YOUR GROUP INSURANCE PLAN BENEFITS

BRYAN COUNTY BOARD OF EDUCATION

CLASS 0001

CRITICAL ILLNESS, CANCER BENEFITS

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

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

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

New Mexico Residents
Consumer Complaint Notice

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

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

CCN-2019-NM B999.0042

Guardian®

The Guardian Life Insurance Company of America
10 Hudson Yards, New York, New York 10001

Critical Illness insurance member guide

Welcome to Guardian!

We've been selected by your organization to provide group critical illness insurance. We'd like to welcome you to our company!

This is the Member Guide

This member guide explains how this insurance works and includes important details about the coverage.

We're here to help. Contact us if you have any questions or want to talk about any part of this member guide.

1-800-627-4200 **guardianlife.com**

Planholder: BRYAN COUNTY BOARD OF EDUCATION

Plan Number: 00552324

Important Notice: This is a limited plan of critical illness insurance. It's a supplement to health insurance. It isn't a substitute for hospital or medical expense insurance, a health maintenance organization (HMO) contract, or major medical expense insurance. Please read this member guide carefully to fully understand what it covers, what it doesn't cover, and what limits it has.

B660.0004

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Important information regarding your insurance

If you need to contact someone about this insurance for any reason, please contact your agent or us. You may contact us at the following address and telephone number:

The Guardian Life Insurance Company of America
10 Hudson Yards
New York, New York 10001
Telephone: 800-541-7846

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

Virginia State Corporation Commission
Bureau of Insurance
P.O. Box 1157
Richmond, VA 23218

Telephone Numbers
National Toll-Free Number: (877) 310-6560
Toll-Free Number: (800) 552-7945
Local Number: (804) 371-9691
Fax Number: 804-371-9944

It's better to submit written correspondence so that a record of your inquiry is maintained. When contacting your agent, us or the Bureau of Insurance, have your policy number available.

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Guide basics

This Member Guide is part of a group insurance Plan

We've entered into an agreement with the Planholder listed on the first page to provide this insurance coverage. The details of the agreement are contained in a Policy we've issued to the Planholder.

This is the member guide part of the Policy. This member guide is considered a certificate of insurance. It's important because it tells you how this insurance coverage works. To make things easier, we usually refer to this simply as the guide.

Unless we specifically say otherwise, when we mention "you" and "your" in this guide, we're referring to you, a member of the organization listed on the first page as the Planholder. Where we say "we" and "us", we're referring to The Guardian Life Insurance Company of America. We usually refer to ourselves simply as Guardian.

If you're eligible for coverage, as explained in the **Who's eligible** section of this guide, this coverage offers the benefits for which you've enrolled and paid the appropriate premium.

Some benefit amounts may require you to submit information about your health before we'll agree to insure you for the full amount. Please see the **Information about your health** section and **the Information about your family's health section** for more information.

If you have any questions about whether this coverage is available to you, check with the Planholder.

If we mention "calendar year" in this guide, we mean the period that begins on January 1st and ends on December 31st.

How this guide is organized

This guide has five sections. Here's what you'll find in each section:

- **Your benefits**
  This section will help you understand the benefits that are available through this guide. We'll also explain the situations where benefits won't be paid. And we'll tell you what could change your benefits.
- **How to submit a claim**
  This is where you'll find how you can submit a claim for benefits.
- **Member coverage & family coverage**
  Here's where we explain who's eligible for this coverage and what you need to do to obtain coverage. We also explain when your coverage begins and when it ends.
- **Other things you should know about getting and keeping this coverage**
  You should review and understand these other items that are also important to your coverage.
- **Covered Illnesses Guide**
  This may be a separate document but is considered part of this guide. It lists the different illnesses covered by this guide and explains the details and requirements you need to know.

If this guide is translated into another language

If this guide is translated into another language, the English language version will be used to resolve any disputes or conflicts.

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Option D

Your benefits

Critical illness benefits

This section tells you about the critical illness benefits available through this guide, including:

- The illnesses that are covered
- How much we'll pay

When we mention family and family members in this section, we're referring to family members who are covered by this guide.

B660.0007

Option D

Benefit amount

The benefits available for the illnesses covered by this guide are based on the benefit amount you select.

The benefit amounts from which you can choose are shown below.

Family members covered by this guide will have their own benefit amounts. The benefit amount for family members is a percentage of your benefit amount. The amounts from which you can choose are also shown below.

B660.0010

Option D

Your benefit options

Benefit amount:

B660.0331

Option D

$5,000.00 to $30,000.00 in increments of $5,000.00

B660.0393

Option D

Spouse benefits:

B660.0353

Option D

$2,500.00 to $15,000.00 in increments of $2,500.00 up to 50% of Member benefit

B660.0408

Option D

Child benefits:

B660.0458

Option D

25% of Member benefit

B660.0432

Option D

Covered Illnesses

The illnesses that are covered by this guide are listed in the table below. You'll see each illness has a percentage that appears next to it for its first occurrence. This is the percentage of your benefit amount we'll pay if you become eligible to receive benefits for the first occurrence of that illness.

For some illnesses, you'll see there's also a percentage listed for a recurrence of that illness. This is the percentage of your benefit amount we'll pay if you become eligible to receive benefits for a recurrence of that illness.

A recurrence is when an illness that previously occurred returns or happens again. See the **Recurrent illnesses** section for more information on when benefits are available for an illness that recurs.

See the Covered Illnesses Guide for a detailed explanation of each illness and when it occurs.

If family members are covered by this guide we'll pay the same percentage listed below, but it will be a percentage of the benefit amount for the family member that has the illness.

B660.0015

Option D Covered illnesses	Benefit for First Occurrence	Benefit for Recurrence
Option D **Heart disorders**		
Option D Coronary artery disease	30%	30%
Option D Coronary artery disease - requiring a bypass	50%	0%
Option D Heart attack	100%	100%
Option D Heart failure	100%	100%
Option D Pacemaker	10%	0%
Option D **Lung and vascular disorders**		
Option D Aneurysm	10%	0%
Option D Pulmonary embolism	30%	0%
Option D Stroke - moderate	50%	50%
Option D Stroke - severe	100%	100%
Option D Transient ischemic attack (TIA)	10%	0%
Option D **Neurological disorders**		
Option D Alzheimer’s disease - early stage	50%	0%

Option D		
Alzheimer’s disease - advanced stage	100%	0%
Option D		
Amyotrophic lateral sclerosis (ALS)	100%	0%
Option D		
Dementia - other causes	100%	0%
Option D		
Huntington’s disease	30%	0%
Option D		
Multiple sclerosis (MS) - early stage	50%	0%
Option D		
Multiple sclerosis (MS) - advanced stage	100%	0%
Option D		
Myasthenia gravis	30%	0%
Option D		
Parkinson’s disease - early stage	50%	0%
Option D		
Parkinson’s disease - advanced stage	100%	0%

Option D

Additional disorders

Option D		
Addison’s disease	30%	0%
Option D		
Coma	100%	0%
Option D		
Infectious/Contagious disease	30%	0%
Option D		
Kidney failure	100%	100%
Option D		
Loss of hearing	100%	0%
Option D		
Loss of sight	100%	0%

Option D		
Loss of speech	100%	0%
Option D		
Major organ failure - liver, pancreas, lungs	100%	100%
Option D		
Permanent paralysis	100%	0%
Option D		
Severe burns	100%	0%
Option D		

Childhood illnesses and disorders

Option D		
Autism spectrum disorder	100%	0%
Option D		
Cerebral palsy	100%	0%
Option D		
Cleft lip or cleft palate	100%	0%
Option D		
Clubfoot	100%	0%
Option D		
Congenital heart defect	100%	0%
Option D		
Cystic fibrosis	100%	0%
Option D		
Diabetes - type 1	100%	0%
Option D		
Down syndrome	100%	0%
Option D		
Hemophilia	100%	0%
Option D		
Multisystem inflammatory syndrome (MIS)	100%	0%
Option D		
Muscular dystrophy	100%	0%

Option D

Spina bifida	100%	0%

Option D

Your other benefits

This section explains the other benefits available through this guide.

If any benefits listed below are for a service or treatment, the service or treatment must be received while your coverage under this Plan is in place.

When we say "you" and "your" in this section, we're referring to a person that's covered by this guide. This could be you, the member, or a family member.

When we mention family and family members in this section, we're referring to family members who you've enrolled in this Plan.

If any benefits are available only to you, the member, or only to you and your spouse, we'll tell you this where we describe the benefits below.

B660.0267

Option D

Health screening

Your benefits	Spouse benefits	Child benefits
Benefit amount $50.00	$50.00	$50.00

We'll pay the benefit amount shown if you receive one of the following tests or procedures:

Health screening tests and procedures

- Abdominal aortic aneurysm ultrasonography
- Blood test for triglycerides
- Bone marrow testing
- Bone density screening
- Breast ultrasound
- CA 15-3 (blood test for breast cancer)
- CA125 (blood test for ovarian cancer)
- Carotid ultrasound
- CEA (blood test for colon cancer)
- Chest X-ray
- Colonoscopy
- Completion of a smoking cessation program
- Completion of a weight reduction program
- Double contrast barium enema
- Flexible sigmoidoscopy
- Hemoccult stool analysis
- Immunizations
- Lymphocyte genome sensitivity test (LGS)
- Mammography
- Pap Smear
- PSA (blood test for prostate cancer)
- Routine/annual physical
- Serum cholesterol test for HDL and LDL
- Serum protein electrophoresis (blood test for myeloma)
- Skin cancer biopsy
- Stress test on bicycle or treadmill
- Thermography
- Thinprep pap test

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EKG

Virtual colonoscopy

Fasting blood glucose test

- We'll pay this benefit without regard to the test results.
- This benefit is available for one health screening test or procedure performed or received during any calendar year.
- This benefit is available to you and each of your family members separately.

B660.0306

Option D

Waiver of Premium

If you receive benefits for any of the illnesses listed in the **Covered illnesses** section and you become disabled by the same illness for at least 90 days, you won't have to pay additional premiums for this coverage for as long as you remain disabled.

- To be considered disabled, you must be all of the following:
  - Unable to work at any job that you're qualified for by education, training or experience
  - Not working any job for pay or benefits
  - Under the regular care of a physician who has the appropriate training or specialization needed to manage the illness in accordance with generally accepted medical standards
- No refund will be made for premiums already paid.
- Premiums will become payable again beginning with the first day you no longer meet the above requirements.
- This benefit is available to you, the member only, but the cost of your family members' coverage will also be waived if you become eligible for this benefit.

B660.0555

Option D

When we won't pay benefits

This section describes situations where benefits may be limited or unavailable.

B660.0576

Option D

Recurrent illnesses

B660.0578

Option D

Illnesses that were diagnosed before your coverage begins

No benefits listed under the **Critical illness benefits** section are available for any illness or condition that was already diagnosed before your coverage under this guide begins.

If family members are covered by this guide, no benefits listed under the **Critical illness benefits** section are available for any family member's illness or condition that was already diagnosed before that family member's coverage under this guide begins.

B660.0592

Option D

Pre-existing illnesses and conditions diagnosed after your coverage begins Critical illness benefits

B660.0593

Option D

Critical illness benefits are available immediately for an illness or condition that existed before your coverage under this guide begins as long as it isn't diagnosed for the first time until after your coverage under this guide begins.

If family members are covered by this guide, critical illness benefits are available immediately for a family member's illness or condition that existed before the family member's coverage under this guide begins as long as it isn't diagnosed for the first time until after the family member's coverage under this guide begins.

B660.0595

Option D

Exclusions - other situations that aren't covered

See the **What isn't covered - Exclusions** section of the Covered Illnesses Guide for other reasons benefits won't be available.

B660.0612

Option D

Things that can increase your benefits

B660.0613

Option D

Choose a different benefit option

If you'd like to increase your benefit amount by choosing a different option offered by your Planholder, you can do so at any time. You can choose from the following options:

B660.0614

Option D

- Any amount ranging from $5,000.00 to $30,000.00, in increments of $5,000.00

B660.0615

Option D

You can be insured under only one option at any time.

You must notify the Planholder if you'd like to increase your benefits and pay the required premium. Please contact your Planholder if you have any questions about how to make this change.

Information about your health may be required to increase your benefits, as explained in the **Information about your health** section.

If we reject a request to increase benefits because of information about your health, you'll have to submit updated health information for any subsequent increases in any amount. See the **Information about your health** section for more information.

An increase in your benefits may also require you to give us information about your family's health, as explained in the **Information about your family's health** section.

B660.0645

Option D

If you choose to increase your benefits

If benefits under this guide are increased, the additional benefits will be subject to the **Pre-existing illness** section. The **Pre-existing illness** limitations for the additional benefits, including what's considered an illness or condition that existed before your coverage begins, will be based on the date the increase in benefits begins.

If information about your health isn't required, the increase in benefits will begin at 12:01 AM Eastern Standard Time on the first day of the month immediately following the open enrollment period.

If information about your health is required, the increase will begin at 12:01 AM Eastern Standard Time on the first day of the month immediately following our approval.

Any increase will also be subject to the **When an increase in your benefits begins** section.

B660.0649

Option D

Choose a different benefit option

If you'd like to decrease your benefit amount by choosing a different option offered by your Planholder, you can do so at any time.

You can be insured under only one option at any time.

You must notify the Planholder if you'd like to reduce your benefit amount and pay the required premium. Please contact your Planholder if you have any questions about how to make this change.

If you choose to decrease your benefits
The reduction will take effect at 12:01 AM Eastern Standard Time on the date immediately following our being notified by the Planholder of the change.

B660.0658

Option D

Information about your health

Before we can agree to provide the insurance coverage you elect, you may have to submit additional information about your health and medical history.

If information about your health is required, we'll provide you with the forms you need to complete.

Coverage for benefit amounts that require you submit information about your health won't take effect until we have received this information and approved it in writing. Our acceptance of any premium doesn't eliminate or waive this requirement. If we review your health information and find that we can't issue the coverage you requested, we'll issue a refund of any overpaid premium.

B660.0660

Option D

Guaranteed issue amount

You can elect a benefit amount of up to $30,000.00 without having to provide information about your health.

B660.0662

Option D

Information about your health is required when any of the following occur:

B660.0665

Option D

- You enroll for this coverage outside of the open enrollment period, unless you're able to do so because of a qualifying life event.

B660.0668

Option D

- You elect a benefit amount greater than $30,000.00.

B660.0671

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Option D

- You enroll for this coverage more than 31 days after the date you became eligible to enroll.
- You were previously declined for additional benefits under this Plan.

B660.0675

Option D

Things that can increase your family benefits

If benefits under this guide are increased, the additional benefits will be subject to the **Pre-existing illness** section. The **Pre-existing illness** limitations for the additional benefits, including what's considered an illness or condition that existed before your coverage begins, will be based on the date the increase in benefits begins.

If information about your health isn't required, the increase in benefits will begin at 12:01 AM Eastern Standard Time on the first day of the month immediately following the open enrollment period.

If information about your health is required, the increase will begin at 12:01 AM Eastern Standard Time on the first day of the month immediately following our approval.

The increase in benefits will begin at 12:01 AM Eastern Standard Time on the first day of the month immediately following our approval.

Any increase will also be subject to the **When an increase in your benefits begins** section.

B660.0677

Option D

Choose a different benefit option

If you'd like to increase your spouse benefit amount by choosing a different option offered by your Planholder, you can do so at any time. You can choose from the following options:

B660.0678

Option D

$2,500.00 to $15,000.00 in increments of $2,500.00 up to 50% of Member benefit

B660.0408

Option D

A spouse can be insured under only one option at any time.

You must notify the Planholder if you'd like to change your spouse benefit amount and pay the required premium. Please contact your Planholder if you have any questions about how to make this change.

Information about your spouse's health may be required to increase your benefits, as explained in the **Information about your family's health** section.

If we reject a request to increase benefits because of information about your spouse's health, you'll have to submit updated health information for any subsequent increases in any amount. See the **Information about your family's health** section for more information.

B660.0707

Option D

Choose a different benefit option

If you'd like to decrease your family member benefit amount by choosing a different option offered by your Planholder, you can do so at any time.

A family member can be insured under only one option at any time.

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You must notify the Planholder if you'd like to reduce your family member benefit amount and pay the required premium. Please contact your Planholder if you have any questions about how to make this change.

If you choose to decrease your family benefits
The reduction will take effect at 12:01 AM Eastern Standard Time on the date immediately following our being notified by the Planholder of the change.

B660.0717

Option D

Information about your family's health

Before we can agree to provide the insurance coverage you want, you may have to submit additional information about your family members' health and medical history.

If information about your family members' health is required, we'll provide you with the forms you need to complete.

Coverage for benefit amounts that require you submit information about your family members' health won't take effect until we have received this information and approved it in writing. Our acceptance of any premiums doesn't eliminate or waive this requirement. If we review your family members' health information and find that we can't issue the coverage you requested, we'll issue a refund of any overpaid premiums.

B660.0719

Option D

Guaranteed issue amount

You can elect a spouse benefit amount of up to $15,000.00 without having to provide information about your health.

B660.0721

Option D

Guaranteed issue amount

You can elect a child benefit amount of up to $7,500.00 without having to provide information about your health.

B660.0725

Option D

Information about your family's health is needed when any of the following occur:

B660.0728

Option D

- You enroll a family member for this coverage outside of the open enrollment period, unless you're able to do so because of a qualifying life event.

B660.0731

Option D

- You elect a spouse benefit amount greater than $15,000.00.

B660.0734

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Option D

- You can elect a child benefit amount greater than $7,500.00.

B660.0738

Option D

- You enroll a family member for this coverage more than 31 days after the date you became eligible to enroll.
- Your family member was previously declined for additional benefits under this Plan.

B660.0742

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Option D

What you should do when you have a claim

In this section, we'll explain what to do if you think you're eligible for any of the benefits available under this guide.

Step 1 - Start your claim

When you have a claim, you can submit it electronically. Visit guardianlife.com and follow the instructions provided.

If you prefer to submit a paper claim, you'll need to complete a claim form. When it's complete, send it to us at:

Guardian Life/Critical Illness Claims
PO Box 14334
Lexington, KY 40512

You can print a claim form by going to guardianlife.com.

You can also call us at 800-541-7846 to request a claim form.

You can also write to us to tell us you have a claim. Our address for claims is:

Guardian Life/Critical Illness Claims
PO Box 14334
Lexington, KY 40512

If you don't receive a claim form within 10 days of when you asked for it, you can still submit your claim. To do so, mail us a description of your claim and include any documentation you have that supports the claim. This should identify who you are and include the date(s) and details about the illness with which you've been diagnosed, or any services, treatments or products received. Send this to the address listed above.

Step 2 - Submit your claim

If you're submitting your claim electronically, follow the instructions at guardianlife.com.

If you're submitting a paper claim, the completed claim form should be mailed to:

Guardian Life/Critical Illness Claims
PO Box 14334
Lexington, KY 40512

Be sure to include all the information and copies of any documents the instructions indicate are necessary. The claim form, the supporting documents, and the information we require to decide if benefits are payable are referred to as "proof of loss".

You should submit your proof of loss as soon as you can, but you must submit it within 12 months of the date the illness for which you're seeking benefits occurred, or the service, treatment or product for which you're seeking benefits was received.

We'll only consider claims submitted after this 12-month period if you were legally incapacitated and unable to submit it within the time allowed.

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What we'll do when we receive your claim

We'll review your claim to make sure it's complete

- We'll conduct a full and fair review of your claim.
- We'll complete our review of your claim within 90 days of receiving it. For a Waiver of Premium benefit claim, we'll complete our review within 45 days of receiving it.
- In the event we need more time to consider your claim, which might be the case if we need more information, we can extend this review period by an additional 90 days. We can extend this period by only 60 days for a Waiver of Premium claim. We'll notify you in writing if this happens and we'll explain the reason(s) more time is needed.
- If we need more information to consider your claim, we may request this information directly from your physician. We may need to obtain medical records, including X-rays, pathological reports, etc. to consider your claim. Your physician must provide us with the information we need to determine the benefits payable.
- If we need additional information from you, we'll let you know. You'll need to provide us with the information we need to determine the benefits payable.

We'll determine if benefits are payable

- We'll make a decision within 30 days of our receiving the information needed to consider your claim.
- If benefits are payable, we'll pay the amount specified in this guide.
- If we deny any part of your claim, we'll provide a written explanation of the specific reason(s) your claim wasn't paid. We'll also include information on how you can appeal our decision.

When we'll pay

- If we determine benefits are payable, they'll be paid promptly, and no more than 30 days from the date we receive the information needed to make the decision on your claim.

Who we'll pay

We'll pay the benefits to you unless you instruct us to pay another party. If you'd like us to pay another party, you'll have to request we do so in writing. You can do this at the time you submit your claim.

If you're no longer living, we have the right to pay your benefits to one of the following, in the order listed:

- Your spouse
- Your children
- Your parents
- Your estate

If benefits are payable to your estate, and the amount is $500.00 or less, we can pay someone related to you by blood or marriage who we believe is entitled to the benefits. Any such payment will meet our obligations under this Plan.

What happens if your claim is denied

If we deny your claim or a part of your claim, we'll provide a written explanation within 30 days of our receiving the information we needed to make the decision. This explanation will include the specific reasons the claim was denied.

If we deny your claim because you or your physician didn't reply to our requests for information, we'll provide a written explanation within 30 days of the date our requests indicated the information was due. This explanation will list the information you or your physician were asked to submit.

We'll also provide instructions listing your rights to appeal your claim. They will explain the following:

- You'll need to submit a written appeal within 60 days of receiving our claims decision. You have 180 days to appeal a waiver of Premium claim that's denied. The appeal should include any additional information or documentation you or your physician think would be important for us to consider. Send your appeal to the address listed in the appeal instructions.
- We'll conduct a full and fair review of your appeal.
- We'll complete our review within 60 days of our receipt of your appeal. For a waiver of Premium claim, we'll complete our review with 45 days of receiving your appeal.
- In the event we need more time to consider your appeal, which might happen if we need additional information, we can extend this review period by another 60 days. We can extend this period by only 45 days for a waiver of Premium claim. We'll let you know if additional time or information is needed.
- We'll let you know of our decision in writing. If we deny your appeal, we'll provide the specific reasons for the denial.
- You should refer to the instructions included with any denial for more information on the appeals process.

B660.0748

Option D

Other things you should know about claims

Overpayments

If we find we paid more in benefits than this guide offers, you'll have to return the amount of the overpayment to us. We may require you to send us the overpayment, or we can deduct the overpayment from future benefits.

Legal action

You can't bring a legal action under this Plan until 60 days after you've submitted proof of loss. You also can't bring a legal action more than three years from the time proof of loss is required, or the date we make a final decision on your claim, whichever is later.

Examination and autopsy

While we're reviewing your claim or appeal, we may require that you be examined by a medical practitioner of our choice as often as reasonably necessary.

In the case of death, we can have an autopsy performed if it's permitted by law.

We'll pay for any examination or autopsy we require.

Insurance fraud

We can terminate this coverage if you or your representative commit fraud with respect to a claim.

B660.0750

Member coverage

Who's eligible

To be eligible for coverage under the Plan, you must meet the following requirements:

You must be in an eligible class of members

Your Planholder may choose to offer coverage to all members or only to those in certain job classifications.

A job classification, or class of member, is a group of members that fit into the same category. For example, a Planholder could have one class for hourly employees and another class for salaried employees.

If only certain classes are eligible for coverage, you must be in one of these classes to obtain coverage. If you have any questions about your eligibility, please contact your Planholder.

You must meet the minimum number of working hours required

You need to be actively working and performing the regular duties of your job. You must be working the number of hours your Planholder requires for your class, and not less than 20 hours per week.

Temporary, contract and seasonal workers aren't eligible for coverage under this Plan.

You must work and live in an approved location

You must be working at a location approved by your Planholder. We must approve your working or living in a country or region outside of the United States before you can be covered by this Plan. If you have any questions about this requirement, please contact your Planholder.

You must wait to be eligible for coverage

Your Planholder has a waiting period that new members must meet before they can be eligible for this coverage. Your Planholder can tell you if you must meet a waiting period and how long it lasts.

How to get coverage

If you meet the eligibility rules listed above, you must also do the following to obtain coverage:

You must enroll within the time allowed

You must enroll within 31 days of the date you first become eligible for coverage.

You can also enroll when you have a qualifying life event

If you don't enroll within the time allowed, you can enroll or change your benefit selections within 31 days of a qualifying life event. This includes:

- Your coverage ending under another critical illness plan
- Your legal separation or divorce or dissolution of a civil union
- Your loss of coverage under your spouse's critical illness plan
- An event required by state or federal law or specified by your Planholder's guidelines

See the **Things that can increase your benefits** and **Things that can decrease your benefits** sections for information on changing your benefit selections.

What happens if you enroll late

If you don't enroll within the time allowed, you'll be able to enroll during the next open enrollment period.

Enrollment periods usually occur once every year. We agree with your Planholder on when open enrollment periods happen, and how long they last.

If you have any questions about the open enrollment periods or when you can enroll, please contact your Planholder.

Your premium must be paid

We must receive the premium required for your coverage.

B660.0754

Option D

When your coverage begins

If you're eligible for coverage and have done what's required to obtain coverage, as explained under **How to get coverage,** your coverage begins at 12:01 AM Eastern Standard Time on the first day you become eligible for coverage.

If, because of a qualifying life event, you're permitted to enroll for coverage outside the time normally allowed, your coverage begins 12:01 AM Eastern Standard Time on the first day of the month after the qualifying life event occurs.

You must be actively at work, performing the major duties of your regular job and working the required number of hours at the location required by your Planholder on the date your coverage is scheduled to begin. If you don't meet this requirement for any reason other than sickness or injury, your coverage won't begin until you return to being actively at work, performing the major duties of your regular job and working the required number of hours at the location required by your Planholder.

Your coverage may be scheduled to begin on or during one of the following:

- A holiday
- A vacation day
- A day you're not scheduled to work
- A temporary layoff that's less than 180 days
- An approved leave of absence of 90 days or less that isn't due to a sickness or injury
- A period of absence that's less than 7 days

If this happens, coverage will begin on that same day if you were capable of performing the major duties of your regular job and working the required number of hours at the location required by your Planholder on that day, and you were actively at work, performing the major duties of your regular job and working the required number of hours at the location required by your Planholder on your last regularly scheduled workday.

If you're not actively at work on the date coverage was scheduled to begin because of a sickness or injury, it will still begin on the date if all the following are true:

- This Plan replaced a prior plan and there was no interruption in coverage.
- You were covered by the prior plan at the time it ended.
- You're no longer eligible for coverage under the prior plan.
- You're not receiving and aren't eligible to receive benefits under the prior plan.

A prior plan is the plan that your Planholder had immediately before this Plan. For it to be considered a prior plan, it must have ended the day before this Plan began.

B660.0760

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Option D

When an increase in your benefits begins

If you elect to increase your benefits, or benefits increase because of a change in class the increase will be subject to the same rules listed above. See the **Things you can do to increase your benefits** section for more information on when the increase takes effect.

B660.0761

Option D

Delay in an increase in benefits when you're not working due to sickness or injury

If you're not actively at work on the date your increase in benefits is scheduled to begin because of a sickness or injury, this increase won't begin until you have returned to work, are performing the major duties of your regular job and working the required number of hours at the location required by your Planholder for at least 10 days without missing a day of work due to the same illness or injury.

B660.0762

Option D

Change in your class

If an increase in benefits results from a change in class, any additional premium must be paid. If the required premium isn't paid within 31 days of when the increase in benefits is scheduled to begin, the increase won't go into effect until the required premium is paid and we agree to the increase after reviewing information about your health. See the **Information about your health** section for more information.

If a decrease in benefits results from a change in class, the reduction will take effect at 12:01 AM Eastern Standard Time on the date immediately following our being notified by the Planholder of the change.

B660.0763

Option D

When your coverage ends

Your coverage will end at 11:59 PM Eastern Standard Time on the earliest of the following:

- The last day of the month in which you're no longer eligible according to the **Who's eligible** section.
- The date this coverage is no longer available to the class of members to which you belong.
- The last day of the period for which the required premiums have been paid.
- The day you die.
- The day this Plan ends.

B660.0765

Option D

Keeping your coverage when you're not working

If you temporarily stop working, there may be a limited period of time during which you can keep your coverage.

Premiums must continue to be paid during this time. Please contact your Planholder if you have any questions. Details on when you can keep this coverage if you're not working are explained below.

B660.0766

Option D

Temporary layoff

If you're temporarily laid off by your Employer, you can keep this coverage until the earlier of:

- The end of the period approved by your Employer
- 1 month(s) from the date your layoff begins

B660.0767

Option D

Temporary leave of absence

When you take a leave of absence that's been approved by your Employer, you can keep this coverage until the earlier of:

- The end of the period approved by your Employer
- 1 month(s) from the date your leave of absence begins

B660.0768

Option D

Family leave of absence

Family and Medical Leave Act (FMLA) and Uniformed Services Employment and Re-employment Rights Act (USERRA)

These options are available only if your Employer is legally required to allow for a family leave of absence. You can confirm with your Employer if these options are available.

If these options are available to you, you can keep this coverage when you take a leave of absence approved by your Employer for one of the following reasons:

- To care for a seriously injured or ill spouse, child, or parent
- To care for a child within 12 months following the child's birth or adoption
- Due to your own serious health condition
- To care for a spouse, child, parent or next of kin, who's your closest blood relative and who suffered a sickness or injury while on active duty in the US Armed Forces

You can keep this coverage while on leave for up to 12 weeks in any 12-month period. However, if the leave is to care for a family member who was injured or became ill while on active duty, as explained above, you'll be able to keep this coverage for up to 26 weeks of leave in a 12-month period.

If you take a family leave for any other reason during this same 12-month period, this will also count toward the 26-week maximum.

Any subsequent leave to care for a service member will be limited to 12 weeks in a 12-month period.

B660.0769

Option D

Rehire eligibility

If this coverage ends because your employment ends, you'll be able to resume your coverage if you:

- Become eligible again within six months of the date your coverage ended
- Enroll for coverage within 31 days of becoming eligible again

When your coverage resumes, it will be at the current benefit amounts.

If you had met any portion of a waiting period when your employment ended, you'll be given credit for the time served if your employment resumes within 31 days.

B660.0770

Option D

Portability - keeping your insurance coverage if your eligibility ends

You may be able to keep your critical illness insurance if your eligibility ends for one of the following reasons:

- Your employment with the Policyholder ends
- You stop being a member of an eligible class
- You move to a class with a lower benefit level
- The Plan ends

You can request to keep your critical illness insurance if all of the following are true:

- You're less than age 70 on the date your eligibility ends
- You didn't cancel this coverage or fail to pay the premiums

B660.0772

Option D

How much of your coverage you can keep

You can keep the full Benefit Amount in place on the date your eligibility ends.

B660.0774

Option D

How much of your family member coverage you can keep

If you elect to keep your critical illness insurance, you can also keep your coverage for your spouse if your spouse was covered by this member guide and less than age 70 on the date your eligibility ends.

If you elect to keep your critical illness insurance, you can also keep your coverage for your child if your child was covered by this member guide on the date your eligibility ends.

You don't have to keep dependent coverage to keep coverage for yourself.

B660.0780

Option D

Keeping family member coverage if you die

Your spouse can request to keep your family member coverage in place if you die while covered under this guide. Your spouse can keep up to 100% of the Benefit Amount in place on the date of your death. Your children can keep up to 100% of the Benefit Amount in place on the date of your death.

Only family members that were covered on the date you die can be eligible to keep this coverage. If your spouse doesn't survive you or is age 70 or older on the date of your death, your children won't be able to keep this coverage.

How much your coverage will cost

The premiums may change when you exercise this option. Please contact your Planholder for more information about the cost.

What you must do to keep coverage

To keep this coverage as explained above, you or your spouse must send us a written request within 31 days of the date your eligibility ends. The request should be sent to:

Guardian
National Conversion Department
6255 Sterners Way
Bethlehem, PA 18017

You can also submit it via fax: 920-749-6219

Or you can send it via e-mail to: national_conversions@glic.com

We'll send you an endorsement

If you're eligible to keep this coverage, we'll send you an endorsement explaining how and when to pay the premiums. This endorsement will also tell you about your benefits and any aspects of this guide that are being changed.

B660.0786

Option D

Family coverage

Who's eligible

The following family members are eligible for coverage:

- Your spouse

Your spouse is the person to whom you're legally married or your civil union partner.

Your child, who's:

- Unmarried
- Under the age of 26

Your child is one of the following:

- Your biological child
- Your stepchild
- A child placed with you for adoption or foster care
- A child for whom you've been appointed a legal guardian and who you claim as a dependent on your federal income taxes

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A child who's incapable of self-support because of mental, physical, or developmental disability may be able to keep this coverage past the maximum age. See the **Keeping this coverage for a child who reaches the age limit** section.

B660.0788

Option D

Family members that aren't eligible

The following family members aren't eligible for coverage:

- A family member who's on active duty in the US Armed Forces.
- A child who's an eligible dependent of more than one member can be covered through only one member.
- A family member who's also eligible for coverage as a member under this Plan can't be covered more than once.

B660.0791

Option D

How to get coverage for your family

If your family members are eligible, you must do the following to obtain coverage:

You must be enrolled

In order to enroll your family members, you must already be enrolled for coverage, or you must enroll yourself when you enroll them.

You must enroll your family members

You can enroll your eligible family members when you first become eligible and enroll yourself.

You can enroll family members when there's a qualifying life event

You can also enroll an eligible family member or change your family benefit selections within 31 days of a qualifying life event. This includes:

- Your marriage
- Your legal separation or divorce or dissolution of a civil union
- The birth or adoption of your child or your assuming legal responsibility for a foster child
- Your spouse's loss of coverage under another critical illness plan
- Your spouse's loss of employment
- The death of your spouse

Your biological children are automatically covered for the first 31 days following their birth.

Your adopted children and foster children are automatically covered for the first 31 days from the earlier of the following:

- the date of a court order
- the date they're placed in your care

You must enroll biological, adopted, and foster children and pay the required premium within this 31-day period or their coverage will end when the 31 days are over.

See the **Things that can increase your family benefits** and **Things that can decrease your family benefits** sections for information on changing your family benefit selections.

What happens if you enroll family members late

If you don't enroll your eligible family members within the time allowed, you'll be able to enroll them at any time after you have enrolled yourself, subject to the approval of your Planholder.

The premium must be paid

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We must receive the premium required for family coverage.

B660.0795

Option D

When family coverage begins

If you enroll your family members when you enroll yourself, their coverage begins at the same time your coverage begins. If you don't enroll your family members at the same time you enroll yourself, their coverage will begin at 12:01 AM Eastern Standard Time on the date you enroll them.

If, because of a qualifying life event, you're permitted to enroll family members for coverage outside the time normally allowed, their coverage begins 12:01 AM Eastern Standard Time on the date the qualifying life event occurs.

This coverage won't begin on the day it's otherwise supposed to for any family member, other than a newborn child, who, is any of the following:

- In the hospital or other healthcare facility
- Confined to home
- Incapable, because of a medical condition, of performing two or more of the Activities of Daily Living without hands-on or stand-by (within arm's reach) assistance of another person:
    - Bathing - washing in a tub or a shower, or taking a sponge bath, and toweling dry
    - Continence - controlling bowel and bladder function and, in the event of incontinence, maintaining personal hygiene
    - Dressing - putting on and taking off all clothes, braces, and artificial limbs
    - Eating - getting food into the body once it has been prepared and made available
    - Toileting - getting to and from and on and off the toilet, and performing associated personal hygiene
    - Transferring - moving in or out of a bed, chair or wheelchair

Coverage will begin on the first day after the family member:

- Is no longer a patient or resident in a hospital or other healthcare facility
- Is no longer confined to home
- No longer requires assistance with two or more of the Activities of Daily Living due to a medical condition

If coverage is postponed because the family member is hospitalized or receiving care, as described above, it will still begin on the date it was supposed to if all the following are true:

- This Plan replaced a prior plan and there was no interruption in coverage.
- The family member was covered by the prior plan at the time it ended.
- The family member is no longer eligible for coverage under the prior plan.
- The family member isn't receiving and isn't eligible to receive benefits under the prior plan.

A prior plan is the plan that your Planholder had immediately before this Plan. For it to be considered a prior plan, it must have ended the day before this Plan began.

B660.0796

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When family coverage ends

Coverage for your family members will end at 11:59 PM Eastern Standard Time on the earliest of the following:

- The date your coverage ends.
- The date you stop being a member of a class that's eligible for family member coverage.
- The last day of the period for which the required premiums were paid.
- For a spouse, the last day of the month in which your marriage ends in divorce or annulment or your civil union is dissolved.
- For a child, the last day of the month in which your child reaches the maximum age or no longer meets the conditions listed under **Keeping this coverage for a child who reaches the age limit.**
- For a child, the last day of the month in which your child marries or enters a domestic partnership.
- The date the family member becomes ineligible for any of the reasons listed in the **Family members that aren't eligible** section.
- The date the family member dies.

B660.0805

Option D

Keeping this coverage for a child who reaches the age limit

A child may keep this coverage past the age limit if the child is all the following:

- Unable to live independently due to a mental, physical, or developmental disability which began before reaching the maximum age
- Primarily dependent upon you for financial support
- Not married or in a domestic partnership
- Continuously covered by this Plan, or by the group plan this Plan replaced, through the time the maximum age was reached

You'll have to send us proof that your child meets these requirements within 31 days of the date the maximum age is reached.

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

Coverage extended in accordance with this section will end when your child no longer meets the conditions above. Even when your child does meet the requirements listed above, this coverage can end due to any of the other reasons listed under the **When family coverage end** section.

B660.0809

Option D

Other things you should know about getting and keeping this coverage

Paying the premiums

For your insurance coverage to begin and remain in place, the required premiums must be paid. We worked with your Planholder to decide how and when the premium payments must be made. This is explained in the Policy we've issued to the Planholder.

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The premiums can be changed at any time. We'll give your Planholder 31 days advance notice of any change in premiums.

If you have any questions about premium payments, please contact the Planholder.

B660.0810

Option D

Be sure to give us complete and accurate information

If we asked you to provide personal, health or medical information about yourself or your family members at the time of enrollment, it's important that the information you provided was complete and accurate. If it wasn't, we have the right to challenge a claim for benefits. This means we can deny a claim that might otherwise be covered.

If you don't give us complete and accurate information, we may also have the right to rescind this coverage. This means we would declare your guide to be null and void as of its effective date. In that case, we'd refund all the premiums paid and it would be as though your insurance coverage had never been issued.

During the first two years this guide is effective, we can rescind it if any material information you provided in, or with, an enrollment form or application was missing or inaccurate. Information is considered material if it would've caused us to do any of the following:

- Not issue any coverage
- Issue your guide with different coverage or benefit amounts
- Issue your guide with different premium amounts

After this guide has been in place for more than two years, we can only rescind it if you committed fraud.

We won't challenge a claim or contest whether this coverage is valid unless the statement in question was made in writing and signed by you.

Any increase in benefits will be subject to these same requirements, with the two years described above beginning on the effective date of the increase.

Review the information you provided at the time of enrollment or application to make sure it's complete and accurate. If you find anything is missing or inaccurate, you must immediately notify us in writing at the address listed on the first page of this guide.

B660.0811

Option D

Misstatement of age

If your age or a family member's age is found to be incorrect, we'll have to make an adjustment to the coverage or premiums, or both, if the true age would've impacted the amount of coverage we issued or the cost of the coverage.

The coverage in place prior to this adjustment will be the amount the premiums already paid would have purchased at the true age. This amount won't, however, exceed the amount allowed by any age restrictions or limits included with the Plan.

If the true age would've prevented us from issuing any coverage, this coverage will be terminated from the beginning and a refund of premiums will be made. Any benefits previously paid will be deducted from the refund.

B660.0821

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Guardian

The Guardian Life Insurance Company of America
10 Hudson Yards, New York, New York 10001

Covered illnesses guide

This is the covered illnesses guide

This guide explains the illnesses, diseases and disorders that are covered by this Plan.

We're here to help. Contact us if you've any questions or want to talk about any part of this guide.

1-800-541-7846 **guardianlife.com**

Planholder: BRYAN COUNTY BOARD OF EDUCATION

Plan Number: 00552324

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Guide basics

What's covered

This is where we give you details about the illnesses that are covered by this Plan.

What it is - you'll see this listed for each illness that's covered by this guide. This is a basic explanation, intended to help you understand the nature of each covered illness.

When it Occurs - you'll also see this listed for each illness that appears in this guide. This explains what it takes to qualify for benefits for the illness. Each covered illness has its own requirements.

In addition to the specific requirements listed under each illness, there are also some general rules that apply to each of the illnesses covered by this guide. For benefits to be available, both of the following must also be true:

- The illness must occur while you're covered by this Plan. For a family member's illness, the illness must occur while the family member is covered by this Plan.

  This guide will tell you when each illness is considered to occur.

- The illness must be diagnosed by a physician who has the appropriate training or specialization needed to make the diagnosis in accordance with generally accepted medical standards.

  - A diagnosis is the definitive establishment of a medical disorder.

  - The diagnosis must be supported by the symptoms, test results and other criteria listed in this guide for that specific illness. All of this must be documented in your medical records. (We don't pay any benefits for the cost of any evaluation or test this guide indicates is needed to confirm the diagnosis.)

  - A physician is a medical practitioner of the healing arts who's both of the following:

    - Appropriately licensed or certified by the state where care or services are provided

    - Acting within the scope of that license or certification

See the **Your benefits** section of the member guide for more information on the benefits available for the illnesses listed in this guide, including any limitations that apply to these benefits. Also, see the **What isn't covered - exclusions** section of this guide for information on other situations where we won't pay benefits.

When we say "you" and "your" in this Covered Illnesses Guide, we're referring to a person that's covered by the Plan. This could be you, the member, or a family member who you've enrolled in this Plan.

Nothing in this guide should be considered medical advice or relied upon for treatment.

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Covered illnesses

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Option D

Heart disorders

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Option D

Coronary Artery Disease

What it is:
This is the narrowing or blockage of a coronary artery. The coronary arteries feed blood to the heart. Your physician may refer to this as arteriosclerosis, coronary artery disease, coronary heart disease or ischemic heart disease.

When it occurs:
Coronary Artery Disease occurs on the date a physician diagnoses coronary artery disease to be so severe that it requires one or more of the following procedures:

- o atherectomy (rotation or laser)
- o balloon angioplasty
- o laser angioplasty
- o stent implantation
- o thrombectomy (angiojet)

- This benefit isn't available if the procedure is performed on the same day as a bypass.

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Option D

Coronary Artery Disease - requiring a bypass

What it is:
This is the narrowing or blockage of one or more coronary arteries that requires bypass surgery. The coronary arteries feed blood to the heart. Your physician may refer to this condition as arteriosclerosis, coronary artery disease, coronary heart disease or ischemic heart disease.

A bypass is a surgical procedure that uses a healthy artery to create a bypass around the blockage and allows blood to flow to the heart.

When it occurs:
Coronary Artery Disease - requiring a bypass occurs on the date a physician diagnoses coronary artery disease to be of such a severity that it requires one or more coronary artery bypass grafts.

- A bypass graft doesn't include coronary angioplasty or any other intra-catheter procedure.

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Option D

Heart Attack

What it is:
This is the death of heart muscle caused by an inadequate blood supply. This is also called acute myocardial infarction.

When it occurs:
Heart Attack occurs on the date this medical event happens.

- The diagnosis must be confirmed by at least two of the following symptoms of cardiac ischemia:
  - typical clinical symptoms, such as central chest pain
  - diagnostic increase of specific cardiac markers
  - electrocardiogram changes indicating new ischemia (new ST-T changes or new left bundle branch block)
  - development of pathological Q waves in the electrocardiogram
  - imaging evidence of new loss of viable myocardium or new regional wall motion abnormality
- If the heart attack causes death, an autopsy report or death certificate may be used to confirm the diagnosis of heart attack.
- Benefits aren't available for a heart attack that occurs during surgery or any other medical procedure.
- Sudden cardiac arrest isn't a heart attack.

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Heart Failure

What it is:
This is the irreversible failure of the heart to pump blood effectively.

When it occurs:
Heart Failure occurs on the earlier of the following:

- The date a physician diagnoses heart failure to be of such a severity that it requires a heart valve replacement.
- The date you're accepted onto the heart transplant waiting list of a recognized transplant program in the United States.

- If you're too ill for a heart valve replacement or a heart transplant, Heart Failure occurs on the date a physician deems that you otherwise meet the criteria for a heart valve replacement or being on the heart transplant waiting list of a recognized transplant program in the United States but you're too ill for the surgery or transplant.

B661.0013

Option D

Pacemaker

What it is:
This is a device that's surgically placed and electronically manages heart rate.

When it occurs:
Pacemaker occurs on the date a physician diagnoses one or more of the following disorders that's of such a severity that it requires a pacemaker:

- Sinus node dysfunction
- High-grade atrioventricular block
- Serious cardiac arrhythmia

- This diagnosis must be confirmed by one or more of the following tests:
  - Electrocardiography (ECG or EKG)
  - Echocardiography
  - Holter monitoring
  - Event recorder
  - Electrophysiology study (EP study)
  - Stress test

B661.0015

Option D

Lung & Vascular disorders

B661.0017

Option D

Aneurysm

What it is:
This is a balloon-like bulge or weakening in the walls of an artery.

When it occurs:
Aneurysm occurs on the date any of the following types of aneurysms ruptures or tears and surgical repair is recommended by a physician:

- Abdominal aortic aneurysm - this is located in the abdominal aorta in the abdomen
- Carotid aneurysm - this is located in the carotid artery in the neck
- Cerebral aneurysm - this is located in the brain and is sometimes called an intracranial or brain aneurysm
- Renal artery aneurysm - this is located in the renal artery
- Thoracic aortic aneurysm - this is located in the thoracic artery in the chest

- The diagnosis must be confirmed by an ultrasound, CT scan, angiogram or magnetic resonance imaging (MRI).

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- This benefit will be available once, regardless of how many aneurysms are diagnosed at the same time.
- Benefits aren't available for any aneurysm not listed above or for an aneurysm caused by trauma.

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Pulmonary Embolism

What it is:
This is a sudden blockage in a pulmonary artery or a branch of a pulmonary artery due to a blood clot. The pulmonary arteries return blood from the heart to the lungs, where the blood picks up new oxygen.

When it occurs:
Pulmonary Embolism occurs on the date this medical event happens.

- This diagnosis must be confirmed by one or more of the following:
  - o Pulmonary angiogram
  - o Ventilation perfusion scan
  - o Computerized tomography scan (CT scan)
  - o Magnetic resonance imaging (MRI)
  - o Other reliable imaging technique

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Stroke - moderate

What it is:
This is the death of brain tissue caused by a blockage or bleeding within the brain. This is also called a cerebrovascular accident (CVA).

When it occurs:
Stroke - moderate occurs on the date this medical event happens.

- This diagnosis must be confirmed by all of the following:
  - o Clinical evidence of infarction of brain tissue, or intracranial or subarachnoid hemorrhage
  - o A computerized tomography scan (CT scan), magnetic resonance imaging (MRI) or similar imaging technique that shows clear evidence a stroke has occurred
  - o A neurological impairment resulting from the stroke that didn't exist prior to the date of the event
- In the event of death, an autopsy report or death certificate confirming stroke as the cause of death may be accepted.
- This benefit isn't available for any of the following:
  - o Transient Ischemic Attack (TIA)

- Migraine
- Hypoxia
- Traumatic injury to the brain tissue or blood vessels
- Vascular disease affecting the eye, optic nerve, or vestibular functions

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Option D

Stroke - severe

What it is:
This is the death of brain tissue caused by a blockage or bleeding within the brain. This is also called a cerebrovascular accident (CVA).

When it occurs:
Stroke - severe occurs on the date this medical event happens.

- This diagnosis must be confirmed by all of the following:
  - Clinical evidence of infarction of brain tissue, or intracranial or subarachnoid hemorrhage
  - A computerized tomography scan (CT scan), magnetic resonance imaging (MRI) or similar imaging technique that shows clear evidence a stroke has occurred
  - A permanent neurological deficit measured at least 30 days after the event that results in a score of two or higher on the Modified Rankin Scale for stroke outcome
- In the event of death, an autopsy report or death certificate confirming Stroke as the cause of death may be accepted.
- This benefit isn't available for any of the following:
  - Transient Ischemic Attack (TIA)
  - Migraine
  - Hypoxia
  - Traumatic injury to the brain tissue or blood vessels
  - Vascular disease affecting the eye, optic nerve, or vestibular functions
- If the **Stroke - moderate** benefit is paid under this Plan for the same event, the benefit available for **Stroke - severe** will be reduced by that amount.

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Option D

Transient Ischemic Attack (TIA)

What it is:
This is a temporary interruption of adequate blood flow to the brain. It usually lasts only a few minutes and doesn't cause permanent damage.

When it occurs:
TIA occurs on the date this medical event happens.

- The diagnosis must be confirmed by all of the following:
    - A new ischemic event with no cerebral tissue damage and reversible impairment
    - Measurable, functional neurological impairments that are focal and confined to an area of the brain that's supplied blood by a specific artery
    - Recommendations made by your physician for stroke prevention

B661.0023

Option D

Neurological disorders

B661.0024

Option D

Alzheimer's disease - early stage

What it is:
This is the early stage of a degenerative brain disease that affects cognitive ability and functioning.

When it occurs:
Alzheimer's disease - early stage occurs on the date a physician diagnoses Alzheimer's disease with a cognitive decline that's progressed to the point where there's one or more of the following symptoms:

- Memory impairment, such as difficulty remembering events
- Difficulty concentrating, planning or problem-solving
- Problems finishing daily tasks at home or at work, such as writing or using eating utensils
- Confusion with location or passage of time
- Having visual or space difficulties, such as not understanding distance in driving, getting lost or misplacing items
- Language problems, such as word-finding problems or reduced vocabulary in speech or writing
- Using poor judgment in decisions
- Withdrawal from work events or social engagements
- Changes in mood, such as depression or other behavior and personality changes

- This diagnosis must be confirmed by two or more of the following:
    - Medical records that document the above loss of intellectual capacity and impairment in memory and judgement
    - An evaluation and testing of cognitive function, including A Mini-Mental State Examination (MMSE) score of 19 or lower
    - Neuroradiological tests such as a computerized tomography scan (CT scan), magnetic resonance imaging scan (MRI) or positron emission tomography scan (PET scan).

A similar test future technology permits that's generally accepted by neurologists to diagnose such disorders can also be used.

- This benefit isn't available for other brain disorders, psychiatric illnesses, or dementing illnesses.
- This benefit isn't payable if you've been diagnosed with Parkinson's disease.

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Option D

Alzheimer's disease - advanced stage

What it is:
This is a more advanced stage of a degenerative brain disease that affects cognitive ability and functioning.

When it occurs:
Alzheimer's disease - advanced stage occurs on the date a physician diagnoses Alzheimer's disease with a cognitive decline that's progressed to the point where there's a permanent inability to perform two or more of the following Activities of Daily Living without hands-on or stand-by (within arm's reach) assistance of another person:

- o Bathing - washing in a tub or a shower, or taking a sponge bath, and toweling dry
- o Dressing - putting on and taking off all clothes, braces, and artificial limbs
- o Toileting - getting to and from and on and off the toilet, and performing associated personal hygiene
- o Continence - controlling bowel and bladder function and, in the event of incontinence, maintaining personal hygiene
- o Eating - getting food into the body once it has been prepared and made available

- This diagnosis must be confirmed by two or more of the following:
  - o Medical records that document the above loss of intellectual capacity and impairment in memory and judgement
  - o An evaluation and testing of cognitive function, including A Mini-Mental State Examination (MMSE) score of 14 or lower
  - o Neuroradiological tests such as a computerized tomography scan (CT scan), magnetic resonance imaging (MRI) or positron emission tomography scan (PET scan).

    A similar test future technology permits that's generally accepted by neurologists to diagnose such disorders can also be used.
- This benefit isn't available for other brain disorders, psychiatric illnesses, or dementing illnesses.
- This benefit isn't payable if you've been diagnosed with Parkinson's disease.
- If the **Alzheimer's disease - early stage** benefit is paid under this Plan, the benefit available for **Alzheimer's disease - advanced stage** will be reduced by that amount.

B661.0026

Option D

Amyotrophic Lateral Sclerosis (ALS)

What it is:
This is a nervous system disease that affects nerve cells in the brain and spinal cord and causes loss of muscle control. This is also called Lou Gehrig's disease.

When it occurs:
ALS occurs on the date it's diagnosed by a physician.

B661.0027

Option D

Dementia - other causes

What it is:
This is a decline in memory and other cognitive functioning that's caused by disease or an abnormality in the brain.

When it occurs:
Dementia - other causes occurs on the date one of the following disorders is diagnosed by a physician:

- Corticobasal degeneration
- Creutzfeldt-Jakob disease
- Frontotemporal dementia
- Lewy body dementia
- Normal-pressure hydrocephalus
- Primary progressive aphasia
- Progressive supranuclear palsy

- The diagnosis must be confirmed by an electroencephalogram (EEG), computerized tomography scan (CT scan), magnetic resonance imaging (MRI), positron emission tomography scan (PET scan) that documents changes to the brain.

  A similar test future technology permits that's generally accepted by neurologists to diagnose such disorders can also be used.

- This benefit isn't available for any of the following:
  - Alzheimer's disease
  - Dementia caused by a mental or nervous disorder, such as schizophrenia, psychosis or neurosis
  - Huntington's disease
  - Parkinson's disease dementia
  - Reversible dementias such as those caused by thyroid or other hormonal abnormalities, or vitamin deficiencies
  - Alcohol or drug abuse-induced disorders

B661.0028

Option D

Huntington's disease

What it is:
This is a disease that causes a degeneration of nerve cells in the brain and results in cognitive, psychiatric and movement disorders.

When it occurs:
Huntington's disease occurs on the date it's diagnosed by a physician.

- The diagnosis must be confirmed through genetic testing and be based on two or more of the following groups of symptoms being present:
  - difficulty concentrating and memory lapses (both symptoms must be present)
  - depression
  - stumbling and clumsiness (both symptoms must be present)
  - involuntary jerking or fidgety movements of the limbs and body (either symptom may be present)
  - mood swings and personality changes (both symptoms must be present)
  - problems swallowing, speaking and breathing (all three symptoms must be present)

B661.0029

Option D

Multiple Sclerosis (MS) - early stage

What it is:
This is an autoimmune disorder that affects the central nervous system and causes muscle weakness, chronic pain, numbness, fatigue, balance and coordination problems, and vision problems.

When it occurs:
MS - early stage occurs on the date it's diagnosed by a physician.

- The diagnosis must be confirmed by all of the following:
  - Neurological exam demonstrating functional impairments
  - Imaging studies of the brain or spine showing lesions consistent with MS
  - Analysis of cerebrospinal fluid that's consistent with MS

B661.0030

Option D

Multiple Sclerosis (MS) - advanced stage

What it is:
This is an autoimmune disorder that affects the central nervous system and causes muscle weakness, chronic pain, numbness, fatigue, balance and coordination problems, and vision problems.

When it occurs:
MS - advanced stage occurs on the date it's diagnosed by a physician and neurological deficits have been present for at least six months.

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- The diagnosis must be confirmed by all of the following:
    - Neurological exam demonstrating functional impairments
    - Imaging studies of the brain or spine showing lesions consistent with MS
    - Analysis of cerebrospinal fluid that's consistent with MS
- If the **MS - early stage** benefit is paid under this Plan, the benefit available for **MS - advanced stage** will be reduced by that amount.

B661.0031

Option D

Myasthenia Gravis

What it is:
This is an autoimmune neuromuscular disease that causes the loss of voluntary muscle control.

When it occurs:
Myasthenia Gravis occurs on the date it's diagnosed by a physician.

- This diagnosis must be supported by at least two of the following test results:
    - A positive edrophonium test
    - A blood test positive for the presence of antibodies that interfere with muscle receptor sites
    - Abnormal electrodiagnostic results

B661.0032

Option D

Parkinson's disease - early stage

What it is:
This is the earlier stages of a progressive nervous system disorder that affects movement.

When it occurs:
Parkinson's disease - mild or early stage occurs on the date it's diagnosed by a physician with at least one of the following symptoms present:

- Tremors at rest
- Slowed, physical movement (bradykinesia), or difficulty initiating movement
- Difficulty with speech, such as monotone voice or lack of inflection
- Muscular rigidity
- Inexpressive face
- Festinating gait
- Rapid, persistent blinking (blepharospasm)

- This diagnosis must be confirmed by all of the following:
    - A neurological exam
    - Cognitive testing

- Imaging studies.

B661.0033

Option D

Parkinson's disease - advanced stage

What it is:
This is the more advanced stage of a progressive nervous system disorder that affects movement.

When it occurs:
Parkinson's disease - advanced stage occurs on the date it's diagnosed by a physician with three or more of the following symptoms present:

- Tremors at rest
- Slowed, physical movement (bradykinesia), or difficulty initiating movement
- Difficulty with speech, such as monotone voice or lack of inflection
- Muscular rigidity
- Inexpressive face
- Festinating gait
- Rapid, persistent blinking (blepharospasm)

- This diagnosis must be confirmed by all of the following:
  - A neurological exam
  - Cognitive testing
  - Imaging studies.
- If the **Parkinson's disease - early stage** benefit is paid under this Plan, the benefit available for **Parkinson's disease - advanced stage** will be reduced by that amount.

B661.0034

Option D

Additional disorders

B661.0051

Option D

Addison's disease

What it is:
This is a disorder of the adrenal gland where the body can't produce enough of a critical hormone known as cortisol, and sometimes another critical hormone known as aldosterone.

When it occurs:
Addison's disease occurs on the date it's diagnosed by a physician.

- The diagnosis must be confirmed by laboratory tests that show insufficient levels of cortisol.

B661.0063

Option D

Coma

What it is:
This is a state of complete mental unresponsiveness with no evidence of appropriate response to stimulation. It's characterized by the absence of eye opening, verbal response, and motor response.

When it occurs:
Coma occurs on the date it's diagnosed by a physician.

- This condition must last for at least seven consecutive days and require intubation for respiratory assistance.
- This benefit isn't available for a medically induced coma.

B661.0052

Option D

Infectious/Contagious disease

What it is:
This is one of the following bacterial or viral infections:

- Antibiotic resistant bacteria (including MRSA)
- Coronavirus, including Covid-19
- Diphtheria
- Encephalitis
- Legionnaire's disease
- Lyme disease
- Malaria
- Meningitis
- Necrotizing fasciitis (flesh eating bacteria)
- Osteomyelitis
- Rabies
- Tuberculosis

When it occurs:
Infectious/Contagious disease occurs on the date both of the following occur:

- One of the above infections is diagnosed by a physician.
- You're confined to a hospital for five or more consecutive days because of the infection.

If you die while confined to a hospital, but before meeting this requirement, we'll still pay this benefit if the other requirements are met.

B661.0053

Option D

Kidney Failure

What it is:
This is the chronic, irreversible failure of both kidneys to work effectively.

When it occurs:
Kidney Failure occurs on the earlier of the following:

- The date renal or peritoneal dialysis begins.
- The date you're accepted onto the kidney transplant waiting list of a recognized kidney transplant program in the United States.
- If you're too ill for a transplant, the date a physician deems that you otherwise meet the criteria for being on the waiting list of a recognized kidney transplant program in the United States but you're too ill for a transplant.

- This benefit isn't available for acute kidney failure that's reversible.

B661.0055

Option D

Loss of Hearing

What it is:
This is the irreversible loss of hearing in both ears that results from illness or injury.

When it occurs:
Loss of Hearing occurs on the date a licensed audiologist does both of the following:

- Performs an examination and certifies a clinically proven auditory threshold of more than 90 decibels
- Confirms this loss has continued without interruption for at least six months since the date of an earlier examination where there was also a clinically proven auditory threshold of more than 90 decibels

- This benefit isn't available if surgery, a hearing aid, device, or implant could restore partial or total hearing.
- This benefit isn't available for a child who's less than 3 years old when the diagnosis is made, unless both of the following are true:
  - The child was covered by this Plan when the initial diagnosis was made.
  - The diagnosis is confirmed by a licensed audiologist after the child reaches age 3.

B661.0056

Option D

Loss of Sight

What it is:
This is a severe and permanent loss of vision in both eyes.

When it occurs:
Loss of Sight occurs on the date an ophthalmologist performs an examination and certifies at least one of the following:

- the best corrected visual acuity is 20/400
- a visual field of 20 degrees or less in the better eye

- This benefit isn't available if surgery, a device, or an implant could restore partial or total vision.
- This benefit isn't available for a child that's less than three years old when the diagnosis is made, unless both of the following are true:
  - The child was covered by this Plan when the initial diagnosis was made.
  - The diagnosis is confirmed by an ophthalmologist after the child reaches age three.

B661.0057

Option D

Loss of Speech

What it is:
This is the total and permanent loss of the ability to speak that results from illness or injury.

When it occurs:
Loss of Speech occurs on the date a licensed speech pathologist does both of the following:

- Performs an examination and certifies a clinically proven, total and permanent loss of the ability to speak
- Confirms this loss has continued without interruption for at least six months since the date of an earlier examination where there was also a clinically proven, total and permanent loss of the ability to speak

- This benefit isn't available if surgery, device, or implant could restore partial or total speech.
- This benefit isn't available for a child that's less than 3 years old when the diagnosis is made, unless both of the following are true:
  - The child was covered by this Plan when the initial diagnosis was made.
  - The diagnosis is confirmed by a licensed speech pathologist after the child reaches age 3.

B661.0058

Option D

Major Organ Failure - Liver, Pancreas, Lungs

What it is:
This is the irreversible failure of the liver, pancreas or both lungs that requires a human-to-human transplant.

When it occurs:
Major Organ Failure - Liver, Pancreas, Lungs occurs on the earlier of the following:

- The date you're accepted onto the liver, pancreas or lung transplant waiting list of a recognized transplant program in the United States.
- If you're too ill for a transplant, the date a physician deems that you otherwise meet the criteria for being on the liver, pancreas or lung transplant waiting list of a recognized transplant program in the United States but you're too ill for a transplant.

- This benefit isn't available if the transplant is done at the same time as a heart transplant.
- This benefit isn't available when a single lung is transplanted.

B661.0060

Option D

Permanent Paralysis

What it is:
This is the complete and irreversible loss of muscle function in the arms or legs.

When it occurs:
Permanent Paralysis occurs on the date it's diagnosed by a physician.

- Permanent Paralysis must be the direct result of sickness or injury, other than a stroke.
- We'll pay the full benefit for the permanent paralysis of one or more limbs.

B661.0061

Option D

Severe Burns

What it is:
This is full-thickness or 3rd degree burns from exposure to fire, heat, caustics, electricity, or radiation that covers 25% or more of the body.

When it occurs:
Severe Burns occurs on the date the burn happens.

B661.0062

Option D

Childhood illnesses and disorders

B661.0074

Option D

Autism Spectrum Disorder

What it is:
This is a developmental disorder characterized by difficulties with social interaction and communication, and restricted or repetitive patterns of thought and behavior.

When it occurs:
Autism Spectrum Disorder occurs on the date it's diagnosed by a physician.

- The diagnosis must be supported by:
  - Clinically approved psychological screenings
  - A severity level rating of 1, 2 or 3 on the autism spectrum using the criteria described in the current Diagnostic and Statistical Manual of Mental Disorders (DSM)

B661.0075

Option D

Cerebral Palsy

What it is:
This is a group of disorders caused by abnormal brain development or damage to the developing brain that affects the ability to move and maintain balance and posture.

When it occurs:
Cerebral Palsy occurs on the date it's diagnosed by a physician.

- The diagnosis must be made after live birth.
- Benefits aren't available for similar disorders, such as degenerative nerve disorders, genetic diseases, muscle diseases, metabolic disorders, nervous system tumors, coagulation disorders, or other injuries or disorders which delay early development but which might be outgrown.

B661.0076

Option D

Cleft Lip or Cleft Palate

What it is:
Cleft Lip is a narrow opening or gap in the skin of the upper lip that extends to the base of the nose.

Cleft Palate is an opening between the roof of the mouth and the nasal cavity on one or both sides of the mouth.

When it occurs:
Cleft Lip or Cleft Palate occurs on the date it's diagnosed by a physician.

- The diagnosis must be made after live birth.
- This benefit is available for either a Cleft Lip or Cleft Palate, but not both.

B661.0077

Option D

Clubfoot

What it is:
This is a congenital deformity of the feet.

When it occurs:
Clubfoot occurs on the date it's diagnosed by a physician.

- The diagnosis must be made after live birth.
- This benefit is available a single time, regardless of whether Clubfoot is present in one or both feet.

B661.0078

Option D

Congenital Heart Defect

What it is:
This is a defect that exists at birth and affects the structure of the heart and the way it works.

When it occurs:
Congenital Heart Defect occurs on the date it's diagnosed by a physician to be of such severity that it requires surgery.

- The diagnosis must be made after live birth.
- This benefit is available a single time, regardless of the number of defects present.

B661.0079

Option D

Cystic Fibrosis

What it is:
This is a disorder that causes mucus buildup in the lungs and other organs, and problems with breathing and digestion.

When it occurs:
Cystic Fibrosis occurs on the date it's diagnosed by a physician.

- The diagnosis must be made after live birth.
- The diagnosis must be confirmed by a sweat test that shows sweat chloride concentrations greater than 60 mmol/L.

B661.0080

Option D

Diabetes - Type I

What it is:
This is a disorder where the pancreas produces little or no insulin. This is sometimes called juvenile diabetes.

When it occurs:
Diabetes - Type I occurs on the date it's diagnosed by a physician.

- Dependence on insulin must last for an uninterrupted period of at least 3 months.

B661.0081

Option D

Down Syndrome

What it is:
This disorder is caused by the presence of all or a part of a third copy of chromosome 21. This includes Trisomy, Translocation or Mosaicism.

When it occurs:
Down Syndrome occurs on the date it's diagnosed by a physician.

- The diagnosis must be made after live birth.
- The diagnosis must be confirmed by chromosome tests.

B661.0082

Option D

Hemophilia

What it is:
This is a disorder that prevents blood from clotting in the usual way because of missing or defective clotting proteins.

When it occurs:
Hemophilia occurs on the date it's diagnosed by a physician.

- The diagnosis must be confirmed through a blood test.

B661.0083

Option D

Multisystem Inflammatory Syndrome (MIS)

What it is:
This is a disorder associated with an infection in which the heart, lungs, kidneys, gastrointestinal organs, brain, eyes or skin become inflamed.

When it occurs:

MIS occurs on the date it's diagnosed by a physician.

B661.0084

Option D

Muscular Dystrophy

What it is:
This is a group of neuromuscular diseases that causes progressive weakness and loss of muscle mass.

When it occurs:
Muscular Dystrophy occurs on the date it's diagnosed by a physician.

- The diagnosis must be made after live birth.
- The diagnosis must be based on well-defined neurological abnormalities and confirmed by electromyography and muscle biopsy.

B661.0085

Option D

Spina Bifida

What it is:
This is a birth defect in which the spine and spinal cord don't form properly.

When it occurs:
Spina Bifida occurs on the date a physician diagnoses either of the following types of Spina Bifida:

  - o Meningocele - the protective covering of the spinal cord (meninges) comes through the open part of the spine like a sack that's pushed out. Cerebrospinal fluid is in the sac and there's usually no nerve damage.
  - o Myelomeningocele - the protective covering of the spinal cord (meninges) comes through the open part of the spine.

- The diagnosis must be made after live birth.
- This benefit isn't available for Spina Bifida Occulta.
- This benefit is available a single time, regardless of the number of types of Spina Bifida present.

B661.0086

Option D

What isn't covered - exclusions

No benefits are payable for the following:

- An illness that's not listed in the **Covered illnesses** section.
- An illness that's diagnosed after your death unless there's an exception specifically listed in this guide that we'll accept a death certificate or autopsy report confirming the diagnosis of that illness.
- An illness that's diagnosed when you're not covered by this Plan.

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- Any care, service or treatment that's received when this coverage isn't in place.
- An illness or condition that's contributed to or results from any of the following:
    - Participating in a felony, riot or insurrection
    - Intentionally causing a self-inflicted injury
    - Suicide or attempted suicide while sane or insane
    - Engaging in any illegal activity
    - Serving in the armed forces or any auxiliary unit of the armed forces of any country
    - The voluntary use of any poison, chemical, substance defined as a controlled substance by Title II of the Comprehensive Drug Abuse Prevention and Control Act of 1970, or prescription drug, unless prescribed by a physician and used as prescribed
    - The voluntary use of a non-prescription drug inconsistent with package instructions
    - War or act of war, even if war isn't declared
- An illness or condition that's diagnosed outside the United States unless the diagnosis is confirmed in the United States. If the diagnosis is confirmed in the United States, the diagnosis will be considered to have been made on the date it was made outside the United States.
- Any care, treatment or service received outside the United States.
- Any illness, care, treatment or service that violates local, state or federal law or for which our paying a benefit would violate local, state or federal law.
- Any claim for a benefit that isn't specifically listed as an available benefit under the member guide.
- An illness that's diagnosed by you or a member of your immediate family or a business associate.

  Immediate family includes the following:

    - Your spouse or anyone with whom you live and share financial assets and obligations.
    - Your child
    - Your parents, including stepparents and mother-in-law and father-in-law
    - Your siblings, including stepbrothers and stepsisters
    - Your brothers-in-law and sisters-in-law
    - Your grandparents, including step-grandparents
    - Your grandchildren, including step-grandchildren
    - Any relative living with you

  Immediate family also includes the spouse of anyone listed above.

  If coverage is available for family members under this Plan, there may be additional requirements that must be met for the purpose of determining who's eligible for coverage. Please see the **Who's eligible** section of the member guide.

See the **When we won't pay benefits** section of the member guide for other reasons benefits won't be available.

B661.0088

CI-23-CIG-2

Option D

Here is a notice to help you better understand your rights if your Plan is governed by ERISA. The notice isn't part of the group insurance policy or member guide.

B651.1025

Option D

STATEMENT OF ERISA RIGHTS

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

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

ERISA provides that all plan participants shall be entitled to:

Receive Information about Your Plan and Benefits

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

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

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

Prudent Actions by Plan Fiduciaries

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

Enforcement of Your Rights

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

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report from the plan and do not receive them within 30 days, you may file suit in Federal court. In such a case, the court may require the plan administrator to provide the materials and pay you up to $110.00 a day until you receive the material, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or federal court. If it should happen that plan fiduciaries misuse the 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.

B661.0119

Critical Illness Insurance Claims Procedure

If you seek benefits under the plan you should complete, execute and submit a request for claim. Instructions for filing claims may be obtained from The Guardian Life Insurance Company of America (hereinafter referenced as Guardian.)

Guardian is the Claims Fiduciary with the authority to interpret and construe the terms of the Policy, the Certificate, the Schedule of Benefits, and any riders, or other documents or forms that may be attached to the Certificate or the Policy, and any other plan documents. Guardian has the authority to determine eligibility for benefits and coverage under those documents. Guardian has the right to secure independent professional healthcare advice and to require such other evidence as needed to decide your claim.

In addition to the basic claim procedure explained in your Certificate, Guardian will also observe the procedures listed below. These procedures are the minimum requirements for benefit claims procedures of employee benefit plans covered by Title 1 of ERISA.

Definitions

"Adverse determination" means a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit, including any such denial, reduction, termination, or failure to provide or make payment that is based on a determination of a participant s or beneficiary's eligibility to participate in a plan.

Timing for Initial Benefit Determination of Critical Illness Insurance Claims

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

Guardian will provide a benefit determination not later than 90 days from the date of receipt of a claim. This period may be extended by up to 90 days if Guardian determines that an extension is necessary due to special circumstances, and so notifies the claimant before the end of the initial 90-day period. Such notification will include the reason for the special circumstances requiring the extension and a date by which the determination is expected to be made.

A notification of an extension to the time period in which a benefit determination will be made will include an explanation of the standards upon which entitlement to a benefit is based, any unresolved issues that prevent a decision of the claim, and the additional information needed to resolve those issues.

Adverse Benefit Determination of Critical Illness Insurance Claims

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

- The specific reason(s) for the adverse determination;
- References to the specific provisions in the Policy, Certificate, plan or other documents, on which the determination is based;
- A description of any additional material or information needed to perfect the claim, and an explanation of why such material or information is necessary;
- A description of the plan's claim review procedures which a claimant may follow to have a claim for benefits reviewed and the time limits applicable to such procedures; and
- A description of the plan's review procedures and the time limits applicable to such procedures, including a statement of the claimant's right to bring a civil action under ERISA Section 502(a) following an adverse benefit determination on review.

B661.0120

Appeals of Adverse Determinations of Critical Illness Insurance Claims

If a claim is wholly or partially denied, you will have up to 60 days to make an appeal. Guardian will conduct a full and fair review of an appeal which includes providing to claimants the following:

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

In reviewing an appeal, Guardian will notify the claimant of its decision not later than 60 days after receipt of the request for review of the adverse determination. This period may be extended by an additional period of up to 60 days if Guardian determines that special circumstances require an extension of the time period for processing and so notifies the claimant before the end of the initial 60-day period.

A notification with respect to an extension will indicate the special circumstances requiring an extension of the time period for review, and the date by which the final determination will be made. In the event Guardian denies the appeal of an adverse benefit determination, it will:

- Provide the specific reason or reasons why the appeal was denied;
- Refer to the specific provisions in the Policy, Certificate, plan, or other documents on which the benefit determination is based;
- Provide a statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of all documents, records, and other information relevant to the claimant s claim for benefits.

Alternative Dispute Options

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

B661.0121

YOUR BENEFITS INFORMATION - ANYTIME, ANYWHERE

www.guardianlife.com

You can access helpful, secure information about your Guardian benefits online 24 hours a day, 7 days a week.

Anytime, anywhere you have internet access, you'll be able to:

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

To register, go to **www.guardianlife.com**

B101.0002

The Guardian Life Insurance Company of America
10 Hudson Yards
New York, New York 10001

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