITY FOR GROUP VISION INSURANCE COVERAGE

B435.0005

All Options

Employee Eligibility

You are eligible for vision coverage if You are:

- In an eligible class of Employees;
- An active Full-Time Employee; and
- Working at least the minimum required number of hours in Your eligible class at:
  - The Employer's place of business;
  - Some place where the Employer's business requires You to travel; or
  - Any other place You and the Employer have agreed upon for the performance of the major duties of Your job.

You are **not** eligible for vision coverage if You are:

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

Enrollment: If You must pay all or part of the cost of Employee coverage, You must enroll and agree to make required payments within 31 days of Your eligibility date. If You fail to do this, You cannot enroll until the plan's next vision open Enrollment Period. "Open Enrollment period" means an annual open enrollment period set up by the Employer and agreed to by Us.

This plan's vision open Enrollment Period occurs from December 1st to December 31st of each year.

Once You enroll in this plan, You cannot drop Your or Your dependent's vision coverage until this plan's next vision open Enrollment Period. Once You drop Your or Your dependent's vision coverage, You will not be permitted to enroll again until the next vision open Enrollment Period which starts after the date coverage is dropped.

If You initially waived vision coverage under this plan because You were covered under another group vision care plan, and You wish to enroll in this plan because Your coverage under the other plan ended, You may do so without waiting until the next vision open Enrollment Period. But, Your coverage under the other plan must have ended due to one of the events listed below:

- Termination of Your Spouse's or Domestic Partner's employment.
- Loss of eligibility under Your Spouse's or Domestic Partner's vision plan.
- Divorce.
- Death of Your Spouse or Domestic Partner.
- Termination of the other vision plan.

In that case, You must enroll in the vision coverage under this plan within 30 days of the date that any of the events listed above occurs.

B435.2361

All Options

Dependent Eligibility

Your eligible dependents are Your:

- Spouse or Domestic Partner; and
- Dependent child, including:
  - A newborn child from the moment of birth, natural child, stepchild or a child placed with You for adoption or foster care who is under age 26; and
  - A full-time student who is at least age 26 and who is under age 26; and
  - A child who is incapable of self-support because of an intellectual disability or physical handicap. A dependent child may remain eligible for dependent benefits past the age limit, subject to the conditions below:
    - The condition started before he or she reached the age limit; and
    - The child remained continuously covered until he or she reached the age limit; and
    - You send Us written proof, and We approve such proof, of the child's disability and dependence within 31 days from the date he or she reaches the age limit. After the two year period following the child's attainment of the age limit, We can ask for periodic proof that the child's condition continues, but We cannot ask for this proof more than once a year.

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

B435.2372

All Options

Eligibility Waiting Period

You and Your dependents are eligible under this Certificate after You complete the eligibility waiting period, if any, established by the Employer.

B400.0087

All Options

When Coverage Starts

Your Employer will inform You of Your Effective Date under the Group Vision Policy. Your coverage begins on the date:

- You and Your eligible dependents are eligible for the Group Vision Policy as stated in the Conditions Of Eligibility for Group Vision Insurance section; and
- You and Your eligible dependents have enrolled in the Group Vision Policy; and
- Required premiums have been paid. For a newborn child, premiums are required to be paid within 31 days after the date of birth in order for the coverage to continue beyond the 31-day period.

B435.2373

All Options

Exception to When Coverage Starts

Sometimes a scheduled Eligibility Date is not a regularly scheduled work day. If the scheduled Eligibility Date falls on:

- A holiday;
- A vacation day;
- A non-scheduled work day;

and if:

- You were fully capable of performing Active Work for the Employer for the minimum number of hours of the Employee in Your eligible class at 12:01 AM Standard Time for Your place of residence on the scheduled Eligibility Date; and

- You were Actively at Work and working the minimum number of hours of the Employee in Your eligible class on Your last regularly scheduled work day.

Your coverage will start on the scheduled Eligibility 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 Certificate replaced.

B400.0094

All Options

Family Status Change

You may request the addition of Vision Insurance Coverage if You have experienced a Family Status Change.

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

- Marriage or divorce;
- Death of a Spouse or Domestic Partner or child;
- Birth or adoption of a child;
- Your Spouse's or Domestic Partner's termination of employment or a change in Your Spouse's or Domestic Partner's employment that results in the loss of group coverage.

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

If a change in Family Status occurs, You may request the addition of Vision Insurance Coverage for which You were not previously insured. You must provide proof of the Family Status Change and request the addition of Vision Insurance Coverage in writing within 31 days after the date of the Family Status Change as described above.

Refer to the When Coverage Starts section for information regarding when this coverage is effective.

B435.2375

All Options

When Your Coverage Ends

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

- The date Your Active Full-Time Work ends for any reason, except as shown below under Continuation of Coverage.
- The date You stop being an eligible Employee under this Certificate.

- The date the group Certificate ends, or is discontinued for a class of Employees to which You belong.
- The last day of the period for which required payments are made for or by You subject to the grace period set forth below.
- The date You die.

B435.2379

All Options

When Your Dependent Coverage Ends

Your dependent coverage will end on the first of the following events:

- When Your coverage ends.
- When You stop being an eligible Employee under this Certificate.
- The date the group Certificate ends, or dependent coverage is discontinued for a class of Employees to which You belong.
- The last day of the period for which required payments are made for Your dependent subject to the grace period set forth below.
- On the last day of the month in which Your child attains the age limit, except as described in the Dependent Eligibility section.
- For your Spouse or Domestic Partner, on the last day of the month in which Your marriage ends in legal divorce or annulment.

B435.2382

All Options

Grace Period For Payment Of Premiums - Termination Of Certificate

A grace period of 31 days, without interest charge, will be allowed for each premium payment, except the first. If any premium is not paid before the end of the grace period, this Certificate shall terminate at midnight on the last day of the grace period. If You give Us advance written notice of an earlier termination date during the grace period, this Certificate will end as of such earlier date.

B435.2387

CONTINUATION OF COVERAGE

You may have the right to continue certain group benefits for a limited time after Your coverage would otherwise end. Read this Certificate carefully for details and discuss with Your Employer or administrator.

Continuation Rights

You may be eligible to continue Your group vision coverage under more than one Continuation Rights section at the same time. If You choose to continue Your group vision coverage under more than one section, the continuations: (1) start at the same time; (2) run concurrently; and (3) end independently, on their own terms.

If continuing coverage under more than one continuation section: (1) You will not be entitled to duplicate benefits; and (2) You will not be subject to the premium requirements of more than one section at the same time.

Uniformed Services Continuation Rights

USERRA (Uniformed Services Employment and Reemployment Rights Act) is a federal law that provides reemployment rights for veterans and members of the National Guard and Reserve following military service. It also prohibits employer discrimination against any person on the basis of that person's past military service, current military obligations or intent to join one of the uniformed services.

If Your group vision coverage under the Policy would otherwise end because You enter into active military service, You may elect to continue such coverage for Yourself and Your eligible dependents in accordance with the provisions of USERRA.

You may contact Your Employer for additional information.

COBRA Continuation Rights

If vision insurance for You or Your dependents ends, You or Your dependents may qualify for continuation of such insurance under the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended (COBRA). For more information, You may contact Your Employer or visit Our website at www.guardianlife.com.

Family Medical Leave Of Absence (FMLA)

There are certain leaves of absence that may qualify for continuation of insurance under the Family and Medical Leave Act of 1993 (FMLA), or other similar laws. Please contact Your Employer for information regarding such legally mandated leave of absence laws.

B435.0038

All Options

Full-Time Students - Medical Leave of Absence

A dependent full-time student that takes a medical leave of absence, or reduces his/her course load to part-time status due to a medical condition, shall qualify for continued dependent coverage. This continued dependent coverage shall end at the earlier of: 12 months after the dependent ceases to be a full-time student; or when the coverage would have otherwise ended in accordance with the terms of this Certificate for reason(s) other than the change in full-time student status.

To qualify for this continued dependent coverage, the need for the medical leave of absence or part-time status must be certified as medically necessary by the dependent's duly-licensed physician at the time said dependent withdraws from being a full-time student.

The dependent's status as a full-time student shall be determined in accordance with the criteria established by the institution in which he/she is enrolled.

B435.2388

All Options

Dependent Survivorship Benefit

If You die while covered, We will continue dependent coverage for those of Your dependents who were covered when You died. We will do this for six months at no cost, provided: 1) this Employer's vision coverage remains in force; 2) the dependents remain eligible dependents; and 3) in the case of a Spouse or Domestic Partner, the Spouse or Domestic Partner does not remarry.

If a surviving dependent elects to continue his or her dependent benefits under another continuation provision, if any, this free continuation period will be provided as the first six months of such continuation.

B435.2389

VISION CLAIM PROVISIONS

You may visit any provider. After Davis Vision pays its portion of the covered charges, You are responsible for the rest. This includes any Deductible, Copayment, and amounts above any coverage maximum, as well as, any remaining charges up to the provider's total charge for services received.

Your reimbursement will be based on Davis Vision's fee schedule for Your specific Policy. Please refer to Your Schedule of Benefits.

B435.2390

All Options

Filing A Claim

Notice of Claim: You must send Us, or Our authorized agent, written notice of claim within 20 days after the occurrence of any loss for which this Certificate offers benefits, or as soon thereafter as is reasonably possible. This notice should include Your name and the Policy number. If the claim is being made for any other Covered Person, his or her name should also be shown.

Claim Forms: To obtain a claim form visit Our website at www.guardianlife.com. Claim forms will be provided within 15 days of Your receiving notice of a claim.

If We do not furnish the forms on time, We will accept a written description and adequate proof of the vision services that are 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.

Submitting Your Claim: If You have services performed by a Preferred Provider, Your claim will be submitted for You and the payment will be sent directly to Your Preferred Provider.

If You have services performed by a Non-Preferred Provider, You will need to submit Your own claim.

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

- Obtain only such information that is necessary to evaluate a claim for benefits. This information will be obtained as set forth herein with respect to Notice and Proof of Loss.
- Consider and interpret the terms of this Certificate and all information obtained by Us and submitted that relates to a claim for benefits and make a determination based on that information and in accordance with the terms of this Certificate and applicable state law.

- If a claim is approved, review the determination as often as is reasonably necessary to determine continued eligibility for benefits.
- If a claim is denied, provide the claimant, within a reasonable period of time, a written notification of an adverse determination. Such notification will include the specific reason(s) for the adverse determination.

Proof Of Loss: You must send written proof of loss to Our designated office within 90 days of the loss. We will not void or reduce Your claim if You cannot send Us proof of loss within the required time. In that case, You must send Us proof as soon as reasonably possible. However, under no circumstances will We pay benefits if written proof of loss is delayed for more than one year, unless You are unable to provide proof of loss because You are not legally competent or You lack legal capacity.

Payment Of Benefits: We will pay Vision benefits as soon as We receive written proof of loss, subject to all the terms and conditions of this Policy.

Unless otherwise required by law or regulation, We pay all Vision benefits to You if You are living or to Your Preferred Provider if the services were performed by a Preferred Provider.

If You are not living, We have the right to pay all Vision benefits, not to exceed $5,000, to one of the following:

Your

- Estate;
- Spouse or Domestic Partner;
- Parents;
- Children; or
- Brothers and sisters.

Otherwise, all benefits payable after Your death will be paid to Your estate or to your Preferred Provider if the services were performed by a Preferred Provider.

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

The Guardian Life Insurance Company of America
Vision Care Processing Unit
P.O. Box 1525
Latham, NY 12110-1525

Examination: We have the right to have a doctor of Our choice examine the Covered Person for whom a claim is being made under this Policy as often as is reasonably necessary while the claim is pending. We will pay for all such examinations.

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

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

B435.2392

All Options

CLAIM APPEALS AND ARBITRATION OF DISPUTES

The Guardian Life Insurance Company
Vision Appeals
PO Box 2350
Rancho Cordova, CA 95741

The written request must be made to Davis Vision within 180 days following the denial of benefits. The request should contain sufficient information to identify the Covered Person whose benefits were denied. This includes his or her name, Your social security number and Your date of birth. The Covered Person must state the reasons he or she believes that the denial of the claim was in error. And, he or she may provide any pertinent documents which he or she wishes to be reviewed.

Davis Vision will review the claim. Davis Vision will also give the Covered Person the opportunity to: (1) review pertinent documents; (2) submit any statements, documents or written arguments in support of the claim; and (3) appear personally to present materials or arguments.

Davis Vision's decision, including specific reasons, will be sent to the Covered Person in writing within 60 days after receipt of a request for review.

Any dispute or question arising between Davis Vision and a Covered Person which involves the application, interpretation or performance under this Certificate will 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 will be conducted pursuant to the rules of the American Arbitration Association.

If arbitration is needed and conducted pursuant to the American Arbitration Association, We will pay all of the imposed costs of the mediation and arbitration from the American Arbitration Association, however each party will pay for any of their own witnesses, personal expenses and legal fees of counsel. The proceedings will be held in the county closest to the Covered Person's residence. There can be one arbitrator selected by the American Arbitration Association from its panel of neutrals.

The results of the arbitration will not be binding on any party. If either party does not except the decision of the arbitrator, that party would be free to file an action in a court having jurisdiction.

Preferred Provider Grievance Procedures

If a Covered Person has complaints or grievances concerning Preferred Providers, he or she may: (1) call Davis Vision's Customer Care Team at 877- 393-7363, Monday through Friday, 7:00 a.m. to 8:00 p.m. Eastern Time, or (2) submit the complaint in writing, to:

Davis Vision
PO Box 791
Latham, NY 12110
Telephone No: 877-393-7363

The following procedures apply:

- The Covered Person's written complaint or grievance will be referred to Davis Vision's Complaint and Grievance Department for action.
- The complaint or grievance will be evaluated and, if deemed appropriate, the original examining doctor will be contacted.
- If the complaint or grievance can be resolved within 30 days, the Covered Person will be advised of the disposition. Otherwise, a notice of receipt of the complaint or grievance will be sent to the Covered Person advising the time needed for resolution.
- A record of all complaints and grievances will be retained in Davis Vision's Complaint and Grievance Department.

Consumer Assistance

If You have any questions regarding an appeal or grievance concerning the health care services that You have been provided that have not been satisfactorily addressed by Your plan, You may contact the Office of the Managed Care Ombudsman for assistance.

Address: Office of the Managed Care Ombudsman
Bureau of Insurance
P.O. Box 1157
Richmond, Virginia 23218
Telephone: 1-877-310-6560 toll-free
1-804-371-9032 in the Richmond Metropolitan Area
Ombudsman E-mail: ombudsman@scc.virginia.gov
Bureau of Insurance Website: www.scc.virginia.gov

B435.2396

VISION EXPENSE BENEFITS

This coverage will pay many of a Covered Person's vision care expenses. We pay benefits for Covered Charges incurred by a Covered Person. What We pay and the terms for payment are explained below.

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

B435.0043

All Options

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

The Policy is designed to provide high quality vision care while controlling the cost of such care. To do this, the Policy encourages a Covered Person to seek vision care from vision care practitioners and vision care facilities that belong to Davis Vision, a vision care Preferred Provider Organization (PPO).

The vision care PPO is made up of Preferred Providers in a Covered Person's geographic area. When a Covered Person is enrolled in the Policy, he or she will get an enrollment packet. The packet will: (1) explain how to obtain benefits; and (2) contain information about current vision care Preferred Providers. He or she will also receive information on how to obtain a list of Davis Vision Preferred Providers in his or her area.

A Covered Person may receive vision services from any Davis Vision Preferred Provider. If a Preferred Provider ends his or her relationship with Davis Vision for any reason, Davis Vision will be responsible for furnishing vision services to Covered Persons either through that provider or another Davis Vision Preferred Provider.

Use of the vision care PPO is voluntary. A Covered Person may receive vision care from any vision care provider he or she chooses. And he or she is free to change providers at any time. But, the Policy usually pays more in benefits for covered services furnished by a Preferred Provider. Conversely, it usually pays less for covered services not furnished by a vision care Preferred Provider.

What We pay is based on all of the terms of the Policy. Please read this Certificate carefully for specific benefit levels, Copayments, Deductibles, Payment Rates and Payment Limits.

A Covered Person may call Davis Vision should he or she have any questions about the vision coverage.

Davis Vision's Customer Service

800-999-5431

Obtaining Services from a Preferred Provider

When a Covered Person wishes to receive services from a Preferred Provider, he or she must contact the Preferred Provider before receiving the services. The Preferred Provider will contact Davis Vision to verify the Covered Person's coverage.

What We pay for charges for covered services is subject to all of the terms of this Certificate.

B435.2398

All Options

How This Plan Works

We pay benefits for the covered charges a Covered Person incurs as shown below. The services and supplies covered under this Certificate are explained in Covered Services and Supplies. What We pay is subject to all of the terms of this Certificate. Read the entire Certificate to find out what We limit or exclude.

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 covered by this Certificate. Charges in excess of any Payment Limits shown in this Certificate are not covered.

If a Covered Person plans to use the services of a Preferred Provider, the Preferred Provider must receive authorization from Davis Vision. See Obtaining Services from a Preferred Provider.

If a Covered Person receives services or supplies from a Non-Preferred Provider, he or she must submit the itemized bill to Davis Vision for claims payment. Please refer to Vision Claim Provisions in this Certificate.

Copayments: A Covered Person must pay a Copayment each time he or she receives a vision examination. And, he or she must pay a Copayment each time he or she receives lenses or a frame or a complete pair of eyeglasses covered by this Certificate. We pay benefits for the covered charges a Covered Person incurs in excess of the Copayment. This Certificate's Copayments are shown in the Schedule of Benefits.

Cash Deductibles: There are separate cash Deductibles for each covered service furnished by a Non-Preferred Provider. These cash Deductibles are shown in the Schedule of Benefits. The Covered person must have covered charges in excess of the cash Deductible before We pay benefits for the service or supply. The cash Deductible will be subtracted from the reimbursement to the member.

Payment Limits: Payment Limits, durational or monetary, are shown in Covered Services and Supplies. When a monetary Payment Limit is set for a pair of materials, the limit is halved if only one item is purchased.

Payment Rates: Once a Covered Person has paid any applicable Copayment or Deductible, We pay benefits for covered charges under this Certificate at the Payment Rate shown in the Schedule of Benefits. What We pay is subject to all of the terms of this Certificate.

B435.1030

All Options

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 Certificate. Read the entire Certificate to find out what We limit or exclude.

B435.0048

All Options

Vision Examinations: We cover charges for comprehensive vision care examinations of visual functions and prescription of corrective eyewear. We only cover charges for one vision examination for each Covered Person in any one calendar year Benefit Period. The comprehensive vision care examination does not include a contact lens exam (evaluation and fitting).

If a Covered Person receives a vision examination from a Preferred Provider, We pay benefits in full for the covered charges for that examination.

If a Covered Person receives a vision examination from a Non-Preferred Provider, We pay benefits for the covered charges for that examination, up to $50.00.

B435.0049

All Options

Vision Materials We cover charges for either glass or plastic prescription single vision, bifocal, trifocal or Lenticular Lenses. We cover charges for frames. And, We cover charges for prescription contact lenses. Benefit allowances provide no remaining balance for future use within the same Benefit Period.

In any one calendar year Benefit Period We cover charges for either glasses or contact lenses, but not both.

B435.1189

All Options

Standard Lenses: We cover charges for single vision, bifocal, trifocal or Lenticular Lenses. They must be glass or plastic lenses or for dependent children to age 19, for monocular individuals and Covered Persons with prescriptions of > +/- 6.00 diopters, Polycarbonate Lenses.

B435.1038

All Options

We only cover charges for one pair of Standard Lenses in any one calendar year Benefit Period.

B435.0187

All Options

If a Covered Person uses a Non-Preferred Provider, We limit what We pay to: (1) $48.00 for each pair of single vision lenses; (2) $67.00 for each pair of bifocal lenses; (3) $86.00 for each pair of trifocal lenses; and (4) $126.00 for each pair of Lenticular Lenses.

B435.0057

All Options

We pay the following benefits in full when a Covered Person purchases lenses from a Preferred provider:

- Scratch Resistant Coating
- Oversize Lenses
- Fashion and Gradient Tinting of Plastic Lenses

B435.1040

All Options

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 $130.00 for a non-collection frame. Most Preferred Providers discount any amount over the allowance by 20%. Discounts may not be available at all locations, check with Your Preferred Provider.

If a Preferred Provider offers Davis Vision's exclusive frame collection, We pay benefits for covered charges for any fashion or designer collection frame in full. And, We pay benefits for covered charges for any premier collection frame selected in full in excess of an additional $25.00 Copayment.

If a Covered Person uses a Non-Preferred Provider, We limit what We pay for a set of Standard Frames to $48.00.

We only cover charges for one set of Standard Frames in any one calendar Year period.

B435.2400

All Options

Necessary Contact Lenses: We cover charges for necessary contact lenses but only in place of all other lens and frame benefits available herein. This means that utilization of contact lens benefits exhausts all of the Covered Person's lens and frame benefits for the current Benefit Period, and future eligibility for lenses and frames will be determined as if spectacle lenses and frames were obtained in the current Benefit Period. We cover necessary contact lenses and charges for related professional services when a Preferred Provider obtains prior approval from Davis Vision but only if the lenses are needed: (1) following cataract surgery; (2) to correct extreme visual acuity problems that cannot be corrected with spectacle lenses; (3) for certain conditions of: Anisometropia; Aniseikonia; Keratoconus; Irregular Astigmatism; Corneal Disorders; Aphakia; Aniridia; or High Myopia.

And, We only cover charges for one pair of necessary contact lenses in any one calendar year Benefit Period.

If a Covered Person receives necessary contact lenses from a Preferred Provider, We pay 100% of the covered charges.

If a Covered Person receives necessary contact lenses from a Non-Preferred Provider, We limit what We pay for covered charges for such lenses to $210.00 in any one calendar year Benefit Period.

B435.1079

All Options

Elective Contact Lenses: We cover charges for elective contact lenses. We cover charges for hard, rigid gas permeable, soft, disposable, 30-day extended wear, daily-wear and planned replacement elective contact lenses.

If the Covered Person chooses elective contact lenses, We do not cover charges for Standard Lenses for one calendar year from the date the elective contact lenses are purchased.

If a Covered Person uses a Preferred Provider, We limit what We pay for non-Collection elective contact lenses to $130.00. Most Preferred Providers will discount any amount over the allowance by 15%. Discounts may not be available at all locations, check with Your Preferred Provider. Covered Persons must obtain all the elective contact lenses available within the Benefit Period at the same time. Any amounts remaining cannot be banked for future use.

If a Preferred Provider offers Davis Vision's elective contact lenses collection, We pay benefits for covered charges for any elective contact lenses selected from the collection in excess of the Copayment, if any. We cover two boxes of planned replacement or four boxes of disposable elective contact lenses. Contact lens fitting and evaluation (contact lens exam) is included at no additional cost only when collection contacts are purchased. The collection is not available at retail locations.

If a Covered Person uses a Non-Preferred Provider, We limit what We pay for elective contact lenses to $105.00.

We cover charges for one set of elective contact lenses in any one calendar year Benefit Period.

Charges are covered up to the contact lens allowance. The allowance may be applied towards an elective contact lens Fitting and Evaluation at some provider locations.

B435.1086

All Options

Exclusions

No benefits will be paid for services or materials connected with, or charges arising from:

- Orthoptics or vision training and any associated supplemental testing.
- Aniseikonic lenses.
- Medical and/or surgical treatment of the eyes or supporting structures.
- Any vision examination or corrective eyewear or safety eyewear required by an employer as a condition of employment unless specifically covered under this Certificate.
- Services provided as a result of any Workers' Compensation law, or similar legislation, or required by any governmental agency or program whether federal, state or subdivisions thereof.
- Services or materials provided by any other group benefit plan providing vision care.
- Plano Lenses (non-prescription lenses with less than a +/- .50 diopter power).
- Plano contact lenses to change eye color cosmetically or artistically painted contact lenses.
- Non-prescription sunglasses.
- Two sets of glasses in lieu of bifocals.
- Replacement of lenses, frames, glasses or contact lenses furnished under this Certificate which are lost or broken, except at normal intervals when services are otherwise available.
- Refitting of contact lenses after the initial 90 day fitting period.
- Routine maintenance of contact lenses, such as polishing or cleaning or modifications to contact lenses.
- Corneal refractive therapy (CRT) or orthokeratology (using contact lenses to change the shape of the cornea to reduce myopia).

- A frame that costs more than this Certificate allowance.
- Unused allowance amounts cannot be banked for future use. The allowance must be used during the same office visit.
- Benefits cannot be split. Frames and lenses must be purchased during the same office visit.
- Blended Lenses
- Progressive Multi-Focal Lenses
- Polycarbonate Lenses for adults
- High Index Lenses
- Anti-Reflective Coating of the lens or lenses
- Polarized/Laminated Lenses
- Ultraviolet Coating of Lenses
- Transition Lenses
- Photochromic Lenses
- Mirror and Ski Coating
- Edge Treatment

Charges not covered due to these exclusions are not considered charges for covered vision services and cannot be used to satisfy this Certificate's Copayments or Deductibles, if any.

B435.1128

All Options

DEFINITIONS

This section defines certain terms appearing in Your Certificate.

B040.0004

All Options

Active Work or Actively At Work or Actively Working: These terms mean You are able to perform, and are performing all of the regular duties of Your work for the Employer, at:

- One of the Employer's usual places of business;
- Some place where the Employer's business requires You to travel; or
- Any other place You and the Employer have agreed on for Your work.

B435.0102

All Options

Aniridia: This term means the absence of the iris in the eye, occurring congenitally or as a result of trauma or surgery.

B435.1042

All Options

Aniseikonia: This term means a condition that results from an excessive difference in the prescription between the eyes. This causes a difference in image size perceived between the eyes from unequal magnification, and can manifest with symptoms of headache, dizziness, disorientation, and excessive eye strain.

B435.1043

All Options

Anisometropia: This term means a condition in which two eyes have unequal refractive power. Each eye can be nearsighted (myopia), farsighted (hyperopia), or a combination of both, which is called antimetropia. Generally a difference in power of two diopters or more is the accepted threshold to label the condition anisometropia.

B435.1044

All Options

Anti-Reflective Coating: This term means a clear lens coating that limits light reflection by allowing the maximum amount of light to pass through the lens.

B435.0105

All Options

Aphakia: This term means the absence of the lens of an eye, occurring congenitally or as a result of trauma or surgery without implantation of an intraocular lens.

B435.0106

All Options

Benefit Period: This term means the time period beginning when a covered service is received and extending for the period shown in this Certificate, during which benefits for the covered service are available to a Covered Person.

B040.0846

Blended Lenses: This term means bifocals which do not have a visible dividing line.

B040.0847

Certificate: This term means this Certificate of Coverage, including the Schedule of Benefits and any riders and enrollment forms that may be attached to this Certificate.

B435.0108

Copayment: This term means a charge, expressed as a fixed dollar amount, required to be paid by or on behalf of a Covered Person to a Preferred Provider at the time covered services are received.

B435.0109

All Options

Corneal Disorders: This term means any condition (other than Keratoconus) of congenital, pathological or surgical etiology causing compromised integrity of the corneal curvature or media resulting in best correctable acuity of 20/70 or less with spectacles in one or both eyes.

B435.0110

All Options

Covered Person: This term means You, if You are covered by the Policy, and any of Your covered dependents.

B435.0185

All Options

Deductible: This term means a fixed dollar amount the Covered Person is responsible for paying before Guardian will begin paying the cost of covered benefits.

B435.0111

All Options

Domestic Partner: This term means an opposite or same sex partner who has met all of the following requirements for at least 12 months: (1) resides with the Covered Person; (2) shares financial assets and obligations with the Covered Person; (3) is not related by blood to the Covered Person to a degree of closeness that would prohibit a legal marriage; (4) is at least the age of consent in the state in which they reside; and (5) neither the Covered Person or Domestic Partner is married to anyone else, nor has any other Domestic Partner. We require proof of the Domestic Partner relationship in the form of a signed and completed Affidavit of Domestic Partnership.

B435.2401

All Options

Edge Treatment: This term means a cosmetic service to make the sides of a cut lens look clear rather than a milky white.

B435.0112

All Options

Effective Date: The date the Policy goes into force and effect as stated on the cover page of the Certificate of Coverage, or any change to the Policy as requested by the Employer and approved by Us and in force and effect as stated on cover page of the Certificate of Coverage.

B435.0113

All Options

Eligibility Date: This term means the earliest date You are eligible for coverage under this Certificate as directed by the Employer, and you have satisfied all requirements for coverage to begin, as required by this Certificate.

B435.0114

All Options

Employee: This term means the member of the group determined to be eligible by the Employer.

B435.0115

All Options

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

B435.0116

All Options

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

B040.0858

All Options

Fashion and Gradient Tinting of Plastic Lenses: This term means lenses which have an additional substance added to produce constant tint or coating that is darker at the top of the lens, fading to lighter at the bottom.

B435.1045

All Options

Fitting and Evaluation: This term means an examination for the proper fit of contacts and evaluating vision with the contacts. Includes prescription, fitting, evaluation, modification and/or dispensing of contact lenses.

B435.0117

All Options

Full-time: This term means:

You are not a Part-Time Employee as defined by Your Employer and You work at least the minimum required number of hours for the Employer in Your Eligible class (but not less than 30 hours per week), at:

- Your Employer's place of business;
- Some place where the Employer's business requires You to travel; or
- Any other place You and Your Employer have agreed upon for the performance of Your job.

B435.0145

All Options

High Index Lenses: This term means material that is used to create thinner lenses than normal plastic. The material does not contain the impact-resistant qualities of polycarbonate.

B435.0120

All Options

High Myopia: Refractive error greater than plus or minus 10.00 diopters of correction; best correctable visual acuity with spectacles of 20/40 or less in either eye; at least two lines improvement in best correctable visual acuity (as measured with standard Snellen chart) with contact lenses.

B435.0121

All Options

Incurred, or Incurred Date: These terms mean: (1) the placing of an order for lenses, frames or contact lenses; or (2) the date on which such an order was placed.

B040.0860

All Options

Irregular Astigmatism: This term means greater than or equal to 2.00 diopters of astigmatism in either eye where the principal meridians are separated by less than 90 degrees, resulting in best correctable acuity of 20/70 or less in the affected eye with spectacles.

B435.0123

All Options

Keratoconus: This term means a development or dystrophic deformity of the cornea in which it becomes cone shaped due to a thinning and stretching of the tissue in its central area. Diagnosis confirmed by keratometric readings, or corneal topography best correctable visual acuity with spectacles of 20/40 or less in either eye; at least two lines improvement in best correctable visual acuity (as measured with standard Snellen chart) with rigid contact lenses.

B435.0124

All Options

Lenticular Lenses: This term means mean high-powered lenses with the desired prescription power found only in the central portion. The outer portion has a front surface with a changing radius of curvature.

B040.0862

All Options

Low Vision: This term means a partial loss of vision; a loss of acuity or sharpness or a loss of side/peripheral vision; and that the Covered Person's most favorable corrected visual acuity is 20/70 or worse in one or both eyes.

B435.1046

All Options

Low Vision Supplemental Care: This term means subsequent Low Vision therapy, when visually necessary or appropriate.

B435.1047

All Options

Low Vision Supplementary Testing: This term means a Low Vision analysis and diagnosis. The analysis and diagnosis includes: (a) a comprehensive examination of visual functions; and (b) the prescription of corrective eyewear or vision aids, when required.

B435.1048

All Options

Mirror and Ski Coating: This term means a thin deposit of appropriate material to the front surface of a lens, causing a portion of the light striking the lens to reflect directly from the front surface.

B435.0125

All Options

Non-Preferred Provider: This term means any optometrist, optician, ophthalmologist, or other licensed and qualified vision care provider that is not under contract, directly or indirectly, with Davis Vision as a Preferred Provider.

B435.1049

All Options

Orthoptics: This term means the teaching and training process for the improvement of visual perception and coordination of two eyes for efficient and comfortable binocular vision.

B040.0865

All Options

Oversize Lenses: This term means larger than a standard lens blank, to accommodate prescriptions.

B040.0868

All Options

Payment Limit: This term means the maximum amount this Certificate pays for covered services and supplies during a specified Benefit Period.

B435.0128

All Options

Payment Rate: This term means the percentage rate that this Certificate pays for covered services and supplies.

B435.0129

All Options

Photochromic Lenses: This term means lenses which change color with the intensity of sunlight.

B040.0870

All Options

Plano Lenses: This term means lenses which have no refractive power (lenses with less than a greater than or equal to .38 diopter power).

B435.0130

All Options

Polarized/Laminated Lenses: This term means lenses that block light reflected from horizontal surfaces such as water, in order to reduce glare.

B435.0131

All Options

Policy: This term means the group Vision Insurance Coverage described in the Policy and this Certificate.

B435.0132

All Options

Polycarbonate Lenses: This term means the highest impact-resistant lens material available. Its high-index properties result in lenses 20-25% thinner than regular plastic. This material is often used for safety and children's eyewear as well as for sports and cosmetic purposes.

B435.0133

All Options

Preferred Provider: This term means an optometrist, optician, ophthalmologist or other licensed and qualified vision care provider who has entered into a contract, directly or indirectly with Davis Vision to provide vision care services and or Vision Materials to Covered Persons.

B435.1050

All Options

Progressive Multi-Focal Lenses: This term means lenses that have no line, but progresses from distance, to intermediate, to near vision.

B435.0135

All Options

Registered Reciprocal Beneficiaries: This term means an employee and his or her reciprocal beneficiary: (a) who have filed a Declaration of Reciprocal Beneficiary Relationship with the Director of Health of the State of Hawaii as provided in section 572C-5 of the Hawaii Revised Statutes; (b) the declaration has been registered by the Director; and (c) a certificate of reciprocal beneficiary relationship has been provided to each party named on the declaration.

B435.1984

All Options

Reciprocal Beneficiary: This term means an adult who is a party to a valid reciprocal beneficiary relationship and who meets the following requirements for such a relationship:

- Each of the parties must be at least eighteen years old.
- Neither of the parties can be married nor a party to another reciprocal beneficiary relationship.

- The parties must be legally prohibited from marrying one another under chapter 572 of the Hawaii Revised Statutes.
- Consent of either party to the reciprocal beneficiary relationship has not been obtained by force, duress, or fraud.
- Each of the parties must sign a Declaration of Reciprocal Beneficiary Relationship.

B435.1985

All Options

Scratch Resistant Coating: This term means a coating applied to spectacle lenses to increase the scratch resistance of the lens surface.

B435.0136

All Options

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

B435.2402

All Options

Standard Frames: This term means frames valued up to the limit published by Davis Vision which is given to Preferred Providers.

B435.1051

All Options

Standard Lenses: This term means regular glass or plastic lenses.

B435.0139

All Options

Tinted Lenses: This term means lenses which have an additional substance added to produce constant tint.

B040.0878

All Options

Transition Lenses: This term means plastic lenses that turn dark when exposed to the ultraviolet rays of the sun.

B435.0140

All Options

Ultraviolet Coating (UV): This term means a coating that blocks ultraviolet rays.

B435.0141

All Options

Usual And Customary: This term means that the charge for the covered vision condition: (1) is the provider's standard charge for the service furnished; and (2) is not more than the usual charge made by most other providers with similar training and experience in the same geographic area. 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.

B040.0879

All Options

Vision Materials: This term means (1) Elective Contact Lenses; or (2) Standard Lenses, Standard Frames or a complete pair of eyeglasses (lenses and frames).

B435.0142

All Options

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

B435.0143

All Options

You, Your or Your: These terms mean the covered Employee.

B435.0144

STATEMENT OF ERISA RIGHTS

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

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

ERISA provides that all plan participants shall be entitled to:

Receive Information about Your Plan and Benefits

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

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

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

Prudent Actions by Plan Fiduciaries

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

Enforcement of Your Rights

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

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

Assistance with Questions

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

Qualified Medical Child Support Order and Qualified Domestic Relations Order

Federal law required that group health plans provide medical coverage for a dependent child pursuant to a qualified medical child support order (QMCSO). A dependent child also includes a child for whom You must provide Vision Insurance due to a QMCSO as defined in the ERISA Section 609(a) United States Employee Retirement Income Security Act of 1974, as amended.

You and your beneficiaries can obtain, without charge, from the plan administrator, a copy of any procedures governing Qualified Domestic Relations Orders (QDRO) and QMCSO. You may also obtain this information on the U.S. Department of Labor's website or You may contact them in your telephone directory.

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

If you have questions about this section, see your plan administrator.

Vision Benefits Claims Procedure

Claim forms and instructions for filing claims may be obtained from The Guardian Life Insurance Company of America (hereinafter referenced as Guardian).

Guardian is the Claims Fiduciary with discretionary authority to interpret and construe the terms of the Policy, the Certificate, the Schedule of Benefits, and any riders, or other documents or forms that may be attached to the Certificate or the Policy, and any other plan documents. Guardian has discretionary authority to determine eligibility for benefits and coverage under those documents. Guardian has the right to secure independent professional healthcare advice and to require such other evidence as needed to decide your claim.

In addition to the basic claim procedure explained in your certificate, Guardian will also observe the procedures listed below. These procedures are the minimum requirements for benefit claims procedures of employee benefit plans covered by Title 1 of ERISA.

B435.0148

All Options

Definitions

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

Timing for Initial Benefit Determination

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

Guardian will provide a Benefit Determination not later than 45 days from the date of receipt of a claim. This period may be extended by up to 30 days if Guardian determines that an extension is necessary due to matters beyond the control of the plan, and so notifies the claimant before the end of the initial 45-day period. Such notification will include the reason for the extension and a date by which the determination will be made. If prior to the end of the 30-day period Guardian determines that an additional extension is necessary due to matters beyond the control of the plan, and so notifies the claimant, the time period for making a Benefit Determination may be extended for up to an additional period of up to 30 days. Such notification will include the special circumstances requiring the extension and a date by which the final determination will be made.

A notification of an extension to the time period in which a Benefit Determination will be made will include an explanation of the standards upon which entitlement to a benefit is based, any unresolved issues that prevent a decision of the claim, and the additional information needed to resolve those issues.

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

Adverse Benefit Determination

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

- The specific reason(s) for the Adverse Benefit Determination;
- References to the specific provisions in the Policy, Certificate, plan or other documents, on which the determination is based;
- A description of any additional material or information necessary to reconsider the claim and an explanation of why such material or information is necessary;
- A description of the plan's claim review procedures which a claimant may follow to have a claim for benefits reviewed and the time limits applicable to such procedures;
- Identification and description of any specific internal rule, guideline or protocol that was relied upon in making an Adverse Benefit Determination, or a statement that a copy of such information will be provided to the claimant free of charge upon request;
- A description of the plan s review procedures and the time limits applicable to such procedures, including a statement of the claimant's right to bring a civil action under ERISA Section 502(a) following an Adverse Benefit Determination on appeal, and;
- In the case of an Adverse Benefit Determination based on medical necessity or experimental treatment, either an explanation of the scientific or clinical basis for the determination, or a statement that such explanation will be provided free of charge upon request.

Appeal of Adverse Benefit Determinations

If a claim is wholly or partially denied, the claimant will have up to 180 days to make an appeal. Guardian will conduct a full and fair review of an appeal which includes providing to claimant(s) the following:

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

In reviewing an appeal, Guardian will:

- Provide for a review conducted by a named fiduciary who is neither the person who made the initial Adverse Benefit Determination nor that person's subordinate;

- In deciding an appeal based upon a vision or 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 vision or medical experts whose advice was obtained in connection with an Adverse Benefit Determination;
- Ensure that a health care professional engaged for consultation regarding an appeal based upon a professional judgment shall be neither the person who was consulted in connection with the Adverse Benefit Determination, nor that person's subordinate.

Guardian will notify the claimant of its decision not later than 45 days after receipt of the request for review of the Adverse Benefit Determination. This period may be extended by an additional period of up to 45 days if Guardian determines that special circumstances require an extension of the time period for processing and so notifies the claimant before the end of the initial 45-day period.

A notification with respect to an extension will indicate the special circumstances requiring an extension of the time period for review, and the date by which the final determination will be made.

In the event Guardian denies the appeal of an Adverse Benefit Determination, it will:

- Provide the specific reason or reasons why the appeal was denied;
- Refer to the specific provisions in the Policy, Certificate, plan, or other documents on which the benefit determination is based;
- Provide a statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claimant's claim for benefits;
- If applicable, provide the internal rule, guideline, protocol, or other similar criterion relied upon in making the Adverse Benefit Determination, either the specific rule, guideline, protocol, or other similar criterion; or a statement that such rule, guideline, protocol, or other similar criterion was relied upon in making the Adverse Benefit Determination and that a copy of the rule, guideline, protocol, or other similar criterion will be provided free of charge to the claimant upon request.

Alternative Dispute Options

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

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All Options

THE GUARDIAN LIFE INSURANCE COMPANY OF AMERICA

VISION INSURANCE COVERAGE SCHEDULE OF BENEFITS

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

B435.2411

All Options

Initial Election You may choose to be covered under one of the plans of vision expense coverage offered by Your Employer. You may only be covered under one plan at a time. You must notify the Employer of Your election and pay the required premium.

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All Options

Group Enrollment Period A group enrollment period is held each year from December 1st to December 31st. During this period, You may choose to enroll for vision insurance coverage under the Policy. In that case, coverage is scheduled to start on the date determined by Your Employer that next follows the date You enroll.

B435.0155

All Options

PPO Copayments	Examinations	$10.00
	Standard Frames and/or Standard Lenses	$25.00
	Low Vision Examinations and Services	None
	Low Vision Materials	None
Non-PPO Cash Deductibles	Examinations	$10.00
	Standard Frames and/or Standard Lenses	$25.00
	Low Vision Examinations and Services	None
	Low Vision Materials	None
Payment Rates	For Covered Charges	100%

B435.1137

Changes in Coverage Amounts

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

Changes In Insurance Classification

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

If a contribution is required for the new classification for which a larger amount of coverage is provided, You must make the required contribution for the amount within 31 days of the change. If You do not make the required contribution within 31 days of the change or within 31 days of becoming Actively At Work on a Full-Time basis, if You are not Actively At Work on a Full-Time basis, when Your classification changes, no increase will be allowed due to such change or any later change.

B435.0163

YOUR BENEFITS INFORMATION - ANYTIME, ANYWHERE

www.guardianlife.com

You can access helpful, secure information about your Guardian benefits online 24 hours a day, 7 days a week.

Anytime, anywhere you have internet access, you'll be able to:

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

To register, go to **www.guardianlife.com**

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Guardian

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