



# **YOUR GROUP INSURANCE PLAN BENEFITS**

**HOUSE STAFF BENEFITS PLAN OF THE COMMITTEE OF INTERNS AND RESIDENTS  
CLASS 0001 - INTERNS AND RESIDENTS  
(BASIC LIFE AND LONG TERM DISABILITY)**

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](http://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:**

**<http://www.osi.stat.nm.us/ConsumerAssistance/index.aspx>**

CCN-2019-NM

B999.0042



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**CERTIFICATE OF COVERAGE**

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**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

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

CGP-3-R-STK-90-3

B110.0023



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## GENERAL PROVISIONS

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As used in this booklet:

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

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

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

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

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

CGP-3-R-GENPRO-90

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### **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

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### **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

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### **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.

## Accident and Health Claims Provisions (Cont.)

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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 120 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.

CGP-3-R-AHC-90

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## ELIGIBILITY FOR LIFE COVERAGES

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### Employee Coverage

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

CGP-3-EC-90-1.0

B264.0064

**When Your Coverage Starts** *Employee* benefits that don't require *proof* that you are insurable are scheduled to start on your effective date.

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

But you must be actively at work on a *full-time* basis on the scheduled effective date or dates. And you must have met all of the applicable conditions explained above, and any applicable waiting period. If you are not 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

B264.3202

**When Your Coverage Ends** Your coverage ends on the date 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.

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

CGP-3-EC-90-3.0

B264.0034

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

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

**Continuation of Coverage** Life insurance may be continued at your employer's option. You must contact your employer to find out if you may continue this insurance.

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

**When Continuation Ends** Insurance may continue until the earliest of the following:

- The date you return to active work.
- In the case of a leave granted to you to care for a covered servicemember: The end of a total leave period of 26 weeks in one 12 month period. This 26 week total leave period applies to all leaves granted to you under this section for all reasons. If you take an additional leave of absence in a subsequent 12 month period, continued coverage will cease at the end of a total leave period of 12 weeks.
- In any other case: The end of a total leave period of 12 weeks in any 12 month period.
- The date on which your *Employer's Plan* is terminated or you are no longer eligible for coverage under this *Plan*.
- The end of the period for which the premium has been paid.

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

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

- **Covered Servicemember:** This term means a member of the Armed Forces, including a member of the National Guard or Reserves, who for a serious injury or illness: (a), is undergoing medical treatment, recuperation, or therapy; (b) is otherwise in outpatient status; or (c) is otherwise on the temporary disability retired list.
- **Next Of Kin:** This term means the nearest blood relative of the *employee*.
- **Outpatient Status:** This term means, with respect to a covered servicemember, that he or she is assigned to: (a) a military medical treatment facility as an outpatient; or (b) a unit established for the purpose of providing command and control of members of the Armed Forces receiving medical care as outpatients.
- **Serious Injury Or Illness:** This term means, in the case of a covered servicemember, an injury or illness incurred by him or her in line of duty on active duty in the Armed Forces that may render him or her medically unfit to perform the duties of his or her office, grade, rank, or rating.

CGP-3-EC-90-3.0

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## Dependent Life Coverage

CGP-3-DEP-90-1.0

B264.0056

**Eligible Dependents For Basic Dependent Life Benefits** Your *eligible dependents* are: your legal spouse and your unmarried dependent children who are 14 or more days old, until they reach age 23 and your unmarried dependent children, from age 23 until they reach age 25, who are enrolled as full-time students at accredited schools.

If a child is an eligible dependent of more than one employee under this plan, the child may be insured for dependent life benefits by only one employee at a time.

CGP-3-DEP-00-3.0

B264.0512

**Adopted Children** Your "unmarried dependent children" include your dependent legally adopted children. We treat a child as legally adopted from the time the child is placed in your home for the purpose of adoption. We treat such a child this way whether or not a final adoption order is ever issued.

**Dependents Not Eligible** We exclude any dependent who is insured by this *plan* as an *employee*. And we exclude any dependent who is on active duty in any armed force.

CGP-3-DEP-00-3.0-NY

B264.0521

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

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

## Dependent Coverage (Cont.)

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

CGP-3-DEP-90-5.0

B200.0288

### When Dependent Coverage Starts

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

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

If you do this within the *enrollment period*, the coverage is scheduled to start on the later of the date you sign the enrollment form; and the date you become insured for employee coverage.

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

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

A *newly acquired dependent* will be covered for those dependent benefits not subject to *proof of insurability* from the later of the date you notify us and agree to make any additional payments, and the date the *newly acquired dependent* is first eligible.

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

CGP-3-DEP-90-6.0

B200.0315

### Exception

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

CGP-3-DEP-90-7.0

B200.0692

### When Dependent Coverage Ends

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

## Dependent Coverage (Cont.)

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

An individual dependent's coverage ends when he stops being an *eligible dependent*. This happens to a child at 12:01 a.m. on the date the child attains this *plan's* age limit, when he marries, or when a step-child is no longer dependent on the employee for support and maintenance. It happens to a spouse when a marriage ends in legal divorce or annulment.

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

CGP-3-DEP-90-9.0

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## GROUP TERM LIFE INSURANCE SCHEDULE

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CGP-3-R-SCH-90

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### Employee Basic Term Life Insurance

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CGP-3-R-SCH-90

B265.0003

**Your Basic Term Life Insurance Amount** Insurance Amount . . . . . \$150,000.00  
CGP-3-R-SCH-90 B265.0011

**Reduction of Basic Life Insurance Amount Based on Age** If an employee is less than age 65 when his or her insurance under this plan starts, his or her insurance amount is reduced, on the date he or she reaches age 65, by 35% of the amount which otherwise applies to his or her classification and/or option. But in no case will such reduced amount be less than \$1,000.00.

The preceding reduction also applies to an employee's initial insurance amount if his or her insurance starts after he or she reaches age 65 but before he or she reaches age 70.

If an employee is less than age 70 when his or her insurance under this plan starts, the employee's basic life insurance amount is reduced, when he or she reaches age 70, by 50% of the amount which otherwise applies to his or her classification and/or option. But in no case will such reduced amount be less than \$1,000.00.

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

CGP-3-R-SCH-90

B265.0483

**Limitations For Future Entrants** However, regardless of any of the above reductions, we limit the amount of insurance for which you are eligible if your insurance under this plan starts both: (a) after this plan's effective date; and (b) after you reach age 70.

If you provide us with proof of insurability, and we approve it in writing, the amount of your insurance will be 50% of the amount which otherwise applies to your classification and/or option. But in no event will this reduced amount be less than \$1,000.00.

If we do not approve the proof, your insurance amount will be \$1,000.00.

CGP-3-R-SCH-90

B265.0569

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### Dependent Basic Term Life Insurance

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CGP-3-R-SCH-90

B265.0456

**Your Basic Dependent Spouse Insurance Amount** Insurance Amount . . . . . \$20,000.00  
CGP-3-R-SCH-90 B265.0457



## Dependent Basic Term Life Insurance (Cont.)

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Your Basic Dependent Child Insurance Amount	Child's Age At Death	Benefit Amount
	At least 14 days but less than 6 months . . . . .	\$ 1,000.00
	At least 6 months but less than 23 years . . . . .	\$ 1,000.00
	At least 23 years but less than 25 years if a full-time student . . . . .	\$ 1,000.00
	CGP-3-R-SCH-90	B265.0623
	In no event may the insurance amount of a dependent spouse exceed 50% of the insurance amount of an employee.	
	In no event may the insurance amount of a dependent child exceed 10% of the insurance amount of an employee.	
	CGP-3-R-SCH-90	B265.0844

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**Employee Group Term Life Insurance**

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**Basic Life Benefit** If an employee dies while insured for this benefit, we'll pay his beneficiary the amount shown in the schedule.

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

**The Beneficiary** The employee decides who gets this insurance if he dies. He should have named his beneficiary on his enrollment form. The employee can change his beneficiary at any time by giving us written notice, unless he's assigned this insurance. But, the change won't take effect until we tell him we've received the notice.

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

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

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

We suggest the employee speak to his lawyer before he makes any assignment. If he decides he wants to assign this insurance, he should ask the employer for details or write to us.

**Payment to a Minor or Incompetent** If the employee's beneficiary is a minor or incompetent, we have the option of paying this insurance in monthly installments. We would pay them to the person who cares for and supports his beneficiary.

**Payment of Funeral or Last Illness Expenses** We have the option of paying up to \$500.00 of this insurance to any person who incurred expenses for the employee's funeral or last illness.

**Settlement Option** If the employee or his beneficiary asks us, we'll pay all or part of this insurance in installments. Any request must be made to us in writing. The amounts of the installments and how they would be paid depends on what we offer at the time the request is made.

**Incontestability** After the employee has been insured for this insurance for two years, we can't dispute any medical statements he made in his signed application.

## Portability Privilege

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- Applicability** This provision applies only to this plan's employee and dependent Basic group term life insurance. It does not apply to supplemental life insurance, if any is included in this plan. And it does not apply to Accidental Death and Dismemberment Insurance.
- Important Restriction** You may not elect a portable certificate of coverage unless you have been covered by this group plan, or the one it replaced, for employee Basic group term life insurance for at least three consecutive months prior to the date your coverage under this plan ends.
- Portability Of Basic Group Term Life Insurance** You may elect to continue all or part of your employee Basic group term life insurance and dependent Basic group term life insurance, by choosing a portable certificate of coverage, subject to the following terms.
- You may port your coverage if coverage under this plan ends because you: (a) have terminated employment; or (b) stop being a member of an eligible class of employees.
- You may not port your coverage or coverage for any of your dependents, if you: (a) have reached your 70th birthday on the day coverage under this plan ends; or (b) are eligible for this plan's Basic Group Term Life Insurance Extended Life Benefit.
- You may not port your coverage or coverage for any of your dependents if coverage under this plan ends due to: (a) failure to pay any required premium; or (b) the end of this group plan.
- You may port: (a) the full amount(s) of your Basic term life insurance as of the day your coverage under this plan ends, or (b) 50% of such amount, if such amount under this plan is at least \$50,000.00.
- You may port: (a) the full amount(s) of your dependent Basic term life insurance as of the day your coverage under this plan ends; or (b) 50% of such amount(s) if: (i) your dependent spouse amount under this plan is at least \$5,000.00; and (ii) your dependent child amount under this plan is at least \$2,000.00. However, if you port the full amount of your insurance, any dependent amount(s) ported must be a full amount. And, if you elect to port 50% of your insurance, any dependent amount(s) ported must be 50% of such amount(s).
- You may port: (a) your insurance only; (b) your insurance and insurance of your covered spouse; (c) your insurance and the insurance of all of your covered dependents; or (d) if you are a single parent, your insurance and the insurance of all of your covered dependent children. No other combinations will be allowed.
- To be eligible to port, a dependent must be insured as of the day your coverage under this plan ends.
- If You Die While Insured** If you die while insured for dependent Basic term life insurance, your spouse may port the insurance of your dependents as described above. But, your spouse and dependents must be insured on the date of death. No dependents will be allowed to port if: (a) there is no surviving spouse; or (b) your surviving spouse has reached his or her 70th birthday on the day you die.

## Portability Privilege (Cont.)

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**The Portable Certificate Of Coverage** You or your surviving spouse can port to a portable certificate of coverage. The certificate provides group term insurance. It does not provide any: (a) accidental death and dismemberment benefits; (b) income replacement benefits; or (c) extended life benefits or waiver of premium privileges. The benefits provided by the portable certificate of coverage may not be the same as the benefits of this group plan.

The premium for the portable certificate of coverage will be based on: (a) your and/or your dependent's rate class under this plan; and (b) your or your surviving spouse's age bracket as shown in the Basic Life Portability Coverage Premium Notice.

**Conversion Privilege Contained In Portable Certificate** The portable certificate of coverage contains information about how to convert to an individual insurance policy. A person covered under the portable certificate of coverage will be allowed to convert subject to New York Insurance Law.

**How To Port** To get a portable certificate of coverage, you or your surviving spouse must: (a) apply to us in writing; and (b) pay the required premium. You have 31 days from the date your coverage under this plan ends to do this. We won't ask for proof that you are insurable.

**Defined Term** As used in this provision, the term "port" means to choose a portable certificate of coverage which provides group term life insurance.

**Notice Of Portability Right** If you are entitled to obtain a ported policy under this section, the employer must give you written notice of such right. The employer must give you the notice in person, or mail it to your last known address.

This notice should be given within 15 days before or after the date group life coverage ends. If the notice is given more than 15 days but less than 90 days after the date group life coverage ends, you will have 45 days from the date notice is given to apply for the ported policy and pay the required premium. If notice is not given within 90 days following the date group life coverage ends, the time allowed for porting expires at the end of such 90 day period.

CGP-3-R-LP-00-NY

B270.0410

## Information About Conversion and Portability

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No covered person is allowed to convert his or her coverage, and elect a portable certificate of coverage at the same time. If a situation arises in which a covered person would be eligible to both convert and port, he or she may only exercise one of these privileges. A covered person may never be insured under both a converted policy and a portable certificate of coverage at the same time. The covered person should read his or her plan, as well as any related materials carefully before making an election.

CGP-3-R-LPN-95

B270.0326

**THE FOLLOWING PROVISION APPLIES TO YOUR BASIC TERM LIFE INSURANCE:**

B275.0076

## Converting This Group Term Life Insurance

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**If Employment Or Eligibility Ends** Your group life insurance ends if: (a) your employment ends; or (b) you stop being a member of an eligible class of employees. If either happens, you can convert your group life insurance to an individual life insurance policy, customarily offered by us, as explained below.

If you are not totally disabled, as defined below, you can convert to a permanent life insurance policy. You can convert all or part of the amount for which you were covered under this plan.

If you: (a) are totally disabled, as defined below; and (b) have not yet been approved for this plan's Extended Life Benefit, you can convert to: (i) a permanent life insurance policy; or (ii) a term insurance policy. Read the section labeled "Term Insurance". You can convert: (a) the amount for which you were covered under this plan; less (b) any group life benefits you become eligible for in the 45 days after this insurance ends.

Total disability or totally disabled mean that, due to sickness or injury, you are not able to perform any work for wage or profit. We consider you totally and permanently disabled when you have been totally disabled for nine continuous months.

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

**If The Group Plan Ends Or Group Life Insurance Is Dropped** Your group life insurance also ends if: (a) this group plan ends; or (b) life insurance is dropped from the group plan for all employees or for your class. If either happens, you may convert to a policy of life insurance customarily offered by us, as explained below. We will not require proof of insurability.

You can convert to: (a) a permanent life insurance policy; or (b) a term insurance policy. Read the section labeled "Term Insurance". But, the amount you can convert is limited to: (i) the amount of your insurance under this plan; less (ii) any group life benefits you become eligible for in the 45 days after this insurance ends.

**If The Group Life Insurance Is Reduced** You may convert if your group life insurance is reduced:

- (a) on account of age, provided: (i) the first reduction occurs on or after the date you reach age 60; and (ii) the reduction or series of reductions equals at least 20% of the amount of insurance inforce before the first age-related reduction;

(b) due to a change in class which results in a reduction; or

(c) due to an amendment of the group plan which results in a reduction.

You may convert: (a) the amount of group life insurance inforce prior to the reduction; less (b) the amount of insurance remaining inforce.

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

**Term Insurance** As explained above, you may have the option to convert your coverage to an individual term life insurance policy. The individual term policy requires lower premiums than an individual permanent insurance policy.

## Converting This Group Term Life Insurance (Cont.)

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The term insurance policy is available for only one year from the date: (a) the group plan ends; or (b) group life insurance is dropped for all employees or for your class. After one year, the term insurance expires, and you must convert to an individual permanent life insurance policy, or coverage will end. We will not require proof of insurability. Premiums for the individual permanent life insurance policy will be based on your age, as of the date you convert from the interim term insurance policy.

If you are totally and permanently disabled, you may convert to a renewable term insurance policy. The renewable term insurance policy can be converted to a permanent life insurance policy, at any time, without proof of insurability. If you have converted and are later approved for this plan's Extended Life Benefit, the converted insurance policy is cancelled, as of our approval date.

**How And When To Convert** To get a converted policy, you must: (a) apply to us in writing; and (b) pay the required premium. You have 31 days after your group life insurance ends to do this. We won't ask for proof that you are insurable.

**Death During The Conversion Period** If you die in the 31 days allowed for conversion, we'll pay your beneficiary the amount you could have converted. We'll pay whether or not you applied for conversion.

**Notice Of Conversion Right** If you are entitled to obtain a converted policy under this section, full compliance with this provision for notice of Conversion Right will be satisfied by written notice: (a) given to you by the employer; (b) mailed to you by the employer at your last known address; or (c) mailed to you by us at your last known address that is supplied to us by the employer.

This notice should be given within 15 days before or after the date group life coverage ends. If the notice is given more than 15 days but less than 90 days after the date group life coverage ends, you will have 45 days from the date notice is given to apply for the converted policy and pay the required premium. If notice is not given within 90 days following the date group life coverage ends, the time allowed for conversion expires at the end of such 90 day period.

CGP-3-R-LCONV-99-NY

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## Your Accelerated Life Benefit

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

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

**Accelerated Life Benefit** If you have a medical condition that is expected to result in your death within 6 months, you may apply for an Accelerated Life Benefit. An Accelerated Life Benefit is a payment of part of your group term life insurance made to you before you die.

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

By "group term life insurance" we mean any Employee Basic Group Term Life Insurance for which you are insured under this plan. "Group term life insurance" does not mean Accidental Death and Dismemberment Benefits, any insurance provided under this plan for covered persons other than you or any scheduled increase in the amount of any Employee Group Term Life Insurance that is due within the 6 month period after the date you apply for the Accelerated Life Benefit.

By "gross amount" we mean the amount of an Accelerated Life Benefit elected by you, before the discount and the processing fee are subtracted.

For the purposes of this section, "terminal condition" means a medical condition that is expected to result in your death within 6 months.

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

**Maximum Benefit Amount** The amount of the Accelerated Life Benefit for which you may apply is based on the amount of group term life insurance for which you are insured on the day before you apply for the benefit. The minimum benefit amount is the lesser of: (a) \$50,000.00; or (b) 50% of the inforce amount. The maximum benefit amount is the lesser of: (a) \$100,000.00; or (b) 50% of the inforce amount.

**Discount** The amount for which you apply is discounted to the present value in 6 months from the date the benefit is paid, based on the maximum adjustable policy loan interest rate permitted in the state in which your employer is located.

The Accelerated Life Benefit amount is calculated as shown below:

**Step 1:**

If Discount period is less than 12 months,

$$\text{Discount factor} = 1 + (\text{Annual Interest Rate}/(12/\text{Discount period}))$$

If Discount period = 12 months

$$\text{Discount factor} = (1 + \text{Annual Interest Rate})(\text{Discount period}/12)$$

**Step 2:**

$$\text{Accelerated Life Benefit Payment Amount} = (\text{Life Benefit Accelerated} / \text{Discount factor}) - \text{Processing Fee}$$

The interest rate will never exceed the current yield on the 90-day Treasury Bills available on the date of the application for an accelerated death benefit.

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

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

**How And When To Apply** To receive the Accelerated Life Benefit, you must send us written proof from a licensed doctor who is operating within the scope of his or her license that your medical condition is expected to result in your death within 6 months of the date of the written medical proof. We must approve such proof in writing before the Accelerated Life Benefit will be paid.

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

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

Even if you are receiving an Extended Life Benefit under this plan, you can still apply for an Accelerated Life Benefit. However, once you convert your group term life insurance, the terms of the converted life policy will apply. The sum of the amount of insurance converted plus the gross amount of insurance accelerated cannot exceed the total amount of group term life insurance in effect prior to acceleration. Please read "Your Remaining Group Term Life Insurance" provision for restrictions that may apply.

**If You Have Assigned Your Group Term Life Insurance** If you have already assigned your group term life insurance, according to the terms of this plan, you can't apply for an Accelerated Life Benefit.

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

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

The premium cost of your remaining coverage is based on the amount of group term life insurance for which you would be covered if you had not elected acceleration.



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

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

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## **Extended Life Benefit With Waiver Of Premium**

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

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

Total Disability or Totally Disabled means, due to sickness or injury, you are:

- (a) not able to perform any work for wages or profit; and
- (b) you are receiving regular doctor's care appropriate to the cause of disability; unless you have reached your maximum point of recovery, yet are still disabled under the terms of this plan.

**How And When To Apply** To apply for this extension, you must submit acceptable written medical proof of your total disability. You must provide this proof during the period of disability. Failure to provide proof within the required time will not invalidate or reduce any claim if proof is provided: (a) as soon as reasonably possible; and (b) in no event, except in the absence of legal capacity, later than one year from the time proof is otherwise required.

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

- (a) become totally disabled before you reach age 60 and while insured by the group plan; and
- (b) remain totally disabled for 09 continuous months.

You may apply for this benefit immediately upon the onset of disability.

**Continued Eligibility For Extended Life Benefit** We require periodic written proof that you remain totally disabled to maintain this extension. This written proof of your: (a) continued disability; and (b) doctor's care must be provided to us within 30 days of the date we make each such request.

We can require you to take part in a medical assessment, with a medical specialist of our choice. During the first two years of this extension, we may require this as often as we feel is reasonably necessary. But after two years, we can't have you examined more than once a year.

## Extended Life Benefit With Waiver Of Premium (Cont.)

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**Until You've Been Approved For This Extended Life Benefit** Your life insurance under the group plan may end after you've become totally disabled but before we've approved you for this extension. During this time period, you may either:

- (a) continue group premium payments, including any portion which would have been paid by the employer, until you are approved or declined for this extension; or
- (b) convert to an individual permanent or term policy. Please read the section labeled "Converting This Group Term Life Insurance" for details on how to convert.

However, you must convert if: (i) this group plan terminates; and (ii) you are totally disabled and eligible, but not yet approved, for this extended benefit. You must remain insured under such policy until approved by us for the extended benefit.

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

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

- (a) 09 continuous months from the date active full-time service ends due to total disability; or
- (b) the date we approve you for this benefit.

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**When This Extension Ends** Your extension will end on the earliest of:

- (a) the date you are no longer disabled;
- (b) the date you refuse to be examined by our doctor;
- (c) the date you do not give us required proof of disability;
- (d) the date you are no longer receiving appropriate doctor's care; or
- (e) The day before the date you reach age 65.

You can convert as if your employment just ended if: (a) this extension ends; and (b) you are not insured by the group plan again as an active full-time employee. Read the section labeled "Converting This Group Term Life Insurance".

## **Extended Life Benefit With Waiver Of Premium (Cont.)**

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**If You Die While Covered By This Extension** If you die while covered by this extension we'll pay your beneficiary the amount for which you were covered under this extension. What we pay is subject to all reductions which would have applied had you stayed an active employee.

**Proof Of Death** We'll pay as soon as we receive

- (a) acceptable written proof of your death; and
- (b) medical proof that you were continuously disabled until your death. This must be sent within one year of the date of death.

CGP-3-R-LW-TD-99-2-NC

B275.0139

## **Dependent Term Life Insurance**

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**The Benefits** If one of an Employee's dependents dies while insured for the benefits, we pay the amount shown in the schedule. We pay this in a lump sum when we receive written proof of death. The proof should be sent to us as soon as possible.

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

**Payment to a Minor or Incompetent** If the beneficiary is a minor or not competent, we have the right to pay in monthly installments. We would pay the person who cares for and supports the beneficiary. We completely discharge our liability for any amounts paid this way.

**Incontestability** We can't dispute any medical statements made in the application after a dependent has been insured for these benefits for two years.

## **Converting This Dependent Term Life Insurance**

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**If The Employee's Group Life Insurance Ends or He Stops Being Eligible** Dependent term life insurance ends for all of an employee's dependents when the employee's group life insurance ends. The employee's insurance ends when: (a) his active full-time employment ends; (b) he stops being a member of a class of employees eligible for employee group life insurance; (c) his group life insurance is extended under the Extended Life Benefit provision; or (d) he dies.

Dependent term life insurance also ends when an employee stops being a member of a class of employees eligible for dependent term life insurance.

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

**If The Employee's Group Life Insurance is Reduced** Sometimes, when the employee's group life insurance is reduced, there may be a related reduction in the dependent's group term life insurance amount. If this happens, each dependent can convert the reduced amount of his dependent term life insurance.

## **Converting This Dependent Term Life Insurance (Cont.)**

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**If This Plan Ends or Life Insurance is Dropped** Dependent term life insurance also ends for all of an employee's dependents when this plan ends. And it ends if either employee or dependent term life insurance is dropped from this plan less any group life benefits he becomes eligible for in the 31 days after his insurance ends.

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

**The Converted Policy** The dependent can convert to one of the individual life insurance policies we normally issue. That policy can't include disability benefits. And, it can't be a term policy. But, it can be preceded by single premium term insurance for up to one year.

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

Write to us for details.

**How and When to Convert** To get a converted policy, the dependent must apply to us in writing and pay the required premium. He has 31 days after his group health insurance ends to do this. We won't ask for proof that he's insurable.

If the dependent is a minor or not competent, the person who cares for and supports the dependent may apply for him.

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

**Notice of Conversion Right** If a dependent is entitled to obtain a converted policy under this section, the employer should give the employee written notice of such right. The employer may give the notice in person, or mail it to the employee's last known address.

This notice should be given within 15 days before or after dependent life insurance ends. If the notice isn't given at the proper time, the dependent will have 45 days from the date the notice is given to apply for the converted policy and pay the required premium. But, whether or not the notice is given, the extra time won't extend more than 90 days past the period otherwise allowed for the dependent to convert.

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## ELIGIBILITY FOR DISABILITY COVERAGE

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### Employee Coverage

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**Eligible Employees** To be eligible for coverage under this *plan*, you must meet the following conditions: (a) you must be an *active full-time resident* employed by HOUSE STAFF BENEFITS PLAN OF THE COMMITTEE OF INTERNS AND RESIDENTS; (b) you must hold the degree of Doctor of Medicine; and (c) you must be a member of, or eligible for membership in, the American Medical Association.

"Active full-time resident" means you are performing all the duties associated with a program of *residency*, for at least the number of hours in a normal work week established by HOUSE STAFF BENEFITS PLAN OF THE COMMITTEE OF INTERNS AND RESIDENTS for persons engaged in such a program.

CGP-3-R-EE-MR-05

B329.0195-R

**When Your Coverage Starts** *Employee* benefits that don't require *proof* that you are insurable are scheduled to start on your effective date.

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

But you must be actively at work on a *full-time* basis on the scheduled effective date or dates. And you must have met all of the applicable conditions explained above, and any applicable waiting period. If you are not 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

B264.3202

**When Your Coverage Ends** Your long term disability coverage ends on the date 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.

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

CGP-3-EC-90-3.0

B329.0053

## LONG TERM DISABILITY HIGHLIGHTS

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

CGP-3-LTD94-A-HL B350.0929

**Elimination Period** For disability due to injury . . . . . 180 days.  
 For disability due to sickness . . . . . 180 days.

CGP-3-LTD94-B-HL B350.0939

**Gross Monthly Benefit** . . . . . \$3,500.00.

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

CGP-3-LTD94-A-HL B350.0931

**Maximum Payment Period** For a disability starting before the employee reaches age 60, the maximum payment period will last until the Social Security Normal Retirement Age as shown in the following table:

Employee's Year of Birth	Social Security Normal Retirement Age
Before 1938 . . . . .	65
1938 . . . . .	65 and 2 months
1939 . . . . .	65 and 4 months
1940 . . . . .	65 and 6 months
1941 . . . . .	65 and 8 months
1942 . . . . .	65 and 10 months
1943-1954 . . . . .	66
1955 . . . . .	66 and 2 months
1956 . . . . .	66 and 4 months
1957 . . . . .	66 and 6 months
1958 . . . . .	66 and 8 months
1959 . . . . .	66 and 10 months
After 1959 . . . . .	67

For a disability starting on or after the employee reaches age 60, the maximum payment period will be determined according to the following table:

Age When Disability Starts	Maximum Payment Period
Age 60 . . . . .	5.00 years
Age 61 . . . . .	4.00 years
Age 62 . . . . .	3.50 years
Age 63 . . . . .	3.00 years
Age 64 . . . . .	2.50 years

## Long Term Disability Highlights (Cont.)

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Age 65	2.00 years
Age 66	1.75 years
Age 67	1.50 years
Age 68	1.25 years
Age 69 or older	1.00 year

But if an employee whose disability starts after age 60 reaches the end of the maximum payment from this table before he reaches the Social Security Normal Retirement Age, we will extend his maximum payment period until he reaches Social Security Normal Retirement Age.

CGP-3-LTD94-B-HL

B350.0816

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## LONG TERM DISABILITY INCOME INSURANCE

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This insurance replaces part of your income when it is reduced by disability. What we pay and the terms for payment are explained below. All terms in *italics* are defined terms with special meanings. Their definitions are shown at the end of this section. Other terms are defined where they are used.

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### Claim Provisions

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**Filing A Claim For Benefits** You must send us written notice of an *injury* or *sickness* for which you intend to file a long term disability claim within 30 days of the *injury* or start of the *sickness* for which a claim is being made. This notice should include your name and Social Security number and the *plan* number.

We will furnish you with claim forms for filing proof of *disability* within 15 days of our receipt of the initial notice of your intent to file a claim. The completed claim forms must be returned to us within a reasonable period of time. If we do not furnish the forms within the time stated, we will accept a written description of the *injury* or *sickness* that is the basis for the claim in place of our form. You must detail the nature and extent of the *disability* for which the claim is being made. If necessary to determine our liability, as part of proof of loss, we may require:

- (a) certification of the extent and nature of your *disability* from all *doctors* who have treated you for the cause of your *disability*;
- (b) certification of income from any other sources of income to which you may be entitled which may affect our benefit payments;
- (c) satisfactory evidence that you have applied for all benefits and payments from other income sources to which you may be entitled; and
- (d) proof of any income from other sources that you have received.

We may require you to authorize release of medical and income data by the sources of such data, including the providers of medical and/or dental services. Any information not furnished or for which the release of authorization to obtain data is not obtained can result in suspension or delay of long term disability benefit payments until such information or authorization is received by us.

**Time Limit For The Filing Of A Claim** Any claim not filed within a reasonable period of time following the end of the elimination period will be denied and no long term disability benefits will be payable unless we receive written proof that you lacked the legal capacity to file the claim or that it was not reasonably possible for you to file the claim. In no event will benefits be payable for more than one year retroactively from the date the claim is filed.

**Continued Proof Of Disability** Additional proof will be required. Written proof of your continued *disability* and *doctor's* care must be provided to us within 30 days of each date we make such request.



## Claim Provisions (Cont.)

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**Payment Of Benefits** Benefits for the long term disability income insurance are payable once every month, provided you continue to submit periodic written proof of loss and any current earnings as required by us. We pay all long term disability benefits to you, if legally competent. If you are not legally competent, we will pay all benefits to which you are entitled to the legal representative of your estate. We have the right to pay any benefits to which you are entitled which remain unpaid at your death to one of the following: (a) your estate; or (b) your spouse, parents, children or brothers and sisters.

**Examination** If you make a claim for benefits, we have the right to require that you be examined by a *doctor* as often as we feel is necessary. And we have the right to terminate or suspend your *net monthly payments* if you fail to attend such an examination. In such case, your *net monthly payments* may be resumed, provided that: (a) the required examination occurs within a reasonable period of time; and (b) you continue to be entitled to *net monthly payments* under all other provisions of this *plan*.

For other information on filing a claim, see this plan's "Accident and Health Claims Provisions."

CGP-3-LTD94-B-1.0-NY

B350.0602

## How This Plan Works

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**When And How This Plan's Net Monthly Payments Start** To start getting *net monthly payments* under this *plan*, you must meet all of the following conditions:

- you must: (a) become disabled while insured by this *plan*; and (b) stay both disabled and insured by this *plan* continuously throughout the elimination period.
- you must be: (a) under a *doctor's* regular care for the cause of your *disability*; and (b) receiving appropriate medical care for the cause of your *disability* and for any other *sickness* or *injury* which exists before, or occurs during, the period you are disabled under the *plan*.
- you must send us acceptable written proof of: (a) your *disability*; (b) your *prior monthly earnings*; and (c) any *current monthly earnings*.

We reserve the right to determine when you meet the above conditions.

Failure to pass your regular occupational physical checkup does not constitute *disability* under this *plan*. We do not accept, as proof of *disability*, certification from a *doctor* who is: (a) yourself; or (b) your business associate, spouse, parent, child, brother or sister.

Once we approve your initial proofs of *disability* and *earnings* we start to make *net monthly payments*. The first *net monthly payment* is made one month after the end of the elimination period.

**The Elimination Period** The elimination period is the period of time you must be continuously disabled before long term disability benefits are payable.

- For *disability* due to *injury*, the elimination period is 180 days.

## How This Plan Works (Cont.)

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- For *disability* due to *sickness*, the elimination period is 180 days.

Any days of *disability* which result from a *disability* for which this *plan* does not pay benefits will not count toward the elimination period. Any days during which you are not disabled will not count toward the elimination period.

The elimination period will be considered continuous if you return to work in your *regular occupation* for not more than 90 consecutive days during the elimination period. The elimination period will be extended by one day for each day you temporarily return to work. This interruption of the elimination period will not apply if you become eligible under any other group long term disability plan.

### Continued Payment Of This Plan's Net Monthly Payments

To continue to be entitled to *net monthly payments* under this *plan*, you must continue to provide adequate proof of:

- (a) your continued *disability*;
- (b) continued regular *doctor's* care for the cause of the *disability*;
- (c) any *current monthly earnings*; and
- (d) any other income we integrate with that you are entitled to receive.

In addition, we may, at any time, require you to be examined by a *doctor* or medical professional of our choosing.

Your *net monthly payments* under this *plan* can be terminated or suspended if at any time you fail to comply with any of the above requirements.

See "Accident and Health Claims Provisions" for how often we can require continued proof of the items shown above.

How long we continue to make *net monthly payments* under this *plan* will be subject to all the terms of this *plan*.

CGP-3-LTD94-B-2.0

B350.0519

### When Disability Ends

Your *disability* ends on the earliest of: (a) the date you earn or we determine you are able to earn at a rate of at least 80% of your *indexed prior monthly earnings*; or (b) the date we determine you are able to perform the major duties of your *regular occupation* or employment on a full-time basis, even if you choose not to perform such duties; or (c) after you have received 24 consecutive net monthly payments, the date we determine you are able to perform the major duties required of a Doctor of Medicine or any other medical practitioner, other than *rehabilitative work*, as allowed under this *plan* even if you choose not to perform such duties.

CGP-3-RES98-3

B350.3686-R

## How This Plan Works (Cont.)

**When This Plan's  
Payments End**

This *plan's net monthly payments* end on the earliest of:

- (a) the date your *disability* ends;
- (b) the date you die;
- (c) the end of the *maximum payment period*;
- (d) the date you fail to give us any proof of *disability* we require;
- (e) the date you refuse to allow any physical exam we require;
- (f) the date you are no longer under the regular and continuing care of a *doctor*;
- (g) the date benefits end in accord with any rehabilitation provision of this *plan*.

**Maximum Payment  
Period**

For a disability starting before the employee reaches age 60, the maximum payment period will last until the Social Security Normal Retirement Age as shown in the following table:

Employee's Year of Birth	Social Security Normal Retirement Age
Before 1938 . . . . .	65
1938 . . . . .	65 and 2 months
1939 . . . . .	65 and 4 months
1940 . . . . .	65 and 6 months
1941 . . . . .	65 and 8 months
1942 . . . . .	65 and 10 months
1943-1954 . . . . .	66
1955 . . . . .	66 and 2 months
1956 . . . . .	66 and 4 months
1957 . . . . .	66 and 6 months
1958 . . . . .	66 and 8 months
1959 . . . . .	66 and 10 months
After 1959 . . . . .	67

For a disability starting on or after the employee reaches age 60, the maximum payment period will be determined according to the following table:

Age When Disability Starts	Maximum Payment Period
Age 60 . . . . .	5.00 years
Age 61 . . . . .	4.00 years
Age 62 . . . . .	3.50 years
Age 63 . . . . .	3.00 years
Age 64 . . . . .	2.50 years
Age 65 . . . . .	2.00 years
Age 66 . . . . .	1.75 years
Age 67 . . . . .	1.50 years
Age 68 . . . . .	1.25 years
Age 69 or older . . . . .	1.00 year

But if an employee whose disability starts after age 60 reaches the end of the maximum payment from this table before he reaches the Social Security Normal Retirement Age, we will extend his maximum payment period until he reaches Social Security Normal Retirement Age.

**Recurring Disability** Benefits for *disability* cease when your *disability* ends, as described above. If your benefit ceased because your *disability* ended, and you become disabled again under this *plan* we will consider the later period of *disability* to be a recurring *disability* if:

- (a) you return to active, full-time work right after a period of *disability* for which this *plan* has paid benefits;
- (b) your *disability* recurs less than six months after the end of the period for which you were last entitled to a *net monthly payment* under this *plan*;
- (c) your later *disability* is due to the same *sickness* or *injury* that caused the earlier period of *disability*;
- (d) you do not become covered under any other group long term disability income plan during the period you are performing active full-time work;
- (e) this *plan* does not terminate during the time that you are performing active full-time work; and
- (f) you remain insured under this *plan* and the *employer* resumes premium payment for the coverage during any time you are performing active full-time work.

If we consider the *disability* to be a recurring *disability*, the *disability* will be treated as a continuation of the earlier *disability*. This means you will not be required to satisfy a new elimination period before benefits will be payable under this *plan* for the later *disability*. It also means that if, during any period of time you are receiving benefits under this *plan*, or during the period of *active work* that separates an earlier *disability* and a recurring *disability*: (a) any of the benefit provisions under this *plan* change; or (b) your *basic monthly earnings* or class change; those changes will not apply to the recurring disability. The benefits payable for the recurring *disability* will be based on the terms of the *plan* that applied to the earlier *disability*.

If the later period of *disability*:

- (a) is due to an unrelated cause;
- (b) begins six months or more after the end of the period for which *disability* benefits were payable under this *plan*; or
- (c) begins after the date this *plan* ends;

the *disability* will not be considered recurring and will be treated like a new period of *disability*.

You must provide all proof of loss required by this *plan* for *disability* before benefits will be payable for a recurring *disability*.

## How This Plan Works (Cont.)

**Income We Integrate With** When you receive, or are entitled to receive, certain other income while this *plan* pays benefits, we integrate your *gross monthly benefit* with that other income. See "How Net Monthly Payments Are Calculated" for how this is done.

We integrate this *plan's* benefits with:

- commission or monies received, eligible to be received, or paid after *disability* benefits commence. This includes vested and nonvested renewal commissions.
- all disability benefits you receive from any compulsory benefit act or law. This includes any applicable temporary disability or state disability benefits required by state law.
- all disability benefits you are entitled to receive from any group plan sponsored by the *employer*, whether insured or self-insured. This includes payments made under a group life insurance plan because of your *disability*. This does not include payments made under a group life insurance plan's accelerated death benefit or similar provision which allows payment of that plan's proceeds because of your terminal illness.
- all disability benefits you are entitled to receive from any other group plan.
- all disability income you are entitled to receive under any other plan issued to you because of your employment by, or association with, the *employer*; or as a result of your membership in any: (a) union; (b) fraternal benefit society; (c) association; or (d) other similar organization.
- all income from a sick leave or salary continuation plan to which you are entitled. This includes lump sum or periodic payments of accumulated sick leave benefits, regardless of whether such plan is sponsored on a formal or informal basis.
- benefits from the United States Social Security Act, the Railroad Retirement Act, or any other like U.S. or Canadian plan or act, as follows:
  - (a) all disability benefits that: (i) you receive; and (ii) your spouse and children receive as a result of your *disability*;
  - (b) all unreduced retirement benefits that: (i) you receive; and (ii) your spouse and children receive as a result of your eligibility; and
  - (c) all reduced retirement benefits paid to: (i) you; and (ii) your spouse and children as a result of your receipt of such benefits.

This *plan* will integrate with any benefits shown above to which your spouse or children are entitled on account of your *disability* regardless of: (a) your marital status; (b) your place of residence; (c) your spouse's place of residence; (d) your child(ren)'s place of residence; or (e) any custody arrangements made on behalf of your children.

- all *retirement plan retirement benefits* funded by the *employer's* deposits for your benefit.
- all *retirement plan disability benefits* to which you are entitled.
- all *retirement benefits* or *retirement plan disability benefits* paid under any other *government plan* not otherwise shown, which you receive as a result of your *disability*.

## How This Plan Works (Cont.)

- all disability benefits to which you are entitled under any: (a) *no-fault motor vehicle coverage*; (b) motor vehicle financial responsibility act; or (c) similar law. This does not apply if state law or regulation does not allow group disability benefits to be reduced by benefits from such coverage.
- all benefits you receive from: (a) a Workers' Compensation law; (b) an occupational disease law; or (c) any other act or law of like intent. This includes: (i) the Jones' Act; (ii) the Longshoreman's and Harbor Workers' Compensation Act; or (iii) any Maritime doctrine of Maintenance, Wages or Cure.

### **Lump Sum Payments Of Income We Integrate With**

If any of the benefits described above are paid in a lump sum, we will integrate this *plan's gross monthly benefit* by the equivalent monthly rate stated in the award. If no equivalent monthly rate is specified, then the lump sum will be equally prorated over the lesser of: (a) 60 months; or (b) your *maximum payment period*.

CGP-3-LTD94-B-5.0-NY

B350.1498

### **Application For Other Income Required**

You must apply for any disability or retirement benefits we integrate with, which we feel, you may be entitled to receive. If such benefits are denied we require you to apply for them again. You are required to continue to appeal all denials until: (a) you receive written notification from the Guardian that no further appeals are necessary; or (b) all possible appeals have been exhausted.

If we feel that you are entitled to any of the benefits shown above, we will: (a) assume you are receiving such benefits; and (b) integrate the *gross monthly benefit* with the estimated amount of such benefits payable to you and any applicable dependents on behalf of your *disability*. But we do not do this if you sign our agreement concerning benefits under which you promise: (a) to apply for any benefits we integrate with; and (b) at our request, to reapply for such benefits or appeal any denial of such benefits until no further appeals can be made; and (c) repay any overpayment due to an award of such benefits. This paragraph does not apply to: (i) disability benefits from any compulsory benefit act or law; (ii) retirement benefits or retirement plan disability benefits under any other government plan which you receive as a result of your disability; and (iii) benefits from a Workers' Compensation law, an occupational disease law, or any other act or law of like intent.

If we do estimate them, we adjust your *net monthly payments* when we receive written proof: (a) of the amount awarded; or (b) that such benefits are denied after any reapplications or appeals we require. In the case of (b), if such adjustment shows we underpaid you, we pay you the full amount of the underpayment in a lump sum.

CGP-3-LTD94-B-6.0-NY

B350.0788

### **How Net Monthly Payments Are Calculated**

Your *net monthly payment* under this *plan* is based on the plan of benefits that applied to you on the date your *disability* began. For the duration of your *disability*, including recurring *disabilities* as defined by this *plan*, your *gross monthly benefit*, *net monthly benefit*, or *net monthly payment* will not be affected by changes in the plan of benefits for your classification. However, your *net monthly payment* will be adjusted when your *current monthly earnings* change.

## How This Plan Works (Cont.)

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When we compute your *net monthly payments*, we first calculate your *gross monthly benefit* and *net monthly benefit*.

### Computing Your Gross Monthly Benefit From This Plan

Your *gross monthly benefit* is \$3,500.00.

The amount of your *prior monthly earnings* used in computing your *gross monthly benefit* may be less than your actual *prior monthly earnings* right before the start of your *disability*. This will happen if:

- (a) you have not submitted any proof of insurability required by this *plan*;
- (b) you have submitted proof of insurability as required by this *plan*, but have not received a written approval of the proof from us;
- (c) this *plan* has a maximum *gross monthly benefit* which does not allow the full amount of your *prior monthly earnings* to be used in the benefit calculation; or
- (d) this *plan's* definition of *basic monthly earnings* specifies that your *earnings* are only updated once a year. When this happens, your *gross monthly benefit* will be based on the amount of your *basic monthly earnings* reported to us by the *employer* on the last scheduled reporting date.

### Computing Your Net Monthly Benefit From This Plan

Your *net monthly benefit* under this *plan* is your *gross monthly benefit*, as determined on your initial date of *disability*, integrated with any other income with which this *plan* integrates that you receive or are entitled to receive. To compute your *net monthly benefit* under this *plan*:

- (a) determine your *gross monthly benefit* as shown above; and
- (b) from the *gross monthly benefit*, subtract the sum of all of the income with which we integrate that you receive or are entitled to receive.

The result is your *net monthly benefit*.

CGP-3-LTD94-B-7.0-NY

B350.1576

### Computing Your Net Monthly Payment From This Plan

Your *net monthly payment* under this *plan* is your *net monthly benefit* determined above, reduced by 50% of any *current monthly earnings* you earn while disabled.

CGP-3-LTD94-C-8.0

B350.0556

If, during any month for which this *plan* pays benefits, the sum of the following:

- (a) your *net monthly payment*, as figured above;
- (b) the total amount of all other income with which this *plan* integrates that you receive or are entitled to receive; and
- (c) the amount of your *current monthly earnings*;

## How This Plan Works (Cont.)

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is greater than the amount of your *indexed prior monthly earnings*, your *net monthly payment* for that month will be further reduced by that portion in excess of 100% of your *indexed prior monthly earnings*. This will not apply during any period of time that you are a participant in a Guardian rehabilitation program, as described in this *plan*, and have signed a valid *rehabilitation agreement* with us.

CGP-3-LTD94-B-9.0-NY

B350.0791

**Cost Of Living Freeze** After we compute the first *net monthly benefit*, we do not reduce your benefit due to cost of living increases in social security benefits or other income benefits with which we integrate. We do adjust *net monthly payments* if: (a) your *current monthly earnings* change; or (b) your social security benefits or other income benefits with which we integrate change due to a recalculation of the benefit when updated information is received after the initial benefit is calculated.

**Minimum Net Monthly Payment** This *plan's* minimum *net monthly payment* is \$100.00.

**Payments For Partial Months** When *disability* lasts part of a month, we pay 1/30 of the *net monthly payment* for each day for which we are liable. In no event will benefits be paid for any more than 30 days for any one month.

**Waiver Of Premium** We waive all premiums for your long term disability income insurance which fall due while you are entitled to receive a *net monthly payment* from this *plan*.

**If This Plan Ends** This insurance ends when the group *plan* ends. It also ends when this insurance is dropped from the group *plan* for all employees, or for your class. If either happens while you are disabled, we pay you benefits as if your insurance did not end. But what we pay will be based on all of the terms of this *plan*.

**Overpayments - Our Recovery Rights** If we determine that we overpaid you, you must reimburse us in full. In addition, we have the right to stop paying benefits until the overpayment is satisfied. We have the right to recover overpayments made for any reason, including those that result from lump sum awards by any of the income benefits we integrate with.

CGP-3-LTD94-B-10.0-NY

B350.1653

**The Indexing Benefit** If you return to work while disabled, an indexing benefit is applied to your *prior monthly earnings* as described below. This benefit increases the amount of *current monthly earnings* you may earn while disabled. The indexing benefit does not increase your *gross monthly benefit*, *net monthly benefit* or *net monthly payment*.

You are eligible for this *plan's* indexing benefit after: (a) this *plan's* elimination period; (b) you have received 12 consecutive *net monthly payments* from this *plan*; and (c) you have returned to work.

When you first become eligible for this *plan's* indexing benefit, we multiply your *prior monthly earnings* by the indexing factor to obtain your *indexed prior monthly earnings*.



## How This Plan Works (Cont.)

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For each later year for which you are eligible for this *plan's* indexing benefit, your *indexed prior monthly earnings* will be determined by multiplying your *indexed prior monthly earnings* for the previous year by the current indexing factor.

The indexing factor is the lesser of: (a) 10%; or (b) one half the percentage change in the *CPI-W* for the prior calendar year of coverage.

While you are eligible for this indexing benefit, we calculate a new indexing factor once a year.

CGP-3-LTD94-IXB

B350.0701

### Rehabilitation Benefits Under This Plan

If you are disabled under this *plan* and meet selection criteria as established by the Guardian, you may be selected to enter into a *rehabilitation agreement* with us. This agreement starts when: (a) we inform you in writing that you have been accepted into the rehabilitation program; and (b) you agree in writing to participate in the rehabilitation program. You may be chosen for this program anytime you are disabled according to the terms of this *plan*. This includes during this *plan's* elimination period.

The exact terms of the *rehabilitation agreement* may be different for each employee, but all agreements will set forth a plan designed to return you to gainful employment. Gainful employment is employment that is appropriate to your disability, skills, experience and *prior monthly earnings*.

If you are chosen for a *rehabilitation agreement*, you will be entitled to an enhanced benefit based on 110% of the *net monthly payment* to which you would have been entitled had you not entered into the *rehabilitation agreement*. If you are chosen for such an agreement with us, you will continue to be subject to all the terms of this *plan*.

The enhanced benefit will start on the later of:

- (a) the effective date shown on the *rehabilitation agreement*; or
- (b) the date you complete the elimination period.

Your eligibility for the enhanced benefit will extend until the earliest of:

- (a) the date you are no longer disabled under this *plan*;
- (b) the date you earn or are able to earn at a rate of at least 80% of your *indexed prior monthly earnings*;
- (c) the date you die;
- (d) the end of this *plan's maximum payment period*;
- (e) the date you violate any of the terms of the *rehabilitation agreement*;
- (f) the date you elect to end the rehabilitation program; or
- (g) the date the *rehabilitation agreement* expires.

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## How This Plan Works (Cont.)

If you end a *rehabilitation agreement* on a basis that is not agreeable to the Guardian, you may be required to repay any benefits paid that are in excess of what this *plan* would have paid had you not participated in the *rehabilitation agreement*.

There are additional advantages available to an employee who participates in a *rehabilitation agreement* as described above. For more information on these incentives and how you may become eligible to receive them, contact the Guardian *rehabilitation specialist*.

CGP-3-LTD94-RHB-NY

B350.0761

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## Special Limitations

### **Mental Or Emotional Conditions, Alcohol Abuse And Drug Abuse**

If you are disabled, as defined by this *plan*, by a mental or emotional condition, alcohol abuse or drug abuse, we limit this *plan's* benefits. For the long term disability income coverage of this *plan*, a mental or emotional condition will include, but is not limited to, any of the following:

- bipolar affective disorder (manic depressive syndrome).
- schizophrenia.
- delusional (paranoid) disorders.
- psychotic disorders.
- depressive disorders.
- anxiety disorders.
- somatoform disorders (psychosomatic illness).
- eating disorders.
- mental illness.

For each *disability* due to a mental or emotional condition, alcohol or drug abuse, our payments stop at the earliest of: (a) the date during any one period of *disability* that you have received 60 net monthly payments; (b) the end of the *maximum payment period*; or (c) the date *disability* ends.

Also, payments will be limited to a total of 60 months in your lifetime for all *disabilities* contributed to, or caused by, any and all of the conditions shown above.

But, if at the end of benefit payments, you are being treated for the cause of your *disability* as an inpatient in a qualified institution for at least 14 consecutive days, we extend our payments. We extend them until the earliest of: (a) 90 days from the date of your discharge; (b) the end of the *maximum payment period*; or (c) the date *disability* ends.

By "qualified institution," we mean a legally operated hospital or other public or private facility licensed to provide inpatient medical care and treatment for the cause of your *disability*.

CGP-3-LTD94-B-11.0-NY

B350.0605-R

## Special Limitations (Cont.)

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**Pre-Existing Conditions** A pre-existing condition is a *sickness* or *injury*, including all related conditions and complications, for which, in the three months before your insurance under this *plan* starts, you: (a) receive advice or treatment from a *doctor*; take prescribed drugs; or receive other medical care or treatment, including consultation with a *doctor*; or (b) exhibit symptoms which would cause an ordinarily prudent person to seek medical advice, diagnosis, care or treatment.

A pregnancy which exists on the date your insurance under this *plan* starts is also a pre-existing condition.

We do not cover *disability* caused by such a condition until the later of: (i) the day following the date you are insured under this *plan* for at least 12 consecutive months; and (ii) the date benefit payments would otherwise start in the absence of this provision.

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

CGP-3-LTD94-B-12.0-NY

B350.1345

**If This Plan Replaces Another Plan** The pre-existing condition limitation shown above will not apply if you: (a) were insured on the day before this *plan* started under a long term disability plan the *employer* had with another insurer; and (b) meet the requirements shown below. But, this *plan* must start right after the old plan ends.

The pre-existing condition limitation will be waived if you: (a) are actively working on a full-time basis on the effective date of this *plan*; and (b) have fulfilled the requirements of any pre-existing condition exclusion or limitation of the old plan.

If you: (a) are actively working on a full-time basis on the effective date of this *plan*; but (b) have not fulfilled the requirements of any pre-existing condition limitation or exclusion of the old plan; then we will apply any period of time credited toward the satisfaction of the pre-existing condition limitation or exclusion under the old plan toward satisfaction of this *plan's* pre-existing condition limitation.

We will deduct all payments made by the old plan under an extension provision. Any benefits for a *disability* caused by a pre-existing condition that we agree to pay will be subject to all other terms of this *plan*.

## Special Limitations (Cont.)

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This provision does not affect your rights as described in the "Credit for Prior Coverage" provision below.

CGP-3-LTD94-B-13.1-NY

B350.1347

### Credit For Prior Coverage

If you are a new employee, you may have been covered under a previous group or blanket disability insurance plan or policy, or employer-provided disability arrangement, that was substantially similar to this *plan*, prior to your enrollment in this *plan*. When this happens, we give credit for the time you were covered under the previous plan. To determine if a condition is pre-existing, we go back to the date your coverage under the previous plan started. But your active full-time service with the *employer* must start within 60 days of the date your coverage under the previous plan ended. And, you must enroll in this *plan* within 31 days of the date you first become eligible under this *plan*. If the employer has included an eligibility waiting period in the plan, you must still meet it before becoming insured under this *plan*.

CGP-3-LTD94-B-14.0-NY

B350.1348

## Exclusions

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- We do not cover any period of *disability* caused, directly or indirectly, by: (a) declared or undeclared war or act of war or armed aggression; (b) your service in the armed forces, National Guard, or military reserves of any state or country; (c) your taking part in a riot or other civil disorder; (d) your commission of, or attempt to commit, a felony; (e) your being engaged in an unlawful occupation; or (f) intentional self injury or attempted suicide.
- We do not pay benefits for any period during which you are not under the regular care or treatment of a *doctor*.
- We do not pay benefits for any period of *disability* which starts before you are insured by this *plan*.

In addition, no benefits will be payable for any period during which your loss of *earnings* is not solely due to your *disability*.

CGP-3-LTD94-B-15.0-NY

B350.1670

## Definitions

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**Active Work** For The Long Term Disability Income Insurance "**active work**" means you are physically able to perform and are performing all of the regular duties of your work for the *employer* in the usual way and on a full-time basis, either at one of the *employer's* usual places of business or at some location to which the *employer's* business requires you to travel. Any changes in your long term disability benefits that are scheduled to occur on a date you are not actively working will not take place until the date you return to *active work*. However, if your return to *active work* is followed by a later period of disability which is considered a recurring *disability*, as described in this *plan*, changes which occur before or during that period of *active work* will not take place.

## Definitions (Cont.)

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**CPI-W** means that part of the United States Department of Labor Consumer Price Index, which measures the relative value of the cost of a typical urban wage earner's purchase of certain goods and services. The change in cost is expressed as a percentage of the cost of those goods and services in a base period. In computing the value of our indexing factor, we use the percentage that the *CPI-W* published in December of that year changes from the *CPI-W* published in December of the prior calendar year. If the Department of Labor stops publishing the *CPI-W*, we have the right to use some other similar standard.

CGP-3-LTD94-B-16.0

B350.0656

**Disability** means, solely due to your *sickness* or *injury*:

- (1) For the first 24 months for which this *plan* pays benefits:
  - (a) you are completely unable to perform the major duties of your *regular occupation* on a full-time basis; and
  - (b) your *current monthly earnings*, if any, are less than 80% of your *indexed prior monthly earnings*.
- (2) After this *plan* has paid benefits for 24 consecutive months, the definition of *disability* changes. For the duration of the *disability*, disability means:
  - (a) you are completely unable to perform, on a full-time basis, the major duties of a Doctor of Medicine or any other medical practitioner; and
  - (b) your *current monthly earnings*, if any, are less than 80% of your *indexed prior monthly earnings*.

While you are disabled, you can engage in: (i) any other occupation full or part-time; (ii) some, but not all, of the major duties of your *regular occupation* full or part-time; or (iii) all of the major duties of your *regular occupation* part-time.

This *plan* only covers *disability* that starts while you are insured by this *plan*.

You will not be considered *disabled* under this *plan* if you are not under the regular care and treatment of a *doctor*.

In no event will the loss of a professional or occupational license, in itself, constitute *disability*.

CGP-3-RES98-DEF-1

B350.3709-R

**Doctor** means any medical practitioner we're required by law to recognize, who: (a) is properly licensed or certified as such by the laws of the state where he or she practices; and (b) provides services that are within the lawful scope of his or her practice.

**Earnings** has the following meanings for this plan's long term disability income insurance:

## Definitions (Cont.)

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- **"Basic monthly earnings"** are based on the amount of your *earnings* received from the *employer* as reported to us. These *earnings* are used in determining the amount of premiums due for the coverage and for projecting your *gross monthly benefit* under this *plan*. *Basic monthly earnings* means an *employee's* rate of monthly *earnings* on the day before *disability* begins. Bonuses, commissions, expense accounts, overtime pay and any other extra compensation are excluded. Any employee compensation based on your monthly earnings which is deposited into a cash or deferred compensation plan, or a salary reduction plan, qualified under IRC Section 401(k) is included. Any *employee* compensation based on excluded income listed above and any *employer* contributions deposited into such 401(k) is excluded. In case of weekly *earnings*, it refers to those *earnings* for a normal work week not exceeding forty hours. Such weekly *earnings* are multiplied by 4.333. Subject to any of this *plan's* *proof of insurability* requirements as of the date of each change in an *employee's* earnings, we use the *employee's* then current monthly *earnings* to set rates and to project the *employee's* gross monthly benefit for billing purposes. But the *employee* must be actively at work on a full-time basis on that date. If he is not, we do this on the date he returns to active full-time work.
- **"Current monthly earnings"** are the exact amount of monthly *earnings* you earn from working while disabled. Your *current monthly earnings* will include any income you earn while disabled but which is returned to your *employer*, partnership or any other similar business arrangement to cover any business or overhead expenses. Your *current monthly earnings* are used in determining your *net monthly payment*.
- **"Prior monthly earnings"** means your rate of *basic monthly earnings* as last reported to us prior to the start of your *disability*. Your *prior monthly earnings* are used in determining your *gross monthly benefit* under this *plan*.
- **"Indexed prior monthly earnings"** means your rate of *prior monthly earnings* adjusted annually by an indexing factor. Your *indexed prior monthly earnings* are used in determining the maximum amount of *current monthly earnings* you can earn under this *plan* and still receive benefits. For more information on this *plan's* indexing benefit see "The Indexing Benefit".

As part of proof of loss that we require, you must give us acceptable proof of your *earnings*. If you do not, we will not pay any benefits. Such proof must consist of: (a) copies of your U.S. Individual Tax Returns; (b) a statement from a certified public accountant; or (c) any other records we agree to accept.

**Employer** means HOUSE STAFF BENEFITS PLAN OF THE COMMITTEE OF INTERNS AND RESIDENTS .

CGP-3-LTD94-B-18.0

B350.1005

## Definitions (Cont.)

- Government Plan** means: (a) the United States Social Security Act; (b) the Railroad Retirement Act; (c) the Canadian Pension Plan; or (d) any other plan provided under the laws of a state, province or any other political subdivision. It also includes any public employee *retirement plan*; or any plan provided as an alternative to the above plan or acts. It does not include: (i) any Workers' Compensation Act or similar law; (ii) the Jones' Act; (iii) the Longshoreman's and Harbor Workers' Compensation Act; or (iv) the Maritime Doctrine of Maintenance, Wages or Cure.
- Gross Monthly Benefit** means this *plan's* monthly benefit before it is integrated with other income and *earnings*.
- Injury** means: (a) all bodily *injury* due to an accident that occurs, independent of all other causes, while you are insured by this *plan*; and (b) all complications thereof. *Disability* will be considered caused by an injury only if that *disability*: (a) is directly caused by the *injury*; and (b) begins within 90 days of the date of such *injury*.
- Maximum Payment Period** means the longest period that benefits are paid by this *plan* for continuous *disability*.
- Net Monthly Benefit** means this *plan's* monthly benefit after the *gross monthly benefit* is integrated with other income but before it is reduced by any *current monthly earnings*.
- Net Monthly Payment** means this *plan's net monthly benefit* less any reduction by *current monthly earnings*. See "How We Compute Net Monthly Payments" for details.
- No-Fault Motor Vehicle Coverage** means a motor vehicle plan that pays disability or medical benefits without considering who was at fault in any accident.
- Plan** means the Guardian group long term disability income insurance *plan* the *employer* bought.
- Regular Occupation** means your occupation as performed in the general labor market in the national economy. When determining the duties of your *regular occupation* we use both the job description provided for you by the *employer* as well as the duties of that occupation as shown in the most recent version of the Dictionary of Occupational Titles, published by the U.S. Department of Labor.
- Rehabilitation Agreement** means a signed, written agreement between you and the Guardian. It outlines a program of vocational rehabilitation in which you agree to participate. The program outlined in the *rehabilitation agreement* is designed to return you to gainful work.
- Rehabilitation Specialist** means a designated employee or representative of the Guardian who is trained in vocational rehabilitation.
- Rehabilitative Work** means any program of work or job training that we approve in writing for you. The aim of such work is to restore your wage earning abilities.

**Retirement Plan** means a defined benefit or a defined contribution plan funded wholly or in part by the *employer's* deposits for your benefit. The term does not include: (a) profit sharing plans; (b) thrift plans; (c) non-qualified deferred compensation plans; (d) individual retirement accounts; (e) tax sheltered annuities; or (f) stock ownership plans.

*Retirement plan "retirement benefits"* are lump sum or periodic payments by a *retirement plan* at normal or early retirement. Some *retirement plans* also make payments for disability (as defined by those plans) that start before normal retirement age. When such payments actuarially reduce the amount that would otherwise have been paid at normal retirement age, they are "**retirement benefits.**" When such payments do not so reduce the normal retirement amount, they are "**disability benefits.**"

**Sickness** means: (a) any illness or disease; (b) all related conditions; and (c) all complications and recurrences thereof. This plan treats pregnancy like a *sickness*.

**We, Us, Our, and Guardian** mean the Guardian Life Insurance Company of America.

Other terms with special meanings are defined where they are used.

CGP-3-LTD94-B-20.0

B350.0547

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## Converting Your Group Long Term Disability Income Insurance

**Eligibility For Conversion** When your coverage under this group long term disability income *plan* ends, you may obtain a converted individual disability income policy, subject to the conditions below. You will be eligible for the converted individual disability income policy if you: (a) are not *disabled* under the terms of this *plan*; (b) have been covered under this *plan* (or a prior group disability income plan which this *plan* replaced) for at least 12 consecutive months immediately prior to the date your group coverage ends; (c) have successfully completed the residency program in which you were enrolled; and (d) apply to us in writing within 45 days after the date on which your coverage under this *plan* ends. By residency program, we mean a program of internship or residency in a medical specialty, accredited by the American Council for Graduate Medical Education.

But you will not be eligible for a converted individual disability income policy if your group long term disability coverage ends because you: (a) fail to make a required contribution; (b) change to a class not eligible under this *plan*; (c) fail to complete a program of residency; (d) retire; or (e) because coverage ends for all persons or all persons in a class under this *plan*.

You do not have to provide evidence of good health to obtain the converted individual disability income policy, but you may be subject to other underwriting criteria. You must provide details concerning other disability income insurance in force or applied for, or for which you would become eligible under another plan within 45 days after the date that this group coverage ends. The Guardian will not issue a converted individual disability income policy if such policy would result in your being overinsured by our standards.



## **Converting Your Group Long Term Disability Income Insurance (Cont.)**

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**To Obtain A  
Converted  
Individual Disability  
Income Policy** You must apply to us in writing and pay any required premium to obtain a converted individual disability income policy. You must do this within 45 days of the date on which your group long term disability coverage ends. If you fail to apply to us in writing and pay any required premium within 45 days of the date your group long term disability coverage ends, you are no longer eligible to obtain a converted individual disability income policy.

**The Converted  
Individual Disability  
Income Policy** Your converted individual disability income policy, if issued, will be effective on the day your coverage under this group *plan* ends. The benefits, terms and conditions of the converted individual disability income policy will be those of the policy in use for such purpose in the state where you then live. These may be different from the benefits, terms and conditions of this group long term disability plan. The premium for the converted individual disability income policy will be that in effect for your age and class of risk on the date the policy is issued.

CGP-3-RES98-CONV

B355.0019-R

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## CERTIFICATE AMENDMENT

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This rider amends the pre-existing conditions limitation in this plan's long term disability income insurance so that the following is added:

In no event will this plan's pre-existing condition limitation result in the exclusion of coverage for a disability caused by a pre-existing condition for a period in excess of 12 months following the effective date of an employee's insurance under this plan.

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

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

CGP-3-A-PREX-NY-08

B360.0132

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## CERTIFICATE AMENDMENT

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(To be attached to and made a part of the Certificate)

The Settlement Option provision under the Employee Group Term Life Insurance Benefit is amended in its entirety to read as follows:

**Settlement Option** Unless otherwise elected by the certificate holder or beneficiary, benefits will be paid in a single lump sum check. We may make other options available in addition to the single check option.

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

**The Guardian** Life Insurance Company of America

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

**PLEASE RETAIN THIS COPY FOR YOUR RECORDS**

CGP-1-R-SO-12

B531.0106

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## CERTIFICATE AMENDMENT

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This rider amends this Plan to provide additional services as described below.

### **ADDITIONAL SERVICES**

Guardian has arranged to make available selected services for eligible Guardian policyholders and/or covered persons to receive certain services from third party vendors in addition to the insurance coverage. The policyholders pay a premium of \$0.215 to Guardian to provide these services listed below for their covered persons.

The services identified below, and agreed to by the providers of these services, are not provided by Guardian. Guardian receives no fee from the respective vendors to make available the selected services. Further, Guardian will not be liable for the negligent provision of services by third party vendors.

Policyholders and covered persons will be instructed to obtain information regarding available services by logging onto [www.GuardianAnytime.com](http://www.GuardianAnytime.com) or a Guardian supported website provided to the Policyholders and covered persons.

Policyholders and covered persons will be provided with complete details about available services and a telephone number to call with questions about the service.

The policyholder and covered persons will be provided the following service(s):

CGP-3-A-VAP-18-NY-H

B531.0642

- **Comprehensive Employee Assistance (EAP) Services:** These services are available for each covered person. The intent of these services is to help with problems of daily living, whether professional or personal. Examples include, but are not limited to:
  - Help with child care issues,
  - Personal issues,
  - Elderly parent issues, and
  - Stress in the workplace.

Services can be for everyday issues, or those related to a crisis. Services may be accessed 24 hours a day, 7 days a week through a website, or a 1-800 telephone number. Information about the program, including how to access it and the services it provides, can be obtained from the Policyholder.

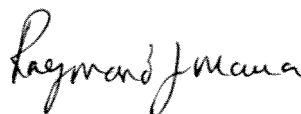
Services are provided by Integrated Behavioral Health, Inc. (IBH). All services and products are provided solely by IBH and its contractors which are unaffiliated to Guardian. Guardian is not responsible for care or advice given by any provider or resource provided under this program. There is no additional charge above the premium to the covered person for these services. The IBH website is [www.ibhworklife.com](http://www.ibhworklife.com).

When this plan ends, access to the services ends for the policyholder and for all persons covered under the plan. When a policyholder no longer meets the conditions for eligibility for insurance coverage, access to that service ends for the policyholder and for all persons covered under the plan.

When a covered person's coverage under this plan ends, access to the service ends for that person. When a covered person no longer meets the conditions for eligibility for insurance coverage access to that service ends for the covered person.

Guardian reserves the right to terminate, modify or replace any program at any time.

**The Guardian** Life Insurance Company of America

A handwritten signature in black ink, appearing to read "Raymond J. Marra". The signature is written in a cursive style with a large initial 'R'.

Raymond Marra, Senior Vice President, Group and Worksite Markets

B531.0640

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## CERTIFICATE AMENDMENT

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This plan is amended so that if a covered person is injured because of a third party's wrongful act or negligence:

- we will pay medical, dental or loss of earnings benefits for the injury, to the extent otherwise covered by this plan, if the covered person: (a) agrees in writing to The Guardian being subrogated to any recovery or right of recovery the covered person has against that third party; (b) does not take any action which would prejudice our subrogation rights; and (c) cooperates in doing what is reasonably necessary to assist us in any recovery;
- we will be subrogated only to the extent of benefits paid by this plan because of that injury; and
- we will be subrogated only when the amounts (or portion) received by the covered person through a third party settlement or satisfied judgment is specifically identified as amounts paid as benefits under this plan.

As used in this rider:

"Subrogation" means our right to recover any benefit payments made under this plan:

- because of an injury to a covered person caused by a third party's wrongful act or negligence; and
- which the covered person later recovers from the third party or the third party's insurer.

"Third Party" means any person or organization other than The Guardian, the employer or the covered person.

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

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

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## REQUIRED DISCLOSURE STATEMENT

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**For Group Plan No.:** G -00348692-HN

The schedule of insurance on page CGP-3-SI of the certificate booklet is a short summary of the health insurance benefits this plan provides. These benefits, including any exclusions and limitations, are fully explained in other parts of the certificate booklet. READ THE CERTIFICATE BOOKLET WITH CARE.

As evidenced by your certificate booklet, this plan provides the following health insurance benefits:

B610.0001

Long Term Disability Income Insurance (defined as Disability Income Insurance by the New York State Insurance Department).

B610.0004

This plan does not provide Basic Hospital Insurance, Basic Medical Insurance, Medicare Supplement Insurance, or Major Medical Insurance, as defined by the New York State Insurance Department.

B610.0016

**Notice** The above statements are not part of the group policy. The group policy alone determines the rights and duties of: (a) the employer to whom this plan is issued; (b) the policyholder (if other than such employer); (c) the Guardian; and (d) any person covered by this plan.

B610.0017

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## GLOSSARY

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	This Glossary defines the italicized terms appearing in your booklet.	
	CGP-3-GLOSS-90	B900.0118
<b>Eligibility Date</b>	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
<b>Eligible Dependent</b>	is defined in the provision entitled "Dependent Coverage."	
	CGP-3-GLOSS-90	B750.0015
<b>Employee</b>	means a person who works for the <i>employer</i> at the <i>employer's</i> place of business, and whose income is reported for tax purposes using a W-2 form.	
	CGP-3-GLOSS-90	B750.0006
<b>Employer</b>	means HOUSE STAFF BENEFITS PLAN OF THE COMMITTEE OF INTERNS AND RESIDENTS .	
	CGP-3-GLOSS-90	B900.0051
<b>Enrollment Period</b>	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
<b>Full-time</b>	means the <i>employee</i> regularly works at least the number of hours in the normal work week set by the <i>employer</i> (but not less than 20 hours per week), at his <i>employer's</i> place of business.	
	CGP-3-GLOSS.1	B750.0230
<b>Initial Dependents</b>	means those <i>eligible dependents</i> you have at the time you first become eligible for <i>employee</i> coverage. If at this time you do not have any <i>eligible dependents</i> , but you later acquire them, the first <i>eligible dependents</i> you acquire are your <i>initial dependents</i> .	
	CGP-3-GLOSS-90	B900.0006
<b>Newly Acquired Dependent</b>	means an <i>eligible dependent</i> you acquire after you already have coverage in force for <i>initial dependents</i> .	
	CGP-3-GLOSS-90	B900.0008
<b>Plan</b>	means the <i>Guardian</i> group <i>plan</i> purchased by your <i>employer</i> , 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
<b>Proof or Proof of Insurability</b>	means an application for insurance showing that a person is insurable.	
	CGP-3-GLOSS-90	B900.0010



**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.**

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## STATEMENT OF ERISA RIGHTS

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### The Guardian Life Insurance Company of America

10 Hudson Yards  
New York, New York 10001  
(212) 598-8000

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

ERISA provides that all plan participants shall be entitled to:

#### **Receive Information about Your Plan and Benefits**

- Examine, without charge, at the plan administrator's office and at other specified locations, such as worksites and union halls, all documents governing the plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the plan with the U. S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.
- Obtain, upon written request to the plan administrator, copies of documents governing the operation of the plan, including insurance contracts, collective bargaining agreements and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The administrator may make a reasonable charge for the copies.
- Receive a summary of the plan's annual financial report. The plan administrator is required by law to furnish each participant with a copy of this summary annual report.

#### **Prudent Actions by Plan Fiduciaries**

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

#### **Enforcement of Your Rights**

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

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

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

**Life Insurance Claims Procedure** If you seek benefits under the plan you should complete, execute and submit a claim form. Claim forms and instructions for filing claims may be obtained from the Guardian Life Insurance Company of America (hereinafter referenced as Guardian.)

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

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

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

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

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

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

**Adverse Benefit  
Determination of  
Life Insurance  
Claims**

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

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

B752.0186

**Appeals of Adverse  
Determinations of  
Life Insurance  
Claims**

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

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

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

A notification with respect to an extension will indicate the special circumstances requiring an extension of the time period for review, and the date by which the final determination will be made.

In the event Guardian denies the appeal of an adverse benefit determination, it will:

- Provide the specific reason or reasons why the appeal was denied;
- Refer to the specific provisions in the Policy, Certificate, plan, or other documents on which the benefit determination is based;
- Provide a statement that the claimant is entitled to receive, upon request and free of charge, reasonably access to, and copies of all documents, records, and other information relevant to the claimant's claim for benefits; and
- Provide a statement describing any voluntary appeal procedures offered by the Plan, the claimant's right to obtain information about such procedures, and a statement that the claimant's right to bring an action under ERISA section 502(a).

**Waiver of Premium** If you apply for an extension of life insurance benefits due to Total Disability under the Waiver of Premium benefit under this plan, these claim procedures will apply to such request:

**Timing For Initial Benefit Determination for Waiver of Premium** The benefit determination period begins when claim is received. Guardian will make a benefit determination and notify a claimant within a reasonable period of time, but not later than the time period shown below. A written or electronic notification of any adverse determination must be provided.

Guardian will make a determination of whether the claimant meets the plan's standard for total disability not later than 45 days from the date of receipt of a claim. This period may be extended by up to 30 days if Guardian determines that an extension is necessary due to matters beyond the control of the plan, and so notifies the claimant before the end of the initial 45-day period. Such notification will include the reason for the extension and a date by which the determination will be made. If prior to the end of the 30-day period Guardian determines that an additional extension is necessary due to matters beyond the control of the plan, and so notifies the claimant, the time period for making a benefit determination may be extended for up to an additional period of up to 30 days. Such notification will include the special circumstances requiring the extension and a date by which the final determination will be made.

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

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

**Adverse Benefit Determination** If a claim for an extension of benefits is denied, Guardian will provide a notice that will set forth:

- The specific reason(s) for the adverse determination;
- References to the specific provisions in the Policy, Certificate, plan or other documents, on which the determination is based;
- A description of any additional material or information needed to perfect the claim, and an explanation of why such material or information is necessary;
- A description of the plan's claim review procedures which a claimant may follow to have a claim for benefits reviewed and the time limits applicable to such procedures;
- A description of the plan's review procedures and the time limits applicable to such procedures, including a statement of the claimant's right to bring a civil action under ERISA Section 502(a) following an adverse benefit determination; and
- In the case of adverse benefit determination based on medical necessity or experimental treatment, notice will either include an explanation of the scientific or clinical basis for the determination, or a statement that such explanation will be provided free of charge upon request.

B997.0365

**Appeals of Adverse Determinations for Waiver of Premium** If a claim for Waiver of Premium is denied, the claimant will have up to 180 days to make an appeal. Guardian will conduct a full and fair review of an appeal which includes providing to claimants the following:

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

In reviewing an appeal, Guardian will:

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

- Ensure that a health care professional engaged for consultation regarding an appeal based upon a medical judgment shall be neither the person who was consulted in connection with the adverse benefit determination, nor that person's subordinate.

Guardian will notify the claimant of its decision not later than 45 days after receipt of the request for review of the adverse determination. This period may be extended by an additional period of up to 45 days if Guardian determines that special circumstances require an extension of the time period for processing and so notifies the claimant before the end of the initial 45-day period.

A notification with respect to an extension will indicate the special circumstances requiring an extension of the time period for review, and the date by which the final determination will be made.

In the event Guardian denies the appeal of an adverse benefit determination, it will:

- Provide the specific reason or reasons why the appeal was denied;
- Refer to the specific provisions in the Policy, Certificate, plan, or other documents on which the benefit determination is based;
- Provide a statement that the claimant is entitled to receive, upon request and free of charge, reasonably access to, and copies of all documents, records, and other information relevant to the claimant's claim for benefits;
- Provide a statement disclosing any internal rule, guideline, protocol or similar criterion relied on in making the adverse benefit determination (or a statement that such information will be provided free of charge upon request); or a statement that no internal rule, guideline, protocol or similar criterion was relied upon in making the adverse benefit determination;
- If applicable, provide an explanation of the basis of disagreement with or not following the views presented by you, of health care professionals who treated you, and vocational professionals who evaluated you;
- If applicable, provide an explanation of the basis for disagreeing with or not following the views of any medical or vocational expert whose advice was obtained on our behalf in connection with the adverse benefit determination, without regard to whether the advice was relied upon in making the determination;
- If applicable, provide an explanation of the basis for disagreeing with or not following a disability determination made by the Social Security Administration that you present to us;
- Provide a statement describing the claimant's right to bring a civil suit under Section 502(a) of the Employee Retirement Income Security Act of 1974 which shall also describe any applicable contractual limitations period that applies the claimant's right to bring such an action, including the calendar date on which the contractual limitations period expires for the claim, and;

- In the event the adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, provide either an explanation of the scientific or clinical judgment for the determination, applying the terms of the plan to the claimant's medical circumstances, or a statement that such explanation will be provided free of charge upon request.

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

In addition to any legal rights you may have under section 502(a), if you believe that we have violated ERISA's procedural requirements, you may request that we review any claimed violation(s) and we will respond to you within ten days.

B997.0366



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## STATEMENT OF ERISA RIGHTS

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

Your group Short Term and/or Long Term Disability Income benefits may be covered by the Employee Retirement Income Security Act of 1974 (ERISA). If so, you are entitled to certain rights and protections under ERISA.

ERISA provides that all plan participants shall be entitled to:

**Receive Information  
about Your Plan and  
Benefits**

- (a) Examine, without charge, at the plan administrator's office and at other specified locations, such as worksites and union halls, all documents governing the plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the plan with the U. S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.
- (b) Obtain, upon written request to the plan administrator, copies of documents governing the operation of the plan, including insurance contracts, collective bargaining agreements and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The administrator may make a reasonable charge for the copies.
- (c) Receive a summary of the plan's annual financial report. The plan administrator is required by law to furnish each participant with a copy of this summary annual report.

**Prudent Actions by  
Plan Fiduciaries**

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

**Enforcement of  
Your Rights**

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

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

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

**Disability Benefits Claims Procedure** If you seek benefits under the plan you should complete, execute and submit a claim form. Claim forms and instructions for filing claims may be obtained from The Guardian Life Insurance Company of America (hereinafter referenced as Guardian).

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

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

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

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

Guardian will provide a benefit determination not later than 45 days from the date of receipt of a claim. This period may be extended by up to 30 days if Guardian determines that an extension is necessary due to matters beyond the control of the plan, and so notifies the claimant before the end of the initial 45-day period. Such notification will include the reason for the extension and a date by which the determination will be made. If prior to the end of the 30-day period Guardian determines that an additional extension is necessary due to matters beyond the control of the plan, and so notifies the claimant, the time period for making a benefit determination may be extended for up to an additional period of up to 30 days. Such notification will include the special circumstances requiring the extension and a date by which the final determination will be made.

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

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

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**Adverse Benefit  
Determination**

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

- The specific reason(s) for the adverse determination;
- References to the specific provisions in the Policy, Certificate, plan or other documents, on which the determination is based;
- A description of any additional material or information necessary to perfect the claim and an explanation of why such material or information is necessary;
- A description of the plan's claim review procedures which a claimant may follow to have a claim for benefits reviewed and the time limits applicable to such procedures;
- A statement disclosing any internal rule, guideline, protocol or similar criterion relied on in making the adverse benefit determination (or a statement that such information will be provided free of charge upon request); or a statement that no internal rule, guideline, protocol or similar criterion was relied upon in making the adverse benefit determination;
- If applicable, an explanation of the basis of disagreement with or not following the views presented by you, of health care professionals who treated you and vocational professionals who evaluated you;
- If applicable, an explanation of the basis for disagreeing with or not following the views of any medical or vocational expert whose advice was obtained on our behalf in connection with the adverse benefit determination, without regard to whether the advice was relied upon in making the determination;

- If applicable, an explanation of the basis for disagreeing with or not following a disability determination made by the Social Security Administration that you present to us;
- A description of the plan's review procedures and the time limits applicable to such procedures, including a statement of the claimant's right to bring a civil action under ERISA Section 502(a) following an adverse benefit determination on appeal, and;
- In the case of an adverse benefit determination based on medical necessity or experimental treatment, notice will either include an explanation of the scientific or clinical basis for the determination, or a statement that such explanation will be provided free of charge upon request.

**Appeal of Adverse  
Benefit  
Determinations**

If a claim is wholly or partially denied, the claimant will have up to 180 days to make an appeal. Guardian will conduct a full and fair review of an appeal which includes providing to claimants the following:

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

In reviewing an appeal, Guardian will:

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

Guardian will notify the claimant of its decision not later than 45 days after receipt of the request for review of the adverse determination. This period may be extended by an additional period of up to 45 days if Guardian determines that special circumstances require an extension of the time period for processing and so notifies the claimant before the end of the initial 45-day period.

A notification with respect to an extension will indicate the special circumstances requiring an extension of the time period for review, and the date by which the final determination will be made.

In the event Guardian denies the appeal of an adverse benefit determination, it will:

- Provide the specific reason or reasons why the appeal was denied;
- Refer to the specific provisions in the Policy, Certificate, plan, or other documents on which the benefit determination is based;
- Provide a statement that the claimant is entitled to receive, upon request and free of charge, reasonably access to, and copies of all documents, records, and other information relevant to the claimant's claim for benefits;
- Provide a statement disclosing any internal rule, guideline, protocol or similar criterion relied on in making the adverse benefit determination (or a statement that such information will be provided free of charge upon request); or a statement that no internal rule, guideline, protocol or similar criterion was relied upon in making the adverse benefit determination;
- If applicable, provide an explanation of the basis of disagreement with or not following the views presented by you, of health care professionals who treated you, and vocational professionals who evaluated you;
- If applicable, provide an explanation of the basis for disagreeing with or not following the views of any medical or vocational expert whose advice was obtained on our behalf in connection with the adverse benefit determination, without regard to whether the advice was relied upon in making the determination;
- If applicable, provide an explanation of the basis for disagreeing with or not following a disability determination made by the Social Security Administration that you present to us;
- Provide a statement describing the claimant's right to bring a civil suit under Section 502(a) of the Employee Retirement Income Security Act of 1974 which shall also describe any applicable contractual limitations period that applies the claimant's right to bring such an action, including the calendar date on which the contractual limitations period expires for the claim, and;

- In the event the adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, provide either an explanation of the scientific or clinical judgment for the determination, applying the terms of the plan to the claimant's medical circumstances, or a statement that such explanation will be provided free of charge upon request.

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

In addition to any legal rights you may have under section 502(a), if you believe that we have violated ERISA's procedural requirements, you may request that we review any claimed violation(s) and we will respond to you within ten days.

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