Guardian®

YOUR GROUP INSURANCE PLAN BENEFITS

This document contains information for 2 plans:
Critical Illness & Cancer.

- Cancer Plan - Option A (Low Plan) & Option B (High Plan): pages 1 to page 62
- Critical Illness Plan (without Cancer) - Option D: starting on page 63

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

CERTIFICATE OF COVERAGE

The Guardian
10 Hudson Yards
New York, New York 10001

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

Group Policy No.	Certificate No.	Effective Date
Issued To		

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

The Guardian Life Insurance Company of America

Michael Prestileo, Senior Vice President

CGP-3-R-STK-90-3 B110.0023

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Options A , B

GENERAL PROVISIONS

As used in this booklet:

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

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

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

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

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

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

CGP-3-R-GENPRO-90 B160.0002

Options A , B

Limitation of Authority

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

CGP-3-R-LOA-90 B160.0004

Options A , B

Incontestability

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

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

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

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

Options A , B

Examination and Autopsy

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

CGP-3-R-EA-90 B160.0006

Options A , B

Accident and Health Claims Provisions

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

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

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

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

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

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

We pay all *accident and health* benefits to you, if you're living. If you're not living, we have the right to pay all *accident and health* benefits, except dismemberment benefits, to one of the following: (a) your estate; (b) your spouse; (c) your parents; (d) your children; (e) your brothers and sisters; and (f) any unpaid provider of health care services. See "Your Accidental Death and Dismemberment Benefits" for how dismemberment benefits are paid.

When you file proof of loss, you may direct us, in writing, to pay health care benefits to the recognized provider of health care who provided the covered service for which benefits became payable. We may honor such direction at our option. But we can't tell you that a particular provider must provide such care. And you may not assign your right to take legal action under this *plan* to such provider.

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

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

Options A , B

ELIGIBILITY FOR CANCER INSURANCE

Employee Coverage

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

Other Conditions If *you* must pay all or part of the cost of *employee* coverage, *we* won't insure *you* until *you* enroll and agree to make the required payments.

We require that *you* answer insurability questions. The answers to these questions will determine whether or not *you* will be covered by this *plan.*

We require that *you* answer insurability questions again to change to a richer plan of benefits, if offered by *your employer.* The answers to these questions will determine whether or not *you* will be covered for the richer benefits.

CGP-3-EC-90-1.0 B477.0054

Options A , B

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

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

CGP-3-EC-90-2.0 B476.3878

Options A , B

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

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

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

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

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

Group Cancer Insurance Coverage During a Family Leave of Absence

This section may not apply to an employer's *plan. You* must contact *your* employer to find out if:

- the employer must allow for a leave of absence under Federal law, in which case;
- the section applies to *you.*

Group Cancer Insurance may normally end for *you* because *you* cease work due to an approved leave of absence. But, *you* may continue *your* coverage if the leave of absence has been granted: (a) to allow the *you* to care for a seriously injured or ill spouse, child, or parent; (b) after the birth or adoption of a child; (c) due to *your* own serious health condition; or (d) because of any serious injury or illness arising out of the fact that *your* spouse, child, parent, or next of kin, who is a covered service member, is on active duty(or has been notified of an impending call or order to active duty) in the Armed Forces in support of a contingency operation. *You* will be required to pay the same share of the premium as *you* paid before the leave of absence.

Group Cancer Insurance may continue until the earliest of the following:

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

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

Active Duty: This term means duty under a call or order to active duty in the Armed Forces of the United States.

Contingency Operation: This term means a military operation that: (a) Is designated by the Secretary of Defense as an operation in which members of the armed forces are or may become involved in military actions, operations, or hostilities against an enemy of the United States or against an opposing military force; or (b) results in the call or order to, or retention on, active duty of members of the uniformed services under any provision of law during a war or during a national emergency declared by the President or Congress.

Covered Servicemember: This term means a member of the Armed Forces, including a member of the National Guard or Reserves, who for a serious injury or illness: (a), is undergoing medical treatment, recuperation, or therapy; (b) is otherwise in outpatient status; or (c) is otherwise on the temporary disability retired list.

Next Of Kin: This term means the nearest blood relative of the *employee.*

Outpatient Status: This term means, with respect to a covered servicemember, that he or she is assigned to: (a) a military medical treatment facility as an outpatient; or (b) a unit established for the purpose of providing command and control of members of the Armed Forces receiving medical care as outpatients.

Serious Injury Or Illness: This term means, in the case of a covered servicemember, an injury or illness incurred by him or her in line of duty on active duty in the Armed Forces that may render him or her medically unfit to perform the duties of his or her office, grade, rank, or rating.

Options A , B

Dependent Coverage

CGP-3-DEP-90-1.0 B473.0009

Options A , B

Eligible Dependents For Dependent Cancer Coverage

Your eligible dependents are: (1) *your* legal spouse; And (2) *your* unmarried dependent children from birth until they reach age 26.

CGP-3-DEP-90-2.0 B477.0070

Options A , B

Adopted Children And Step-Children

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

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

Dependents Not Eligible

We exclude any dependent who is insured by this *plan* as an *employee.* And, *we* exclude any dependent who is on active duty in any armed force. Upon notice of entry into service, pro rata unearned premiums will be refunded.

A child may be an eligible dependent of more than one *employee* who is insured under this *plan.* In that case, the child may be insured for dependent cancer benefits by only one *employee* at a time.

CGP-3-DEP-90-3.0 B477.0071

Options A , B

Handicapped Children

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

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

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

The child's coverage ends when *your* coverage does.

CGP-3-DEP-90-4.0 B477.0073

Options A , B

Proof of Insurability

We require that *you* answer insurability questions with respect to *your* dependents. The answers to these questions will determine whether or not *your* dependents will be covered by this *plan.*

CGP-3-DEP-90-5.0 B477.0075

Options A , B

When Dependent Coverage Starts

In order for *your* dependent coverage to start, *you* must: (a) already be insured for *employee* coverage; or (b) enroll for *employee* and dependent coverage at the same time.

Subject to all of the terms of this *plan,* the date *your* dependent coverage is scheduled to start depends on when *you* elect to enroll *your* initial dependents and agree to make the required payments.

If *you* do this on or before *your* eligibility date, the dependent coverage is scheduled to start on the later of: (a) *your* eligibility date; and (b) the date *you* become insured for *employee* coverage.

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

Once *you* have dependent child coverage for *your* initial dependent child(ren), any *newly acquired dependent* children will be covered as of the date they are eligible.

CGP-3-DEP-90-6.0 B477.0074

Options A , B

Exception

We will postpone the effective date of a dependent's, other than a newborn child's, coverage if, on that date, he or she is: (1) confined to a hospital or other health care facility; (2) home confined; or (3) unable to perform two or more activities of daily living. In that case, *we* will postpone the effective date of his or her coverage until the day after the date: (a) of his or her discharge from such facility; (b) his or her home confinement ends; or (c) he or she is no longer requires assistance with two or more activities of daily living. If a dependent was covered under a prior plan at transfer, this language will not apply to the amount of coverage that was in force with the prior plan.

CGP-3-DEP-90-7.0 B477.0076

Options A , B

When Dependent Coverage Ends

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

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

An individual dependent's coverage ends when he or she stops being an eligible dependent. This happens to a child on the last day of the month in which the child attains this Plan's age limit, on the last day of the month in which he or she marries, or on the last day of the month in which a step-child is no longer dependent on the employee for support and maintenance, or for an employee's handicapped child who has reached the age limit, on the last day of the month in which he or she marries or is no longer dependent on the employee for support and maintenance. It happens to a spouse on the last day of the month in which a marriage ends in legal divorce or annulment.

CGP-3-DEP-90-9.0 B477.0643

SCHEDULE OF INSURANCE

Cancer Benefit

Air Ambulance: $2,000.00 per trip.
Limited to 2 one-way trips per *hospital confinement.*

Alternative Care (Palliative Care or Lifestyle Benefits): $50.00 per visit.
Limited to 20 visits per *benefit year* combined.

Ambulance: $250.00 per trip.
Limited to 2 one-way trips per *hospital confinement.*

Anesthesia: 25% of surgery benefit.

Anti-Nausea Medication: $50.00 per day up to $250.00 per month.

Attending Doctor: $25.00 per day.
Limited to 75 visits per *hospital confinement.*

Bone Marrow and Stem Cells: $10,000.00 for *bone marrow transplant.*
$2,500.00 for *stem cell transplant.*
50% for second transplant.
Limited to two of each in a covered person's lifetime
$1,500.00 if a covered person donates bone marrow, limited to one benefit in a covered person's lifetime.

Cancer Screening: $75.00 per *benefit year.*

Cancer Screening Follow-Up: $75.00 per *benefit year.*

Experimental Treatment: $200.00 per day.
Limited to $2,400.00 per month.

Extended Care Facility/Skilled Nursing Care: $150.00 per day.
Limited to 90 days per *benefit year.*

Government or Charity Hospital: $400.00 per day in lieu of other other benefits provided by this *plan.*

Home Health Care: $100.00 per visit.
Limited to 30 visits per *benefit year.*

Hormone Therapy $50.00 per treatment.
Limited to 12 per benefit year.

Hospice: $100.00 per day.
Limited to 100 days per lifetime.

Hospital Confinement: $400.00 for first 30 days per *period of hospital confinement.*
$800.00 for 31st day and thereafter per *period of hospital confinement.*

Immunotherapy: $500.00 per month.
$2,500.00 per lifetime.

Intensive Care Unit Confinement:	$600.00 for first 30 days per confinement. $800.00 for 31st day and thereafter confinement.
Inpatient Special Nursing:	$150.00 per day. Limited to 30 days per *benefit year.*
Medical Imaging:	$200.00 per image. Limited to 2 images per *benefit year.*
Outpatient and Family Member Lodging:	$100.00 per day. Limited to 90 days per *benefit year.*
Outpatient or Ambulatory Surgical Center:	$350.00 per day. Limited to 3 days per procedure.
Physical or Speech Therapy:	$50.00 per visit. Limited to 4 visits per month. Limited to $1,000.00 per lifetime.
Surgically Implanted Prosthetic Devices:	$3,000.00 per device. Limited to $6,000.00 per lifetime.
Non-Surgically Implanted Prosthetic Devices:	$300.00 per device. Limited to $600.00 per lifetime.

Reconstructive Surgery:

Breast TRAM flap	$3,000.00
Breast reconstruction	$700.00
Breast symmetry	$350.00
Facial reconstruction	$700.00

Reproductive Benefits:	$1,500.00 for egg harvesting $500.00 for egg storage. $500.00 for sperm storage. $2,000.00 lifetime limit for all reproductive benefits.
Second Surgical Opinion:	$300.00 Limited to one per surgical procedure.

Skin Cancer:

Biopsy only	$100.00
Reconstructive surgery following excision of a skin cancer	$250.00
Excision of a skin cancer with no flap or graft	$375.00
Excision of a skin cancer with flap or graft	$600.00

Surgical Benefits:

Surgery	**Surgical Benefit**
Abdomen - Cholecystectomy	$770.00
Abdomen - Exploratory laparotomy	$580.00

Abdomen - Paracentesis	$150.00
Bladder - (TUR) transurethral resection bladder tumors	$580.00
Bladder - Cystectomy (complete)	$1,980.00
Bladder - Cystectomy (partial)	$990.00
Bladder - Cystectomy (with ureteroileal conduit)	$3,960.00
Bladder - Cystoscopy	$150.00
Brain - Burr holes not followed by surgery	$770.00
Brain - Excision brain tumor	$3,850.00
Brain - Exploratory craniotomy	$1,650.00
Brain - Ventriculoperitoneal shunt	$770.00
Brain - Hemispherectomy	$5,500.00
Breast - lumpectomy	$380.00
Breast - mastectomy partial	$580.00
Breast - mastectomy radical	$1,150.00
Breast - mastectomy simple	$770.00
Chest - Bronchoscopy	$330.00
Chest - Lobectomy	$1,650.00
Chest - Mediastinoscopy	$330.00
Chest - Pneumonectomy	$2,310.00
Chest - Thoracentesis	$150.00
Chest - Thoracostomy	$330.00
Chest - Thoracotomy	$770.00
Chest - Wedge resection	$1,320.00
Esophagus - Esophagogastrectomy	$1,650.00
Esophagus - Esophagoscopy	$300.00
Esophagus - Resection of esophagus	$2,200.00
Eye - Enucleation	$550.00
Eye - P32 uptake	$270.00
Female Reproductive - Abdominal hysterectomy/uterus only	$990.00
Female Reproductive - Colposcopy	$190.00
Female Reproductive - D&C	$190.00
Female Reproductive - Oophorectomy	$580.00
Female Reproductive - Uterus, tubes & ovaries	$1,920.00
Female Reproductive - Uterus, tubes & ovaries with exenteration	$5,500.00

Female Reproductive - Vaginal hysterectomy/uterus only	$580.00
Intestines - Abdominal-perineal resection	$2,750.00
Intestines - Colectomy	$990.00
Intestines - Colonoscopy (does not include virtual or CT Colonography)	$300.00
Intestines - Colostomy/or revision of	$380.00
Intestines - ERCP	$380.00
Intestines - Excesional on rectum for biopsy	$300.00
Intestines - Ileostomy	$380.00
Intestines - Proctosigmoidoscopy	$150.00
Intestines - Resection of small intestine	$2,310.00
Intestines - Sigmoidoscopy	$150.00
Kidney - Nephrectomy (radical)	$3,960.00
Kidney - Nephrectomy (simple)	$2,310.00
Liver - Resection of liver	$2,750.00
Lymphatic - Axillary node dissection	$770.00
Lymphatic - Excision of lymph nodes	$190.00
Lymphatic - Lymphadenectomy (bilaterial)	$990.00
Lymphatic - Lymphadenectomy (unilateral)	$770.00
Lymphatic - Splenectomy	$770.00
Mandible - Mandibulectomy	$1,540.00
Misc - Bone marrow aspiration	$150.00
Misc - Pathological hip fracture (chemo)	$960.00
Misc - Venous-Catheters/venous port (chemo)	$150.00
Misc - Peripherally inserted central catheter (PICC)	$150.00
Misc - Pathological fracture (chemo)	$440.00
Mouth - Glossectomy	$770.00
Mouth - Hemiglossectomy	$380.00
Mouth - Resection of palate	$770.00
Mouth - Tonsil/Mucous membranes	$580.00
Pancreas - Jejunostomy	$990.00
Pancreas - Pancreatectomy	$2,310.00
Pancrease - Whipple procedure	$3,960.00
Penis - amputation, complete	$770.00

Penis - amputation, partial	$380.00
Penis - amputation, radical	$990.00
Prostate - (TUR) transurethral resection prostate	$580.00
Prostate - Cystoscopy	$150.00
Prostate - Radical Prostatectomy	$1,540.00
Radium Implants - Insertion	$1,100.00
Radium Implants - Removal	$550.00
Salivary glands - Parotidectomy	$770.00
Salivary glands - Radical neck dissection	$1,980.00
Spine - Cordotomy	$580.00
Spine - Laminectomy	$990.00
Stomach - Gastrectomy (complete)	$1,540.00
Stomach - Gastrectomy (partial)	$990.00
Stomach - Gastrojejunostomy	$990.00
Stomach - Gastroscopy	$330.00
Testis - Orchiectomy (bilateral)	$530.00
Testis - Orchiectomy (unilateral)	$380.00
Throat - Laryngectomy (w/out neck dissection)	$990.00
Throat - Laryngectomy (with neck dissection)	$1,980.00
Throat - Laryngoscopy	$330.00
Throat - Tracheostomy	$330.00
Thyroid - Thyroidectomy (partial: one lobe)	$580.00
Thyroid - Thyroidectomy (total: both lobes)	$770.00
Vulva - Vulvectomy (partial)	$580.00
Vulva - Vulvectomy (radical)	$1,540.00
Transportation/Companion Transportation:	$0.50 per mile. Limited to $1,500 per round trip.

SCHEDULE OF INSURANCE

Cancer Benefit

Air Ambulance:	$1,500.00 per trip. Limited to 2 one-way trips per *hospital confinement.*
Ambulance:	$200.00 per trip. Limited to 2 one-way trips per *hospital confinement.*
Anesthesia:	25% of surgery benefit.
Anti-Nausea Medication:	$50.00 per day up to $150.00 per month.
Attending Doctor:	$25.00 per day. Limited to 75 visits per *hospital confinement.*
Bone Marrow and Stem Cells:	$7,500.00 for *bone marrow transplant.* $1,500.00 for *stem cell transplant.* 50% for second transplant. Limited to two of each in a covered person's lifetime $1,000.00 if a covered person donates bone marrow, limited to one benefit in a covered person's lifetime.
Cancer Screening:	$50.00 per *benefit year.*
Cancer Screening Follow-Up:	$50.00 per *benefit year.*
Experimental Treatment:	$100.00 per day. Limited to $1,000.00 per month.
Extended Care Facility/Skilled Nursing Care:	$100.00 per day. Limited to 90 days per *benefit year.*
Government or Charity Hospital:	$300.00 per day in lieu of other benefits provided by this *plan.*
Home Health Care:	$50.00 per visit. Limited to 30 visits per *benefit year.*
Hormone Therapy	$25.00 per treatment. Limited to 12 per benefit year.
Hospice:	$50.00 per day. Limited to 100 days per lifetime.
Hospital Confinement:	$300.00 for first 30 days per *period of hospital confinement.* $600.00 for 31st day and thereafter per *period of hospital confinement.*
Immunotherapy:	$500.00 per month. $2,500.00 per lifetime.

Intensive Care Unit Confinement: $400.00 for first 30 days per confinement.
$600.00 for 31st day and thereafter confinement.

Inpatient Special Nursing: $100.00 per day.
Limited to 30 days per *benefit year.*

Medical Imaging: $100.00 per image.
Limited to 2 images per *benefit year.*

Outpatient and Family Member Lodging: $75.00 per day.
Limited to 90 days per *benefit year.*

Outpatient or Ambulatory Surgical Center: $250.00 per day.
Limited to 3 days per procedure.

Physical or Speech Therapy: $25.00 per visit.
Limited to 4 visits per month.
Limited to $400.00 per lifetime.

Surgically Implanted Prosthetic Devices: $2,000.00 per device.
Limited to $4,000.00 per lifetime.

Non-Surgically Implanted Prosthetic Devices: $200.00 per device.
Limited to $400.00 per lifetime.

Reconstructive Surgery:

Breast TRAM flap	$2,000.00
Breast reconstruction	$500.00
Breast symmetry	$250.00
Facial reconstruction	$500.00

Second Surgical Opinion: $200.00
Limited to one per surgical procedure.

Skin Cancer:

Biopsy only	$100.00
Reconstructive surgery following excision of a skin cancer	$250.00
Excision of a skin cancer with no flap or graft	$375.00
Excision of a skin cancer with flap or graft	$600.00

Surgical Benefits:

Surgery	**Surgical Benefit**
Abdomen - Cholecystectomy	$575.00
Abdomen - Exploratory laparotomy	$435.00
Abdomen - Paracentesis	$110.00
Bladder - (TUR) transurethral resection bladder tumors	$435.00
Bladder - Cystectomy (complete)	$1,485.00
Bladder - Cystectomy (partial)	$740.00

Bladder - Cystectomy (with ureteroileal conduit)	$2,970.00
Bladder - Cystoscopy	$110.00
Brain - Burr holes not followed by surgery	$575.00
Brain - Excision brain tumor	$2,885.00
Brain - Exploratory craniotomy	$1,235.00
Brain - Ventriculoperitoneal shunt	$575.00
Brain - Hemispherectomy	$4,125.00
Breast - lumpectomy	$285.00
Breast - mastectomy partial	$435.00
Breast - mastectomy radical	$860.00
Breast - mastectomy simple	$575.00
Chest - Bronchoscopy	$245.00
Chest - Lobectomy	$1,235.00
Chest - Mediastinoscopy	$245.00
Chest - Pneumonectomy	$1,730.00
Chest - Thoracentesis	$110.00
Chest - Thoracostomy	$245.00
Chest - Thoracotomy	$575.00
Chest - Wedge resection	$990.00
Esophagus - Esophagogastrectomy	$1,235.00
Esophagus - Esophagoscopy	$225.00
Esophagus - Resection of esophagus	$1,650.00
Eye - Enucleation	$410.00
Eye - P32 uptake	$200.00
Female Reproductive - Abdominal hysterectomy/uterus only	$740.00
Female Reproductive - Colposcopy	$140.00
Female Reproductive - D&C	$140.00
Female Reproductive - Oophorectomy	$435.00
Female Reproductive - Uterus, tubes & ovaries	$1,440.00
Female Reproductive - Uterus, tubes & ovaries with exenteration	$4,125.00
Female Reproductive - Vaginal hysterectomy/uterus only	$435.00
Intestines - Abdominal-perineal resection	$2,060.00
Intestines - Colectomy	$740.00

Intestines - Colonoscopy (does not include virtual or CT Colonography)	$225.00
Intestines - Colostomy/or revision of	$285.00
Intestines - ERCP	$285.00
Intestines - Excesional on rectum for biopsy	$225.00
Intestines - Ileostomy	$285.00
Intestines - Proctosigmoidoscopy	$110.00
Intestines - Resection of small intestine	$1,730.00
Intestines - Sigmoidoscopy	$110.00
Kidney - Nephrectomy (radical)	$2,970.00
Kidney - Nephrectomy (simple)	$1,730.00
Liver - Resection of liver	$2,060.00
Lymphatic - Axillary node dissection	$575.00
Lymphatic - Excision of lymph nodes	$140.00
Lymphatic - Lymphadenectomy (bilaterial)	$740.00
Lymphatic - Lymphadenectomy (unilateral)	$575.00
Lymphatic - Splenectomy	$575.00
Mandible - Mandibulectomy	$1,155.00
Misc - Bone marrow aspiration	$110.00
Misc - Pathological hip fracture (chemo)	$720.00
Misc - Venous-Catheters/venous port (chemo)	$110.00
Misc - Peripherally inserted central catheter (PICC)	$110.00
Misc - Pathological fracture (chemo)	$330.00
Mouth - Glossectomy	$575.00
Mouth - Hemiglossectomy	$285.00
Mouth - Resection of palate	$575.00
Mouth - Tonsil/Mucous membranes	$435.00
Pancreas - Jejunostomy	$740.00
Pancreas - Pancreatectomy	$1,730.00
Pancrease - Whipple procedure	$2,970.00
Penis - amputation, complete	$575.00
Penis - amputation, partial	$285.00
Penis - amputation, radical	$740.00
Prostate - (TUR) transurethral resection prostate	$435.00

Prostate - Cystoscopy	$110.00
Prostate - Radical Prostatectomy	$1,155.00
Radium Implants - Insertion	$825.00
Radium Implants - Removal	$410.00
Salivary glands - Parotidectomy	$575.00
Salivary glands - Radical neck dissection	$1,485.00
Spine - Cordotomy	$435.00
Spine - Laminectomy	$740.00
Stomach - Gastrectomy (complete)	$1,155.00
Stomach - Gastrectomy (partial)	$740.00
Stomach - Gastrojejunostomy	$740.00
Stomach - Gastroscopy	$245.00
Testis - Orchiectomy (bilateral)	$395.00
Testis - Orchiectomy (unilateral)	$285.00
Throat - Laryngectomy (w/out neck dissection)	$740.00
Throat - Laryngectomy (with neck dissection)	$1,485.00
Throat - Laryngoscopy	$245.00
Throat - Tracheostomy	$245.00
Thyroid - Thyroidectomy (partial: one lobe)	$435.00
Thyroid - Thyroidectomy (total: both lobes)	$575.00
Vulva - Vulvectomy (partial)	$435.00
Vulva - Vulvectomy (radical)	$1,155.00
Transportation/Companion Transportation:	$0.50 per mile. Limited to $1,000 per round trip.

Options A , B

CANCER COVERAGE

Important Notice: **This is *Cancer* coverage. It provides a limited specified benefit. It is a supplement to, and not a substitute for, medical coverage. Please read this *plan* carefully to fully understand what it covers, limits, and excludes.**

Subject to all of this *plan's* terms, this *plan* will pay the benefits described below if a *covered person* is *diagnosed* with *cancer* after the date he or she becomes insured by this *plan.* This *plan* pays no benefits other than what is specifically listed below.

All services or treatment must be received by the covered person within 120 days of the date his or coverage under this *plan* ends.

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

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Option B

Benefits

Air Ambulance *We* will pay the amount shown in the schedule of insurance if a licensed professional air ambulance is used to transport a *covered person* to a *hospital* where a *covered person* is confined as an *inpatient* for internal *cancer* treatment. *We* limit what *we* pay to two one-way trips per *period of hospital confinement.*

Alternative Care *We* pay the amount shown in the schedule of insurance for alternative care benefits if a *covered person* is *diagnosed* with *internal cancer. We* will require that the *cancer diagnosis* be reconfirmed on a regular basis, either by proof of ongoing treatment, or by a *doctor's* recertification. *We* limit what *we* pay each *benefit year* to the number of visits shown in the schedule of insurance for *palliative care* and lifestyle benefits combined. And *we* limit what *we* pay for *palliative care* and Lifestyle Benefits combined to two *benefit years* in a *covered person's* lifetime.

1. *Palliative Care* Benefit: *We* will pay the amount shown in the schedule of insurance for each visit to an *accredited practitioner* for *bio-feedback* and hypnosis.
2. Lifestyle Benefit - *We* will pay the amount shown in the schedule of insurance for each visit to an *accredited practitioner* for smoking cessation, yoga, meditation, relaxation techniques and nutritional counseling.

Ambulance *We* will pay the amount shown in the schedule of insurance if a licensed professional ambulance is used to transport a *covered person* to a *hospital* where a *covered person* is confined as an *inpatient* for *internal cancer* treatment. *We* limit what *we* pay to two one-way trips per *period of hospital confinement.*

Anesthesia If general anesthesia is provided to a *covered person* in connection with a surgical procedure covered under the Surgical Benefits section, *we* will pay 25% of the amount shown in the schedule of insurance for the surgical procedure.

Anti-Nausea Medication *We* will pay the amount shown in the schedule of insurance if a *doctor* prescribes a *covered person* drugs to control nausea related to chemotherapy or radiation for *internal cancer* treatments. *We* limit what *we* pay each month to the amount shown in the schedule of insurance.

Attending Doctor *We* will pay the amount shown in the schedule of insurance if a *covered person* is visited by a *doctor* for the treatment of *internal cancer* while confined in a *hospital* . *We* don't pay for visits by the operating surgeon. *We* limit what *we* pay per *period of hospital confinement* to the number of days shown in the schedule of insurance.

Blood, Plasma and Platelets *We* will pay the amount shown in the schedule of insurance for each day a *covered person* receives blood, plasma and/or platelets for the treatment of *internal cancer. We* pay whether the blood, plasma and/or platelets is received as an *inpatient* in a *hospital* or as an outpatient in a *doctor's* office, *hospital* or *ambulatory surgical center.* We don't pay for blood, plasma and/or platelets for any other reason, including replacement of blood during surgery. And *we* limit what *we* pay in the 12 months which starts on the date of the first treatment to the amount shown in the schedule of insurance.

Bone Marrow and Stem Cells *We* will pay the amount shown in the schedule of insurance if a *covered person* receives a *bone marrow transplant* or *stem cell transplant* to treat *internal cancer.*

Cancer Screening Once per *benefit year, we* will pay the amount in the schedule of insurance if *you* provide *proof* satisfactory to *us* that a *covered person* received at least one of the following tests for *internal cancer* : (1) bone marrow testing; (2) BRCA testing; (3) breast ultrasound; (4) breast MRI; (5) colonoscopy or virtual colonoscopy; (6) CA 125 test (blood test for ovarian *cancer*); (7) CA 15-3 test (blood test for breast *cancer*); (8) CEA (blood test for colon *cancer*) (9) chest x-ray; (10) CT scans or MRI scans; (11) flexible sigmoidoscopy; (12) hemocult stool specimen (lab confirmed); (13) mammogram; (14) pap smear; (15) PSA (blood test for prostate *cancer*); (16) Serum Protein Electrophoresis (test for myeloma); (17) testicular ultrasound; (18) thermography; or (19) ThinPrep.

We will pay this benefit once per *benefit year* for each *covered person* regardless of whether multiple tests are performed. *We* will pay this benefit whether or not *cancer* is *diagnosed.*

Cancer Screening Follow-Up Once per *benefit year, we* will pay the amount shown in the schedule of insurance for an additional invasive diagnostic procedure provided to a *covered person. We* will pay this benefit only if the procedure is recommended by a *doctor* as necessary due to the results of the initial *cancer* screening procedure.

Experimental Treatment

We pay the amount shown in the schedule of insurance if a *doctor* prescribes experimental treatment for a *covered person* for the purpose of destroying or changing abnormal tissue, and the treatment is administered by medical personnel in a *doctor's* office, *clinic* or *hospital.* All treatment must be *NCI-listed* as viable experimental treatment for *internal cancer.*

We will not pay benefits under this provision for laboratory tests, *immunotherapy,* diagnostic x-rays, and therapeutic devices or other procedures related to the treatments. *We* will not pay benefits under this provision for the same day the radiation and chemotherapy benefit is payable. However if a *covered person* is eligible for both the experimental treatment benefit and the radiation and chemotherapy benefit on the same day, then *we* will pay the higher benefit.

Extended Care Facility/Skilled Nursing Care

If *we* pay benefits under this *plan's hospital* confinement section for a *covered person,* and such *covered person* subsequently is confined to an *extended care* or *skilled nursing facility* for the treatment of *internal cancer, we* will pay the amount in the schedule of insurance. The *extended care* or *skilled nursing facility* confinement must start within 30 days of the end of the *hospital* confinement. *We* limit what *we* pay each *benefit year* to the number of days shown in the schedule of insurance.

Government or Charity Hospital

In lieu of all the other benefits provided by this *plan, we* will pay the amount shown in the schedule of insurance per day when a *covered person* is confined to: (a) a *hospital* operated by or for the U.S. Government (including the Veteran's Administration); or (b) a *hospital* that does not charge for its services (charity). The confinement must be for the treatment of *internal cancer.*

Home Health Care

We pay the amount shown in the schedule of insurance if a *covered person* receives home health care or health support services for the treatment of *internal cancer. We* limit what *we* pay each *benefit year* to the limit shown in the schedule of insurance.

However, these services must start within seven days of release from a *hospital.* And the *covered person's doctor* must certify that the *covered person* would need to be *hospital* confined if home health care was not available.

We will pay benefits under this section only if the home health care or health support services providers are licensed or certified and as qualified as caregivers providing comparable services at a *hospital* or other appropriate medical facility. This benefit will not be paid for any day a benefit is paid under the *hospice* section. If a *covered person* is eligible for both a benefit under the home health care and *hospice* sections on the same day, *we* will pay the higher amount.

Hormone Therapy

If a *doctor* prescribes, and a *covered person* receives hormone therapy as a treatment for *internal cancer, we* will pay the amount shown in the schedule of insurance. *We* limit what *we* pay to the number of treatments shown in the schedule of insurance each *benefit year.*

Hospice

We pay the amount shown in the schedule of insurance per day if a covered person receives hospice care. We limit what we pay to the number of days shown in the schedule of insurance during the covered person's lifetime.

We require that the covered person's doctor certify in writing that the covered person is terminally ill as a result of internal cancer, with a life expectancy of less than six months.

This benefit is not payable on the same day the extended care facility, home health care or hospital confinement benefit is payable. However, if a covered person is eligible for the extended care facility, home health care, hospice or hospital confinement benefit on the same day, we will pay the highest benefit.

Hospital Confinement We will pay the amount shown in the schedule of insurance for each day during a period of hospital confinement in which a covered person is confined in a hospital for the treatment of internal cancer.

Intensive Care Unit Confinement We will pay the amount shown in the schedule of insurance if a covered person is confined in a hospital's intensive care unit for the treatment of internal cancer. We don't pay for intensive care unit confinement and hospital confinement on the same day.

Option A

Benefits

Air Ambulance *We* will pay the amount shown in the schedule of insurance if a licensed professional air ambulance is used to transport a *covered person* to a *hospital* where a *covered person* is confined as an *inpatient* for internal *cancer* treatment. *We* limit what *we* pay to two one-way trips per *period of hospital confinement.*

Ambulance *We* will pay the amount shown in the schedule of insurance if a licensed professional ambulance is used to transport a *covered person* to a *hospital* where a *covered person* is confined as an *inpatient* for *internal cancer* treatment. *We* limit what *we* pay to two one-way trips per *period of hospital confinement.*

Anesthesia If general anesthesia is provided to a *covered person* in connection with a surgical procedure covered under the Surgical Benefits section, *we* will pay 25% of the amount shown in the schedule of insurance for the surgical procedure.

Anti-Nausea Medication *We* will pay the amount shown in the schedule of insurance if a *doctor* prescribes a *covered person* drugs to control nausea related to chemotherapy or radiation for *internal cancer* treatments. *We* limit what *we* pay each month to the amount shown in the schedule of insurance.

Attending Doctor *We* will pay the amount shown in the schedule of insurance if a *covered person* is visited by a *doctor* for the treatment of *internal cancer* while confined in a *hospital* . *We* don't pay for visits by the operating surgeon. *We* limit what *we* pay per *period of hospital confinement* to the number of days shown in the schedule of insurance.

Blood, Plasma and Platelets

We will pay the amount shown in the schedule of insurance for each day a *covered person* receives blood, plasma and/or platelets for the treatment of *internal cancer. We* pay whether the blood, plasma and/or platelets is received as an *inpatient* in a *hospital* or as an outpatient in a *doctor's* office, *hospital* or *ambulatory surgical center.* We don't pay for blood, plasma and/or platelets for any other reason, including replacement of blood during surgery. And *we* limit what *we* pay in the 12 months which starts on the date of the first treatment to the amount shown in the schedule of insurance.

Bone Marrow and Stem Cells

We will pay the amount shown in the schedule of insurance if a *covered person* receives a *bone marrow transplant* or *stem cell transplant* to treat *internal cancer.*

Cancer Screening

Once per *benefit year, we* will pay the amount in the schedule of insurance if *you* provide *proof* satisfactory to *us* that a *covered person* received at least one of the following tests for *internal cancer* : (1) bone marrow testing; (2) BRCA testing; (3) breast ultrasound; (4) breast MRI; (5) colonoscopy or virtual colonoscopy; (6) CA 125 test (blood test for ovarian *cancer*); (7) CA 15-3 test (blood test for breast *cancer*); (8) CEA (blood test for colon *cancer*) (9) chest x-ray; (10) CT scans or MRI scans; (11) flexible sigmoidoscopy; (12) hemocult stool specimen (lab confirmed); (13) mammogram; (14) pap smear; (15) PSA (blood test for prostate *cancer*); (16) Serum Protein Electrophoresis (test for myeloma); (17) testicular ultrasound; (18) thermography; or (19) ThinPrep.

We will pay this benefit once per *benefit year* for each *covered person* regardless of whether multiple tests are performed. *We* will pay this benefit whether or not *cancer* is *diagnosed.*

Cancer Screening Follow-Up

Once per *benefit year, we* will pay the amount shown in the schedule of insurance for an additional invasive diagnostic procedure provided to a *covered person. We* will pay this benefit only if the procedure is recommended by a *doctor* as necessary due to the results of the initial *cancer* screening procedure.

Experimental Treatment

We pay the amount shown in the schedule of insurance if a *doctor* prescribes experimental treatment for a *covered person* for the purpose of destroying or changing abnormal tissue, and the treatment is administered by medical personnel in a *doctor's* office, *clinic* or *hospital.* All treatment must be *NCI-listed* as viable experimental treatment for *internal cancer.*

We will not pay benefits under this provision for laboratory tests, *immunotherapy,* diagnostic x-rays, and therapeutic devices or other procedures related to the treatments. *We* will not pay benefits under this provision for the same day the radiation and chemotherapy benefit is payable. However if a *covered person* is eligible for both the experimental treatment benefit and the radiation and chemotherapy benefit on the same day, then *we* will pay the higher benefit.

Extended Care Facility/Skilled Nursing Care

If *we* pay benefits under this *plan's hospital* confinement section for a *covered person,* and such *covered person* subsequently is confined to an *extended care* or *skilled nursing facility* for the treatment of *internal cancer, we* will pay the amount in the schedule of insurance. The *extended care* or *skilled nursing facility* confinement must start within 30 days of the end of the *hospital* confinement. *We* limit what *we* pay each *benefit year* to the number of days shown in the schedule of insurance.

Government or Charity Hospital

In lieu of all the other benefits provided by this *plan, we* will pay the amount shown in the schedule of insurance per day when a *covered person* is confined to: (a) a *hospital* operated by or for the U.S. Government (including the Veteran's Administration); or (b) a *hospital* that does not charge for its services (charity). The confinement must be for the treatment of *internal cancer.*

Home Health Care

We pay the amount shown in the schedule of insurance if a *covered person* receives home health care or health support services for the treatment of *internal cancer. We* limit what *we* pay each *benefit year* to the limit shown in the schedule of insurance.

However, these services must start within seven days of release from a *hospital.* And the *covered person's doctor* must certify that the *covered person* would need to be *hospital* confined if home health care was not available.

We will pay benefits under this section only if the home health care or health support services providers are licensed or certified and as qualified as caregivers providing comparable services at a *hospital* or other appropriate medical facility. This benefit will not be paid for any day a benefit is paid under the *hospice* section. If a *covered person* is eligible for both a benefit under the home health care and *hospice* sections on the same day, *we* will pay the higher amount.

Hormone Therapy

If a *doctor* prescribes, and a *covered person* receives hormone therapy as a treatment for *internal cancer, we* will pay the amount shown in the schedule of insurance. *We* limit what *we* pay to the number of treatments shown in the schedule of insurance each *benefit year.*

Hospice

We pay the amount shown in the schedule of insurance per day if a covered person receives hospice care. We limit what we pay to the number of days shown in the schedule of insurance during the covered person's lifetime.

We require that the covered person's doctor certify in writing that the covered person is terminally ill as a result of internal cancer, with a life expectancy of less than six months.

This benefit is not payable on the same day the extended care facility, home health care or hospital confinement benefit is payable. However, if a covered person is eligible for the extended care facility, home health care, hospice or hospital confinement benefit on the same day, we will pay the highest benefit.

Hospital Confinement

We will pay the amount shown in the schedule of insurance for each day during a period of hospital confinement in which a covered person is confined in a hospital for the treatment of internal cancer.

Intensive Care Unit Confinement

We will pay the amount shown in the schedule of insurance if a covered person is confined in a hospital's intensive care unit for the treatment of internal cancer. We don't pay for intensive care unit confinement and hospital confinement on the same day.

Option B

Immunotherapy

If a doctor prescribes immunotherapy for a covered person as treatment for internal cancer, we will pay the amount shown in the schedule of insurance each month. And we limit what we pay in a covered person's lifetime to the amount shown in the schedule of insurance.

We will not pay benefits under this provision for the same treatment under this plan's radiation or chemotherapy provision or the experimental treatment provision. However, if a covered person is eligible for the immunotherapy, radiation therapy or chemotherapy and the experimental treatment benefit on the same day, then we will pay the highest benefit.

Inpatient Special Nursing

While a covered person is an inpatient being treated for internal cancer, we pay the amount shown in the schedule of insurance each day for inpatient special nursing if a covered person requires full-time nursing care. Full-time means at least 8 hours of attendance in a 24 hour period. We limit what we pay each benefit year to the number of days shown in the schedule of insurance.

Nursing care must be ordered by a doctor for the treatment of internal cancer, and must be provided by a licensed registered graduate nurse or licensed practical or vocational nurse. Care can't be provided by a family member.

Medical Imaging

We will pay the amount shown in the schedule of insurance if a covered person receives a medical imaging procedure related to a diagnosed internal cancer. We limit what we pay each benefit year to the number of images shown in the schedule of insurance.

Outpatient and Family Member Lodging

We pay the amount in the schedule of insurance per day for lodging as described below. We limit what we pay for lodging to the number of days shown in the schedule of insurance.

We pay a daily lodging benefit when a covered person stay in a hotel, motel or other commercial accommodation in conjunction with receiving treatment of internal cancer. Such treatment must be ordered by a doctor and must not be able to be obtained locally. Lodging must occur more than 50 miles from the covered person's home.

We pay a daily lodging benefit for one adult family member who stays in a hotel, motel or other commercial accommodation in order to be near the covered person while confined in a hospital for internal cancer treatment. The hospital must be at least 50 miles from the covered person's home.

We don't pay for any day that a stay begins more than 24 hours prior to treatment or more than 24 hours after treatment.

Outpatient or Ambulatory Surgical Center

We will pay the amount shown in the schedule of insurance when a covered person uses an outpatient or ambulatory surgical center for a surgical procedure covered under this plan's surgical benefits section. We limit what we pay to three days per surgical procedure.

Physical or Speech Therapy

We will pay the amount shown in the schedule of insurance for physical or speech therapy provided to a covered person for restoration of normal body function following treatment of internal cancer. Such therapy must be provided by a licensed or certified physical or speech therapist.

We limit what we pay combined for physical and speech therapy to the number of visits per month shown in the schedule of insurance. We limit what we pay for physical and speech therapy combined to the lifetime limit shown in the schedule of insurance.

Prosthetic Devices

We will pay the amount shown in the schedule of insurance for prosthetic devices provided to a covered person as a direct result of treatment of internal cancer. There are separate amounts shown in the schedule of insurance for surgically implanted prosthetic devices and non-surgically implanted prosthetic devices. We limit what we pay for prosthetic devices in a covered person's lifetime to the amounts shown in the schedule of insurance.

Surgically implanted prosthetic devices must be the direct result or consequence of the surgical treatment of internal cancer.

The prosthetic device coverage does not include coverage for a Breast Transverse Rectus Abdominis Myocutaneous (TRAM) Flap procedure as listed under the Reconstructive Surgery benefit.

Radiation Therapy or Chemotherapy

We will pay the amounts shown in the schedule of insurance if a covered person receives radiation therapy or chemotherapy as internal cancer treatment for the purpose of changing or destroying abnormal tissue. Such therapy must be administered by medical personnel in a hospital, doctor's office or clinic. Benefits will be paid only for days on which treatment is performed.

Benefits will not be paid for office visits, laboratory tests, diagnostic x-rays, treatment planning, simulation, treatment devices, dosimetry, radiation physics, teletherapy or other treatments related to radiation therapy or chemotherapy treatments. Hormone therapy and immunotherapy is not covered under this provision.

Radiation therapy and chemotherapy treatments must be approved for the treatment of cancer by the United States Food and Drug Administration.

Reconstructive Surgery

We will pay the amount shown in the schedule of insurance if a covered person has reconstructive surgery performed related to the treatment of internal cancer. We pay only for the following procedures: (a) Breast symmetry (modification of the non-cancerous breast performed within 5 years of reconstructing the cancerous breast); (b) Breast reconstruction; (c) Facial reconstruction; and (d) Breast transverse rectus abdominis myocutaneous (TRAM) flap.

Also, we will pay 25% of the reconstructive surgery amounts shown in the schedule of insurance for general anesthesia used during these procedures.

Reproductive Benefits

We pay the amount shown in the insurance for a covered person to have oocytes extracted and harvested.

Also, once per covered person, we will pay the amount shown in the schedule of insurance for the storage of a covered person's oocytes or sperm with a licensed reproductive tissue bank or a similarly licensed facility. Any such extraction, harvesting or storage must occur prior to chemotherapy or radiation treatment that has been prescribed for the covered person's treatment of cancer.

We limit what we pay in a covered person's lifetime for covered reproductive benefits to the amount shown in the schedule of insurance.

Second Surgical Opinion

If a doctor has diagnosed a covered person with internal cancer requiring surgery and a covered person obtains a second surgical opinion, we will pay the amount shown in the schedule of insurance. However, the second surgical opinion must be from a different doctor than the one who recommended the surgery. We limit what we pay to one benefit per surgical procedure.

Skin Cancer

We will pay the amount shown in the schedule of insurance if a doctor performs any of the following procedures for the purpose of treating diagnosed skin cancer in a covered person: (a) biopsy; (b) reconstructive surgery following previous excision of skin cancer; (c) excision of skin cancer without flap or graft; or (d) excision of skin cancer with flap or graft.

The amount shown in the schedule of insurance includes the amount payable for anesthesia services.

Surgical Benefits

We pay the amount shown in the schedule of insurance if a doctor performs one of the procedures shown in the of insurance for the purpose of treating internal cancer diagnosed in a covered person. The schedule of insurance for surgical procedures does not apply to surgery for skin cancer, which will be covered only under the skin cancer section.And the schedule of insurance for surgical procedures does not apply to reconstructive surgery, which is covered only under the reconstructive surgery section.

If more than one surgical procedure is performed through the same incision, benefits will be paid for only one procedure based upon the highest eligible benefit.

Transportation/ Companion Transportation

We pay the amount shown in the schedule of insurance for transportation and companion transportation as follows.

We pay a transportation benefit upon completion of a round trip to transport a covered person to a hospital or clinic for the purpose of internal cancer treatment. However the hospital or clinic must be at least 50 miles from the covered person’s home. And transportation cannot be by the use of an ambulance or air ambulance.

If commercial travel (coach-class plane, train or bus) is necessary, we will pay for one additional person to accompany the covered person. If treatment is for a covered dependent child, we will pay for up to two adults to accompany the covered dependent child

Option A

Immunotherapy

If a doctor prescribes immunotherapy for a covered person as treatment for internal cancer, we will pay the amount shown in the schedule of insurance each month. And we limit what we pay in a covered person’s lifetime to the amount shown in the schedule of insurance.

We will not pay benefits under this provision for the same treatment under this plan’s radiation or chemotherapy provision or the experimental treatment provision. However, if a covered person is eligible for the immunotherapy, radiation therapy or chemotherapy and the experimental treatment benefit on the same day, then we will pay the highest benefit.

Inpatient Special Nursing

While a covered person is an inpatient being treated for internal cancer, we pay the amount shown in the schedule of insurance each day for inpatient special nursing if a covered person requires full-time nursing care. Full-time means at least 8 hours of attendance in a 24 hour period. We limit what we pay each benefit year to the number of days shown in the schedule of insurance.

Nursing care must be ordered by a doctor for the treatment of internal cancer, and must be provided by a licensed registered graduate nurse or licensed practical or vocational nurse. Care can't be provided by a family member.

Medical Imaging

We will pay the amount shown in the schedule of insurance if a covered person receives a medical imaging procedure related to a diagnosed internal cancer. We limit what we pay each benefit year to the number of images shown in the schedule of insurance.

Outpatient and Family Member Lodging

We pay the amount in the schedule of insurance per day for lodging as described below. We limit what we pay for lodging to the number of days shown in the schedule of insurance.

We pay a daily lodging benefit when a covered person stay in a hotel, motel or other commercial accommodation in conjunction with receiving treatment of internal cancer. Such treatment must be ordered by a doctor and must not be able to be obtained locally. Lodging must occur more than 50 miles from the covered person's home.

We pay a daily lodging benefit for one adult family member who stays in a hotel, motel or other commercial accommodation in order to be near the covered person while confined in a hospital for internal cancer treatment. The hospital must be at least 50 miles from the covered person's home.

We don't pay for any day that a stay begins more than 24 hours prior to treatment or more than 24 hours after treatment.

Outpatient or Ambulatory Surgical Center

We will pay the amount shown in the schedule of insurance when a covered person uses an outpatient or ambulatory surgical center for a surgical procedure covered under this plan's surgical benefits section. We limit what we pay to three days per surgical procedure.

Physical or Speech Therapy

We will pay the amount shown in the schedule of insurance for physical or speech therapy provided to a covered person for restoration of normal body function following treatment of internal cancer. Such therapy must be provided by a licensed or certified physical or speech therapist.

We limit what we pay combined for physical and speech therapy to the number of visits per month shown in the schedule of insurance. We limit what we pay for physical and speech therapy combined to the lifetime limit shown in the schedule of insurance.

Prosthetic Devices

We will pay the amount shown in the schedule of insurance for prosthetic devices provided to a covered person as a direct result of treatment of internal cancer. There are separate amounts shown in the schedule of insurance for surgically implanted prosthetic devices and non-surgically implanted prosthetic devices. We limit what we pay for prosthetic devices in a covered person's lifetime to the amounts shown in the schedule of insurance.

Surgically implanted prosthetic devices must be the direct result or consequence of the surgical treatment of internal cancer.

The prosthetic device coverage does not include coverage for a Breast Transverse Rectus Abdominis Myocutaneous (TRAM) Flap procedure as listed under the Reconstructive Surgery benefit.

Radiation Therapy or Chemotherapy

We will pay the amounts shown in the schedule of insurance if a covered person receives radiation therapy or chemotherapy as internal cancer treatment for the purpose of changing or destroying abnormal tissue. Such therapy must be administered by medical personnel in a hospital, doctor's office or clinic. Benefits will be paid only for days on which treatment is performed.

Benefits will not be paid for office visits, laboratory tests, diagnostic x-rays, treatment planning, simulation, treatment devices, dosimetry, radiation physics, teletherapy or other treatments related to radiation therapy or chemotherapy treatments. Hormone therapy and immunotherapy is not covered under this provision.

Radiation therapy and chemotherapy treatments must be approved for the treatment of cancer by the United States Food and Drug Administration.

Reconstructive Surgery

We will pay the amount shown in the schedule of insurance if a covered person has reconstructive surgery performed related to the treatment of internal cancer. We pay only for the following procedures: (a) Breast symmetry (modification of the non-cancerous breast performed within 5 years of reconstructing the cancerous breast); (b) Breast reconstruction; (c) Facial reconstruction; and (d) Breast transverse rectus abdominis myocutaneous (TRAM) flap.

Also, we will pay 25% of the reconstructive surgery amounts shown in the schedule of insurance for general anesthesia used during these procedures.

Second Surgical Opinion

If a doctor has diagnosed a covered person with internal cancer requiring surgery and a covered person obtains a second surgical opinion, we will pay the amount shown in the schedule of insurance. However, the second surgical opinion must be from a different doctor than the one who recommended the surgery. We limit what we pay to one benefit per surgical procedure.

Skin Cancer

We will pay the amount shown in the schedule of insurance if a doctor performs any of the following procedures for the purpose of treating diagnosed skin cancer in a covered person: (a) biopsy; (b) reconstructive surgery following previous excision of skin cancer; (c) excision of skin cancer without flap or graft; or (d) excision of skin cancer with flap or graft.

The amount shown in the schedule of insurance includes the amount payable for anesthesia services.

Surgical Benefits

We pay the amount shown in the schedule of insurance if a doctor performs one of the procedures shown in the of insurance for the purpose of treating internal cancer diagnosed in a covered person. The schedule of insurance for surgical procedures does not apply to surgery for skin cancer, which will be covered only under the skin cancer section.And the schedule of insurance for surgical procedures does not apply to reconstructive surgery, which is covered only under the reconstructive surgery section.

If more than one surgical procedure is performed through the same incision, benefits will be paid for only one procedure based upon the highest eligible benefit.

Transportation/ Companion Transportation

We pay the amount shown in the schedule of insurance for transportation and companion transportation as follows.

We pay a transportation benefit upon completion of a round trip to transport a covered person to a hospital or clinic for the purpose of internal cancer treatment. However the hospital or clinic must be at least 50 miles from the covered person's home. And transportation cannot be by the use of an ambulance or air ambulance.

If commercial travel (coach-class plane, train or bus) is necessary, we will pay for one additional person to accompany the covered person. If treatment is for a covered dependent child, we will pay for up to two adults to accompany the covered dependent child

DEFINITIONS

Accredited Practitioner This term means a *naturopathic doctor, ayurvedic practitioner, bio-feedback practitioner or hypnotherapist* who is licensed (if applicable) under the laws of the state where treatment is received as qualified to treat the type of condition for which a claim is being made. If licensed, the practitioner must be practicing within the scope of his or her license.

Ayurvedic Medicine This term means a practice of health promotion, disease prevention, and personal growth that includes physical, psychological and spiritual aspects. ayurvedic practices are intended to promote well being and reduce stress and may include yoga, meditation, massage, dietary changes and herbs.

Ayurvedic Practitioner This term means an *accredited practitioner* who has been certified through the American Association of Drugless Accredited Practitioners for Ayurvedic Medicine.

Ambulatory Surgical Center This term means a facility in which outpatient surgery is done. It must meet all of the requirements shown below:

- have a medical staff of *doctors,* nurses, and licensed anesthesiologist;
- maintain at least two operating rooms; and one recovery room;
- maintain diagnostic lab and x-ray facilities;
- be staffed and equipped to give emergency care;
- have a blood supply;
- maintain medical records;
- have agreements with *hospitals* for immediate acceptance of patients who need *inpatient* confinement; and
- be licensed in accord with the laws of the appropriate legally authorized agency. A facility is not an *ambulatory surgical center* if it is part of a *hospital.*

Benefit Year This term means each period of 12 months in a row which starts on starts on January 1st and ends on December 31st.

Bio-Feedback This term means a therapy that trains and uses the mind to control body functions that are typically regulated automatically such as muscle tension, heart rate, blood pressure or temperature.

Bio-Feedback Practitioner This term means an *accredited practitioner* who has a bachelor's degree in a health related profession, such as a degree in medicine, osteopathy or naturopathic medicine and who has received certification from the Biofeedback Society of America and is currently licensed in the state where he or she practices.

Board Certified This term means a *doctor* who has been certified in the appropriate medical specialty by a member board of the American Board of Medical Specialties.

Bone Marrow Transplant This term means a procedure in which a patient's bone marrow is replaced with cellular elements to reconstitute the bone marrow. It may be preceded by chemotherapy, radiotherapy, or other treatments which cause residual bone marrow to be destroyed. The collection of stem cells or other peripheral blood cells and their reinfusion is not a *bone marrow transplant.*

Cancer This term means *you* have been *diagnosed* with a disease manifested by the presence of a malignant tumor characterized by the uncontrolled growth and spread of malignant cells in any part of the body. This includes leukemia, Hodgkin's disease, lymphoma, sarcoma, malignant tumors and melanoma. *Cancer* includes carcinomas in- situ (in the natural or normal place, confined to the site of origin, without having invaded neighboring tissue). Pre-malignant conditions or conditions with malignant potential, such as myelodyplastic and myeloproliferative disorders, carcinoid, leukoplakia, hyperplasia, actinic keratosis, polycythemia, and nonmalignant melanoma, moles or similar diseases or lesions will not be considered *cancer.*

Clinic This term means an institution, building or part of a building where outpatients receive treatment for Diagnoses.

Covered Person This term means *you,* if *you* are covered under this *plan* and *your* covered dependents.

Diagnosed or Diagnosis These terms mean the establishment of *cancer* by a *doctor* through the use of clinical and/or lab findings. Diagnosis of *cancer* must be based on microscopic (histologic) exam of: (a) fixed tissues; or (b) preparations of blood or bone marrow. Such exam must be documented in a written report by a *doctor* who is *board certified* in pathology. If, however, in the opinion of the attending *doctor,* a pathological diagnosis is medically inappropriate, a clinical diagnosis of *cancer* will be accepted.

Doctor This term means any practitioner of the healing arts that: (a) is properly licensed or certified by the laws of the state in which he or she practices; and (b) provides services that are within the lawful scope of his or license.

Extended Care Facility or Skilled Nursing Facility This term means a facility which mainly provides full-time *inpatient* skilled nursing care for sick or injured people who do not need to be in a *hospital.* This *plan* recognizes such a place if it carries out its stated purpose under all relevant state and local laws, and it is: (a) accredited for its stated purpose by the Joint Commission of Healthcare Organizations; or (b) approved for its stated purpose by Medicare. In some places an extended care facility is called: (a) a rehabilitation facility; or (b) a skilled nursing facility; or (c) a sub-acute facility.

Family Member This term means *your* spouse, brother or sister (including stepbrother or stepsister), children (including stepchildren), parents (including stepparents), grandchildren, father or mother-in-law, and spouses, if applicable, of any of these.

Hospice This term means a licensed facility or program which provides a coordinated set of services at home or in a facility for persons who are certified by a *doctor* as terminally ill.

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

(1) is primarily engaged in providing, by or under the continuous supervision of *doctors,* to *inpatients,* diagnostic services and therapeutic services for diagnosis, treatment and care of sick or injured persons;

(2) has organized departments of medicine and major surgery;

(3) has a requirement that every patient must be under the care of a *doctor* or *dentist;*

(4) provides 24 hour nursing service by or under the supervision of a registered professional nurse (R.N.);

(5) is duly licensed by the agency responsible for licensing such *hospitals;* and

(6) is not, other than incidentally: (a) a place of rest; (b) a place primarily for the treatment of tuberculosis; (c) a place for the aged; (d) a place for drug addicts or alcoholics; or (e) a place for convalescent, custodial, educational or rehabilitative care.

Hypnotherapist This term means an *accredited practitioner* who has been certified by the American Board of Hypnotherapy or the American Clinical Board of Hypnotherapy.

Hypnotherapy This term means a change in a person's conscious awareness, induced by another person, which may alter memory and consciousness, increase susceptibility to suggestions, and bring about responses and ideas that may be considered unusual.

Immunotherapy This term means treatments intended to improve the immune system by providing antibodies, colony stimulating factors, or immunoglobulins for the purpose of treating *cancer.*

Inpatient This term means: (a) a *covered person* who is physically confined as a registered bed patient in a *hospital* or other recognized health care facility; or (b) the confinement itself.

Intensive Care Unit This term means a *hospital* area of special care, which at the time of admission is separate and apart from the surgical recovery room, other rooms, beds or wards normally used for patient confinement. In addition, the unit must provide the following: (a) 24 hour continuous nursing care attended by nurses assigned to the unit on a full-time basis; (b) direction and/or supervision by a full time doctor director or a standing "intensive care" committee of the medical staff; and (c) special medical apparatus used to treat the critically ill.

Internal Cancer This term means a *cancer* contained within the body. *Internal cancers* do not include skin *cancer* except for melanomas classified as Clark's level III and higher or a Breslow level greater than or equal to 1.5mm.

Naturopathic Doctor This term means an *accredited practitioner* who has graduated from a four year naturopathic medical school, which is accredited by the Council on Naturopathic Medical Education.

NCI-Listed This term means a *cancer* treatment protocol that is listed in the National Cancer Institute's (NCI) Physician Data Query (PDQ). The PDQ is an on-line database that contains *cancer* information summaries, listings of clinical trials, and directories of *doctors* and organization involved in *cancer* care.

Palliative Care This term means treatment or services designed to reduce the severity of a condition or symptoms without curing the underlying disease.

Period of Hospital Confinement This term means *hospital* confinement for a continuous and uninterrupted period of time while under the regular care and attendance of a *doctor.* A new period of *hospital* confinement will begin if a new *hospital* confinement occurs 30 or more days after the end of the previous *hospital* confinement or if the *hospital* confinement results from a completely independent cause from the previous *hospital* confinement.

Plan This term means the group *cancer* coverage described in the *plan* and this certificate.

Pre-Existing Condition A pre-existing condition is a *cancer,* whether diagnosed or misdiagnosed, for which in the 12 months before a person becomes covered by this *plan,* he or she: (1) received advice or treatment from a *doctor;* (2) underwent diagnostic procedures; (3) was prescribed or took prescription drugs; or (4) received other medical care or treatment, including consultation with a *doctor.*

Proof or Proof Of Insurability These terms mean an application for coverage showing that a person is insurable.

Stem Cell Transplant This term means the delivery of autologous or allogeneic stem cells to a person who has received chemotherapy or radiology to treat *internal cancer.* This definition does not include allogeneic or autogeneic bone marrow collection and infusion of bone marrow under general anesthesia.

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

You or Your These terms mean the insured *employee.*

DEFINITIONS

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- have a blood supply;
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- have agreements with *hospitals* for immediate acceptance of patients who need *inpatient* confinement; and
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Hospital This term means a short-term, acute care general facility, which:

(1) is primarily engaged in providing, by or under the continuous supervision of *doctors,* to *inpatients,* diagnostic services and therapeutic services for diagnosis, treatment and care of sick or injured persons;

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(3) has a requirement that every patient must be under the care of a *doctor* or *dentist;*

(4) provides 24 hour nursing service by or under the supervision of a registered professional nurse (R.N.);

(5) is duly licensed by the agency responsible for licensing such *hospitals;* and

(6) is not, other than incidentally: (a) a place of rest; (b) a place primarily for the treatment of tuberculosis; (c) a place for the aged; (d) a place for drug addicts or alcoholics; or (e) a place for convalescent, custodial, educational or rehabilitative care.

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Period of Hospital Confinement This term means *hospital* confinement for a continuous and uninterrupted period of time while under the regular care and attendance of a *doctor.* A new period of *hospital* confinement will begin if a new *hospital* confinement occurs 30 or more days after the end of the previous *hospital* confinement or if the *hospital* confinement results from a completely independent cause from the previous *hospital* confinement.

Plan This term means the group *cancer* coverage described in the *plan* and this certificate.

Pre-Existing Condition A pre-existing condition is a *cancer,* whether diagnosed or misdiagnosed, for which in the 12 months before a person becomes covered by this *plan,* he or she: (1) received advice or treatment from a *doctor;* (2) underwent diagnostic procedures; (3) was prescribed or took prescription drugs; or (4) received other medical care or treatment, including consultation with a *doctor.*

Proof or Proof Of Insurability These terms mean an application for coverage showing that a person is insurable.

Stem Cell Transplant This term means the delivery of autologous or allogeneic stem cells to a person who has received chemotherapy or radiology to treat *internal cancer.* This definition does not include allogeneic or autogeneic bone marrow collection and infusion of bone marrow under general anesthesia.

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

You or Your These terms mean the insured *employee.*

Limitations

Proof Of Insurability

The *covered person's* coverage may not become effective until he or she submits *proof of insurability* to *us.* These requirements are shown in the schedule of insurance.

Pre-Existing Conditions

A *pre-existing condition* is a *cancer,* whether *diagnosed* or misdiagnosed, for which in the 12 months before a person becomes covered by this *plan,* he or she: (1) received advice or treatment from a *doctor;* (2) underwent diagnostic procedures; (3) was prescribed or took prescription drugs; or (4) received other medical care or treatment, including consultation with a *doctor.* This *plan* will not pay benefits for *cancer* that is caused by, or results from, a *pre-existing condition* if the *cancer* occurs during the first 12 months that a *covered person* is covered by this *plan.*

If This Plan Replaces Another Plan

This *plan* may be replacing a similar plan that the *employer* had with some other insurer. In that case, the *pre-existing condition* limitation will not apply to any *covered person* who: (1) was covered under the *employer's* old plan on the day before this *plan* started; and (2) has met the requirements of any *pre-existing conditions* limitation of the old plan; and (3) you are *actively at work on a full-time* basis on the effective date of this *plan.*

If the *covered person:* (1) was covered under the old plan when it ended; (2) enrolls for insurance under this *plan* on or before this *plan's* effective date; and (3) is actively working on the effective date of this *plan;* but(4) has not fulfilled the requirements of any pre-existing condition provision of the old plan; this *plan* will credit any time used to meet the old plan's pre-existing condition provision toward meeting this *plan's* pre-existing condition provision.

But, this *plan* limits a *covered person's* benefit under this *plan* if: (1) the *cancer* is a *pre-existing condition;* and (2) this *plan* pays benefit because this *plan* credits time as explained above. In this case, this *plan* limits the benefit to the amount the *covered person* would have been entitled to under the old plan.

This *plan* deducts all payments made by the old plan under an extension provision.

Options A , B

Exclusions

This *plan* will not pay benefits for:

- Services or treatment not included in the Schedule of Insurance.
- Services or treatment provided by a *family member.*
- Services or treatment rendered outside the United States or Canada.
- Treatment of any *cancer* diagnosed solely outside of the United States or Canada.
- Services or treatment provided primarily for cosmetic purposes.
- Services or treatment for premalignant conditions.
- Services or treatment for conditions with malignant potential.
- Services or treatment for non-cancer *sicknesses.*
- *Cancer* caused by, contributed to by, or resulting from: (1) participating in a felony, riot or insurrection; (2) intentionally causing a self- inflicted injury; (3) committing or attempting to commit suicide while sane or insane; (4) a *covered person's* mental or emotional disorder, alcoholism or drug addiction; (5) engaging in any illegal activity; or (6) serving in the armed forces or any auxiliary unit of the armed forces of any country.
- *Cancer* arising from war or act of war, even if war is not declared.

CGP-3-CAN-EXC-12 B477.0030

Options A , B

Waiver of Premium

If, while covered by this *plan,* an *employee* becomes disabled due to *cancer* that is diagnosed after the *employee's* effective date, and such *employee* remains disabled for 90 days, *we* will waive the premium due after such 90 days for as long as the *employee* remains disabled.

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

CGP-3-CAN-WP-12 B477.0031

PORTABILITY

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

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

- *You* may port *your* coverage or coverage for any of *your* dependents if coverage under this *plan* ends because *you:* (a) have terminated employment; (2) stop being a member of an eligible class of employees; or (3) this *plan* ends.
- *You* may not Port *your* coverage or coverage for any of *your* dependents if(1) coverage under this *plan* ends due to *your* failure to pay any required premium; or (2) you have reached age 70 on or before *your* coverage under this *plan* ends.

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

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

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

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

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

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

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

Options A , B

CERTIFICATE AMENDMENT - ELIGIBILITY FOR CANCER COVERAGE

The Guardian Life Insurance Company of America
DOMICILED IN NEW YORK
10 Hudson Yards, New York, New York 10001

Effective on the latter of (i) the original effective date of the Certificate; or (ii) the effective date of any applicable amendment requested by the Policyholder and approved by the Insurance Company, this rider amends this Plan by replacing the following:

Conditions of Eligibility

Proof of Insurability

Part or all of *your* insurance amounts may be subject to Proof of Insurability. *You* and *your* dependents will not be covered for any amount that requires such Proof of Insurability until *you* give the Proof of Insurability to *us* and *we* approve that Proof of Insurability in writing.

If *you* elect to enroll within 31 days after *your eligibility date,* coverage is scheduled to start on *your eligibility date.*

If *you* do not elect this coverage within 31 days of *your eligibility date, you* must answer health questions, or wait until the next scheduled group enrollment period. Once each year, during the group enrollment period, *you* may elect to enroll in this coverage as offered by the *employer.* As used here, "group enrollment period" means an annual open enrollment period set by the *employer* and agreed to by *us.* If *you* elect to enroll outside of the group open enrollment period, *you* must provide Proof of Insurability by answering health questions, or wait until the next group enrollment period.

If Proof of Insurability is required, *you* and *your* dependents will not be covered by this *plan* until *we* approve that Proof of Insurability in writing and notify *you* of *your* effective date of coverage.

When Employee Coverage Starts

Your eligibility date is the date *you* have met all of the conditions of eligibility.

Whether *you* must pay all or part of the cost of *your* coverage, *you* must elect to enroll and agree to make the required payments before *your* coverage will start. If *you* do this on or before *your eligibility date, your* coverage is scheduled to start on *your eligibility date.* If *you* do this within 31 days after *your eligibility date, your* coverage is scheduled to start on *your eligibility date.* If *you* elect to enroll and agree to make the required payments more than 31 days after *your eligibility date, your* coverage will not be scheduled to start until *you* send *us* Proof of Insurability or until You enroll during the next group enrollment period. If Proof of Insurability is required, *you* will not be covered by this *plan* until *we* approve that Proof of Insurability in writing and notify *you* of *your* effective date of coverage.

If *your* active service ends before *you* meet any Proof of Insurability requirements that apply, *you* will still have to meet those requirements if *you* are later re-employed by the *employer* or an associated company.

On the date all or part of *your* coverage is scheduled to start, *you* must be: (1) *actively at work;* (2) fully capable of performing the major duties of *your* regular occupation; and (3) working *your* regular number of hours. In that case, *your* coverage will start at 12:01 A.M. Standard Time for *your* place of residence on that date. In any other case, *We* will postpone the start of *your* coverage until the date *you:* (a) return to *active work;* (b) are working *your* regular number of hours; and (c) are fully capable of performing the major duties of *your* regular occupation. Sometimes, a scheduled effective date is not a regularly scheduled work day. If the scheduled effective date falls: on a holiday; on a vacation day; on a non-scheduled work day; during a layoff of less than 180 days in duration; during an approved leave of absence not due to sickness or injury, of 90 days or less; or on a day during a period of absence that is less than 7 days in duration; and if: (a) *you* were fully capable of performing the major duties of *your* regular occupation for the *employer* on a full-time basis at 12:01 AM Standard Time for *your* place of residence on the scheduled effective date; and (b) *you* were performing the major duties of *your* regular occupation and working *your* regular number of hours on *your* last regularly scheduled work day; *your* coverage will start on the scheduled effective date.

DEPENDENT COVERAGE

Proof of Insurability

Part or all of *your initial dependent's* insurance amounts may be subject to Proof of Insurability. *your initial dependents* will not be covered for any amount that requires such Proof of Insurability until *you* give the Proof of Insurability to *us* and *we* approve that Proof of Insurability in writing.

If *you* elect to enroll *your initial dependents* within 31 days after *your eligibility date,* coverage is scheduled to start on *your eligibility date.*

If *you* do not elect *initial dependent* coverage within 31 days of *your eligibility date, your initial dependents* must answer health questions, or wait until the next scheduled group enrollment period to enroll. Once each year, during the group enrollment period, *you* may elect to enroll *initial dependents* in this coverage as offered by the *employer.* As used here, "group enrollment period" means an annual open enrollment period set by the *employer* and agreed to by *us.* If *you* elect to enroll *your initial dependents* outside of the group open enrollment period, *you* must provide Proof of Insurability by answering health questions, or wait until the next group enrollment period.

If Proof of Insurability is required, *your initial dependents* will not be covered by this *plan* until *we* approve that Proof of Insurability in writing and notify *you* of *your initial dependent's* effective date of coverage.

In the case of a *newly acquired dependent,* other than the first newborn child, *you* may elect to enroll a *newly acquired dependent* within 31 days. If *you* do not elect to enroll a *newly acquired dependent* within 31 days of his or her *eligibility date, your newly acquired dependent(s)* may have to answer health questions, or wait until the next scheduled group enrollment period to enroll.

If *your* dependent coverage ends for any reason, including failure to make the required payments, *your* dependent will not be covered by this *plan* again until *you* give *us* new Proof of Insurability that they are insurable and *we* approve that Proof of Insurability in writing, or wait until the next group enrollment period.

When Dependent Coverage Starts

In order for *your* dependent coverage to start, *you* must already be covered for *employee* coverage, or enroll for *employee* and dependent coverage at the same time.

If *you* enroll *your* dependents on or before *your eligibility date,* the dependent's coverage is scheduled to start on the later of *your eligibility date* and the date *you* become covered for *employee* coverage.

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

If *you* do this after the group enrollment period ends, *your* dependent coverage may be subject to Proof of Insurability and will not start until *we* approve that Proof of Insurability in writing.

Once *you* have dependent child coverage for *your initial dependent* child(ren) any *newly acquired dependent* children will be covered as of the date he or she is first eligible.

Whether *you* must pay all or part of the cost of *your* coverage, *you* must elect to enroll and agree to make the required payments before *your* coverage will start. If *you* do this on or before *your eligibility date, your* coverage is scheduled to start on *your eligibility date.* If *you* do this within 31 days after *your eligibility date, your* coverage is scheduled to start on *your eligibility date.* If *you* elect to enroll and agree to make the required payments more than 31 days after *your eligibility date, your* coverage will not be scheduled to start until *you* send *us* Proof of Insurability or until you enroll during the next group enrollment period. If Proof of Insurability is required, *you* will not be covered by this *plan* until *we* approve that Proof of Insurability in writing and notify *you* of *your* effective date of coverage.

If Proof of Insurability is required for dependent benefits as explained above, those benefits will not be scheduled to start until *you* give *us* Proof of Insurability that the dependent is insurable. Once *we* have approved that Proof of Insurability, those benefits will be scheduled to start on the effective date shown in the endorsement section of *your* application.

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

The Guardian Life Insurance Company of America

Michael Prestileo, Senior Vice President

B477.0479

CGP-1-A

Option A

CERTIFICATE AMENDMENT

The certificate is amended to add the following:

Initial Diagnosis Benefit

We pay a one-time benefit when *you* are diagnosed for the first time as having *internal cancer,* other than carcinomas in-situ. The first *diagnosis* must occur while *you* are covered by this *plan.*

The benefit is $2,500.00 for *you,* $2,500.00 for *your* spouse and $2,500.00 for *your* child.*We* pay this benefit once per *covered person in a covered person's* lifetime.

We don't pay this benefit for a *diagnosis* of skin cancer.

We don't pay the benefit if the *diagnosis* occurred prior to the *covered person's* effective date under this *plan.*

We don't pay this benefit for a recurrence, extension or metastatic spread of an *internal cancer* that was *diagnosed* : (a) prior to a *covered person's* effective date under this *plan;* or (b) during this *plan's benefit waiting period.*

We don't pay this benefit if the diagnosis was made solely outside of the United States or Canada.

Benefit Waiting Period: This plan has a *benefit waiting period.* It is 30 days. This period starts on the date a *covered person* is first covered by this *plan. We* do not pay an initial *diagnosis* benefit for *cancer* that is *diagnosed* during the *benefit waiting period.*

If this *plan* replaces a similar plan the *employer* had with some other insurer, the *benefit waiting period* under this *plan* will be waived if for any *covered person* who was covered under the *employer's* old plan on the day before this *plan* starts and is covered by this *plan* on the day it starts.

As used in this rider, *benefit waiting period* means the period of time a *covered person* must be covered under this *plan* before we pay an Initial Diagnosis Benefit.

As used in this rider, carcinomas in-situ means *cancer* that is confined to the site of origin, without having invaded neighboring tissue.

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

The Guardian Life Insurance Company of America

Michael Prestileo, Senior Vice President

CGP-3-A-CAN-IDB-12 B477.0036

Option B

CERTIFICATE AMENDMENT

The certificate is amended to add the following:

Initial Diagnosis Benefit

We pay a one-time benefit when *you* are diagnosed for the first time as having *internal cancer,* other than carcinomas in-situ. The first *diagnosis* must occur while *you* are covered by this *plan.*

The benefit is $5,000.00 for *you,* $5,000.00 for *your* spouse and $5,000.00 for *your* child.*We* pay this benefit once per *covered person in a covered person's* lifetime.

We don't pay this benefit for a *diagnosis* of skin cancer.

We don't pay the benefit if the *diagnosis* occurred prior to the *covered person's* effective date under this *plan.*

We don't pay this benefit for a recurrence, extension or metastatic spread of an *internal cancer* that was *diagnosed* : (a) prior to a *covered person's* effective date under this *plan;* or (b) during this *plan's benefit waiting period.*

We don't pay this benefit if the diagnosis was made solely outside of the United States or Canada.

Benefit Waiting Period: This plan has a *benefit waiting period.* It is 30 days. This period starts on the date a *covered person* is first covered by this *plan. We* do not pay an initial *diagnosis* benefit for *cancer* that is *diagnosed* during the *benefit waiting period.*

If this *plan* replaces a similar plan the *employer* had with some other insurer, the *benefit waiting period* under this *plan* will be waived if for any *covered person* who was covered under the *employer's* old plan on the day before this *plan* starts and is covered by this *plan* on the day it starts.

As used in this rider, *benefit waiting period* means the period of time a *covered person* must be covered under this *plan* before we pay an Initial Diagnosis Benefit.

As used in this rider, carcinomas in-situ means *cancer* that is confined to the site of origin, without having invaded neighboring tissue.

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

The Guardian Life Insurance Company of America

Michael Prestileo, Senior Vice President

CGP-3-A-CAN-IDB-12 B477.0036

Option A

CERTIFICATE AMENDMENT

(To be attached to certificates issued to employees)

The certificate is amended to add the following:

This rider amends the certificate Schedule of Insurance for *internal cancer.* *We* pay the amount shown below per *covered person* for *internal cancer* or a *specified disease.* Terms that are not defined specifically in this rider are defined in the certificate or in the *specified disease* rider.

Blood, Plasma and Platelets: Actual costs up to $10,000.00 per 12 month period.

Radiation Therapy and Chemotherapy: Actual costs up to $10,000.00 per 12 month period.

This rider also amends the **Benefits** section of the certificate as follows:

Blood, Plasma and Platelets: *We* pay Actual costs, up to the limit stated above, for:

- blood, plasma and platelets (including transfusions and administration charges;
- processing and procurement costs; and
- cross-matching

received by a *covered person* in conjunction with *internal cancer* or *specified disease* treatment. *We* limit what *we* pay in the 12 months which starts on the date of the first treatment to the amount shown in this rider.

We don't pay blood, plasma and/or platelets for any other reason, including replacement of blood during surgery or for blood replaced by donors.

Radiation Therapy and Chemotherapy: *We* pay Actual costs, up to the limit shown above for radiation therapy and chemotherapy received by a *covered person* as part of a treatment for *internal cancer* or a *specified disease* .

We only pay this benefit for *internal cancer* or a *specified disease* treatment consisting of:

- cancericidal chemical substances for the purpose of modification or destruction of *internal cancer* or a *specified disease;* and
- X-ray radiation; and
- radium and cesium implants; and
- cobalt

We limit what *we* pay in the 12 months which starts on the date of the first treatment to the amount shown in this rider.

Administration of radiation therapy or chemotherapy other than by medical personnel in a *doctor's* office or *hospital,* including medications dispensed by a pump, will be limited to the costs of the drugs only, subject to the maximum amount payable per 12 month period explained above.

In addition to the exclusions listed in *your* certificate, *we* do not pay a benefit under this rider for:

- treatment planning;
- treatment consultation;
- treatment management;
- design and construction of treatment devices;
- basic radiation dosimetry calculation;
- any type of laboratory tests, X-ray or other imaging used for diagnosis or disease monitoring;
- diagnostic tests related to these treatments.

This benefit also does not pay for any devices or supplies including intravenous solutions and needles related to these treatments.

For these benefits paid based on Actual Costs up to a specified maximum amount, if specific costs are not obtainable as proof of loss, we will pay 50% of the applicable maximum for benefits payable.

Actual Costs means the amount actually paid by, or on behalf of, the *covered person* and accepted by the provider as full payment for the particular treatment of services provided.

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

The Guardian Life Insurance Company of America

Michael Prestileo, Senior Vice President

CGP-3-A-CAN-RC-16 B477.0387

Option B

CERTIFICATE AMENDMENT

(To be attached to certificates issued to employees)

The certificate is amended to add the following:

This rider amends the certificate Schedule of Insurance for *internal cancer. We* pay the amount shown below per *covered person* for *internal cancer* or a *specified disease.* Terms that are not defined specifically in this rider are defined in the certificate or in the *specified disease* rider.

Blood, Plasma and Platelets: Actual costs up to $15,000.00 per 12 month period.

Radiation Therapy and Chemotherapy: Actual costs up to $15,000.00 per 12 month period.

This rider also amends the **Benefits** section of the certificate as follows:

Blood, Plasma and Platelets: *We* pay Actual costs, up to the limit stated above, for:

- blood, plasma and platelets (including transfusions and administration charges;
- processing and procurement costs; and
- cross-matching

received by a *covered person* in conjunction with *internal cancer* or *specified disease* treatment. *We* limit what *we* pay in the 12 months which starts on the date of the first treatment to the amount shown in this rider.

We don't pay blood, plasma and/or platelets for any other reason, including replacement of blood during surgery or for blood replaced by donors.

Radiation Therapy and Chemotherapy: *We* pay Actual costs, up to the limit shown above for radiation therapy and chemotherapy received by a *covered person* as part of a treatment for *internal cancer* or a *specified disease* .

We only pay this benefit for *internal cancer* or a *specified disease* treatment consisting of:

- cancericidal chemical substances for the purpose of modification or destruction of *internal cancer* or a *specified disease;* and
- X-ray radiation; and
- radium and cesium implants; and
- cobalt

We limit what *we* pay in the 12 months which starts on the date of the first treatment to the amount shown in this rider.

Administration of radiation therapy or chemotherapy other than by medical personnel in a *doctor's* office or *hospital,* including medications dispensed by a pump, will be limited to the costs of the drugs only, subject to the maximum amount payable per 12 month period explained above.

In addition to the exclusions listed in *your* certificate, *we* do not pay a benefit under this rider for:

- treatment planning;
- treatment consultation;
- treatment management;
- design and construction of treatment devices;
- basic radiation dosimetry calculation;
- any type of laboratory tests, X-ray or other imaging used for diagnosis or disease monitoring;
- diagnostic tests related to these treatments.

This benefit also does not pay for any devices or supplies including intravenous solutions and needles related to these treatments.

For these benefits paid based on Actual Costs up to a specified maximum amount, if specific costs are not obtainable as proof of loss, we will pay 50% of the applicable maximum for benefits payable.

Actual Costs means the amount actually paid by, or on behalf of, the *covered person* and accepted by the provider as full payment for the particular treatment of services provided.

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

The Guardian Life Insurance Company of America

Michael Prestileo, Senior Vice President

CGP-3-A-CAN-RC-16 B477.0387

CERTIFICATE AMENDMENT

(To be attached to certificates issued to employees)

The certificate is amended to add the following: Terms that are not defined specifically in this rider are defined in the certificate

Intensive Care Unit Confinement Benefit (For Other Than Internal Cancer)

We pay the amount shown below per *covered person* for each day of continuous *hospital* Intensive Care Unit Confinement for up to 45 days for each period of such confinement for the treatment of any *sickness* or *injury* other than *internal cancer.* A day is a 24 hour period. If confinement is for only a portion of a day, then a pro-rata share of the daily benefit is paid. *We* deem a confinement to be continuous if a *covered person* is discharged and readmitted to the *hospital* Intensive Care Unit for the same *sickness* or *injury* within 30 days.

Intensive Care Unit: This term means a *hospital* area of special care, which at the time of admission is separate and apart from the surgical recovery room, other rooms, beds or wards normally used for patient confinement. In addition, the unit must provide the following: (a) 24 hour continuous nursing care attended by nurses assigned to the unit on a full- time basis; (b) direction and/or supervision by a full time *doctor* director or a standing "intensive care" committee of the medical staff; and (c) special medical apparatus used to treat the critically ill.

Benefit

Intensive Care Unit Confinement Benefit: $200 per day of Intensive Care Unit Confinement per continuous confinement, per *covered person.*

Exclusions

In addition to the Exclusions listed in the certificate we do not pay Intensive Care Unit Confinement Benefit under this rider if a *covered person* is admitted because of:

(1) An attempted suicide; or

(2) Intentional self-inflicted injury; or

(3) Intoxication or being under the influence of drugs not prescribed or recommended by a *doctor;* or

(4) Alcoholism or drug addiction.

If the *covered person* is Intensive Care Unit Confined for treatment of internal cancer or a *specified disease* and a benefit is paid under the certificate for that confinement, *we* do not pay a benefit under this rider for the same days.

We do not pay for confinements in any care unit that does not qualify as a *hospital* Intensive Care Unit. Progressive care units, sub-acute intensive care units, intermediate care units, and private rooms with monitoring, step down units and any other lesser care treatment units do not qualify as *hospital* Intensive Care Units.

We do not pay this benefit for continuous *hospital* Intensive Care Unit confinements that occur during a hospitalization that begins before the effective date of coverage under this Rider.

Children born within 10 months of the effective date are not covered for any continuous *hospital* Intensive Care Unit confinement that occurs or begins during the first 30 days of such child's life.

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

The Guardian Life Insurance Company of America

Michael Prestileo, Senior Vice President

CGP-3-A-CAN-ICU-16 B477.0389

Options A , B

CERTIFICATE AMENDMENT

(To be attached to certificates issued to employees)

The certificate is amended to add the following: Terms that are not defined specifically in this rider are defined in the certificate.

This rider amends this *plan* so that the benefits for the treatment of *cancer* are deemed to also include benefits for treatment of a *specified disease* as defined below. Limitations and Exclusions that apply to *cancer* also apply to *specified disease.* Terms in italic that are not specifically defined in this rider are defined in the certificate.

Diagnosis of *specified disease* must be made by a *doctor* while the *covered person* is insured under the *plan.*

We limit what *we* pay to the treatment of one *specified disease* in each *covered person's* lifetime.

Specified Disease: This term means one of the following; only one *specified disease* for this list may be claimed under this *plan:*

- Addison's Disease
- Amyotrophic Lateral Sclerosis (Lou Gehrig's Disease)
- Brucellosis
- Cerebrospinal Meningitis (bacterial)
- Cystic Fibrosis
- Diphtheria
- Encephalitis
- Hansen's Disease
- Hepatitis (Chronic B or Chronic C with liver failure or hepatoma)
- Legionnaire's Disease (confirmation by culture or sputum)
- Lyme Disease
- Multiple Sclerosis
- Muscular Dystrophy
- Myasthenia Gravis
- Osteomyelitis
- Poliomyelitis
- Primary Biliary Cirrhosis
- Primary Sclerosing Cholangitis (Walter Payton's Liver Disease)
- Rabies
- Reye's Syndrome

- Rocky Mountain Spotted Fever
- Scarlet Fever
- Sickle Cell Anermia
- Systemic Lupus Erythematosus
- Tetanus
- Thallasemia
- Tuberculosis
- Tularemia
- Typhoid Fever

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

The Guardian Life Insurance Company of America

Michael Prestileo, Senior Vice President

CGP-3-A-CAN-SD-16 B477.0390

Options A , B

GLOSSARY

This Glossary defines the italicized terms appearing in your booklet.

CGP-3-GLOSS-90 B900.0118

Options A , B

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

CGP-3-GLOSS-90 B900.0003

Options A , B

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

CGP-3-GLOSS-90 B750.0015

Options A , B

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

CGP-3-GLOSS-90 B750.0006

Options A , B

Employer means BRYAN COUNTY BOARD OF EDUCATION .

CGP-3-GLOSS-90 B900.0051

Options A , B

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

CGP-3-GLOSS-90 B900.0004

Options A , B

Full-time means the *employee* regularly works at least the number of hours in the normal work week set by the *employer* (but not less than 20 hours per week), at his *employer's* place of business.

CGP-3-GLOSS.1 B750.0230

Options A , B

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

CGP-3-GLOSS-90 B900.0006

Options A , B

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

CGP-3-GLOSS-90 B900.0008

Options A , B

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

CGP-3-GLOSS-90 B900.0039

Options A , B

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

STATEMENT OF ERISA RIGHTS

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

Receive Information About Your Plan and Benefits

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

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

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

Prudent Actions By Plan Fiduciaries

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

Enforcement Of Your Rights

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

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

Assistance with Questions

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

B800.0093

Group Health Benefits Claims Procedure

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

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

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

Definitions

"Adverse Benefit Determination" means any denial, reduction or termination of a benefit or failure to provide or make payment (in whole or in part) for a benefit.

"Group Health Benefits" means any accident, cancer, critical illness, or specified disease coverages which are a part of this plan.

Timing For Initial Benefit Determination

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

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

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

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

Adverse Benefit Determination

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

- the specific reason(s) for the adverse determination;
- reference to the specific plan provision(s) on which the determination is based;

- a description of any additional material or information necessary to make the claim valid and an explanation of why such material or information is needed;
- a description of the plan's claim review procedures and the time limits applicable to such procedures, including a statement indicating that the claimant has the right to bring a civil action under ERISA Section 502(a) following an adverse benefit determination;
- identification and description of any specific internal rule, guideline or protocol that was relied upon in making an adverse benefit determination, or a statement that a copy of such information will be provided to the claimant free of charge upon request.

Appeal of Adverse Benefit Determinations

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

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

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

In reviewing an appeal, Guardian will:

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

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

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

Alternative Dispute Options

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

B752.0052

Options A , B

Termination of This Group Plan

Your *employer* may terminate this group *plan* at any time by giving us 31 days advance written notice. This *plan* will also end if your *employer* fails to pay a premium due by the end of this grace period.

We may have the option to terminate this *plan* if the number of people insured falls below a certain level.

When this *plan* ends, you may be eligible to continue your insurance coverage. Your rights upon termination of the *plan* are explained in this booklet.

B800.0086

Option D

Important Notice

You may not be covered by all of the options in this Member Guide

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

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

CI-23-MG-GA

TABLE OF CONTENTS

Option D

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.

B660.1419

CI-23-MG-GA

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.

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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.

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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

Option D

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

B661.0004

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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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Option D

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.

B661.0011

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

B661.0021

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.

B661.0022

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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