

SERFF Tracking Number: GARD-128474947 State: Arkansas
Filing Company: The Guardian Life Insurance Company of America State Tracking Number:
Company Tracking Number:
TOI: H02G Group Health - Accident Only Sub-TOI: H02G.000 Health - Accident Only
Product Name: 9546
Project Name/Number: /9546

Filing at a Glance

Company: The Guardian Life Insurance Company of America

Product Name: 9546

SERFF Tr Num: GARD-128474947 State: Arkansas

TOI: H02G Group Health - Accident Only

SERFF Status: Closed-Approved-
Closed State Tr Num:

Sub-TOI: H02G.000 Health - Accident Only

Co Tr Num:

State Status: Approved-Closed

Filing Type: Form

Reviewer(s): Rosalind Minor

Authors: Diane Pappas, Victoria
Arama, Marilyn Young, Matthew
Noonan

Disposition Date: 06/28/2012

Date Submitted: 06/13/2012

Disposition Status: Approved-
Closed

Implementation Date Requested: On Approval

Implementation Date:

State Filing Description:

General Information

Project Name:

Status of Filing in Domicile:

Project Number: 9546

Date Approved in Domicile:

Requested Filing Mode: Review & Approval

Domicile Status Comments:

Explanation for Combination/Other:

Market Type: Group

Submission Type: New Submission

Group Market Size: Small and Large

Group Market Type: Employer

Overall Rate Impact:

Filing Status Changed: 06/28/2012

State Status Changed: 06/28/2012

Deemer Date:

Created By: Marilyn Young

Submitted By: Marilyn Young

Corresponding Filing Tracking Number:

Filing Description:

The attached forms are being submitted for review and approval by your Department. These forms are new and do not replace any forms previously approved by your Department.

These forms will be used with our group policy insert form GP-1 et al and with our group certificate insert form CGP-3 et al, currently on file with your Department. The certificate forms reflect the policy forms. These new forms provide benefits for a group accident insurance coverage. We are also submitting the following optional riders:

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Forms GP-1-A-AC-AS-12 and CGP-3-A-AC-AS-12 that provides a weekly benefit for a covered person disabled as a result of a sickness or injury.

Forms GP-1-A-AC-DIS-12 and CGP-3-A-AC-DIS-12 that provides a weekly benefit for a covered person disabled as a result of a sickness.

Forms GP-1-A-AC-HC-12 and CGP-3-A-AC-HC-12 that provides a benefit if a covered person is confined to a hospital

The attached forms will be used with our group master application form CMA2007 currently on file with your Department, and with any successor enrollment forms and application forms that may be approved by your Department. A copy of the approval notice for forms CMA2007 is attached for your convenience. The attached forms will be used with our group enrollment form CEF2011 which is being submitted under a separate filing.

The group accident insurance coverage includes a portability option to allow a covered person to continue their existing group accident insurance coverage when they leave the group plan. Portability coverage is provided under the Group Conversion and Portability Trust Policy issued in the state of Rhode Island. This policy references "Group Conversion" because it is also used for a non-statutory Long Term Disability Insurance conversion option when a covered person ends their insurance under their employer's plan. This conversion is not part of this portability option.

Under this policy a covered person electing to port their coverage will be issued a Portability Certificate of Coverage.

We are submitting the following for informational purposes:

Group Conversion and Portability Trust Policy, Forms GCPT-95-1 through GCPT-95-5 that describe the terms and conditions of this group policy.

Certificate Form PC-AC-12 which provides evidence of coverage for covered persons who have exercised the portability option. Also included are the following portability certificate riders which provide optional benefits that a covered person elected under the plan for which the person is porting:

Forms PC-A-AC-AS-12;
Forms PC-A-AC-DIS-12;
Forms PC-A-AC-HC-12.

We are also submitting the following administrative forms for use with the portability option:

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Accident Insurance Election of Portability Coverage Form GG-016348. This form will be completed by a covered person who terminates employment with a Group Planholder, or if available, a surviving spouse who loses coverage under the Group Plan, and elects to port their Accident Insurance.

Accident Insurance Portability Coverage Premium Notice Form GG-016349. This form provides a notice of premium used for a covered person who terminates employment with a Group Planholder, or if available, a surviving spouse who loses coverage under the Group Plan, and elects to port their Accident Insurance.

Variable language is indicated and numbered to correspond with the explanations in the attached memorandum.

The forms in this submission were developed using simplified language. Each form has a Flesch reading ease test score of at least 40. The forms were computer scored. The certification of readability scores required by your jurisdiction is attached. Also is a listing of forms.

Since the new forms were developed for use in your jurisdiction, they will not be filed with our domiciliary state, New York, until they are approved by your Department.

Your early consideration of this submission will be greatly appreciated.

Sincerely,

Marilyn Young
Contract Coordinator
Group Contracts and Regulatory Affairs
Ph:(212) 598-8762
Fax:(212) 919-3339
E-mail: Marilyn_Young@glic.com

State Narrative:

Company and Contact

Filing Contact Information

Marilyn Young, Contract Analyst
7 Hanover Square
19 H
New York, NY 10004

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212-598-8762 [Phone]
212-919-3339 [FAX]

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Filing Company Information

The Guardian Life Insurance Company of America CoCode: 64246 State of Domicile: New York
 7 Hanover Square Group Code: 429 Company Type: Life
 New York, NY 10004 Group Name: State ID Number:
 (212) 598-8704 ext. [Phone] FEIN Number: 13-5123390

Filing Fees

Fee Required? Yes
 Fee Amount: \$50.00
 Retaliatory? No
 Fee Explanation:
 Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
The Guardian Life Insurance Company of America	\$50.00	06/13/2012	60113456
The Guardian Life Insurance Company of America	\$950.00	06/19/2012	60258417

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Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	06/28/2012	06/28/2012

Objection Letters and Response Letters

Objection Letters				Response Letters		
Status	Created By	Created On	Date Submitted	Responded By	Created On	Date Submitted
Pending Industry Response	Rosalind Minor	06/19/2012	06/19/2012	Victoria Arama	06/28/2012	06/28/2012

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Disposition

Disposition Date: 06/28/2012

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

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Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification	Approved-Closed	Yes
Supporting Document	Application	Approved-Closed	Yes
Supporting Document	Variable Memorandum	Approved-Closed	Yes
Supporting Document	Supporting Forms	Approved-Closed	Yes
Form	Benefit	Approved-Closed	Yes
Form	Definition	Approved-Closed	Yes
Form	Exclusions	Approved-Closed	Yes
Form	ACCIDENT COVERAGE	Approved-Closed	Yes
Form	Portability PRIVILEGE	Approved-Closed	Yes
Form	Waiver of Premium	Approved-Closed	Yes
Form	Policy Rider	Approved-Closed	Yes
Form	Policy Rider	Approved-Closed	Yes
Form	Policy Rider	Approved-Closed	Yes
Form	Benefit	Approved-Closed	Yes
Form	Definition	Approved-Closed	Yes
Form	Exclusion	Approved-Closed	Yes
Form	Accident Coverage	Approved-Closed	Yes
Form	Portability Privilege	Approved-Closed	Yes
Form	Waiver of Premium	Approved-Closed	Yes
Form	Certificate Amendment	Approved-Closed	Yes
Form	Certificate Amendment	Approved-Closed	Yes
Form	Certificate Amendment	Approved-Closed	Yes
Form	Accident Insurance Election of Portability Coverage	Approved-Closed	Yes
Form	Premium Notice	Approved-Closed	Yes

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Objection Letter

Objection Letter Status Pending Industry Response
Objection Letter Date 06/19/2012
Submitted Date 06/19/2012
Respond By Date 07/19/2012

Dear Marilyn Young,

This will acknowledge receipt of the captioned filing.

Objection 1

- Benefit, GP-1-AC-BEN-12 (Form)
- Definition, GP-1-AC-DEF-12 (Form)
- Exclusions, GP-1-AC-EXC-12 (Form)
- ACCIDENT COVERAGE, GP-1-AC-IC-12 (Form)
- Portability PRIVILEGE, GP-1-AC-PORT-12 (Form)
- Waiver of Premium, GP-1-AC-WP-12 (Form)
- Policy Rider, GP-1-A-AC-AS-12 (Form)
- Policy Rider, GP-1-A-AC-DIS-12 (Form)
- Policy Rider, GP-1-A-AC-HC-12 (Form)
- Benefit, CGP-3-AC-BEN-12 (Form)
- Definition, CGP-3-AC-DEF-12 (Form)
- Exclusion, CGP-3-AC-EXC-12 (Form)
- Accident Coverage, CGP-3-AC-IC-12 (Form)
- Portability Privilege, CGP-3-AC-PORT-12 (Form)
- Waiver of Premium, CGP-3-AC-WP-12 (Form)
- Certificate Amendment, CGP-3-A-AC-AS-12 (Form)
- Certificate Amendment, CGP-3-AC-A-DIS-12 (Form)
- Certificate Amendment, CGP-3-AC-A-HC-12 (Form)
- Accident Insurance Election of Portability Coverage, GG-016348 (Form)
- Premium Notice, GG-016349 (Form)

Comment:

Our filing fees under Rule and Regulation 57 have been updated. Please review the General Instructions for ArkansasLH or Rule and Regulation 57.

The fee for this submission is \$50.00 per form for a total of \$1,000.00. Please submit an additional \$950.00 for this submission.

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We will begin our review of this submission upon receipt of the additional filing fee.

A.C.A. 23-79-109(1)-(5) sets forth the procedure by which filings may be deemed approved upon the expiration of certain time periods with no affirmative action by the commissioner. If the commissioner determines that additional information is needed to make a decision regarding approval, such request for information will be made to the company. The filing will not be considered complete until said additional information is received. The time periods set forth in this statute will not begin to run until the filing is complete.

Please feel free to contact me if you have questions.

Sincerely,
Rosalind Minor

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Response Letter

Response Letter Status Submitted to State
Response Letter Date 06/28/2012
Submitted Date 06/28/2012

Dear Rosalind Minor,

Comments:

Response 1

Comments: Additional fees submitted 6/19/12.

Related Objection 1

Applies To:

- Benefit, GP-1-AC-BEN-12 (Form)
- Definition, GP-1-AC-DEF-12 (Form)
- Exclusions, GP-1-AC-EXC-12 (Form)
- ACCIDENT COVERAGE, GP-1-AC-IC-12 (Form)
- Portability PRIVILEGE, GP-1-AC-PORT-12 (Form)
- Waiver of Premium, GP-1-AC-WP-12 (Form)
- Policy Rider, GP-1-A-AC-AS-12 (Form)
- Policy Rider, GP-1-A-AC-DIS-12 (Form)
- Policy Rider, GP-1-A-AC-HC-12 (Form)
- Benefit, CGP-3-AC-BEN-12 (Form)
- Definition, CGP-3-AC-DEF-12 (Form)
- Exclusion, CGP-3-AC-EXC-12 (Form)
- Accident Coverage, CGP-3-AC-IC-12 (Form)
- Portability Privilege, CGP-3-AC-PORT-12 (Form)
- Waiver of Premium, CGP-3-AC-WP-12 (Form)
- Certificate Amendment, CGP-3-A-AC-AS-12 (Form)
- Certificate Amendment, CGP-3-AC-A-DIS-12 (Form)
- Certificate Amendment, CGP-3-AC-A-HC-12 (Form)
- Accident Insurance Election of Portability Coverage, GG-016348 (Form)
- Premium Notice, GG-016349 (Form)

Comment:

Our filing fees under Rule and Regulation 57 have been updated. Please review the General Instructions for

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ArkansasLH or Rule and Regulation 57.

The fee for this submission is \$50.00 per form for a total of \$1,000.00. Please submit an additional \$950.00 for this submission.

We will begin our review of this submission upon receipt of the additional filing fee.

Changed Items:

No Supporting Documents changed.

No Form Schedule items changed.

No Rate/Rule Schedule items changed.

Sincerely,
Diane Pappas, Marilyn Young, Matthew Noonan, Victoria Arama

SERFF Tracking Number: GARD-128474947

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State Tracking Number:

Company Tracking Number:

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Form Schedule

Lead Form Number: GP-1-AC-BEN-12

Schedule Item	Form Number	Form Type Form Name	Action	Action Specific Data	Readability	Attachment
Approved-Closed 06/28/2012	GP-1-AC-BEN-12	Policy/Cont Benefit ract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider	Initial		0.000	GP-1-AC-BEN-12_V1, 05-01- 2012_.pdf
Approved-Closed 06/28/2012	GP-1-AC-DEF-12	Policy/Cont Definition ract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider	Initial		0.000	GP-1-AC-DEF-12_V1, 05-01- 2012_.pdf
Approved-Closed 06/28/2012	GP-1-AC-EXC-12	Policy/Cont Exclusions ract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider	Initial		0.000	GP-1-AC-EXC-12_V1, 05-01- 2012_.pdf
Approved-Closed 06/28/2012	GP-1-AC-IC-12	Policy/Cont ACCIDENT ract/Fraternal COVERAGE	Initial		0.000	GP-1-AC-IC-12_V1, 05-01-2012_.pdf

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Certificate:
 Amendmen
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Approved- Closed 06/28/2012	GP-1-AC- PORT-12	Policy/Cont Portability ract/Fratern PRIVILEGE al Certificate: Amendmen t, Insert Page, Endorseme nt or Rider	Initial	0.000	GP-1-AC- PORT-12 _V1, 05-01- 2012_.pdf
Approved- Closed 06/28/2012	GP-1-AC- WP-12	Policy/Cont Waiver of Premium ract/Fratern al Certificate: Amendmen t, Insert Page, Endorseme nt or Rider	Initial	0.000	GP-1-AC-WP- 12_V1, 05- 01-2012_.pdf
Approved- Closed 06/28/2012	GP-1-A- AC-AS-12	Policy/Cont Policy Rider ract/Fratern al Certificate: Amendmen t, Insert Page, Endorseme nt or Rider	Initial	0.000	GP-1-A-AC- AS-12_V1, 05-01- 2012_.pdf
Approved- Closed 06/28/2012	GP-1-A- AC-DIS-12	Policy/Cont Policy Rider ract/Fratern al Certificate:	Initial	0.000	GP-1-A-AC- DIS-12_V1, 05-01- 2012_.pdf

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	Amendmen t, Insert Page, Endorseme nt or Rider		
Approved- Closed 06/28/2012	GP-1-A- AC-HC-12 Policy/Cont ract/Fratern al Certificate: Amendmen t, Insert Page, Endorseme nt or Rider	Initial	0.000 GP-1-A-AC- HC-12 _V1, 05-01- 2012_.pdf
Approved- Closed 06/28/2012	CGP-3-AC- BEN-12 Certificate Amendmen t, Insert Page, Endorseme nt or Rider	Benefit Initial	0.000 CGP-3-AC- BEN-12 _V1, 05-01- 2012_.pdf
Approved- Closed 06/28/2012	CGP-3-AC- DEF-12 Certificate Amendmen t, Insert Page, Endorseme nt or Rider	Definition Initial	0.000 CGP-3-AC- DEF-12 _V1, 05-01- 2012_.pdf
Approved- Closed 06/28/2012	CGP-3-AC- EXC-12 Certificate Amendmen t, Insert Page, Endorseme nt or Rider	Exclusion Initial	0.000 CGP-3-AC- EXC-12 _V1, 05-01- 2012_.pdf
Approved- Closed 06/28/2012	CGP-3-AC- IC-12 Certificate Amendmen t, Insert Page, Endorseme	Accident Coverage Initial	0.000 CGP-3-AC- IC-12 V1,_ 05-01- 2012_.pdf

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Approved- Closed 06/28/2012	CGP-3-AC- PORT-12 Certificate Amendmen t, Insert Page, Endorseme nt or Rider	Portability Privilege Initial	0.000 CGP-3-AC- PORT-12 _V1, 05-01- 2012_.pdf
Approved- Closed 06/28/2012	CGP-3-AC- WP-12 Certificate Amendmen t, Insert Page, Endorseme nt or Rider	Waiver of Premium Initial	0.000 CGP-3-AC- WP-12 _V1, 05-01- 2012_.pdf
Approved- Closed 06/28/2012	CGP-3-A- AC-AS-12 Certificate Amendmen t, Insert Page, Endorseme nt or Rider	Certificate Certificate Amendment Initial	0.000 CGP-3-A-AC- AS-12 _V1, 05-01- 2012_.pdf
Approved- Closed 06/28/2012	CGP-3-AC- A-DIS-12 Certificate Amendmen t, Insert Page, Endorseme nt or Rider	Certificate Certificate Amendment Initial	0.000 CGP-3-A-AC- DIS-12 _V1, 05-01- 2012_.pdf
Approved- Closed 06/28/2012	CGP-3-AC- A-HC-12 Certificate Amendmen t, Insert Page, Endorseme nt or Rider	Certificate Certificate Amendment Initial	0.000 CGP-3-A-AC- HC-12 _V1, 05-01- 2012_.pdf
Approved- Closed 06/28/2012	GG-016348 Application/ Enrollment Form	Accident Insurance Election of Portability Coverage Initial	0.000 GG- 016348.pdf
Approved- Closed 06/28/2012	GG-016349 Other	Premium Notice Initial	0.000 GG- 016349.pdf

Benefits

¹**[Accident Emergency Room Treatment:** We pay the amount shown in the Schedule of Insurance if a *covered person* is examined or treated by a doctor in a *hospital emergency room* for the initial treatment of injuries sustained in a *covered accident* within ⁴[72] hours after the *covered accident*. This benefit is payable once per *covered person* per *covered accident*. We will not pay the Accident Emergency Room Treatment benefit and the Initial Doctor's Office/Urgent Care Facility benefit for the same *covered accident*.]

¹**[Accident Follow-Up Visit – :** We pay the amount shown in the Schedule of Insurance if a *covered person* requires additional follow up treatments (not including occupational, speech or *physical therapy* or chiropractic treatment) after initial *emergency room* treatment or *doctor's office/urgent care facility* treatment. We pay up to ⁵[6] treatments per *covered person* per *covered accident*. Treatment must begin within ⁶[60] days of a *covered accident* and be completed within ⁹[365] days.]

¹**[Accidental Death:** We pay the amount shown in the Schedule of Insurance if a *covered person* sustains an *injury* in a *covered accident* that causes his or her death. The *injury* must cause his or her death within ² [90] days of the *covered accident*. If we pay this benefit, we will not pay the Accidental Death Common Carrier benefit.]

¹**[Accidental Death Common Carrier:** We pay the amount shown in the Schedule of Insurance if a *covered person's accidental death* is due to a *covered accident* which occurs while the *covered person* is riding as a fare-paying passenger in a public conveyance. If we pay this benefit, we will not pay the Accidental Death benefit.]

¹**[Accidental Death Common Disaster:** We pay the increased amount shown in the Schedule of Insurance if both an employee and his or her insured spouse die in a *covered accident* or in separate *covered accidents* within the same 24 hour period. The benefit increase applies to the insured spouse's benefit.]

¹**[Accidental Dismemberment:** We pay the amount shown in the Schedule of Insurance if a listed loss is sustained by a *covered person* due to injuries caused by a *covered accident*.]

- "Loss of a hand" means the hand is completely severed at or above the wrist.
- "Loss of a foot" means the foot is completely severed at or above the ankle.
- "Loss of sight" means total and permanent loss of 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. This benefit is not payable if benefits have been paid for "Loss of hand".
- "Loss of all toes of same foot" means complete severance at the metatarsalphalangeal joint. This benefit is not payable if benefits have been paid for "Loss of foot".

²⁷[We will not pay more than ⁷[\$10,000] for all losses due to the same *covered accident*.]]

¹**[Accidental Death Seatbelt and Airbag benefit:** We pay the seatbelt amount shown in the Schedule of Insurance if a *covered person* dies due to injuries sustained in a *covered accident* while properly wearing a seatbelt. We will pay the Seatbelt and Airbag amount shown in the Schedule of Insurance if a *covered person* dies as a direct result of an automobile *accident* while both properly wearing a seatbelt, and sitting in a seat equipped with an airbag. We will not pay both the Seatbelt and Seatbelt and Airbag benefit for the same *covered accident*.]

¹**[Air Ambulance:** We pay the amount shown on the Schedule of Insurance if a *covered person* is transported by air ambulance to or from a *hospital* or between medical facilities for treatment of injuries sustained as the result of a *covered accident* within ⁸[48] hours of a *covered accident*. This benefit is payable once per *covered person* per *covered accident*.]

¹**[Ambulance:** We pay the amount shown on the Schedule of Insurance if a licensed ambulance company transports a *covered person* by ground to or from a *hospital* or between medical facilities for treatment of injuries sustained as a result of a *covered accident* within ² [90] days of *covered accident*. This benefit is payable once per *covered person* per *covered accident*.]

¹**[Appliance:** We pay the amount shown on the Schedule of Insurance if a *covered person* uses an *appliance* prescribed by a *doctor* as necessary due to an *injury* sustained as a result of a *covered accident*. An *appliance* includes wheelchairs, leg or back braces, crutches, walkers, walking boot that extends above the ankle, and brace for the neck. Use of the *appliance* must begin within ² [90] days of *covered accident*. This benefit is payable once per *covered person* per *covered accident*.]

¹**[Blood/Plasma/Platelets:** We pay the amount shown in the Schedule of Insurance if as the result of a *covered accident* a *covered person* receives a transfusion, administration, cross matching, typing and processing of blood/plasma/platelets within ² [90] days of the *covered accident*. This benefit is payable once per *covered person* per *covered accident*.]

¹**[Burn:** We pay the amount shown in the Schedule of Insurance if a *covered person* receives burns as a result of a *covered accident* and is treated by a *doctor* within ⁴[72] hours of the *covered accident*. If a *covered person* meets more than one of the burn classifications, we pay the higher amount. This benefit is payable once per *covered person* per *covered accident*.]

¹**[Burn - Skin Graft:** We pay the amount shown in the Schedule of Insurance when medically necessary grafting of the skin is received by a *covered person* for a burn that was payable under the Burn benefit. This benefit is payable once per *covered person* per *covered accident*.]

¹**[Catastrophic Loss:** We pay the amount shown in the Schedule of Insurance if a *covered person* suffers a catastrophic loss within ⁹[365] days of a *covered accident* due to injuries sustained in a *covered accident*. This benefit is payable once per *covered person* per *covered accident*. If a Catastrophic Loss benefit is paid, an Accidental Dismemberment benefit will not be paid for the same or attached body part.]

¹**[Child Organized Sport:** We pay the additional amount shown on the Schedule of Insurance if the *covered accident* occurred while an *employee's* covered dependent child is participating in an *organized sport*. The child must be insured by this plan on the date the *accident* occurred. The covered child must be ¹⁰[18] years of age or younger.]

¹**[Chiropractic visits:** We pay the amount shown in the Schedule of Insurance if as the result of a *covered accident* a *covered person* suffers a structural imbalance and receives *chiropractic care services* by a chiropractor in a chiropractor's office. Treatment must begin within ⁶[60] days after a *covered accident* and be completed within ¹¹[180] days of the *covered accident*. We will pay for up to ⁵[6] visits per *covered person* per *covered accident* but no more than ¹²[12] visits per calendar year.]

¹**[Coma:** We pay the amount shown in the Schedule of Insurance if as the result of a *covered accident* a *covered person* is in a *coma* lasting at least ¹³[7] consecutive days characterized by the absence of eye opening, verbal response, and motor response. The condition must require intubation for respiratory assistance, be diagnosed or treated by a *doctor* within ² [90] days of the *covered accident*. This benefit is not payable for a medically induced *coma*.]

¹**[Concussions:** We pay the amount shown in the Schedule of Insurance if a *covered person* sustains a concussion as the result of a *covered accident* and is diagnosed within ⁴[72] hours of the *covered accident*. This benefit is payable once per *covered person* per *covered accident*.]

¹**[Dislocations:** We pay the amount shown in the Schedule of Insurance if a *covered person* is injured and suffers a *dislocation* as the result of a *covered accident*. A *dislocation* must be diagnosed by a *doctor* within ² [90] days of the *covered accident*. The *dislocation* must be corrected by open (surgical) or closed (non-surgical) reduction.]

For multiple *dislocations* due to the same *covered accident*, we will pay no more than ¹⁴[two] times the benefit amount for the joint involved with the highest benefit amount. For partial *dislocations*, we will pay ¹⁵[25%] of the benefit shown in the Schedule of Insurance for a closed reduction.]

¹**[Diagnostic Exam (Major):** We pay the amount shown in the Schedule of Insurance if a *covered person* receives one of the following imaging studies due to a *covered accident*: ¹⁶[Computerized Tomography (CT scan), computerized axial tomography (CAT), magnetic resonance imaging (MRI) or electroencephalography (EEG).] The imaging study must be prescribed by a *doctor* and performed in a *doctor's* office or in a *hospital* on an *inpatient* or *outpatient* basis. This benefit is payable once per *covered person* per *covered accident*.]

¹**[Emergency Dental Work:** We pay the amount shown in the Schedule of Insurance if a *covered person* suffers a broken tooth as the result of a *covered accident* and it is repaired by a *dentist* with a dental crown and/or dental extraction. The dental services must begin within ⁶[60] days of the *covered accident*. One dental crown and one dental extraction is payable per *covered person* per *accident*.]

¹**[Epidural Anesthesia Pain Management:** We pay the amount shown in the Schedule of Insurance if a *covered person* is prescribed and receives an epidural administered for pain management for injuries received as a result of a *covered accident*. The epidural must be administered in a *hospital* or *doctor's* office and is payable ¹⁷[twice] per *covered person* per *accident*. This benefit is not payable for an epidural administered during a surgical procedure.]

¹**[Eye Injury:** We pay the amount shown in the Schedule of Insurance if a *covered person* is injured as the result of a *covered accident* and suffers an *eye injury*. The *eye injury* must require surgery or the removal of a foreign object by a *doctor* within ² [90] days of a *covered accident*. This benefit is payable once per *covered person* per *covered accident*.]

²**[Family Care:** We pay the amount shown in the Schedule of Insurance if a *covered person* is injured as the result of a *covered accident* and is confined in a *hospital*, ICU or *alternate care* or *rehabilitative facility* and an *employee* has a child or children attending a *child care center*. The benefit is payable for each child attending a *child care center* while the *covered person* is confined. The child attending the *child care center* does not need to be insured under this Policy for Accident coverage but must meet the eligibility requirements found in the Dependent Eligibility section. This benefit is payable for up to ¹⁸[30] days within ⁹[365] days of the *covered accident*. This benefit is payable once per child per *covered accident*.]

³**[Fracture (Bone):** We pay the amount shown in the Schedule of Insurance if a *covered person* suffers a *fracture* as a result of a *covered accident* and it is diagnosed within ² [90] days of the *covered accident*. The *fracture* must require open (surgical) or closed (non-surgical) reduction by a *doctor*. This benefit is payable for up to ¹⁴ [two] *fractures* per *covered person* per *covered accident*. If there are more than ¹⁴[two] *fractures*, we will pay the highest two benefit amounts per *covered person* per *covered accident*. We pay ¹⁵[25%] of the amount shown in the Schedule of Insurance for the closed reduction of a bone with a chip *fracture* that was a result of a *covered accident*.]

¹**[Hospital Admission:** We pay the amount shown in the Schedule of Insurance if a *covered person* is admitted to a *hospital* within ¹¹[180] days of a *covered accident* as a result of injuries sustained in a *covered accident*. This benefit is payable once per *covered person* per *covered accident*. This benefit is not payable for *emergency room* treatment, *outpatient treatment*, or a *hospital* stay less than 20 hours in an observation unit. We will not pay the Hospital Admission and Hospital Intensive Care Unit Admission benefits for the same *covered accident*.]

¹**[Hospital Confinement:** We pay the amount shown in the Schedule of Insurance if a *covered person* is confined to a *hospital* within ¹¹[180] days of a *covered accident* as a result of injuries sustained in a *covered accident*. This benefit is payable up to ⁹[365] days per *covered accident*. This benefit is not payable for a *hospital* stay less than 20 hours. We pay either the Hospital Confinement or the Hospital Intensive Care Unit Confinement benefits for each day.]

¹**[Hospital Intensive Care Unit Admission:** We pay the amount shown in the Schedule of Insurance if a *covered person* is admitted directly to a *hospital intensive care unit* within ¹⁸[30] days of a *covered accident* as a result of injuries sustained in a *covered accident*. This benefit is payable once per *covered person* per *covered accident*. This benefit is not payable for *emergency room* treatment, *outpatient treatment*, or a *hospital* stay less than 20 hours in an observation unit. We will not pay the Hospital Admission and the Hospital Intensive Care Unit Admission benefits for the same *covered accident*.]

¹**[Hospital Intensive Care Unit Confinement:** We pay the amount shown in the Schedule of Insurance if a *covered person* is confined to a *hospital intensive care unit* within ¹⁸[30] days of a *covered accident* as a result of injuries sustained in a *covered accident*. This benefit is payable up to ¹⁹[15] days per *covered accident*. This benefit is not payable for a *hospital intensive care unit* stay less than 20 hours. We pay either the Hospital Confinement or the Hospital Intensive Care Unit Confinement for each day.]

¹[Initial Doctor's Office/Urgent Care Facility Treatment: We pay the amount shown in the Schedule of Insurance if a covered person is examined or treated by a *doctor* in a *doctor's office* or *urgent care facility* for the initial treatment of a *covered accident* within ¹⁸[30] days after the *covered accident*. This benefit is payable once per *covered person* per *covered accident*. We will not pay the Accident Emergency Room Treatment benefit and the Initial Doctor's Office/Urgent Care Facility Treatment benefit for the same *covered accident*.]

¹[Knee Cartilage: We pay the amount shown in the Schedule of Insurance if a *covered person* tears, ruptures or severs knee cartilage (meniscus) as the result of a *covered accident* and requires surgical repair. The *injury* must be treated by a *doctor* within ⁶[60] days after the *covered accident* and repaired through surgery within ⁹[365] days.]

¹[Joint Replacement: We pay the amount shown in the Schedule of Insurance if due to an *injury* sustained in a *covered accident* a *covered person* requires a hip, knee, or shoulder joint replacement. The joint replacement must be performed by a *doctor* within ² [90] days of a *covered accident* and is payable once per *covered person* per *covered accident*.]

¹[Laceration: We pay the amount shown in the Schedule of Insurance if a *covered person* sustains a laceration as a result of a *covered accident* and it is repaired by a *doctor* within ¹⁹[72] hours of the *covered accident*. The amount we pay will be based on the total length of all lacerations received in any one *covered accident* which require repair. This benefit is payable once per *covered person* per *covered accident* for a laceration with no sutures and once per *covered person* per *covered accident* for a laceration which required sutures.]

¹[Lodging: We pay the amount shown in the Schedule of Insurance for a *companion's* hotel/motel stay during the period of time a *covered person* is confined to the *hospital* as the result of a *covered accident*. This benefit is payable up to ¹⁸[30] days per *covered person* per *covered accident* and is only payable while the insured is confined to the *hospital*. The *hospital* must be more than ²⁰[50] miles from the residence of the covered person.]

¹[Occupational or Physical Therapy: We pay the amount shown in the Schedule of Insurance if a *covered person* requires occupational or *physical therapy* due to injuries sustained in a *covered accident*. Treatment must begin within ⁶[60] days of the *covered accident*, be completed within ²¹[6] months, and be performed by a licensed *occupational* or *physical therapist*. This benefit is payable up to ²²[10] treatments per *covered person* per *covered accident*.]

¹[Prosthetic Device/Artificial Limb – We pay the amount shown in the Schedule of Insurance if due to injuries sustained in a *covered accident* a *covered person* receives one or more prosthetic devices/artificial limbs as prescribed by a *doctor* for functional use due to the loss of a hand, foot or sight of an eye. The device or limb must be prescribed within ⁹[365] days of the *covered accident* and is payable once per *covered person* per *covered accident*. This benefit is not payable for hearing aids, dental aids (including false teeth), eyeglasses, or cosmetic prostheses such as hair wigs.]

¹**[Reasonable Accommodation to Home or Vehicle:** We pay the amount shown in the Schedule of Insurance for a required modification made to a *covered person's* place of residence or vehicle if the *covered person* suffers an Accidental Dismemberment or Catastrophic Loss due to a *covered accident*. The modification must be made within ¹⁴[two] years of the *covered accident* and is payable once per *covered person* per *covered accident*.]

¹**[Rehabilitation Unit Confinement:** We pay the amount shown in the Schedule of Insurance if a *covered person* is confined to rehabilitation unit due to injuries sustained in a *covered accident*. This benefit is payable up to ¹⁹[15] days per *covered person* per *covered accident* but cannot exceed ¹⁸[30] days per calendar year. We will not pay the Rehabilitation Unit Confinement and the Hospital Confinement benefits for the same day.]

¹**[Ruptured Disc With Surgical Repair:** We pay the amount shown in the Schedule of Insurance if a *covered person* receives a ruptured disc in his spine as a result of injuries sustained in a *covered accident*. The *injury* must be treated by a *doctor* within ⁶[60] days of the *covered accident* and surgically repaired within ⁹[365] days of the *covered accident*. This benefit is payable once per *covered person* per *covered accident*.]

¹**[Surgery (cranial, open-abdominal, thoracic, hernia):** We pay the amount shown in the Schedule of Insurance if a *covered person* undergoes cranial, open-abdominal, thoracic, or hernia surgery due injuries sustained to a *covered accident*. Cranial, open-abdominal, and thoracic surgery must be performed within ⁴[72] hours of the *covered accident*. Hernia surgery must be diagnosed within ¹⁸[30] days of *covered accident* and surgery must be performed within ⁶[60] days. If more than one surgery is performed, we pay the benefit with the highest dollar amount. This benefit is payable once per *covered person* per *covered accident*.]

¹**[Surgery (Exploratory and Arthroscopic):** We pay the amount shown in the Schedule of Insurance if a *covered person* undergoes exploratory or arthroscopic surgery as a result of injuries sustained in a *covered accident* and the surgery takes place within ⁶[60] days of the *covered accident*. This benefit is payable once per *covered person* per *covered accident*. Hernia repair is not covered under this benefit. This benefit is not payable if the Surgery or Tendon/Ligament/Rotator Cuff benefits are payable for the same surgery.]

¹**[Tendon/Ligament/Rotator Cuff:** We pay the amount shown in the Schedule of Insurance if a *covered person* receives a torn, ruptured or severed tendon, ligament, or rotator cuff as the result of injuries sustained in a *covered accident*. The *injury* must be treated within ⁶[60] days of the *covered accident* and repaired through surgery within ⁹[365] days of the *covered accident*. This benefit is payable once per *covered person* per *covered accident*.]

¹**[Transportation:** We pay the amount shown in the Schedule of Insurance if a *covered person* must travel more than ²⁰[50] miles one way to receive special treatment at a *hospital* or free standing treatment facility due to a *covered accident*. The treatment must be prescribed by a *doctor* and not available locally. This benefit is payable up to ²³[three times] per *covered person* per *covered accident* and is not payable if transportation is provided by *ambulance* or *air ambulance*.]

¹**[Wellness Benefit:** We pay the amount shown in the Schedule of Insurance for one wellness benefit per [calendar] year per covered person if such person has a wellness test performed while coverage is in force. Wellness tests are:

- ²⁴[Abdominal aortic aneurysm ultrasonography
- Blood test for triglycerides
- Bone marrow testing
- Bone density screening
- Breast ultrasound
- CA 15-3 (blood test for breast cancer)
- CA125 (blood test for ovarian cancer)
- Carotid ultrasound
- CEA (blood test for colon cancer)
- Chest x-ray
- Colonoscopy
- Completion of a smoking cessation program
- Completion of a weight reduction program
- Double contrast barium enema
- EKG
- Fasting blood glucose test
- Flexible sigmoidoscopy
- Hemoccult stool analysis
- Immunizations
- Mammography
- Pap smear
- PSA (blood test for prostate cancer)
- Routine/annual physicals
- Serum cholesterol test to determine level of HDL and LDL
- Serum Protein Electrophoresis (blood test for myeloma)
- Skin cancer biopsy
- Stress test on a bicycle or treadmill
- Thermography
- ThinPrep pap test
- Virtual colonoscopy.]

¹**[X – Ray:** We pay the amount shown in the Schedule of Insurance if a *covered person* receives an x-ray as the result of injuries sustained in a *covered accident*. The test must be prescribed by a *doctor* and performed in a *doctor's* office or a *hospital* on an *inpatient* or *outpatient* basis and performed within ² [90] days of the *covered accident*. This benefit is payable once per *covered person* per *covered accident*.]

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

For all other covered losses, we pay the *covered person*, if he or she is living. If not, we pay the beneficiary described below.

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

The Beneficiary: The *employee* decides who gets this benefit if he or she dies. ^{25A} [He or she should have named a beneficiary on his or her enrollment form.] ^{25B} [The *employee's* beneficiary designation should be maintained by his or her *employer*.] The *employee* can change his or her beneficiary at any time by giving us written notice, unless he or she has assigned this insurance. ^{26A} [But the change will not take effect until we give the *employee* written confirmation of the change.] ^{26B} [But the change will not take effect until the *employer* gives the *employee* written confirmation of the change.]

If the *employee* named more than one person, but didn't tell us what their shares should be, they will share equally. If someone the *employee* named dies before the *employee*, that person's share will be divided equally by the beneficiaries still alive, unless the *employee* has specified otherwise.

If there is no beneficiary when the *employee* dies, we will pay this benefit to one of the following: (a) his or her estate; (b) his or her spouse; (c) his or her parents; (d) his or her children; or (e) his or her brothers and sisters.

DEFINITIONS

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

¹**[Accident:** This term means an event or occurrence that was not reasonably foreseeable, or that could not have been reasonably expected or anticipated. The term *accident* does not include a *sickness*.

¹**[Accidental death:** This term means death caused by an *accident* independent of *sickness*, bodily infirmity, or any other cause and which is not excluded under the Limitations & Exclusions section.]

¹**[Alternate Care Facility** This term means a facility that is licensed according to state and/or local laws to provide skilled care, intermediate care, intermingled care, custodial care, or rehabilitative care as an alternative to care at a *Hospital*.]

¹**[Child care center** This term means a program of child care which: (1) is provided in a facility that is licensed as a day care center or is operated by a licensed day care provider; and (2) charges a fee for the care of children. The term does not include child care provided by a: (a) parent; (b) stepparent; (c) grandparent; (d) sibling; (e) aunt; or (f) uncle.]

¹**[Chiropractic Care services** This term means spinal manipulation by a licensed chiropractor to correct a structural imbalance caused by a *covered accident*. This does not include services for massage therapy or treatment of chronic conditions or other injuries not related to structural imbalance.]

¹**[Covered Accident** This term means an *accident* that:

- Occurs while the covered person's coverage under this *plan* is in effect.
- Results in a bodily *injury* and
- Is not otherwise excluded under the terms of this *plan*.]

¹**[Covered Person** This term means an *employee*²[or dependent] insured by this *plan*.]

¹**[Common Carrier** This term means any land, air or water conveyance operated under a license to transport passengers for hire.]

¹**[Coma** This term means a state of complete mental unresponsiveness, due to *injury*, with no evidence of appropriate responses to stimulation, as diagnosed by a *doctor*.]

¹**[Companion** This term means a spouse, domestic partner, civil union partner, sibling, child, parent, grandparent, or any primary care giver.]

¹**[Dentist** This term means a licensed *doctor* of dentistry, operating within the scope of his or her license, in the state in which he or she is licensed.]

¹**[Dislocation** This term means a completely separated joint due to an *injury*. A partial *dislocation* means the joint is misaligned but not completely dislocated, as diagnosed by a *doctor*.]

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

¹**[Emergency room** This term means a department of the *hospital* that is designated for emergency care of accidental injuries. This area must be staffed & equipped to handle trauma, be supervised and provide treatment by *doctors*, and provide care seven days per week, 24 hours per day.]

¹**[Epidural Anesthesia** This term means a form of regional anesthesia involving injection of drugs through a catheter placed into the epidural space. The epidural must be administered due to a *covered accident*, and does not include treatment for childbirth or diseases.]

¹**[Fracture** This term means a broken bone that can be determined by a diagnostic exam. A chip *fracture* is a *fracture* in which a piece of the bone is broken off near a joint at a place where a ligament is usually attached.]

¹**[Hospital** This term means a short-term, acute care general facility, which:

- (1) is primarily engaged in providing, by or under the continuous supervision of *doctors*, to *inpatients*, diagnostic services and therapeutic services for diagnosis, treatment and care of sick or injured persons;
- (2) has organized departments of medicine and major surgery;
- (3) has a requirement that every patient must be under the care of a *doctor* or *dentist*;
- (4) provides 24 hour nursing service by or under the supervision of a registered professional nurse (R.N.);
- (5) is duly licensed by the agency responsible for licensing such *Hospitals*; and
- (6) is not, other than incidentally: (a) a place of rest; (b) a place primarily for the treatment of tuberculosis; (c) a place for the aged; (d) a place for drug addicts or alcoholics; or (e) a place for convalescent, custodial, educational or rehabilitative care.]

¹**[Hospital Intensive Care Unit** This term means a designated area of a *hospital* that

- provides the highest quality of medical care and is restricted to patients who are critically ill or injured and who require intensive comprehensive observation and care;
- is separate and apart from the surgical recovery room and from rooms, beds, wards, and units customarily used for patient confinement
- is permanently equipped with special lifesaving equipment for the care of the critically ill or injured;
- is under continuous observation by a specially trained nursing staff assigned exclusively to the intensive care unit on a 24 hour basis and is assigned a *doctor* on a full-time basis.]

¹**[Hospital Confinement** This term means admission to a *hospital* as an *inpatient* for ³[at least 24 consecutive hours] by a *doctor* for an *injury*.]

¹**[Injury** This term means unintentional physical damage or harm caused directly by an *accident* and not due to *sickness*, disease or any other causes. The *injury* must occur while a *covered person* is insured under this policy.]

¹**[Inpatient** This term means a patient who is admitted to a *hospital* for an *injury*.]

¹**[Occupational Therapy** This term means the treatment of a physically disabled person by means of constructive activities designed and adapted to promote the restoration of the person's ability to satisfactorily accomplish the ordinary tasks of daily living and those tasks required by the person's particular occupational role. *Occupational therapy* does not include diversional, recreational, vocational therapies (i.e. hobbies, arts and crafts).]

¹**[Occupational Therapist** This term means a person, other than the *covered person* or a family member, who: 1) possesses the designation “Occupational Therapists Registered (OTR)”, 2) is licensed by the state to practice *occupational therapy*, 3) performs services which are allowed by his licenses; and 4) performs services for which benefits are provided by this policy.]

¹**[Organized Sport** This term means a sport activity that is governed by an organization and requires formal registration to participate. Proof of registration will be required at claim time.]

¹**[Outpatient Treatment** This term means medical services that the *covered person* receives when not confined as an *Inpatient* in a *Hospital*.]

¹**[Physical Therapy** This term means treatment by physical means, hydrotherapy, heat, or similar modalities, physical agents, bio-mechanical and neuro-physiological principles and devices. Such therapy is given to relieve pain, restore function, and to prevent disability following *injury* or loss of a body part.]

¹**[Physical Therapist** This term means a person, other than the *covered person* or a family member, who: 1) is licensed by the state to practice *physical therapy*; 2) performs services which are allowed by his or her license; 3) performs services for which benefits are provided by this Policy and 4) practices according to the code of ethics of the American Physical Therapy Association.]

¹**[Rehabilitative unit** This term means an appropriately licensed facility or separate section of a *hospital* that provides rehabilitation care services on an *inpatient* basis and is designated, staffed and equipped to provide restorative services under the supervision of a trained and experienced rehabilitation medicine *doctor*. A rehabilitation unit is not: a nursing home; an extended care facility; a skilled nursing facility; a rest home or home for the aged; a hospice care facility; a place for alcoholics or drug addicts; or an assisted living facility.]

¹**[Sickness** This term means a disease, illness or other condition not related to *injury* including diseases or infections except when the due to an accidental cut or wound.]

¹**[Urgent Care Facility** This term means a health care facility that is organizationally separate from a *hospital* and whose primary purpose is the offering and provision of immediate, short term medical care, without appointment, for urgent care.]

¹**[We, Us and Our:** These terms mean The Guardian Life Insurance Company of America.]

EXCLUSIONS

This *plan* will not pay benefits for any injury caused by or related to, directly or indirectly:

- ³[Sickness, disease, mental infirmity or medical or surgical treatment.]
- ³[Voluntary use of any poison, chemical, prescription or non-prescription drug or controlled substance unless: (1) it was prescribed for a *covered person* by a *doctor*, and (2) it was used as prescribed. In the case of a non-prescription drug, this *plan* does not pay for any *accident* resulting from or contributed to by use in a manner inconsistent with package instructions. "Controlled substance" means anything called a controlled substance in Title II of the Comprehensive Drug Abuse Prevention and Control Act of 1970, as amended from time to time.]
- ³[The *covered person* being legally intoxicated.]
- ³[. Declared or undeclared war, act of war, or armed aggression.]
- ³[Service in the armed forces, National Guard, or military reserves of any state or country.]
- ³[Taking part in a riot or civil disorder.]
- ³[Commission of, or attempt to commit a felony.]
- ³[Treatment rendered or *hospital confinement* outside the United States ⁴[or Canada.]]
- ³[Intentionally self inflicted injury, while sane or insane.]
- ³[Suicide or attempted suicide, while sane or insane.]
- ³[Travel or flight in any kind of aircraft, including any aircraft owned by or for the *employer* except as a fare-paying passenger on a common carrier.]
- ³[Participation in any kind of sporting activity for compensation or profit, including coaching or officiating.]
- ³[Riding in or driving any motor-driven vehicle in a race, stunt show or speed test.]
- ³[Participation in hang gliding, bungee jumping, sailgliding, parasailing, parakiting ballooning, parachuting, .or skydiving.]
-
- ³[²[Job related or on the job injuries.]]
- ³[An accident that occurred before the *covered person* is covered by this *plan*.]
- ³[¹[Injuries to a dependent child received during the birth.]]

ACCIDENT COVERAGE

Subject to all of this *plan's* terms, this *plan* will pay the benefits described below if a *covered person* sustains an injury or incurs a loss as a result of a covered accident which occurs on or after the date he or she becomes insured by this *plan*. This *plan* pays no benefits other than what is specifically listed below.

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

PORTABILITY PRIVILEGE

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

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

- The *employee* may port his or her coverage ¹[or coverage for any of *his or her* dependents] if coverage under this *plan* ends because he or she: (a) has terminated employment; (2) stops being a member of an eligible class of *employees*; or (3) this *plan* ends.
- ⁸[The *employee* may not Port his or her coverage ¹ [or coverage for any of *his or her* dependents] unless he or she has been covered by this *plan*, or the *plan* it replaced, for *accident* coverage for at least ⁹[12] months in a row prior to the date his or her coverage under this *plan* ends. And the employee must have been *actively at work* on a *full-time* ⁶[or *part-time*] basis for at least ¹⁰[30] scheduled working days in a row prior to the date his or her coverage under this *plan* ends.
- The employee may not Port his or her coverage ¹[or coverage for any of *his or her* dependents] if (1) coverage under this *plan* ends due to his or her failure to pay any required premium ²[; or (2) he or she has reached age ³[70] on or before *his or her* coverage under this *plan* ends.]

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

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

If an employee dies while covered for dependent *accident* coverage, his or her spouse may port the dependent *accident* coverage as described above. The employee's spouse and dependent children must be covered under this *plan* on the date of his or her death. But this option is not available if ¹¹[(1)] there is no surviving spouse ¹¹[; or (2) the surviving spouse has reached age ³[70] on the date the *employee* dies] .]

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

The premium for the portable certificate of coverage will be based on: the *covered person's* rate class under this *plan* ¹[; and (2) the *covered person* [or his or her surviving spouse's] age bracket as shown in the Accident Portability Coverage Premium Notice.

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

⁴[We will not ask for *proof* that the employee ¹[or his or her surviving spouse] are in good health.]

⁵[We require *proof* of insurability satisfactory to *us* if the employee ¹[or his or her surviving spouse] Port for any reason, other than the end of the group *plan*. And, we must approve that *proof* in writing.]

¹[Waiver of Premium]

If, while covered by this *plan*, an *employee* becomes disabled due to a *covered accident* and such *employee* remains disabled for ²[90] days, we will waive the premium due after such ²[90] days for as long as the *employee* remains disabled.

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

ATTACHED TO AND MADE PART OF GROUP INSURANCE POLICY NO. G ¹[-(99999999)]
issued by

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

To

¹[ABC Company]
(herein called the Policyholder)

Effective ¹[99/99/99], this rider amends this *plan* by the addition of the following:

**DISABILITY SICKNESS AND ACCIDENT [ON & OFF THE JOB][OFF THE JOB]
SCHEDULE OF INSURANCE**

WEEKLY BENEFIT AMOUNT FOR COVERED ⁴¹[EMPLOYEE]: ² [\$50-\$1000]

¹⁶[WEEKLY BENEFIT AMOUNT FOR COVERED DEPENDENT SPOUSE: ² [\$50-\$1000]]

MAXIMUM BENEFIT PERIOD FOR COVERED ⁴¹[EMPLOYEE]: ³ [9-52] WEEKS

¹⁶[MAXIMUM BENEFIT PERIOD FOR COVERED DEPENDENT SPOUSE: ⁴[\$50-\$1000]]

ELIMINATION PERIOD FOR COVERED ⁴¹[EMPLOYEE] ACCIDENT: ⁵ [0-180] DAYS

¹⁶[ELIMINATION PERIOD FOR COVERED DEPENDENT SPOUSE ACCIDENT: ⁵ [0-180]
DAYS]

ELIMINATION PERIOD FOR COVERED ⁴¹[EMPLOYEE] SICKNESS: ⁵ [0-180] DAYS

¹⁶[ELIMINATION PERIOD FOR COVERED DEPENDENT SPOUSE SICKNESS: ⁵ [0-180]
DAYS]

BENEFITS

We will pay the weekly benefit amount shown in the schedule of insurance if a *covered person* becomes disabled as a result of a *sickness*, or an *injury* sustained in a *covered accident*. The *sickness* or the *covered accident* must occur and the *disability* must begin while the *covered person* is covered under this *plan*. ⁴⁶[*Disability* must begin within ⁴⁵[90] days of the *covered accident* or *sickness*.]

How Payments Start: To start getting payments from this *plan*, a *covered person* must meet all of the conditions listed below.

- he or she must: (1) become *disabled* while covered by this *plan*; and (2) remain *disabled* and covered for this *plan's* *elimination period*.
- he or she must provide proof of loss, as described in the Claim Provisions, herein.

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

^{6A}[A covered ⁴¹[*employee*] can satisfy the *elimination period* while working, provided he or she is *disabled*.]

^{6B} [A covered ⁴¹[employee] may not satisfy this *plan's elimination period* while working.]

⁷ [If a covered ⁴¹[employee] performs any work for wage or profit, he or she will not be eligible for benefits under this *plan*.]

⁸ [**Waiver Of Premium:** We waive a *covered person's* premiums for this coverage while he or she is entitled to receive a Weekly Benefit payment from this *plan*.]

When Payments End: A *covered person's* benefits from this *plan* will end on the earliest of the dates shown below:

- The date he or she is no longer *disabled*.
- The date he or she fails to provide proof of loss as required by this *plan*
- The date he or she has been outside the United States ^{9A} [and/or Canada] ^{9B} [and/or a country or region approved by Us] for more than ¹⁰ [two months] in a ¹¹ [12 month] period] .
- The date he or she dies.
- The end of the Maximum Payment Period.
- The date he or she is no longer receiving *regular and appropriate care* from a *doctor*.

Maximum Payment Period: The Maximum Payment Period is shown in the Schedule of Insurance.

Recurring Disability: Benefits from this *plan* end if a covered ⁴¹[employee] ceases to be *disabled*. But, a later *disability* may be treated as a *recurring disability*, if all of the terms listed below are met:

- A covered ⁴¹[employee] must return to *active work* right after his or her benefits end.
- The disability must recur less than ¹² [two weeks] after he or she was last entitled to benefits.
- The later *disability* must be due to the same or related cause of his or her earlier *disability*.
- This *plan* must not end during his or her return to *active work*.
- During the time he or she returns to *active work*, he or she must: (1) stay covered by this *plan*; and (2) premium payments must be made on his or her behalf.
- His or her benefits must not have ended because he or she has used up the Maximum Payment Period.

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

If all of the terms listed above are not met, the later *disability* will be treated as a new period of disability. A covered ⁴¹[employee] will be required to complete a new *elimination period*. The new period of *disability* will be subject to all the terms of the *plan* in effect on the date the new period of *disability* starts.

DEFINITIONS

¹³[This section defines certain terms appearing in this rider.

Active Work: This term means a covered ⁴¹[employee] is able to perform, and is performing, all of the regular duties of his or her work for the ⁴²[employer], ¹⁴ [on a Full-Time basis] ¹⁵ [or a part-time basis] at: (1) one of the ⁴²[employer's] usual places of business; (2) some place where the ⁴²[employer's] business requires a covered ⁴¹[employee] to travel; or (3) any other place a covered ⁴¹[employee] and the ⁴²[employer] have agreed on for a covered ⁴¹[employee's] work.]

¹³⁴⁸ ¹⁶ **Activities of Daily Living** means:

1. **Bathing:** the ability to wash in a tub or shower; or by taking a sponge bath; and to towel dry; with or without equipment or adaptive devices.]]
2. ⁴⁸ ¹⁶ **Dressing:** the ability to put on and take off all clothes; and those medically necessary braces or prosthetic limbs usually worn; and also to fasten or unfasten them.
3. **Toileting:** the ability to get to and from and on and off the toilet; to maintain personal hygiene; and to care for clothes.
4. **Transferring:** the ability to move in and out of a chair or bed with or without equipment such as: canes; walkers; crutches; grab bars; or any other support devices.
5. **Continence:** the ability to control bowel and bladder function; or, in the event of incontinence, the ability to maintain personal hygiene.
6. **Eating:** the ability to get food into the body by any means once it has been prepared and made available.]

⁴⁸ ¹⁶ **Cognitive Impairment or Cognitively Impaired:** These terms mean a decline or loss in intellectual aptitude. Such loss may result from: (a) *injury*; (b) *sickness*; (c) Alzheimer's disease, or (d) like forms of senility or irreversible dementia. It must be supported by clinical proof and standardized tests that precisely measure decline in the areas of: (i) short term memory; (ii) orientation to time, place and person; (iii) deductive or abstract reasoning; and (iv) judgement as it relates to awareness of safety. Cognitive impairment does not include decline or loss due to a *mental illness*.]]

Covered Accident This term means an *accident* that:

- Occurs while the covered person's coverage under this plan is in effect.
- Results in a bodily *injury* or *sickness*.
- Is not otherwise excluded under the terms of this *plan*; and
- Is covered under the Accident coverage of this *plan*.

Covered Person This term means an ⁴¹[*employee*] ¹⁶[or his or her dependent spouse] covered by this *plan*.

Disability or Disabled: [These terms mean that an *injury* sustained in a covered accident or a *sickness* causes physical or mental impairment to such a degree that: ¹⁶ [(A)] a covered ⁴¹[*employee*] is: (1) not able to perform ¹⁴ [, on a *full-time* basis] ¹⁵[or a, *part-time* basis] the major duties of his or her ¹⁷ [Own Job ¹⁶ [; (B) a covered dependent spouse is (i) not able to perform two or more *activities of daily living*, on a routine basis, without help or (ii) *cognitively impaired* and in need of verbal cueing to protect himself or herself or others..

⁴⁷[If the covered ⁴¹[*employee*] does not have a full-time job at the time of disability, these terms mean that the covered ⁴¹[*employee*] is (i) not able to perform two or more *activities of daily living*, on a routine basis, without help or (ii) *cognitively impaired* and in need of verbal cueing to protect himself or herself or others.]

¹⁸ [A covered ⁴¹[*employee*] is not *disabled* if he or she performs any work for wage or profit] ¹⁹ [during the *elimination period*] .]

²⁰ [A covered ⁴¹[*employee*] may be required, on average, to work more than ²¹ [40] hours per week. In this case, he or she is not *disabled* if he or she is able to work for ²¹ [40] hours per week.]]

¹³[Neither loss of a professional or occupational license due to misconduct or unlawful activity or receipt of, or entitlement to, Social Security *disability* benefits in and of themselves constitute *disability* under this *plan*.

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

Elimination Period: This term means the period of time a *covered person* must be *disabled*, due to a covered *disability*, before this *plan's* benefits are payable.

⁴¹[**Employee:** ²² [This term means a person who works for the ⁴²[*employer*] and whose income is reported for tax purposes using a W-2 or 1099 form.]

⁴²[**Employer:** This term means ¹ [ABC Company, Inc] .

¹⁴ [**Full-Time:** This term means a covered ⁴¹[*employee*] who regularly works at least the number of hours in the normal work week set by the ⁴²[*employer*] (but not less than ²¹ [30] hours per week) at: (1) the covered ⁴¹[*employee's*] ⁴²[*employer's*] place of business; (2) some place where the ⁴²[*employer's*] business requires the covered ⁴¹[*employee*] to travel; or (3) any other place the covered ⁴¹[*employee*] and his or her ⁴²[*employer*] have agreed upon for the performance of occupational duties.]]

Injury: This term means a bodily *injury* due to a *covered accident* that occurs, independent of all other ⁴²[*employer's*] when the *disability* starts within ³²[90 days] of the date of such *injury*.

Maximum Payment Period: This term means the longest time that benefits are paid by this *plan*, subject to all terms, limitations and exclusions.

⁴⁹ [**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* have the right to use some other similar standard. A *mental illness* may be caused by, contributed to by, result in physical, biological or chemical factors or symptoms. For purposes of this Plan, *mental illness* does not include: (1) irreversible dementia caused by Alzheimer's disease, stroke, trauma or viral infection; or (2) any other condition not typically treated by a psychiatrist, clinical psychologist or other qualified mental health practitioner with psychotherapy or psychotropic drugs.]

Objective Medical Evidence: This term includes, but is not limited to: (1) diagnostic testing; (2) laboratory reports; and (3) 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.

^{23A} [**Own Job:** This term means the covered ⁴¹[*employee's*] job for the *employer*. *We* use the job description provided by the ⁴²[*employer*] to determine the duties and requirements of the covered ⁴¹[*employee's*] Own Job.]

^{23B} [**Own Occupation:** This term means the occupation: (1) the covered ⁴¹[*employee*] is routinely performing immediately prior to *disability*; (2) which is the covered ⁴¹[*employee's*] primary source of income prior to *disability*; and (3) for which he or she is covered under this *plan*. Occupation includes any employment, trade or profession that are related in terms of similar tasks, functions, skills, abilities, knowledge, training and experience required by ⁴²[*employers*] from those engaged in a particular occupation in the general labor market in the national economy. Occupation is not specific to a certain ⁴²[*employer*] or a certain location.]]

¹³¹⁵ [**Part-Time:** This term means with respect to eligibility for coverage, the covered ⁴¹[*employee*] regularly works at least the number of hours in the normal work week set by the ⁴²[*employer*] (but not less than ²⁴ [15] hours per week), at: (1) the covered ⁴¹[*employee's*]⁴²[*employer's*] place of business; (2) some place where the ⁴²[*employer's*] business requires the covered ⁴¹[*employee*] to travel; or (3) any other place the covered ⁴¹[*employee*] and his or her ⁴²[*employer*] have agreed upon for the performance of occupational duties.]

Plan: This term means the Accident coverage described in the Policy..

²⁵ [**Proof of Insurability:** This term means an application for coverage showing that a person is insurable.]

Recurring disability: This term means a later disability that: (1) is related to an earlier disability for which this *plan* paid benefits; and (2) meets the conditions described in the *recurring disability* section of this *plan*.

Regular and Appropriate Care: This term means, with respect to the *covered person's* disabling condition and any other condition which, if left untreated, would adversely affect the *covered person's* disabling condition, the *covered person*: (1) visits a *doctor* as frequently as medically required, according to generally accepted medical standards, to effectively manage these conditions; and (2) is 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 a *covered person's*: (a) *disability*; and (b) any other conditions which left untreated would adversely affect the *covered person's* disabling condition. Generally accepted medical standards are those supported by nationally recognized authorities in the health care field including: (i) the American Medical Association (AMA); (ii) the AMA Board of Medical Specialties; (iii) the Food and Drug Administration; (iv) the Centers for Disease Control; (v) the National Cancer Institute; (vi) the National Institutes of Health; (vii) the Department of Health and Human Services; and (viii) any other agency of similar repute.

Sickness: These terms means an illness or disease.

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

LIMITATIONS AND EXCLUSIONS

³⁹[**Pre-Existing Conditions:** A pre-existing condition is an *injury* or a *sickness*, whether diagnosed or misdiagnosed, and any symptoms of it, for which, in the look back period, the *covered person*: (1) received advice or treatment from a *doctor*; (2) underwent diagnostic procedures ³³[other than routine screening in the absence of symptoms or suspicion of disease process by a *doctor*] ; (3) was prescribed or took prescription drugs; or (4) received other medical care or treatment, including consultation with a *doctor*.

The "look back period" is the ³⁴[three months] before the latest of: (1) the effective date of the *covered person's* coverage under this *plan*; (2) the effective date of a change that increases the benefits payable by this *plan*; and (3) the effective date of a change in the *covered person's* benefit election that increases the benefit payable by this *plan*.

⁴⁰[No benefits are payable for *disability* caused by, contributed to by or resulting from a pre-existing condition; unless the *disability* starts ¹⁶[(a)] ³⁵[after the *covered* ⁴¹[*employee*] completes at least one full day of *active work*] after the date the *covered* ⁴¹[*employee*] has been covered under this *plan* for ³⁶[12 months] in a row; ¹⁶[or (b) the date the covered dependent spouse has been covered under this *plan* for ³⁶[12 months] in a row.]

³⁷ [For any *disability* caused by, contributed to by or resulting from a pre-existing condition, we limit the Maximum Payment Period to ³⁸ [two weeks,] unless the *disability* starts ¹⁶ [(a)] ³⁵ [after the covered ⁴¹ [employee] completes at least one full day of *active work*] after the date the covered ⁴¹ [employee] has been covered under this *plan* for ³⁶ [12 months] in a row;] ¹⁶ [or (b) the date the covered dependent spouse has been covered under this *plan* for ³⁶ [12 months] in a row.

A *covered person's disability* caused by, contributed to by or resulting from; a pre-existing condition may begin after: (1) a change which provides for an increase in the benefits payable by this *plan*; or (2) a change in the *covered person's* benefit election which increases the benefit payable by this *plan*. In this case, the *covered person's* 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 the *covered person's disability* starts ¹⁶ [(a)] ³⁵ [after] the covered ⁴¹ [employee] completes at least one full day of *active work*] after the date the change has been in force for ³⁶ [12 months] in a row ¹⁶ [or (b) the date the covered dependent spouse has been covered under this *plan* for 36 [12 months] in a row.

We do not cover any *disability* that starts before the *covered person's* coverage under this *plan*.]

³⁹ [**Prior Coverage Credit:** If this *plan* replaces a similar *disability* plan the *employer* had with another insurer, the pre-existing condition provision may not apply to the *covered person*. This *plan* must start right after the old plan ends.

The pre-existing condition provision will be waived for a covered ⁴¹ [employee] if he or she: (1) is at *active work* on the effective date of this *plan*; and (2) have fulfilled the requirements of any pre-existing condition provision of the old plan.

The covered ⁴¹ [employee] may have been covered under the old plan when it ended, but have not met the requirements of any pre-existing condition provision of the old plan. In that case, we credit any time used to meet the old plan's pre-existing condition provision toward meeting this *plan*'s pre-existing conditions provision. The covered ⁴¹ [employee] must: (1) enroll for coverage under this *plan* on or before this *plan's* effective date; and (2) be *active work* on the effective date of this *plan*.

But, we limit the covered ⁴¹ [employee's] maximum Weekly Benefit under this *plan* if: (1) it is more than the maximum Weekly Benefit for which the covered ⁴¹ [employee] was covered under the old plan; (2) he or she became *disabled* due to a pre-existing condition; and (3) this *plan* 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 the covered ⁴¹ [employee] would have been entitled under the old plan.

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

Exclusions: The exclusions contained in this *plan* apply to the ^{26A} [Off the Job] ^{26B} [On & Off the Job] *disability* benefit.

This *plan* does not pay any benefits for any period of *disability*:

- During which the *covered person* is confined to a facility as a result of a *covered person's* conviction of a crime;
- During which he or she is receiving medical treatment or care outside the United States ⁵⁰ [or Canada] ²⁷ [unless expressly authorized by us;]
- Which starts before he or she is covered by this *plan*; or
- During which the *covered person's* loss of earnings is not solely due to his or her *disability*.]

Claim Provisions

Authority: We have the sole discretionary authority to: (1) interpret the terms of this *plan*; and (2) determine a *covered person's* eligibility for coverage and benefits under the *plan*. 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: A *covered person* must send us written notice of his or her intent to file a claim under this *plan* as described in the *covered person's* Certificate's Accident and Health Claims Provisions. For details, a *covered person* can call us at ²⁸ [1-800-268-2525.]

Proof Of Loss: When we receive a *covered person's* notice, we will provide him or her with a claim form for filing proof of loss. This form requires data from the ⁴²[*employer*], the *covered person*, and the *doctor(s)* treating the *covered person*. Proof of loss must be given to us within the time stated in the *covered person's* Certificate's Accident and Health Claims Provisions. If the *covered person* does not receive a claim form within 15 days of the date he or she sent his or her notice, he or she should send us written proof of loss without waiting for the form.

Proof of loss, provided at the *covered person's* expense, consists of the following. Failure to provide this information may delay, suspend, reduce or terminate the *covered person's* benefits.

- The date *disability* began.
- The covered ⁴¹[*employee's*] last day of *active work*.
- The cause of *disability*.
- The extent of *disability*, including limitations and restrictions ¹⁶[(A)] preventing the covered ⁴¹[*employee*] from performing the major duties of his or her ^{26A} [Own Occupation] ^{26B} [Own Job] and ¹⁶[(B) causing the covered dependent spouse to be (i) unable to perform two or more *activities of daily living* on a routine basis without help or (ii) *cognitively impaired* and in need of verbal cueing to protect himself or herself or others.
- ⁴⁷[If the covered ⁴¹[*employee*] does not have a full-time job at the time of *disability*, the extent of *disability*, including limitations and restrictions causing the covered ⁴¹[*employee*] to (i) not be able to perform two or more *activities of daily living*, on a routine basis, without help or (ii) be *cognitively impaired* and in need of verbal cueing to protect yourself or others.]
- If a covered ⁴¹[*employee's*] s occupation requires that he or she carry liability or malpractice insurance, any changes to such insurance that becomes effective on or after the date of *disability*.
- *Objective medical evidence* in support of a *covered person's* limitations and restrictions, beginning with the date *disability* began.
- The prognosis of *disability*.
- The name and address of all *doctors*, hospitals and health care facilities where a *covered person* has been treated for his or her *disability* since the date *disability* began.
- Proof that the *covered person* is currently receiving *regular and appropriate care* from a *doctor*.
- Proof that the *covered person* has been receiving *regular and appropriate care* from a *doctor*, from the date *disability* began.

A *covered person* must provide *objective medical evidence* from a *doctor* who is not a *covered person*, a *covered person's* spouse, child, parent, sibling or business associate.

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

⁴³ [The Guardian Life Insurance Company of America
Group Short Term disability Claims Department
P.O. Box 26160
Lehigh Valley, PA 18002-6160.]

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

Right To Request Medical, Financial Or Vocational Assessment: *We* may ask a *covered person* to take part in a medical, financial, vocational or other assessment that *we* feel is necessary to determine whether the terms of the *plan* are met. *We* may require this as often as *we* feel is reasonably necessary. *We* will pay for all such assessments. But, if a *covered person* postpones a scheduled assessment without *our* approval, he or she will be responsible for any rescheduling fees. If he or she does not take part in or cooperate with the assessment, *we* have the right to stop or suspend his or her payments under this *plan*.

Ongoing Proof Of Loss: To continue to receive payments from this *plan*, the *covered person* must give *us* current proof of loss as often as *we* may reasonably require. Ongoing proof of loss must be provided to *us* within ²⁷ [30 days] of the date *we* request it.

Payment Of Benefits: *We* pay benefits to a *covered person*, if he or she is legally competent. If the *covered person* is not, *we* pay benefits to the legal representative of his or her estate. Benefits are paid in US dollars.

We pay benefits ²⁸ [biweekly] at the end of the period for which they are payable.

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

Benefits to which a *covered person* is entitled may remain unpaid at the *covered person's* death. Such benefits may be paid at *our* discretion to: (1) a *covered person's* estate; or (2) his or her spouse, parents, children, or brothers and sisters.

Partial Week Payment: The *covered person* may be disabled for only part of a week. In this case, *We* compute a *covered person's* payment as ²⁹ [1/7th] of the benefit to which he or she would be entitled for the full week times the number of days the *covered person* are disabled.

Overpayment Recovery: If *we* overpaid a *covered person*, he or she must repay *us* in full. *We* have the right to reduce a *covered person's* payment or apply any benefits payable, including the minimum payment, toward recovery of the overpayment.

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

⁴⁴[Dated at New York, NY This First Day of January, 2000

ABC Company

Full or Corporate Name of Policyholder

John Doe BY: Jane Roe, President]

Witness

Signature And Title

The Guardian Life Insurance Company of America

⁴⁴[



Vice President, Risk Management and
Chief Actuary]

ATTACHED TO AND MADE PART OF GROUP INSURANCE POLICY NO. G ¹[-(99999999)]
issued by

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

To

¹[ABC Company]
(herein called the Policyholder)

Effective ¹[99/99/99], this rider amends this *plan* by the addition of the following:

DISABILITY ACCIDENT ^{26A}[ON & OFF THE JOB] ^{26B}[OFF THE JOB]

SCHEDULE OF INSURANCE

WEEKLY BENEFIT AMOUNT FOR COVERED ³³[EMPLOYEE]: ²[\$50-\$1000]

¹⁶[WEEKLY BENEFIT AMOUNT FOR COVERED DEPENDENT SPOUSE: ²[\$50-\$1000]]

MAXIMUM BENEFIT PERIOD FOR COVERED ³³[EMPLOYEE]: ³[9-52] WEEKS

¹⁶[MAXIMUM BENEFIT PERIOD FOR COVERED DEPENDENT SPOUSE: ⁴[\$50-\$1000]]

ELIMINATION PERIOD FOR COVERED ³³[EMPLOYEE]: ⁵[0-180] DAYS

¹⁶[ELIMINATION PERIOD FOR COVERED DEPENDENT SPOUSE: ⁵[0-180] DAYS]

BENEFITS

We will pay the weekly benefit amount shown in the schedule of insurance if a *covered person* becomes disabled as a result of an *injury* sustained in a *covered accident*. The *covered accident* must occur and the *disability* must begin while the *covered person* is covered under this *plan*. ³⁷[Disability must begin within ³⁸[90] days of the *covered accident*.]

How Payments Start: To start getting payments from this *plan*, a *covered person* must meet all of the conditions listed below.

- he or she must: (1) become *disabled* while covered by this *plan*; and (2) remain *disabled* and covered for this *plan's elimination period*.
- he or she must provide proof of loss, as described in the Claim Provisions, herein.

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

^{6A} [A covered ³³[employee] can satisfy the *elimination period* while working, provided he or she is *disabled*.]

^{6B} [A covered ³³[employee] may not satisfy this *plan's elimination period* while working.]

⁷ [If a covered ³³[employee] performs any work for wage or profit, he or she will not be eligible for benefits under this *plan*.]

⁸ [**Waiver Of Premium:** We waive a *covered person's* premiums for this coverage while he or she is entitled to receive a Weekly Benefit payment from this *plan*.]

When Payments End: A covered person's benefits from this plan will end on the earliest of the dates shown below:

- The date he or she is no longer *disabled*.
- The date he or she fails to provide proof of loss as required by this plan
- The date he or she has been outside the United States ^{9A}[and/or Canada] ^{9B}[and/or a country or region approved by Us] for more than ¹⁰[two months] in a ¹¹[12 month] period] .
- The date he or she dies.
- The end of the Maximum Payment Period.
- The date he or she is no longer receiving *regular and appropriate care* from a *doctor*.

Maximum Payment Period: The Maximum Payment Period is shown in the Schedule of Insurance.

Recurring Disability: Benefits from this plan end if a covered ³³[employee] ceases to be *disabled*. But, a later *disability* may be treated as a *recurring disability*, if all of the terms listed below are met:

- A covered ³³[employee] must return to *active work* right after his or her benefits end.
- The disability must recur less than ¹²[two weeks] after he or she was last entitled to benefits.
- The later *disability* must be due to the same or related cause of his or her earlier *disability*.
- This plan must not end during his or her return to *active work*.
- During the time he or she returns to *active work*, he or she must: (1) stay covered by this plan; and (2) premium payments must be made on his or her behalf.
- His or her benefits must not have ended because he or she has used up the Maximum Payment Period.

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

If all of the terms listed above are not met, the later *disability* will be treated as a new period of disability. A covered ³³[employee] will be required to complete a new *elimination period*. The new period of *disability* will be subject to all the terms of the plan in effect on the date the new period of *disability* starts.

DEFINITIONS

¹³[This section defines certain terms appearing in this rider.

Active Work: This term means a covered ³³[employee] is able to perform, and are performing, all of the regular duties of his or her work for the ³⁴[employer], ¹⁴[on a Full-Time basis] ¹⁵[or a part-time basis] at: (1) one of the ³⁴[employer's] usual places of business; (2) some place where the ³⁴[employer's] business requires a covered ³³[employee] to travel; or (3) any other place a covered ³³[employee] and the ³⁴[employer] have agreed on for a covered ³³[employee's] work.

⁴¹ ¹⁶[**Activities of Daily Living** means:

1. **Bathing:** the ability to wash in a tub or shower; or by taking a sponge bath; and to towel dry; with or without equipment or adaptive devices.]
2. ⁴¹ ¹⁶ ¹³[**Dressing:** the ability to put on and take off all clothes; and those medically necessary braces or prosthetic limbs usually worn; and also to fasten or unfasten them.
3. **Toileting:** the ability to get to and from and on and off the toilet; to maintain personal hygiene; and to care for clothes.]

4. ¹³**[Transferring:** the ability to move in and out of a chair or bed with or without equipment such as: canes; walkers; crutches; grab bars; or any other support devices.]
5. ¹³**[Continence:** the ability to control bowel and bladder function; or, in the event of incontinence, the ability to maintain personal hygiene.
6. **Eating:** the ability to get food into the body by any means once it has been prepared and made available.]

⁴¹ ¹⁶ **[Cognitive Impairment or Cognitively Impaired:** These terms mean a decline or loss in intellectual aptitude. Such loss may result from: (a) *injury*; (b) *sickness*; (c) Alzheimer's disease, or (d) like forms of senility or irreversible dementia. It must be supported by clinical proof and standardized tests that precisely measure decline in the areas of: (i) short term memory; (ii) orientation to time, place and person; (iii) deductive or abstract reasoning; and (iv) judgement as it relates to awareness of safety. Cognitive impairment does not include decline or loss due to a *mental illness*.)]

Covered Accident This term means an *accident* that:

- Occurs while the covered person's coverage under this plan is in effect.
- Results in a bodily *injury*.
- Is not otherwise excluded under the terms of this *plan*; and
- Is covered under the Accident coverage of this *plan*.

Covered Person This term means an ³³*[employee]* ¹⁶*[or his or her dependent spouse]* covered by this *plan*.

Disability or Disabled: These terms mean that an *injury* sustained in a covered accident causes physical or mental impairment to such a degree that: ¹⁶*[(A)]* a covered ³³*[employee]* is: (1) not able to perform ¹⁴*[on a Full-Time basis]* ¹⁵*[or a part-time basis]* the major duties of his or her ¹⁷*[Own Job]* ¹⁶*;* .or (B) a covered dependent spouse is (i) not able to perform two or more *activities of daily living*, on a routine basis, without help or (ii) *cognitively impaired* and in need of verbal cueing to protect himself or herself or others.

³⁹*[If the covered ³³[employee] does not have a full-time job at the time of disability, these terms mean that the covered ³³[employee] is (i) not able to perform two or more activities of daily living, on a routine basis, without help or (ii) cognitively impaired and in need of verbal cueing to protect himself or herself or others.]*

¹⁸*[A covered ³³[employee] is not disabled if he or she performs any work for wage or profit] ¹⁹[during the elimination period] .]*

²⁰*[A covered ³³[employee] may be required, on average, to work more than ²¹[40] hours per week. In this case, he or she is not disabled if he or she is able to work for ²¹[40] hours per week.]*

Neither loss of a professional or occupational license due to misconduct or unlawful activity or receipt of, or entitlement to, Social Security *disability* benefits in and of themselves constitute *disability* under this *plan*.

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

Elimination Period: This term means the period of time a *covered person* must be *disabled*, due to a covered *disability*, before this *plan's* benefits are payable.

³³**[Employee]:** ²²*[This term means a person who works for the ³⁴[employer] and whose income is reported for tax purposes using a W-2 or 1099 form.]]*

¹³³⁴**[Employer]:** This term means ¹ [ABC Company, Inc] .]

¹⁴**[Full-Time:** This term means a covered ³³[employee] who regularly works at least the number of hours in the normal work week set by the ³⁴[employer] (but not less than ²¹[30] hours per week) at: (1) the covered ³³[employee] 's ³⁴[employer's] place of business; (2) some place where the ³⁴[employer's] business requires the covered ³³[employee] to travel; or (3) any other place the covered ³³[employee] and his or her ³⁴[employer] have agreed upon for the performance of occupational duties.]]

Injury: This term means a bodily *injury* due to a *covered accident* that occurs, independent of all other causes, while the *covered person* is covered by this *plan*. We will cover a *disability* caused by an *injury* when the *disability* starts within ³² [90 days] of the date of such *injury*.

Maximum Payment Period: This term means the longest time that benefits are paid by this *plan*, subject to all terms, limitations and exclusions.

⁴⁰**[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 have the right to use some other similar standard. A *mental illness* may be caused by, contributed to by, result in physical, biological or chemical factors or symptoms. For purposes of this Plan *mental illness* does not include: (1) irreversible dementia caused by Alzheimer's disease, stroke, trauma or viral infection; or (2) any other condition not typically treated by a psychiatrist, clinical psychologist or other qualified mental health practitioner with psychotherapy or psychotropic drugs.]

Objective Medical Evidence: This term includes, but is not limited to: (1) diagnostic testing; (2) laboratory reports; and (3) 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.

^{23A}**[Own Job:** This term means the covered ³³[employee] 's job for the ³⁴[employer]. We use the job description provided by the ³⁴[employer] to determine the duties and requirements of the covered ³³[employee]'s Own Job.]

^{23B}**[Own Occupation:** This term means the occupation: (1) the covered ³³[employee] is routinely performing immediately prior to *disability*; (2) which is the covered ³³[employee]'s primary source of income prior to *disability*; and (3) for which he or she is covered under this *plan*. Occupation includes any employment, trade or profession that are related in terms of similar tasks, functions, skills, abilities, knowledge, training and experience required by ³⁴[employers] from those engaged in a particular occupation in the general labor market in the national economy. Occupation is not specific to a certain ³⁴[employer] or a certain location.]

¹⁵**[Part-Time:** This term means with respect to eligibility for coverage, the covered ³³[employee] regularly works at least the number of hours in the normal work week set by the ³⁴[employer] (but not less than ²⁴[15] hours per week), at: (1) the covered ³³[employee's] ³⁴[employer's] place of business; (2) some place where the ³⁴[employer's] business requires the covered ³³[employee] to travel; or (3) any other place the covered ³³[employee] and his or her ³⁴[employer] have agreed upon for the performance of occupational duties.]

Plan: This term means the Accident coverage described in the Policy and this Certificate.

²⁵**[Proof of Insurability:** This term means an application for coverage showing that a person is insurable.]

Recurring disability: This term means a later disability that: (1) is related to an earlier disability for which this *plan* paid benefits; and (2) meets the conditions described in the *recurring disability* section of this *plan*.]

¹³**[Regular and Appropriate Care:** This term means, with respect to the *covered person's* disabling condition and any other condition which, if left untreated, would adversely affect the *covered person's* disabling condition, the *covered person*: (1) visits a *doctor* as frequently as medically required, according] to generally accepted medical standards, to effectively manage these conditions; and (2) is 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 a *covered person's*: (a) *disability*; and (b) any other conditions which left untreated would adversely affect the *covered person's* disabling condition. Generally accepted medical standards are those supported by nationally recognized authorities in the health care field including: (i) the American Medical Association (AMA); (ii) the AMA Board of Medical Specialties; (iii) the Food and Drug Administration; (iv) the Centers for Disease Control; (v) the National Cancer Institute; (vi) the National Institutes of Health; (vii) the Department of Health and Human Services; and (viii) any other agency of similar repute.

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

EXCLUSIONS

The exclusions contained in this *plan* apply to the ^{26A}[Off the Job] ^{26B}[On & Off the Job] *disability* benefit. This *plan* does not pay any benefits for any period of *disability*:

- During which the *covered person* is confined to a facility as a result of a *covered person's* conviction of a crime;
- During which he or she is receiving medical treatment or care outside the United States ⁴²[or Canada] ²⁷[unless expressly authorized by Us;]
- Which starts before he or she is covered by this *plan*; or
- During which the *covered person's* loss of earnings is not solely due to his or her *disability*.

Claim Provisions

Authority: We have the sole discretionary authority to: (1) interpret the terms of this *plan*; and (2) determine a *covered person's* eligibility for coverage and benefits under the *plan*. 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: A *covered person* must send us written notice of his or her intent to file a claim under this *plan* as described in the *covered person's* Certificate's Accident and Health Claims Provisions. For details, a *covered person* can call us at ²⁸[1-800-268-2525.]

Proof Of Loss: When we receive a *covered person's* notice, we will provide him or her with a claim form for filing proof of loss. This form requires data from the ³⁴[*employer*], the *covered person*, and the *doctor(s)* treating the *covered person*. Proof of loss must be given to us within the time stated in the *covered person's* Certificate's Accident and Health Claims Provisions. If the *covered person* does not receive a claim form within 15 days of the date he or she sent his or her notice, he or she should send us written proof of loss without waiting for the form.

Proof of loss, provided at the *covered person's* expense, consists of the following. Failure to provide this information may delay, suspend, reduce or terminate the *covered person's* benefits.

- The date *disability* began.
- The covered ³³[*employee's*] last day of *active work*.
- The cause of *disability*.

[The extent of *disability*, including limitations and restrictions ¹⁶ [(A)] preventing the covered ³³ [employee] from performing the major duties of his or her ^{26A} [Own Occupation] ^{26B} [Own Job] and ¹⁶ [(B) causing the covered dependent spouse to be (i) unable to perform two or more *activities of daily living* on a routine basis without help or (ii) *cognitively impaired* and in need of verbal cueing to protect himself or herself or others.

- ³⁹[If the covered ⁴¹ [employee] does not have a full-time job at the time of disability, the extent of *disability*, including limitations and restrictions causing the covered ⁴¹ [employee] to (i) not be able to perform two or more *activities of daily living*, on a routine basis, without help or (ii) be *cognitively impaired* and in need of verbal cueing to protect yourself or others.]
- If a covered ³³ [employee's] occupation requires that he or she carry liability or malpractice insurance, any changes to such insurance that becomes effective on or after the ^e date of *disability*.
- *Objective medical evidence* in support of a covered person's limitations and restrictions, beginning with the date *disability* began.
- The prognosis of *disability*.
- The name and address of all *doctors*, hospitals and health care facilities where a *covered person* has been treated for his or her *disability* since the date *disability* began.
- Proof that the *covered person* is currently receiving *regular and appropriate care* from a *doctor*.
- Proof that the *covered person* has been receiving *regular and appropriate care* from a *doctor*, from the date *disability* began.

A *covered person* must provide *objective medical evidence* from a *doctor* who is not a *covered person*, a *covered person's* spouse, child, parent, sibling or business associate.

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

³⁵ [The Guardian Life Insurance Company of America
Group Short Term disability Claims Department
P.O. Box 26160
Lehigh Valley, PA 18002-6160.]

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

Right To Request Medical, Financial Or Vocational Assessment: We may ask a *covered person* to take part in a medical, financial, vocational or other assessment that we feel is necessary to determine whether the terms of the *plan* are met. We may require this as often as we feel is reasonably necessary. We will pay for all such assessments. But, if a *covered person* postpones a scheduled assessment without our approval, he or she will be responsible for any rescheduling fees. If he or she does not take part in or cooperate with the assessment, we have the right to stop or suspend his or her payments under this *plan*.

Ongoing Proof Of Loss: To continue to receive payments from this *plan*, the *covered person* must give us current proof of loss as often as we may reasonably require. Ongoing proof of loss must be provided to us within ²⁹ [30 days] of the date we request it.

Payment Of Benefits: We pay benefits to a *covered person*, if he or she is legally competent. If the *covered person* is not, we pay benefits to the legal representative of his or her estate. Benefits are paid in US dollars.

We pay benefits ³⁰ [biweekly] at the end of the period for which they are payable.

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

Benefits to which a *covered person* is entitled may remain unpaid at the *covered person's* death. Such benefits may be paid at *our* discretion to: (1) a *covered person's* estate; or (2) his or her spouse, parents, children, or brothers and sisters.

Partial Week Payment: The *covered person* may be disabled for only part of a week. In this case, We compute a *covered person's* payment as ³¹[1/7th] of the benefit to which he or she would be entitled for the full week times the number of days the *covered person* are disabled.

Overpayment Recovery: If we overpaid a *covered person*, he or she must repay us in full. We have the right to reduce a *covered person's* payment or apply any benefits payable, including the minimum payment, toward recovery of the overpayment.

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

¹[Dated at New York, NY This First Day of January , 2000

ABC Company

Full or Corporate Name of Policyholder

 John Doe BY: Jane Roe, President]
Witness Signature And Title

The Guardian Life Insurance Company of America

³⁶[



Vice President, Risk Management and
Chief Actuary]

ATTACHED TO AND MADE PART OF GROUP INSURANCE PLAN NO. G ¹[-(99999999)]
issued by

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

To

¹[**ABC Company**]
(herein called the Planholder)

Effective ¹[99/99/99], this rider amends this *plan* by the addition of the following

SICKNESS HOSPITAL CONFINEMENT BENEFIT
SCHEDULE OF INSURANCE OF INSURANCE

DAILY HOSPITAL CONFINEMENT BENEFIT AMOUNT FOR COVERED ²³[EMPLOYEE:]
²[\$50-\$1000]

⁸[DAILY HOSPITAL CONFINEMENT BENEFIT AMOUNT FOR COVERED DEPENDENT:
²[\$50-\$1000]]

MAXIMUM BENEFIT PERIOD PER CONFINEMENT FOR COVERED ²³[EMPLOYEE:] ³[30]
DAYS

⁸[MAXIMUM BENEFIT PERIOD PER CONFINEMENT FOR COVERED DEPENDENT: ³[30]
DAYS]

ELIMINATION PERIOD FOR COVERED ²³[EMPLOYEE:] ⁴[3] DAYS

⁸[ELIMINATION PERIOD FOR COVERED DEPENDENT: ⁴[3] DAYS]

BENEFITS

Hospital Confinement: We pay the amount shown in the schedule of insurance if a *covered person* is confined to a *hospital* as the result of a *sickness*. This benefit is payable up to the maximum benefit period shown in the schedule of insurance per *covered person*. If a *covered person* is confined for more than one *sickness* at the same time, we will only pay one *hospital confinement* benefit per day.

Recurrent Hospital Confinement: We will treat a *recurrent hospital confinement* as part of the prior claim if the *covered person* has a *sickness* that begins within ²⁶[90] days of the end of the prior claim.

The *recurrent hospital confinement* will be subject to the remaining *maximum benefit period* under the prior claim.

DEFINITIONS

⁵[**Active Work:** This term means a covered ²³[*employee*] is able to perform, and is performing, all of the regular duties of his or her work for the ²⁴[*employer*], ⁶[on a Full-Time basis] ⁷[or a part-time basis] at: (1) one of the ²⁴[*employer's*] usual places of business; (2) some place where the ²⁴[*employer's*] business requires a covered ²³[*employee*] to travel; or (3) any other place a covered ²³[*employee*] and the ²⁴[*employer*] have agreed on for a covered ²³[*employee's*] work.]

⁵**[Covered Person]** This term means an ²³**[employee]** ⁸**[or his or her dependent]** covered by this *plan*.

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

Elimination Period: This term means the ⁹**[31 days]** period which starts on the date that an ²³**[employee]** ⁸**[or his or her dependent]** is first admitted to the *hospital*.

²³**[Employee]:** ¹⁰**[This term means a person who works for the ²⁴[employer] and whose income is reported for tax purposes using a W-2 or 1099 form.]**

²⁴**[Employer]:** This term means ¹**[ABC Company, Inc]** .

¹¹**[Full-Time:** This term means a covered ²³**[employee]** who regularly works at least the number of hours in the normal work week set by the ²⁴**[employer]** (but not less than ¹²**[30]** hours per week) at: (1) the covered ²³**[employee's]** ²⁴**[employer's]** place of business; (2) some place where the ²⁴**[employer's]** business requires the covered ²³**[employee]** to travel; or (3) any other place the covered ²³**[employee]** and his or her ²⁴**[employer]** have agreed upon for the performance of occupational duties.]

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

- (1) is primarily engaged in providing, by or under the continuous supervision of *doctors*, to *inpatients*, diagnostic services and therapeutic services for diagnosis, treatment and care of sick or injured persons;
- (2) has organized departments of medicine and major surgery;
- (3) has a requirement that every patient must be under the care of a *doctor* or *dentist*;
- (4) provides 24 hour nursing service by or under the supervision of a registered professional nurse (R.N.);
- (5) is duly licensed by the agency responsible for licensing such *hospitals*; and
- (6) is not, other than incidentally: (a) a place of rest; (b) a place primarily for the treatment of tuberculosis; (c) a place for the aged; (d) a place for drug addicts or alcoholics; or (e) a place for convalescent, custodial, educational or rehabilitative care.

Hospital Confinement This term means admission to a *hospital* as an inpatient for at least 24 consecutive hours by a *doctor* for treatment or diagnosis of a *sickness*. *Hospital confinement* does not include confinement for a newborn child following birth, unless the newborn child has a covered *sickness*.

¹³**[Part-Time:** This term means with respect to eligibility for coverage, the covered ²³**[employee]** regularly works at least the number of hours in the normal work week set by the ²⁴**[employer]** (but not less than ¹⁴**[15]** hours per week), at: (1) the covered ²³**[employee's]** ²⁴**[employer's]** place of business; (2) some place where the ²⁴**[employer's]** business requires the covered ²³**[employee]** to travel; or (3) any other place the covered ²³**[employee]** and his or her ²⁴**[employer]** have agreed upon for the performance of occupational duties.]

Plan: This term means the Accident coverage described in the Policy..

Recurrent Hospital Confinement This term means a *hospital confinement* that is caused by a *sickness* which is the same as or related to the *sickness* causing the *hospital confinement* in a prior claim.

Sickness: This term means an illness or disease that results in *hospital confinement* and which begins while a *covered person* is covered under this *plan*. Pregnancy is treated as a *sickness* under this *plan*.]

EXCLUSIONS & LIMITATIONS

¹⁵**[Pre-Existing Conditions:** A pre-existing condition is a *sickness*, whether diagnosed or misdiagnosed, and any symptoms of it, for which, in the look back period, the *covered person*: (1) received advice or treatment from a *doctor*; (2) underwent diagnostic procedures ¹⁶**[other than routine screening in the absence of symptoms or suspicion of disease process by a *doctor*]** ; (3) was prescribed or took prescription drugs; or (4) received other medical care or treatment, including consultation with a *doctor*.

The "look back period" is the ¹⁷**[three months]** before the latest of: (1) the effective date of the *covered person's* coverage under this *plan*; (2) the effective date of a change that increases the benefits payable by this *plan*; and (3) the effective date of a change in the *covered person's* benefit election that increases the benefit payable by this *plan*.

¹⁸**[No benefits are payable for a *hospital confinement* caused by, contributed to by or resulting from a pre-existing condition; unless the *hospital confinement* starts ⁸**[(a)]** ¹⁹**[after the *covered* ²³**[employee]** completes at least one full day of *active work*]** after the date the *covered* ²³**[employee]** has been covered under this *plan* for ²⁰**[12 months]** in a row;] ⁸**[or (b) the date the covered dependent has been covered under this *plan* for ²⁰**[12 months]** in a row.]****

²¹**[For any *hospital confinement* caused by, contributed to by or resulting from a pre-existing condition, we limit the Maximum Payment Period Per Confinement to ²²**[two weeks,]** unless the *hospital confinement* starts ⁸**[(a)]** ¹⁹**[after the *covered* ²³**[employee]** completes at least one full day of *active work*]** after the date the *covered* ²³**[employee]** has been covered under this *plan* for ²⁰**[12 months]** in a row; ⁸**[or (b) the date the covered dependent has been covered under this *plan* for ²⁰**[12 months]** in a row]****

A *covered person's hospital confinement* caused by, contributed to by or resulting from; a pre-existing condition may begin after: (1) a change which provides for an increase in the benefits payable by this *plan*; or (2) a change in the *covered person's* benefit election which increases the benefit payable by this *plan*. In this case, the *covered person's* 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 the *covered person's hospital confinement* starts ⁸**[(a)]** ¹⁹**[after the *covered* ²³**[employee]** completes at least one full day of *active work*]** after the date the change has been in force for ²⁰**[12 months]** in a row ⁸**[or (b) the date the covered dependent has been covered under this *plan* for ²⁰**[12 months]** in a row.]**

We do not cover any *hospital confinement* that starts before the *covered person's* coverage under this *plan*.]

¹⁵**[Prior Coverage Credit:** If this *plan* replaces a similar *hospital confinement* plan the ²⁴**[employer]** had with another insurer, the pre-existing condition provision may not apply to the *covered person*. This *plan* must start right after the old plan ends.

The pre-existing condition provision will be waived for a *covered* ²³**[employee]** if he or she: (1) is at *active work* on the effective date of this *plan*; and (2) have fulfilled the requirements of any pre-existing condition provision of the old plan.

The *covered* ²³**[employee]** may have been covered under the old plan when it ended, but have not met the requirements of any pre-existing condition provision of the old plan. In that case, we credit any time used to meet the old plan's pre-existing condition provision toward meeting this *plan*'s pre-existing conditions provision. The *covered* ²³**[employee]** must: (1) enroll for coverage under this *plan* on or before this *plan's* effective date; and (2) be *active work* on the effective date of this *plan*.

But, we limit the *covered* ²³**[employee's]** daily *hospital confinement* benefit under this *plan* if: (1) it is more than the daily *hospital confinement* benefit for which the *covered* ²³**[employee]** was covered under the old plan; (2) he or she is hospitalized due to a pre-existing condition; and (3) this *plan* pays benefits for

such *hospital confinement* because we credit time as explained above. In this case, we limit the daily *hospital confinement* benefit to the amount to which the covered ²³[employee] would have been entitled under the old plan.

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

Exclusions: The exclusions contained in this plan apply to the *hospital sickness rider*. In addition, this plan does not pay benefits for *hospital confinement* caused by, or related to:

- Injury
- Treatment for dental care or dental care procedures
- Elective procedures and/or cosmetic surgery or reconstructive surgery; unless it is a result of infection congenital defect, or other disease
- ²⁷[A *sickness* arising out of or in the course of any employment for wage or profit].

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

¹[Dated at New York, NY This First Day of January, 2000

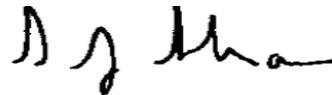
ABC Company

Full or Corporate Name of Planholder

John Doe BY: Jane Roe, President
Witness Signature And Title]

The Guardian Life Insurance Company of America

²⁵[



Vice President, Risk Management and
Chief Actuary]

Benefits

- ¹[Accident Emergency Room Treatment]** We pay the amount shown in the Schedule of Insurance if a covered person is examined or treated by a *doctor* in a *hospital emergency room* for the initial treatment of injuries sustained in a *covered accident* within ⁴[72] hours after the *covered accident*. This benefit is payable once per *covered person* per *covered accident*. We will not pay the Accident Emergency Room Treatment benefit and the Initial Doctor's Office/Urgent Care Facility benefit for the same *covered accident*.
- ¹[Accident Follow-Up Visit – Doctor]** We pay the amount shown in the Schedule of Insurance if a covered person requires additional follow up treatments (not including occupational, speech or physical therapy or chiropractic treatment) after initial *emergency room* treatment or Doctor's Office/Urgent Care Facility Treatment. We pay up to ⁵[6] treatments per a *covered person* per *covered accident*. Treatment must begin within ⁶[60] days of a *covered accident* and be completed within ⁹[365] days.
- ¹[Accidental Death]** We pay the amount shown in the Schedule of Insurance if a *covered person* sustains an injury in a *covered accident* that causes his or her death. The injury must cause his or her death within ²[90] days of the *covered accident*. If we pay this benefit, we will not pay the Accidental Death Common Carrier benefit.
- ¹[Accidental Death Common Carrier]** We pay the amount shown in the Schedule of Insurance if a *covered person's accidental death* is due to an *covered accident* which occurs while a *covered person* is riding as a fare-paying passenger in a public conveyance. If we pay this benefit, we will not pay the Accidental Death benefit.
- ¹[Accidental Death Common Disaster]** We pay the increased amount shown in the Schedule of Insurance if both *you* and *your* insured spouse die in a *covered accident* or separate *covered accidents* within the same 24 hour period. The benefit increase applies to *your* insured spouse's benefit.
- ¹[Accidental Dismemberment]** We pay the amount shown in the Schedule of Insurance if a listed loss is sustained by a *covered person* due to injuries caused by a *covered accident*.
- "Loss of a hand" means the hand is completely severed at or above the wrist.
 - "Loss of a foot" means the foot is completely severed at or above the ankle.
 - "Loss of sight" means total and permanent loss of 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. This benefit is not payable if benefits have been paid for "Loss of hand".
 - "Loss of all toes of same foot" means complete severance at the metatarsalphalangeal joint. This benefit is not payable if benefits have been paid for "Loss of foot".
- ²⁷[We will not pay more than ⁷[\$10,000] for all losses due to the same *covered accident*.]

- ¹[Accidental Death Seatbelt and Airbag benefit]** We pay the seatbelt amount shown in the Schedule of Insurance if a *covered person* dies due to injuries sustained in a *covered accident* while properly wearing a seatbelt. We will pay the Seatbelt & Airbag amount shown in the Schedule of Insurance if a *covered person* dies as a direct result of an automobile *accident* while both properly wearing a seatbelt, and sitting in a seat equipped with an airbag. We will not pay both the Seatbelt and Seatbelt and Airbag benefit for the same *covered accident*.]
- ¹[Air Ambulance]** We pay the amount shown on the Schedule of Insurance if a *covered person* is transported by air ambulance to or from a *hospital* or between medical facilities for treatment of *injuries* sustained as the result of a *covered accident* within ⁸[48] hours of a *covered accident*. This benefit is payable once per a *covered person* per *covered accident*.]
- ¹[Ambulance]** We pay the amount shown on the Schedule of Insurance if a licensed ambulance company transports a *covered person* by ground to or from a *hospital* or between medical facilities for treatment of *injuries* sustained as a result of a *covered accident* within ² [90] days of *covered accident*. This benefit is payable once per a *covered person* per *covered accident*.]
- ¹[Appliance]** We pay the amount shown on the Schedule of Insurance if a *covered person* uses an appliance is prescribed by a *doctor* as necessary due to an injury sustained as a result of a *covered accident*. An appliance includes wheelchairs, leg or back braces, crutches, walkers, walking boot that extends above the ankle, and brace for the neck. Use of the appliance must begin within ² [90] days of *covered accident*. This benefit is payable once per a *covered person* per *covered accident*.]
- ¹[Blood/Plasma/Platelets]** We pay the amount shown in the Schedule of Insurance if as the result of a *covered accident* a *covered person* receives a transfusion, administration, cross matching, typing and processing of blood/plasma/platelets within ² [90] days of the *covered accident*. This benefit is payable once per a *covered person* per *covered accident*.]
- ¹[Burn]** We pay the amount shown in the Schedule of Insurance if a *covered person* receives burns as a result of a *covered accident* and is treated by a *doctor* within ⁴[72] hours of the *covered accident*. If a *covered person* meets more than one of the burn classifications, we pay the higher amount. This benefit is payable once per a *covered person* per *covered accident*.]
- ¹[Burn - Skin Graft]** We pay the amount shown in the Schedule of Insurance when medically necessary grafting of the skin is received by a *covered person* for a burn that was payable under the Burn benefit. This benefit is payable once per a *covered person* per *covered accident*.]
- ¹[Catastrophic Loss]** We pay the amount shown in the Schedule of Insurance if a *covered person* suffers a catastrophic loss within ⁹[365] days of a *covered accident* due to injuries sustained in a *covered accident*. This benefit is payable once per *covered person* per *covered accident*. If a Catastrophic Loss benefit is paid, an Accidental Dismemberment benefit will not be paid for the same or attached body part.]
- ¹[Child Organized Sport]** We pay the additional amount shown on the Schedule of Insurance if the *covered accident* occurred while a *covered person's* covered dependent child is participating in an organized sport. The child must be insured by this plan on the date the *accident* occurred. The covered child must be ¹⁰[18] years of age or younger.]

- ¹[Chiropractic visits]** We pay the amount shown in the Schedule of Insurance if as the result of a *covered accident* a *covered person* suffers a structural imbalance and receives *chiropractic care services* by a chiropractor in a chiropractor's office. Treatment must begin within ⁶[60] days after a *covered accident* and be completed within ¹¹[180] days of the *covered accident*. We will pay for up to ⁵[6] visits per a *covered person* per *covered accident* but no more than ¹²[12] visits per calendar year.]
- ¹[Coma]** We pay the amount shown in the Schedule of Insurance if as the result of a *covered accident* a *covered person* is in a *coma* lasting at least ¹³[7] consecutive days characterized by the absence of eye opening, verbal response, and motor response. The condition must require intubation for respiratory assistance, be diagnosed or treated by a *doctor* within ² [90] days of the *covered accident*. This benefit is not payable for a medically induced *coma*.]
- ¹[Concussions]** We pay the amount shown in the Schedule of Insurance if a *covered person* sustains a concussion as the result of a *covered accident* and is diagnosed within ⁴[72] hours of the *covered accident*. This benefit is payable once per a *covered person* per *covered accident*.]
- ¹[Dislocations]** We pay the amount shown in the Schedule of Insurance if a *covered person* is injured and suffer a *dislocation* as the result of a *covered accident*. A *dislocation* must be diagnosed by a *doctor* within ² [90] days of the *covered accident*. The *dislocation* must be corrected by open (surgical) or closed (non-surgical) reduction.
- For multiple *dislocations* due to the same *covered accident*, we will pay no more than ¹⁴[two] times the benefit amount for the joint involved with the highest benefit amount.
- For partial *dislocations*, we will pay ¹⁵[25%] of the benefit shown in the Schedule of Insurance for a closed reduction.]
- ¹[Diagnostic Exam (Major)]** We pay the amount shown in the Schedule of Insurance if a *covered person* receives one of the following imaging studies due to a *covered accident*: ¹⁶[Computerized Tomography (CT scan), computerized axial tomography (CAT), magnetic resonance imaging (MRI or electroencephalography (EEG).] The imaging study must be prescribed by a *doctor* & performed in a *doctor's* office or *hospital*, on an *inpatient* or outpatient basis. This benefit is payable once per *covered person* per *covered accident*.]
- ¹[Emergency Dental Work]** We pay the amount shown in the Schedule of Insurance if a *covered person* suffers a broken tooth as the result of a *covered accident* and it is repaired by a *dentist* with a dental crown and/or dental extraction. The dental services must begin within ⁶[60] days of the *covered accident*. One dental crown and one dental extraction is payable per *covered person* per *accident*.]
- ¹[Epidural Anesthesia Pain Management]** We pay the amount shown in the Schedule of Insurance if a *covered person* is prescribed and receives an epidural administered for pain management for injuries received as a result of a *covered accident*. The epidural must be administered in a *hospital* or *doctor's* office and is payable ¹⁷[twice] per *covered person* per *accident*. This benefit is not payable for an epidural administered during a surgical procedure.]

- ¹[**Eye Injury** We pay the amount shown in the Schedule of Insurance if a *covered person* is injured as the result of a *covered accident* and suffers an eye injury. The eye injury must require surgery or the removal of a foreign object by a *doctor* within [90] days of a *covered accident*. This benefit is payable once per *covered person* per *covered accident*.]
- ¹[**Family Care** We pay the amount shown in the Schedule of Insurance if a *covered person* is injured as the result of a *covered accident* and confined in a *hospital*, ICU or *alternate care* or *rehabilitative facility* and the *covered person* has a child or children attending a *child care center*. The benefit is payable for each child attending a *child care center* while the *covered person* is confined. The child attending the *child care center* does not need to be insured under this *plan* for *accident* coverage but must meet the eligibility requirements found in the Dependent Eligibility section. This benefit is payable for up to ¹⁸[30] days within ⁹[365] days of the *covered accident*. This benefit is payable once per *covered person* per *covered accident*.]
- ³[**Fracture (Bone)** We pay the amount shown in the Schedule of Insurance if *covered person* suffers a *fracture* as a result of a *covered accident* and it is diagnosed within ²[90] days of the *covered accident*. The *fracture* must require open (surgical) or closed (non-surgical) reduction by a *doctor*. This benefit is payable for up to ¹⁴[two] *fractures* per *covered person* per *covered accident*. If there are more than ¹⁴[two] *fractures*, we will pay the highest two benefit amounts per *covered person* per *covered accident*. We pay ¹⁵[25%] of the amount shown in the Schedule of Insurance for the closed reduction of a bone with a chip *fracture* that was a result of a *covered accident*.]
- ¹[**Hospital Admission** We pay the amount shown in the Schedule of Insurance if a *covered person* is admitted to a *hospital* within ¹¹[180] days of a *covered accident* as a result of injuries sustained in a *covered accident*. This benefit is payable once per *covered person* per *covered accident*. This benefit is not payable for *emergency room* treatment, *outpatient treatment*, or a *hospital* stay less than 20 hours in an observation unit. We will not pay the Hospital Admission and Hospital Intensive Care Unit Admission benefits for the same *covered accident*.]
- ¹[**Hospital Confinement** We pay the amount shown in the Schedule of Insurance if a *covered person* is confined to a *hospital* within ¹¹[180] days of a *covered accident* as a result of injuries sustained in a *covered accident*. This benefit is payable up to ⁹[365] days per *covered accident*. This benefit is not payable for a *hospital* stay less than 20 hours. We pay either the Hospital Confinement or the Hospital Intensive Care Unit Confinement benefits for each day.]
- ¹[**Hospital Intensive Care Unit Admission** We pay the amount shown in the Schedule of Insurance if a *covered person* is admitted directly to a *hospital intensive care unit* within ¹⁸[30] days of a *covered accident* as a result of injuries sustained in a *covered accident*. This benefit is payable once per *covered person* per *covered accident*. This benefit is not payable for *emergency room* treatment, *outpatient treatment*, or a *hospital* stay less than 20 hours in an observation unit. We will not pay the Hospital Admission and Hospital Intensive Care Unit Admission benefits for the same *covered accident*.]

- ¹[Hospital Intensive Care Unit Confinement]** We pay the amount shown in the Schedule of Insurance if a *covered person* is confined to a *hospital intensive care unit* within ¹⁸[30] days of a *covered accident* as a result of injuries sustained in a *covered accident*. This benefit is payable up to ¹⁹[15] days per *covered accident*. This benefit is not payable for a *hospital intensive care unit* stay less than 20 hours. We pay either the Hospital Confinement or the Hospital Intensive Care Unit Confinement for each day.]
- ¹[Initial Doctor's office/Urgent care facility treatment]** We pay the amount shown in the Schedule of Insurance if a *covered person* is examined or treated by a *doctor* in a *doctor's office* or *urgent care facility* for the initial treatment of a *covered accident* within ¹⁸[30] days after the *covered accident*. This benefit is payable once per *covered person* per *covered accident*. We will not pay the Accident Emergency Room Treatment benefit and the Initial Doctor's Office/Urgent Care Facility benefit for the same *covered accident*.]
- ¹[Knee Cartilage]** We pay the amount shown in the Schedule of Insurance if a *covered person* tears, ruptures or severs knee cartilage (meniscus) as the result of a *covered accident* and requires surgical repair. The *injury* must be treated by a *doctor* within ⁶[60] days after the *covered accident* and repaired through surgery within ⁹[365] days.]
- ¹[Joint Replacement]** We pay the amount shown in the Schedule of Insurance if due to an *injury* sustained in a *covered accident* a *covered person* requires a hip, knee, or shoulder joint replacement. The joint replacement must be performed by a *doctor* within ² [90] days of a *covered accident* and is payable once per *covered person* per *covered accident*.]
- ¹[Laceration]** We pay the amount shown in the Schedule of Insurance if a *covered person* sustains a laceration as a result of a *covered accident* and it is repaired by a *doctor* within ¹⁹[72] hours of the *covered accident*. The amount we pay will be based on the total length of all lacerations received in any one *covered accident* which require repair. This benefit is payable once per *covered person* per *covered accident* for a laceration with no sutures and once per *covered person* per *covered accident* for a laceration which required sutures.]
- ¹[Lodging]** We pay the amount shown in the Schedule of Insurance for a *companion's* hotel/motel stay during the period of time a *covered person* is confined to the *hospital* as the result of a *covered accident*. This benefit is payable up to ¹⁸[30] days per *covered person* per *covered accident* and is only payable while the *covered person* is confined to the *hospital*. The *hospital* must be more than ²⁰[50] miles from the residence of the *covered person*.]
- ¹[Occupational or Physical Therapy]** We pay the amount shown in the Schedule of Insurance if a *covered person* requires occupational or physical therapy due to injuries sustained in a *covered accident*. Treatment must begin within ⁶[60] days of the *covered accident*, be completed within ²¹[6] months, and be performed by a licensed *occupational* or *physical therapist*. This benefit is payable up to ²²[10] treatments per *covered accident*.]

- ¹[Prosthetic Device/Artificial Limb]** We pay the amount shown in the Schedule of Insurance if due to injuries sustained in a *covered accident* a *covered person* receives one or more prosthetic devices/artificial limbs as prescribed by a *doctor* for functional use due to the loss of a hand, foot or sight of an eye. The device or limb must be prescribed within ⁹[365] days of the *covered accident* and is payable once per *covered person* per *covered accident*. This benefit is not payable for hearing aids, dental aids (including false teeth), eyeglasses, or cosmetic prostheses such as hair wigs.]
- ¹[Reasonable Accommodation to Home or Vehicle]** We pay the amount shown in the Schedule of Insurance for a required modification made to a *covered person's* place of residence or vehicle if the *covered person* suffers an Accidental Dismemberment or Catastrophic Loss due to a *covered accident*. The modification must be made within ¹⁴[two] years of the *covered accident* and is payable once per *covered person* per *covered accident*.]
- ¹[Rehabilitation Unit Confinement]** We pay the amount shown in the Schedule of Insurance if a *covered person* is confined to rehabilitation unit due to injuries sustained in a *covered accident*. This benefit is payable up to ¹⁹[15] days per *covered person* per *covered accident* but cannot exceed ¹⁸[30] days per calendar year. We will not pay the Rehabilitation Unit Confinement and the Hospital Confinement benefits for the same day.]
- ¹[Ruptured Disc With Surgical Repair]** We pay the amount shown in the Schedule of Insurance if a *covered person* receives a ruptured disc in his or her spine as a result of injuries sustained in a *covered accident*. The *injury* must be treated by a *doctor* within ⁶[60] days of the *covered accident* and surgically repaired within ⁹[365] days of the *covered accident*. This benefit is payable once per *covered person* per *covered accident*.]
- ¹[Surgery (cranial, open-abdominal, thoracic, hernia)]** We pay the amount shown in the Schedule of Insurance if a *covered person* undergoes cranial, open-abdominal, thoracic, or hernia surgery due to injuries sustained to a *covered accident*. Cranial, open-abdominal, and thoracic surgery must be performed within ⁴[72] hours of the *covered accident*. Hernia surgery must be diagnosed within ¹⁸[30] days of *covered accident* and surgery must be performed within ⁶[60] days. If more than one surgery is performed, we pay the benefit with the highest dollar amount. This benefit is payable once per *covered person* per *covered accident*.]
- ¹[Surgery (Exploratory and Arthroscopic)]** We pay the amount shown in the Schedule of Insurance if a *covered person* undergoes exploratory or arthroscopic surgery as a result of injuries sustained in a *covered accident* and the surgery takes place within ⁶[60] days of the *covered accident*. This benefit is payable once per *covered person* per *covered accident*. Hernia repair is not covered under this benefit. This benefit is not payable if the Surgery or Tendon/Ligament/Rotator Cuff benefits are payable for the same surgery.]
- ¹[Tendon/Ligament/Rotator Cuff]** We pay the amount shown in the Schedule of Insurance if a *covered person* receives a torn, ruptured or severed tendon, ligament, or rotator cuff as the result of injuries sustained in a *covered accident*. The *injury* must be treated within ⁶[60] days of the *covered accident* and repaired through surgery within ⁹[365] days of the *covered accident*. This benefit is payable once per *covered person* per *covered accident*.]

¹**[Transportation** We pay the amount shown in the Schedule of Insurance if a *covered person* must travel more than ²⁰[50] miles one way to receive special treatment at a *hospital* or free standing treatment facility due to a *covered accident*. The treatment must be prescribed by a *doctor* and not available locally. This benefit is payable up to ²³[three] times per *covered person* per *covered accident* and is not payable if transportation is provided by ambulance or air ambulance.]

¹**[Wellness Benefit** We pay the amount shown in the Schedule of Insurance for one Wellness benefit per [calendar] year per *covered person* if a *covered person* has a wellness test performed while coverage is in force. Wellness tests are:

- ²⁴[Abdominal aortic aneurysm ultrasonography
 - Blood test for triglycerides
 - Bone marrow testing
 - Bone density screening
 - Breast ultrasound
 - CA 15-3 (blood test for breast cancer)
 - CA125 (blood test for ovarian cancer)
 - Carotid ultrasound
 - CEA (blood test for colon cancer)
 - Chest x-ray
 - Colonoscopy
 - Completion of a smoking cessation program
 - Completion of a weight reduction program
 - Double contrast barium enema
 - EKG
 - Fasting blood glucose test
 - Flexible sigmoidoscopy
 - Hemocult stool analysis
 - Immunizations
 - Mammography
 - Pap smear
 - PSA (blood test for prostate cancer)
 - Routine/annual physicals
 - Serum cholesterol test to determine level of HDL and LDL
 - Serum Protein Electrophoresis (blood test for myeloma)
 - Skin cancer biopsy
 - Stress test on a bicycle or treadmill
 - Thermography
 - ThinPrep pap test
- Virtual colonoscopy]

¹[X – Ray We pay the amount shown in the Schedule of Insurance if a *covered person* receives an x-ray as the result of injuries sustained in a *covered accident*. The test must be prescribed by a *doctor* and performed in a *doctor's office* or a *hospital* on an *inpatient* or outpatient basis and performed within ² [90] days of the *covered accident*. This benefit is payable once per *covered person* per *covered accident*.]

Payment of Benefits: For covered loss of life, we pay *your* beneficiary described below.

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

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

The Beneficiary: *You* decide who gets this benefit if *you* die. ^{25A}[*You* should have named a beneficiary on *your* enrollment form.] ^{25B}[*Your* beneficiary designation should be maintained by *your employer*.] *You* can change *your* beneficiary at any time by giving *us* written notice, unless *you* have assigned this insurance. ^{26A}[But the change will not take effect until *we* give *you* written confirmation of the change.] ^{26B}[But the change will not take effect until the *employer* gives *you* written confirmation of the change.]

If *you* named more than one person, but didn't tell *us* what their shares should be, they will share equally. If someone *you* named dies before *you*, that person's share will be divided equally by the beneficiaries still alive, unless *you* have specified otherwise.

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

DEFINITIONS

- ¹**[Accident]** This term means an event or occurrence that was not reasonably foreseeable, or that could not have been reasonably expected or anticipated. The term *accident* does not include a *sickness*.
- ¹**[Accidental Death]** This term means death caused by an *accident* independent of *sickness*, bodily infirmity, or any other cause and which is not excluded under the Limitations and Exclusions section.]
- ¹**[Alternate Care Facility]** This term means a facility that is licensed according to state and/or local laws to provide skilled care, intermediate care, intermingled care, custodial care, or rehabilitative care as an alternative to care at a *hospital*.]
- ¹**[Child Care Center]** This term means a program of child care which: (1) is provided in a facility that is licensed as a day care center or is operated by a licensed day care provider; and (2) charges a fee for the care of children. The term does not include child care provided by a: (a) parent; (b) stepparent; (c) grandparent; (d) sibling; (e) aunt; or (f) uncle.]
- ¹**[Chiropractic Care Services]** This term means spinal manipulation by a licensed chiropractor to correct a structural imbalance caused by a *covered accident*. This does not include services for massage therapy or treatment of chronic conditions or other injuries not related to structural imbalance.]
- ¹**[Covered Accident]** This term means an *accident* that:
- Occurs while *your* coverage or *your* dependent's coverage under this policy is in effect.
 - Results in a bodily *injury* and
- Is not otherwise excluded under the terms of this policy.]
- ¹**[Common Carrier]** This term means any land, air or water conveyance operated under a license to transport passengers for hire.]
- ¹**[Covered Person]** This term means an *employee* ²[or dependent] insured by this *plan*.]
- ¹**[Coma]** This term means a state of complete mental unresponsiveness, due to *injury*, with no evidence of appropriate responses to stimulation, as diagnosed by a *doctor*.]
- ¹**[Companion]** This term means a spouse, domestic partner, civil union partner, sibling, child, parent, grandparent, or any primary care giver.]
- ¹**[Dentist]** This term means a licensed *doctor* of dentistry, operating within the scope of his or her license, in the state in which he or she is licensed.]
- ¹**[Dislocation]** This term means a completely separated joint due to an *injury*. A partial *dislocation* means the joint is misaligned but not completely dislocated, as diagnosed by a *doctor*.]
- ¹**[Doctor]** This term means any medical practitioner We are required by law to recognize. He or she must: (1) be properly licensed or certified by the laws of the state where he or she practices; and (2) provide services that are within the lawful scope of his or her practice.]
- ¹**[Emergency Room]** This term means a department of the *hospital* that is designated for emergency care of accidental injuries. This area must be staffed and equipped to handle trauma, be supervised and provide treatment by *doctors*, and provide care seven days per week, 24 hours per day.]

- ¹[Epidural Anesthesia]** This term means a form of regional anesthesia involving injection of drugs through a catheter placed into the epidural space. The epidural must be administered due to a *covered accident*, and does not include treatment for childbirth or diseases.]
- ¹[Fracture]** This term means a broken bone that can be determined by a diagnostic exam. A chip *fracture* is a *fracture* in which a piece of the bone is broken off near a joint at a place where a ligament is usually attached.]
- ¹[Hospital]** This term means a short-term, acute care general facility, which:
- (1) is primarily engaged in providing, by or under the continuous supervision of *doctors*, to *inpatients*, diagnostic services and therapeutic services for diagnosis, treatment and care of sick or injured persons;
 - (2) has organized departments of medicine and major surgery;
 - (3) has a requirement that every patient must be under the care of a *doctor* or *dentist*;
 - (4) provides 24 hour nursing service by or under the supervision of a registered professional nurse (R.N.);
 - (5) is duly licensed by the agency responsible for licensing such *hospitals*; and
 - (6) is not, other than incidentally: (a) a place of rest; (b) a place primarily for the treatment of tuberculosis; (c) a place for the aged; (d) a place for drug addicts or alcoholics; or (e) a place for convalescent, custodial, educational or rehabilitative care.]
- ¹[Hospital Intensive Care Unit]** This term means a designated area of a *hospital* that
- (1) provides the highest quality of medical care and is restricted to patients who are critically ill or injured and who require intensive comprehensive observation and care;
 - (2) is separate and apart from the surgical recovery room and from rooms, beds, wards, and units customarily used for patient confinement
 - (3) is permanently equipped with special lifesaving equipment for the care of the critically ill or injured;
- is under continuous observation by a specially trained nursing staff assigned exclusively to the intensive care unit on a 24 hour basis and is assigned a *doctor* on a full-time basis.]
- ¹[Hospital Confinement]** This term means admission to a *hospital* as an *inpatient* for ³[at least 24 consecutive hours] by a *doctor* for an *injury*.]
- ¹[Injury]** This term means unintentional physical damage or harm caused directly by an *accident* and not due to *sickness*, disease or any other causes. The *injury* must occur while you ²[or your covered dependent] are insured under this *plan*.]
- ¹[Inpatient]** This term means a patient who is admitted to a *hospital* for an *injury*.]
- ¹[Occupational Therapy]** This term means the treatment of a physically disabled person by means of constructive activities designed and adapted to promote the restoration of the *covered person's* ability to satisfactorily accomplish the ordinary tasks of daily living and those tasks required by the *covered person's* particular occupational role. Occupational therapy does not include diversional, recreational, vocational therapies (i.e. hobbies, arts and crafts).]

- ¹[Occupational Therapist]** This term means a person, other than you or a family member, who: 1) possesses the designation "Occupational Therapists Registered (OTR)", 2) is licensed by the state to practice *occupational therapy*, 3) performs services which are allowed by his licenses; and 4) performs services for which benefits are provided by this *plan*.]
- ¹[Organized Sport]** This term means a sport activity that is governed by an organization and requires formal registration to participate. Proof of registration will be required at claim time.]
- ¹[Outpatient Treatment]** This term means medical services that a *covered person* receives when not confined as an *inpatient* in a *hospital*.]
- ¹[Physical Therapy]** This term means treatment by physical means, hydrotherapy, heat, or similar modalities, physical agents, bio-mechanical and neuro-physiological principles and devices. Such therapy is given to relieve pain, restore function, and to prevent disability following *injury* or loss of a body part.]
- ¹[Physical Therapist]** This term means a person, other than you or a family member, who: 1) is licensed by the state to practice *physical therapy*; 2) performs services which are allowed by his or her license; 3) performs services for which benefits are provided by this Policy and 4) practices according to the code of ethics of the American Physical Therapy Association.]
- ¹[Rehabilitative Unit]** This term means an appropriately licensed facility or separate section of a *hospital* that provides rehabilitation care services on an *inpatient* basis and is designated, staffed and equipped to provide restorative services under the supervision of a trained and experienced rehabilitation *doctor*. A rehabilitation unit is not: a nursing home; an extended care facility; a skilled nursing facility; a rest home or home for the aged; a hospice care facility; a place for alcoholics or drug addicts; or an assisted living facility.]
- ¹[Sickness]** This term means a disease, illness or other condition not related to *injury* including diseases or infections except when the due to an accidental cut or wound.]
- ¹[Urgent Care Facility]** This term means a health care facility that is organizationally separate from a *hospital* and whose primary purpose is the offering and provision of immediate, short term medical care, without appointment, for urgent care.]
- ¹[We, Us and Our]** These terms mean The Guardian Life Insurance Company of America.]
- ¹[You or Your]** These terms mean the insured ⁴[*employee*].]

Exclusions

This *plan* will not pay benefits for any *injury* caused by or related to directly or indirectly:

- ³[*Sickness*, disease, mental infirmity or medical or surgical treatment.]
- ³[Voluntary use of any poison, chemical, prescription or non-prescription drug or controlled substance unless: (1) it was prescribed for a *covered person* by a *doctor*, and (2) it was used as prescribed. In the case of a non-prescription drug, this *plan* does not pay for any *accident* resulting from or contributed to by use in a manner inconsistent with package instructions. "Controlled substance" means anything called a controlled substance in Title II of the Comprehensive Drug Abuse Prevention and Control Act of 1970, as amended from time to time.]
- ³[The *covered person* being legally intoxicated.]
- ³[Declared or undeclared war, act of war, or armed aggression.]
- ³[Service in the armed forces, National Guard, or military reserves of any state or country.]
- ³[Taking part in a riot or civil disorder.]
- ³[Commission of, or attempt to commit a felony.]
- ³[Treatment rendered or *hospital confinement* outside the United States ⁴[or Canada.]]
- ³[Intentionally self inflicted *injury*, while sane or insane.]
- ³[Suicide or attempted suicide, while sane or insane.]
- ³[Travel or flight in any kind of aircraft, including any aircraft owned by or for the policyholder, except as a fare-paying passenger on a common carrier.]
- ³[Participation in any kind of sporting activity for compensation or profit, including coaching or officiating.]
- ³[Riding in or driving any motor-driven vehicle in a race, stunt show or speed test.]
- ³[Participation in hang gliding, bungee jumping, sailgliding, parasailing, parakiting, ballooning, parachuting, or skydiving.]
- ³²[Job related or on the job injuries.]]
- ³[An accident that occurred before the *covered person* is covered by this *plan*.]
- ³¹[Injuries to a dependent child received during the birth.]]

ACCIDENT COVERAGE

Subject to all of this *plan's* terms, this *plan* will pay the benefits described below if a *covered person* sustains an injury or incurs a loss as a result of a covered accident which occurs on or after the date he or she becomes insured by this *plan*. This *plan* pays no benefits other than what is specifically listed below.

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

PORTABILITY

Note This section does not apply to residents of ⁷[Kansas, Maine, or South Dakota.]

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

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

- You may port *your* coverage ¹[or coverage for any of *your* dependents] if coverage under this *plan* ends because *you*: (a) have terminated employment; (2) stop being a member of an eligible class of employees; or (3) this *plan* ends.
- ⁸[You may not Port *your* coverage ¹[or coverage for any of *your* dependents] unless You have been covered by this *plan*, or the Plan it replaced, for *accident* coverage for at least ⁹[12] months in a row prior to the date *your* coverage under this *plan* ends. And] *you* must have been *actively at work on a full-time* ⁶[or *part-time*] basis for at least ¹⁰[30] scheduled working days in a row prior to the date *your* coverage under this *plan* ends.
- -You may not Port *your* coverage ¹[or coverage for any of *your* dependents] if (1) coverage under this *plan* ends due to *your* failure to pay any required premium ²[; or (2) you have reached age ³[70] on or before *your* coverage under this *plan* ends.

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

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

If *you* die while covered for dependent *accident* coverage, *your* spouse may port *your* dependent Accident coverage as described above. *your* spouse and dependent children must be covered under this *plan* on the date of *your* death. But this option is not available if ¹¹[(1)] there is no surviving spouse; ¹¹[or (2) the surviving spouse has reached age ³[70] on the date *you* die.]

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

The premium for the portable certificate of coverage will be based on: *your* rate class under this *plan*; and (2) *your* ¹[or *your* surviving spouse's] age bracket as shown in the Accident Portability Coverage Premium Notice.

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

⁴[We will not ask for *proof* that *you* ¹ [or *your* surviving spouse] are in good health.]

⁵[We require *proof of insurability* satisfactory to us if *you* ¹[or *your* surviving spouse] Port for any reason, other than the end of the group *plan*. And, we must approve that *proof* in writing.]

¹[Waiver of Premium]

If, while covered by this *plan*, *you* become disabled due to a *covered accident* and *you* remain disabled for ²[90] days, *we* will waive the premium due after such ²[90] days for as long as *you* remain disabled.

To be considered disabled *you* must: (1) be unable to work at any job for which *you* are qualified by education, training or experience; and (2) not be working at any job for pay or benefits; and (3) be under the care of a *doctor* for the treatment *injuries* sustained in a *covered accident*.]

CERTIFICATE AMENDMENT

(To be attached to certificates issued to employees)

The certificate is amended by adding the following: to the Accident coverage provisions of this *plan*.

DISABILITY SICKNESS AND ACCIDENT [ON & OFF THE JOB][OFF THE JOB]

SCHEDULE OF INSURANCE

WEEKLY BENEFIT AMOUNT FOR COVERED ⁴¹[EMPLOYEE]: ² [\$50-\$1000]

¹⁶[WEEKLY BENEFIT AMOUNT FOR COVERED DEPENDENT SPOUSE: ² [\$50-\$1000]]

MAXIMUM BENEFIT PERIOD FOR COVERED ⁴¹[EMPLOYEE]: ³ [9-52] WEEKS

¹⁶[MAXIMUM BENEFIT PERIOD FOR COVERED DEPENDENT SPOUSE: ⁴[\$50-\$1000]]

ELIMINATION PERIOD FOR COVERED ⁴¹[EMPLOYEE] ACCIDENT: ⁵ [0-180] DAYS

¹⁶[ELIMINATION PERIOD FOR COVERED DEPENDENT SPOUSE ACCIDENT: ⁵ [0-180] DAYS]

ELIMINATION PERIOD FOR COVERED ⁴¹[EMPLOYEE] SICKNESS: ⁵ [0-180] DAYS

¹⁶[ELIMINATION PERIOD FOR COVERED DEPENDENT SPOUSE SICKNESS: ⁵ [0-180] DAYS]

BENEFITS

We will pay the weekly benefit amount shown in the Schedule of Insurance if a *covered person* becomes disabled as a result of a *sickness*, or an *injury* sustained in a *covered accident*. The *sickness* and the *covered accident* must occur and the *disability* must begin while the covered person is covered under this plan. ⁴⁶[Disability must begin within ⁴⁵[90] days of the covered accident or *sickness*.]

How Payments Start: To start getting payments from this *plan*, you ¹⁶[or your *covered dependent spouse*] must meet all of the conditions listed below.

- He or she must: (1) become *disabled* while covered by this plan; and (2) remain *disabled* and covered for this *plan's elimination period*.
- He or she must provide proof of loss, as described in the Claim Provisions, herein.

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

^{6A} [You can satisfy the *elimination period* while working, provided you are *disabled*.]

^{6B} [You may not satisfy this *plan's elimination period* while working.]

⁷ [If you perform any work for wage or profit, you will not be eligible for benefits under this *plan*.]

⁸ [**Waiver Of Premium:** We waive your premiums for this coverage while you are entitled to receive a Weekly Benefit payment from this *plan*.]

When Payments End: Your ¹⁶[and your covered dependent's] benefits from this *plan* will end on the earliest of the dates shown below:

- The date he or she is no longer disabled.
- The date he or she fails to provide proof of loss as required by this *plan*
- The date he or she has been outside the United States ^{9A} [and/or Canada] ^{9B} [and/or a country or region approved by Us] for more than ¹⁰ [two months] in a ¹¹ [12 month] period] .
- The date he or she dies.
- The end of the Maximum Payment Period.
- The date he or she is no longer receiving *regular and appropriate care* from a *doctor*.

Maximum Payment Period: The Maximum Payment Period is shown in the Schedule Of Insurance.

Recurring disability: Benefits from this *plan* end if you ¹⁶[or your covered dependent spouse] cease¹⁶[s] to be *disabled*. But, a later *disability* may be treated as a *recurring disability*, if all of the terms listed below are met:

- You must return to active work right after your benefits end.
- The *disability* must recur less than ¹² [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 *plan* must not end during your return to *active work*.
- During the time you return to *active work*, you must: (1) stay covered by this *plan*; and (2) premium payments must be made on your behalf.
- Your benefits must not have ended because you have used up the Maximum Payment Period.

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

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

DEFINITIONS

¹³[This section defines certain terms appearing in your Certificate.

Active Work: This term means *you* are able to perform, and are performing, all of the regular duties of *your* work for the ⁴²[*employer*], ¹⁴ [on a Full-Time basis] ¹⁵ [or a part-time basis] at: (1) one of the *employer* 's usual places of business; (2) some place where the ⁴²[*employer* 's] business requires *you* to travel; or (3) any other place *you* and the ⁴²[*employer*] have agreed on for *your* work.

⁴⁸ [¹⁶ [**Activities of Daily Living** means:

1. **Bathing:** the ability to wash in a tub or shower; or by taking a sponge bath; and to towel dry; with or without equipment or adaptive devices.
2. **Dressing:** the ability to put on and take off all clothes; and those medically necessary braces or prosthetic limbs usually worn; and also to fasten or unfasten them.
3. **Toileting:** the ability to get to and from and on and off the toilet; to maintain personal hygiene; and to care for clothes.
4. **Transferring:** the ability to move in and out of a chair or bed with or without equipment such as: canes; walkers; crutches; grab bars; or any other support devices.
5. **Continence:** the ability to control bowel and bladder function; or, in the event of incontinence, the ability to maintain personal hygiene.
6. **Eating:** the ability to get food into the body by any means once it has been prepared and made available.]]

⁴⁸ [¹⁶ [**Cognitive Impairment or Cognitively Impaired:** These terms mean a decline or loss in intellectual aptitude. Such loss may result from: (a) *injury*; (b) *sickness*; (c) Alzheimer's disease, or (d) like forms of senility or irreversible dementia. It must be supported by clinical proof and standardized tests that precisely measure decline in the areas of: (i) short term memory; (ii) orientation to time, place and person; (iii) deductive or abstract reasoning; and (iv) judgment as it relates to awareness of safety. Cognitive impairment does not include decline or loss due to a *mental illness*.]]

Covered Accident This term means an *accident* that:

- Occurs while the covered person's coverage under this plan is in effect.
- Results in a bodily *injury* or *sickness*.
- Is not otherwise excluded under the terms of this *plan*; and
- Is covered under the Accident coverage of this *plan*.

Covered Person This term means *you* ¹⁶[or *your* dependent spouse] covered by this *plan*.

Disability or Disabled: These terms mean that an *injury* sustained in a *covered accident* or a *sickness* causes physical or mental impairment to such a degree that ⁶ [(A)] *you* are: (1) not able to perform ¹⁴ [, on a *full-time* basis] ¹⁵[or a *part-time* basis] the major duties of your ¹⁷ [Own Job] ¹⁶[or (B) *your* covered dependent spouse is (i) not able to perform two or more *activities of daily living*, on a routine basis, without help or (ii) *cognitively impaired* and in need of verbal cueing to protect himself or herself or others.]

¹³ [

⁴⁷[If you do not have a full-time job at the time of disability, these terms mean that you are (i) not able to perform two or more *activities of daily living*, on a routine basis, without help or (ii) *cognitively impaired* and in need of verbal cueing to protect yourself or others.]

¹⁸ [You are not *disabled* if you perform any work for wage or profit] ¹⁹ [during the *elimination period*] .]

²⁰ [You may be required, on average, to work more than ²¹ [40] hours per week. In this case, you are not disabled if you are able to work for ²¹ [40] hours per week.]

Neither loss of a professional or occupational license due to misconduct or unlawful activity or receipt of, or entitlement to, Social Security disability benefits in and of themselves constitute disability under this *plan*.

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

Elimination Period: This term means the period of time you ¹⁶[or your covered dependent spouse] must be *disabled*, due to a covered *disability*, before this *plan's* benefits are payable.

⁴¹[**Employee**]: ²² [This term means a person who works for the ⁴²[*employer*] and whose income is reported for tax purposes using a W-2 or 1099 form.]

⁴²[**Employer**]: This term means ¹ [ABC Company, Inc] .

¹⁴ [**Full-Time:** This term means you regularly work at least the number of hours in the normal work week set by the ⁴²[*employer*] (but not less than ²¹ [30] hours per week) at: (1) your *employer's* place of business; (2) some place where the *employer's* business requires you to travel; or (3) any other place you and your ⁴²[*employer*] have agreed upon for the performance of occupational duties.]

Injury: This term means a bodily *injury* due to a *covered accident* that occurs, independent of all other causes, while you ¹⁶[or your covered dependent spouse] is covered by this *plan*. We will cover a *disability* caused by an *injury* when the *disability* starts within ³² [90 days] of the date of such *injury*.

Maximum Payment Period: This term means the longest time that benefits are paid by this *plan*, subject to all terms, limitations and exclusions.

⁴⁹[**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 have the right to use some other similar standard. A *mental illness* may be caused by, contributed to by, result in physical, biological or chemical factors or symptoms. For purposes of this plan, *mental illness* does not include: (1) irreversible dementia caused by Alzheimer's disease, stroke, trauma or viral infection; or (2) any other condition not typically treated by a psychiatrist, clinical psychologist or other qualified mental health practitioner with psychotherapy or psychotropic drugs.]]

¹³**[Objective Medical Evidence:** This term includes, but is not limited to: (1) diagnostic testing; (2) laboratory reports; and (3) 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.

^{23A} **[Own Job:** This term means your job for the ⁴²[*employer*]. We use the job description provided by the ⁴²[*employer*] to determine the duties and requirements of your Own Job.]

^{23B}**[Own Occupation:** This term means the occupation: (1) *you* are routinely performing immediately prior to *disability*; (2) which is your primary source of income prior to *disability*; and (3) for which *you* are covered under this *plan*. Occupation includes any employment, trade or profession that are related in terms of similar tasks, functions, skills, abilities, knowledge, training and experience required by ⁴²[*employers*] from those engaged in a particular occupation in the general labor market in the national economy. Occupation is not specific to a certain ⁴²[*employer*] or a certain location.]

¹⁵ **[Part-Time:** This term means with respect to eligibility for coverage, *you* regularly work at least the number of hours in the normal work week set by the ⁴²[*employer*] (but not less than ²⁴ [15] hours per week), at: (1) your ⁴²[*employer 's*] place of business; (2) some place where the ⁴²[*employer 's*] business requires *you* to travel; or (3) any other place *you* and your ⁴²[*employer*] have agreed upon for the performance of occupational duties.]

Plan: This term means the Accident coverage described in the *plan* and this Certificate.

²⁵ **[Proof Of Insurability:** This terms means an application for coverage showing that a person in insurable.]

Recurring disability: This term means a later *disability* that: (1) is related to an earlier *disability* for which this *plan* paid benefits; and (2) meets the conditions described in the *recurring disability* section of this plan.

Regular and Appropriate Care: This term means, with respect to your disabling condition and any other condition which, if left untreated, would adversely affect your disabling condition, *you*: (1) visit a *doctor* as frequently as medically required, according to generally accepted medical standards, to effectively manage these conditions; and (2) 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: (a) *disability*; and (b) 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: (i) the American Medical Association (AMA); (ii) the AMA Board of Medical Specialties; (iii) the Food and Drug Administration; (iv) the Centers for Disease Control; (v) the National Cancer Institute; (vi) the National Institutes of Health; (vii) the Department of Health and Human Services; and (viii) any other agency of similar repute.

Sickness: These terms means an illness or disease.

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

¹³**[You or Your:** These terms mean the covered ⁴¹*[employee]*.]

LIMITATIONS AND EXCLUSIONS

³⁹**[Pre-Existing Conditions:** A pre-existing condition is an *injury or a sickness*, whether diagnosed or misdiagnosed, and any symptoms of it, for which, in the look back period, *you* ¹⁶*[or your dependent spouse]*: (1) received advice or treatment from a *doctor*; (2) underwent diagnostic procedures [other than routine screening in the absence of symptoms or suspicion of disease process by a *doctor*] ; (3) was prescribed or take prescription drugs; or (4) received other medical care or treatment, including consultation with a *doctor*.

The “look back period” is the ³⁴ [three months] before the latest of: (1) the effective date of your ¹⁶*[or your dependent spouse]* coverage under this plan; (2) the effective date of a change that increases the benefits payable by this plan; and (3) the effective date of a change in your ¹⁶*[or your dependent spouse]* benefit election that increases the benefit payable by this plan.

⁴⁰ [No benefits are payable for *disability* caused by, contributed to by or resulting from a pre-existing condition; unless the disability starts ¹⁶[(a)] ³⁵ [after *you* complete at least one full day of *active work*] after the date *you* have been covered under this plan for ³⁶ [12 months] in a row. ¹⁶*[or (b) the date your dependent spouse has been covered under this plan for [12 months] in a row.]*

³⁷ [For any *disability* caused by, contributed to by or resulting from a pre-existing condition, *We* limit the Maximum Payment Period to ³⁸ [two weeks,] unless the *disability* starts ¹⁶[(a)] ³⁵ [after *you* complete at least one full day of *active work*] after the date *you* have been covered under this plan for ³⁶ [12 months] in a row. ¹⁶*[or (b) the date your dependent spouse has been covered under this plan for ³⁶ [12 months] in a row.]*

Your ¹⁶*[or your dependent spouse's]* *disability* caused by, contributed to by or resulting from; a pre-existing condition may begin after: (1) a change which provides for an increase in the benefits payable by this plan; or (2) a change in your ¹⁶*[or your dependent spouse's]* benefit election which increases the benefit payable by this plan. In this case, his or her 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 his or her *disability* starts ¹⁶[(a)] ³⁵ [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 ¹⁶*[or (b) the date your dependent spouse has been covered under this plan for [12 months] in a row.]*.

We do not cover any disability that starts before your coverage under this plan.]

³⁹ [**Prior Coverage Credit:** If this plan replaces a similar disability plan the *employer* had with another insurer, the pre-existing condition provision may not apply to *you*. This plan must start right after the old plan ends.]

³⁹ [The pre-existing condition provision will be waived for *you* if *you*: (1) are at *active work* on the effective date of this *plan*; and (2) have fulfilled the requirements of any pre-existing condition provision of the old plan.

You may have been covered under the old plan when it ended, but have not met the requirements of any pre-existing condition provision of the old plan. In that case, *we* credit any time used to meet the old plan's pre-existing condition provision toward meeting this *plan's* pre-existing conditions provision. *You* must: (1) enroll for coverage under this *plan* on or before this *plan's* effective date; and (2) be at *active work* on the effective date of this *plan*.

But, *we* limit your maximum Weekly Benefit under this *plan* if: (1) it is more than the maximum Weekly Benefit for which *you* were covered under the old plan; (2) *you* become disabled due to a pre-existing condition; and (3) this *plan* 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 old plan.

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

Exclusions: The exclusions contained in this policy apply to the ^{26A} [Off the Job] ^{26B} [On & Off the Job] *disability* benefit. This *plan* does not pay any benefits for any period of *disability*:

- During which *you* ¹⁶[or *your* covered dependent spouse] is confined to a facility as a result of your conviction of a crime;
- During which he or she is receiving medical treatment or care outside the United States ⁵⁰[or Canada] [unless expressly authorized by Us;]
- Which starts before he or she is covered by this *plan*; or
- During which *your* loss of earnings is not solely due to *your disability*.]

Claim Provisions

Authority: *We* have the sole discretionary authority to: (1) interpret the terms of this *plan*; and (2) determine your eligibility for coverage and benefits under the *plan*. 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 *plan* as described in your Certificate's Accident and Health Claims Provisions. For details, *you* can call *us* at ²⁷ [1-800-268-2525.] ¹⁶[If the claim is being made for your covered dependent spouse, his or her name also should be noted.]

Proof Of Loss: When *we* receive *your* notice, *we* will provide *you* with a claim form for filing proof of loss. This form requires data from the ⁴²[*employer*], *you*, and the *doctor(s)* treating *your injury* or *sickness*. Proof of loss must be given to *us* within the time stated in *your* Certificate's Accident and Health Claims Provisions. 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.

Proof of loss, provided at *your* expense, consists of the following. Failure to provide this information may delay, suspend, reduce or terminate *your* benefits.

- The date *disability* began.
- *Your* last day of *active work*.
- The cause of *disability*.
- The extent of *disability*, including limitations and restrictions ¹⁶[(A)] preventing *you* from performing the major duties of *your* ^{26A} [Own Occupation] ^{26B} [Own Job] and ¹⁶[(B)] causing *your* covered dependent spouse to be (i) unable to perform two or more *activities of daily living* on a routine basis without help or (ii) *cognitively impaired* and in need of verbal cueing to protect himself or herself or others.
- ⁴⁷[If you do not have a full-time job at the time of disability, the extent of *disability*, including limitations and restrictions causing you to, (i) not be able to perform two or more *activities of daily living*, on a routine basis, without help or (ii) be *cognitively impaired* and in need of verbal cueing to protect yourself or others.]
- If *your* occupation requires that *you* carry liability or malpractice insurance, any changes to such insurance that becomes effective on or after the date of *disability*.
- *Objective medical evidence* in support of *your* ¹⁶[or your covered dependent spouse's] limitations and restrictions, beginning with the date *disability* began.
- The prognosis of *disability*.
- The name and address of all *doctors*, hospitals and health care facilities where *you* ¹⁶[or your covered dependent spouse] have been treated for *your* ¹⁶[or your covered dependent spouse's] *disability* since the date *disability* began.
- Proof that *you* ¹⁶[or your covered dependent spouse] are currently receiving *regular and appropriate care* from a *doctor*.
- Proof that *you* ¹⁶[or your covered dependent spouse] have been receiving *regular and appropriate care* from a *doctor*, from the date *disability* began.

You ¹⁶[or your covered dependent spouse] must provide *objective medical evidence* from a *doctor* who is not yourself, *your* spouse, child, parent, sibling or business associate.

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

⁴³[The Guardian Life Insurance Company of America
Group Short Term disability Claims Department
P.O. Box 26160

Lehigh Valley, PA 18002-6160.]

Authorization Required: You ¹⁶[or your covered dependent spouse] must provide us with written, unaltered authorizations to obtain medical, financial, vocational, occupational, and governmental information required to determine our liability under this plan. You ¹⁶[or your covered dependent spouse] must provide us with such authorizations as often as we may require, in order that they remain current. Failure to provide such authorizations may delay, suspend or terminate your ¹⁶[or your covered dependent spouse's] benefits.

Right To Request Medical, Financial Or Vocational Assessment: We may ask you ¹⁶[or your covered dependent spouse] to take part in a medical, financial, vocational or other assessment that we feel is necessary to determine whether the terms of the plan are met. We may require this as often as we feel is reasonably necessary. We will pay for all such assessments. But, if you ¹⁶[or your covered dependent spouse] postpone a scheduled assessment without our approval, you ¹⁶[or your covered dependent spouse] will be responsible for any rescheduling fees. If you ¹⁶[or your covered dependent spouse] do not take part in or cooperate with the assessment, we have the right to stop or suspend your ¹⁶[or your covered dependent spouse] payments under this plan.

Ongoing Proof Of Loss: To continue to receive payments from this plan, you ¹⁶[or your covered dependent spouse] must give us current proof of loss as often as we may reasonably require. Ongoing proof of loss must be provided to us within ²⁷ [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 the legal representative of your estate. Benefits are paid in US dollars.

We pay benefits ²⁸ [biweekly] at the end of the period for which they are payable.

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

Benefits to which you ¹⁶[or your covered dependent spouse] are entitled may remain unpaid at your ¹⁶[or your covered dependent spouse's] death. Such benefits may be paid at our discretion to: (1) your estate; or (2) your spouse, parents, children, or brothers and sisters.

Partial Week Payment: You ¹⁶[or your covered dependent spouse] may be disabled for only part of a week. In this case, we compute your ¹⁶[or your covered dependent spouse's] payment as ²⁹ [1/7th] of the benefit to which you ¹⁶[or your covered dependent spouse] would be entitled for the full week times the number of days you ¹⁶[or your covered dependent spouse] are disabled.

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

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

The Guardian Life Insurance Company of America

⁴⁴[

SPECIMEN


Vice President, Risk Management & Chief Actuary, Group Insurance]

CERTIFICATE AMENDMENT

(To be attached to certificates issued to ³³[employees])

The certificate is amended by adding the following: to this *plan*

DISABILITY ACCIDENT ^{26A} [ON & OFF THE JOB] ^{26B} [OFF THE JOB] SCHEDULE OF INSURANCE

WEEKLY BENEFIT AMOUNT FOR COVERED ³³[EMPLOYEE]: ²[\$50-\$1000]

¹⁶[WEEKLY BENEFIT AMOUNT FOR COVERED DEPENDENT SPOUSE: ²[\$50-\$1000]]

MAXIMUM BENEFIT PERIOD FOR COVERED ³³[EMPLOYEE]: ³[9-52] WEEKS

¹⁶[MAXIMUM BENEFIT PERIOD FOR COVERED DEPENDENT SPOUSE: ⁴[\$50-\$1000]]

ELIMINATION PERIOD FOR COVERED ³³[EMPLOYEE]: ⁵[0-180] DAYS

¹⁶[ELIMINATION PERIOD FOR COVERED DEPENDENT SPOUSE: ⁵[0-180] DAYS]

BENEFITS

We will pay the weekly benefit amount shown in the Schedule of Insurance if a *covered person* becomes disabled as a result of an *injury* sustained in a *covered accident*. The *covered accident* must occur and the *disability* must begin while the covered person is covered under this plan. ³⁷[Disability must begin within ³⁸[90] days of the covered accident.]

How Payments Start: To start getting payments from this *plan*, you ¹⁶[or your *covered dependent spouse*] must meet all of the conditions listed below.

- He or she must: (1) become *disabled* while covered by this plan; and (2) remain *disabled* and covered for this *plan's elimination period*.
- He or she must provide proof of loss, as described in the Claim Provisions, herein.

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

^{6A} [You can satisfy the *elimination period* while working, provided you are *disabled*.]

^{6B} [You may not satisfy this *plan's elimination period* while working.]

⁷ [If you perform any work for wage or profit, you will not be eligible for benefits under this *plan*.]

⁸ [**Waiver Of Premium:** We waive your premiums for this coverage while you are entitled to receive a Weekly Benefit payment from this *plan*.]

When Payments End: Your ¹⁶[and your covered dependent's] benefits from this *plan* will end on the earliest of the dates shown below:

- The date he or she is no longer disabled.
- The date he or she fails to provide proof of loss as required by this *plan*
- The date he or she has been outside the United States ^{9A} [and/or Canada] ^{9B} [and/or a country or region approved by Us] for more than ¹⁰ [two months] in a ¹¹ [12 month] period] .
- The date he or she dies.
- The end of the Maximum Payment Period.
- The date he or she is no longer receiving *regular and appropriate care* from a *doctor*.

Maximum Payment Period: The Maximum Payment Period is shown in the Schedule Of Insurance.

Recurring disability: Benefits from this *plan* end if you ¹⁶[or your covered dependent spouse] cease¹⁶[s] to be *disabled*. But, a later *disability* may be treated as a *recurring disability*, if all of the terms listed below are met:

- You must return to active work right after your benefits end.
- The *disability* must recur less than ¹² [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 *plan* must not end during your return to *active work*.
- During the time you return to *active work*, you must: (1) stay covered by this *plan*; and (2) premium payments must be made on your behalf.
- Your benefits must not have ended because you have used up the Maximum Payment Period.

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

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

DEFINITIONS

¹³[This section defines certain terms appearing in this rider.

Active Work: This term means you are able to perform, and are performing, all of the regular duties of your work for the ³⁴[employer,] ¹⁴ [on a Full-Time basis] ¹⁵ [or part-time basis] at: (1) one of the *employer*'s usual places of business; (2) some place where the ³⁴[employer 's] business requires you to travel; or (3) any other place you and the ³⁴[employer] have agreed on for your work.]

¹³¹⁶ [**Activities of Daily Living** means:

1. **Bathing:** the ability to wash in a tub or shower; or by taking a sponge bath; and to towel dry; with or without equipment or adaptive devices.
2. **Dressing:** the ability to put on and take off all clothes; and those medically necessary braces or prosthetic limbs usually worn; and also to fasten or unfasten them.
3. **Toileting:** the ability to get to and from and on and off the toilet; to maintain personal hygiene; and to care for clothes.
4. **Transferring:** the ability to move in and out of a chair or bed with or without equipment such as: canes; walkers; crutches; grab bars; or any other support devices.
5. **Continence:** the ability to control bowel and bladder function; or, in the event of incontinence, the ability to maintain personal hygiene.
6. **Eating:** the ability to get food into the body by any means once it has been prepared and made available.]

⁴⁸ ¹⁶ [**Cognitive Impairment or Cognitively Impaired:** These terms mean a decline or loss in intellectual aptitude. Such loss may result from: (a) *injury*; (b) *sickness*; (c) Alzheimer's disease, or (d) like forms of senility or irreversible dementia. It must be supported by clinical proof and standardized tests that precisely measure decline in the areas of: (i) short term memory; (ii) orientation to time, place and person; (iii) deductive or abstract reasoning; and (iv) judgment as it relates to awareness of safety. Cognitive impairment does not include decline or loss due to a *mental illness*.]]

Covered Accident This term means an *accident* that:

- Occurs while the covered person's coverage under this plan is in effect.
- Results in a bodily *injury*.
- Is not otherwise excluded under the terms of this *plan*; and
- Is covered under the Accident coverage of this *plan*.

Covered Person This term means *you* ¹⁶[or *your* dependent spouse] covered by this *plan*.

Disability or Disabled: These terms mean that an *injury* sustained in a *covered accident* causes physical or mental impairment to such a degree that ¹⁶[(A)] *you* are: (1) not able to perform ¹⁴[on a Full-Time basis] ¹⁵[or a part-time basis] the major duties of your ¹⁷ [*Own Job*] ¹⁶[or (B) *your* covered dependent spouse is (i) not able to perform two or more *activities of daily living*, on a routine basis, without help, or (ii) *cognitively impaired* and in need of verbal cueing to protect himself or herself or others

³⁹[If you do not have a full-time job at the time of disability, these terms mean that you are (i) not able to perform two or more *activities of daily living*, on a routine basis, without help or (ii) *cognitively impaired* and in need of verbal cueing to protect yourself or others.]

¹⁸ [*You* are not *disabled* if *you* perform any work for wage or profit] ¹⁹ [during the *elimination period*]].

¹³²⁰ [You may be required, on average, to work more than ²¹ [40] hours per week. In this case, you are not disabled if you are able to work for ²¹ [40] hours per week.]

Neither loss of a professional or occupational license due to misconduct or unlawful activity or receipt of, or entitlement to, Social Security disability benefits in and of themselves constitute disability under this *plan*.]

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

Elimination Period: This term means the period of time you ¹⁶[or your covered dependent spouse] must be *disabled*, due to a covered *disability*, before this *plan's* benefits are payable.

³³**[Employee]:** ²² [This term means a person who works for the ³⁴[*employer*] and whose income is reported for tax purposes using a W-2 or 1099 form.]

³⁴**[Employer]:** This term means ¹[ABC Company, Inc].

¹⁴ [**Full-Time:** This term means you regularly work at least the number of hours in the normal work week set by the ³⁴[*employer*] (but not less than [30] hours per week) at: (1) your *employer's* place of business; (2) some place where the *employer's* business requires you to travel; or (3) any other place you and your ³⁴[*employer*] have agreed upon for the performance of occupational duties.]

Injury: This term means a bodily *injury* due to a *covered accident* that occurs, independent of all other causes, while you ¹⁶[or your covered dependent spouse] are covered by this *plan*. We will cover a *disability* caused by an *injury* when the *disability* starts within ³² [90 days] of the date of such *injury*.

Maximum Payment Period: This term means the longest time that benefits are paid by this *plan*, subject to all terms, limitations and exclusions.

⁴⁰ [**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 have the right to use some other similar standard. A *mental illness* may be caused by, contributed to by, result in physical, biological or chemical factors or symptoms. For purposes of this plan, *mental illness* does not include: (1) irreversible dementia caused by Alzheimer's disease, stroke, trauma or viral infection; or (2) any other condition not typically treated by a psychiatrist, clinical psychologist or other qualified mental health practitioner with psychotherapy or psychotropic drugs.]

Objective Medical Evidence: This term includes, but is not limited to: (1) diagnostic testing; (2) laboratory reports; and (3) 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.]

¹³^{23A} [**Own Job:** This term means your job for the ³⁴[*employer*]. We use the job description provided by the ³⁴[*employer*] to determine the duties and requirements of your Own Job.]

^{23B} [**Own Occupation:** This term means the occupation: (1) *you* are routinely performing immediately prior to *disability*; (2) which is your primary source of income prior to *disability*; and (3) for which *you* are covered under this *plan*. Occupation includes any employment, trade or profession that are related in terms of similar tasks, functions, skills, abilities, knowledge, training and experience required by ³⁴[*employers*] from those engaged in a particular occupation in the general labor market in the national economy. Occupation is not specific to a certain ³⁴[*employer*] or a certain location.]

¹⁵ [**Part-Time:** This term means with respect to eligibility for coverage, *you* regularly work at least the number of hours in the normal work week set by the ³⁴[*employer*] (but not less than ²⁴ [15] hours per week), at: (1) your ³⁴[*employer 's*] place of business; (2) some place where the ³⁴[*employer 's*] business requires *you* to travel; or (3) any other place *you* and your ³⁴[*employer*] have agreed upon for the performance of occupational duties.]

Plan: This term means the Accident coverage described in the Policy and this Certificate.

²⁵[**Proof Of Insurability:** This terms means an application for coverage showing that a person in insurable.]

Recurring disability: This term means a later *disability* that: (1) is related to an earlier *disability* for which this *plan* paid benefits; and (2) meets the conditions described in the *recurring disability* section of this plan.

Regular and Appropriate Care: This term means, with respect to your disabling condition and any other condition which, if left untreated, would adversely affect your disabling condition, *you*: (1) visit a *doctor* as frequently as medically required, according to generally accepted medical standards, to effectively manage these conditions; and (2) 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: (a) *disability*; and (b) 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: (i) the American Medical Association (AMA); (ii) the AMA Board of Medical Specialties; (iii) the Food and Drug Administration; (iv) the Centers for Disease Control; (v) the National Cancer Institute; (vi) the National Institutes of Health; (vii) the Department of Health and Human Services; and (viii) any other agency of similar repute.

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

You or Your: These terms mean the covered ³³[*employee*].]

EXCLUSIONS

The exclusions contained in this policy apply to the ^{26A}[Off the Job] ^{26B}[On & Off the Job] *disability* benefit. This *plan* does not pay any benefits for any period of *disability*:

- During which *you* ¹⁶[or *your* covered dependent spouse] are confined to a facility as a result of your conviction of a crime;
- During which he or she is receiving medical treatment or care outside the United States ⁴²[or Canada] ²⁷ [unless expressly authorized by Us;]
- Which starts before he or she is covered by this *plan*; or
- During which *your* loss of earnings is not solely due to *your disability*.

Claim Provisions

Authority: We have the sole discretionary authority to: (1) interpret the terms of this *plan*; and (2) determine your eligibility for coverage and benefits under the *plan*. 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 *plan* as described in your Certificate's Accident and Health Claims Provisions. For details, *you* can call *us* at ²⁸ [1-800-268-2525.]] ¹⁶[If the claim is being made for your covered dependent spouse, his or her name also should be noted.]

Proof Of Loss: When *we* receive *your* notice, *we* will provide *you* with a claim form for filing proof of loss. This form requires data from the ³⁴[*employer*], *you*, and the *doctor(s)* treating *your injury*. Proof of loss must be given to *us* within the time stated in *your* Certificate's Accident and Health Claims Provisions. 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.

Proof of loss, provided at *your* expense, consists of the following. Failure to provide this information may delay, suspend, reduce or terminate *your* benefits.

- The date *disability* began.
- *Your* last day of *active work*.
- The cause of *disability*.
- The extent of *disability*, including limitations and restrictions ¹⁶[(A)] preventing *you* from performing the major duties of *your* ^{26A}[Own Occupation] ^{26B}[Own Job] and ¹⁶[(B) causing *your* covered dependent spouse to be (i) unable to perform two or more *activities of daily living* on a routine basis without help or (ii) *cognitively impaired* and in need of verbal cueing to protect himself or herself or others..
- ³⁹[If you do not have a full-time job at the time of disability, the extent of *disability*, including limitations and restrictions causing you to, (i) not be able to perform two or more *activities of daily living*, on a routine basis, without help or (ii) be *cognitively impaired* and in need of verbal cueing to protect yourself or others.]

- If *your* occupation requires that *you* carry liability or malpractice insurance, any changes to such insurance that becomes effective on or after the date of *disability*.
- *Objective medical evidence* in support of *your* ¹⁶[or your covered dependent spouse's] limitations and restrictions, beginning with the date *disability* began.
- The prognosis of *disability*.
- The name and address of all *doctors*, hospitals and health care facilities where *you* ¹⁶[or your covered dependent spouse] have been treated for *your* ¹⁶[or your covered dependent spouse's] *disability* since the date *disability* began.
- Proof that *you* ¹⁶[or your covered dependent spouse] are currently receiving *regular and appropriate care* from a *doctor*.
- Proof that *you* ¹⁶[or your covered dependent spouse] have been receiving *regular and appropriate care* from a *doctor*, from the date *disability* began.

You ¹⁶[or your covered dependent spouse] must provide *objective medical evidence* from a *doctor* who is not yourself, *your* spouse, child, parent, sibling or business associate.

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

³⁵[The Guardian Life Insurance Company of America
Group Short Term disability Claims Department
P.O. Box 26160
Lehigh Valley, PA 18002-6160.]

Authorization Required: *You* ¹⁶[or your covered dependent spouse] must provide *us* with written, unaltered authorizations to obtain medical, financial, vocational, occupational, and governmental information required to determine *our* liability under this *plan*. *You* ¹⁶[or your covered dependent spouse] must provide *us* with such authorizations as often as *we* may require, in order that they remain current. Failure to provide such authorizations may delay, suspend or terminate *your* ¹⁶[or your covered dependent spouse] benefits.

Right To Request Medical, Financial Or Vocational Assessment: *We* may ask *you* ¹⁶[or your covered dependent spouse] to take part in a medical, financial, vocational or other assessment that *we* feel is necessary to determine whether the terms of the *plan* are met. *We* may require this as often as *we* feel is reasonably necessary. *We* will pay for all such assessments. But, if *you* ¹⁶[or your covered dependent spouse] postpone a scheduled assessment without *our* approval, *you* ¹⁶[or your covered dependent spouse] will be responsible for any rescheduling fees. If *you* ¹⁶[or your covered dependent spouse] do not take part in or cooperate with the assessment, *we* have the right to stop or suspend *your* ¹⁶[or your covered dependent spouse] payments under this *plan*.

Ongoing Proof Of Loss: To continue to receive payments from this *plan*, you¹⁶ [or your covered dependent spouse] must give us current proof of loss as often as we may reasonably require. Ongoing proof of loss must be provided to us within²⁹ [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 the legal representative of *your* estate. Benefits are paid in US dollars.

We pay benefits³⁰ [biweekly] at the end of the period for which they are payable.

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

Benefits to which *you*¹⁶ [or your covered dependent spouse] are entitled may remain unpaid at *your*¹⁶ [or your covered dependent spouse] death. Such benefits may be paid at *our* discretion to: (1) *your* estate; or (2) *your* spouse, parents, children, or brothers and sisters.

Partial Week Payment: *You*¹⁶ [or your covered dependent spouse] may be disabled for only part of a week. In this case, we compute *your*¹⁶ [or your covered dependent spouse's] payment as³¹ [1/7th] of the benefit to which *you*¹⁶ [or your covered dependent spouse] 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 payment or apply any benefits payable, including the minimum payment, toward recovery of the overpayment.

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

The Guardian Life Insurance Company of America

³⁶ [

SPECIMEN


Vice President, Risk Management & Chief Actuary, Group Insurance]

CERTIFICATE AMENDMENT

(To be attached to certificates issued to ²³[employees])

The certificate is amended by adding the following: to the Accident coverage provisions of this *plan*

SICKNESS HOSPITAL CONFINEMENT BENEFIT

SCHEDULE OF INSURANCE

DAILY HOSPITAL CONFINEMENT BENEFIT AMOUNT FOR COVERED ²³[EMPLOYEE]: ²[\$50-\$1000]

⁸[DAILY HOSPITAL CONFINEMENT BENEFIT AMOUNT FOR COVERED DEPENDENT: ²[\$50-\$1000]]

MAXIMUM BENEFIT PERIOD PER CONFINEMENT FOR COVERED ²³[EMPLOYEE]: ³[30] DAYS

⁸[MAXIMUM BENEFIT PERIOD PER CONFINEMENT FOR COVERED DEPENDENT: ³[30] DAYS]

ELIMINATION PERIOD FOR COVERED ²³[EMPLOYEE]: ⁴[3] DAYS

⁸[ELIMINATION PERIOD FOR COVERED DEPENDENT: ⁴[3] DAYS]

BENEFITS

Hospital Confinement: We pay the amount shown in the schedule of insurance if a *covered person* is confined to a hospital as the result of a *sickness*. This benefit is payable up to the maximum benefit period shown in the schedule of insurance per *covered person*. If a *covered person* is confined for more than one *sickness* at the same time, we will only pay one *hospital confinement* benefit per day.

Recurrent Hospital Confinement: We will treat a *recurrent hospital confinement* as part of the prior claim if the *covered person* has a *sickness* that begins within ²⁶[90] days of the end of the prior claim.

The *recurrent hospital confinement* will be subject to the remaining Maximum Benefit Period under the prior claim.

DEFINITIONS

⁵[**Active Work:** This term means *you* are able to perform, and are performing, all of the regular duties of *your* work for the ²⁴[*employer*], [⁶[on a Full-Time basis] ⁷[or a part-time basis] at: (1) one of the ²⁴[*employer* 's] usual places of business; (2) some place where the ²⁴[*employer* 's] business requires *you* to travel; or (3) any other place *you* and the ²⁴[*employer*] have agreed on for *your* work.

Covered Person This term means an *you* or ⁸[or *your* dependent] covered by this *plan*.]

⁵**Doctor:** This term means any medical practitioner we are required by law to recognize. He or she must: (1) be properly licensed or certified by the laws of the state where he or she practices; and (2) provide services that are within the lawful scope of his or her practice.

Elimination Period: This term means the ⁹[31 days] period which starts on the date that you ⁸[or your dependent] is first admitted to the *hospital*.

²³**Employee:** ¹⁰ [This term means a person who works for the ²⁴[employer] and whose income is reported for tax purposes using a W-2 or 1099 form.]

²⁴**Employer:** This term means ¹ [ABC Company, Inc] .

¹¹ [**Full-Time:** This term means you regularly work at least the number of hours in the normal work week set by the ²⁴[employer] (but not less than ¹² [30] hours per week) at: (1) your ²⁴[employer's] place of business; (2) some place where the ²⁴[employer's] business requires you to travel; or (3) any other place you and your ²⁴[employer] have agreed upon for the performance of occupational duties.]

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

- (1) is primarily engaged in providing, by or under the continuous supervision of *doctors*, to *inpatients*, diagnostic services and therapeutic services for diagnosis, treatment and care of sick or injured persons;
- (2) has organized departments of medicine and major surgery;
- (3) has a requirement that every patient must be under the care of a *doctor* or *dentist*;
- (4) provides 24 hour nursing service by or under the supervision of a registered professional nurse (R.N.);
- (5) is duly licensed by the agency responsible for licensing such *hospitals*; and
- (6) is not, other than incidentally: (a) a place of rest; (b) a place primarily for the treatment of tuberculosis; (c) a place for the aged; (d) a place for drug addicts or alcoholics; or (e) a place for convalescent, custodial, educational or rehabilitative care.

Hospital Confinement This term means admission to a hospital as an inpatient for at least 24 consecutive hours by a *doctor* for treatment or diagnosis of a *sickness*. *Hospital confinement* does not include confinement for a newborn child following birth, unless the newborn child has a covered *sickness*.

¹³ [**Part-Time:** This term means with respect to eligibility for coverage, you regularly work at least the number of hours in the normal work week set by the ²⁴[employer] [(but not less than ¹² [15] hours per week), at: (1) your ²⁴[employer's] place of business; (2) some place where the ²⁴[employer's] business requires you to travel; or (3) any other place you and your ²⁴[employer] have agreed upon for the performance of occupational duties.]

Plan: This term means the Accident coverage described in the *plan* and this Certificate.

Recurrent Hospital Confinement means a *hospital confinement* that is caused by a *sickness* which is the same as or related to the *sickness* causing the *hospital confinement* in a prior claim.

Sickness: This term means an illness or disease that results in *hospital confinement* and which begins while a *covered person* is covered under this *plan*. Pregnancy is treated as a *sickness* under this *plan*.]

EXCLUSIONS & LIMITATIONS

¹⁵**[Pre-Existing Conditions:** A pre-existing condition is a *sickness*, whether diagnosed or misdiagnosed, and any symptoms of it, for which, in the look back period, you ⁸[or your dependent]: (1) received advice or treatment from a *doctor*; (2) underwent diagnostic procedures ¹⁶ [other than routine screening in the absence of symptoms or suspicion of disease process by a *doctor*] ; (3) was prescribed or take prescription drugs; or (4) received other medical care or treatment, including consultation with a *doctor*.

The "look back period" is the ¹⁷ [three months] before the latest of: (1) the effective date of your ⁸[or your dependent] coverage under this plan; (2) the effective date of a change that increases the benefits payable by this plan; and (3) the effective date of a change in your ⁸[or your dependent] benefit election that increases the benefit payable by this plan.

¹⁸ [No benefits are payable for *hospital confinement* caused by, contributed to by or resulting from a pre-existing condition; unless the *hospital confinement* starts ⁸[(a)] ¹⁹ [after you complete at least one full day of *active work*] after the date you have been covered under this plan for ²⁰ [12 months] in a row.] ⁸[or (b) the date your dependent has been covered under this *plan* for ²⁰ [12 months] in a row.]

²¹ [For any *hospital confinement* caused by, contributed to by or resulting from a pre-existing condition, We limit the Maximum Payment Period Per Confinement to ²² [two weeks,] unless the *hospital confinement* starts ⁸[(a)] ¹⁹ [after you complete at least one full day of *active work*] after the date you have been covered under this plan for ²⁰ [12 months] in a row. ⁸[or (b) the date your dependent has been covered under this *plan* for ²⁰ [12 months] in a row.]

You ⁸[or your dependent's] *hospital confinement* caused by, contributed to by or resulting from; a pre-existing condition may begin after: (1) a change which provides for an increase in the benefits payable by this plan; or (2) a change in your ⁸[or your dependent's] benefit election which increases the benefit payable by this plan. In this case, his or her 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 his or her *hospital confinement* starts ⁸[(a)] ¹⁹ [after you complete at least one full day of *active work*] after the date the change has been in force for ²⁰ [12 months] in a row ⁸[or (b) the date your dependent has been covered under this *plan* for ²⁰ [12 months] in a row.].

We do not cover any hospital confinement that starts before your coverage under this plan.]

¹⁵ [**Prior Coverage Credit:** If this plan replaces a similar hospital confinement plan the ²⁴[*employer*] had with another insurer, the pre-existing condition provision may not apply to *you*. This plan must start right after the old plan ends.

The pre-existing condition provision will be waived for *you* if *you*: (1) are at active work on the effective date of this *plan*; and (2) have fulfilled the requirements of any pre-existing condition provision of the old plan.

You may have been covered under the old plan when it ended, but have not met the requirements of any pre-existing condition provision of the old plan. In that case, we credit any time used to meet the old plan's pre-existing condition provision toward meeting this *plan's* pre-existing conditions provision. *You* must: (1) enroll for coverage under this *plan* on or before this *plan's* effective date; and (2) be at active work on the effective date of this *plan*.

But, we limit your daily *hospital confinement* benefit under this *plan* if: (1) it is more than the daily *hospital confinement* benefit for which *you* were covered under the old plan; (2) *you* become disabled due to a pre-existing condition; and (3) this *plan* pays benefits for such *hospital confinement* because we credit time as explained above. In this case, we limit the daily *hospital confinement* benefit to the amount to which *you* would have been entitled under the old plan.

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

Exclusions: The exclusions contained in this plan apply to the Hospital Sickness Rider. In addition, this *plan* does not pay benefits for *hospital confinement* caused by, or related to:

- Injury
- Treatment for dental care or dental care procedures
- Elective procedures and/or cosmetic surgery or reconstructive surgery; unless it is a result of infection congenital defect, or other disease
- ²⁷[A *sickness* arising out of or in the course of any employment for wage or profit].

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

The Guardian Life Insurance Company of America

²⁵ [

SPECIMEN


Vice President, Risk Management & Chief Actuary, Group Insurance]



Accident Insurance Election of Portability Coverage

Planholder Name (Company Name) Group Plan No. Employee's Name (Last, First, MI) Soc. Sec. No. Birth Date Sex Home Address (Street, City, State, Zip) Home Telephone Number Work Telephone Number Date Employment Terminated Reason Employment Terminated

Please complete the following information for all dependents to be covered:

Table with 5 columns: Name (Last, First, MI), Social Security Number, Sex, Birth Date, F/T Student. Rows include Spouse and Child(ren).

Accident Insurance may be ported for the following individuals: the employee; the employee and his/her spouse; or the employee and all eligible dependents. Also, in the event of the employee's death, a surviving spouse under age 70 may port the coverage for him/herself and all eligible dependent children.

Ported coverage is being elected for:

- Employee Only, Employee and Spouse, Employee and All Eligible Dependents, Surviving Spouse, Surviving Spouse and Child(ren)

1[Ported Accident amounts will be reduced by any benefits previously paid under the Group Plan.]

The enclosed Premium Notice outlines the monthly premium rates for this coverage and the modes of payment.]

2[Monthly premium rates will be equal to monthly premium rates under your group plan, including any amount paid by your employer.]

Within 31 days of the date the Group Plan coverage ends due to your termination of employment, or the date your dependent's coverage ends as a result of your death, you or your surviving spouse must submit: (a) this completed form and (b) the premium payment. For ported insurance to remain in force all subsequent premium payments must be received within 31 days of the applicable premium due date. If premium payments are not received in a timely fashion, coverage will automatically terminate at the end of the 31 day period and all unpaid premiums will remain due from you or your surviving dependent's for the period this coverage was inforce.

Signature: _____ Date: _____



Accident Portability Coverage Premium Notice

The following premium rates are applicable for the employee who terminates employment under the Group Planholder or a surviving spouse who loses coverage under the Group Plan, and elects to port (continue) the Accident Insurance.

The premium for a dependent or surviving spouse is based upon the employee's age bracket when coverage under the Group Plan terminates.

	MONTHLY RATE
EMPLOYEE	
SPOUSE	
CHILD	

The mode of payment for the ported policy is determined based on the amount of annual premium for the ported policy.

ANNUAL PORTED PREMIUM	MODE OF PAYMENT
LESS THAN \$500	ANNUAL
\$500 TO \$1,000	SEMI ANNUAL
MORE THAN \$1,000	QUARTERLY

SERFF Tracking Number: GARD-128474947 State: Arkansas
 Filing Company: The Guardian Life Insurance Company of America State Tracking Number:
 Company Tracking Number:
 TOI: H02G Group Health - Accident Only Sub-TOI: H02G.000 Health - Accident Only
 Product Name: 9546
 Project Name/Number: /9546

Supporting Document Schedules

	Item Status:	Status Date:
Satisfied - Item: Flesch Certification	Approved-Closed	06/28/2012
Comments:		
Attachment: Cert. of Read.pdf		

	Item Status:	Status Date:
Satisfied - Item: Application	Approved-Closed	06/28/2012
Comments:		
Attachment: AR appr'vl (GLIC-H).pdf		

	Item Status:	Status Date:
Satisfied - Item: Variable Memorandum	Approved-Closed	06/28/2012
Comments:		
Attachments: VM PORTABILITY ACCIDENT CERT _V1, 05-01-2012_.pdf VARIABLE MEMORANDUM PC RIDERS _V1, 05-01-2012_.pdf VARIABLE MEMORANDUM GG-016348.pdf VARIABLE MEMORANDUM _V1, 05-01-2012_.pdf		

	Item Status:	Status Date:
Satisfied - Item: Supporting Forms	Approved-Closed	06/28/2012
Comments:		
Attachments: PORT CERT PC-AC-12 [V1, 05-01-2012].pdf Specimen GCPT-95-1 et al Port_Trust_Policy _Accident_.pdf PC-A-AC-AS-12 _V1, 05-01-2012_.pdf		

SERFF Tracking Number: GARD-128474947

State: Arkansas

Filing Company: The Guardian Life Insurance Company of
America

State Tracking Number:

Company Tracking Number:

TOI: H02G Group Health - Accident Only

Sub-TOI: H02G.000 Health - Accident Only

Product Name: 9546

Project Name/Number: /9546

PC-A-AC-DIS-12 _V1,05-01-2012_.pdf

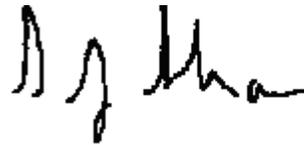
PC-A-AC-HC-12 _V1, 05-01-2012_.pdf

CERTIFICATION OF READABILITY

Form number(s): GP-1-AC-IC-12 et al .

The undersigned individuals have carefully reviewed, and know the contents of, the filing submitted herewith, and except as qualified, do hereby certify the following:

1. The said form(s) meet the minimum reading ease requirements of your jurisdiction.
2. The captioned form(s) have a Flesch reading ease test score of at least 45 with no exemptions.
3. The said form(s) are printed in 10-point or larger type.



(Signature of Officer)



Date: 6/12/12_____

Group Contracts

Disposition for GARD-125263963

Close

SERFF Tracking Number:	GARD-125263963	State:	Arkansas
Filing Company:	The Guardian Life Insurance Company of America	State Tracking Number:	36726
Company Tracking Number:			
TOI:	H21 Health - Other	Sub-TOI:	H21.000 Health - Other
Product Name:	7993AR H		
Project Name/Number:			

Disposition Date: 09/10/2007

Implementation Date:

Status: Approved

Comment:

Schedule Items

Item Type	Item Name	Item Status	Public Access
Supporting Document	Certification/Notice	Approved	Yes
Supporting Document	Application	Approved	Yes
Supporting Document	Health - Actuarial Justification	Approved	Yes
Supporting Document	Outline of Coverage	Approved	Yes
Supporting Document	Var. memo.	Approved	Yes
Supporting Document	Fee form	Approved	Yes
Supporting Document	Cover letter	Approved	Yes
Form	CMA2007, Application/Enrollment Form, Application For a Plan of Group Insurance	Approved	Yes

VARIABLE MEMORANDUM

Form PC-AC-12

1. Signature block may vary.
2. This info will be completed on a case-by-case basis.
3. This value may vary. Other possible values are 10, 15, 25 and 30.
4. Table of contents will be completed on a case-by-case basis
5. References in the schedule to benefits that are not included in a particular ported certificate will be removed. The values may vary. The range of values may vary from the amount shown by an amount equal to plus or minus 75% of the amount shown.
6. Definitions that are not referenced in the certificate may be deleted. Definitions will appear in accordance with the same plan definitions that appear in the plan from which the individual is porting.
7. This text will be removed for certificates ported from cases with issue-age rates.
8. This value may vary. Other possible values range from 30-90.
9. This text will be removed for certificate which do not contain coverage of dependents.
10. This name may vary.
11. This reflects our standard text and may vary according to plan.
12. Benefits will appear in accordance with the same plan benefits that appear in the plan from which the individual is porting. Durations and amounts, etc will appear according to the same items that appear in the plan from which the individual is porting.
13. This text will be deleted if the plan does not require domestic partners to be of the same gender.
14. This item may vary. The range of values for this item is from three months through 12 months.
15. This text will be deleted if the plan does not provide coverage for children of domestic partners.
16. The name and title of the Officer may change.
17. This text will be deleted if an age restriction does not apply.
18. This item may vary. The range of the value for this item is from 60 through 80.
19. This text in 19A or 19B will be used based on a planholder's election.

20. Either the text in 20A or 20B will be used. The text in 20A will be used when Guardian tracks beneficiary designations. The text in 20B will be used when the employer tracks beneficiary designations.
21. This text will be removed on cases that cover job-related injuries.
22. This text will be deleted if an age restriction does not apply.
23. This item may vary. The range of the value for this item is from 60 through 80.
24. This text may be replaced by another period, e.g. benefit year.
25. This text will be deleted if the exclusion does not apply.
26. This text will be deleted if the exclusion does not apply to treatment in Canada.
27. This item may vary. The range of values for this item is from 24 through 96.
28. This item may vary. The range of values for this item is from 2 through 12.
29. This item may vary. The range of values for this item is from 30 through 120.
30. This item may vary. The range of values for this item is from 180 through 730.
31. This item may vary. The range of values for this item is from 45 through 365.
32. This item may vary. The range of values for this item is from \$2500 through \$20,000.
33. This item may vary. The range of values for this item is from 24 through 96.
34. This text may vary according to the age requirements of the plan from which coverage is ported.
35. This item may vary. The range of values for this item is from 16 through 24.
36. This item may vary. The range of values for this item is from 90 through 365.
37. This item may vary. The range of values for this item is from 6 through 24.

38. This item may vary. The range of values for this item is from 3 through 14.
39. This item may vary. The range of values for this item is from 1 through 6.
40. This item may vary. The range of values for this item is from 10% through 100%.
41. We reserve the right to add or delete diagnostic exams.
42. Other values may be once, three times and four times.
43. This item may vary. The range of values for this item is from 15 through 90.
44. This item may vary. The range of values for this item is from 3 through 30.
45. This item may vary. The range of values for this item is from 25 through 200.
46. This item may vary. The range of values for this item is from 3 through 12.
47. This item may vary. The range of values for this item is from 3 through 30.
48. This item may vary. The range of values for this item is from 1 through 6.
49. We reserve the right to add or delete exams.
50. The text may vary with respect to age limits and requirements placed on dependent children.
51. This text may be deleted if a domestic partner is not covered.
52. This text may be deleted if a child of a domestic partner is not covered.
53. This text may be deleted.

VARIABLE MEMORANDUM

Form PC-A-AC-DIS-12

1. This text is illustrative and may vary on a case by case basis.
2. The weekly amounts may change. The range of values for this item will be \$50 through \$1,000.
3. The period may change. The range of values for this item will be 9 weeks through 104 weeks.
4. The maximum amount may change. The range of values for this item will be \$50 through \$1,000.
5. The duration may change. The range of values for this item will be 0 days through 180 days.
6. Either the text in (6A) or (6B) will be used. The text in (6A) will be used when the covered person can satisfy the elimination period while working. The text in (6B) will be used when the covered person cannot satisfy the elimination period while working.
7. This text will be deleted if the plan allows a covered person to work and receive benefits.
8. This text will be deleted if the plan does not waive premiums while a covered person is receiving benefits.
9. The text in (9A) will be deleted if Canada is not included in the out of country restriction. The text in (9B) will be deleted if another country or region is not included in the out of country restriction. The language may appear as shown or may vary to reflect specific countries or regions approved by us.
10. This item may vary. The range of values for this item is from one month through 24 months.
11. This item may vary. The range of values for this item is from six months through 60 months.
12. This item may vary. The range of values for this item is from two weeks through three months.
13. The text will be deleted if the defined term is not used.
14. This text will be deleted if the plan provides coverage for part-time employees.
15. This text will be included if the plan provides coverage for part-time employees.
16. This text will be deleted if the plan does not provide coverage for dependents.
17. This text may vary to include other basis for disability, for example the inability to perform a person's own occupation.

18. This text will be deleted if the plan permits a covered person to work during the elimination period.
19. This text will be deleted if the plan permits a covered person to work during the elimination period.
20. This text will be deleted if the plan does not permit a covered person to work while disabled.
21. This item may vary. The range of values for this item is from 30 through 50.
22. This text is illustrative. It will be filled in on a case-by-case basis according to the planholder's definition of employee. Or, this text may vary to specify the relationship with the entity that purchased the plan.
23. Either the text in (23A) or (23B) will be used. The text in (23A) will be used when disability is based on inability to perform the covered person's own occupation. The text in (23B) will be used when the definition of disability is based on inability to perform the covered person's own job.
24. This item may vary. The range of values for this item is from 12 hours through 20 hours.
25. This text will be deleted if evidence is not required.
26. This text will reflect the type of disability benefit. Item (26A) will be used if the benefit is non-occupational and (26B) will be used for a 24 hour benefit.
27. This text will be deleted if approval is not required.
28. This text may vary to reflect an updated toll free telephone number.
29. This item may vary. The range of values for this item is from 30 days through 90 days.
30. This text may vary to reflect either "weekly" or "twice each month."
31. This item may vary to reflect a number of days in the work week of from four through seven.
32. This item may vary to include another duration. The range of values for this item is from 90 days through 365 days.
33. This term may be replaced by another term, e.g. member, union member.
34. This term may be replaced by another term, e.g. participating employer.
35. The text may vary to reflect updated contact information.
36. The officer name and title may vary.
37. This text may be deleted or only reference to sickness may be deleted.
38. This item may vary. The range of values for this item is from 30 through 360 days.
39. This text will not appear if an ADL definition of disability is not used when an employee is not working full time at the time of disability.

40. This term will be deleted if it does not appear in the rider.
41. This text may be deleted if disability is not based on activities of daily living or being cognitively impaired.
42. This text will be deleted if the exclusion does not apply to treatment in Canada.

Form PC-A-AC-AS-12

1. This text is illustrative and may vary on a case by case basis.
2. The weekly amounts may change. The range of values for this item will be \$50 through \$1,000.
3. The period may change. The range of values for this item will be 9 weeks through 104 weeks.
4. The maximum amount may change. The range of values for this item will be \$50 through \$1,000.
5. The duration may change. The range of values for this item will be 0 days through 180 days.
6. Either the text in (6A) or (6B) will be used. The text in (6A) will be used when the covered person can satisfy the elimination period while working. The text in (6B) will be used when the covered person cannot satisfy the elimination period while working.
7. This text will be deleted if the plan allows a covered person to work and receive benefits.
8. This text will be deleted if the plan does not waive premiums while a covered person is receiving benefits.
9. The text in (9A) will be deleted if Canada is not included in the out of country restriction. The text in (9B) will be deleted if another country or region is not included in the out of country restriction. The language may appear as shown or may vary to reflect specific countries or regions approved by us.
10. This item may vary. The range of values for this item is from one month through 24 months.
11. This item may vary. The range of values for this item is from six months through 60 months.
12. This item may vary. The range of values for this item is from two weeks through three months.
13. The text will be deleted if the defined term is not used.

14. This text will be deleted if the plan provides coverage for part-time employees.
15. This text will be included if the plan provides coverage for part-time employees.
16. This text will be deleted if the plan does not provide coverage for dependents.
17. This text may vary to include other basis for disability, for example the inability to perform a person's own occupation.
18. This text will be deleted if the plan permits a covered person to work during the elimination period.
19. This text will be deleted if the plan permits a covered person to work during the elimination period.
20. This text will be deleted if the plan does not permit a covered person to work while disabled.
21. This item may vary. The range of values for this item is from 30 through 50.
22. This text is illustrative. It will be filled in on a case-by-case basis according to the planholder's definition of employee. Or, this text may vary to specify the relationship with the entity that purchased the plan.
23. Either the text in (23A) or (23B) will be used. The text in (23A) will be used when disability is based on inability to perform the covered person's own occupation. The text in (23B) will be used when the definition of disability is based on inability to perform the covered person's own job.
24. This item may vary. The range of values for this item is from 12 hours through 20 hours.
25. This text will be deleted if evidence is not required.
26. This text will reflect the type of disability benefit. Item (26A) will be used if the benefit is non-occupational and (26B) will be used for a 24 hour benefit.
27. This text will be deleted if approval is not required.
28. This text may vary to reflect an updated toll free telephone number.
29. This item may vary. The range of values for this item is from 30 days through 90 days.
30. This text may vary to reflect either "weekly" or "twice each month."
31. This item may vary to reflect a number of days in the work week of from four through seven.
32. This item may vary to include another duration. The range of values for this item is from 90 days through 365 days.
33. This text will be deleted if the plan includes routine screening as a pre-existing condition.
34. This item may vary. The range of values for this item is from three months through 12 months.

35. This text will be deleted if the plan does not require completion of a day of work after the end of the pre-existing period.
36. This item may vary. The range of values for this item is from three months through 24 months.
37. The text will be used when there is a pre-existing conditions limitation for disability that starts within a specified time from the covered person's effective date.
38. This item may vary. The range of values for this item is from two weeks through 52 weeks.
39. This text will be deleted if the plan does not contain a pre-existing conditions provision.
40. This text will be used when there is a pre-existing conditions exclusion for disability that starts within a specified time from the covered person's effective date.
41. This term may be replaced by another term, e.g. member, union member.
42. This term may be replaced by another term, e.g. participating employer.
43. The text may vary to reflect updated contact information.
44. The officer name and title may vary.
45. This item may vary. The range of values for this item is from 30 through 360 days.
46. This text may be deleted or only reference to sickness may be deleted.
47. This text will not appear if an ADL definition of disability is not used when an employee is not working full time at the time of disability.
48. This text may be deleted if disability is not based on activities of daily living or being cognitively impaired.
49. This term will be deleted if it does not appear in the rider.
50. This text will be deleted if the exclusion does not apply to treatment in Canada.
- 51.

Form PC-A-AC-HC-12

1. This text is illustrative and may vary on a case by case basis.
2. The weekly amounts may change. The range of values for this item is \$50 through \$1000.
3. The text may vary. The range of values for this item is from 4 through 90 days.
4. The text may vary. The range of values for this item is from 0 through 5 days..

5. This text will be deleted if the defined term is not used.
6. This text will be deleted if the plan provides coverage for part-time employees.
7. This text will be included if the plan provides coverage for part-time employees.
8. This text will be deleted if the plan does not provide coverage for dependents.
9. This item may vary. The range of values for this item is) to 180 days.
10. This text is illustrative. It will be filled in on a case-by-case basis according to the planholder's definition of employee. Or, this text may vary to specify the relationship with the entity that purchased the plan.
11. This text will be deleted if the plan provides coverage for part-time employees.
12. This item may vary. The range of values for this item is from 30 through 50.
13. This text will be included if the plan provides coverage for part-time employees.
14. This item may vary. The range of values for this item is from 12 hours through 20 hours.
15. This text will be deleted if the plan does not contain a pre-existing conditions provision.
16. This text will be deleted if the plan includes routine screening as a pre-existing condition.
17. This item may vary. The range of values for this item is from three months through 12 months.
18. This text will be used when there is a pre-existing conditions exclusion for disability that starts within a specified time from the covered person's effective date.
19. This text will be deleted if the plan does not require completion of a day of work after the end of the pre-existing period.
20. This item may vary. The range of values for this item is from three months through 24 months.
21. This text will be used when there is a pre-existing conditions limitation for disability that starts within a specified time from the covered person's effective date.

22. This item may vary. The range of values for this item is from two weeks through 52 weeks.
23. This term may be replaced by another term, e.g. member, union member.
24. This term may be replaced by another term, e.g. participating employer.
25. The officer name and title may vary.
26. This item may vary. The range of values for this item is from 30 through 360 days.
27. This text may be deleted for on and off the job coverage.

**VARIABLE MEMORANDUM
FORM GG-016348**

1. This text may be deleted if rates are not changing at the time coverage is ported.
2. This text may be deleted or included based on how premium rates are determined.

VARIABLE MEMORANDUM

Forms GP-1-AC-BEN-12 and CGP-3-AC-BEN-12

1. This item will be deleted if the plan does not include this particular benefit. Also, references to other provisions will be deleted if those other provisions are not used for a particular case.
2. This item may vary. The range of values for this item is from 45 days through 365 days.
3. This text will be deleted if the plan does not provide coverage for dependents.
4. This item may vary. The range of values for this item is from 24 through 96.
5. This item may vary. The range of values for this item is from 2 through 12.
6. This item may vary. The range of values for this item is from 30 through 120.
7. This item may vary. The range of values for this item is from \$2500 through \$20,000.
8. This item may vary. The range of values for this item is from 24 through 96.
9. This item may vary. The range of values for this item is from 180 through 730.
10. This item may vary. The range of values for this item is from 16 through 24.
11. This item may vary. The range of values for this item is from 90 through 365.
12. This item may vary. The range of values for this item is from 6 through 24.
13. This item may vary. The range of values for this item is from 3 through 14.
14. This item may vary. The range of values for this item is from 1 through 6.
15. This item may vary. The range of values for this item is from 10% through 100%.
16. We reserve the right to add or delete diagnostic exams.
17. Other values are once, three times and four times.
18. This item may vary. The range of values for this item is from 15 through 90.
19. This item may vary. The range of values for this item is from 3 through 30.
20. This item may vary. The range of values for this item is from 25 through 200.

21. This item may vary. The range of values for this item is from 3 through 12.
22. This item may vary. The range of values for this item is from 3 through 30.
23. This item may vary. The range of values for this item is from 1 through 6.
24. We reserve the right to add or delete exams.
25. The text in 25A or 25B will be used based on a planholder's election.
26. Either the text in 26A or 26B will be used. The text in 26A will be used when Guardian tracks beneficiary designations. The text in 26B will be used when the employer tracks beneficiary designations.
27. The text may be deleted.

Forms GP-1-AC-DEF-12 and CGP-3-AC-DEF-12

1. This text will be deleted if the defined term is not used.
2. This text will be deleted if the plan does not provide coverage for dependents.
3. This text may vary to show another duration.
4. This text may vary to include another term. e.g. a union member.

Forms GP-1-AC-PORT-12 and CGP-3-AC-PORT-12

1. This text will be deleted if the plan does not provide coverage for dependents.
2. This text will be deleted if an age restriction does not apply.
3. This item may vary. The range of values for this item is from 60 through 90.
4. This text will be deleted if proof of insurability is required. The text in (4) and (5) will not be used on the same case.
5. This text will be deleted if proof of insurability is not required. The text in (5) and (4) will not be used on the same case.
6. This text will be deleted if the plan does not cover part-time employees.
7. This text may vary to include other jurisdictions.
8. This text will be deleted if there is not requirement to be insured prior to porting.

9. This item may vary. The range of values for this item is from 0 to 12 months.
10. This item may vary. The range of values for this item is from 1 through 90.
11. This text will be deleted if this limitation does not apply.

Forms GP-1-AC-WP-12 and CGP-3-AC-WP-12

1. This text will be deleted if a waiver of premium is not included.
2. This item may vary. The range of values for this item is from 45 through 180.

Forms GP-1-AC-EXC-12 and CGP-3-AC-EXC-12

1. This text will be deleted if the plan does not provide coverage for dependents.
2. This text will be removed on cases that cover job-related injuries.
3. This text will be deleted if the exclusion does not apply.
4. This text will be deleted if the exclusion does not apply to treatment in Canada.

PORTABLE ACCIDENT CERTIFICATE OF COVERAGE

The Guardian Life Insurance Company of America (Guardian) certifies that it has issued a Group Conversion and Portability Trust Insurance Policy (Group Policy) to the Trustee of The Guardian Life Group Conversion and Portability Trust. The Group Policy insures those certificate holders: (a) who have applied for coverage; and (b) who have paid the first full premium. Terms which affect coverage are shown in the following pages. The Group Policy is issued in the State of Rhode Island in accordance with its laws and rules. Those laws and rules govern in resolving any questions about the Group Policy.

The Guardian Life Insurance Company of America

¹[



SPECIMEN

Second Vice President & Actuary, Group Insurance]

Certificate Holder: ²[John Doe

Group Policy Number: G-310685

Certificate Number: 12345

Certificate Date of Issue: January 1, 2007

Certificate Anniversary Date: January 1 of Each Later Year

Administrative Office: 123 Elm Street
The Guardian
Appleton Wisconsin

Claims Office: 123 Elm Street
The Guardian
Bethlehem, Pennsylvania]

Right To Cancel This certificate may be returned to us for any reason within ³[20 days] of its receipt. It can be returned in person or by first class mail to our administrative office. At the time of such delivery or mailing, the certificate will be deemed void from its effective date. Any premium paid will be refunded to you.

TABLE OF CONTENTS

- ⁴[Schedule of Insurance
- Definitions
- General Provisions
- Claims Provisions
- When Coverage Begins And Ends
- Accident Benefit
 - Limitations
 - Exclusions]

[SCHEDULE OF INSURANCE

⁵[Accident Benefit

For limitations regarding the number of benefit payments per covered accident please refer to the BENEFIT section of this certificate.

Benefits

Accident Emergency Room Treatment	\$150
Accident Follow-Up Visit - Doctor	\$25 up to 6 treatments
Accidental Death	Yourself \$10,000 Your Spouse \$5,000 Your Children \$5,000
Accidental Death Common Carrier	200% of the Accidental Death benefit amount
Accidental Death Common Disaster	200% of the Accidental Death benefit amount
Accidental Dismemberment	Loss of a hand, foot or sight: 50% of AD&D benefit. Multiple Losses of hand, foot or sight: For more than one covered loss due to the same Accident, we will pay 100% of the Accidental Death benefit. Loss of thumb and index finger of same hand or Loss of four fingers of same hand: 25% of Accidental Death benefit Loss of all toes of same foot: 25% of Accidental Death benefit
Accidental Death Seatbelt & Airbag benefit	Seatbelt \$10,000 Seatbelt & Airbag \$15,000
Air Ambulance	\$100-\$5000
Ambulance	\$100-\$1000
Appliance	\$50-\$2000
Blood/Plasma/Platelets	\$50-\$500
Burn	<u>2nd Degree</u> 9 sq to 18sq: \$50-\$50,000 18 to 35 sq: \$50-\$50,000 over 35: \$50-\$50,000 <u>3rd degree</u> 9 sq to 18sq: \$50-\$50,000 18 to 35 sq: \$50-\$50,000 over 35: \$50-\$50,000]

⁵ [Burn - Skin Graft	25% of burn benefit
Catastrophic Loss	Quadriplegia: 100% of Accidental Death Loss of speech and hearing (both ears):100% of Accidental Death Loss of cognitive function:100% of Accidental Death Hemiplegia:50% of Accidental Death Paraplegia:50% of Accidental Death
Child Organized Sport	Additional 10% of payable benefits
Chiropractic Visits	\$25-\$500 per visit
Coma	\$7,500
Concussions	\$50
Dislocations	Closed/Open
Hip	\$1800/\$3600
Knee	\$900/\$1800
Shoulder	\$270/\$540
Collar bone (sternoclavicular)	\$450/900
Collar bone (acromioclavicular and separation)	\$90/180
Ankle or foot	\$720/1440
Lower jaw	\$270/540
Wrist or elbow	\$270/540
Toe or finger	\$90/180
Bones of the hand	\$270/540
Diagnostic Exam (Major)	\$100
Emergency Dental Work	Crown: \$50-\$5000 Extraction: \$50-\$5000
Epidural Anesthesia Pain Management	\$25
Eye Injury	\$25
Family Care	\$20 per day
Fracture	Closed/Open
Skull (depressed)	\$2250/\$4500
Skull (non-depressed)	\$900/\$1800
Hip, Thigh (femur)	\$1350/\$2700]
⁵ [Vertebrae, body of (excluding vertebrae processes)	\$675/\$1350
Pelvis	\$675/\$1350
Leg	\$675/\$1350
Bones of the face or nose	\$315/\$630
Upper jaw, maxilla	\$315/\$630
Upper arm (humerous)	\$315/\$630

Lower jaw, mandible	\$270/\$540
Shoulder blade	\$270/\$540
Vertebral process	\$270/\$540
Forearm	\$270/\$540
Kneecap	\$270/\$540
Foot (except toes)	\$270/\$540
Ankle	\$270/\$540
Rib	\$225/\$450
Coccyx	\$180/\$360
Finger, toe	\$90/\$180
Hospital Admission	\$1,500
Hospital Confinement	\$200 per day
Hospital ICU Admission	\$1,500
Hospital ICU Confinement	\$350 per day
Initial Doctor's office/Urgent care facility treatment	\$50
Knee Cartilage	\$500
Joint Replacement	Hip \$100 Knee \$100 Shoulder \$100
Laceration	No sutures required \$20 Lacerations less than 5 cm \$40 Lacerations at least 5 cm but less than 15 cm \$150 Lacerations at least 15 cm or more \$300
Lodging	\$100 per day
Occupational or Physical Therapy	\$25 per day
Prosthetic Device/Artificial Limb	1: \$250 2 or more: \$500]
Reasonable Accomodation to Home or Vehicle	\$1,000
Rehabilitation Unit Confinement	\$100 per day
Ruptured Disc With Surgical Repair	\$400
Surgery	Cranial, open-abdominal or thoracacic: \$1000 Hernia: \$100]
⁵ [Surgery – Exploratory or Arthroscopic	\$150
Tendon/Ligament/Rotator Cuff	\$250 - 1 \$500 - 2 or more
Transportation	\$400
Wellness Benefit	\$50 per year
X – Ray	\$20]]

DEFINITIONS

- ⁶[**Accident** This term means an event or occurrence that was not reasonably foreseeable, or that could not have been reasonably expected or anticipated. The term *accident* does not include a *sickness*.
- Accidental Death** This term means death caused by an *accident* independent of *sickness*, bodily infirmity, or any other cause and which is not excluded under the Limitations and Exclusions section.
- Alternate Care Facility** This term means a facility that is licensed according to state and/or local laws to provide skilled care, intermediate care, intermingled care, custodial care, or rehabilitative care as an alternative to care at a *hospital*.
- Child Care Center** This term means a program of child care which: (1) is provided in a facility that is licensed as a day care center or is operated by a licensed day care provider; and (2) charges a fee for the care of children. The term does not include child care provided by a: (a) parent; (b) stepparent; (c) grandparent; (d) sibling; (e) aunt; or (f) uncle.
- Chiropractic Care Services** This term means spinal manipulation by a licensed chiropractor to correct a structural imbalance caused by a *covered accident*. This does not include services for massage therapy or treatment of chronic conditions or other injuries not related to structural imbalance.
- Covered Accident** This term means an *accident* that:
- Occurs while *your* coverage or *your* dependent's coverage under this policy is in effect.
 - Results in a bodily *injury* and
- Is not otherwise excluded under the terms of this policy.
- Common Carrier** This term means any land, air or water conveyance operated under a license to transport passengers for hire.
- Covered Person** This term means an *employee* ⁹[or dependent] insured by this *plan*.
- Coma** This term means a state of complete mental unresponsiveness, due to *injury*, with no evidence of appropriate responses to stimulation, as diagnosed by a *doctor*.
- Companion** This term means a spouse, domestic partner, civil union partner, sibling, child, parent, grandparent, or any primary care giver.
- Dentist** This term means a licensed *doctor* of dentistry, operating within the scope of his or her license, in the state in which he or she is licensed.
- Dislocation** This term means a completely separated joint due to an *injury*. A partial *dislocation* means the joint is misaligned but not completely dislocated, as diagnosed by a *doctor*.
- Doctor** This term means any medical practitioner We are required by law to recognize. He or she must: (1) be properly licensed or certified by the laws of the state where he or she practices; and (2) provide services that are within the lawful scope of his or her practice.
- ⁹[**Eligible Dependents** ⁵⁰[This term means: (a) your legal spouse ⁵¹[or your domestic partner] who is under age ³⁴[70]; (b) your unmarried dependent children ⁵²[or your domestic partner's unmarried children] until they reach age ³⁴[23]; and (c) your unmarried dependent children, from age ³⁴[23] until they reach age ³⁴[25], who are enrolled as full-time students at accredited schools.]

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

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

A dependent who is on active duty in any armed force is not an eligible dependent.]

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

⁶[**Epidural Anesthesia** This term means a form of regional anesthesia involving injection of drugs through a catheter placed into the epidural space. The epidural must be administered due to a *covered accident*, and does not include treatment for childbirth or diseases.]

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

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

- (1) is primarily engaged in providing, by or under the continuous supervision of *doctors*, to *inpatients*, diagnostic services and therapeutic services for diagnosis, treatment and care of sick or injured persons;
- (2) has organized departments of medicine and major surgery;
- (3) has a requirement that every patient must be under the care of a *doctor* or *dentist*;
- (4) provides 24 hour nursing service by or under the supervision of a registered professional nurse (R.N.);
- (5) is duly licensed by the agency responsible for licensing such *hospitals*; and
- (6) is not, other than incidentally: (a) a place of rest; (b) a place primarily for the treatment of tuberculosis; (c) a place for the aged; (d) a place for drug addicts or alcoholics; or (e) a place for convalescent, custodial, educational or rehabilitative care,

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

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

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

Hospital Confinement This term means admission to a *hospital* as an *inpatient* for at least 24 consecutive hours by a *doctor* for an *injury*.

Injury This term means unintentional physical damage or harm caused directly by an *accident* and not due to *sickness*, disease or any other causes. The *injury* must occur while you ⁹[or your covered dependent] are insured under this *plan*.

Inpatient	This term means a patient who is admitted to a <i>hospital</i> for an <i>injury</i> .]
⁶ [Occupational Therapy	This term means the treatment of a physically disabled person by means of constructive activities designed and adapted to promote the restoration of the <i>covered person's</i> ability to satisfactorily accomplish the ordinary tasks of daily living and those tasks required by the <i>covered person's</i> particular occupational role. Occupational therapy does not include diversional, recreational, vocational therapies (i.e. hobbies, arts and crafts).
Occupational Therapist	This term means a person, other than you or a family member, who: 1) possesses the designation "Occupational Therapists Registered (OTR)", 2) is licensed by the state to practice <i>occupational therapy</i> , 3) performs services which are allowed by his licenses; and 4) performs services for which benefits are provided by this <i>plan</i> .
Organized Sport	This term means a sport activity that is governed by an organization and requires formal registration to participate. Proof of registration will be required at claim time.
Outpatient Treatment	This term means medical services that a <i>covered person</i> receives when not confined as an <i>inpatient</i> in a <i>hospital</i> .
Physical Therapy	This term means treatment by physical means, hydrotherapy, heat, or similar modalities, physical agents, bio-mechanical and neuro-physiological principles and devices. Such therapy is given to relieve pain, restore function, and to prevent disability following <i>injury</i> or loss of a body part.
Physical Therapist	This term means a person, other than you or a family member, who: 1) is licensed by the state to practice <i>physical therapy</i> ; 2) performs services which are allowed by his or her license; 3) performs services for which benefits are provided by this Policy and 4) practices according to the code of ethics of the American Physical Therapy Association.
Rehabilitative Unit	This term means an appropriately licensed facility or separate section of a <i>hospital</i> that provides rehabilitation care services on an <i>inpatient</i> basis and is designated, staffed and equipped to provide restorative services under the supervision of a trained and experienced rehabilitation <i>doctor</i> . A rehabilitation unit is not: a nursing home; an extended care facility; a skilled nursing facility; a rest home or home for the aged; a hospice care facility; a place for alcoholics or drug addicts; or an assisted living facility.
Sickness	This term means a disease, illness or other condition not related to <i>injury</i> including diseases or infections except when the due to an accidental cut or wound.
Urgent Care Facility	This term means a health care facility that is organizationally separate from a <i>hospital</i> and whose primary purpose is the offering and provision of immediate, short term medical care, without appointment, for urgent care.
We, Us and Our	These terms mean The Guardian Life Insurance Company of America.
You or Your	These terms mean the certificateholder.]

GENERAL PROVISIONS

Premiums

- Initial Premium** We have set your initial premium rates. These rates are shown in the premium notice which was given to you either prior to, or with, this Certificate of Coverage. ⁷[Your premium rates increase automatically as you get older.]
- Change In Premium** We may set new premium rates which will become effective at any time. We will give you ⁸[31 days] advance written notice of the change.
- Premium Payment** Your first premium payment must be submitted with your application for coverage. Later premium payments are due as specified in the premium notice which has been given to you.
- Grace Period** You will be allowed a ⁸[31 day] grace period for each premium payment except the first. During the grace period, your coverage will remain in force. If your owed premium is not paid by the end of the grace period, your coverage will end as of the day the premium first became due.

Non-Renewal And Cancellation

- Non-Renewal** We will renew this coverage on the Certificate Anniversary Date except for one of the following reasons: (a) non-payment of premiums; or (b) when we are refusing to continue all plans of this type due to cancellation of the Group Policy.
- Except for non-payment of premiums, we will provide you with ⁸[31 days] advance written notice of our intent not to renew.
- Cancellation** You may cancel this coverage at any time by giving us written notice. Your coverage will then end for you ⁹[and any covered dependents] as of the date we receive it, or any later date specified in the notice.
- If you cancel your coverage, we will return any unearned portion of the premium paid on a pro-rata basis.
- No Prejudice To Claims** Cancellation will be without prejudice to claims incurred prior to the date of cancellation.

Other General Provisions

- The Contract - Changes** This Certificate of Coverage is not an insurance policy. It is an evidence of coverage under a Group Policy issued to ¹⁰[Bank Newport] as policyholder and trustee. The Group Policy includes any amendments to the Group Policy, the applications of people insured under the Group Policy, the applications of the trustee for insurance, and each Certificate of Coverage issued under the Group Policy. These items when read together are the contract for the insurance provided. The terms of coverage and benefits applicable to you are explained in this Certificate of Coverage, but determined in accordance with the terms of the Group Policy.
- The Group Policy may be amended at any time, without your consent or the consent of any other person having a beneficial interest in the Group Policy. But any such amendment will be without prejudice to any claim arising prior to the date of the change.
- Limitation Of Authority** No person, except by a writing signed by the President, a Vice President or a Secretary of Guardian, has the authority to act for us to: (a) determine whether any Certificate of Coverage is to be issued; (b) waive or alter any provisions of the Group Policy or Certificate of Coverage, or any requirements of Guardian; (c) bind us by any statement or promise relating to any Certificate of Coverage issued or to be issued; or (d) accept any information or representation which is not in a signed application.
- Time Limit On Certain Defenses** We cannot use a misstatement made in any application, whether under the group plan from which you ported, or this Certificate of Coverage, to void this coverage or to deny a claim for a loss incurred after the end of two years from the date you signed any such application.
- Examination And Autopsy** We have the right to have a *doctor* of our choice examine the person for whom a claim is being made under this *plan* as often as we feel necessary. And, where allowed by law, we have the right to have an autopsy performed prior to the payment of any benefits under this *plan*. We will pay for all such examinations and autopsies.

CLAIMS PROVISIONS

Your right to make a claim for any accident benefits provided by this *plan*, is governed as shown below.

Notice You must send us written notice of a *accident* for which a claim is being made within ¹¹[20 days] of the date the *accident* starts. This notice should include your name, certificate number, and policy number. ⁹[If the claim is being made for one of your covered dependents, his or her name should also be noted.]

Proof Of Loss We will furnish you with forms for filing proof of loss within ¹¹ [15 days] of receipt of notice. But, if we do not furnish the forms on time, we will accept a written description and adequate documentation of the *accident* 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 ¹¹ [90 days] of the loss.

Late Notice Or Proof We will not void or reduce your claim if you cannot 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 This *plan* pays all *accident* benefits to you, if you are living. If you are not living, this *plan* has the right to pay all *accident* 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.

Limitations Of Actions You cannot bring a legal action against this *plan* until ¹¹ [60 days] from the date you file proof of loss. And, you cannot bring legal action against this *plan* after ¹¹ [three years] from the date you file proof of loss.

WHEN COVERAGE BEGINS AND ENDS

Effective Date Your coverage under this *plan* becomes effective as of 12:01 A.M. Standard Time on the Certificate Date of Issue in the place you signed your application.

⁹[Coverage for your spouse, ⁵⁰[your domestic partner] ⁵¹[and/or] your dependent child(ren)⁵¹[and your domestic partner's dependent children] becomes effective on the date your coverage becomes effective, but only if: (a) they are *eligible dependents*; (b) they were covered under the group plan from which this port was made on the date you lost that prior coverage; and (c) they are listed on your application.]

¹[**Adding Dependents** You may not add any dependents after the Certificate Date of Issue.]

Termination Of Coverage Your coverage ends on the earliest of the following dates: (a) the date the Group Policy is terminated; (b) the date you fail to pay any required premium; (c) the date you die ²²[; (d) the date you reach age ²³[70];

⁹[Coverage ends for each dependent on the date your coverage ends. Coverage for a dependent also ends on the date each dependent ceases to be an *eligible dependent*. If you ask us to terminate the coverage of your spouse or all of your dependent children, that coverage will end as of the date your request is received, or any later date specified in the notice.]

If your ⁹[and/or a dependent's] coverage ends, we will return any unearned portion of the premium paid on a pro-rata basis.

[THE ACCIDENT BENEFIT]

Subject to all of this *plan's* terms, this *plan* will pay the benefits described below, less any benefit amounts paid under the group plan from which this coverage ported, if you or ⁹[your covered dependent] sustains an injury or incurs a loss as a result of a covered accident which occurs on or after the date he or she becomes insured by this *plan*. This *plan* pays no benefits other than what is specifically listed below.

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

**¹²[Accident
Emergency Room
Treatment**

We pay the amount shown in the Schedule of Insurance if a covered person is examined or treated by a *doctor* in a *hospital emergency room* for the initial treatment of injuries sustained in a *covered accident* within ²⁷[72] hours after the *covered accident*. This benefit is payable once per *covered person* per *covered accident*. We will not pay the Accident Emergency Room Treatment benefit and the Initial Doctor's Office/Urgent Care Facility benefit for the same *covered accident*.

**Accident Follow-Up
Visit – Doctor**

We pay the amount shown in the Schedule of Insurance if a covered person requires additional follow up treatments (not including occupational, speech or physical therapy or chiropractic treatment) after initial *emergency room* treatment or Doctor's Office/Urgent Care Facility Treatment. We pay up to ²⁸[6] treatments per a *covered person* per *covered accident*. Treatment must begin within ²⁹[60] days of a *covered accident* and be completed within ³⁰[365] days.

Accidental Death

We pay the amount shown in the Schedule of Insurance if a *covered person* sustains an injury in a *covered accident* that causes his or her death. The injury must cause his or her death within ³¹[90] days of the *covered accident*. If we pay this benefit, we will not pay the Accidental Death Common Carrier benefit.

**Accidental Death
Common Carrier**

We pay the amount shown in the Schedule of Insurance if a *covered person's* *accidental death* is due to a *covered accident* which occurs while a *covered person* is riding as a fare-paying passenger in a public conveyance. If we pay this benefit, we will not pay the Accidental Death benefit.

**Accidental Death
Common Disaster**

We pay the increased amount shown in the Schedule of Insurance if both *you* and *your* insured spouse die in a *covered accident* or separate *covered accidents* within the same 24 hour period. The benefit increase applies to *your* insured spouse's benefit.

**Accidental
Dismemberment**

We pay the amount shown in the Schedule of Insurance if a listed loss is sustained by a *covered person* due to injuries caused by a *covered accident*.

- "Loss of a hand" means the hand is completely severed at or above the wrist.
- "Loss of a foot" means the foot is completely severed at or above the ankle.
- "Loss of sight" means total and permanent loss of 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. This benefit is not payable if benefits have been paid for "Loss of hand".
- "Loss of all toes of same foot" means complete severance at the metatarsalphalangeal joint. This benefit is not payable if benefits have been paid for "Loss of foot".

⁵³[We will not pay more than ³²[\$10,000] for all losses due to the same *covered accident*.]

Accidental Death Seatbelt and Airbag benefit	<i>We pay the seatbelt amount shown in the Schedule of Insurance if a covered person dies due to injuries sustained in a covered accident while properly wearing a seatbelt. We will pay the Seatbelt & Airbag amount shown in the Schedule of Insurance if a covered person dies as a direct result of an automobile accident while both properly wearing a seatbelt, and sitting in a seat equipped with an airbag. We will not pay both the Seatbelt and Seatbelt and Airbag benefit for the same covered accident.]</i>
¹² [Air Ambulance	<i>We pay the amount shown on the Schedule of Insurance if a covered person is transported by air ambulance to or from a hospital or between medical facilities for treatment of injuries sustained as the result of a covered accident within ³³[48] hours of a covered accident. This benefit is payable once per a covered person per covered accident.</i>
Ambulance	<i>We pay the amount shown on the Schedule of Insurance if a licensed ambulance company transports a covered person by ground to or from a hospital or between medical facilities for treatment of injuries sustained as a result of a covered accident within ³¹[90] days of covered accident. This benefit is payable once per a covered person per covered accident.</i>
Appliance	<i>We pay the amount shown on the Schedule of Insurance if a covered person uses an appliance is prescribed by a doctor as necessary due to an injury sustained as a result of a covered accident. An appliance includes wheelchairs, leg or back braces, crutches, walkers, walking boot that extends above the ankle, and brace for the neck. Use of the appliance must begin within ³¹[90] days of covered accident. This benefit is payable once per a covered person per covered accident.</i>
Blood/Plasma/ Platelets	<i>We pay the amount shown in the Schedule of Insurance if as the result of a covered accident a covered person receives a transfusion, administration, cross matching, typing and processing of blood/plasma/platelets within ³¹[90] days of the covered accident. This benefit is payable once per a covered person per covered accident.</i>
Burn	<i>We pay the amount shown in the Schedule of Insurance if a covered person receives burns as a result of a covered accident and is treated by a doctor within ²⁷[72] hours of the covered accident. If a covered person meets more than one of the burn classifications, we pay the higher amount. This benefit is payable once per a covered person per covered accident.</i>
Burn - Skin Graft	<i>We pay the amount shown in the Schedule of Insurance when medically necessary grafting of the skin is received by a covered person for a burn that was payable under the Burn benefit. This benefit is payable once per a covered person per covered accident.</i>
Catastrophic Loss	<i>We pay the amount shown in the Schedule of Insurance if a covered person suffers a catastrophic loss within ³⁰[365] days of a covered accident due to injuries sustained in a covered accident. This benefit is payable once per covered person per covered accident. If a Catastrophic Loss benefit is paid, an Accidental Dismemberment benefit will not be paid for the same or attached body part.</i>
Child Organized Sport	<i>We pay the additional amount shown on the Schedule of Insurance if the covered accident occurred while a covered person's covered dependent child is participating in an organized sport. The child must be insured by this plan on the date the accident occurred. The covered child must be ³⁵[18] years of age or younger.</i>
Chiropractic visits	<i>We pay the amount shown in the Schedule of Insurance if as the result of a covered accident a covered person suffers a structural imbalance and receives chiropractic care services by a chiropractor in a chiropractor's office. Treatment must begin within ²⁹[60] days after a covered accident and be completed within ³⁶[180] days of the covered accident. We will pay for up to ²⁸[6] visits per a</i>

covered person per covered accident but no more than ³⁷[12] visits per calendar year.

¹² **[Coma]** We pay the amount shown in the Schedule of Insurance if as the result of a covered accident a covered person is in a coma lasting at least ³⁸[7] consecutive days characterized by the absence of eye opening, verbal response, and motor response. The condition must require intubation for respiratory assistance, be diagnosed or treated by a doctor within ³¹[90] days of the covered accident. This benefit is not payable for a medically induced coma.

Concussions We pay the amount shown in the Schedule of Insurance if a covered person sustains a concussion as the result of a covered accident and is diagnosed within ²⁷[72] hours of the covered accident. This benefit is payable once per a covered person per covered accident.

Dislocations We pay the amount shown in the Schedule of Insurance if a covered person is injured and suffer a dislocation as the result of a covered accident. A dislocation must be diagnosed by a doctor within ³¹[90] days of the covered accident. The dislocation must be corrected by open (surgical) or closed (non-surgical) reduction.

For multiple dislocations due to the same covered accident, we will pay no more than ³⁹[two] times the benefit amount for the joint involved with the highest benefit amount.

For partial dislocations, we will pay ⁴⁰[25%] of the benefit shown in the Schedule of Insurance for a closed reduction.

Diagnostic Exam (Major) We pay the amount shown in the Schedule of Insurance if a covered person receives one of the following imaging studies due to a covered accident: ⁴¹[Computerized Tomography (CT scan), computerized axial tomography (CAT), magnetic resonance imaging (MRI or electroencephalography (EEG).] The imaging study must be prescribed by a doctor & performed in a doctor's office or hospital, on an inpatient or outpatient basis. This benefit is payable once per covered person per covered accident.]

Emergency Dental Work We pay the amount shown in the Schedule of Insurance if a covered person suffers a broken tooth as the result of a covered accident and it is repaired by a dentist with a dental crown and/or dental extraction. The dental services must begin within ²⁹[60] days of the covered accident. One dental crown and one dental extraction is payable per covered person per accident.

Epidural Anesthesia Pain Management We pay the amount shown in the Schedule of Insurance if a covered person is prescribed and receives an epidural administered for pain management for injuries received as a result of a covered accident. The epidural must be administered in a hospital or doctor's office and is payable ⁴²[twice] per covered person per accident. This benefit is not payable for an epidural administered during a surgical procedure.

Eye Injury We pay the amount shown in the Schedule of Insurance if a covered person is injured as the result of a covered accident and suffers an eye injury. The eye injury must require surgery or the removal of a foreign object by a doctor within ³¹[90] days of a covered accident. This benefit is payable once per covered person per covered accident.]

¹² **[Family Care]** We pay the amount shown in the Schedule of Insurance if a covered person is injured as the result of a covered accident and confined in a hospital, ICU or alternate care or rehabilitative facility and the covered person has a child or children attending a child care center. The benefit is payable for each child attending a child care center while the covered person is confined. The child attending the child care center does not need to be insured under this plan for

accident coverage but must meet the eligibility requirements found in the Dependent Eligibility section. This benefit is payable for up to ⁴³[30] days within ³⁰[365] days of the *covered accident*. This benefit is payable once per *covered person* per *covered accident*.

Fracture (Bone) We pay the amount shown in the Schedule of Insurance if *covered person* suffers a *fracture* as a result of a *covered accident* and it is diagnosed within ³¹[90] days of the *covered accident*. The *fracture* must require open (surgical) or closed (non-surgical) reduction by a *doctor*. This benefit is payable for up to ³⁹[two] *fractures* per *covered person* per *covered accident*. If there are more than ³⁹[two] *fractures*, we will pay the highest two benefit amounts per *covered person* per *covered accident*. We pay ⁴⁰[25%] of the amount shown in the Schedule of Insurance for the closed reduction of a bone with a chip *fracture* that was a result of a *covered accident*.

Hospital Admission We pay the amount shown in the Schedule of Insurance if a *covered person* is admitted to a *hospital* within ³⁶[180] days of a *covered accident* as a result of injuries sustained in a *covered accident*. This benefit is payable once per *covered person* per *covered accident*. This benefit is not payable for *emergency room* treatment, *outpatient treatment*, or a *hospital* stay less than 20 hours in an observation unit. We will not pay the Hospital Admission and Hospital Intensive Care Unit Admission benefits for the same *covered accident*.

Hospital Confinement We pay the amount shown in the Schedule of Insurance if a *covered person* is confined to a *hospital* within ³⁶[180] days of a *covered accident* as a result of injuries sustained in a *covered accident*. This benefit is payable up to ³⁰[365] days per *covered accident*. This benefit is not payable for a *hospital* stay less than 20 hours. We pay either the Hospital Confinement or the Hospital Intensive Care Unit Confinement benefits for each day.

Hospital Intensive Care Unit Admission We pay the amount shown in the Schedule of Insurance if a *covered person* is admitted directly to a *hospital intensive care unit* within ⁴³[30] days of a *covered accident* as a result of injuries sustained in a *covered accident*. This benefit is payable once per *covered person* per *covered accident*. This benefit is not payable for *emergency room* treatment, *outpatient treatment*, or a *hospital* stay less than 20 hours in an observation unit. We will not pay the Hospital Admission and Hospital Intensive Care Unit Admission benefits for the same *covered accident*.

Hospital Intensive Care Unit Confinement We pay the amount shown in the Schedule of Insurance if a *covered person* is confined to a *hospital intensive care unit* within ⁴³[30] days of a *covered accident* as a result of injuries sustained in a *covered accident*. This benefit is payable up to ⁴⁴[15] days per *covered accident*. This benefit is not payable for a *hospital intensive care unit* stay less than 20 hours. We pay either the Hospital Confinement or the Hospital Intensive Care Unit Confinement for each day.]

¹² **[Initial Doctor's office/Urgent care facility treatment** We pay the amount shown in the Schedule of Insurance if a *covered person* is examined or treated by a *doctor* in a *doctor's office* or *urgent care facility* for the initial treatment of a *covered accident* within ⁴³[30] days after the *covered accident*. This benefit is payable once per *covered person* per *covered accident*. We will not pay the Accident Emergency Room Treatment benefit and the Initial Doctor's Office/Urgent Care Facility benefit for the same *covered*

accident.

- Knee Cartilage** We pay the amount shown in the Schedule of Insurance if a *covered person* tears, ruptures or severs knee cartilage (meniscus) as the result of a *covered accident* and requires surgical repair. The *injury* must be treated by a *doctor* within ²⁹[60] days after the *covered accident* and repaired through surgery within ³⁰[365] days.
- Joint Replacement** We pay the amount shown in the Schedule of Insurance if due to an *injury* sustained in a *covered accident* a *covered person* requires a hip, knee, or shoulder joint replacement. The joint replacement must be performed by a *doctor* within ³¹[90] days of a *covered accident* and is payable once per *covered person* per *covered accident*.
- Laceration** We pay the amount shown in the Schedule of Insurance if a *covered person* sustains a laceration as a result of a *covered accident* and it is repaired by a *doctor* within ²⁷[72] hours of the *covered accident*. The amount we pay will be based on the total length of all lacerations received in any one *covered accident* which require repair. This benefit is payable once per *covered person* per *covered accident* for a laceration with no sutures and once per *covered person* per *covered accident* for a laceration which required sutures.
- Lodging** We pay the amount shown in the Schedule of Insurance for a *companion's* hotel/motel stay during the period of time a *covered person* is confined to the *hospital* as the result of a *covered accident*. This benefit is payable up to ⁴³[30] days per *covered person* per *covered accident* and is only payable while the *covered person* is confined to the *hospital*. The *hospital* must be more than 45[50] miles from the residence of the *covered person*.
- ¹[Occupational or Physical Therapy] We pay the amount shown in the Schedule of Insurance if a *covered person* requires occupational or physical therapy due to injuries sustained in a *covered accident*. Treatment must begin within ²⁹[60] days of the *covered accident*, be completed within ⁴⁶[6] months, and be performed by a licensed *occupational* or *physical therapist*. This benefit is payable up to ⁴⁷[10] treatments per *covered accident*.
- Prosthetic Device/Artificial Limb** We pay the amount shown in the Schedule of Insurance if due to injuries sustained in a *covered accident* a *covered person* receives one or more prosthetic devices/artificial limbs as prescribed by a *doctor* for functional use due to the loss of a hand, foot or sight of an eye. The device or limb must be prescribed within ³⁰[365] days of the *covered accident* and is payable once per *covered person* per *covered accident*. This benefit is not payable for hearing aids, dental aids (including false teeth), eyeglasses, or cosmetic prostheses such as hair wigs.
- Reasonable Accommodation to Home or Vehicle** We pay the amount shown in the Schedule of Insurance for a required modification made to a *covered person's* place of residence or vehicle if the *covered person* suffers an Accidental Dismemberment or Catastrophic Loss due to a *covered accident*. The modification must be made within ³⁹[two] years of the *covered accident* and is payable once per *covered person* per *covered accident*.]
- ¹² [Rehabilitation Unit Confinement] We pay the amount shown in the Schedule of Insurance if a *covered person* is confined to rehabilitation unit due to injuries sustained in a *covered accident*. This benefit is payable up to ⁴⁴[15] days per *covered person* per *covered accident* but cannot exceed ⁴³[30] days per calendar year. We will not pay the Rehabilitation Unit Confinement and the Hospital Confinement benefits for the same day.
- Ruptured Disc With Surgical Repair** We pay the amount shown in the Schedule of Insurance if a *covered person* receives a ruptured disc in his or her spine as a result of injuries sustained in a *covered accident*. The *injury* must be treated by a *doctor* within ²⁹[60] days of

the *covered accident* and surgically repaired within ³⁰[365] days of the *covered accident*. This benefit is payable once per *covered person* per *covered accident*.

Surgery (cranial, open-abdominal, thoracic, hernia) We pay the amount shown in the Schedule of Insurance if a *covered person* undergoes cranial, open-abdominal, thoracic, or hernia surgery due to injuries sustained to a *covered accident*. Cranial, open-abdominal, and thoracic surgery must be performed within ²⁷[72] hours of the *covered accident*. Hernia surgery must be diagnosed within ⁴³[30] days of *covered accident* and surgery must be performed within ²⁹[60] days. If more than one surgery is performed, we pay the benefit with the highest dollar amount. This benefit is payable once per *covered person* per *covered accident*.

Surgery (Exploratory and Arthroscopic) We pay the amount shown in the Schedule of Insurance if a *covered person* undergoes exploratory or arthroscopic surgery as a result of injuries sustained in a *covered accident* and the surgery takes place within ²⁹[60] days of the *covered accident*. This benefit is payable once per *covered person* per *covered accident*. Hernia repair is not covered under this benefit. This benefit is not payable if the Surgery or Tendon/Ligament/Rotator Cuff benefits are payable for the same surgery.

Tendon/Ligament/Rotator Cuff We pay the amount shown in the Schedule of Insurance if a *covered person* receives a torn, ruptured or severed tendon, ligament, or rotator cuff as the result of injuries sustained in a *covered accident*. The *injury* must be treated within ²⁹[60] days of the *covered accident* and repaired through surgery within ³⁰[365] days of the *covered accident*. This benefit is payable once per *covered person* per *covered accident*.

Transportation We pay the amount shown in the Schedule of Insurance if a *covered person* must travel more than ⁴⁵[50] miles one way to receive special treatment at a *hospital* or free standing treatment facility due to a *covered accident*. The treatment must be prescribed by a *doctor* and not available locally. This benefit is payable up to ⁴⁸[three] times per *covered person* per *covered accident* and is not payable if transportation is provided by ambulance or air ambulance.

Wellness Benefit We pay the amount shown in the Schedule of Insurance for one Wellness benefit per ²⁴[calendar] year per *covered person* if a *covered person* has a wellness test performed while coverage is in force. Wellness tests are:

- ⁴⁹[Abdominal aortic aneurysm ultrasonography]
- Blood test for triglycerides
- Bone marrow testing
- Bone density screening
- Breast ultrasound
- CA 15-3 (blood test for breast cancer)
- CA125 (blood test for ovarian cancer)]
- ¹²[Carotid ultrasound]
- CEA (blood test for colon cancer)]
- Chest x-ray
- Colonoscopy
- Completion of a smoking cessation program
- Completion of a weight reduction program
- Double contrast barium enema
- EKG
- Fasting blood glucose test
- Flexible sigmoidoscopy
- Hemoccult stool analysis

- Immunizations
- Mammography
- Pap smear
- PSA (blood test for prostate cancer)
- Routine/annual physicals
- Serum cholesterol test to determine level of HDL and LDL
- Serum Protein Electrophoresis (blood test for myeloma)
- Skin cancer biopsy
- Stress test on a bicycle or treadmill
- Thermography
- ThinPrep pap test
- Virtual colonoscopy]

X – Ray We pay the amount shown in the Schedule of Insurance if a *covered person* receives an x-ray as the result of injuries sustained in a *covered accident*. The test must be prescribed by a *doctor* and performed in a *doctor's* office or a *hospital* on an *inpatient* or outpatient basis and performed within ³¹[90] days of the *covered accident*. This benefit is payable once per *covered person* per *covered accident*.]

Beneficiary for Death Benefits: You decide who gets this benefit if *you* die. ^{19A}[You should have named a beneficiary on *your* enrollment form.] ^{19B}[Your beneficiary designation should be maintained by *your employer*.]

You can change *your* beneficiary at any time by giving *us* written notice, unless *you* have assigned this insurance. ^{20A} [But the change will not take effect until we give *you* written confirmation of the change.] ^{20B}[But the change will not take effect until the *employer* gives *you* written confirmation of the change.]]

¹²If *you* named more than one person, but didn't tell *us* what their shares should be, they will share equally. If someone *you* named dies before *you*, that person's share will be divided equally by the beneficiaries still alive, unless *you* have specified otherwise.

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

This *plan* will not pay benefits for any *injury* caused by or related to, directly or indirectly:

-
- ²⁵[*Sickness*, disease, mental infirmity or medical or surgical treatment.]
- ²⁵ [Voluntary use of any poison, chemical, prescription or non-prescription drug or controlled substance unless: (1) it was prescribed for a *covered person* by a *doctor*, and (2) it was used as prescribed. In the case of a non-prescription drug, this *plan* does not pay for any *accident* resulting from or contributed to by use in a manner inconsistent with package instructions. "Controlled substance" means anything called a controlled substance in Title II of the Comprehensive Drug Abuse Prevention and Control Act of 1970, as amended from time to time.]
- ²⁵ [The *covered person* being legally intoxicated.]
- ²⁵ [Declared or undeclared war, act of war, or armed aggression.]
- ²⁵ [Service in the armed forces, National Guard, or military reserves of any state or country.]
- ²⁵ [Taking part in a riot or civil disorder.]
- ²⁵ [Commission of or attempt to commit a felony.]
- ²⁵ [Treatment rendered or *hospital confinement* outside the United States ²⁶ [or Canada.]]
- ²⁵ [Intentionally self inflicted *injury*, while sane or insane.]
- ²⁵ [Suicide or attempted suicide, while sane or insane.]
- ²⁵ [Travel or flight in any kind of aircraft, including any aircraft owned by or for the policyholder, except as a fare-paying passenger on a common carrier.]
- ²⁵ [Participation in any kind of sporting activity for compensation or profit, including coaching or officiating.]
- ²⁵ [Riding in or driving any motor-driven vehicle in a race, stunt show or speed test.]
- ²⁵ [Participation in hang gliding, bungee jumping, sailgliding, parasailing, parakiting, ballooning, parachuting, or skydiving.]
- ²⁵ [²¹[Job related or on the job injuries.]]
- ²⁵ [An accident that occurred before the *covered person* is covered by this *plan*.]
- ²⁵ [⁹[Injuries to a dependent child received during the birth.]]

GROUP CONVERSION AND PORTABILITY TRUST INSURANCE POLICY

A Group Insurance Policy Providing On A Contributory Basis, The Benefits Specified In The Certificate of Coverage Applicable To Each Insured Hereunder

The Guardian Life Insurance Company of America (herein called "we," "us," "our," or "The Guardian"), in consideration of the Policyholder's application and executed Trustee Agreement, and of the payment of premiums as stated herein, agrees to pay benefits to persons entitled to insurance provided by this Group Conversion and Portability Trust Insurance Policy (herein called the Group Policy), subject to all of its terms and conditions.

Policyholder: ¹[Trustees of The Guardian Group Conversion and Portability Trust

Group Policy: G - 12345
Delivered in the state of Rhode Island

Policy Effective Date: January 1, 1999

Policy Anniversary: With respect to individual insureds, the date specified in each certificate.

Home Office 7 Hanover Square
New York, New York 10004]

This Group Policy takes effect on the Policy Effective Date specified above. In witness of this we cause this Group Policy to be executed as of its date of issue which is ¹[January 1, 1999].

¹[

The Guardian Life Insurance Company of America


SPECIMEN

Vice President, Group Products]

Dividends Apportioned Annually

Definitions

As used in this Group Policy, the following terms have the following meanings. Except for the terms “we”, “us” and “our”, when each defined term is used, it appears with the first letter of each word in capital letters. When each defined term is used, it appears with the first letter of each word in capital letters.

Certificate of Coverage	The certificate of coverage issued to a person who is insured.
Certificate Holder	The named insured of each Certificate of Coverage.
Group Policy	This group conversion and portability trust insurance policy
Trustee	The ² [Citizens Bank], or its successor, appointed under a Trustee Agreement which is approved and signed by us.
We, Us, Our	The Guardian Life Insurance Company of America, herein called The Guardian.

Specimen

GENERAL PROVISIONS

Premiums

Initial Premiums: The Guardian has set the initial premium rates to be paid by each Certificate Holder. These rates are shown in the premium notice which was given to each Certificate Holder either prior to, or with the Certificate of Coverage.

Change In Premium: We may set new premium rates which will become effective at any time. We will give each Certificate Holder ³[31 days] advance written notice of the change.

Premium Payment: Each Certificate Holder's first premium payment must be submitted with his or her application for coverage. Subsequent premium payments are due as specified in the premium notice which is given to each Certificate Holder.

Grace Period: Each Certificate Holder will be allowed a ³[31 day] grace period for premium payment except the first. During this grace period, coverage will remain in force. If the owed premium is not paid by the end of the grace period, the Certificate Holder's coverage will end as of the day the premium first became due.

Term of Policy and Certificates of Coverage – Renewal Privilege

Renewal of Certificates of Coverage: The terms of a Certificate Holder's coverage are described in his or her Certificate of Coverage.

Cancellation of Policy: We have the right to cancel this Group Policy at any time, by providing the Policyholder with at least ³[31 days] advance written notice. Each Certificate Holder's coverage ends when the Group Policy ends. Termination of the Group Policy will not prejudice any claims incurred by an insured person prior to the date the Group Policy ends.

Specimen

Other General Provisions

The Contract – Changes: The entire contract between the parties consists of the Group Policy, including any amendments to the Group Policy, the applications of people insured under the Group Policy, the application of the trustee for insurance, and each Certificate of Coverage issued under the Group Policy.

We can amend the Group Policy at any time by notifying the Policyholder. We will give the Policyholder at least ³[31 days] advance written notice of the change.

No agent has the authority to change the Group Policy, or to waive any of its terms or conditions.

Certificates: We will give each Certificate Holder a Certificate of Coverage. The certificate will control: (a) benefit amounts, limits and other scheduled information; (b) benefit plan provisions; (c) eligibility, effective date and termination rules; (d) exclusions and limitations; (e) premium payment and grace period provisions; and (f) other provisions pertaining to coverage, including state insurance law requirements.

Clerical Error – Misstatements: A clerical error in keeping records pertaining to the Group Policy, or delays in making entries on those records, will not invalidate insurance otherwise validly in force or continue insurance otherwise validly terminated. This is true regardless of whether the error was made by the Policyholder, an insured, or us. But upon discovery of such an error or delay, we have the right to make an equitable adjustment of premium.

If an insured person misstates any information, and because of this, premiums are affected, we have the right to make an equitable adjustment of premium. If the misstatement affects the existence or the amount of insurance, we will use the true facts in determining whether insurance is in force under the terms of this Group Policy and in what amount.

Statements: No statement will avoid the insurance or be used in defense of a claim under this Group Policy unless: (a) in the case of the Certificate Holder's former employer, from whose group plan the Certificate Holder has ported or converted, it is contained in a writing signed by him or her; and (b) in the case of a Certificate Holder, it is contained in a written request or application signed by the Certificate Holder, a copy of which has been furnished to him or her.

All statements shall be deemed representations and not warranties.

Suspension During Military Service: If an insured goes on active duty in the military service of any country or international authority, his or her coverage will be suspended on the date his or her active duty starts. But this provision doesn't apply to temporary active duty by reservists for military training that lasts ³[30 days] or less. We will refund that part of any premium paid for the period of such suspension.

If the insured's active duty lasts no longer than ³[five years], he or she may place his or her coverage back in force, without providing proof that he or she is insurable, as of the date his or her active duty ends.

Other General Provisions (Cont.)

Conformity With State Statutes: This Group Policy is governed by the laws of the state of Rhode Island. However, with respect to each Certificate Holder, any terms in his or her Certificate of Coverage which are in conflict with any insurance statute of the state where he or she lives on his or her effective date, are hereby amended to conform to the minimum requirements of such statute.

Incontestability: Except for non-payment of premium, the Group Policy cannot be contested after it, or any rider or amendment subsequently added to it, has been in force for a period of ³[two years].

Time Periods: All periods affecting the coverage under a Certificate of Coverage begin and end at 12:01 A.M., standard time, at each Certificate Holder's address of record.

Participation: This Group Policy is entitled to participate in the divisible surplus of The Guardian. Dividends may be paid in such manner, under such conditions and to such extent as our Board of Directors may from time to time determine.

Specimen

Incorporated Certificates: The following certificates are hereby added to and made part of the Group Policy:

⁴[PC-LIFE-95-1 et al (Portable Life Certificate of Coverage)]

PC-AC-12 et al (Portable Accident Coverage Certificate of Coverage)]

Specimen

CERTIFICATE AMENDMENT

(To be attached to certificates issued to employees)

The certificate is amended by adding the following: to the Accident coverage provisions of this *plan*

DISABILITY SICKNESS AND ACCIDENT [ON & OFF THE JOB][OFF THE JOB]

SCHEDULE OF INSURANCE

WEEKLY BENEFIT AMOUNT FOR COVERED ⁴¹[EMPLOYEE]: ² [\$50-\$1000]

¹⁶[WEEKLY BENEFIT AMOUNT FOR COVERED DEPENDENT SPOUSE: ² [\$50-\$1000]]

MAXIMUM BENEFIT PERIOD FOR COVERED ⁴¹[EMPLOYEE]: ³ [9-52] WEEKS

¹⁶[MAXIMUM BENEFIT PERIOD FOR COVERED DEPENDENT SPOUSE: ⁴[\$50-\$1000]]

ELIMINATION PERIOD FOR COVERED ⁴¹[EMPLOYEE] ACCIDENT: ⁵ [0-180] DAYS

¹⁶[ELIMINATION PERIOD FOR COVERED DEPENDENT SPOUSE ACCIDENT: ⁵ [0-180] DAYS]

ELIMINATION PERIOD FOR COVERED ⁴¹[EMPLOYEE] SICKNESS: ⁵ [0-180] DAYS

¹⁶[ELIMINATION PERIOD FOR COVERED DEPENDENT SPOUSE SICKNESS: ⁵ [0-180] DAYS]

BENEFITS

We will pay the weekly benefit amount shown in the Schedule of Insurance if a *covered person* becomes disabled as a result of a *sickness*, or an *injury* sustained in a *covered accident*. The *sickness* and the *covered accident* must occur and the *disability* must begin while the covered person is covered under this plan. ⁴⁶[Disability must begin within ⁴⁵[90] days of the covered accident or *sickness*.]

How Payments Start: To start getting payments from this *plan*, you ¹⁶[or your *covered dependent spouse*] must meet all of the conditions listed below.

- He or she must: (1) become *disabled* while covered by this plan; and (2) remain *disabled* and covered for this *plan's elimination period*.
- He or she must provide proof of loss, as described in the Claim Provisions, herein.

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

^{6A} [You can satisfy the *elimination period* while working, provided you are *disabled*.]

^{6B} [You may not satisfy this *plan's elimination period* while working.]

⁷ [If you perform any work for wage or profit, you will not be eligible for benefits under this *plan*.]

⁸ [**Waiver Of Premium:** We waive your premiums for this coverage while you are entitled to receive a Weekly Benefit payment from this *plan*.]

When Payments End: Your ¹⁶[and your covered dependent's] benefits from this *plan* will end on the earliest of the dates shown below:

- The date he or she is no longer disabled.
- The date he or she fails to provide proof of loss as required by this *plan*
- The date he or she has been outside the United States ^{9A} [and/or Canada] ^{9B} [and/or a country or region approved by Us] for more than ¹⁰ [two months] in a ¹¹ [12 month] period] .
- The date he or she dies.
- The end of the Maximum Payment Period.
- The date he or she is no longer receiving *regular and appropriate care* from a *doctor*.

Maximum Payment Period: The Maximum Payment Period is shown in the Schedule Of Insurance.

Recurring disability: Benefits from this *plan* end if you ¹⁶[or your covered dependent spouse] cease¹⁶[s] to be *disabled*. But, a later *disability* may be treated as a *recurring disability*, if all of the terms listed below are met:

- You must return to active work right after your benefits end.
- The *disability* must recur less than ¹² [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 *plan* must not end during your return to *active work*.
- During the time you return to *active work*, you must: (1) stay covered by this *plan*; and (2) premium payments must be made on your behalf.
- Your benefits must not have ended because you have used up the Maximum Payment Period.

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

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

DEFINITIONS

¹³[This section defines certain terms appearing in your Certificate.

Active Work: This term means *you* are able to perform, and are performing, all of the regular duties of *your* work for the ⁴²[*employer*], ¹⁴ [on a Full-Time basis] ¹⁵ [or a part-time basis] at: (1) one of the *employer* 's usual places of business; (2) some place where the ⁴²[*employer* 's] business requires *you* to travel; or (3) any other place *you* and the ⁴²[*employer*] have agreed on for *your* work.

⁴⁸ [¹⁶ [**Activities of Daily Living** means:

1. **Bathing:** the ability to wash in a tub or shower; or by taking a sponge bath; and to towel dry; with or without equipment or adaptive devices.
2. **Dressing:** the ability to put on and take off all clothes; and those medically necessary braces or prosthetic limbs usually worn; and also to fasten or unfasten them.
3. **Toileting:** the ability to get to and from and on and off the toilet; to maintain personal hygiene; and to care for clothes.
4. **Transferring:** the ability to move in and out of a chair or bed with or without equipment such as: canes; walkers; crutches; grab bars; or any other support devices.
5. **Continence:** the ability to control bowel and bladder function; or, in the event of incontinence, the ability to maintain personal hygiene.
6. **Eating:** the ability to get food into the body by any means once it has been prepared and made available.]]

⁴⁸ [¹⁶ [**Cognitive Impairment or Cognitively Impaired:** These terms mean a decline or loss in intellectual aptitude. Such loss may result from: (a) *injury*; (b) *sickness*; (c) Alzheimer's disease, or (d) like forms of senility or irreversible dementia. It must be supported by clinical proof and standardized tests that precisely measure decline in the areas of: (i) short term memory; (ii) orientation to time, place and person; (iii) deductive or abstract reasoning; and (iv) judgment as it relates to awareness of safety. Cognitive impairment does not include decline or loss due to a *mental illness*.]]

Covered Accident This term means an *accident* that:

- Occurs while the covered person's coverage under this plan is in effect.
- Results in a bodily *injury* or *sickness*.
- Is not otherwise excluded under the terms of this *plan*; and
- Is covered under the Accident coverage of this *plan*.

Covered Person This term means *you* ¹⁶[or *your* dependent spouse] covered by this *plan*.

Disability or Disabled: These terms mean that an *injury* sustained in a *covered accident* or a *sickness* causes physical or mental impairment to such a degree that ⁶ [(A)] *you* are: (1) not able to perform ¹⁴ [, on a *full-time* basis] ¹⁵[or a *part-time* basis] the major duties of your ¹⁷ [Own Job] ¹⁶[or (B) *your* covered dependent spouse is (i) not able to perform two or more *activities of daily living*, on a routine basis, without help or (ii) *cognitively impaired* and in need of verbal cueing to protect himself or herself or others..

⁴⁷[If you do not have a full-time job at the time of disability, these terms mean that you are (i) not able to perform two or more *activities of daily living*, on a routine basis, without help or (ii) *cognitively impaired* and in need of verbal cueing to protect yourself or others.]

¹⁸ [You are not *disabled* if you perform any work for wage or profit] ¹⁹ [during the *elimination period*] .]

²⁰ [You may be required, on average, to work more than ²¹ [40] hours per week. In this case, you are not disabled if you are able to work for ²¹ [40] hours per week.]

¹³[Neither loss of a professional or occupational license due to misconduct or unlawful activity or receipt of, or entitlement to, Social Security disability benefits in and of themselves constitute disability under this *plan*.

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

Elimination Period: This term means the period of time you ¹⁶[or your covered dependent spouse] must be *disabled*, due to a covered *disability*, before this *plan's* benefits are payable.

⁴¹[**Employee**]: ²² [This term means a person who works for the ⁴²[*employer*] and whose income is reported for tax purposes using a W-2 or 1099 form.]

⁴²[**Employer**]: This term means ¹ [ABC Company, Inc] .

¹⁴ [**Full-Time:** This term means you regularly work at least the number of hours in the normal work week set by the ⁴²[*employer*] (but not less than ²¹ [30] hours per week) at: (1) your *employer's* place of business; (2) some place where the *employer's* business requires you to travel; or (3) any other place you and your ⁴²[*employer*] have agreed upon for the performance of occupational duties.]

Injury: This term means a bodily *injury* due to a *covered accident* that occurs, independent of all other causes, while you ¹⁶[or your covered dependent spouse] is covered by this *plan*. We will cover a *disability* caused by an *injury* when the *disability* starts within ³² [90 days] of the date of such *injury*.

Maximum Payment Period: This term means the longest time that benefits are paid by this *plan*, subject to all terms, limitations and exclusions.

⁴⁹[**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 have the right to use some other similar standard. A *mental illness* may be caused by, contributed to by, result in physical, biological or chemical factors or symptoms. For purposes of this plan, *mental illness* does not include: (1) irreversible dementia caused by Alzheimer's disease, stroke, trauma or viral infection; or (2) any other condition not typically treated by a psychiatrist, clinical psychologist or other qualified mental health practitioner with psychotherapy or psychotropic drugs.]

Objective Medical Evidence: This term includes, but is not limited to: (1) diagnostic testing; (2) laboratory reports; and (3) 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.

^{23A} [**Own Job:** This term means your job for the ⁴²[*employer*]. We use the job description provided by the ⁴²[*employer*] to determine the duties and requirements of your Own Job.]]

¹³[^{23B} [**Own Occupation:** This term means the occupation: (1) *you* are routinely performing immediately prior to *disability*; (2) which is your primary source of income prior to *disability*; and (3) for which *you* are covered under this *plan*. Occupation includes any employment, trade or profession that are related in terms of similar tasks, functions, skills, abilities, knowledge, training and experience required by ⁴²[*employers*] from those engaged in a particular occupation in the general labor market in the national economy. Occupation is not specific to a certain ⁴²[*employer*] or a certain location.]]

¹⁵ [**Part-Time:** This term means :

- With respect to eligibility for coverage, *you* regularly work at least the number of hours in the normal work week set by the ⁴²[*employer*] (but not less than ²⁴ [15] hours per week), at: (1) your ⁴²[*employer 's*] place of business; (2) some place where the ⁴²[*employer 's*] business requires *you* to travel; or (3) any other place *you* and your ⁴²[*employer*] have agreed upon for the performance of occupational duties.]

Plan: This term means the Accident coverage described in the *plan* and this Certificate.

²⁵ [**Proof Of Insurability:** This terms means an application for coverage showing that a person in insurable.]

Recurring disability: This term means a later *disability* that: (1) is related to an earlier *disability* for which this *plan* paid benefits; and (2) meets the conditions described in the *recurring disability* section of this plan.

Regular and Appropriate Care: This term means, with respect to your disabling condition and any other condition which, if left untreated, would adversely affect your disabling condition, *you*: (1) visit a *doctor* as frequently as medically required, according to generally accepted medical standards, to effectively manage these conditions; and (2) 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: (a) *disability*; and (b) 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: (i) the American Medical Association (AMA); (ii) the AMA Board of Medical Specialties; (iii) the Food and Drug Administration; (iv) the Centers for Disease Control; (v) the National Cancer Institute; (vi) the National Institutes of Health; (vii) the Department of Health and Human Services; and (viii) any other agency of similar repute.

Sickness: These terms means an illness or disease.

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

You or Your: These terms mean the covered ⁴¹[*employee*].]

LIMITATIONS AND EXCLUSIONS

³⁹[**Pre-Existing Conditions:** A pre-existing condition is an *injury or a sickness*, whether diagnosed or misdiagnosed, and any symptoms of it, for which, in the look back period, *you* ¹⁶[*or your dependent spouse*]: (1) received advice or treatment from a *doctor*; (2) underwent diagnostic procedures [other than routine screening in the absence of symptoms or suspicion of disease process by a *doctor*] ; (3) was prescribed or take prescription drugs; or (4) received other medical care or treatment, including consultation with a *doctor*.

The "look back period" is the ³⁴ [three months] before the latest of: (1) the effective date of your ¹⁶[*or your dependent spouse*] coverage under this plan; (2) the effective date of a change that increases the benefits payable by this plan; and (3) the effective date of a change in your ¹⁶[*or your dependent spouse*] benefit election that increases the benefit payable by this plan.

⁴⁰ [No benefits are payable for *disability* caused by, contributed to by or resulting from a pre-existing condition; unless the disability starts ¹⁶ [(a)] ³⁵ [after *you* complete at least one full day of *active work*] after the date *you* have been covered under this plan for ³⁶ [12 months] in a row. ¹⁶[*or* (b) the date *your dependent spouse* has been covered under this *plan* for [12 months] in a row.]

³⁷ [For any *disability* caused by, contributed to by or resulting from a pre-existing condition, *We* limit the Maximum Payment Period to ³⁸ [two weeks,] unless the *disability* starts ¹⁶[(a)] ³⁵ [after *you* complete at least one full day of *active work*] after the date *you* have been covered under this plan for ³⁶ [12 months] in a row. ¹⁶[*or* (b) the date *your dependent spouse* has been covered under this *plan* for ³⁶ [12 months] in a row.]

Your ¹⁶[*or your dependent spouse's*] *disability* caused by, contributed to by or resulting from; a pre-existing condition may begin after: (1) a change which provides for an increase in the benefits payable by this plan; or (2) a change in your ¹⁶[*or your dependent spouse's*] benefit election which increases the benefit payable by this plan. In this case, his or her 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 his or her *disability* starts ¹⁶[(a)] ³⁵ [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 ¹⁶[*or* (b) the date *your dependent spouse* has been covered under this *plan* for [12 months] in a row.].

We do not cover any disability that starts before your coverage under this plan.]

³⁹ [**Prior Coverage Credit:** If this plan replaces a similar disability plan the *employer* had with another insurer, the pre-existing condition provision may not apply to *you*. This plan must start right after the old plan ends.]

³⁹ [The pre-existing condition provision will be waived for *you* if *you*: (1) are at *active work* on the effective date of this *plan*; and (2) have fulfilled the requirements of any pre-existing condition provision of the old plan.

You may have been covered under the old plan when it ended, but have not met the requirements of any pre-existing condition provision of the old plan. In that case, *we* credit any time used to meet the old plan's pre-existing condition provision toward meeting this *plan's* pre-existing conditions provision. *You* must: (1) enroll for coverage under this *plan* on or before this *plan's* effective date; and (2) be at *active work* on the effective date of this *plan*.

But, *we* limit your maximum Weekly Benefit under this *plan* if: (1) it is more than the maximum Weekly Benefit for which *you* were covered under the old plan; (2) *you* become disabled due to a pre-existing condition; and (3) this *plan* 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 old plan.

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

Exclusions: The exclusions contained in this policy apply to the ^{26A} [Off the Job] ^{26B} [On & Off the Job] *disability* benefit. This *plan* does not pay any benefits for any period of *disability*:

- During which *you* ¹⁶[or *your* covered dependent spouse] is confined to a facility as a result of your conviction of a crime;
- During which he or she is receiving medical treatment or care outside the United States ⁵⁰[or Canada] [unless expressly authorized by Us;]
- Which starts before he or she is covered by this *plan*; or
- During which *your* loss of earnings is not solely due to *your disability*.]

Claim Provisions

Authority: *We* have the sole discretionary authority to: (1) interpret the terms of this *plan*; and (2) determine your eligibility for coverage and benefits under the *plan*. 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 *plan* as described in your Certificate's Accident and Health Claims Provisions. For details, *you* can call *us* at ²⁷ [1-800-268-2525.] ¹⁶[If the claim is being made for your covered dependent spouse, his or her name also should be noted.]

Proof Of Loss: When *we* receive *your* notice, *we* will provide *you* with a claim form for filing proof of loss. This form requires data from the ⁴²[*employer*], *you*, and the *doctor(s)* treating *your injury* or *sickness*. Proof of loss must be given to *us* within the time stated in *your* Certificate's Accident and Health Claims Provisions. 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.

Proof of loss, provided at *your* expense, consists of the following. Failure to provide this information may delay, suspend, reduce or terminate *your* benefits.

- The date *disability* began.
- *Your* last day of *active work*.
- The cause of *disability*.
- The extent of *disability*, including limitations and restrictions ¹⁶[(A)] preventing *you* from performing the major duties of *your* ^{26A} [Own Occupation] ^{26B} [Own Job] and ¹⁶[(B)] causing *your* covered dependent spouse to be (i) unable to perform two or more *activities of daily living* on a routine basis without help or (ii) *cognitively impaired* and in need of verbal cueing to protect himself or herself or others.
- ⁴⁷[If you do not have a full-time job at the time of disability, the extent of *disability*, including limitations and restrictions causing you to, (i) not be able to perform two or more *activities of daily living*, on a routine basis, without help or (ii) be *cognitively impaired* and in need of verbal cueing to protect yourself or others.]
- If *your* occupation requires that *you* carry liability or malpractice insurance, any changes to such insurance that becomes effective on or after the date of *disability*.
- *Objective medical evidence* in support of *your* ¹⁶[or your covered dependent spouse's] limitations and restrictions, beginning with the date *disability* began.
- The prognosis of *disability*.
- The name and address of all *doctors*, hospitals and health care facilities where *you* ¹⁶[or your covered dependent spouse] have been treated for *your* ¹⁶[or your covered dependent spouse's] *disability* since the date *disability* began.
- Proof that *you* ¹⁶[or your covered dependent spouse] are currently receiving *regular and appropriate care* from a *doctor*.
- Proof that *you* ¹⁶[or your covered dependent spouse] have been receiving *regular and appropriate care* from a *doctor*, from the date *disability* began.

You ¹⁶[or your covered dependent spouse] must provide *objective medical evidence* from a *doctor* who is not yourself, *your* spouse, child, parent, sibling or business associate.

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

⁴³[The Guardian Life Insurance Company of America
Group Short Term disability Claims Department
P.O. Box 26160
Lehigh Valley, PA 18002-6160.]

Authorization Required: You ¹⁶[or your covered dependent spouse] must provide us with written, unaltered authorizations to obtain medical, financial, vocational, occupational, and governmental information required to determine our liability under this plan. You ¹⁶[or your covered dependent spouse] must provide us with such authorizations as often as we may require, in order that they remain current. Failure to provide such authorizations may delay, suspend or terminate your ¹⁶[or your covered dependent spouse's] benefits.

Right To Request Medical, Financial Or Vocational Assessment: We may ask you ¹⁶[or your covered dependent spouse] to take part in a medical, financial, vocational or other assessment that we feel is necessary to determine whether the terms of the plan are met. We may require this as often as we feel is reasonably necessary. We will pay for all such assessments. But, if you ¹⁶[or your covered dependent spouse] postpone a scheduled assessment without our approval, you ¹⁶[or your covered dependent spouse] will be responsible for any rescheduling fees. If you ¹⁶[or your covered dependent spouse] do not take part in or cooperate with the assessment, we have the right to stop or suspend your ¹⁶[or your covered dependent spouse] payments under this plan.

Ongoing Proof Of Loss: To continue to receive payments from this plan, you ¹⁶[or your covered dependent spouse] must give us current proof of loss as often as we may reasonably require. Ongoing proof of loss must be provided to us within ²⁷ [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 the legal representative of your estate. Benefits are paid in US dollars.

We pay benefits ²⁸ [biweekly] at the end of the period for which they are payable.

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

Benefits to which you ¹⁶[or your covered dependent spouse] are entitled may remain unpaid at your ¹⁶[or your covered dependent spouse's] death. Such benefits may be paid at our discretion to: (1) your estate; or (2) your spouse, parents, children, or brothers and sisters.

Partial Week Payment: You ¹⁶[or your covered dependent spouse] may be disabled for only part of a week. In this case, we compute your ¹⁶[or your covered dependent spouse] payment as ²⁹ [1/7th] of the benefit to which you ¹⁶[or your covered dependent spouse] would be entitled for the full week times the number of days you ¹⁶[or your covered dependent spouse] are disabled.

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

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

The Guardian Life Insurance Company of America

⁴⁴[

SPECIMEN


Vice President, Risk Management & Chief Actuary, Group Insurance]

CERTIFICATE AMENDMENT

(To be attached to certificates issued to ³³[employees])

The certificate is amended by adding the following: to this *plan*

DISABILITY ACCIDENT ^{26A} [ON & OFF THE JOB] ^{26B} [OFF THE JOB]

SCHEDULE OF INSURANCE

WEEKLY BENEFIT AMOUNT FOR COVERED ³³[EMPLOYEE]: ²[\$50-\$1000]

¹⁶[WEEKLY BENEFIT AMOUNT FOR COVERED DEPENDENT SPOUSE: ²[\$50-\$1000]]

MAXIMUM BENEFIT PERIOD FOR COVERED ³³[EMPLOYEE]: ³[9-52] WEEKS

¹⁶[MAXIMUM BENEFIT PERIOD FOR COVERED DEPENDENT SPOUSE: ⁴[\$50-\$1000]]

ELIMINATION PERIOD FOR COVERED ³³[EMPLOYEE]: ⁵[0-180] DAYS

¹⁶[ELIMINATION PERIOD FOR COVERED DEPENDENT SPOUSE: ⁵[0-180] DAYS]

BENEFITS

We will pay the weekly benefit amount shown in the Schedule of Insurance if a *covered person* becomes disabled as a result of an *injury* sustained in a *covered accident*. The *covered accident* must occur and the *disability* must begin while the covered person is covered under this plan. ³⁷[Disability must begin within ³⁸[90] days of the covered accident.]

How Payments Start: To start getting payments from this *plan*, you ¹⁶[or your *covered dependent spouse*] must meet all of the conditions listed below.

- He or she must: (1) become *disabled* while covered by this plan; and (2) remain *disabled* and covered for this *plan's elimination period*.
- He or she must provide proof of loss, as described in the Claim Provisions, herein.

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

^{6A} [You can satisfy the *elimination period* while working, provided you are *disabled*.]

^{6B} [You may not satisfy this *plan's elimination period* while working.]

⁷ [If you perform any work for wage or profit, you will not be eligible for benefits under this *plan*.]

⁸ [**Waiver Of Premium:** We waive your premiums for this coverage while you are entitled to receive a Weekly Benefit payment from this *plan*.]

When Payments End: Your ¹⁶[and your covered dependent's] benefits from this *plan* will end on the earliest of the dates shown below:

- The date he or she is no longer disabled.
- The date he or she fails to provide proof of loss as required by this *plan*
- The date he or she has been outside the United States ^{9A} [and/or Canada] ^{9B} [and/or a country or region approved by Us] for more than ¹⁰ [two months] in a ¹¹ [12 month] period] .
- The date he or she dies.
- The end of the Maximum Payment Period.
- The date he or she is no longer receiving *regular and appropriate care* from a *doctor*.

Maximum Payment Period: The Maximum Payment Period is shown in the Schedule Of Insurance.

Recurring disability: Benefits from this *plan* end if you ¹⁶[or your covered dependent spouse] cease¹⁶[s] to be *disabled*. But, a later *disability* may be treated as a *recurring disability*, if all of the terms listed below are met:

- You must return to active work right after your benefits end.
- The *disability* must recur less than ¹² [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 *plan* must not end during your return to *active work*.
- During the time you return to *active work*, you must: (1) stay covered by this *plan*; and (2) premium payments must be made on your behalf.
- Your benefits must not have ended because you have used up the Maximum Payment Period.

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

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

DEFINITIONS

¹³[This section defines certain terms appearing in this rider.

Active Work: This term means you are able to perform, and are performing, all of the regular duties of your work for the ³⁴[employer,] ¹⁴ [on a Full-Time basis] ¹⁵ [or part-time basis] at: (1) one of the *employer* 's usual places of business; (2) some place where the ³⁴[employer 's] business requires you to travel; or (3) any other place you and the ³⁴[employer] have agreed on for your work.

¹⁶[**Activities of Daily Living** means:

1. **Bathing:** the ability to wash in a tub or shower; or by taking a sponge bath; and to towel dry; with or without equipment or adaptive devices.
2. **Dressing:** the ability to put on and take off all clothes; and those medically necessary braces or prosthetic limbs usually worn; and also to fasten or unfasten them.
3. **Toileting:** the ability to get to and from and on and off the toilet; to maintain personal hygiene; and to care for clothes.
4. **Transferring:** the ability to move in and out of a chair or bed with or without equipment such as: canes; walkers; crutches; grab bars; or any other support devices.
5. **Continence:** the ability to control bowel and bladder function; or, in the event of incontinence, the ability to maintain personal hygiene.
6. **Eating:** the ability to get food into the body by any means once it has been prepared and made available.]

⁴⁸[¹⁶[**Cognitive Impairment or Cognitively Impaired:** These terms mean a decline or loss in intellectual aptitude. Such loss may result from: (a) *injury*; (b) *sickness*; (c) Alzheimer's disease, or (d) like forms of senility or irreversible dementia. It must be supported by clinical proof and standardized tests that precisely measure decline in the areas of: (i) short term memory; (ii) orientation to time, place and person; (iii) deductive or abstract reasoning; and (iv) judgment as it relates to awareness of safety. Cognitive impairment does not include decline or loss due to a *mental illness*.]]

Covered Accident This term means an *accident* that:

- Occurs while the covered person's coverage under this plan is in effect.
- Results in a bodily *injury*.
- Is not otherwise excluded under the terms of this *plan*; and
- Is covered under the Accident coverage of this *plan*.

Covered Person This term means *you* ¹⁶[or *your dependent spouse*] covered by this *plan*.

Disability or Disabled: These terms mean that an *injury* sustained in a *covered accident* causes physical or mental impairment to such a degree that ¹⁶[(A)] *you* are: (1) not able to perform ¹⁴[on a Full-Time basis] ¹⁵[or a part-time basis] the major duties of your ¹⁷ [Own Job] ¹⁶[or (B) *your covered dependent spouse* is (i) not able to perform two or more *activities of daily living*, on a routine basis, without help, or (ii) *cognitively impaired* and in need of verbal cueing to protect himself or herself or others

³⁹[If you do not have a full-time job at the time of disability, these terms mean that you are (i) not able to perform two or more *activities of daily living*, on a routine basis, without help or (ii) *cognitively impaired* and in need of verbal cueing to protect yourself or others.]

¹⁸ [*You* are not *disabled* if *you* perform any work for wage or profit] ¹⁹ [during the *elimination period*] .]

²⁰ [*You* may be required, on average, to work more than ²¹ [40] hours per

week. In this case, *you* are not disabled if *you* are able to work for ²¹ [40] hours per week.]

Neither loss of a professional or occupational license due to misconduct or unlawful activity or receipt of, or entitlement to, Social Security disability benefits in and of themselves constitute disability under this *plan*.]

¹³**[Doctor:** This term means any medical practitioner *we* are required by law to recognize. He or she must: (1) be properly licensed or certified by the laws of the state where he or she practices; and (2) provide services that are within the lawful scope of his or her practice.

Elimination Period: This term means the period of time *you* ¹⁶[or your covered dependent spouse] must be *disabled*, due to a covered *disability*, before this *plan's* benefits are payable.

³³**[Employee]:** ²² [This term means a person who works for the ³⁴[*employer*] and whose income is reported for tax purposes using a W-2 or 1099 form.]

³⁴**[Employer]:** This term means ¹[ABC Company, Inc] .

¹⁴ [**Full-Time:** This term means *you* regularly work at least the number of hours in the normal work week set by the ³⁴[*employer*] (but not less than [30] hours per week) at: (1) your *employer's* place of business; (2) some place where the *employer's* business requires *you* to travel; or (3) any other place *you* and your ³⁴[*employer*] have agreed upon for the performance of occupational duties.]

Injury: This term means a bodily *injury* due to a *covered accident* that occurs, independent of all other causes, while *you* ¹⁶[or your covered dependent spouse] are covered by this *plan*. *We* will cover a *disability* caused by an *injury* when the *disability* starts within ³² [90 days] of the date of such *injury*.

Maximum Payment Period: This term means the longest time that benefits are paid by this *plan*, subject to all terms, limitations and exclusions.

⁴⁰**[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* have the right to use some other similar standard. A *mental illness* may be caused by, contributed to by, result in physical, biological or chemical factors or symptoms. For purposes of this plan, *mental illness* does not include: (1) irreversible dementia caused by Alzheimer's disease, stroke, trauma or viral infection; or (2) any other condition not typically treated by a psychiatrist, clinical psychologist or other qualified mental health practitioner with psychotherapy or psychotropic drugs.]

Objective Medical Evidence: This term includes, but is not limited to: (1) diagnostic testing; (2) laboratory reports; and (3) 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.

^{23A} [**Own Job:** This term means your job for the ³⁴[*employer*]. *We* use the job description provided by the ³⁴[*employer*] to determine the duties and

requirements of your Own Job.]]

^{13-23B} [**Own Occupation:** This term means the occupation: (1) *you* are routinely performing immediately prior to *disability*; (2) which is your primary source of income prior to *disability*; and (3) for which *you* are covered under this *plan*. Occupation includes any employment, trade or profession that are related in terms of similar tasks, functions, skills, abilities, knowledge, training and experience required by ³⁴[*employers*] from those engaged in a particular occupation in the general labor market in the national economy. Occupation is not specific to a certain ³⁴[*employer*] or a certain location.]

¹⁵ [**Part-Time:** This term means :

- With respect to eligibility for coverage, *you* regularly work at least the number of hours in the normal work week set by the ³⁴[*employer*] (but not less than ²⁴ [15] hours per week), at: (1) your ³⁴[*employer 's*] place of business; (2) some place where the ³⁴[*employer 's*] business requires *you* to travel; or (3) any other place *you* and your ³⁴[*employer*] have agreed upon for the performance of occupational duties.]

Plan: This term means the Accident coverage described in the Policy and this Certificate.

²⁵ [**Proof Of Insurability:** This terms means an application for coverage showing that a person in insurable.]

Recurring disability: This term means a later *disability* that: (1) is related to an earlier *disability* for which this *plan* paid benefits; and (2) meets the conditions described in the *recurring disability* section of this plan.

Regular and Appropriate Care: This term means, with respect to your disabling condition and any other condition which, if left untreated, would adversely affect your disabling condition, *you*: (1) visit a *doctor* as frequently as medically required, according to generally accepted medical standards, to effectively manage these conditions; and (2) 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: (a) *disability*; and (b) 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: (i) the American Medical Association (AMA); (ii) the AMA Board of Medical Specialties; (iii) the Food and Drug Administration; (iv) the Centers for Disease Control; (v) the National Cancer Institute; (vi) the National Institutes of Health; (vii) the Department of Health and Human Services; and (viii) any other agency of similar repute.

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

You or Your: These terms mean the covered ³³[*employee*].]

EXCLUSIONS

The exclusions contained in this policy apply to the ^{26A}[Off the Job] ^{26B}[On & Off the Job] *disability* benefit. This *plan* does not pay any benefits for any period of *disability*:

- During which *you* ¹⁶[or *your* covered dependent spouse] are confined to a facility as a result of your conviction of a crime;
- During which he or she is receiving medical treatment or care outside the United States ⁴²[or Canada] ²⁷ [unless expressly authorized by Us;]
- Which starts before he or she is covered by this *plan*; or
- During which *your* loss of earnings is not solely due to *your disability*.

Claim Provisions

Authority: We have the sole discretionary authority to: (1) interpret the terms of this *plan*; and (2) determine your eligibility for coverage and benefits under the *plan*. 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 *plan* as described in your Certificate's Accident and Health Claims Provisions. For details, *you* can call *us* at ²⁸ [1-800-268-2525.]] ¹⁶[If the claim is being made for your covered dependent spouse, his or her name also should be noted.]

Proof Of Loss: When *we* receive *your* notice, *we* will provide *you* with a claim form for filing proof of loss. This form requires data from the ³⁴[*employer*], *you*, and the *doctor(s)* treating *your injury*. Proof of loss must be given to *us* within the time stated in *your* Certificate's Accident and Health Claims Provisions. 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.

Proof of loss, provided at *your* expense, consists of the following. Failure to provide this information may delay, suspend, reduce or terminate *your* benefits.

- The date *disability* began.
- *Your* last day of *active work*.
- The cause of *disability*.
- The extent of *disability*, including limitations and restrictions ¹⁶[(A)] preventing *you* from performing the major duties of *your* ^{26A}[Own Occupation] ^{26B}[Own Job] and ¹⁶[(B) causing *your* covered dependent spouse to be (i) unable to perform two or more *activities of daily living* on a routine basis without help or (ii) *cognitively impaired* and in need of verbal cueing to protect himself or herself or others.
- ³⁹[If you do not have a full-time job at the time of disability, the extent of *disability*, including limitations and restrictions causing you to, (i) not be able to perform two or more *activities of daily living*, on a routine basis, without help or (ii) be *cognitively impaired* and in need of verbal cueing to protect yourself or others.]
- If *your* occupation requires that *you* carry liability or malpractice insurance, any changes to such insurance that becomes effective on or after the date of *disability*.

- *Objective medical evidence* in support of *you*¹⁶[or your covered dependent spouse's] limitations and restrictions, beginning with the date *disability* began.
- The prognosis of *disability*.
- The name and address of all *doctors*, hospitals and health care facilities where *you*¹⁶[or your covered dependent spouse] have been treated for *your*¹⁶[or your covered dependent spouse's] *disability* since the date *disability* began.
- Proof that *you*¹⁶[or your covered dependent spouse] are currently receiving *regular and appropriate care* from a *doctor*.
- Proof that *you*¹⁶[or your covered dependent spouse] have been receiving *regular and appropriate care* from a *doctor*, from the date *disability* began.

*You*¹⁶[or your covered dependent spouse] must provide *objective medical evidence* from a *doctor* who is not yourself, *your* spouse, child, parent, sibling or business associate.

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

³⁵[The Guardian Life Insurance Company of America
Group Short Term disability Claims Department
P.O. Box 26160
Lehigh Valley, PA 18002-6160.]

Authorization Required: *You*¹⁶[or your covered dependent spouse] must provide *us* with written, unaltered authorizations to obtain medical, financial, vocational, occupational, and governmental information required to determine *our* liability under this *plan*. *You*¹⁶[or your covered dependent spouse] must provide *us* with such authorizations as often as *we* may require, in order that they remain current. Failure to provide such authorizations may delay, suspend or terminate *your*¹⁶[or your covered dependent spouse] benefits.

Right To Request Medical, Financial Or Vocational Assessment: *We* may ask *you*¹⁶[or your covered dependent spouse] to take part in a medical, financial, vocational or other assessment that *we* feel is necessary to determine whether the terms of the *plan* are met. *We* may require this as often as *we* feel is reasonably necessary. *We* will pay for all such assessments. But, if *you*¹⁶[or your covered dependent spouse] postpone a scheduled assessment without *our* approval, *you*¹⁶[or your covered dependent spouse] will be responsible for any rescheduling fees. If *you*¹⁶[or your covered dependent spouse] do not take part in or cooperate with the assessment, *we* have the right to stop or suspend *your*¹⁶[or your covered dependent spouse] payments under this *plan*.

Ongoing Proof Of Loss: To continue to receive payments from this *plan*, *you*¹⁶[or your covered dependent spouse] must give *us* current proof of loss as often as *we* may reasonably require. Ongoing proof of loss must be provided to *us* within ²⁹ [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 the legal representative of *your* estate. Benefits are paid in US dollars.

We pay benefits ³⁰ [biweekly] at the end of the period for which they are payable.

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

Benefits to which *you* ¹⁶[or your covered dependent spouse] are entitled may remain unpaid at *your* ¹⁶[or your covered dependent spouse] death. Such benefits may be paid at *our* discretion to: (1) *your* estate; or (2) *your* spouse, parents, children, or brothers and sisters.

Partial Week Payment: *You* ¹⁶[or your covered dependent spouse] may be disabled for only part of a week. In this case, *we* compute *your* ¹⁶[or your covered dependent spouse's] payment as ³¹ [1/7th] of the benefit to which *you* ¹⁶[or your covered dependent spouse] 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 payment or apply any benefits payable, including the minimum payment, toward recovery of the overpayment.

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

The Guardian Life Insurance Company of America

³⁶[



Vice President, Risk Management & Chief Actuary, Group Insurance]

CERTIFICATE AMENDMENT

(To be attached to certificates issued to ²³[employees])

The certificate is amended by adding the following: to the Accident coverage provisions of this *plan*

SICKNESS HOSPITAL CONFINEMENT BENEFIT

SCHEDULE OF INSURANCE

DAILY HOSPITAL CONFINEMENT BENEFIT AMOUNT FOR COVERED ²³[EMPLOYEE]: ²[\$50-\$1000]

⁸[DAILY HOSPITAL CONFINEMENT BENEFIT AMOUNT FOR COVERED DEPENDENT: ²[\$50-\$1000]]

MAXIMUM BENEFIT PERIOD PER CONFINEMENT FOR COVERED ²³[EMPLOYEE]: ³[30] DAYS

⁸[MAXIMUM BENEFIT PERIOD PER CONFINEMENT FOR COVERED DEPENDENT: ³[30] DAYS]

ELIMINATION PERIOD FOR COVERED ²³[EMPLOYEE]: ⁴[3] DAYS

⁸[ELIMINATION PERIOD FOR COVERED DEPENDENT: ⁴[3] DAYS]

BENEFITS

Hospital Confinement: We pay the amount shown in the schedule of insurance if a *covered person* is confined to a hospital as the result of a *sickness*. This benefit is payable up to the maximum benefit period shown in the schedule of insurance per *covered person*. If a *covered person* is confined for more than one *sickness* at the same time, we will only pay one *hospital confinement* benefit per day.

Recurrent Hospital Confinement: We will treat a *recurrent hospital confinement* as part of the prior claim if the *covered person* has a *sickness* that begins within ²⁶[90] days of the end of the prior claim.

The *recurrent hospital confinement* will be subject to the remaining Maximum Benefit Period under the prior claim.

DEFINITIONS

⁵[**Active Work:** This term means *you* are able to perform, and are performing, all of the regular duties of *your* work for the ²⁴[*employer*], [⁶[on a Full-Time basis] ⁷[or a part-time basis] at: (1) one of the ²⁴[*employer* 's] usual places of business; (2) some place where the ²⁴[*employer* 's] business requires *you* to travel; or (3) any other place *you* and the ²⁴[*employer*] have agreed on for *your* work.

Covered Person This term means an *you* or ⁸[or *your* dependent] covered by this *plan*.

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

Elimination Period: This term means the ⁹[31 days] period which starts on the date that you ⁸[or your dependent] is first admitted to the *hospital*.

²³[**Employee**]: ¹⁰ [This term means a person who works for the ²⁴[*employer*] and whose income is reported for tax purposes using a W-2 or 1099 form.]

²⁴[**Employer**]: This term means ¹ [ABC Company, Inc] .

¹¹ [**Full-Time:** This term means you regularly work at least the number of hours in the normal work week set by the ²⁴[*employer*] (but not less than ¹² [30] hours per week) at: (1) your ²⁴[*employer's*] place of business; (2) some place where the ²⁴[*employer's*] business requires you to travel; or (3) any other place you and your ²⁴[*employer*] have agreed upon for the performance of occupational duties.]

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

- (1) is primarily engaged in providing, by or under the continuous supervision of *doctors*, to *inpatients*, diagnostic services and therapeutic services for diagnosis, treatment and care of sick or injured persons;
- (2) has organized departments of medicine and major surgery;
- (3) has a requirement that every patient must be under the care of a *doctor* or *dentist*;
- (4) provides 24 hour nursing service by or under the supervision of a registered professional nurse (R.N.);
- (5) is duly licensed by the agency responsible for licensing such *hospitals*; and
- (6) is not, other than incidentally: (a) a place of rest; (b) a place primarily for the treatment of tuberculosis; (c) a place for the aged; (d) a place for drug addicts or alcoholics; or (e) a place for convalescent, custodial, educational or rehabilitative care.

Hospital Confinement This term means admission to a hospital as an inpatient for [at least 24 consecutive hours] by a *doctor* for treatment or diagnosis of a *sickness*. *Hospital confinement* does not include confinement for a newborn child following birth, unless the newborn child has a covered *sickness*.

¹³ [**Part-Time:** This term means :

- With respect to eligibility for coverage, you regularly work at least the number of hours in the normal work week set by the ²⁴[*employer*] [(but not less than ¹² [15] hours per week), at: (1) your ²⁴[*employer's*] place of business; (2) some place where the ²⁴[*employer's*] business requires you to travel; or (3) any other place you and your ²⁴[*employer*] have agreed upon for the performance of occupational duties.]

Plan: This term means the Accident coverage described in the *plan* and this Certificate.

Recurrent Hospital Confinement means a *hospital confinement* that is

caused by a *sickness* which is the same as or related to the *sickness* causing the *hospital confinement* in a prior claim.

Sickness: This term means an illness or disease that results in *hospital confinement* and which begins while a *covered person* is covered under this *plan*. Pregnancy is treated as a *sickness* under this *plan*.]

EXCLUSIONS & LIMITATIONS

¹⁵**[Pre-Existing Conditions:** A pre-existing condition is a *sickness*, whether diagnosed or misdiagnosed, and any symptoms of it, for which, in the look back period, you ⁸[or your dependent]: (1) received advice or treatment from a *doctor*; (2) underwent diagnostic procedures ¹⁶ [other than routine screening in the absence of symptoms or suspicion of disease process by a *doctor*] ; (3) was prescribed or take prescription drugs; or (4) received other medical care or treatment, including consultation with a *doctor*.

The “look back period” is the ¹⁷ [three months] before the latest of: (1) the effective date of your ⁸[or your dependent’s] coverage under this plan; (2) the effective date of a change that increases the benefits payable by this plan; and (3) the effective date of a change in your ⁸[or your dependent’s] benefit election that increases the benefit payable by this plan.

¹⁸ [No benefits are payable for *hospital confinement* caused by, contributed to by or resulting from a pre-existing condition; unless the *hospital confinement* starts ⁸[(a)] ¹⁹ [after you complete at least one full day of *active work*] after the date you have been covered under this plan for ²⁰ [12 months] in a row.] ⁸[or (b) the date your dependent has been covered under this *plan* for ²⁰ [12 months] in a row.]

²¹ [For any *hospital confinement* caused by, contributed to by or resulting from a pre-existing condition, We limit the Maximum Payment Period Per Confinement to ²² [two weeks,] unless the *hospital confinement* starts ⁸[(a)] ¹⁹ [after you complete at least one full day of *active work*] after the date you have been covered under this plan for ²⁰ [12 months] in a row. ⁸[or (b) the date your dependent has been covered under this *plan* for ²⁰ [12 months] in a row.]

You ⁸[or your dependent’s] *hospital confinement* caused by, contributed to by or resulting from; a pre-existing condition may begin after: (1) a change which provides for an increase in the benefits payable by this plan; or (2) a change in your ⁸[or your dependent’s] benefit election which increases the benefit payable by this plan. In this case, his or her 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 his or her *hospital confinement* starts ⁸[(a)] ¹⁹ [after you complete at least one full day of *active work*] after the date the change has been in force for ²⁰ [12 months] in a row ⁸[or (b) the date your dependent has been covered under this *plan* for ²⁰ [12 months] in a row.]

We do not cover any hospital confinement that starts before your coverage

under this plan.]

¹⁵ [**Prior Coverage Credit:** If this plan replaces a similar hospital confinement plan the ²⁴[*employer*] had with another insurer, the pre-existing condition provision may not apply to *you*. This plan must start right after the old plan ends.

The pre-existing condition provision will be waived for *you* if *you*: (1) are at active work on the effective date of this *plan*; and (2) have fulfilled the requirements of any pre-existing condition provision of the old plan.

You may have been covered under the old plan when it ended, but have not met the requirements of any pre-existing condition provision of the old plan. In that case, *we* credit any time used to meet the old plan's pre-existing condition provision toward meeting this *plan's* pre-existing conditions provision. *You* must: (1) enroll for coverage under this *plan* on or before this *plan's* effective date; and (2) be at active work on the effective date of this *plan*.

But, *we* limit your daily *hospital confinement* benefit under this *plan* if: (1) it is more than the daily *hospital confinement* benefit for which *you* were covered under the old plan; (2) *you* become disabled due to a pre-existing condition; and (3) this *plan* pays benefits for such *hospital confinement* because *we* credit time as explained above. In this case, *we* limit the daily *hospital confinement* benefit to the amount to which *you* would have been entitled under the old plan.

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

Exclusions: The exclusions contained in this plan apply to the Hospital Sickness Rider. In addition, this *plan* does not pay benefits for *hospital confinement* caused by, or related to:

- Injury
- Treatment for dental care or dental care procedures
- Elective procedures and/or cosmetic surgery or reconstructive surgery; unless it is a result of infection congenital defect, or other disease
- ²⁷[A *sickness* arising out of or in the course of any employment for wage or profit.]

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

The Guardian Life Insurance Company of America

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SPECIMEN
[Handwritten signature]

Vice President, Risk Management & Chief Actuary, Group Insurance]