YOUR GROUP INSURANCE PLAN BENEFITS

WILLAMETTE UNIVERSITY

CLASS 0001

AD&D, OPTIONAL LIFE, LTD, LIFE, VOLUNTARY AD&D

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

This Booklet Includes All Benefits For Which You Are Eligible.

You are covered for any benefits provided to you by the policyholder at no cost.

But if you are required to pay all or part of the cost of insurance you will only be covered for those benefits you elected in a manner and mode acceptable to Guardian such as an enrollment form and for which premium has been received by Guardian.

"Please Read This Document Carefully".

B853.0012

CERTIFICATE OF COVERAGE

Guardian
7 Hanover Square
New York, New York 10004

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

Group Policy No.	Certificate No.	Effective Date
Issued To		

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

The Guardian Life Insurance Company of America

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

CGP-OR-01 B851.0003

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The forms listed below are attached to and made part of this certificate. The listed forms describe the coverages which the *Planholder* has elected.

All terms in italics are defined terms with special meanings. Definitions are shown in the Glossary or are defined where they are used.

GENERAL PROVISIONS

As used in this certificate:

"Accident and health" means any accidental death and dismemberment, dental, long term disability, short term disability, vision or critical illness insurance provided by this *plan.*

"Covered person" means *you* or any of *your* dependents insured by this *plan,* except in the "Repayment" section where "covered person" has a special meaning. See that section for details.

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

"Employer" and "Planholder" mean the employer who purchased this *plan.*

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

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

"You," "your," and "certificateholder" mean an *employee* covered by this *plan.*

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 contract, *plan* or certificate of insurance is to be issued; (b) waive or alter any provisions of any insurance contract or *plan,* or any requirements of *Guardian;* (c) bind *us* by any statement or promise relating to any insurance contract issued or to be issued; or (d) accept any information or representation which is not in a signed application.

Incontestability

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

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

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

Examination and Autopsy

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

Conformity with State Statute

The group *plan* is governed by the laws of the state of Oregon. However, with respect to this certificate, any terms which are in conflict with any insurance statute or regulation of the jurisdiction where the *certificateholder* resides and which are applied regardless of where the policy is issued, are hereby amended to conform to the minimum requirements of such statute or regulation.

This provision will apply only to those *certificateholders* who are residents of that other jurisdiction and who are insured by the group *plan* on the date the claim for benefits is made.

Accident and Health Claims Provisions

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

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

We will not void or reduce a claim if notice is not given within the required time. But, notice must be given to *us* as soon as reasonably possible.

Claim Forms *We* will provide forms for filing proof of loss within 15 days of receipt of notice. But if *we* do not provide the forms on time, *we* will accept a written description and adequate documentation of the injury or sickness that is the basis of the claim as proof of loss. The nature and extent of the loss for which the claim is being made must be detailed.

Proof of Loss Written proof of loss must be furnished to *us* at *our* designated office.

This proof must be furnished within 90 days of the loss.

We will not void or reduce a claim if proof is not given within the required time. But, proof must be given as soon as reasonably possible and, except in the absence of legal capacity, no later than one year from the time proof is otherwise required.

Claims Communications *We* will reply, not later than the 30th day after receipt, to all pertinent communications about a pending claim from a claimant that reasonably indicates a response is expected.

Payment of Benefits *We* completely discharge *our* liability for any amounts paid as follows: *We* will pay benefits for loss of income at least once per month for as long as *we* are liable, provided periodic written proof of loss is given to *us* as stated above. Any balance remaining unpaid at the end of *our* liability will be paid as soon as *we* receive due written proof .

We will pay all other *accident and health* benefits as soon as *we* receive written proof of loss.

Unless otherwise required by law or regulation, *we* pay all *accident and health* benefits to *you* if *you* are living. If *you* or any other payee is not living, *we* have the right to pay all *accident and health* benefits, except accidental death and dismemberment benefits, to one of the following: (a) *your* estate; (b) *your* spouse; (c) *your* parents; (d) *your* children; (e) *your* brothers and sisters; or (f) any unpaid provider of health care services.

See the section of this *plan* that describes accidental death and dismemberment benefits for *employees* for how these benefits are paid.

Legal Actions No legal action against this *plan* will be brought until 60 days from the date proof of loss has been given as stated above. And, no legal action will be brought against this *plan* after three years from the date written proof of loss is required to be given.

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

All Options

Repayment

We will not pay any benefits under this *plan,* to or on behalf of a *covered person,* who has received payment in whole or in part from a *third party,* or its insurer for past or future loss of earnings or accidental death or dismemberment benefits, resulting from the negligence, intentional act, or no-fault tort liability of a *third party.*

If a *covered person* or his or her beneficiary makes a claim to *us* for loss of earnings or accidental death or dismemberment benefits under this *plan* prior to receiving payment from a *third party* or its insurer, the *covered person* or his or her beneficiary must agree, in writing, to repay *us* from any amount of money they receive from the *third party,* or its insurer. This agreement will not apply to any damages awarded by a court for pain and suffering.

The repayment will be equal to the amount of benefits paid by *us.* However, the *covered person* or his or her beneficiary may deduct the *reasonable pro-rata expenses incurred* in effecting the *third party* payment from the repayment to *us.*

The repayment agreement will be binding upon the *covered person* or his or her beneficiary whether: (a) the payment received from the *third party,* or its insurer, is the result of a legal judgement, an arbitration award, a compromise settlement, or any other arrangement; or (b) the *third party,* or its insurer, has admitted liability for the payment; or (c) the, or loss of earnings, or accidental death or dismemberment benefits are itemized in the *third party* payment.

As used in this provision:

"Covered person" means *you* or your dependent, including the legal representative of a minor or incompetent, insured by this *plan.*

"Reasonable pro-rata expenses" are those costs, such as lawyers fees and court costs, *incurred* to effect a third party payment, expressed as a percentage of such payment.

"Third party" means anyone other than *Guardian,* the *employer* or the *covered person.*

ELIGIBILITY FOR LIFE AND ACCIDENTAL DEATH AND DISMEMBERMENT COVERAGES

B864.0008

All Options

Employee Coverage

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

Other Conditions *You* (unless *you* are a *qualified retiree)* must:

(a) be legally working in the United States, or working outside of the United States for a United States based employer in a country or region approved by us.

(b) be regularly working at least the number of hours in the normal work week set by *your employer* (but not less than 30 hours per week), at:

(i) *your employer's* place of business;

(ii) some place where *your employer's* business requires *you* to travel; or

(iii) any other place *you* and *your employer* have agreed upon for performance of occupational duties.

If *you* must pay all or part of the cost of employee coverage, *we* will not insure *you* until *you* enroll and agree to make the required payments. If *you* do this: (a) more than 31 days after *you* first become eligible; or (b) after *you* previously had coverage which ended because *you* failed to make a required payment, *we* also ask for proof that *you* are insurable. And *you* will not be covered until *we* approve that proof in writing.

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

If *your* employment ends before *you* meet any *proof of insurability* requirements that apply to *you, you* will still have to meet those requirements if *you* are later re-employed.

CGP-OR-LIFE-01 B864.0193

All Options

When Your Coverage Starts

Employee benefits that do not require proof that *you* are insurable are scheduled to start on the effective date shown on the sticker attached to the inside front cover of this booklet.

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

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

If *you* are a *qualified retiree, you* can not be confined to a hospital or other health care facility or home confined on the scheduled effective date of coverage. We will postpone *your* coverage until the day after *you* are discharged from such facility or are no longer home confined. And *you* must have also met all of the applicable conditions of eligibility and any applicable waiting period in order for coverage to start.

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

CGP-OR-LIFE-01 B864.0145

All Options

Delayed Effective Date For Employee Voluntary Life Coverage

With respect to this *plan's* employee voluntary group term life insurance, if *you* are not *actively at work* on the date *your* coverage is scheduled to start, due to sickness or injury, *we* will postpone coverage for an otherwise covered loss due to that condition. *We* will postpone such coverage until *you* complete 10 consecutive days of *active work* without missing a work day due to the same condition.

Coverage for an otherwise covered loss due to all other conditions will start on the date *you* return to *active work.*

CGP-OR-LIFE-01 B864.0027

All Options

When Your Coverage Ends

If *you* are an active *employee, your* coverage ends on the date *you* cease *active work* for any reason. Such reasons include disability, death, retirement (except for *qualified retirees),* layoff, leave of absence and the end of employment.

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

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

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

For Employee Basic Life and Accidental Death and Dismemberment Insurance pursuant to a severance agreement with the Employer for up to the earlier of: 3 years; or the date that you attain your Social Security Normal Retirement Age.

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

CGP-OR-LIFE-01 B864.0204-R

All Options

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

Important Notice

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

Continuation of Coverage

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

If Your Group Coverage Would End

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

When Continuation Ends

Insurance may continue until the earliest of the following:

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

Definitions

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

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

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

CGP-OR-LIFE-01 B864.0169

All Options

Dependent Coverage

B864.0043

All Options

Eligible Dependents for Voluntary Dependent Life and Accidental Death and Dismemberment Benefits

Your eligible dependents are: *your* legal spouse who is under age 70; and *your* unmarried dependent children who are 14 or more days old, until the day they reach age 26; and *your* unmarried dependent children, from age 26 until the day they reach age 26, who are enrolled as full-time students at accredited schools.

Your legal spouse includes a domestic partner when the domestic partnership is in accordance with Oregon law. We treat the domestic partner as a spouse in marriage and the domestic partnership as a marriage. Any reference to divorce or annulment shall also mean the dissolution of a domestic partnership.

CGP-OR-LIFE-01 B864.0232

All Options

Adopted Children and Step-Children

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

Dependents Not Eligible

We exclude any dependent who is on active duty in any armed force.

CGP-OR-LIFE-01 B864.0255

All Options

Proof of Insurability

We require proof that a dependent is insurable, if *you* : (a) enroll a dependent and agree to make the required payments after the end of the enrollment period; (b) in the case of a *newly acquired dependent,* other than the first newborn child, have other eligible dependents who *you* have not elected to enroll; or (c) in the case of a newly acquired dependent, have other eligible dependents whose coverage previously ended because *you* failed to make the required contributions, or otherwise chose to end such coverage.

A dependent is not insured by any part of this *plan* that requires such proof until *you* give *us* this proof, and *we* approve it in writing.

If the dependent coverage ends for any reason, including failure to make the required payments, *your* dependents will not be covered by this *plan* again until *you* give *us* new proof that they are insurable and *we* approve that proof in writing.

CGP-OR-LIFE-01 B864.0050

All Options

When Dependent Coverage Starts

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

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

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

If *you* do this after the *enrollment period* ends, *your* dependent coverage is subject to *proof of insurability* and will not start until *we* approve that proof in writing.

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

A *newly acquired dependent* will be covered for those dependent benefits not subject to *proof of insurability* from the date the dependent is first eligible, if you notify us and agree to make any additional payments within 31 days of the date the dependent is first eligible. If you notify us and agree to make any additional payments more than 31 days after the date the dependent is first eligible, a *newly acquired dependent* will be covered from the date you notify us and agree to make any additional payments.

If proof of insurability is required for dependent benefits as explained above, those benefits are scheduled to start, subject to the "Exception" stated below, on the effective date shown in the "Endorsement" section of your application, provided that you send us the proof we require and we approve that proof in writing.

A copy of the approved application is furnished to you.

CGP-OR-LIFE-01 B864.0168-R

All Options

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

CGP-OR-LIFE-01 B864.0054

All Options

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

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

An individual dependent's coverage ends when he or she stops being an eligible dependent. This happens to a child at 12:01 a.m. on the date the child attains this *coverage's* age limit, when he or she marries, or when a step-child is no longer dependent on *your* support and maintenance. It happens to a spouse when a marriage ends in legal divorce or annulment, and with respect to voluntary life and accidental death and dismemberment coverage, it happens at 12:01 a.m. on the date the spouse reaches age 70.

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

All Options

GROUP TERM LIFE AND ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE SCHEDULE

CGP-OR-LIFE-01 B865.0003

All Options

Employee Basic Term Life Insurance

All Options

Basic Term Life Insurance Amount An amount equal to 200% of *your* annual earnings, rounded to the next higher $1,000.00, if not already a multiple thereof, to a maximum of $1,000,000.00, but not less than $20,000.00.

CGP-OR-LIFE-01 B865.0017

All Options

Redetermination Subject to any of the *plan's proof of insurability* requirements, *your* basic life insurance amount will be redetermined each April 1st , to an amount in accordance with the parameters enumerated above, on the basis of *your* then current annual earnings. If the *employee* is not *actively at work* on that date, his or her insurance amount will be redetermined on the date he or she returns to *active work.* However, if *your* benefits were previously reduced because of an age or retirement reduction, the benefit will not be redetermined due to the change in earnings.

All Options

Earnings Definition Annual earnings means *your* annual rate of earnings excluding bonuses, commissions, expense accounts, overtime pay and any other extra compensation. *We* do not include pay for hours worked or billed over 40 per week.

Any compensation based on *your* annual earnings which is deposited into a cash or deferred compensation plan, or salary reduction plan, qualified under IRC Section 401(k), 403(b) or 457 is included. Earnings based on excluded income and employer contributions deposited into such 401(k), 403(b) or 457 plan are excluded.

Annual earnings is calculated using the earnings components described above applicable as of the most current redetermination date on which *your employer* has provided earnings data to *us.* Proof of earnings will be required. Proof may consist of: (1) copies of *your* U.S. Individual Income Tax Returns; (2) a statement from a certified public accountant; or (3) any other records *we* agree to accept.

CGP-OR-LIFE-01 B865.0731

All Options

Reduction of Insurance Amount Based on Age

If *you* are less than age 70 when *your* insurance under this *plan* starts, *your* insurance amount is reduced, on the date *you* reach age 70, by 33% of the amount which otherwise applies to *your* classification and/or option. But in no case will such reduced amount be less than $1,000.00.

The preceding reduction also applies to *your* initial insurance amount if *your* insurance starts after *you* reach age 70 but before *you* reach age 75.

If *you* are less than age 75 when *your* insurance under this *plan* starts, *your* insurance amount is reduced, when *you* reach age 75, by 50% of the amount which otherwise applies to *your* classification and/or option. But in no case will such reduced amount be less than $1,000.00.

The preceding reduction also applies to *your* initial insurance amount if *your* insurance starts after *you* reach age 75.

CGP-OR-LIFE-01 B865.0041

All Options

Proof of Insurability Requirements

Proof of insurability requirements apply to *your* basic term life insurance. Such requirements may apply to *your* full benefit amount or just part of it. When *proof of insurability* requirements apply, it means *you* must submit to *us* proof that *you* are insurable, and *we* must approve *your* proof in writing before *your* insurance, or the specified part becomes effective.

We require proof as follows:

All Options

We require proof for amounts of basic term life insurance in excess of $600,000.00.

All Options

For Employees Under Age 65

After *we* have approved the initial excess amount, *we* require proof for additional amounts on the earlier of: (a) the date further salary increases, when combined, would increase *your* group term life benefit by more than $25,000.00 since *we* last approved proof for *you;* or (b) on the date it has been three years or more since *we* last approved *you.*

If this *plan's* maximum group term life benefit exceeds $1,000,000.00, *we* require proof for all amounts in excess of $1,000,000.00.

CGP-OR-LIFE-01 B865.0063

All Options

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

All Options

Basic AD&D Insurance Amount

An amount equal to 200% of *your* annual earnings, rounded to the next higher $1,000.00, if not already a multiple thereof, to a maximum of $1,000,000.00, but not less than $20,000.00.

CGP-OR-LIFE-01 B865.0076

All Options

Spousal Education and Retraining Benefit

Lifetime Maximum Benefit

$20,000

Maximum Number of Benefit Payments

Full-Time Post Secondary Education 8

Part-Time Post Secondary Education 4

CGP-OR-LIFE-01 B865.0079

All Options

Dependent Child Education Benefit

Lifetime Maximum Benefit

$20,000.00 per eligible dependent

Maximum Number of Benefit Payments

8 per lifetime per eligible dependent

Maximum Benefit Period

6 years from the date the first education benefit is made; per eligible dependent.

CGP-OR-LIFE-01 B865.0080

All Options

Redetermination

Subject to any of the *plan's* proof of insurability requirements, *your* basic AD&D insurance amount will be redetermined each April 1st , to an amount in accordance with the parameters enumerated above, on the basis of *your* then current annual earnings. If the *employee* is not *actively at work* on that date, the insurance amount will be redetermined on the date he or she returns to *active work.* However, if *your* benefits were previously reduced because of an age or retirement reduction, the benefit will not be redetermined due to the change in earnings.

All Options

Earnings Definition

Annual earnings means *your* annual rate of earnings excluding bonuses, commissions, expense accounts, overtime pay and any other extra compensation. *We* do not include pay for hours worked or billed over 40 per week.

Any compensation based on *your* annual earnings which is deposited into a cash or deferred compensation plan, or salary reduction plan, qualified under IRC Section 401(k), 403(b) or 457 is included. Earnings based on excluded income and employer contributions deposited into such 401(k), 403(b) or 457 plan are excluded.

Annual earnings is calculated using the earnings components described above applicable as of the most current redetermination date on which *your employer* has provided earnings data to *us.* Proof of earnings will be required. Proof may consist of: (1) copies of *your* U.S. Individual Income Tax Returns; (2) a statement from a certified public accountant; or (3) any other records *we* agree to accept.

CGP-OR-LIFE-01 B865.0731

All Options

Reduction of Basic AD&D Amount Based on Age

If *you* are less than age 70 when *your* insurance under this *plan* starts, *your* insurance amount is reduced, on the date *you* reach age 70, by 33% of the amount which otherwise applies to *your* classification and/or option. But in no case will such reduced amount be less than $1,000.00.

The preceding reduction also applies to *your* initial insurance amount if *your* insurance starts after *you* reach age 70 but before *you* reach age 75.

If *you* are less than age 75 when *your* insurance under this *plan* starts, *your* insurance amount is reduced, when *you* reach age 75, by 50% of the amount which otherwise applies to *your* classification and/or option. But in no case will such reduced amount be less than $1,000.00.

The preceding reduction also applies to *your* initial insurance amount if *your* insurance starts after *you* reach age 75.

CGP-OR-LIFE-01 B865.0102

All Options

Proof of Insurability Requirements

Proof of insurability requirements apply to *your* basic AD&D insurance. Such requirements may apply to *your* full benefit amount or just part of it. When *proof of insurability* requirements apply, it means *you* must submit to *us* proof that *you* are insurable, and *we* must approve *your* proof in writing before *your* insurance, or the specified part becomes effective.

We require proof as follows:

All Options

We require proof for amounts of basic AD&D insurance in excess of $600,000.00.

All Options

For Employees Under Age 65

After we have approved the initial excess amount, we require proof for additional amounts on the earlier of: (a) the date further salary increases, when combined, would increase an employee's group AD&D benefit by more than $50,000.00 since we last approved proof for the employee; or (b) on the date it has been three years or more since we last approved the employee.

If this plan's maximum group AD&D benefit exceeds $1,000,000.00, we require proof for all amounts in excess of $1,000,000.00.

CGP-OR-LIFE-01 B865.0884

All Options

Employee Voluntary Contributory Term Life Insurance

CGP-OR-LIFE-01 B865.0124

All Options

Voluntary Life Election

You may choose to be insured under the plan of voluntary term life insurance shown below. *You* must notify *your* employer of *your* election and pay the required premium.

CGP-OR-LIFE-01 B865.0127

All Options

Voluntary Term Life Insurance Amount

Plan A

You may elect amounts of voluntary term life insurance in increments of $10,000.00, but *your* amount may not be less than $10,000.00 and the amount may not exceed the lesser of: (1) $600,000.00 or (2) 5 times your annual salary.

CGP-OR-LIFE-01 B865.0135-R

All Options

Reduction of Voluntary Life Insurance Amount Based on Age

If *you* are less than age 70 when *your* insurance under this *plan* starts, *your* insurance amount is reduced, on the date *you* reach age 70, by 33% of the amount which otherwise applies to *your* classification and/or option. But in no case will such reduced amount be less than $1,000.00.

The preceding reduction also applies to *your* initial insurance amount if *your* insurance starts after *you* reach age 70 but before *you* reach age 75.

If *you* are less than age 75 when *your* insurance under this *plan* starts, *your* Voluntary life insurance amount is reduced, when *you* reach age 75, by 50% of the amount which otherwise applies to *your* classification and/or option. But in no case will such reduced amount be less than $1,000.00.

The preceding reduction also applies to *your* initial insurance amount if *your* insurance starts after *you* reach age 75.

CGP-OR-LIFE-01 B865.0179

All Options

Proof of insurability Requirements

Proof of insurability requirements apply to *your* voluntary term life insurance. Such requirements may apply to *your* full benefit amount or just part of it. When *proof of insurability* requirements apply, it means *you* must submit to *us* proof that you are insurable, and *we* must approve *your* proof in writing before *your* insurance, or the specified part becomes effective.

We require proof as follows:

CGP-OR-LIFE-01 B865.0188

All Options

We require proof before *you* switch from *your* current increment of voluntary term life insurance to an increment which provides a greater amount of insurance.

All Options

We require proof before *we* will insure *you* who enrolls for voluntary term life insurance after the time allowed for enrolling as specified in this *plan.*

All Options

We require proof for amounts of voluntary term life insurance in excess of $300,000.00.

All Options

For Employees Under Age 65

After *we* have approved the initial excess amount, *we* require proof for additional amounts on the earlier of: (a) the date further salary increases, when combined, would increase *your* voluntary life benefit by more than $25,000.00 since *we* last approved proof for *you;* or (b) on the date it has been three years or more since *we* last approved *you.*

If this *plan's* maximum voluntary life benefit exceeds $1,000,000.00, *we* require proof for all amounts in excess of $1,000,000.00.

CGP-OR-LIFE-01 B865.0239

All Options

Employee Voluntary Contributory Accidental Death and Dismemberment Insurance (AD&D)

All Options

Voluntary AD&D Enrollment Period

You may choose to be insured under the plan of voluntary AD&D insurance which is equal to 100% of the voluntary life amount. You may only be insured under one plan at a time. You must notify the employer of your election and pay the required premium.

CGP-OR-LIFE-01 B865.0758

All Options

Your Voluntary AD&D Insurance Amount

Plan A

You may elect amounts of voluntary AD&D insurance in increments of $10,000.00, but your amount may not be less than $10,000.00 and the amount may not exceed the lesser of: (1) $600,000.00 or (2) 5 times your annual salary.

CGP-OR-LIFE-01 B865.0757-R

All Options

Spousal Education and Retraining Benefit

Lifetime Maximum Benefit

$20,000

Maximum Number of Benefit Payments

Full-Time Post Secondary Education 8

Part-Time Post Secondary Education 4

CGP-OR-LIFE-01 B865.0277

All Options

Dependent Child Education Benefit

Lifetime Maximum Benefit	$20,000.00 per eligible dependent
Maximum Number of Benefit Payments	8 per lifetime per eligible dependent
Maximum Benefit Period	6 years from the date the first education benefit is made; per eligible dependent.

CGP-OR-LIFE-01 B865.0278

All Options

Reduction of Voluntary AD&D Amount Based on Age

If an employee is less than age 70 when his or her insurance under this plan starts, his or her insurance amount is reduced, on the date he or she reaches age 70, by 33% of the amount which otherwise applies to his or her classification and/or option. But in no case will such reduced amount be less than $1,000.00.

The preceding reduction also applies to an employee's initial insurance amount if his or her insurance starts after he or she reaches age 70 but before he or she reaches age 75.

If an employee is less than age 75 when his or her insurance under this plan starts, the employee's optional life insurance amount is reduced, when he or she reaches age 75, by 50% of the amount which otherwise applies to his or her classification and/or option. But in no case will such reduced amount be less than $1,000.00.

The preceding reduction also applies to an employee's initial insurance amount if his or her insurance starts after he or she reaches age 75.

CGP-OR-LIFE-01 B865.0766

All Options

Dependent Voluntary Term Life Insurance

Dependent Voluntary Life Enrollment Period

You may choose one of the plans of dependent spouse voluntary term life insurance, and one of the plans of dependent child voluntary term life insurance shown below. *You* may only be insured under one spouse plan and one child plan at a time. *You* must notify *your* employer of *your* elections and pay the required premium.

You may switch to other plans during the dependent voluntary life enrollment period. Each year, the dependent voluntary life enrollment period starts on March 1st and ends on March 31st . *We* may require *proof of insurability* before *you* become insured under a new plan of benefits. See below for details. If *we* do not require proof, *you* will become insured under a new plan of benefits as of the April 1st which coincides with or next follows the end of the dependent voluntary life enrollment period.

CGP-OR-LIFE-01 B865.0339

All Options

Your Optional Dependent Spouse Term Life Insurance Amount

Plan A

You may elect amounts of optional dependent spouse term life insurance, up to 100% of the employee's optional term life amount, in increments of $10,000.00, but the amount may not be less than $10,000.00 and may not exceed $250,000.00.

CGP-OR-LIFE-01 B865.0963

All Options

Voluntary Dependent Child Insurance Amount

Plan A

Child's Age At Death	Benefit Amount
At least 14 days but less than 6 months	$ 5,000.00
At least 6 months but less than 26 years	$ 5,000.00
At least 26 years but less than 26 years if a full-time student	$ 5,000.00

CGP-OR-LIFE-01 B865.0358

All Options

Voluntary Dependent Child Insurance Amount

Plan B

Child's Age At Death	Benefit Amount
At least 14 days but less than 6 months	$ 10,000.00
At least 6 months but less than 26 years	$ 10,000.00
At least 26 years but less than 26 years if a full-time student	$ 10,000.00

CGP-OR-LIFE-01 B865.0358

All Options

In no event may the insurance amount of *your* dependent spouse exceed 100% of *your* voluntary term life insurance amount.

CGP-OR-LIFE-01 B865.0947

All Options

In no event may the insurance amount of *your* dependent child exceed 100% of *your* voluntary term life insurance amount.

CGP-OR-LIFE-01 B865.0950

All Options

Proof of Insurability Requirements

Proof of insurability requirements apply to *your* dependent voluntary term life insurance. Such requirements may apply to the full benefit amounts or just part of them. When *proof of insurability* requirements apply, it means *you* must submit to *us* proof that a dependent is insurable, and *we* must approve the proof in writing before the insurance, or the specified part becomes effective.

We require proof as follows:

CGP-OR-LIFE-01 B865.0364

All Options

We require proof before *you* switch from *your* current increment of dependent voluntary term life insurance to an increment which provides a greater amount of insurance.

CGP-OR-LIFE-01 B865.0365

All Options

We require proof before *we* will insure any spouse who is enrolled for dependent voluntary term life insurance after the time allowed for enrolling as specified in this *plan.*

CGP-OR-LIFE-01 B865.0371

All Options

We require proof for any amount of dependent voluntary term life insurance in excess of $ 20,000.00 with respect to *your* dependent spouse.

CGP-OR-LIFE-01 B865.0372

All Options

We require proof before *we* will insure any child who is enrolled for dependent voluntary term life insurance after the time allowed for enrolling as specified in this *plan.*

CGP-OR-LIFE-01 B865.0384

All Options

We require proof for any increase in the amount of- dependent voluntary term life insurance with respect to a dependent child.

CGP-OR-LIFE-01 B865.0388

All Options

Dependent Voluntary Accidental Death and Dismemberment Insurance (AD&D)

CGP-OR-LIFE-01 B865.0775

All Options

Dependent Voluntary AD&D Election

You may choose the plan of dependent spouse voluntary AD&D insurance, and the plan of dependent child voluntary AD&D insurance which is equal to 100% of the voluntary spouse and child life amount as shown below.

CGP-OR-LIFE-01 B865.0776

All Options

Dependent Spouse Voluntary AD&D Insurance Amount

Plan A

An amount of voluntary dependent child term AD&D Insurance, as elected by you, up to 100% of your amount of voluntary term AD&D insurance, in increments of $10,000.00, but the amount may not be less than $10,000.00 and may not exceed $250,000.00.

CGP-OR-LIFE-01 B865.0958

All Options

Dependent Child Voluntary AD&D Insurance Amount

Plan A

Child's Age At Death	Benefit Amount
At least 14 days but less than 6 months	$5,000.00
At least 6 months but less than 26 years	$ 5,000.00
At least 26 years but less than 26 years if a full-time student	$ 5,000.00

CGP-OR-LIFE-01 B865.0885

All Options

Dependent Child Voluntary AD&D Insurance Amount

Plan B

Child's Age At Death	Benefit Amount
At least 14 days but less than 6 months	$10,000.00
At least 6 months but less than 26 years	$ 10,000.00
At least 26 years but less than 26 years if a full-time student	$ 10,000.00

CGP-OR-LIFE-01 B865.0889

All Options

In no event may the insurance amount of a dependent spouse exceed 100% of the insurance amount of an employee.

CGP-OR-LIFE-01 B865.0954

All Options

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

CGP-OR-LIFE-01 B865.0955

All Options

Proof of Insurability Requirements

Proof of insurability requirements apply to your voluntary AD&D insurance. Such requirements may apply to your full *benefit amount* or just part of it. When *proof of insurability* requirements apply, it means you must submit to us *proof* that you're insurable, and we must approve your *proof* in writing before your insurance, or the specified part becomes effective.

We require *proof* as follows:

CGP-OR-LIFE-01 B865.0856

All Options

We require *proof* before we will insure any *employee* who enrolls for voluntary accidental death and dismemberment insurance after the time allowed for enrolling as specified in this *plan.*

CGP-OR-LIFE-01 B865.0860

All Options

We require *proof* before an *employee* switches from his or her current *plan* of voluntary accidental death and dismemberment insurance to a *plan* which provides greater benefits.

CGP-OR-LIFE-01 B865.0862

LIFE INSURANCE

B866.0044

All Options

Employee Basic Group Term Life Insurance

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

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

The Beneficiary *You* decide who gets this insurance if *you* die. *You* should have named *your* beneficiary on *your* enrollment form. *You* can change *your* beneficiary at any time by giving *your employer* written notice, unless *you* have assigned this insurance. But the change will not take effect until *your employer* gives *you* written confirmation of the change. This change will take effect on the date the notice is signed, subject to *our* receipt of the notice. But, it will not apply to any amount paid by *us* before *we* receive the notice.

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

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

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

We will recognize an assignee as the owner of the rights assigned only if: (a) the assignment is in writing and signed by *you;* and (b) a signed or certified copy of the written assignment has been received and approved by *us.*

We will not be responsible for legal, tax or other effects of any assignment, or for any benefits we pay under this *plan* before *we* receive and approve any assignment.

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

Payment to a Minor or Incompetent If *your* beneficiary is a minor or incompetent, *we* will pay this insurance to the person who cares for and supports the beneficiary. *We* have the right to pay in monthly installments. *We* completely discharge *our* liability for any amounts paid this way.

Payment of Funeral or Last Illness Expenses

We have the option of paying up to $500.00 of this insurance to any person who incurs expenses for *your* funeral or last illness.

Payment of the Life Benefit

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

If a lump sum payment is requested, and if *we* fail to pay this insurance within 30 days of receipt of proof of death, *we* will pay interest on any amount due and unpaid after the end of the 30 day period. Interest will be computed at the current withdrawal interest rate for life policies issued by *us. We* will compute the interest from the date of *your* death until the date of payment.

We completely discharge *our* liability for any amounts paid this way.

CGP-OR-LIFE-01 B866.0042

All Options

Employee Voluntary Group Term Life Insurance

Life Benefit

Subject to the limitations and exclusions below, if *you* die while insured for this benefit, *we* will pay *your* beneficiary the amount shown in the schedule for the plan of benefits *you* have elected. The life benefit may be subject to reductions based on *your* age. These reductions are also shown in the schedule. *Your* benefit amount, a portion thereof, or increases in such amount may not become effective until *you* submit *proof of insurability* to *us,* and *we* approve it in writing. These requirements are also shown in the schedule.

Proof of Death

Subject to all of the terms of this *plan, we* will pay this insurance as soon as *we* receive written proof of death which is acceptable to *us.* This should be sent to *us* as soon as possible.

Suicide Exclusion

We pay no benefits if *your* death is due to suicide, if such death occurs within two years from *your* voluntary group term life insurance effective date under this *plan.* Also, *we* pay no increased benefit amount if *your* death is due to suicide, if such death occurs within two years from the effective date of the increase.

Seatbelt and Airbag Benefits

If *you* die as a direct result of a motor vehicle accident while properly wearing a seatbelt, *we* will increase *your* benefit amount by $10,000.00. And if *you* die as a direct result of a motor vehicle accident while both: (a) properly wearing a seatbelt; and (b) sitting in a seat equipped with an airbag; *we* will increase *your* benefit amount by another $5,000.00, for a total increase of $15,000.00.

The Beneficiary

You decide who gets this insurance if *you* die. *You* should have named *your* beneficiary on *your* enrollment form. *You* can change *your* beneficiary at any time by giving *your employer* written notice, unless *you* have assigned this insurance. This change will take effect on the date the notice is signed, subject to *our* receipt of the notice. But, it will not apply to any amount paid by *us* before *we* receive the notice.

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

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

Assigning this Life Insurance

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

We will recognize an assignee as the owner of the rights assigned only if: (a) the assignment is in writing and signed by you; and (b) a signed or certified copy of the written assignment has been received and approved by *us.*

We will not be responsible for legal, tax or other effects of any assignment, or for any benefits *we* pay under this *plan* before *we* receive and approve any assignment.

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

Payment to a Minor or Incompetent

If *your* beneficiary is a minor or incompetent, *we* will pay this insurance to the person who cares for and supports the beneficiary. *We* have the right to pay in monthly installments. *We* completely discharge *our* liability for any amounts paid this way.

Payment of Funeral or Last Illness Expense

We have the option of paying up to $500.00 of this insurance to any person who incurs expenses for *your* funeral or last illness.

Payment of the Life Benefit

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

If a lump sum payment is requested, and if *we* fail to pay this insurance within 30 days of receipt of proof of death, *we* will pay interest on any amount due and unpaid after the end of the 30 day period. Interest will be computed at the current withdrawal loan interest rate for life policies issued by *us. We* will compute the interest from the date of *your* death until the date of payment.

We completely discharge *our* liability for any amounts paid this way.

All Options

THE FOLLOWING PROVISION APPLIES TO EMPLOYEE BASIC TERM LIFE INSURANCE:

All Options

Converting This Group Term Life Insurance

If Employment or Eligibility Ends

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

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

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

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

If the Group Plan Ends or Group Life Insurance Is Dropped

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

If *you:* (a) are not disabled, as defined in the "Extended Life Benefit With Waiver of Premium" section, when this coverage ends; and (b) *you* have been insured by a *Guardian* group life plan for at least five years, *you* can convert to a permanent life insurance policy. But, the amount *you* can convert is limited to the lesser of: (a) $10,000.00; or (b) the amount of *your* insurance under this plan, less any group life benefits *you* become eligible for in the 31 days after this insurance ends.

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

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

The Converted Policy

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

Interim Term Insurance

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

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

How and When to Convert

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

Death During the Conversion Period

If *you* die in the 31 days allowed for conversion, *we* will pay *your* beneficiary the amount *you* could have converted. *We* will pay whether or not *you* applied for conversion.

CGP-OR-LIFE-01 B870.0003

All Options

THE FOLLOWING PROVISION APPLIES TO EMPLOYEE VOLUNTARY GROUP TERM LIFE INSURANCE:

All Options

Converting This Group Term Life Insurance

If Employment or Eligibility Ends

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

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

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

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

If the Group Plan Ends or Group Life Insurance Is Dropped

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

If *you:* (a) are not disabled, as defined in the "Extended Life Benefit With Waiver of Premium" section, when this coverage ends; and (b) *you* have been insured by a *Guardian* group life plan for at least five years, *you* can convert to a permanent life insurance policy. But, the amount *you* can convert is limited to the lesser of: (a) $10,000.00; or (b) the amount of *your* insurance under this plan, less any group life benefits *you* become eligible for in the 31 days after this insurance ends.

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

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

The Converted Policy

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

Interim Term Insurance

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

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

How and When to Convert

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

Death During the Conversion Period

If *you* die in the 31 days allowed for conversion, *we* will pay *your* beneficiary the amount *you* could have converted. *We* will pay whether or not *you* applied for conversion.

Employee Accelerated Life Benefit

IMPORTANT NOTICE: USE OF THE BENEFIT PROVIDED BY THIS SECTION MAY HAVE TAX IMPLICATIONS AND MAY AFFECT GOVERNMENT BENEFITS OR CREDITORS. YOU SHOULD CONSULT WITH YOUR TAX OR FINANCIAL ADVISOR BEFORE APPLYING FOR THIS BENEFIT.

PLEASE NOTE: THE AMOUNT OF GROUP TERM LIFE INSURANCE IS PERMANENTLY REDUCED BY THE GROSS AMOUNT OF THE ACCELERATED LIFE BENEFIT PAID TO YOU.

Accelerated Life Benefit

If *you* have a *terminal condition you* may apply for the Accelerated Life Benefit. An Accelerated Life Benefit is a payment of part of *your group term life insurance* made to *you* before *you* die.

We subtract the *gross amount* paid to *you* as an Accelerated Life Benefit from the amount of *your group term life insurance* under this *plan.* The remaining amount of *your group term life insurance* is permanently reduced by the *gross amount* paid to *you.*

You may use the Accelerated Life Benefit in any way *you* choose. But *you* may receive only one Accelerated Life Benefit during *your* lifetime. If *you* live longer than 6 months, or if *you* recover from the condition, the benefit does not have to be repaid. But the amount of this benefit is not restored to *your* remaining *group term life insurance.* And *you* may not receive another Accelerated Life Benefit if *you* have a relapse or develop another *terminal condition.*

Maximum Benefit Amount

The amount of the Accelerated Life Benefit for which *you* may apply is based on the amount of *your group term life insurance* for which *you* are insured on the day before *you* apply for the benefit. The minimum benefit amount is the lesser of: (a) $10,000.00; or (b) 75% of the inforce amount. The maximum benefit amount is the lesser of: (a) $500,000.00; or (b) 75% of the inforce amount.

Discount

The amount for which *you* apply is discounted to the present value in six months from the date the benefit is paid, based on the following maximum interest rate. The maximum interest rate used will not be more than the greater of: (a) the current yield on 90 day treasury bills; or (b) the current maximum statutory adjustable policy loan interest note permitted in the state in which *your employer* is located.

A detailed statement of the method of computing the amount of the Accelerated Life Benefit is filed with each state insurance department. This statement is available from *Guardian* upon request.

Processing Fee

A fee of up to $150.00 may also be required for the administrative cost of evaluating and processing *your* Accelerated Life Benefit. This fee is deducted from the amount of the Accelerated Life Benefit paid to *you.*

Payment of an Accelerated Life Benefit

If *we* approve *your* application for an Accelerated Life Benefit, *we* pay the amount *you* have elected, less the discount and the processing fee. *We* pay the benefit to *you* in one lump sum. *We* completely discharge *our* liability for any amounts paid this way. And what *we* pay is subject to all of the other terms of this *plan.*

How and When to Apply

To receive an Accelerated Life Benefit, *you* must send us written proof from a *doctor* that *your* medical condition is expected to result in *your* death within 6 months of the date of the written medical proof. *We* must approve such proof in writing before the Accelerated Life Benefit will be paid.

We can have *you* examined by a *doctor* of *our* choice to verify the *terminal condition. We* will pay the cost of such examination. *We* will not pay the Accelerated Life Benefit if *our doctor* does not verify the *terminal condition.*

If *we* approve *you* to receive an Accelerated Life Benefit, *we* give *you* a statement which shows: (a) the amount of the maximum Accelerated Life Benefit for which *you* are eligible; (b) the amount by which *your group term life insurance* will be reduced if *you* elect to receive the maximum Accelerated Life Benefit; and (c) the amount of the processing fee.

Even if *you* are receiving an Extended Life Benefit under this *plan, you* can still apply for an Accelerated Life Benefit. However, once *you* convert *your group term life insurance,* the terms of the converted life policy will apply. Any amount to which *you* could otherwise convert is permanently reduced by the *gross amount* of the Accelerated Life Benefit paid to *you.*

Please read "Your Remaining Group Term Life Insurance" for restrictions that may apply.

If You Have Assigned Your Group Term Life Insurance

If *you* have already assigned *your group term life insurance,* according to the terms of this *plan, you* can not apply for an Accelerated Life Benefit.

CGP-OR-LIFE-01 B870.0023

All Options

If You Are Incompetent

If *you* are determined to be legally incompetent, the person the court appoints to handle *your* legal affairs may apply for the Accelerated Life Benefit for *you.*

Your Remaining Group Term Life Insurance

The remaining amount of *group term life insurance* for which *you* are covered after receiving an Accelerated Life Benefit payment is subject to any increases or cutbacks that would otherwise apply to *your* insurance. Applicable cutbacks are applied to the amount of *group term life insurance* for which *you* are insured on the day before *you* apply for the Accelerated Life Benefit.

The premium cost of *your* remaining coverage is based on the amount of *your group term life insurance* for which *you* are insured on the day before *you* apply for the Accelerated Life Benefit.

You may be required to provide *proof of insurability* for increased amounts. If *you* are, *we* must approve that proof in writing before *you* are covered for the new amount.

The total amount of *group term life insurance* the beneficiary would otherwise receive upon *your* death is reduced by the *gross amount* of the Accelerated Life Benefit paid to *you.*

If *you* die after electing the Accelerated Life Benefit, but before *we* send the benefit to *you,* the beneficiary will receive the amount of *your group term life insurance* for which *you* are insured on the day before *you* apply for the Accelerated Life Benefit.

Restrictions *We* will not pay an Accelerated Life Benefit to *you* if *you:*

- are required by law to use the payment to meet the claims of creditors, whether or not *you* are in bankruptcy; or
- are required by court order to pay all or part of the benefit to another person; or
- are required by a government agency to use the payment to apply for, to receive or to maintain a governmental benefit or entitlement; or
- lose *your* coverage under the group *plan* for any reason after *you* elect the Accelerated Life Benefit but before *we* pay such benefit to *you.*

Defined Terms As used in this section:

"Group term life insurance" means any Employee Basic Group Term Life Insurance and Employee Voluntary Group Term Life Insurance for which *you* are insured under this *plan.* "Group term life insurance" does not mean any accidental death and dismemberment benefits, any insurance provided under this *plan* for covered persons other than *you* or any scheduled increase in the amount of any Employee Group Term Life Insurance that is due within the six month period after the date *you* apply for the Accelerated Life Benefit.

"Gross amount" means the amount of an Accelerated Life Benefit elected by *you,* before the discount is subtracted.

"Terminal condition" means a medical condition that is expected to result in *your* death within 6 months.

CGP-OR-LIFE-01 B870.0022

All Options

Extended Life Benefit With Waiver Of Premium

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

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

"Total disability" or "totally disabled" means, due to sickness or injury, *you* are:

(a) not able to perform any work for wages or profit; and

(b) *you* are receiving *regular care* by a *doctor* that is appropriate to the cause of disability.

How and When to Apply

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

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

(a) become *totally disabled* before *you* reach age 60 and while insured by the group *plan;* and

(b) remain *totally disabled* for nine continuous months.

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

Continued Eligibility for Extended Life Benefit

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

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

Until You Have Been Approved for this Extended Life Benefit

Your life insurance under the group *plan* may end after *you* have become *totally disabled,* but before *we* have approved *you* for this extension. During this time period, *you* may either:

(a) continue group premium payments, including any portion which would have been paid by *your employer* until *you* are approved or declined for this extended life benefit; or

(b) convert to an individual permanent or term policy. Please read the "Converting This Group Term Life Insurance" section for details on how to convert.

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

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

When this Extension Begins

Once approved by *us, your* extended benefit will be effective on the later of:

(a) nine continuous months from the date *you* cease *active work* due to *total disability;* or

(b) the date *we* approve *you* for this benefit.

CGP-OR-LIFE-01 B870.0008

All Options

When this Extension Ends

Your extension will end on the earliest of:

(a) the date *you* are no longer disabled;

(b) the date *we* ask *you* to be examined by *our doctor,* and *you* refuse;

(c) the date *you* do not give *us* the proof of disability *we* require;

(d) the date *you* are no longer receiving *regular care* by a *doctor* that is appropriate to the cause of disability; or

(e) the day before the date *you* reach age 65.

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

If You Die While Covered by this Extension

If *you* die while covered by this extension *we* will pay *your* beneficiary the amount for which *you* were covered as of *your* last day of *active work,* subject to all reductions which would have applied had *you* stayed an active *employee.* The benefit amount is also subject to reduction which applies at retirement. *We* will use *your* Social Security Normal Retirement Age, as defined in the 1983 amendment to the Social Security Act, to determine when to apply the retirement reduction to *your* extended life benefit.

Proof of Death

We will pay as soon as *we* receive:

(a) written proof of *your* death, that is acceptable to *us;* and

(b) medical proof that *you* were continuously disabled until *your* death. This must be sent within one year of *your* death.

CGP-OR-LIFE-01 B870.0009

Extended Life Benefit With Waiver Of Premium

Important Notice

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

If You Are Disabled

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

"Total disability" or "totally disabled" means, due to sickness or injury, *you* are:

(a) not able to perform any work for wages or profit; and

(b) *you* are receiving *regular care* by a *doctor* that is appropriate to the cause of disability.

How and When to Apply

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

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

(a) become *totally disabled* before *you* reach age 60 and while insured by the group *plan;* and

(b) remain *totally disabled* for nine continuous months.

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

Continued Eligibility for Extended Life Benefit

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

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

Until You Have Been Approved for this Extended Life Benefit

Your life insurance under the group *plan* may end after *you* have become *totally disabled,* but before *we* have approved *you* for this extension. During this time period, *you* may either:

(a) continue group premium payments, including any portion which would have been paid by *your employer* until *you* are approved or declined for this extended life benefit; or

(b) convert to an individual permanent or term policy. Please read the "Converting This Group Term Life Insurance" section for details on how to convert.

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

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

When this Extension Begins

Once approved by *us, your* extended benefit will be effective on the later of:

(a) nine continuous months from the date *you* cease *active work* due to *total disability;* or

(b) the date *we* approve *you* for this benefit.

All Options

When this Extension Ends

Your extension will end on the earliest of:

(a) the date *you* are no longer disabled;

(b) the date *we* ask *you* to be examined by *our doctor,* and *you* refuse;

(c) the date *you* do not give *us* the proof of disability *we* require;

(d) the date *you* are no longer receiving *regular care* by a *doctor* that is appropriate to the cause of disability; or

(e) the day before the date *you* reach age 65.

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

If You Die While Covered by this Extension

If *you* die while covered by this extension *we* will pay *your* beneficiary the amount for which *you* were covered as of *your* last day of *active work,* subject to all reductions which would have applied had *you* stayed an active *employee.* The benefit amount is also subject to reduction which applies at retirement. *We* will use *your* Social Security Normal Retirement Age, as defined in the 1983 amendment to the Social Security Act, to determine when to apply the retirement reduction to *your* extended life benefit.

Proof of Death

We will pay as soon as *we* receive:

(a) written proof of *your* death, that is acceptable to *us;* and

(b) medical proof that *you* were continuously disabled until *your* death. This must be sent within one year of *your* death.

Dependent Spouse and Child Voluntary Term Life Insurance

The Choices

You may choose one of the plans of dependent spouse voluntary term life insurance, and one of the plans of dependent child voluntary term life insurance offered by *your employer.* These plans are shown in the schedule. However, *you* can only be insured under one spouse plan and one child plan at a time. *You* must notify *your employer* of *your* elections, and pay the required premium.

You may switch to other plans of benefits during the dependent voluntary life enrollment period. The enrollment period is shown in the schedule. Subject to any of this plan's *proof of insurability* requirements, *you* will be insured under the new plan of benefits as of the transfer date shown in the schedule. *You* must notify *your employer* of any desired switch.

The Benefit

Subject to the limitations and exclusions shown below, if one of *your* dependents dies while insured for this benefit, *we* pay the amount shown in the schedule for the plan *you* have elected. *We* pay this insurance as soon as *we* receive written proof of death which is acceptable to *us. You* must send the proof to *us* as soon as possible.

We pay *you,* if *you* are living. If *you* are not living, and the dependent was *your* child, *we* pay *your* spouse. If *your* spouse is not living, *we* pay the child's living brothers and sisters in equal shares. If there are none, *we* pay the child's estate. If the dependent was *your* spouse, *we* pay *your* spouse's estate.

Suicide Exclusion

We pay no benefits if the dependent's death is due to suicide, if such death occurs within two years from the effective date of the dependent's voluntary term life insurance under this *plan.* Also, *we* pay no increased benefit amount if the dependent's death is due to suicide, if such death occurs within two years from the effective date of the increase.

Seatbelt and Airbag Benefits

If a dependent dies as a direct result of a motor vehicle accident while properly wearing a seatbelt, *we* will increase the benefit amount by $5,000.00. And if a dependent dies as a direct result of a motor vehicle accident while: (a) both properly wearing a seatbelt; and (b) sitting in a seat equipped with an airbag; *we* will increase the benefit amount by another $2,500.00, for a total increase of $7,500.00.

Payment to a Minor or Incompetent

If the person to whom the benefit is payable is a minor or not competent, *we* will pay the person who cares for and supports that person. *We* have the right to pay in monthly installments. *We* completely discharge *our* liability for any amounts paid this way.

Payment of the Life Benefit

We will pay this insurance in a lump sum.

If *we* fail to pay this insurance within 30 days of receipt of proof of death, *we* will pay interest on any amount due and unpaid after the end of the 30 day period. Interest will be computed at the current withdrawal loan interest rate for life policies issued by *us. We* will compute the interest from the date of *your* dependent's death until the date of payment.

We completely discharge *our* liability for any amounts paid this way.

Converting This Dependent Term Life Insurance

If Your Group Life Insurance Ends or You Stop Being Eligible

Dependent term life insurance ends for all of *your* dependents when *your* group life insurance ends. *Your* insurance ends when: (a) *your* employment ends; (b) *you* stop being a member of a class of *employees* eligible for *employee* group life insurance; (c) *your* group life insurance is extended under the Extended Life Benefit provision; or (d) *you* die.

Dependent term life insurance also ends when *you* stop being a member of a class of *employees* eligible for dependent term life insurance.

If one of the above happens, each dependent who was insured may convert all or part of his or her insurance.

If this Plan Ends or Life Insurance Is Dropped

Dependent term life insurance also ends for all of *your* dependents when this *plan* ends. And it ends if either *employee* or dependent term life insurance is dropped from this *plan* for all *employees* or for *your* class.

If one of the above happens, and *your* dependents have been insured by a *Guardian* group life plan for at least five years, they can convert. But *we* limit the amount each dependent can convert to the lesser of: (a) $10,000.00; or (b) the amount of his or her insurance under this *plan* less any group life benefits he or she becomes eligible for in the 31 days after this insurance ends.

If a Dependent Stops Being Eligible

A dependent's term life insurance ends when he or she stops being an eligible dependent. This happens to a child when he or she reaches the limiting age shown in the schedule or when he or she marries. And it happens to a spouse when a marriage ends in legal divorce or annulment. If a dependent stops being eligible, that dependent can convert all or part of his or her insurance.

The Converted Policy

The dependent can convert to one of the individual life insurance policies *we* normally issue. That policy can not include disability benefits. And it can not be a term policy.

The premium for the converted policy will be based on: (a) the dependent's risk and rate class under this *plan;* and (b) the dependent's age when the converted policy takes effect. The converted policy takes effect at the end of the period allowed for conversion.

Write to *us* for details.

How and When to Convert

To get a converted policy, the dependent must apply to *us* in writing and pay the required premium. He or she has 31 days after his or her group insurance ends to do this. *We* will not ask for proof that the dependent is insurable. If the dependent is a minor or not competent, the person who cares for and supports the dependent may apply for him or her.

Death During the Conversion Period

If a dependent dies in the 31 days allowed for conversion, we pay the amount he or she could have converted, as stated above. *We* do this whether or not the dependent applied for conversion.

ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE

All Options

Employee Basic Accidental Death and Dismemberment With Catastrophic Loss Benefits

The Benefit *We* will pay the benefits described below if *you* suffer an irreversible covered loss due to an accident that occurs while *you* are insured. The loss must be a direct result of the accident, independent of all other causes. And, it must occur within 180 days of the date of the accident.

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

ACCIDENTAL DEATH AND DISMEMBERMENT

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

CATASTROPHIC LOSS BENEFITS

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

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

Loss of:

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

(b) a hand or foot means it is completely cut off at or above the wrist or ankle.

(c) sight means the total and permanent loss of sight.

(d) speech or hearing means that speech or hearing is lost entirely.

Payment of Benefits

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

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

We will pay benefits as soon as *we* receive proof of loss which is acceptable to *us.* This should be sent to *us* as soon as possible.

We will pay this insurance in a lump sum.

We completely discharge *our* liability for any amounts paid this way.

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All Options

Seatbelt and Airbag Benefits

If *you* die as a direct result of a motor vehicle accident while properly wearing a seatbelt, *we* will increase *your* benefit by $10,000.00. And if *you* die as a direct result of a motor vehicle accident while both: (a) properly wearing a seatbelt; and (b) sitting in a seat equipped with an airbag; *we* will increase *your* benefit by another $5,000.00, for a total increase of $15,000.00.

Repatriation Benefit

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

Exclusions

We will not pay for any loss caused directly or indirectly:

- by willful self-injury, suicide, or attempted suicide;
- by sickness, disease, mental infirmity, medical or surgical treatment;
- by *your* taking part in a riot or other civil disorder; or in the commission of or attempt to commit a felony;

- by travel on any type of aircraft if *you* are an instructor or crew member; or have any duties at all on that aircraft;
- by declared or undeclared war or act of war;
- while *you* are a member of any armed force;
- while *you* are a driver in a motor vehicle accident, if *you* do not hold a current and valid driver's license;
- by *your* legal intoxication; this includes, but is not limited to, *your* operation of a motor vehicle; or
- by *your* voluntary use of a controlled substance, unless: (1) it was prescribed for *you* by a *doctor;* and (2) it was used as prescribed. A controlled substance is anything called a controlled substance in Title II of the Comprehensive Drug Abuse Prevention and Control Act of 1970, as amended from time to time.

All Options

Spousal Education and Retraining Benefit

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

When and How the Spousal Education and Retraining Benefit Begins

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

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

(b) on the date of the accidental injury which results in the *specified loss, you* and *your* spouse share the same place of residence; and

(c) *we* receive proof of *your* spouse's enrollment in an *institute of higher learning. Your* spouse must: (i) be enrolled on the date of the accidental injury which results in the *specified loss;* or (ii) enroll within 12 months of this date.

What We Pay

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

If this benefit is payable under both an Employee Basic and a Voluntary ADDCL plan, the total spousal education benefit paid will not exceed the spouse's *net tuition expense* for the term.

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

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

Continued Eligibility for the Spousal Education and Retraining Benefit

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

When the Spousal Education and Retraining Benefit Ends

The spousal education and retraining benefit ends on the earliest of the following dates:

(a) the date the spouse is no longer enrolled in an *institute of higher learning;*

(b) the date the spouse fails to maintain a minimum grade point average as required above;

(c) the date the spouse fails to furnish proof as required above;

(d) the date the lifetime maximum benefit amount, shown in the schedule, is reached; or

(e) the date the maximum number of benefit payments, shown in the schedule, is reached.

Defined Terms As used in this section:

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

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

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

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

All Options

Day Care Expense Benefit

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

Eligibility for the Day Care Expense Benefit

This *plan* provides a day care expense benefit when all of the following conditions are met:

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

(b) *we* receive proof of a *qualified dependent's* enrollment in a *qualified day care program.* Such enrollment must commence within 12 months of the date of the *specified loss.*

What We Pay

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

If this benefit is payable under both an Employee Basic and a Voluntary ADDCL plan, the total day care expense benefit paid will not exceed the actual annual day care expenses for all of *your qualified dependents.*

If this benefit is payable under both an Employee ADDCL plan and a Dependent ADDCL *plan,* the total day care expense benefit paid will not exceed the actual annual day care expenses for all of *your qualified dependents.*

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

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

Continued Eligibility for the Day Care Expense Benefit

We require periodic proof that a *qualified dependent* remains enrolled in a *qualified day care program. We* require periodic proof of the *qualified dependent's* day care expenses.

When the Day Care Expense Benefit Ends

This *plan's* Day Care Expense Benefits end on the earliest of the following dates:

(a) the date the dependent is no longer qualified, as defined below;

(b) the date the dependent is no longer enrolled in a *qualified day care program;*

(c) the date *we* do not receive proof of qualified day care expenses, as required by this *plan;* or

(d) four years from the date the first day care expense benefit is paid.

Defined Terms As used in this section:

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

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

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

All Options

Dependent Child Education Benefit

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

When and How the Dependent Child Education Benefit Begins

We will pay a Dependent Child Education Benefit when all of the following conditions are met:

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

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

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

If this benefit is payable under both an Employee Basic and a Voluntary ADDCL plan, the total education benefit paid will not exceed the *qualified dependent's net tuition expense* for the term.

If this benefit is payable under both an Employee ADDCL plan and a Dependent ADDCL plan, the total education benefit paid will not exceed the *qualified dependent's net tuition expense* for the term.

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

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

Continued Eligibility for Dependent Education Benefit

We require periodic proof that a dependent remains a *qualified dependent,* as defined below. *We* also require proof, per academic term, of: (a) the *qualified dependent's tuition expenses;* and (b) any scholarships and grants the dependent is entitled to.

When the Dependent Child Education Benefit Ends

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

(a) the date the dependent child is no longer a *qualified dependent,* as defined above;

(b) the date the dependent fails to furnish proof as required below;

(c) the date the lifetime maximum benefit amount, shown in the schedule, is reached;

(d) the date the maximum number of benefit payments, shown in the schedule, is reached; or

(e) the date the maximum benefit period, shown in the schedule, is reached.

Defined Terms As used in this section:

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

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

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

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

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

All Options

Employee Voluntary Accidental Death and Dismemberment With Catastrophic Loss Benefits

The Choices *You* may elect to be insured for any of the plans of *employee* voluntary accidental death and dismemberment with catastrophic loss (ADDCL) insurance offered by *your employer.* These plans are shown in the schedule. However, *you* can only be insured under one plan at a time. *You* must notify *your employer* of *your* election and pay the required premium.

You may switch to another plan of benefits at any time, subject to any of this *plan's proof of insurability* requirements. *You* must notify *your employer* of any desired switch.

The Benefit *We* will pay the benefits described below if *you* suffer an irreversible covered loss due to an accident that occurs while *you* are insured. The loss must be a direct result of the accident, independent of all other causes. And, it must occur within 180 days of the date of the accident.

Covered Losses Benefits will be paid according to the plan *you* have elected, only for losses identified in the following table. The Insurance Amount is shown in the Schedule.

ACCIDENTAL DEATH AND DISMEMBERMENT

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

CATASTROPHIC LOSS BENEFITS

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

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

Loss of:

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

(b) a hand or foot means it is completely cut off at or above the wrist or ankle.

(c) sight means the total and permanent loss of sight.

(d) speech or hearing means that speech or hearing is lost entirely.

Payment of Benefits

For covered loss of life, *we* pay the beneficiary described below.

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

We will pay benefits as soon as *we* receive proof of loss which is acceptable to *us.* This should be sent to *us* as soon as possible.

We will pay this insurance in a lump sum.

We completely discharge *our* liability for any amounts paid this way.

The Beneficiary

You decide who gets this insurance if *you* die. *You* should have named a beneficiary on *your* enrollment form. *You* can change *your* beneficiary at any time by giving *your employer* written notice, unless *you* have assigned this insurance. This change will take effect on the date the notice is signed, subject to *our* receipt of the notice. But, it will not apply to any amount paid by *us* before *we* receive the notice

If *you* named more than one person, but did not tell *us* what their shares should be, *your* insurance will be divided equally by the beneficiaries still alive, unless *you* tell *us* otherwise.

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

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All Options

Seatbelt and Airbag Benefits

If *you* die as a direct result of a motor vehicle accident while properly wearing a seatbelt, *we* will increase *your* benefit by $10,000.00. And if *you* die as a direct result of a motor vehicle accident while both: (a) properly wearing a seatbelt; and (b) sitting in a seat equipped with an airbag; *we* will increase *your* benefit by another $5,000.00, for a total increase of $15,000.00.

Repatriation Benefit

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

Exclusions

We will not pay for any loss caused directly or indirectly:

- by willful self-injury, suicide, or attempted suicide;
- by sickness, disease, mental infirmity, medical or surgical treatment;
- by *your* taking part in a riot or other civil disorder; or in the commission of or attempt to commit a felony;
- by travel on any type of aircraft if *you* are an instructor or crew member; or have any duties at all on that aircraft;
- by declared or undeclared war or act of war;
- while *you* are a member of any armed force;

- while *you* are a driver in a motor vehicle accident, if *you* do not hold a current and valid driver's license;
- by *your* legal intoxication; this includes, but is not limited to, *your* operation of a motor vehicle; or
- by *your* voluntary use of a controlled substance, unless: (1) it was prescribed for *you* by a *doctor;* and (2) it was used as prescribed. A controlled substance is anything called a controlled substance in Title II of the Comprehensive Drug Abuse Prevention and Control Act of 1970, as amended from time to time.

All Options

Spousal Education and Retraining Benefit

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

When and How the Spousal Education and Retraining Benefit Begins

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

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

(b) on the date of the accidental injury which results in the *specified loss, you* and *your* spouse share the same place of residence; and

(c) *we* receive proof of *your* spouse's enrollment in an *institute of higher learning. Your* spouse must: (i) be enrolled on the date of the accidental injury which results in the *specified loss;* or (ii) enroll within 12 months of this date.

What We Pay

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

If this benefit is payable under both an Employee Basic and a Voluntary ADDCL plan, the total spousal education benefit paid will not exceed the spouse's *net tuition expense* for the term.

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

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

Continued Eligibility for the Spousal Education and Retraining Benefit

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

When the Spousal Education and Retraining Benefit Ends

The spousal education and retraining benefit ends on the earliest of the following dates:

(a) the date the spouse is no longer enrolled in an *institute of higher learning;*

(b) the date the spouse fails to maintain a minimum grade point average as required above;

(c) the date the spouse fails to furnish proof as required above;

(d) the date the lifetime maximum benefit amount, shown in the schedule, is reached; or

(e) the date the maximum number of benefit payments, shown in the schedule, is reached.

Defined Terms As used in this section:

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

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

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

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

All Options

Day Care Expense Benefit

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

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

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

(b) *we* receive proof of a *qualified dependent's* enrollment in a *qualified day care program.* Such enrollment must commence within 12 months of the date of the *specified loss.*

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

If this benefit is payable under both an Employee Basic and a Voluntary ADDCL plan, the total day care expense benefit paid will not exceed the actual annual day care expenses for all of *your qualified dependents.*

If this benefit is payable under both an Employee ADDCL plan and a Dependent ADDCL plan, the total day care expense benefit paid will not exceed the actual annual day care expenses for all of *your qualified dependents.*

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

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

Continued Eligibility for the Day Care Expense Benefit

We require periodic proof that a *qualified dependent* remains enrolled in a *qualified day care program. We* require periodic proof of the *qualified dependent's* day care expenses.

When the Day Care Expense Benefit Ends

This *plan's* Day Care Expense Benefits end on the earliest of the following dates:

(a) the date the dependent is no longer qualified, as defined below;

(b) the date the dependent is no longer enrolled in a *qualified day care program;*

(c) the date *we* do not receive proof of qualified day care expenses, as required by this *plan;* or

(d) four years from the date the first day care expense benefit is paid.

Defined Terms As used in this section:

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

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

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

All Options

Dependent Child Education Benefit

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

When and How the Dependent Child Education Benefit Begins

We will pay a Dependent Child Education Benefit when all of the following conditions are met:

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

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

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

If this benefit is payable under both an Employee Basic and a Voluntary ADDCL *plan,* the total education benefit paid will not exceed the *qualified dependent's net tuition expense* for the term.

If this benefit is payable under both an Employee ADDCL *plan* and a Dependent ADDCL plan, the total education benefit paid will not exceed the *qualified dependent's net tuition expense* for the term.

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

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

Continued Eligibility for Dependent Education Benefit

We require periodic proof that a dependent remains a *qualified dependent,* as defined below. *We* also require proof, per academic term, of: (a) the *qualified dependent's tuition expenses;* and (b) any scholarships and grants the dependent is entitled to.

When the Dependent Child Education Benefit Ends

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

(a) the date the dependent child is no longer a *qualified dependent,* as defined below;

(b) the date the dependent fails to furnish proof as required below;

(c) the date the lifetime maximum benefit amount, shown in the schedule, is reached;

(d) the date the maximum number of benefit payments, shown in the schedule, is reached; or

(e) the date the maximum benefit period, shown in the schedule, is reached.

Defined Terms As used in this section:

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

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

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

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

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

All Options

Dependent Voluntary Accidental Death and Dismemberment With Catastrophic Loss Benefits

The Benefit *We* will pay the benefits described below if a covered dependent suffers an irreversible covered loss due to an accident that occurs while he or she is insured. The loss must be a direct result of the accident, independent of all other causes. And, it must occur within 180 days of the date of the accident.

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

ACCIDENTAL DEATH AND DISMEMBERMENT

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

CATASTROPHIC LOSS BENEFITS

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

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

Loss of:

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

(b) a hand or foot means it is completely cut off at or above the wrist or ankle.

(c) sight means the total and permanent loss of sight.

(d) speech or hearing means that speech or hearing is lost entirely.

If loss of life benefits are payable under this *plan* for both *you* and *your* spouse, *we* will increase the benefit payable on behalf of the insured dependent spouse. In lieu of the spouse's insurance amount, *we* will pay 100% of the *your* insurance amount, to a maximum of $250,000. The following conditions must be met:

(a) coverage must be inforce on the date of the accident; and

(b) both *you* and *your* spouse die due to injuries sustained in the same accident; or *you* and *your* spouse die due to injuries sustained in separate accidents that occur within the same 24 hour period.

Payment of Benefits

For all covered losses, *we* pay *you,* if *you* are living. If *you* are not living, and the dependent was *your* child, *we* pay *your* spouse. If *your* spouse is not living, *we* pay the child's living brothers and sisters in equal shares. If there are none, *we* pay the child's estate. If the dependent was *your* spouse, *we* pay the spouse's estate.

We will pay benefits as soon as *we* receive proof of loss which is acceptable to *us.* This should be sent to *us* as soon as possible.

We will pay this insurance in a lump sum.

We completely discharge *our* liability for any amounts paid this way.

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All Options

Seatbelt and Airbag Benefits

If a dependent dies as a direct result of a motor vehicle accident while properly wearing a seatbelt, *we* will increase his or her benefit amount by $5,000.00. And if a dependent dies as a direct result of a motor vehicle accident while both: (a) properly wearing a seatbelt; and (b) sitting in a seat equipped with an airbag; *we* will increase his or her benefit by another $2,500.00, for a total increase of $7,500.00.

Repatriation Benefit

For covered loss of life due to an accident which occurs at least 75 miles from the dependent's home, *we* pay an extra sum. *We* pay up to $5,000.00 for costs to prepare and transport the body to a mortuary chosen by *you.*

Exclusions

We will not pay for any loss caused directly or indirectly:

- by willful self-injury, suicide, or attempted suicide;
- by sickness, disease, mental infirmity, medical or surgical treatment;
- by a dependent taking part in a riot or other civil disorder; or in the commission of or attempt to commit a felony;
- by travel on any type of aircraft if the dependent is an instructor or crew member; or has any duties at all on that aircraft;
- by declared or undeclared war or act of war;
- while the dependent is a member of any armed force;

- while the dependent is a driver in a motor vehicle accident, if he or she does not hold a current and valid driver's license;
- by the dependent's legal intoxication; this includes, but is not limited to, the dependent's operation of a motor vehicle; or
- by the dependent's voluntary use of a controlled substance, unless: (1) it was prescribed for the dependent by a *doctor;* and (2) it was used as prescribed. A controlled substance is anything called a controlled substance in Title II of the Comprehensive Drug Abuse Prevention and Control Act of 1970, as amended from time to time.

All Options

Spousal Education And Retraining Benefit

If *your* covered spouse suffers a *specified loss* due to an accidental bodily injury, *we* will pay a spousal education and retraining benefit subject to all the terms below.

When and How the Spousal Education and Retraining Benefit Begins

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

(a) a benefit is payable under this *plan's* Dependent Voluntary Accidental Death and Dismemberment with Catastrophic Loss (ADDCL) Benefit, due to a *specified loss;*

(b) on the date of the accidental injury which results in the *specified loss, you* and *your* spouse share the same place of residence; and

(c) *we* receive proof of *your* enrollment in an *institute of higher learning. You* must: (i) be enrolled on the date of the accidental injury which results in the *specified loss;* or (ii) enroll within 12 months of this date.

What We Pay

Subject to all the terms of this *plan,* the Spousal Education and Retraining Benefit per academic term is equal to the least of: (i) *your net tuition expense* for the term; (ii) 5% of the Dependent Voluntary ADDCL Benefit paid as a result of the *specified loss;* or (iii) $2,500.00.

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

This benefit is paid per academic term. Benefit duration, as shown in the schedule, is based on whether *you* are enrolled in a part-time or full-time course of study.

Continued Eligibility for the Spousal Education and Retraining Benefit

We require periodic proof of *your* continued enrollment in an *institute of higher learning. You* must maintain a grade point average of at least 2.0 on a 4.0 scale, or the equivalent. *We* also require proof, per academic term, of: (a) *your tuition expenses;* and (b) any scholarships and grants *you* are entitled to.

When the Spousal Education and Retraining Benefit Ends

The spousal education and retraining benefit ends on the earliest of the following dates:

(a) the date *you* are no longer enrolled in an *institute of higher learning;*

(b) the date *you* fail to maintain a minimum grade point average, as required above;

(c) the date *you* fail to furnish proof as required above;

(d) the date the lifetime maximum benefit amount, shown in the schedule, is reached; or

(e) the date the maximum number of benefit payments, shown in the schedule, is reached.

Defined Terms As used in this section:

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

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

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

"Net tuition expense" means *tuition expense* less any scholarships or grants to which *you* are entitled.

All Options

Day Care Expense Benefit

If *your* covered spouse suffers a *specified loss* due to an accidental bodily injury, *we* will pay a Day Care Expense Benefit subject to all the terms below.

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

(a) a benefit is payable under this *plan's* Dependent Voluntary Accidental Death and Dismemberment with Catastrophic Loss (ADDCL) Benefit, due to *your* covered spouse's *specified loss;* and

(b) *we* receive proof of a *qualified dependent's* enrollment in a *qualified day care program.* Such enrollment must commence within 12 months of the date of the *specified loss.*

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

If this benefit is payable under both an Employee ADDCL plan and a Dependent ADDCL plan, the total day care expense benefit paid will not exceed the actual annual day care expenses for all of *your qualified dependents.*

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

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

Continued Eligibility for the Day Care Expense Benefit

We require periodic proof that a *qualified dependent* remains enrolled in a *qualified day care program. We* require periodic proof of the *qualified dependent's* day care expenses.

When the Day Care Expense Benefit Ends

This *plan's* Day Care Expense Benefits end on the earliest of the following dates:

(a) the date the dependent is no longer qualified, as defined below;

(b) the date the dependent is no longer enrolled in a *qualified day care program;*

(c) the date *we* do not receive proof of qualified day care expenses, as required by this *plan;* or

(d) four years from the date the first day care expense benefit is paid.

Defined Terms As used in this section:

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

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

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

All Options

Dependent Child Education Benefit

If *your* covered spouse suffers a *specified loss* due to an accidental bodily injury, *we* will pay an education benefit on behalf of a *qualified dependent,* subject to all the terms below.

When and How the Dependent Child Education Benefit Begins

We will pay a Dependent Child Education Benefit when all of the following conditions are met:

(a) a benefit is payable under this *plan's* Dependent Voluntary Accidental Death and Dismemberment with Catastrophic Loss (ADDCL) Benefit, due to *your* covered spouse's *specified loss;* and

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

What We Pay

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

If this benefit is payable under both an Employee ADDCL *plan* and a Dependent ADDCL *plan,* the total education benefit paid will not exceed the *qualified dependent's net tuition expense* for the term.

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

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

Continued Eligibility for Dependent Education Benefit

We require periodic proof that a dependent remains a *qualified dependent,* as defined below. *We* also require proof, per academic term, of: (a) the *qualified dependent's tuition expenses;* and (b) any scholarships and grants the dependent is entitled to.

When the Dependent Child Education Benefit Ends

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

(a) the date the dependent child is no longer a *qualified dependent,* as defined below;

(b) the date the dependent fails to furnish proof as required above;

(c) the date the lifetime maximum benefit amount, shown in the schedule, is reached;

(d) the date the maximum number of benefit payments, shown in the schedule, is reached; or

(e) the date the maximum benefit period, shown in the schedule, is reached.

Defined Terms As used in this section:

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

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

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

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

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

DISABILITY INCOME INSURANCE

ELIGIBILITY FOR DISABILITY INCOME REPLACEMENT COVERAGE

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All Options

Employee Coverage

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

Other Conditions *You* must:

(a) be legally working in the United States.

(b) be regularly working at least the number of hours in the normal work week set by *your employer* (but not less than 30 hours per week), at:

(i) *your employer's* place of business;

(ii) some place where *your employer's* business requires *you* to travel; or

(iii) any other place *you* and *your employer* have agreed upon for performance of occupational duties.

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

Part or all of *your* insurance amounts may be subject to proof that *you* are insurable. Other parts of this coverage explain if and when *we* require proof. *You* will not be covered for any amount that requires such proof until *you* give the proof to *us* and *we* approve it in writing.

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All Options

When Your Coverage Starts

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

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

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

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

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All Options

When Your Coverage Ends

Your long term disability coverage ends on the date*your* active *full-time* service ends for any reason, except as noted below under "Coverage During Temporary Layoff or Leave of Absence".

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

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

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

However, if *you* are disabled, as defined by this *plan* when your active *full-time* service ends, coverage remains in force during: (a) the elimination period, subject to premium payment, if: (i) the disability is not excluded under the *plan;* and (ii) benefits are not excluded due to application of this *plan's* pre-existing condition provision; and (b) the period for which benefits are payable under the *plan.*

Coverage During Temporary Layoff or Leave of Absence

If *your* active full-time service ends because *you* are laid off or on an *employer* approved leave of absence, *your* insurance may be continued, subject to continued payment of premium, until the earlier of: (a) the end of the temporary layoff or *employer* approved leave of absence; and (b) one month following the date the temporary layoff or approved leave of absence begins. If *you* become disabled under this *plan* while *your* coverage is being continued during a temporary layoff or leave of absence, *your* eligibility for benefits will be governed by all the terms of this *plan.*

Read this booklet carefully if *your* coverage ends. *You* may have the right to replace certain group benefits with converted policies.

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All Options

LONG TERM DISABILITY HIGHLIGHTS

SCHEDULE OF BENEFITS

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

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All Options

Own Occupation Period The first 24 months of benefit payments from this plan.

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All Options

Elimination Period

For disability due to injury . . . . . 90 days

For disability due to sickness . . . . . 90 days

B883.0652

All Options

Maximum Payment Period See the following table:

Age when disability starts	Maximum payment period
Under age 60	To age 65
Age 60	5.00 years
Age 61	4.00 years
Age 62	3.50 years
Age 63	3.00 years
Age 64	2.50 years
Age 65	2.00 years
Age 66	1.75 years
Age 67	1.50 years
Age 68	1.25 years
Age 69 or older	1.00 year

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All Options

Maximum Monthly Benefit

60% of *your insured earnings,* rounded to the nearest $1.00, if not already a multiple thereof, limited to a maximum of $6,000.00.

NOTE: *We* integrate *your gross monthly benefit* with certain other income *you* may receive. Read all the terms of this *plan* to see what income *we* integrate with, and how.

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All Options

Survivor Benefit

3 times the last gross monthly benefit you received.

B883.0712

LONG TERM DISABILITY INCOME INSURANCE

This insurance replaces part of *your* income if *you* become *disabled* due to a covered *sickness* or *injury.* What *we* pay is governed by all the terms of this *plan.*

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.

Benefit Provisions

How Payments Start

To start getting payments from this *plan, you* must meet all of the conditions listed below:

(a) *you* must: (i) become *disabled* while insured by this *plan;* and (ii) remain *disabled* and insured for this *plan's elimination period.*

(b) *you* must provide proof of loss, as described in this *plan's* Claim Provisions section.

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

you can satisfy the *elimination period* while working, provided *you* are *disabled* as defined by this *plan.*

Waiver of Premium *We* waive *your* premiums for this insurance and for short term disability insurance, if included in the *plan sponsor's* plan of insurance while *you* are entitled to receive a *monthly benefit* payment from this *plan.*

When Payments End *your* benefits from this *plan* will end on the earliest of the dates shown below:

(a) The date *you* are no longer *disabled.*

(b) The date *you* fail to provide proof of loss as required by this *plan.*

(c) The date *you* earn, or are able to earn, the maximum earnings allowed while *disabled* under this *plan.*

(d) The date *you* are able to perform the substantial and material duties of *your own occupation* on a full-time basis with *reasonable accommodation.*

(e) After the *own occupation* period, the date *you* are able to perform the substantial and material duties of any *gainful work* on a full-time basis with *reasonable accommodation.*

(f) The date *you* have been outside the United States for more than 2 months in a 12 month period.

(g) The date he or she dies.

(h) The end of the *maximum payment period.*

(i) The date no further benefits are payable under any provision in this *plan* that limits the *maximum payment period.*

(j) The date *you* are no longer receiving *regular and appropriate care* from a *doctor.*

(k) The date payments end in accord with a *rehabilitation agreement.*

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All Options

Maximum Payment Period: The *maximum payment period* is the longest time that benefits are paid by this *plan* for your *disability.* It is determined by the table shown below.

But, it may be less than that shown due to: (a) the nature of your *disability;* (b) the date you was first treated for the cause of his or her *disability;* and (c) the length of time you has been insured by this *plan.* See "Disabilities with a Limited Maximum Payment Period" and "Pre-Existing Conditions."

Age When Disability Starts	Maximum Payment Period
Under age 60	To age 65
Age 60	5.00 years
Age 61	4.00 years
Age 62	3.50 years
Age 63	3.00 years
Age 64	2.50 years
Age 65	2.00 years

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Age 66	. . . . .	1.75 years
Age 67	. . . . .	1.50 years
Age 68	. . . . .	1.25 years
Age 69 or older	. . . . .	1.00 year

B883.0427

All Options

Recurring Disability

Benefits from this *plan* end if *you* cease to be *disabled.* But, a later *disability* may be treated as a *recurring disability,* if all of the terms listed below are met:

(a) *You* must return to *active work* right after *your* benefits end;

(b) The *disability* must recur less than six months after *you* were last entitled to benefits;

(c) The later *disability* must be due to the same or related cause of *your* earlier *disability;*

(d) This *plan* must not end during *your* return to *active work;*

(e) *You* must not become covered under any other similar group income replacement plan during the time *you* return to *active work;*

(f) During the time *you* return to *active work, you* must: (i) stay insured by this *plan;* and (ii) premium payments must be made on *your* behalf; and

(g) *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* occurs.

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All Options

Calculation of Monthly Benefit:

Your benefit is governed by the terms of the *plan* in effect on the date *disability* occurs. Any changes to this *plan* that take place: (a) while *you* are *disabled;* or (b) during a period of *active work* that occurs between an initial period of *disability* and a *recurring disability;* will not affect *your* benefit.

We calculate *your gross monthly benefit* according to the Schedule of Benefits.

From *your gross monthly benefit,* subtract the amount of any income listed in Other Income Benefits that *you* receive. The result is *your monthly benefit.*

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All Options

Redetermination: This plan redetermines *insured earnings* for each covered person on April 1st .

Each April 1st , the *employer* must report current *insured earnings* for all covered persons under the *plan.* Changes to a covered person's *insured earnings* are subject to any proof of insurability requirements of this *plan.* As of this *plan's* redetermination date, *we* use a covered person's *insured earnings* on record with *us* to: (a) set rates; (b) project benefit amounts and limits; and (c) calculate premium payable under this *plan.* However, the covered person must be *actively-at-work* on a full-time basis on that date. If you are not, *we* do not do this until the date you return to *active work* on a full-time basis. But, changes in earnings will not apply to a *recurring disability.*

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All Options

Other Income Benefits: *You* may receive income shown in the list below. *We* will reduce *your gross monthly benefit*by such other income benefits to determine *your monthly benefit*from this *plan.*

- Commissions or monies received after *disability*benefits start. This includes: (a) vested and nonvested renewal commissions; (b) bonuses; (c) royalties; (d) profit sharing; and (e) other distributions.
- Disability benefits from any mandated benefit act or law. This includes all temporary disability or state disability benefits required by law.
- Disability benefits from all the employer's group plans. This includes payments made by a group life insurance plan due to *your disability.*This does not include payments made from a group life insurance plan's: (a) accelerated death benefit; or (b) like provision that allows payment of such plan's proceeds due to terminal illness.
- Disability benefits from any other group plan; but, if the other group plan was in force prior to this *plan,*and the other group plan also deducts for disability benefits from any other group plan, *we* will not deduct these other group disability benefits.
- Income from a sick leave, salary continuance or Paid Time Off plan, but only to the extent that such income plus the amount of *your gross monthly benefit* is more than 100% of *your insured earnings.*This applies whether such plan is sponsored on a formal or informal basis. This includes donated, lump sum and recurrent payments of accrued sick leave benefits. But, if *you* are working while *disabled,we* will account for such income as described in this *plan's* "Adjustment of Monthly Benefit for Disability Earnings".

- Benefits as shown below from: (1) the United States Social Security Act; (2) the Railroad Retirement Act; or (3) any other like U.S. or Canadian plan or act.

  (a) All disability benefits which: (i) *you* receive; and (ii) *your* spouse receives due to *your disability;*

  (b) All unreduced retirement benefits for which: (i) *you* receive; and (ii) *your* spouse receives due to *your* qualification; and

  (c) All reduced retirement benefits paid to: (i) *you;* and (ii) *your* spouse due to *your* receipt of such benefits.

  We do not reduce *your gross monthly benefit* by the retirement benefits described in (b) and (c) above, to the extent that *you* and *your* spouse received such income prior to the start of *disability. We* will reduce the *gross monthly benefit* by marginal increases in such income *you* and *your* spouse receive after *disability* begins.

  We will reduce *your gross monthly benefit* by benefits referred to in (a), (b) and (c) above, net of attorney fees approved by the Social Security Administration.

  We will reduce *your gross monthly benefit* by benefits referred to in (a), (b) and (c) above to which *your* spouse received due to *your* receipt of, or qualification for, disability benefits. *We* do this without regard to: (a) *your* marital status; (b) where you live; (c) where *your* spouse lives.

- Income of the type that is included in *your insured earnings* for purposes of determining *your gross monthly benefit* under this *plan.*

- That portion of *retirement plan retirement benefits* which the *employer* funds.

- That portion of *retirement plan disability benefits* which the *employer* funds. *We* do not include such benefits if *your* receipts of them will reduce *your future retirement benefits.*

- *Retirement benefits or retirement plan disability benefits* , due to *your disability,* from any *government plan* other than those shown above.

- Disability benefits from any: (1) *no-fault motor vehicle* coverage; (2) motor vehicle financial responsibility act; or (3) like law.

- Payment or settlement, with or without admission of liability, from: (1) a Workers' Compensation law; (2) an occupational disease law; or (3) any other act or law of like intent. This includes: (a) the Jones' Act; (b) the Longshoreman's and Harbor Workers' Compensation Act; or (c) any Maritime doctrine of Maintenance, Wages or Cure. If *you* receive a payment net of attorney fees approved by the Workers' Compensation Board or similar authority, *we* reduce *our* benefit by the net payment.

- Disability benefits from any third party when *your disability* is the result of the negligence or intentional tort liability of that third party. This does not include damages awarded by a court for pain and suffering.

- Unemployment compensation benefits.

- Payment from *your employer* as part of a termination or severance agreement.

We integrate *your gross monthly benefit* with income shown above that *you* receive without regard to the reason *you* receive it.

Our right to reduce *your* benefit by such income shall not be negated by a transfer of claim liability to a third party. Payment by such third party by law, settlement, judgment, waiver or otherwise shall not negate *our* right.

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All Options

Other Income Not Subject to Deduction:

We will not reduce *your gross monthly benefit* by any income *you* receive from the list below.

- Deferred compensation arrangements such as 401(k), 403(b) or 457 plans;
- Profit sharing plans;
- Thrift plans;
- Tax sheltered annuities;
- Stock ownership plans;
- Individual Retirement Accounts (IRA);
- Individual disability income plans;
- Credit disability insurance;
- Non qualified plans of deferred compensation;
- Pension plans for partners;
- Retirement plans of another employer not affiliated with this *plan;*
- Military pension and disability plans.

Lump Sum Payments of Other Income:

Income with which *we* integrate may be paid in a lump sum. In this case, *we* take the equivalent monthly rate stated in the award into account when *we* determine *your monthly benefit.* If no monthly rate is given, *we* pro-rate the lump sum over the lesser of: (a) 60 months; or (b) the expected remaining number of months for which *you* would be entitled to benefits from this *plan,* based on the proof of loss submitted to us.

Cost of Living Freeze:

You may receive a cost of living increase in other income with which *we* integrate. In this case, *we* do not further reduce *your* monthly benefit by the amount of such increase.

Application for Other Income:

You must apply for other income benefits to which *you* may be entitled. If these benefits are denied, *you* must appeal until: (a) all possible appeals have been made; or (b) *we* notify *you* that no further appeals are required.

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If *we* feel *you* are entitled to receive such income benefits, *we* will estimate the amount due to *you* and *your* spouse or lawful domestic partner, and children. *We* will take this estimated amount into account when *we* determine *your monthly benefit.* But, *we* will not take this estimated amount into account if *you* sign our reimbursement agreement. In this agreement *you* promise: (a) to apply for any benefits for which *you* may be eligible; (b) to appeal any denial of such benefits until all possible appeals have been made; and (c) to repay any amount *we* overpaid due to an award of such benefits.

If *we* do reduce the *your gross monthly benefit* by an estimated amount, *we* will adjust *your monthly benefit* when *we* receive written proof: (a) of the amount awarded; or (b) that the other income benefits have been denied; and no further appeals are possible. If *we* underpaid *you, we* pay the full amount of the underpayment in a lump sum.

We will assist *you* in applying for other income benefits.

B883.0484

All Options

Adjustment of Monthly Benefit for Disability Earnings:

We adjust the *monthly benefit* for *disability earnings* as follows.

For each of the first 12 months of payments, following the date *you* first have *disability earnings,* add *your gross monthly benefit* and *your disability earnings.*

(a) If the sum is not more than 100% of *your* indexed *insured earnings, we* do not reduce *your monthly benefit.*

(b) If the sum is more than 100% of *your* indexed *insured earnings, we* reduce *your monthly benefit* by the amount over 100% of *your* indexed *insured earnings.*

For each month thereafter, *we* pay the greater of the amount calculated under Method 1 or Method 2.

Method 1:

(a) If *your disability earnings* are less than 20% of *your* indexed *insured earnings, we* do not reduce *your monthly benefit.*

(b) If *your disability earnings* are 20% or more of *your* indexed *insured earnings, we* reduce *your monthly benefit* by 50% of *your disability earnings.*

Method 2:

(a) Subtract *your disability earnings* from *your* indexed *insured earnings.*

(b) Divide the result in (a) above by *your* indexed *insured earnings.*

(c) Multiply the result in (b) above by *your monthly benefit.* This is the amount *we* pay.

If *your disability earnings* fluctuate widely from month to month, *we* may adjust *your monthly benefit* using an average *disability earnings* amount. The average *disability earnings* amount will be computed using *your* most current month's *disability earnings* and the prior two months *disability earnings.*

Maximum Allowable Disability Earnings: This *plan* limits the amount of income *you* may earn, or may be able to earn, and still be considered *disabled.*

If *your disability earnings* are more than the limit shown below, payments from this *plan* will end. Payments from this *plan* will also end if *you* are able to earn more than the limit shown below:

(a) During the *elimination period* and the *own occupation* period, the limit is 80% of *your* indexed *insured earnings.*

(b) After this *plan* has paid benefits for 24 months in a row, the limit is 60% of *your* indexed *insured earnings.*

B883.0490

All Options

Indexing: *We* apply an indexing factor to *your insured earnings* on the date *you* have received 12 consecutive monthly payments and each anniversary thereafter. This factor increases the amount of income *you* may earn and still be considered *disabled.* This adjustment does not increase *your gross monthly benefit, monthly benefit,* or any other benefit under this *plan.*

To make the first adjustment, *we* multiply *your insured earnings* by the indexing factor for that year. To make adjustments in each later year, *we* multiply the amount of *your* last indexed *insured earnings* by the indexing factor for the current year.

The indexing factor is the lesser of: (a) 10%; or (b) one-half of the *CPI-W* from the prior December.

Minimum Payment: The minimum monthly payment for *disability* under this *plan* is the larger of: (a) 10% of *your gross monthly benefit;* or (b) $100.00.

B883.0500

All Options

Limitations and Exclusions

Disabilities with a Limited Maximum Payment Period *We* limit the *maximum payment period,* if *you* are *disabled* due to: (a) a *mental or emotional condition;* or (b) drug or alcohol abuse. However, if *you* have a coexistent condition, not subject to the limitations in this section, which is *disabling* in and of itself, *we* will not limit benefits as described below.

The *maximum payment period* for all periods of *disability* due to: (a) a *mental or emotional condition;* or (b) drug or alcohol abuse is 24 months. This is a combined maximum for all such conditions and all periods of *disability.*

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No benefits will be paid for *disability* due to a *mental illness* or drug or alcohol abuse if *you* are not receiving treatment for the cause of the *disability* from a provider, or in a facility that is: (a) licensed by the state to provide treatment for such condition; and (b) accredited or approved by the Joint Commission on the Accreditation of Health Care Facilities or Medicare.

If payments under this *plan* would end due to the limits in this section, *we* may extend such payments, as shown below. But, *you* must meet all of the following conditions: (a) *you* must be *disabled* due to a condition named above; (b) *you* must be an inpatient in a qualified institution because of *your disability;* and (c) *you* must have been treated as an inpatient for at least 14 days in a row. In such case, *we* extend payments until the earliest of: (i) 90 days from the date of *your* discharge; (ii) the end of this *plan's maximum payment period;* or (iii) the date *your disability* ends.

As used in this section: "qualified institution" means a legally operated hospital or other public or private facility licensed to provide inpatient medical care and treatment for the cause of *your disability.*

B883.0512

All Options

Pre-Existing Conditions: A pre-existing condition is an *injury* or *sickness,* whether diagnosed or misdiagnosed, and any symptoms thereof, for which, in the look back period, *you:*

(a) receive advice or treatment from a *doctor;*

(b) undergo diagnostic procedures other than routine screening in the absence of symptoms or suspicion of disease process by a *doctor;*

(c) are prescribed or take prescription drugs; or

(d) receive other medical care or treatment, including consultation with a *doctor.*

The "look back period" is the three months before the latest of: (a) the effective date of *your* insurance under this *plan;* (b) the effective date of a change that increases the benefits payable by this *plan;* and (c) the effective date of a change in the *your* benefit election that increases the benefit payable by this *plan.*

No benefits are payable for *disability:* (a) caused by; (b) contributed to by; or (c) resulting from; a pre-existing condition; unless the *disability* starts after *you* complete at least one full day of *active work* after the date *you* are insured under this *plan* for 12 months in a row.

Your disability: (a) caused by; (b) contributed to by; or (c) resulting from; a pre-existing condition may begin after: (a) a change which provides for an increase in the benefits payable by this *plan;* or (b) a change in *your* benefit election which increases the benefit payable by this *plan.* In this case, *your* benefit will be limited to the amount that would have been payable had the change not taken place. But, this limit does not apply if *your disability* starts after *you* complete at least one full day of *active work* after the change has been in force for 12 months in a row.

We do not cover any *disability* that starts before *your* insurance under this *plan.*

B883.0519

All Options

Prior Coverage Credit: If this *plan* replaces a similar income replacement 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.

The pre-existing condition provision will be waived for any *employee* who: (a) is *actively working* on the effective date of this *plan;* and (b) fulfilled the requirements of any pre-existing condition provision of the old plan.

If *you:* (a) were covered under the old plan when it ended; (b) enroll for insurance under this *plan* on or before this *plan's* effective date; and (c) are *actively working* on the effective date of this *plan;* but (d) have not fulfilled the requirements of any pre-existing condition provision of the old plan; *we* credit any time used to meet the old plan's pre-existing condition provision toward meeting this *plan's* pre-existing condition provision.

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

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

B883.0521

Exclusions: This *plan* does not pay benefits for *disability* caused by, or related to:

(a) declared or undeclared war or act of war;

(b) service in the armed forces, National Guard, or military reserves of any state or country;

(c) you take part in a riot or insurrection;

(d) *your* engagement in an illegal occupation;

(e) *your* commission of, or attempt to commit a felony;

(f) *your* participation in any sport for compensation or profit;

(g) *your* voluntary use of any poison, chemical, prescription or non-prescription drug or controlled substance unless: (a) it was prescribed for you by a *doctor;* and (b) it was used as prescribed. In the case of a non-prescription drug, we do not pay for any loss resulting from or contributed to by *your* use in a manner inconsistent with package instructions. A controlled substance is anything called a controlled substance in Title II of the Comprehensive Drug Abuse Prevention and Control Act of 1970, as amended from time to time; or

(h) intentional self-inflicted injuries.

We do not pay any benefits for any period of *disability:*

(1) during which you receive medical treatment or care outside the United States or Canada unless expressly authorized by us;

(2) which starts before you are insured by this *plan;* or

(3) during which *your* loss of earnings is not solely due to *your disability.*

Services

Social Security Assistance: This *plan* requires all *disabled* covered persons to apply for Social Security benefits. (See the "Application for Other Income" section of this *plan.)* If *we* believe a *you* to be eligible for such benefits, *we* may offer to assist *you* in applying for them. Receiving Social Security benefits will protect *your* earnings record for retirement and enable *you* to qualify for Medicare coverage after 24 months.

Services *we* can provide include:

(a) Help in completing *your* application for such benefits, and any related forms;

(b) Assistance finding suitable legal counsel; and

(c) Copies of medical and vocational data needed to file *your* claim.

We may also provide these and other services if *your* benefits are under review for possible termination by the Social Security Administration.

You must apply for all income benefits for which *you* may be eligible, whether or not *you* use our help. Using our help does not cancel *your* duties shown in the "Application for Other Income" section of this *plan.*

Rehabilitation and Case Management: *We* will review *your disability* to see if certain services are likely to help him or her return to *gainful work.* If needed, *we* may ask for more medical or vocational information.

When our review is complete, *we* may offer *you* a *rehabilitation program.*

The *rehabilitation program* will start when a written *rehabilitation agreement* is signed by: (1) *you;* (2) us; and (3) *your* employer, if needed. The program may include, but is not limited to:

(a) vocational assessment of *your* work potential;

(b) coordination and transition planning with an employer for *your* return to work;

(c) consulting with *your doctor* on *your* return to work and need for accommodations;

(d) training in job seeking skills and resume preparation;

(e) retraining; and

(f) assistance with child care expenses *you* incur in order to participate in a *rehabilitation program.* (See the "Dependent Care Expenses" section of this *plan.)*

We have the right to determine which services are appropriate.

If the *you* accept the *rehabilitation agreement, we* will pay an enhanced benefit. The enhanced benefit will be 110% of the *monthly benefit* that would otherwise be paid. This enhanced benefit will be payable as of the first *monthly benefit* after the *rehabilitation program* starts.

We stop paying the enhanced benefit on the earliest of:

(a) The date *your* benefits from this *plan* end;

(b) The date *you* violate the terms of the *rehabilitation agreement;*

(c) The date *you* end the *rehabilitation program;* and

(d) The date the *rehabilitation agreement* ends.

If *you* end a *rehabilitation program* without our consent, *you* must repay any enhanced benefits paid.

Dependent Care Expenses: While *you* are participating in a *rehabilitation program, we* will pay a dependent care expense benefit, when all of the following conditions are met:

(a) *you* incur expense to provide care for a qualified dependent;

(b) the care is provided by a licensed provider other than a family member.

A qualified dependent is: (a) dependent upon the covered person for main support and maintenance; and (b) under the age of fourteen and *your:* (i) biological child; (ii) lawfully adopted child; (iii) stepchild; or (iv) any other child who is living with *you* in a regular parent-child relationship.

The dependent care expense benefit will be the lesser of: (a) $350 per month per qualified dependent; not to exceed $1,000 per month for all qualified dependents combined; and (b) the actual monthly day care expense incurred by *you.*

We will stop paying the dependent care expense benefit on the earlier of the date *you* are no longer: (a) incurring dependent care expenses for a qualified dependent; (b) participating in a *rehabilitation program;* or (c) entitled to receive a *monthly benefit* from this *plan.*

B883.0525

All Options

Worksite Modification Benefit: In order to accommodate *your disability,* an employer may incur a cost to modify *your* worksite. *We* may reimburse the employer, up to $2,500 for the cost of the worksite modification. *We* make this payment if *we* agree that the modification will enable *your* to: (a) return to work; or (b) remain at work.

B883.0526

Early Intervention Services

This *plan* includes Early Intervention Services as part of *our* disability management program. The intent of these services is to: (a) assist *disabled* persons in reaching better outcomes; and (b) support the *employer's* absence management goals by promoting: (1) stay-at work agendas; and (2) return-to work agendas; where possible.

The key to success of an early intervention program is prompt notification of work absences which have the potential to exceed this *plan's elimination period.* With a prompt notification, *we* are able to more effectively manage the potential claim. claim.

When *you* are *disabled* from one of the conditions listed below, a long term disability claim form should be completed as soon as possible following the date of *disability.* To facilitate an immediate intervention, the form should be submitted to *us* within one week of the date *your disability* begins.

- Chronic fatigue conditions, including Epstein-barr syndrome
- *Mental or emotional condition*
- Repetitive motion syndromes or injuries
- Fibromyalgia
- Back pain/strain
- Neck pain/strain
- Chronic pain
- Diabetes
- Cardiovascular conditions

Upon receipt of the completed claim form, *we* will determine whether the claim is appropriate for Early Intervention services. *You* will be notified of our decision. Examples of services, which *we* may provide, at *our* discretion, include, but are not limited to: (a) job accommodation; (b) ergonomic adjustments to workstations; (c) proactive case management consultations with *your doctor* or other providers of medical care.

Supplemental Benefits

Cost of Living Benefit

We apply a cost of living adjustment to *your monthly benefit* each year. This allows *your monthly benefit* to change with inflation. The cost of living benefit supplements this *plan's monthly benefit* after it is adjusted for *disability earnings.*

This benefit begins on the first of the month that follows or coincides with the date *you* are entitled to receive 12 monthly payments in a row from this *plan.*

When *we* make a cost of living adjustment, *we* add a cost of living benefit to *your monthly benefit* after it is adjusted for *disability earnings.* How *we* do this is shown below.

(a) Take *your monthly benefit* for the month before *you* are first entitled to a cost of living adjustment; and adjust it for *disability earnings.*

(b) Multiply the amount in (a) by the current cost of living factor.

(c) Add the result in (b) to the *monthly benefit,* after it is adjusted for *disability earnings,* that is currently payable.

The cost of living factor is 3%.

The cost of living adjustments may cause *your* benefit to be more than the maximum *monthly benefit.*

If the *CPI-W* drops, then the cost of living adjustment reflects the drop. But, *your monthly benefit* after it is adjusted for *disability earnings* will not be less than what it would have been in the absence of this benefit.

B883.0798

All Options

The Survivor Benefit

We may pay a survivor benefit if *you* die after *you:* (a) had been *disabled* for at least six months in a row ; and (b) were entitled to receive at least one full *monthly benefit.* When *we* receive proof of *your* death, *we* pay *your* eligible survivor a lump sum benefit.

We pay a benefit equal to 3 times the amount of *your* last *gross monthly benefit* after it is reduced by *disability earnings.* but, *we* first apply such benefit to reduce any overpayment *you* may owe us.

If *you* have no eligible survivor, no survivor benefit is paid.

Your eligible survivor is *your* spouse or lawful domestic partner, if living.

If *your* spouse is not living, *your* eligible survivor is *your:* (a) unmarried child under age 20; and (b) unmarried child under age 26 who is enrolled as a full-time student at an accredited school. If there is more than one such child when *you* die, this benefit will be paid to each child in equal shares.

Accelerated Survivor Benefit

If *you* have a terminal illness, *we* may accelerate payment of this *plans'* survivor benefit.

For purposes of the accelerated survivor benefit, a terminal illness means a medical condition that is expected to result in *your* death within 6 months.

To receive an accelerated survivor benefit, *you* must: (a) be entitled to receive a *monthly benefit* from this *plan;* (b) request this benefit in writing; and (c) provide written proof of terminal illness from a *doctor.* However, *we* will not pay an accelerated survivor benefit if there are less than 6 months remaining in the maximum benefit period.

If *you* elect to receive an accelerated survivor benefit, no survivor benefit is payable upon *your* death.

B883.0561

Critical Disability Supplement Benefit

If you have a functional disability, you may be eligible for this benefit.

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To start getting this benefit, *you* must meet all of the conditions shown below:

(a) *you* must be *disabled* while insured by this *plan;*

(b) *you* must stay *disabled* for this *plan's elimination period;*

(c) *you* must have a *functional disability:* (i) while entitled to receive a *monthly benefit* from this *plan;* and (ii) that lasts at least 30 days in a row; and

(d) *you* must be receiving *regular care* from a *doctor.*

We use an independent entity to assess *your functional disability.*

You must also permit timely reassessments of *your functional disability* when *we* request them.

If *you* meet the conditions stated above, *we* pay: 20% of *your insured earnings. We* round this amount to the nearest dollar. The monthly maximum for this benefit is $$5,000.00.

We stop paying this benefit on the earlier of the dates shown below:

(a) the date *your monthly benefits* from this *plan* end;

(b) the date *you* no longer have a *functional disability;*

(c) the date *your* coverage under this *plan* ends; or

(d) the date this *plan* is changed to end this benefit.

B883.0718

All Options

Income Recovery Benefit

This *plan* may pay an Income Recovery Benefit, if *monthly benefits* cease because *you* are no longer *disabled.*

To be eligible for the Income Recovery Benefit, *you* must be:

(a) able to perform the substantial and material duties of *your own occupation;* or

(b) if this *plan* has already paid benefits for the *own occupation* period, able to perform the substantial and material duties of any *gainful occupation;* and

(c) working in *your own occupation* the same number of hours as *you* did prior to *disability;* and

(d) unable to earn this *plan's* maximum allowable *disability earnings,* due to the *sickness* or *injury* which caused the prior *disability*.

We pay this benefit monthly, in arrears. *We* determine the amount *we* pay in two steps. In step one, *we* compute the following: (a) *your* gross monthly benefit as of the last month *you* were disabled under the terms of this *plan;* less (b) any other income this *plan* integrates with that *you* are entitled to receive. In step two *we* make a current earnings adjustment. *We* add: (a) *your gross monthly benefit* as of the last month *you* were disabled under the terms of this *plan;* and (b) *your* current *disability earnings.* If such sum exceeds 100% of *your* insured earnings, *we* pay the amount in step one less the excess over 100%. If such sum does not exceed 100%, *we* pay the amount in step one.

We stop paying this benefit on the earliest of:

(a) the date *you* are able to earn this *plan's* maximum allowable *disability earnings;*

(b) the date *you* become disabled;

(c) the date *you* stop working;

(d) the date 12 consecutive months after the first Income Recovery Benefit is paid; or

(e) the end of the *maximum payment period.*

We will not pay more than 12 monthly Income Recovery Benefit payments following any one period of *disability,* including any *recurrent disability.*

B883.0575

All Options

Converting This Group Long Term Disability Income Insurance

When Group Coverage Ends: When *your* coverage under this group long term disability income insurance *plan* ends, *you* may apply to convert *your* group coverage, subject to all the terms below.

You may apply to convert *your* coverage if *you:* (a) are not *disabled* as defined by this *plan* and (b) have been covered under this *plan* for at least 12 months in a row. To meet this 12 months requirement, we will include any time *you* were covered under a similar group disability income replacement plan which this *plan* replaced. We do not include any time *you* were *disabled,* as defined by this *plan.*

But, *you* will not be eligible to apply for conversion if *your* coverage under this *plan* ends because: (a) *you:* (i) fail to make a required contribution; (ii) change to a class not eligible under this *plan;* (iii) retire; or (iv) do not become insured again under this group *plan* after *your disability* ends. *You* will also not be eligible to apply for conversion if *your* coverage ends because: (a) this *plan* ends; or (b) this *plan* is amended to end coverage for all persons in a class.

How and When to Convert: *You* must apply to *us* in writing and pay any required premium for the converted coverage. *You* must do this within 31 days of the date *your* coverage under this *plan* ends.

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You do not have to provide proof of good health. But, issuance of the converted coverage may be subject to other underwriting criteria. *You* must give *us* details about all other disability income insurance: (a) that *you* have; (b) for which *you* have applied; and (c) for which *you* may become eligible under another plan within 31 days after *your* coverage under this *plan* ends.

Guardian will not issue the converted coverage if such coverage would result in the person being overinsured by our standards.

Coverage Under the Conversion Policy: *Your* converted coverage, if issued, will be effective on the date *your* coverage under this *plan* ends. The benefits, terms and conditions of the converted coverage will be those in use in the state where *you* then live. These may be different from the benefits, terms and conditions of this *plan.*

The premium for the converted coverage will be that in effect for *r* age and class of risk on the date the converted coverage is issued.

B883.0583

All Options

Claim Provisions

Authority: *We* have the sole discretionary authority to: (a) interpret the terms of this *plan;* and (b) determine *your* eligibility for: (i) coverage; and (ii) 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 his or her intent to file a claim under this *plan* as described in "Accident and Health Claims Provisions."

For details, *you* can call Guardian at 1-800-538-4583.

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 *employer, you,* and the *doctor(s)* treating *you* for *your sickness* or *injury.* Proof of loss must be given to *us* within the time stated in "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.

(a) The date *disability* began;

(b) *Your* last day of *active work;*

(c) The cause of *disability;*

(d) The extent of *disability,* including limitations and restrictions preventing *you* from performing the substantial and material duties of *your own occupation* and any *gainful occupation.*

(e) If *your* occupation requires that he or she carry liability or malpractice insurance, any changes to such insurance that become effective on or after the date of *disability;*

(f) *Objective medical evidence* in support of *your* limitations and restrictions, beginning with the date *disability* began;

(g) The prognosis of *disability;*

(h) The name and address of all *doctors,* hospitals and health care facilities where the *you* have been treated for *your disability* since the date *disability* began;

(i) Proof that *you:* (i) are currently; and (ii) have been receiving *regular and appropriate care* from a *doctor,* from the date *disability* began;

(j) Proof of *insured earnings,* and, if applicable, *disability earnings;*

(k) Payroll or absence data from the *employer* for the three months prior to the date *disability* began, or other period *we* specify;

(l) Proof of application for all other sources of income to which *you* may be entitled, that may affect *your* payment from this *plan;* and

(m) Proof of receipt of other income that may affect *your* payment from this *plan.*

You provide *objective medical evidence* from a *doctor* who is not him or herself, *your* spouse, child, parent, sibling or business associate.

Proof of *insured earnings* and *disability earnings* may consist of: (1) copies of *your* W-2 forms; (2) payroll records from *your* employer(s); (3) copies of *your* U.S. Individual Income Tax Returns; (4) copies of the U.S. income tax returns from any business in which *you* hold an ownership or shareholder interest; (5) a statement from a certified public accountant; (6) copies of any income records accepted or required by the I.R.S; or (7) any other records *we* deem necessary.

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

The Guardian Life Insurance Company of America
Group Long Term Disability Claims Department
P.O. Box 26025
Lehigh Valley, PA 18002-6025

Authorization Required: *You* 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* 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* benefits.

Right to Request Medical, Financial or Vocational Assessment: *We* may ask *you* to take part in a medical, financial, vocational or other assessment that *we* feel is necessary to determine whether the terms of 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* postpone a scheduled assessment without *our* approval, *you* will be responsible for any rescheduling fees. If *you* do not take part in or cooperate with the assessment, *we* have the right to stop or suspend *your* payments under this *plan.*

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

Payment of Benefits: *We* pay benefits to *you,* if *you* are legally competent. If *you* are not, *we* pay benefits to the legal representative of *your* estate. Benefits are paid in US dollars.

We pay benefits once each month 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* are entitled may remain unpaid at *your* death. Such benefits may be paid at *our* discretion to: (a) *your* estate; or (b) *your* spouse, parents, children, or brothers and sisters.

Partial Month Payment: *You* may be *disabled* for only part of a month. In this case, *we* compute *your* payment as 1/30th of the benefit to which *you* would be entitled for the full month times the number of days *you* are *disabled.* Payment will not be made for more than 30 days in any month.

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

B883.0587

Definitions

Active Work, Actively-At-Work or Actively Working *You* are able to perform and are performing all of the regular duties of *your* work for *your employer,* on a full-time basis at: (a) one of *your employer's* usual places of business; (b) some place where *your employer's* business requires *you* to travel; or (c) any other place *you* and *your employer* have agreed on for *your* work.

CPI-W That part of the United States Department of Labor Consumer Price Index that measures the relative value of the cost of a typical urban wage earner's purchase of certain goods and services. If the Department of Labor stops publishing the *CPI-W, we* have the right to use some other similar standard.

B883.0590

All Options

Disability or Disabled These terms mean that a current *sickness* or *injury* causes physical or mental impairment to such a degree that *you* are:

(1) During the *elimination period* and the *own occupation* period, not able to perform, on a full-time basis, the substantial and material duties of *your own occupation.*

(2) After the end of the *own occupation* period, not able to perform, on a full-time basis, the substantial and material duties of any *gainful work.*

You are not *disabled* if *you* earn, or are able to earn, more than this *plan's* maximum allowed *disability earnings.*

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

Neither: (a) loss of a professional or occupational license; or (b) receipt of or entitlement to Social Security disability benefits; in and of themselves constitute *disability* under this *plan.*

B883.0598

All Options

Disability Earnings The monthly income *you* earn from working while *disabled.* It includes salaries, wages, commissions, bonuses and any other compensation earned or accrued while working including pension, profit sharing contributions, sick pay, paid time off, holiday and vacation pay. When *you* have an ownership interest in the business, *disability earnings* also includes business profits, attributable to *you,* whether received or not. It includes any income *you* earn while *disabled* and return to *your employer,* partnership, or any other similar business arrangement to cover any business or overhead expenses. If *you* have the ability to work on a *part-time* or full-time basis, following the earlier of the date *you:* (a) have been terminated from employment with the *employer;* b) have been *disabled* for 12 months in a row; or (c) have been offered a job or workplace modification by the *employer* and *you* do not return to work; *disability earnings* also includes *maximum capacity earnings.*

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

Elimination Period The period of time *you* must be *disabled,* due to a covered *disability,* before this *plan's* benefits are payable.

Any days during which *you* return to work earning more than 80% of *your insured earnings* will not count toward the *elimination period.* If *you* are or become eligible under any other similar group income replacement plan while *you* are working during the *elimination period, you* will not be entitled to benefits from this *plan.*

We do not require *you* to complete an elimination period if: (a) *you* were covered under a similar income replacement plan the *employer* had with another insurer on the day before this plan starts; (b) *your* disability would have been a recurring disability under the prior plan had it remained in effect.

Functional Disability or Functionally Disabled Means due to *sickness* or *injury* you are:

(a) not able to perform two or more activities of daily living on a routine basis, without help; or
(b) cognitively impaired and in need of verbal cueing to protect *yourself* or others.

Gainful Occupation or Gainful Work Work for which *you* are, or may become, qualified by: (a) training; (b) education; or (c) experience. When *you* are able to perform such work on a full-time basis, *you* can be expected to earn at least 60% of *your* indexed *insured earnings* within 12 months of returning to work.

Government Plan Any of the following: (1) the United States Social Security Act; (2) the Railroad Retirement Act; (3) the Canadian Pension Plan; or (4) any other plan provided under the laws of a state, province or any other political subdivision. It also includes: (a) any public employee retirement plan; or (b) any plan provided in place of the above named plan or acts. It does not include: (i) any Workers' Compensation Act or similar law; (ii) the Jones' Act; (iii) the Longshoreman's and Harbor Workers' Compensation Act; or (iv) the Maritime Doctrine of Maintenance, Wages, or Cure.

Gross Monthly Benefit This *plan's monthly benefit* before it is integrated with other income and earnings.

Injury A bodily *injury* due to an accident that occurs, independent of all other causes, while *you* are insured by this plan. *We* will cover a disability caused by an *injury* when the disability starts within 90 days of the date of such *injury.*

All Options

Insured Earnings Only *your* earnings from the *employer* will be included as *insured earnings.*

We calculate benefit amounts and limits based on the amount of *your insured earnings* as of the Redetermination date immediately prior to the start of *your disability.* See the "Redetermination" section of this *plan.*

For Partners and S Corporation Shareholders:

Insured earnings means the sum of the amounts listed below, divided by 12.

(a) *Your* compensation as an employee or S Corporation shareholder, as reported on *your* Federal Income Tax Return, Form 1040, for the prior calendar year, less the gross total of unadjusted employee business expenses as included on the corresponding Schedule A-Itemized Deductions;

(b) *Your* non-passive income (loss) from trade or business as reported on Schedule E-Part II of *your* Federal Income Tax Return, Form 1040, for the prior calendar year, less any expenses incurred and reported elsewhere on *your* Return; and

(c) *Your* contributions during the prior calendar year, deposited into a: (a) cash or deferred compensation plan, or salary reduction plan, qualified under IRC Section: 401(k); 403(b); 457; or similar plan; and (b) elective employee pre-tax deferrals to a Section 125 plan or flexible spending account.

You may not have been a partner or S Corporation shareholder for the entire previous calendar year. In this case, *your* earnings are based on the monthly average of the sum of the listed amounts, averaged for the full number of months that *you* were a partner or an S Corporation shareholder during such calendar year.

For Sole Proprietors:

Insured earnings means: (a) the average monthly net profit as determined from Schedule C - Part II of *your* Federal Income Tax Returns, Form 1040, for the prior calendar year; plus (b) *your* average monthly contribution during the prior calendar year deposited into a: (i) cash or deferred compensation plan, or salary reduction plan, qualified under IRC Section: 401(k); 403(b); 457; or similar plan; and (ii) a Section 125 plan or flexible spending account. Monthly net profit is calculated as gross income less total expenses. *You* may not have been a sole proprietor for the previous calendar year. In this case, *we* calculate average monthly net profit and average monthly contributions using the full number of months that *you* were a sole proprietor during such calendar year.

For Covered Persons Who Are Compensated on Less Than a 12 Month Basis:

Insured earnings means *your* average rate of monthly earnings determined from *your* annual contract salary. Insured earnings also includes *your* contributions deposited into a: (a) cash or deferred compensation plan, or salary reduction plan, qualified under IRC Section: 401(k); 403(b); 457; or similar plan; and (b) elective employee pre-tax deferrals to a Section 125 plan or flexible spending account. Insured earnings does not include bonuses, commissions, overtime pay, expense accounts, stock options and any other extra compensation. *We* do not include pay for hours worked or billed over 40 per week. Earnings based on excluded income and *employer* contributions deposited into such 401(k); 403(b); 457; or similar plan are excluded.

For Covered Persons Whose Income Is Reported on a IRS Form 1099:

Insured earnings means *your* average rate of monthly earnings as figured from the 1099 form received from the *employer* for the prior calendar year, calculated as (a) minus (b), divided by 12 or the number of months *you* worked for the *employer* during such calendar year, if less than 12.

(a) *your* earned income as reported on the 1099 form.

(b) business expenses, as reported on Schedule C - Part II of *your* Federal Income Tax Return, Form 1040. Insured earnings also includes *your* contributions deposited into a: (a) cash or deferred compensation plan, or salary reduction plan, qualified under IRC Section: 401(k); 403(b); 457; or similar plan; and (b) elective employee pre-tax deferrals to a Section 125 plan or flexible spending account.

Earnings based on excluded income and *employer* contributions deposited into such 401(k); 403(b); 457; or similar plan are excluded.

For All Other Covered Persons:

Insured earnings means *your* base monthly salary. Insured earnings also includes *your* contributions deposited into a: (a) cash or deferred compensation plan, or salary reduction plan, qualified under IRC Section: 401(k); 403(b); 457; or similar plan; and (b) elective employee pre-tax deferrals to a Section 125 plan or flexible spending account. Insured earnings does not include bonuses, commissions, overtime pay, expense accounts, stock options and any other extra compensation. *We* do not include pay for hours worked or billed over 40 per week. Earnings based on excluded income and *employer* contributions deposited into such 401(k); 403(b); 457; or similar plan are excluded.

B883.0768

All Options

Maximum Capacity Earnings During the own occupation period, the income *you* could earn if working to the fullest extent *you* are able to in *your* own occupation. After the own occupation period, the income *you* could earn if working to the fullest extent *you* are able to in any gainful occupation. *We* decide the fullest extent of work *you* are able to do based on objective data provided by any or all of the following sources: (a) *your* treating doctor; (b) impartial medical or vocational exams; (c) peer review specialists; (d) functional capacities exams; and (e) other medical and vocational specialists whose area of expertise is appropriate to *your* disability.

Maximum Payment Period The longest time that benefits are paid by this *plan.*

Mental or Emotional Condition 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: (a) caused by; (b) contributed to by; or (c) result in; physical, biological or chemical factors or symptoms. For purposes of this *plan, mental or emotional condition* does not include: (a) irreversible dementia caused by Alzheimer's disease, stroke, trauma or viral infection; or (b) any other condition not typically treated by a psychiatrist, clinical psychologist or other qualified mental health practitioner with psychotherapy or psychotropic drugs.

Monthly Benefit This *plan's gross monthly benefit* reduced by other income. If *you* are working while *disabled, your monthly benefit* will be further reduced based on the amount of *your disability earnings.*

No-Fault Motor Vehicle Coverage A motor vehicle plan that pays disability or medical benefits no matter who was at fault in an accident.

Objective Medical Evidence May include but is not limited to: (a) diagnostic testing; (b) laboratory reports; and (c) medical records of a *doctor* 's exam documenting: (i) clinical signs; (ii) presence of symptoms; and (iii) test results consistent with generally accepted medical standards supported by nationally recognized authorities in the health care field.

Own Occupation Means the occupation: (a) *you* are routinely performing immediately prior to disability; (b) which is *your* primary source of income prior to disability; and (c) for which *you* are insured under this plan. Occupation includes any employment, trade or profession that are related in terms of similar: (i) tasks; (ii) functions; (ii) skills; (iv) abilities; (v) knowledge; (vi) training; and (vii) experience; required by employers from those engaged in a particular occupation in the general labor market in the region, within commuting distance of *your* home. Occupation is not specific to a certain employer or a certain location.

B883.0624

All Options

Part-Time The ability to work and earn between 40% and 80% of *insured earnings* during the *own occupation* period and between 40% and 60%% of *insured earnings* after the *own occupation* period.

Reasonable Accommodation Any modification or adjustment to: (i) a job; (ii) an employment practice; (iii) a work process; or (iv) the work place; that an employer willingly provides. The modification or adjustment must make it possible for a *disabled* person to: (1) reach the same level of performance as a similarly situated non-disabled person; or (2) enjoy equal benefits and privileges of employment as are available to a similarly situated non-disabled person. The modification or adjustment must not place an undue hardship on the employer.

Recurring Disability A later *disability* that: (a) is related to an earlier *disability* for which this *plan* paid benefits; and (b) meets the conditions described in "Recurring Disability."

Regular and Appropriate Care Means, with respect to *your:* (a) disabling condition; and (b) any other condition which, if left untreated, would adversely affect *your* disabling condition; *you* (i) visit a *doctor* as frequently as medically required, according to generally accepted medical standards, to effectively manage these conditions; and (ii) 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(s)* whose specialty is most appropriate for *your:* (a)*disability;* and (b) any other conditions which left untreated would adversely affect *your* disabling condition; according to generally accepted medical standards. Generally accepted medical standards are those supported by nationally recognized authorities in the health care field including: the American Medical Association (AMA); the AMA Board of Medical Specialties; the Food and Drug Administration; the Centers for Disease Control; the National Cancer Institute; the National Institutes of Health; the Department of Health and Human Services; and any other agency of similar repute.

CGP-OR-AG-10

Rehabilitation Agreement A formal agreement between: (a) *you;* (b) *us;* and (c) *your employer,* if needed. It outlines the *rehabilitation program* in which *you* agree to take part.

Rehabilitation Program A program of work or job-related training for *you* that *we* approve in writing. Its aim is to restore *your* wage earning abilities.

Retirement Plan A defined benefit or defined contribution plan funded wholly or in part by the *employer's* deposits for *your* benefit. The term does not include: (a) profit sharing plans; (b) thrift plans; (c) non-qualified deferred compensation plans; (d) individual retirement accounts; (e) tax sheltered annuities; (f) 401(k), 403(b), 457 or similar plans; or (g) stock ownership plans. *Retirement Plan* **"retirement benefits"** are lump sum or periodic payments at normal or early retirement. Some *retirement plans* make payments for disability (as defined by those plans) that start before normal retirement age. When such payments reduce the amount that would have been paid at normal retirement age, they are *retirement benefits.* When such payments do not reduce the normal retirement amount, they are **"disability benefits."**

Sickness An illness or disease. Pregnancy is treated as a *sickness* under this *plan.*

We, Us, and Guardian The Guardian Life Insurance Company of America.

All Options

GLOSSARY

This Glossary defines the italicized terms appearing in *your* certificate.

General Definitions

Active Work, Actively-At-Work Or Actively Working means *you* are able to perform and are performing all the regular duties of *your* work for *your employer* and working *your* regular number of hours at: (a) one of *your employer's* usual places of business; (b) some place where *your employer's* business requires *you* to travel; or (c) any other place *you* and *your employer* have agreed on for *your* work

CGP-OR-01 B891.0002

All Options

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

CGP-OR-01 B891.0003

All Options

Enrollment Period for dependent coverage is the 31 day period which starts on the date that *you* first become eligible for dependent coverage.

CGP-OR-01 B891.0004

All Options

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

CGP-OR-01 B891.0005

All Options

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

CGP-OR-01 B891.0007

All Options

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

CGP-OR-01 B891.0008

All Options

Qualified Retiree means Qualified retirees are covered as outlined in your company's benefit provisions. Please see Your Plan Administrator for details.

CGP-OR-01 B891.0010

Definitions Applicable to Life and Accidental Death and Dismemberment Coverage

CGP-OR-01 B891.0013

All Options

Doctor means any medical practitioner *we* are required by law to recognize. He or she must: (a) be properly licensed or certified by the laws of the state where he or she practices; and (b) provide services that are within the lawful scope of his or her practice. *We* do not recognize *you,* or *your* spouse, child, parent, sibling, or business associate, as a *doctor* with respect to *your* claim for this *plan's* benefits.

CGP-OR-01 B891.0059

All Options

Proof of Insurability means an application for insurance showing that a person is insurable.

CGP-OR-01 B891.0060

All Options

Regular Care means a person is being treated by, or in consultation with, a *doctor* at a frequency that is consistent with his or her condition. The requirement for *regular care* does not apply if he or she has reached his or her maximum point of recovery yet is still *disabled* under the terms of this *plan.*

CGP-OR-01 B891.0061

All Options

No-Fault Motor Vehicle Coverage means a motor vehicle plan that pays disability or medical benefits no matter who was at fault in an accident.

CGP-OR-01 B891.0114

STATEMENT OF ERISA RIGHTS

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

Receive Information About Your Plan and Benefits

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

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

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

Prudent Actions By Plan Fiduciaries

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

Enforcement Of Your Rights

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

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

Assistance with Questions

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

B800.0093

Disability Benefits Claims Procedure

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

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

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

Definitions

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

Timing For Initial Benefit Determination

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

Guardian will provide a benefit determination not later than 45 days from the date of receipt of a claim. This period may be extended by up to 30 days if Guardian determines that an extension is necessary due to matters beyond the control of the plan, and so notifies the claimant before the end of the initial 45-day period. Such notification will include the reason for the extension and a date by which the determination will be made. If prior to the end of the 30-day period Guardian determines that an additional extension is necessary due to matters beyond the control of the plan, and so notifies the claimant, the time period for making a benefit determination may be extended for up to an additional period of up to 30 days. Such notification will include the special circumstances requiring the extension and a date by which the final determination will be made.

A notification of an extension to the time period in which a benefit determination will be made will include an explanation of the standards upon which entitlement to a benefit is based, any unresolved issues that prevent a decision of the claim, and the additional information needed to resolve those issues.

If a claimant fails to provide all information needed to make a benefit determination, Guardian will notify the claimant of the specific information that is needed as soon as possible but no later than 45 days after receipt of the claim.

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

Adverse Benefit Determination

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

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

Appeal of Adverse Benefit Determinations

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

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

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

In reviewing an appeal, Guardian will

- provide for a review conducted by a named fiduciary who is neither the person who made the initial adverse determination nor that person's subordinate;

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

Guardian will notify the claimant of its decision not later than 45 days after receipt of the request for review of the adverse determination. This period may be extended by an additional period of up to 45 days if Guardian determines that special circumstances require an extension of the time period for processing and so notifies the claimant before the end of the initial 45-day period.

A notification with respect to an extension will indicate the special circumstances requiring an extension of the time period for review, and the date by which the final determination will be made.

Alternative Dispute Options

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

B800.0075

All Options

Termination of This Group Plan

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

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

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

B800.0007

Life And Accidental Death And Dismemberment Insurance Claims Procedure

Claim forms and instructions for filing claims may be obtained from the Plan Administrator.

Guardian is the Claims Fiduciary with discretionary authority to determine eligibility for benefits and to construe the terms of the plan with respect to claims.

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

(a) If a claim is wholly or partially denied, the claimant will be notified of the decision within 90 days after Guardian received the claim.

(b) If special circumstances require an extension of time for processing the claim, written notice of the extension shall be furnished to the claimant prior to the termination of the initial 90-day period. In no event shall such extension exceed a period of 90 days from the end of such initial period. The extension notice shall indicate the special circumstances requiring an extension of time and the date by which The Guardian expects to render the final decision.

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

  (1) the specific reason(s) the claim was denied;

  (2) specific references to the pertinent plan provision on which the denial is based;

  (3) a description of any additional material or information needed to make the claim valid, and an explanation of why the material or information is needed;

  (4) an explanation of the plan’s claim review procedure. A claimant must file a request for review of a denied claim within 60 days after receipt of written notification of denial of a claim.

(d) Guardian will notify the claimant of its decision within 60 days of receipt of the request for review. If special circumstances require an extension of time for processing, The Guardian will render a decision as soon as possible, but no later than 120 days after receiving the request. The Guardian will notify the claimant about the extension.

YOUR BENEFITS INFORMATION - ANYTIME, ANYWHERE

www.GuardianAnytime.com

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

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

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

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

To register, go to www.GuardianAnytime.com

GUARDIAN℠

The Guardian Life Insurance Company of America
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New York, New York 10004-2616

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