The GUARDIAN Life Insurance Company of America
A Mutual Life Insurance Company
10 Hudson Yards, New York, New York 10001

Incorporated 1860 By The Laws of The State of New York

Amendment to Group Policy No. G- 00026998-

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

The Policyholder and the Insurance Company hereby agree that Group Policy No. G- 00026998- is hereby amended effective January 1, 2024 as follows:

Your Employer Rider is hereby declared null and void and replaced with the revised corresponding Employer Rider attached hereto.

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

- Cancer Plan - Pages 1 -57
- Critical Illness Plan - starting at page 58

The Guardian Life Insurance Company of America

A Mutual Company - Incorporated 1860 by the State of New York
10 Hudson Yards, New York, New York 10001

POLICYHOLDER: DOUGHERTY COUNTY SCHOOL SYSTEM

GROUP POLICY NUMBER	DELIVERED IN	POLICY DATE
G-00026998	Georgia	January 1, 2022

POLICY ANNIVERSARIES: January 1st of each year, beginning in 2023

THE GUARDIAN LIFE INSURANCE COMPANY OF AMERICA (herein called the Insurance Company) in consideration of the Application for this Policy and of the payment of premiums as stated herein, **AGREES** to pay benefits in accordance with and subject to the terms of this Policy.

Premiums are payable by the Policyholder as hereinafter provided. The first premium is due on the Policy Date, and subsequent premiums are, during the continuance of this Policy, due on the 1st of each month

This Policy is delivered in the jurisdiction specified above and is governed by the laws thereof.

The provisions set forth on the following pages are part of this Policy.

This Policy takes effect on the Policy Date specified above.

IN WITNESS WHEREOF, THE GUARDIAN LIFE INSURANCE COMPANY OF AMERICA has caused this Policy to be executed as of November 3, 2023 which is its date of issue.

Michael Prestileo, Senior Vice President

GROUP INSURANCE POLICY
PROVIDING
BENEFITS AS DESCRIBED HEREIN

Dividends Apportioned Annually

GP-1 P100.9000

SCHEDULE OF INSURANCE AND PREMIUM RATES

This plan's classifications, and the option packages of benefits which are available to covered persons who are members of each classification, are shown below.

Class Description

Class 0001 ALL ELIGIBLE EMPLOYEES ELECTING LOW CRITICAL ILLNESS OR WAIVING CRITICAL ILLNESS

Class 0002 ALL ELIGIBLE EMPLOYEES ELECTING HIGH CRITICAL ILLNESS

GP-1-SI P130.1566

Option Packages Available

Employees may choose from the benefit packages available to members of their class. The option packages are summarized in "Summary of Option Packages" below.

GP-1-SI P130.1710

Members of Class 0001 may choose from benefit option packages A and B.

GP-1-SI P130.1568

Members of Class 0002 may choose from benefit option packages A and B.

GP-1-SI P130.1568

Summary of Option Packages

The following are summaries of the benefit option packages available. For a complete explanation of the benefits provided by this plan, including all limitations and exclusions, please read the entire plan.

GP-1-SI P130.1585

Option A Employee and Dependent Cancer Coverage with an initial diagnosis benefit included.

GP-1-SI P130.8823

Option B Employee and Dependent Cancer Coverage with an initial diagnosis benefit included.

GP-1-SI P130.8823

Cancer Benefit

Benefit	Amount
Air Ambulance:	$1,500.00 per trip. Limited to 2 one-way trips per *hospital confinement.*
Ambulance:	$200.00 per trip. Limited to 2 one-way trips per *hospital confinement.*
Anesthesia:	25% of surgery benefit.
Anti-Nausea Medication:	$50.00 per day up to $150.00 per month.
Attending Doctor:	$25.00 per day. Limited to 75 visits per *hospital confinement.*
Blood, Plasma and Platelets:	$100.00 per day. Limited to $5,000.00 in 12 months.
Bone Marrow and Stem Cells:	$7,500.00 for *bone marrow transplant.* $1,500.00 for *stem cell transplant.* 50% for second transplant. Limited to two of each in a covered person's lifetime $1,000.00 if a covered person donates bone marrow, limited to one benefit in a covered person's lifetime.
Cancer Screening:	$50.00 per *benefit year.*
Cancer Screening Follow-Up:	$50.00 per *benefit year.*
Experimental Treatment:	$100.00 per day. Limited to $1,000.00 per month.
Extended Care Facility/Skilled Nursing Care:	$100.00 per day. Limited to 90 days per *benefit year.*
Government or Charity Hospital:	$300.00 per day in lieu of other benefits provided by this *plan.*
Home Health Care:	$50.00 per visit. Limited to 30 visits per *benefit year.*
Hormone Therapy	$25.00 per treatment. Limited to 12 per benefit year.
Hospice:	$50.00 per day. Limited to 100 days per lifetime.
Hospital Confinement:	$300.00 for first 30 days per *period of hospital confinement.* $600.00 for 31st day and thereafter per *period of hospital confinement.*
Immunotherapy:	$500.00 per month. $2,500.00 per lifetime.
Intensive Care Unit Confinement:	$400.00 for first 30 days per confinement. $600.00 for 31st day and thereafter confinement.
Inpatient Special Nursing:	$100.00 per day. Limited to 30 days per *benefit year.*

Medical Imaging:	$100.00 per image. Limited to 2 images per *benefit year.*
Outpatient and Family Member Lodging:	$75.00 per day. Limited to 90 days per *benefit year.*
Outpatient or Ambulatory Surgical Center:	$250.00 per day. Limited to 3 days per procedure.
Physical or Speech Therapy:	$25.00 per visit. Limited to 4 visits per month. Limited to $400.00 per lifetime.
Surgically Implanted Prosthetic Devices:	$2,000.00 per device. Limited to $4,000.00 per lifetime.
Non-Surgically Implanted Prosthetic Devices:	$200.00 per device. Limited to $400.00 per lifetime.
Radiation Therapy and Chemotherapy:	$10,000.00 per *benefit year.*
Injected cytoxic meds	$800.00 per week.
Pump dispensed cytoxic meds (first prescription then per week for refills)	$800.00 per week.
Oral cytoxic meds	$400.00 per prescription up to $1,200.00 per month.
Cytoxic meds administration by any other method	$800.00 per week.
External radiation therapy	$650.00 per week.
Insertion of interstitial or intracavity admin of radioisotopes or radium	$800.00 per week.
Oral or I.V. radiation	$650.00 per week.
Reconstructive Surgery:	
Breast TRAM flap	$2,000.00
Breast reconstruction	$500.00
Breast symmetry	$250.00
Facial reconstruction	$500.00
Second Surgical Opinion:	$200.00 Limited to one per surgical procedure.
Skin Cancer:	
Biopsy only	$100.00
Reconstructive surgery following excision of a skin cancer	$250.00
Excision of a skin cancer with no flap or graft	$375.00
Excision of a skin cancer with flap or graft	$600.00

Surgical Benefits:

Surgery	**Surgical Benefit**
Abdomen - Cholecystectomy	$575.00

Abdomen - Exploratory laparotomy	$435.00
Abdomen - Paracentesis	$110.00
Bladder - (TUR) transurethral resection bladder tumors	$435.00
Bladder - Cystectomy (complete)	$1,485.00
Bladder - Cystectomy (partial)	$740.00
Bladder - Cystectomy (with ureteroileal conduit)	$2,970.00
Bladder - Cystoscopy	$110.00
Brain - Burr holes not followed by surgery	$575.00
Brain - Excision brain tumor	$2,885.00
Brain - Exploratory craniotomy	$1,235.00
Brain - Ventriculoperitoneal shunt	$575.00
Brain - Hemispherectomy	$4,125.00
Breast - lumpectomy	$285.00
Breast - mastectomy partial	$435.00
Breast - mastectomy radical	$860.00
Breast - mastectomy simple	$575.00
Chest - Bronchoscopy	$245.00
Chest - Lobectomy	$1,235.00
Chest - Mediastinoscopy	$245.00
Chest - Pneumonectomy	$1,730.00
Chest - Thoracentesis	$110.00
Chest - Thoracostomy	$245.00
Chest - Thoracotomy	$575.00
Chest - Wedge resection	$990.00
Esophagus - Esophagogastrectomy	$1,235.00
Esophagus - Esophagoscopy	$225.00
Esophagus - Resection of esophagus	$1,650.00
Eye - Enucleation	$410.00
Eye - P32 uptake	$200.00
Female Reproductive - Abdominal hysterectomy/uterus only	$740.00
Female Reproductive - Colposcopy	$140.00
Female Reproductive - D&C	$140.00
Female Reproductive - Oophorectomy	$435.00
Female Reproductive - Uterus, tubes & ovaries	$1,440.00

Female Reproductive - Uterus, tubes & ovaries with exenteration	$4,125.00
Female Reproductive - Vaginal hysterectomy/uterus only	$435.00
Intestines - Abdominal-perineal resection	$2,060.00
Intestines - Colectomy	$740.00
Intestines - Colonoscopy (does not include virtual or CT Colonography)	$225.00
Intestines - Colostomy/or revision of	$285.00
Intestines - ERCP	$285.00
Intestines - Excesional on rectum for biopsy	$225.00
Intestines - Ileostomy	$285.00
Intestines - Proctosigmoidoscopy	$110.00
Intestines - Resection of small intestine	$1,730.00
Intestines - Sigmoidoscopy	$110.00
Kidney - Nephrectomy (radical)	$2,970.00
Kidney - Nephrectomy (simple)	$1,730.00
Liver - Resection of liver	$2,060.00
Lymphatic - Axillary node dissection	$575.00
Lymphatic - Excision of lymph nodes	$140.00
Lymphatic - Lymphadenectomy (bilaterial)	$740.00
Lymphatic - Lymphadenectomy (unilateral)	$575.00
Lymphatic - Splenectomy	$575.00
Mandible - Mandibulectomy	$1,155.00
Misc - Bone marrow aspiration	$110.00
Misc - Pathological hip fracture (chemo)	$720.00
Misc - Venous-Catheters/venous port (chemo)	$110.00
Misc - Peripherally inserted central catheter (PICC)	$110.00
Misc - Pathological fracture (chemo)	$330.00
Mouth - Glossectomy	$575.00
Mouth - Hemiglossectomy	$285.00
Mouth - Resection of palate	$575.00
Mouth - Tonsil/Mucous membranes	$435.00
Pancreas - Jejunostomy	$740.00
Pancreas - Pancreatectomy	$1,730.00
Pancrease - Whipple procedure	$2,970.00
Penis - amputation, complete	$575.00

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

Cancer Benefit

Benefit	Amount
Air Ambulance:	$2,000.00 per trip. Limited to 2 one-way trips per *hospital confinement.*
Alternative Care (Palliative Care or Lifestyle Benefits):	$50.00 per visit. Limited to 20 visits per *benefit year* combined.
Ambulance:	$250.00 per trip. Limited to 2 one-way trips per *hospital confinement.*
Anesthesia:	25% of surgery benefit.
Anti-Nausea Medication:	$50.00 per day up to $250.00 per month.
Attending Doctor:	$25.00 per day. Limited to 75 visits per *hospital confinement.*
Blood, Plasma and Platelets:	$200.00 per day. Limited to $10,000.00 in 12 months.
Bone Marrow and Stem Cells:	$10,000.00 for *bone marrow transplant.* $2,500.00 for *stem cell transplant.* 50% for second transplant. Limited to two of each in a covered person's lifetime $1,500.00 if a covered person donates bone marrow, limited to one benefit in a covered person's lifetime.
Cancer Screening:	$75.00 per *benefit year.*
Cancer Screening Follow-Up:	$75.00 per *benefit year.*
Experimental Treatment:	$200.00 per day. Limited to $2,400.00 per month.
Extended Care Facility/Skilled Nursing Care:	$150.00 per day. Limited to 90 days per *benefit year.*
Government or Charity Hospital:	$400.00 per day in lieu of other other benefits provided by this *plan.*
Home Health Care:	$100.00 per visit. Limited to 30 visits per *benefit year.*
Hormone Therapy	$50.00 per treatment. Limited to 12 per benefit year.
Hospice:	$100.00 per day. Limited to 100 days per lifetime.
Hospital Confinement:	$400.00 for first 30 days per *period of hospital confinement.* $800.00 for 31st day and thereafter per *period of hospital confinement.*
Immunotherapy:	$500.00 per month. $2,500.00 per lifetime.
Intensive Care Unit Confinement:	$600.00 for first 30 days per confinement. $800.00 for 31st day and thereafter confinement.

Inpatient Special Nursing:	$150.00 per day. Limited to 30 days per *benefit year.*
Medical Imaging:	$200.00 per image. Limited to 2 images per *benefit year.*
Outpatient and Family Member Lodging:	$100.00 per day. Limited to 90 days per *benefit year.*
Outpatient or Ambulatory Surgical Center:	$350.00 per day. Limited to 3 days per procedure.
Physical or Speech Therapy:	$50.00 per visit. Limited to 4 visits per month. Limited to $1,000.00 per lifetime.
Surgically Implanted Prosthetic Devices:	$3,000.00 per device. Limited to $6,000.00 per lifetime.
Non-Surgically Implanted Prosthetic Devices:	$300.00 per device. Limited to $600.00 per lifetime.
Radiation Therapy and Chemotherapy:	$15,000.00 per *benefit year.*
Injected cytoxic meds	$1,200.00 per week.
Pump dispensed cytoxic meds (first prescription then per week for refills)	$1,200.00 per week.
Oral cytoxic meds	$600.00 per prescription up to $1,800.00 per month.
Cytoxic meds administration by any other method	$1,200.00 per week.
External radiation therapy	$1,000.00 per week.
Insertion of interstitial or intracavity admin of radioisotopes or radium	$1,250.00 per week.
Oral or I.V. radiation	$1,000.00 per week.
Reconstructive Surgery:	
Breast TRAM flap	$3,000.00
Breast reconstruction	$700.00
Breast symmetry	$350.00
Facial reconstruction	$700.00
Reproductive Benefits:	$1,500.00 for egg harvesting $500.00 for egg storage. $500.00 for sperm storage. $2,000.00 lifetime limit for all reproductive benefits.
Second Surgical Opinion:	$300.00 Limited to one per surgical procedure.
Skin Cancer:	
Biopsy only	$100.00
Reconstructive surgery following excision of a skin cancer	$250.00

Excision of a skin cancer with no flap or graft	$375.00
Excision of a skin cancer with flap or graft	$600.00

Surgical Benefits:

Surgery	**Surgical Benefit**
Abdomen - Cholecystectomy	$770.00
Abdomen - Exploratory laparotomy	$580.00
Abdomen - Paracentesis	$150.00
Bladder - (TUR) transurethral resection bladder tumors	$580.00
Bladder - Cystectomy (complete)	$1,980.00
Bladder - Cystectomy (partial)	$990.00
Bladder - Cystectomy (with ureteroileal conduit)	$3,960.00
Bladder - Cystoscopy	$150.00
Brain - Burr holes not followed by surgery	$770.00
Brain - Excision brain tumor	$3,850.00
Brain - Exploratory craniotomy	$1,650.00
Brain - Ventriculoperitoneal shunt	$770.00
Brain - Hemispherectomy	$5,500.00
Breast - lumpectomy	$380.00
Breast - mastectomy partial	$580.00
Breast - mastectomy radical	$1,150.00
Breast - mastectomy simple	$770.00
Chest - Bronchoscopy	$330.00
Chest - Lobectomy	$1,650.00
Chest - Mediastinoscopy	$330.00
Chest - Pneumonectomy	$2,310.00
Chest - Thoracentesis	$150.00
Chest - Thoracostomy	$330.00
Chest - Thoracotomy	$770.00
Chest - Wedge resection	$1,320.00
Esophagus - Esophagogastrectomy	$1,650.00
Esophagus - Esophagoscopy	$300.00
Esophagus - Resection of esophagus	$2,200.00
Eye - Enucleation	$550.00
Eye - P32 uptake	$270.00

Female Reproductive - Abdominal hysterectomy/uterus only	$990.00
Female Reproductive - Colposcopy	$190.00
Female Reproductive - D&C	$190.00
Female Reproductive - Oophorectomy	$580.00
Female Reproductive - Uterus, tubes & ovaries	$1,920.00
Female Reproductive - Uterus, tubes & ovaries with exenteration	$5,500.00
Female Reproductive - Vaginal hysterectomy/uterus only	$580.00
Intestines - Abdominal-perineal resection	$2,750.00
Intestines - Colectomy	$990.00
Intestines - Colonoscopy (does not include virtual or CT Colonography)	$300.00
Intestines - Colostomy/or revision of	$380.00
Intestines - ERCP	$380.00
Intestines - Excesional on rectum for biopsy	$300.00
Intestines - Ileostomy	$380.00
Intestines - Proctosigmoidoscopy	$150.00
Intestines - Resection of small intestine	$2,310.00
Intestines - Sigmoidoscopy	$150.00
Kidney - Nephrectomy (radical)	$3,960.00
Kidney - Nephrectomy (simple)	$2,310.00
Liver - Resection of liver	$2,750.00
Lymphatic - Axillary node dissection	$770.00
Lymphatic - Excision of lymph nodes	$190.00
Lymphatic - Lymphadenectomy (bilaterial)	$990.00
Lymphatic - Lymphadenectomy (unilateral)	$770.00
Lymphatic - Splenectomy	$770.00
Mandible - Mandibulectomy	$1,540.00
Misc - Bone marrow aspiration	$150.00
Misc - Pathological hip fracture (chemo)	$960.00
Misc - Venous-Catheters/venous port (chemo)	$150.00
Misc - Peripherally inserted central catheter (PICC)	$150.00
Misc - Pathological fracture (chemo)	$440.00
Mouth - Glossectomy	$770.00
Mouth - Hemiglossectomy	$380.00
Mouth - Resection of palate	$770.00

Mouth - Tonsil/Mucous membranes	$580.00
Pancreas - Jejunostomy	$990.00
Pancreas - Pancreatectomy	$2,310.00
Pancrease - Whipple procedure	$3,960.00
Penis - amputation, complete	$770.00
Penis - amputation, partial	$380.00
Penis - amputation, radical	$990.00
Prostate - (TUR) transurethral resection prostate	$580.00
Prostate - Cystoscopy	$150.00
Prostate - Radical Prostatectomy	$1,540.00
Radium Implants - Insertion	$1,100.00
Radium Implants - Removal	$550.00
Salivary glands - Parotidectomy	$770.00
Salivary glands - Radical neck dissection	$1,980.00
Spine - Cordotomy	$580.00
Spine - Laminectomy	$990.00
Stomach - Gastrectomy (complete)	$1,540.00
Stomach - Gastrectomy (partial)	$990.00
Stomach - Gastrojejunostomy	$990.00
Stomach - Gastroscopy	$330.00
Testis - Orchiectomy (bilateral)	$530.00
Testis - Orchiectomy (unilateral)	$380.00
Throat - Laryngectomy (w/out neck dissection)	$990.00
Throat - Laryngectomy (with neck dissection)	$1,980.00
Throat - Laryngoscopy	$330.00
Throat - Tracheostomy	$330.00
Thyroid - Thyroidectomy (partial: one lobe)	$580.00
Thyroid - Thyroidectomy (total: both lobes)	$770.00
Vulva - Vulvectomy (partial)	$580.00
Vulva - Vulvectomy (radical)	$1,540.00
Transportation/Companion Transportation:	$0.50 per mile. Limited to $1,500 per round trip.

GP-1-SI P130.3343

Options A and B

Changes in Insurance Amounts

Any increase or decrease in the amount of insurance on any individual shall become effective on the effective date of a change in the Employee's classification, except that any increase in the amount of insurance on an Employee or a Qualified Dependent eligible for benefits under an established benefit period shall become effective:

- in the case of an Employee not actively at work, on the day on which he returns to active work on a full-time basis (or the day on which his benefit period terminates, whichever is later) or
- in the case of an Eligible Dependent confined to a hospital, on the day on which the dependent is discharged from the hospital (or the day on which his benefit period terminates, whichever is later).

In no event shall the insurance of an Eligible Dependent of an Employee who is not actively at work on a full-time basis be increased or decreased prior to the date such Employee returns to active work on a full-time basis.

GP-1-SI P130.9324

Options A and B

Changes in Insurance Classification

If an insured Employee's classification changes, the Employee's insurance shall be adjusted automatically to conform to the new classification on the first day on which he is actively at work on full-time and makes a contribution, if required, applicable to the new classification; provided that if thirty-one days elapse after a change to a classification for which a larger amount of insurance is provided, and the Employee fails to make a contribution, if required, applicable to the new classification by the first day thereafter on which he is actively at work on full-time, no increase shall be allowed as a result of such change or any subsequent change unless the Employee furnishes evidence of insurability satisfactory to the Insurance Company. However, any Employee whose benefits were previously reduced because of an age limitation will be retained at the reduced benefits.

GP-1-SI P130.9326

The monthly premium rates, in U.S. dollars, for the insurance provided under this plan are listed below.

GP-1-SI P130.9260

Options A and B — Premium Rates

Employee Cancer Insurance

GP-1-SI *P130.8722*

Option A Classes 0001 and 0002

Rate per Employee

$ 18.98

GP-1-SI P130.8735

Option B Classes 0001 and 0002

Rate per Employee

$ 31.02

GP-1-SI P130.8735

Options A and B — Premium Rates

Dependent Spouse Cancer Insurance

GP-1-SI *P130.8723*

Option A Classes 0001 and 0002

Rate per Insured Spouse

$ 20.78

GP-1-SI P130.8736

Option B Classes 0001 and 0002

Rate per Insured Spouse

$ 34.04

GP-1-SI P130.8736

Options A and B — Premium Rates

Dependent Cancer Insurance

GP-1-SI *P130.8724*

Option A Classes 0001 and 0002

Rate per Insured Child Unit

$ 2.86

GP-1-SI P130.8728

Option B Classes 0001 and 0002

Rate per Insured Child Unit

$ 4.56

GP-1-SI P130.8728

We have the right to change any premium rate(s) set forth above at the times and in the manner established by the provision of the group plan entitled "Premiums".

GP-1-SI P130.9298

Options A and B

GENERAL PROVISIONS

Definitions

As used in this policy:

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

"Plan" means this group insurance policy.

"Covered person" means an employee or dependent insured by this policy.

GP-1-R-GENPRO-90 P140.0136

Options A and B

Incontestability

This Policy shall be incontestable after two years from its policy date, except for non-payment of premiums.

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

If this policy replaces the group policy of another insurer, we may rescind this policy based on misrepresentations made in the policyholder's or a covered person's signed application for up to two years from this policy's policy date.

GP-1-R-INCY-90 P140.0150

Options A and B

Associated Companies

An associated company is a corporation or other business entity affiliated with the policyholder through common ownership of stock or assets.

If the policyholder asks us in writing to include an associated company under this policy, and we give our written approval, we'll treat employees of that company like the policyholder's employees. Our written approval will include the starting date of the company's coverage under this policy. But each eligible employee of that company must still meet all of the terms and conditions of this policy before he'll be insured.

The policyholder must notify us in writing when a company stops being associated with him. On the date a company stops being an associated company, this policy will end for all of that company's employees, except those employed by the policyholder or another covered associated company as eligible employees, on such date.

GP-1-R-AC-90 P140.0151

Options A and B

Premiums

Premiums due under this policy must be paid by the policyholder at an office of the Guardian or to a representative that we have authorized. The premiums must be paid as specified on the first page of this policy, unless by agreement between the policyholder and the Guardian, the interval of payment is changed. In that event, adjustment will be made to provide for payment annually, semi- annually, quarterly or monthly.

The premium due under this policy on each policy due date will be the sum of the premium charges for the insurance coverages provided under this policy. The premium charges are based upon the rates set forth in this policy's "Schedule of Insurance and Premium Rates" section.

However, we may change such rates: (a) on the first day of any policy month; (b) on any date the extent or terms of coverage for a policyholder are changed by amendment of this policy; (c) on any date our obligation under this policy with respect to a policyholder is changed because of statutory or other regulatory requirements; or (d) if this policy supplements, or coordinates with benefits provided by any other insurer, non-profit hospital or medical service plan, or health maintenance organization, on any date our obligation under this policy is changed because of a change in such other benefits.

We must give the policyholder 31 days written notice of the rate change. Such change will apply to any premium due on and after the effective date of the change stated in such notice.

Adjustment of Premiums Payable Other Than Monthly or Quarterly

Under the above provision, if a premium rate is changed after an annual or semi-annual premium became payable with respect to coverage on and after the date of such change, the premium will be adjusted by a proportionate increase or decrease for the unexpired period for which the premium became payable. If the adjustment results in a decrease, the amount of the decrease will be paid to the policyholder by us. If the adjustment results in an increase, the amount of the increase will be considered a premium due on the date of the rate change. This policy's grace period provisions will apply to any such premium due.

Grace in Payment of Premiums - Termination of Policy

A grace period of 45 days, without interest charge, will be allowed the policyholder for each premium payment except the first. If any premium is not paid before the end of the grace period, this policy automatically ends at the end of the grace period. However, if the policyholder gives us advance written notice of an earlier termination date during the grace period, this policy will end as of such earlier date.

If this policy ends during or at the end of the grace period, the policyholder will still owe us premium for all the time this policy was in force during the grace period.

This policy ends immediately on any date when an insurance coverage under this policy ends and, as a result, no benefits remain in effect under this policy.

GP-1-R-PREM-90 P140.0529

Options A and B

Term of Policy - Renewal Privilege

This policy is issued for a term of one (1) year from the policy date shown on the first page of this policy. All policy years and policy months will be calculated from the policy date. All periods of insurance hereunder will begin and end at 12:01 A.M. Standard Time at the policyholder's place of business.

If this policy provides coverage on a non-contributory basis, 100% of the employees eligible for insurance must be enrolled for coverage. If dependent coverage is provided on a non-contributory basis, all eligible dependents must be enrolled.

The policyholder may renew this policy for a further term of one (1) year, on the first and each subsequent policy anniversary. All renewals are subject to the payment of premiums then due, computed as provided in this policy's "Premiums" section.

However, we have the right to decline to renew this policy, or any coverage hereunder on any policy anniversary or premium due date, if, on that date: (a) less than 10 employees are insured under this policy; or (b) with respect to a non-contributory policy, less than 100% of those employees eligible are insured under this policy; or (c) with respect to a contributory policy, less than 75% of those employees eligible are insured under this policy.

P140.0626

If this policy provides dependents coverage, we may decline to renew such coverage on any policy anniversary or premium due date, if: (a) with respect to a non-contributory policy, less than 100% of all eligible dependents are enrolled for coverage under this policy; or (b) with respect to a contributory policy, less than 75% of those employees eligible for dependents coverage are insured as such.

The policyholder may cancel this policy at any time by giving us 31 days advance written notice. This notice must be sent to our Home Office. And the employer will owe us all unpaid premiums for the period this plan is in force.

The Contract

The entire contract between the Guardian and the policyholder consists of this policy, and the policyholder's application, a copy of which is attached hereto or endorsed hereon.

We can amend this policy at any time, without the consent of the insured employees or any other person having a beneficial interest therein, as follows:

We can amend this policy: (a) upon written request made by the policyholder and agreed to by the Guardian; (b) on any date our obligation under this policy with respect to a policyholder is changed because of statutory or other regulatory requirements; or (c) if this policy supplements, or coordinates with benefits provided by any other insurer, non-profit hospital or medical service plan, or health maintenance organization, on any date our obligation under this policy is changed because of a change in such other benefits.

If we amend the policy, except upon request made by the policyholder, we must give the policyholder written notice of such amendment.

Any amendments to this policy will be without prejudice to any claim arising prior to the date of the change.

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

All personal pronouns in the masculine gender used in this policy, will be deemed to include the feminine also, unless the context clearly indicates the contrary.

GP-1-R-TERM-90 P140.0627

Options A and B

Clerical Error - Misstatements

Neither clerical error by the policyholder, a participating employer or the Guardian in keeping any records pertaining to insurance under this policy, nor delays in making entries thereon, will invalidate insurance otherwise validly in force or continue insurance otherwise validly terminated. However, upon discovery of such error or delay, an equitable adjustment of premiums will be made.

Premium adjustments involving return of unearned premium to the policyholder will be limited to the period of 90 days preceding the date of our receipt of satisfactory evidence that such adjustments should be made.

If the age of an employee, or any other relevant facts, are found to have been misstated, and the premiums are thereby affected, an equitable adjustment of premiums will be made. If such misstatement involves whether or not an insurance risk would have been accepted by us, or the amount of insurance, the true facts will be used in determining whether insurance is in force under the terms of this policy, and in what amount.

Statements

No statement will void the insurance under this policy, or be used in defense of a claim hereunder unless: (a) in the case of the policyholder, it is contained in the application signed by him; or (b) in the case of a covered person, it is contained in a written instrument signed by him.

All statements will be deemed representations and not warranties.

GP-1-R-CE-90 P140.0309

Options A and B

Assignment

An employee's right to assign any interest under this policy is governed as follows:

- Any death benefits (including any basic term life, supplemental term life, optional term life or accidental death and dismemberment coverages) provided by this policy, may not be assigned.
- With respect to accident and health insurance, both the employee's certificate and his right to insurance benefits under this policy are not assignable. However, the employee may direct us, in writing, to pay hospital, surgical, major medical, or dental benefits to the recognized provider who provided the covered service for which benefits became payable. We may honor such request at our option. But, the employee may not assign his right to take legal action under this policy to such provider. And we assume no responsibility as to the validity or effect of any such direction.

Assignment By Policyholder

Assignment or transfer of the interest of the policyholder will not bind us without our written consent thereto.

GP-1-R-ASSIGN-90 P140.0165

Options A and B

Dividends

The portion, if any, of the divisible surplus of the Guardian allocable to this policy at each policy anniversary will be determined annually by the Board of Directors of the Guardian and will be credited to this policy as a dividend on such anniversary, provided this policy is continued in force by the payment of all premiums to such anniversary.

Any dividend under this policy will be paid to the policyholder in cash, or at the option of the policyholder it may be applied to the reduction of the premiums then due.

In the event that the employees are contributing toward the cost of the coverage under any group policy issued to the policyholder and the aggregate dividends under this policy and any other group policy or policies issued to the policyholder are in excess of the policyholder's share of the aggregate cost, such excess will be applied by the policyholder for the sole benefit of the employees.

Payment of any dividend to the policyholder will completely discharge our liability with respect to the dividend so paid.

GP-1-R-DIV-90 P140.0168

Options A and B

Employee's Certificate

We will issue to the policyholder, for delivery to each employee insured under this policy, a certificate of coverage. The certificate will state the essential features of the insurance to which the employee is entitled and to whom the benefits are payable. But the certificate does not constitute a part of this policy and will in no way modify any of the terms and conditions set forth in this policy.

In the event this policy is amended, and such amendment affects the material contained in the certificate of coverage, a rider or revised certificate reflecting such amendment will be issued to the policyholder for delivery to affected employees.

Claims of Creditors

Except when prohibited by the laws of the jurisdiction in which this policy was issued, the insurance and other benefits under this policy will be exempt from execution, garnishment, attachment, or other legal or equitable process, for the debts or liabilities of the covered persons or their beneficiaries.

Records - Information To Be Furnished.

The policyholder must keep a record of the insured employees containing, for each employee, the essential particulars of the insurance which apply to the employee. The policyholder must periodically forward to us, on our forms, such information concerning the employees in the classes eligible for insurance under this policy as may reasonably be considered to have a bearing on the administration of the insurance under this policy and on the determination of the premium rates. For benefits which are based on an employee's salary, changes in an employee's salary must promptly be reported to us. The policyholder's payroll and other such records which have a bearing on the insurance must be furnished to us at our request at any reasonable time.

GP-1-R-CERT-90 P140.0167

Options A and B

Examination and Autopsy

We have the right to have a doctor of our choice examine the person for whom a claim is being made under this policy 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.

GP-1-R-EA-90 P140.0166

Options A and B

Accident And Health Claims Provisions

An employee's right to make a claim for any accident and health benefits provided by this plan is governed as follows:

Notice: The employee 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 his name and plan number.

Proof of Loss: We'll furnish the employee 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. The employee must detail the nature and extent of the loss for which the claim is being made. He must send us written proof within 90 days of the loss.

If this plan provides weekly loss-of-time insurance, the employee 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, he must send us written proof of loss within 90 days of the date we request. For any other loss, he must send us written proof within 90 days of the loss.

Late Notice or Proof: We won't void or reduce a claim if the employee can't send us notice or proof of loss within the required time. But he 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 the employee submits periodic written proof of loss as stated above. We'll pay all other accident and health benefits to which the employee's entitled as soon as we receive written proof of loss.

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

When the employee files proof of loss, he 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 the employee that a particular provider must provide such care. And the employee may not assign his right to take legal action under this plan to such provider.

Limitation of Actions: The employee can't bring a legal action against this plan until 60 days from the date he files proof of loss. And he can't bring legal action against this plan after three years from the date he files 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 Worker's Compensation.

GP-1-R-AH-90 P140.0170

Options A and B

ELIGIBILITY FOR CANCER COVERAGE

EMPLOYEE COVERAGE

Eligible Employees

Subject to the conditions of eligibility set forth below, and to all of the other conditions of this plan, an employee is eligible if he is in an eligible class of employees and is an active full-time employee or part-time employee.

If an employee is a partner or proprietor, we will treat him like an employee if he meets this plan's conditions of eligibility.

Conditions Of Eligibility

An employee is eligible for cancer coverage if he is:

- Legally working in the United States, or working outside of the United States for a United States based employer in a country or region approved by us; and
- Regularly working at least the number of hours in the normal work week set by the employer at: (1) the employer's place of business; (2) some place where the employer's business requires the employee to travel; or (3) any other place the employee and the employer have agreed upon for the performance of occupational duties.

An employee is **not** eligible for cancer coverage if he is:

- A temporary or seasonal employee; or
- An employee for whom, pursuant to a collective bargaining agreement, the employer makes any payments to any kind of health and welfare benefit plan other than under this plan.

Enrollment Requirement: If an employee must pay all or part of the cost of coverage, we will not cover him until he enrolls and agrees to make the required payments.

GP-1-EC-90-1.0 P477.0046

Options A and B

Proof of Insurability: We require that the employee answer insurability questions with respect to the employee and his or her dependents. The answers to these questions will determine whether or not the employee and his or her dependents will be covered by this Plan.

We require that the employee answer insurability questions again to change to a richer Plan of benefits, if offered by you. The answers to these questions will determine whether or not the employee and his or her dependents will be covered for the richer benefits.

GP-1-EC-90-4.0 P477.0047

Options A and B

The Service Waiting Period: If the employee is in an eligible class, he is eligible for cancer coverage under this plan after he completes the service waiting period, if any, established by the employer.

GP-1-EC-90-4.0 P477.0048

Options A and B

Multiple Employment: If an employee works for both the employer and a covered associated company, or for more than one covered associated company, we will treat the employee as if only one firm employs him. The employee will not have multiple cancer coverages under this plan. But, if this plan uses the amount of an employee's earnings to set the rates, determine class, figure coverage amounts, or for any other reason, such earnings will be figured as the sum of earnings from all covered employers.

GP-1-EC-90-5.0 P477.0302

Options A and B

Coverage During Temporary Layoff or Leave of Absence: If an employee's active Full-Time service ends because of lay off or leave of absence approved by the employer, the employee may continue his insurance, subject to continued payment of premium, until the earlier of: (a) the end of the temporary layoff or employer approved leave of absence; and (b) 1 months following the date the temporary layoff or approved leave of absence begins. If the employee becomes disabled under this plan while coverage is being continued during a temporary layoff or leave of absence, an employee's eligibility for benefits will be governed by all the term of this Plan.

GP-1-EC-90-5.0 P477.0303

Options A and B

When Employee Coverage Starts

An employee's eligibility date is the date he has met all of the conditions of eligibility.

Whether the employee must pay all or part of the cost of coverage, he must elect to enroll and agree to make the required payments before coverage will start. If the employee does this on or before his eligibility date, his coverage is scheduled to start on his eligibility date. If the employee does this within 31 days after his eligibility date, his coverage is scheduled to start on his eligibility date. If the employee elects to enroll and agrees to make the required payments more than 31 days after his eligibility date, his coverage is scheduled to start on the date he signs the enrollment form.

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

Exception to When Employee Coverage Starts: If an employee is not capable of performing the major duties of his regular occupation for the employer on a full-time basis on the date his coverage is scheduled to start, he will be insured for cancer insurance if:

1. he was insured under the prior insurer's group or individual cancer policy at the time of the transfer;
2. he is a member of an eligible class;
3. premiums for the employee were paid up to date ;and
4. he is not receiving or eligible to receive benefits under the prior insurer's group or individual cancer policy.

Any cancer benefit payable will be the lesser of:

1. the cancer benefit payable under the Group Policy; or
2. the cancer benefit payable under the prior insurer's group cancer or individual policy had it remained in force.

The cancer benefit payable will be reduced by any amount paid by the prior insurer's group or individual cancer policy.

All other provisions under this Policy will apply under the Exception to When Employee Coverage Starts.

The employee will remain insured under this provision until the first to occur of:

1. the date he is fully capable of performing the major duties of his regular occupation for the employer on a full-time basis;
2. the date insurance terminates for one of the reasons stated in When Employee Coverage Ends;
3. the last day of a period of 12 consecutive months which begins on the Policy effective date; or
4. the last day the employee would have been covered under the prior insurer's group or individual Cancer policy, had the prior plan not terminated.

GP-1-EC-90-6.0 P477.0050

Options A and B

An Employee's Right To Continue Cancer Coverage During A Family Leave Of Absence

Important Notice: This section may not apply to the employer's plan. The employee must contact his employer to find out if he or she must allow for a family leave of absence under federal law. If he or she must allow for such leave, this section applies.

If An Employee's Coverage Would End: An employee's cancer coverage would normally end because he ceases work due to an approved leave of absence. But, he may continue his coverage if the leave has been granted to: (1) allow him to care for a seriously injured or ill spouse, child or parent; (2) after the birth or adoption of a child; (3) due to his own serious health condition; or (4) because of a Serious Injury or Illness arising out of the fact that his spouse, child, parent or next of kin who is a covered service member is on active duty, or has been notified of an impending call or order to active duty, in the armed forces in support of a contingency operation. To continue employee's coverage, he will be required to pay the same share of the premium as he paid before the leave of absence.

When Continuation Ends: Continued coverage will end on the earliest of the following:

- The date the employee returns to active work.
- In the case of a leave granted to the employee to care for a covered service member, 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 the employee under this section for all reasons. If the employee takes 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 the employer's plan is terminated or he is no longer eligible for coverage under this Plan.
- The end of the period for which 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: (1) 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 (2) results in the call or order to, or retention on, active duty of members of the uniformed services under any provision of law or during a national emergency declared by the President or Congress.
- **Covered Service member:** 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 is: (1) undergoing medical treatment, recuperation or therapy; (2) otherwise in Outpatient Status; or (3) otherwise on the temporary disability retired list.
- **Next Of Kin:** This term means the employee's nearest blood relative.
- **Outpatient Status:** This term means, in the case of a Covered Service Member, that he or she is assigned to: (1) a military medical treatment facility as an outpatient; or (2) 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 Service Member, 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: (1) office; (2) grade; (3) rank; or (4) rating.

GP-1-EC-90-7.0 P477.0052

Options A and B

When Employee Coverage Ends

The employee's coverage will end on the first of the following dates:

- The last day of the month in which his active service ends for any reason. Active service ends when the employee no longer: (1) is actively at work; and (2) working his regular number of hours.
- The date he stops being an eligible employee under this plan.
- The date he no longer is working in the United States or working outside of the United States for a United States based Employer in a country or region approved by us.
- The date this group Plan ends, or is discontinued for a class of employees to which he belongs.
- The last day of the period for which required payments are made for the employees.

GP-1-EC-90-8.0 P477.0054

Options A and B

Definitions

GP-1-EC-90-DEF-1 P473.0014

Options A and B

Employee: This term means a person who works for you at your place of business, and whose income is reported for tax purposes using a W-2 form.

GP-1-EC-90-DEF-3 P473.0015

Classes 0001 and 0002

Full-time: This term means the employee regularly works at least the number of hours in the normal work week set by you, but not less than 20 hours per week.

GP-1-EC-90-DEF-4 P473.0017

Options A and B

Plan: This term means the Guardian group Cancer Insurance plan purchased by you.

GP-1-EC-90-DEF-6 P477.0055

Options A and B

Proof or Proof of Insurability: This term means an application for insurance showing that a person is insurable.

GP-1-EC-90-DEF-7 P473.0023

Options A and B

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

GP-1-EC-90-DEF-9 P473.0024

Options A and B

You and **Your:** These terms mean the employer who purchased this Cancer Insurance plan.

GP-1-EC-90-DEF-10 P477.0056

Options A and B

DEPENDENT COVERAGE

GP-1-DEP-90-1.0 P473.0027

All Options

Eligible Dependents For Dependent Cancer Coverage

An employee's eligible dependents are: (1) his legal spouse; (2) dependent children from birth until they reach age 26.

GP-1-DEP-90-2.0 P477.0065-R

All Options

Adopted Children And Step-Children

An employee's "dependent children" include his legally adopted children and his step-children. But, step-children must depend on the employee for most of their support and maintenance. We treat a child as legally adopted from the time the child is placed in the employee's home for the purpose of adoption. We treat such a child this way whether or not a final adoption order is ever issued.

Dependents Not Eligible

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

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

GP-1-DEP-90-3.1 P477.0066-R

Options A and B

Handicapped Children

An employee may have an unmarried child who is: (a) incapable of self-sustaining employment by reason of a mental or physical handicap or developmental disability; and (b) chiefly dependent upon the employee for support and maintenance. In that case such a child may remain eligible for dependent benefits past the age limit subject to the conditions shown below.

- His or her condition started before he or she reached the age limit.
- He or she became covered for dependent cancer benefits before he or she reached the age limit, and remained continuously covered until he or she reached the age limit.
- He or she stays unmarried and remains: (i) incapable of self-sustaining employment; and (ii) dependent upon the employee for most of his or her support and maintenance.
- The employee must send us written proof, and we approve such proof, of the child's disability and dependence within 31 days from the date he or she reaches the age limit. After the two year period following the child's attainment of the age limit, we can ask for periodic proof that the child's condition continues, but we cannot ask for this proof more than once a year.

The child's coverage ends when the employee's coverage ends.

GP-1-DEP-90-4.0 P477.0068

Options A and B

Proof Of Insurability

We require that the employee answer insurability questions with respect to his or her dependents. The answers to these questions will determine whether or not the employee's dependents will be covered by this Plan.

GP-1-EC-90-6.0 P477.0069

Options A and B

When Dependent Coverage Starts

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

Subject to the Exception below and to all of the other terms of this plan, the date dependent coverage starts depends on when the employee elects to enroll his initial dependents and agrees to make any required payments.

If an employee does this on or before his eligibility date, the dependent's coverage is scheduled to start on the later of the 1st day of the month which coincides with or next follows his eligibility date and the date the employee becomes covered for employee coverage.

If the employee does this after his eligibility date, the coverage is scheduled to start on the later of the 1st day of the month which coincides with or next follows the date he signs the enrollment form and the date he becomes covered for employee coverage.

Once an employee has dependent child coverage for his initial dependent child(ren) any newly acquired dependent children will be covered as of the date he or she is first eligible.

GP-1-DEP-90-6.0 P477.0070

Options A and B

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

GP-1-DEP-90-7.0 P477.0072

All Options

When Dependent Coverage Ends

Dependent coverage ends for all of an employee's dependents when his employee coverage ends. Dependent coverage also ends for all of an employee's dependents when he stops 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 his class.

If the employee is required to pay all or part of the cost of dependent coverage, and fails to do so, his dependent coverage ends. It ends on the last day of the period for which he made the required payments, unless coverage ends earlier for other reasons.

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

GP-1-DEP-90-9.0 P477.0581-R

Options A and B

Definitions

GP-1-DEP-90-DEF-1 P473.0036

Options A and B

Eligibility Date: For dependent coverage, this term means the earliest date on which: (a) the employee has eligible dependents; and (b) is eligible for dependent coverage.

GP-1-DEP-90-DEF-2 P473.0037

Options A and B

Eligible Dependent: This term is defined in the "Eligible Dependents For Cancer Coverage" section.

GP-1-DEP-90-DEF-3 P477.0089

Options A and B

Enrollment Period: This term means the 31 day period which starts on the date that the employee is eligible for dependent coverage.

GP-1-DEP-90-DEF-4 P473.0040

Options A and B

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

GP-1-DEP-90-DEF-5 P473.0041

Options A and B

Initial Dependents: This term means those eligible dependents the employee has at the time he or she first becomes eligible for employee coverage. He or she may not have any dependents at this time. If he or she later acquires them, the first eligible dependents he or she acquires are his or her initial dependents.

GP-1-DEP-90-DEF-8 P473.0042

Options A and B

Newly Acquired Dependent: This term means an eligible dependent the employee acquires after he or she already has coverage in force for initial dependents.

GP-1-DEP-90-DEF-9 P473.0043

Options A and B

Plan means the Guardian group Cancer Coverage plan purchased by you.

GP-1-DEP-90-DEF-11 P477.0094

Options A and B

Proof or **Proof Of Insurability:** This term means an application for insurance which shows that a person is insurable.

GP-1-DEP-90-DEF-12 P473.0046

Options A and B

CANCER COVERAGE

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

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

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

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

GP-1-CAN-IC-12 P477.0002

Option A

Benefits

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

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

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

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

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

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

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

Cancer Screening: Once per *benefit year, we* will pay the amount in the schedule of insurance if *you* provide *proof* satisfactory to *us* that a *covered person* received at least one of the following tests for *internal cancer* : (1) bone marrow testing; (2) BRCA testing; (3) breast ultrasound; (4) breast MRI; (5) colonoscopy or virtual

colonoscopy; (6) CA 125 test (blood test for ovarian *cancer*); (7) CA 15-3 test (blood test for breast *cancer*); (8) CEA (blood test for colon *cancer*) (9) chest x-ray; (10) CT scans or MRI scans; (11) flexible sigmoidoscopy; (12) hemocult stool specimen (lab confirmed); (13) mammogram; (14) pap smear; (15) PSA (blood test for prostate *cancer*); (16) Serum Protein Electrophoresis (test for myeloma); (17) testicular ultrasound; (18) thermography; or (19) ThinPrep.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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Option B

Benefits

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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Option A

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

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

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

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

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

Outpatient and Family Member Lodging: We pay the amount in the schedule of insurance per day for lodging as described below. We limit what we pay for lodging to the number of days shown in the schedule of insurance.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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Option B

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

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

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

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

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

Outpatient and Family Member Lodging: We pay the amount in the schedule of insurance per day for lodging as described below. We limit what we pay for lodging to the number of days shown in the schedule of insurance.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Option A

DEFINITIONS

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

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

- have a medical staff of *doctors,* nurses, and licensed anesthesiologist;
- maintain at least two operating rooms; and one recovery room;
- maintain diagnostic lab and x-ray facilities;
- be staffed and equipped to give emergency care;
- have a blood supply;
- maintain medical records;
- have agreements with *hospitals* for immediate acceptance of patients who need *inpatient* confinement; and
- be licensed in accord with the laws of the appropriate legally authorized agency.

A facility is not an *ambulatory surgical center* if it is part of a *hospital.*

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

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

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

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

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

Covered Person: This term means an *employee* or dependent insured by this *plan.*

Diagnosed or **Diagnosis:** These terms mean the establishment of *cancer* by a *doctor* through the use of clinical and/or lab findings.

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

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

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

Family Member: This term means *you* are a *covered person's* spouse, brother or sister (including stepbrother or stepsister), children (including stepchildren), parents (including stepparents), grandchildren, father or mother-in- law, and spouses, if applicable, of any of these.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

GP-1-CAN-DEF-12 P477.0100

Option B

DEFINITIONS

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

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

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

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

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

- have a medical staff of *doctors,* nurses, and licensed anesthesiologist;
- maintain at least two operating rooms; and one recovery room;
- maintain diagnostic lab and x-ray facilities;
- be staffed and equipped to give emergency care;
- have a blood supply;
- maintain medical records;
- have agreements with *hospitals* for immediate acceptance of patients who need *inpatient* confinement; and
- be licensed in accord with the laws of the appropriate legally authorized agency.

A facility is not an *ambulatory surgical center* if it is part of a *hospital.*

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

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

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

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

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

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

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

Covered Person: This term means an *employee* or dependent insured by this *plan.*

Diagnosed or **Diagnosis:** These terms mean the establishment of *cancer* by a *doctor* through the use of clinical and/or lab findings.

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

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

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

Family Member: This term means *you* are a *covered person's* spouse, brother or sister (including stepbrother or stepsister), children (including stepchildren), parents (including stepparents), grandchildren, father or mother-in- law, and spouses, if applicable, of any of these.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Options A and B

LIMITATIONS

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

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

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

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

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

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

GP-1-CAN-LIMT-12 P477.0116

Options A and B

EXCLUSIONS

This *plan* will not pay benefits for:

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

GP-1-CAN-EXC-12 P477.0030

Options A and B

Waiver of Premium

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

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

GP-1-CAN-WP-12 P477.0031

Options A and B

PORTABILITY PRIVILEGE

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

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

- The *employee* may port his or her coverage or coverage for any of *his or her* dependents if coverage under this *plan* ends because he or she: (a) has terminated employment; (2) stops being a member of an eligible class of *employees;* or (3) this *plan* ends.
- The employee may not Port his or her coverage or coverage for any of *his or her* dependents if (1) coverage under this *plan* ends due to his or her failure to pay any required premium; or (2) he or she has reached age 70 on or before *his or her* coverage under this *plan* ends.

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

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

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

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

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

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

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

GP-1-CAN-PORT-12 P477.0034

Options A and B

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

POLICY AMENDMENT

ELIGIBILITY FOR CANCER COVERAGE

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

Conditions of Eligibility

Proof of Insurability

Part or all the employee's insurance amounts may be subject to Proof of Insurability. The employee and dependents will not be covered for any amount that requires such Proof of Insurability until the employee gives the Proof of Insurability to us and we approve that Proof of Insurability in writing.

If the employee elects to enroll within 31 days after his or her eligibility date, coverage is scheduled to start on his or her eligibility date.

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

If Proof of Insurability is required, the employee and dependents will not be covered by this Plan until we approve that Proof of Insurability in writing and notify the employee of the effective date of coverage.

When Employee Coverage Starts

The employee's eligibility date is the date he or she has met all of the conditions of eligibility.

Whether the employee must pay all or part of the cost of the coverage, he or she must elect to enroll and agree to make the required payments before his or her coverage will start. If the employee does this on or before his or her eligibility date, his or her coverage is scheduled to start on his or her eligibility date. If the employee does this within 31 days after his or her eligibility date, his or her coverage is scheduled to start on the eligibility date. If the employee elects to enroll and agrees to make the required payments more than 31 days after his or her eligibility date, his or her coverage will not be scheduled to start until he or she sends us Proof of Insurability or until he or she enrolls during the next group enrollment period. If Proof of Insurability is required, the employee will not be covered by this Plan until we approve that Proof of Insurability in writing and notify the employee of his or her effective date of coverage.

If the employee's active service ends before he or she meets any Proof of Insurability requirements that apply, he or she will still have to meet those requirements if he or she is later re-employed by the employer or an associated company.

On the date all or part of the employee's coverage is scheduled to start, he or she must be: (1) actively at work; (2) fully capable of performing the major duties of his or her regular occupation; and (3) working his or her regular number of hours. In that case, the employee's coverage will start at 12:01 A.M. Standard Time for his or her place of residence on that date. In any other case, we will postpone the start of the employee's coverage until the date he or she: (a) returns to active work; (b) is working his or her regular number of hours; and (c) is fully capable of performing the major duties of his or her regular occupation. Sometimes, a

scheduled effective date is not a regularly scheduled work day. If the scheduled effective date falls: on a holiday; on a vacation day; on a non-scheduled work day; during a layoff of less than 180 days in duration; during an approved leave of absence not due to sickness or injury, of 90 days or less; or on a day during a period of absence that is less than 7 days in duration; and if: (a) the employee was fully capable of performing the major duties of his or her regular occupation for the employer on a full-time basis at 12:01 AM Standard Time for his or her place of residence on the scheduled effective date; and (b) he or she was performing the major duties of his or her regular occupation and working his or her regular number of hours on his or her last regularly scheduled work day; his or her coverage will start on the scheduled effective date.

DEPENDENT COVERAGE

Proof of Insurability

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

If the employee elects to enroll his or her initial dependents within 31 days after his or her eligibility date, coverage is scheduled to start on his or her eligibility date.

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

If Proof of Insurability is required, the employee's initial dependents will not be covered by this Plan until we approve that Proof of Insurability in writing and notify the employee of his or her initial dependents effective date of coverage.

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

If the employee's dependent coverage ends for any reason, including failure to make the required payments, the employee's dependent(s) will not be covered by this Plan again until he or she gives us new Proof of Insurability that they are insurable and we approve that Proof of Insurability in writing, or wait until the next group enrollment period.

When Dependent Coverage Starts

In order for the employee's dependent coverage to start, he or she must already be covered for employee coverage, or enroll for employee and dependent coverage at the same time.

If the employee enrolls his or her dependent(s) on or before his or her eligibility date, the dependent's coverage is scheduled to start on the later of the employee's eligibility date and the date he or she becomes covered for employee coverage.

If the employee does this within the group enrollment period, the coverage is scheduled to start on the date he or she becomes covered for employee coverage.
If the employee does this after the group enrollment period ends, his or her dependent coverage may be subject to Proof of Insurability and will not start until we approve that Proof of Insurability in writing.

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

Whether the employee must pay all or part of the cost this coverage, he or she must elect to enroll and agree to make the required payments before his or her coverage will start. If the employee does this on or before his or her eligibility date, his or her coverage is scheduled to start on his or her eligibility date. If the employee

does this within 31 days after his or her eligibility date, his or her coverage is scheduled to start on the eligibility date. If the employee elects to enroll and agree to make the required payments more than 31 days after his or her eligibility date, his or her coverage will not be scheduled to start until he or she sends us Proof of Insurability or until he or she enrolls during the next group enrollment period. If Proof of Insurability is required, the employee will not be covered by this Plan until we approve that Proof of Insurability in writing and notify the employee of his or her effective date of coverage.

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

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

The Guardian Life Insurance Company of America

Michael Prestileo, Senior Vice President

P477.0431

GUR-1

Option A

ATTACHED TO AND MADE PART OF GROUP INSURANCE POLICY NO. G -00026998-
issued by

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

to

DOUGHERTY COUNTY SCHOOL SYSTEM
(herein called the Policyholder)

Effective on the later of (i) the original effective date of Cancer Insurance; or (ii) the effective date of any applicable amendment requested by the Policyholder and approved by the Insurance Company, this rider amends this plan by the addition of the following:

Initial Diagnosis Benefit

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

The benefit is $2,500.00 for *employees,* $2,500.00 for spouse and $2,500.00 for child.

We pay this benefit once per *covered person in a covered person's* lifetime.

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

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

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

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

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

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

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

As used in this rider, carcinomas in-situ means *cancer* that is confined to the site of origin, without having invaded neighboring tissue. This rider is part of this plan. Except as stated in this rider, nothing contained in this rider changes or affects any other terms of this *plan.*

Dated at ______________________ This ______________________ Day of ______________________ , _____

DOUGHERTY COUNTY SCHOOL SYSTEM
Full or Corporate Name of Policyholder

____ BY: ____

Witness Signature and Title

The Guardian Life Insurance Company of America

Michael Prestileo, Senior Vice President

GP-1-A-CAN-IDB-12 P477.0036

Option B

ATTACHED TO AND MADE PART OF GROUP INSURANCE POLICY NO. G -00026998-
issued by

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

to

DOUGHERTY COUNTY SCHOOL SYSTEM
(herein called the Policyholder)

Effective on the later of (i) the original effective date of Cancer Insurance; or (ii) the effective date of any applicable amendment requested by the Policyholder and approved by the Insurance Company, this rider amends this plan by the addition of the following:

Initial Diagnosis Benefit

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

The benefit is $5,000.00 for *employees,* $5,000.00 for spouse and $5,000.00 for child.

We pay this benefit once per *covered person in a covered person's* lifetime.

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

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

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

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

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

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

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

As used in this rider, carcinomas in-situ means *cancer* that is confined to the site of origin, without having invaded neighboring tissue. This rider is part of this plan. Except as stated in this rider, nothing contained in this rider changes or affects any other terms of this *plan.*

Dated at ______________________ This ______________________ Day of ______________________ , _____

DOUGHERTY COUNTY SCHOOL SYSTEM
Full or Corporate Name of Policyholder

______________________________________ BY: ______________________________________
Witness Signature and Title

The Guardian Life Insurance Company of America

Michael Prestileo, Senior Vice President

GP-1-A-CAN-IDB-12 P477.0036

Options A and B

ATTACHED TO AND MADE PART OF GROUP INSURANCE POLICY NO. G -00026998-

issued by

THE GUARDIAN LIFE INSURANCE COMPANY OF AMERICA

to

DOUGHERTY COUNTY SCHOOL SYSTEM

(herein called the Policyholder)

Effective the later of (i) the original effective date of the Policy, or (ii) the effective date of any applicable amendment requested by the Policyholder and approved by the Insurance Company, this rider amends the Plan by the addition of the following:

BENEFIT ADMINISTRATION PROGRAMS

Your Cancer coverage includes access to certain services, which will expedite and streamline the administration process.

Such services include, but are not limited to, quoting of Guardian products, implementation of group insurance plans, communications and education, enrollment, collection and transmission of enrollment/eligibility data, billing, premium collection, payroll services, and plan administration services. These additional services are not provided by Guardian. Guardian assumes no liability for the services provided under these programs, nor for the amounts charged by the companies providing such services.

Charges for the services will be 3% of the Policy's annual premium.

Payment of the services will be issued to the service provider.

Services are provided on a month to month basis while coverage remains in effect, subject to Guardian's terms and conditions. Guardian may terminate any such vendor at any time and will provide 30 days prior written notice of any vendor termination.

When this plan ends, access to the services ends.

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

Dated at ____________________ This ____________________ Day of ____________________ , _____

DOUGHERTY COUNTY SCHOOL SYSTEM
Full or Corporate Name of Policyholder

______________________________ BY: ______________________________
Witness Signature and Title

The Guardian Life Insurance Company of America

Michael Prestileo, Senior Vice President

GP-1-A-BAP-18 P531.0571

Options A and B

ATTACHED TO AND MADE PART OF GROUP INSURANCE POLICY NO. G -00026998-

issued by

THE GUARDIAN LIFE INSURANCE COMPANY OF AMERICA

(herein called Guardian)

to

DOUGHERTY COUNTY SCHOOL SYSTEM

(herein called the Policyholder)

This Rider amends the Policy as follows and is effective on its issue date:

- The "Non-Participating - No Dividends Payable" notice on the Policy face page is replaced with "Dividends Apportioned Annually, if Payable".
- The Dividends provision is added or replaced in its entirety within the General Provisions as shown below.

Dividends

The portion, if any, of the divisible surplus of Guardian allocable to this Policy at each Policy Anniversary will be determined annually by the Board of Directors of Guardian and will be credited to this Policy as a dividend on such anniversary, provided this Policy is continued in force by the payment of all premiums to such anniversary.

Any dividend under this Policy will be paid to the Policyholder in cash, or at the option of the Policyholder it may be applied to the reduction of the premiums then due.

In the event that the Employees are contributing toward the cost of the coverage under any group policy issued to the Policyholder and the aggregate dividends under this Policy and any other group policy or policies issued to the Policyholder are in excess of the Policyholder's share of the aggregate cost, such excess will be applied by the Policyholder for the sole benefit of the Employees.

Finally, please note that it is not expected that any dividends will be payable under this Policy.

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

Dated at Bethlehem, PA This 3rd Day of November , 2023

Harris Oliner, Senior Vice President, Corporate Secretary

Michael Prestileo, Senior Vice President

P070.0043

GP-1-A-DIV-19

*   *   *   *   *

The foregoing amendment shall form a part of said Group Policy, provided both the Policyholder and the Insurance Company have hereto applied their respective signatures, and is subject to the agreements and covenants therein contained.

Dated at Bethlehem, PA This 3rd Day of November , 2023

DOUGHERTY COUNTY SCHOOL SYSTEM
Full or Corporate Name of Policyholder

____________________ BY: ____________________

Witness   Signature and Title

The Guardian Life Insurance Company of America

Michael Prestileo, Senior Vice President

PLEASE RETAIN THIS COPY FOR YOUR RECORDS

GUR-1   P600.9002

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

Group critical illness insurance policy

Welcome to Guardian!

Thank you for choosing Guardian for your critical illness insurance needs. We're very pleased to be able to offer this coverage to your members.

This is the group policy

We have issued this policy based upon your application and payment of the required premiums. This policy is part of your Critical Illness Plan and contains details about our agreement to provide your members with insurance coverage.

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

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

Planholder: DOUGHERTY COUNTY SCHOOL SYSTEM

Plan Number: 00026998

Effective Date: January 1, 2022

Delivered In: Georgia

Signed for Guardian by:

Michael Prestileo, Senior Vice President

Harris Oliner, Senior Vice President and Corporate Secretary

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

Dividends apportioned annually, if payable

P082.0003

CI-23-P-GA

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Options C and D

What makes up your Critical Illness Plan

Your Plan is a legal contract between you and us. It explains what we've agreed to do. It also explains what you've agreed to do.

Your Plan consists of the following:

- This group insurance policy
- The Member Guide
- The Covered Illnesses Guide
- Your application for group insurance
- The Schedule of Premium Rates

Your Plan may also include the following items:

- Any enrollment forms or proof of insurability provided by your members and their families - this refers to any personal or health-related information we need to assess whether we'll offer them coverage
- Optional benefit riders attached to the Member Guide
- Other riders or amendments that modify this policy or the Member Guide

P082.0004

Options C and D

Policy basics

When we mention "you" and "your" in this policy, we're referring to you, the Planholder listed on the first page. Where we say "we" and "us", we're referring to The Guardian Life Insurance Company of America. We usually refer to ourselves simply as Guardian.

Member refers to a person who works for you and whose income is reported to the Internal Revenue Service or a state for tax purposes.

Only members that meet the eligibility requirements described in the Member Guide and who belong to a class listed in the **Classes of members** section can be covered under this policy.

You may call members of your organization employees, associates, team members, subscribers, participants, retirees or some other similar name. We refer to them as "members" in this policy.

The eligibility rules for family members are also explained in the Member Guide.

P082.0006

Options C and D

How this policy is organized

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

- **Things you must do**
  We'll start by explaining what you must do to get your members covered. These items are essential to securing coverage and keeping it in place.

- **Things you can do**
  This section will explain what you may choose to do.

- **Things we must do**
  Here, we'll explain what we've agreed to do.

- **Things we can do**
  This is where we'll explain what we may elect to do.

- **Your coverage selections**
  This lists the classes eligible for coverage and their benefit options.

When this coverage starts

This policy starts at 12:01 AM Eastern Standard Time on the effective date listed on the first page.

When this coverage ends

This policy has been issued for a term of one year. It will automatically renew for another year at the end of every 12-month period unless we cancel it, or you cancel it. If the policy is cancelled, it will end at 11:59 PM Eastern Standard Time on the day before the cancellation takes effect.

If this policy is translated into another language

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

P082.0008

Things you must do

Give us complete and accurate information

You must provide complete and accurate information when applying for this policy. If you give us incomplete, inaccurate, or false information, we could challenge a claim. We can also challenge whether this policy is valid. Our rights are more fully explained under the **Deny a claim or rescind this policy** section.

Members may also need to give us information when enrolling for coverage. This information also needs to be complete and accurate. See the **Be sure to give us complete and accurate information** section of the Member Guide for more information.

Determine if your Members are eligible

The Member Guide explains the requirements your members must meet to be eligible to enroll for coverage under this policy. You're responsible for determining that each member enrolling for this coverage meets these requirements. You're also responsible for determining that each member continues to meet these requirements after enrollment. See the **Member coverage** section of the Member Guide for more information.

For coverage or benefit amounts requiring members submit information about their health, the members must do so as explained by the **Information about your health** section of the Member Guide. Coverage or benefit amounts requiring members submit information about their health won't take effect until we've received the required information and approved it in writing. Our acceptance of any premium doesn't eliminate or waive these requirements. See the **Information about your health** section of the Member Guide for more information.

Keep us up to date

You'll have to periodically provide us with information we need to calculate premiums and meet our commitments under this policy. This may include information regarding:

- Current members and any eligible family members
- Benefit amounts
- Salary, earnings, and occupation
- Coverage terminations
- The country members and their family members are living and working in
- Other information needed to manage a claim

This information must be complete and accurate, and you must provide it on a timely basis. If we find it necessary, you'll have to make payroll, and any other records that have an impact on this policy, available for our review.

You must notify us within 31 days of the date a member's or a family member's eligibility for coverage under this policy ends.

You must also notify us before a member or a family member relocates to a country not previously approved by us. We'll let you know whether we can provide coverage under this policy while the person is living or working in that country.

Your members and their family members may also have to provide proof of insurability. This means they may have to provide information about their health before their coverage can start.

Electronic consent, data security and privacy

You must have the necessary authority and members' consent to electronically transmit information regarding them. You must use methods we've approved and agreed upon for sending and receiving this information.

We're directly responsible for electronic member data that's stored or processed in Guardian systems or the systems of Guardian's service providers. We aren't responsible for the security of any electronic member data that we haven't received and that isn't in our possession.

You're directly responsible for the member data that's stored in your systems or the systems of your service providers.

Keep your members up to date

You must provide your members with their Member Guide.

There may be times we provide you with information that's required by a state or the federal government. If this information must be given to your members, you must deliver it to them.

P082.0009

Options C and D

Pay the premiums

How much

The premiums required for this policy are listed in the attached Schedule of Premium Rates. The premiums shown may change at any time, with advance notice. This is explained in the **Change the premiums** section.

When

You must pay the first premium by the date we agree upon. This date will be no more than 31 days after the effective date listed on the first page.

All other premium payments must be received by the 1st day of each month.

How to pay

We accept various payment methods. We'll agree upon how you'll pay ongoing premiums before the first premium is due. Contact us if you'd like to change the method you use to pay the premiums.

You should also contact us if you'd like to change how often you pay the premiums. A change in how often you pay the premiums will affect the total annual cost. For example, the total yearly cost of paying monthly premiums is more than paying one annual premium.

P082.0013

Options C and D

Meet the participation requirements

You must meet the following minimum participation requirements. If you don't, we can cancel this policy or change the premiums. See the **Things we can do** section for more details.

- At least 15% of the members eligible for this coverage must be enrolled for this coverage.
- You must have at least 15% members to meet our minimum group size requirements.
- You must have the minimum number of members required by the state to be considered an eligible group.
- The member pays most or all the cost of voluntary coverage.

See the **Member coverage** section of the Member Guide for an explanation of who's eligible. See the **Family coverage** section of the Member Guide for an explanation of which family members are eligible.

P082.0016

Things you can do

Choose electronic delivery of documents

You can elect to receive this policy, including the Member Guide, in electronic format. If you choose to receive your documents electronically, you'll still be able to request paper documents at any time.

Add new people to this policy

You can add members and family members to this policy. The members must belong to a class listed in the **Classes of members** section of this policy.

The members and family members must also meet the eligibility rules explained in the Member Guide.

Adding a new class of members will require our approval.

Add new companies to this policy

If you'd like to add an associated company to this policy, you must send us a written request. You must own at least 50% of the associated company.

If we agree to add the associated company, we'll give you the necessary details, including the cost and the date the coverage starts. We'll confirm our approval of the change in writing.

The eligibility rules that apply to members of an associated company are explained in the Member Guide.

You must notify us in writing when a company is no longer an associated company. Coverage for the members of the associated company will end at 11:59 PM Eastern Standard Time on the last day the company is considered associated.

Keep coverage for an inactive member

You may continue coverage for a member whose active work ends in accordance with the **Keeping your coverage when you aren't working** section of the Member Guide. Active work ends when the member is no longer performing all the regular duties of the job for the number of hours required.

Request that we can change this policy

You can ask us to consider changing the terms of this policy at any time by submitting a written request. If we agree to making the changes you request, they'll become effective on a date we agree upon.

Since this policy is an agreement between you and us, changes can be made without the consent of your members or their family members.

Changes you request we make to this policy won't impact any claims that arise prior to the date the changes become effective. This means claims will be handled according to the policy provisions in place at the time the claim event occurs.

Who can and can't change this policy

Only the President, a Senior Vice President, or a Secretary of Guardian has the authority to:

- Waive or modify any policy provisions
- Commit us to any statement or promise relating to this policy
- Accept any information or representation that isn't in a signed application

Agents and brokers don't have the authority to change this policy or waive any of its provisions. They also can't determine whether any policy or Member Guide will be issued.

Cancel this policy

You can cancel this policy at any time by sending us a written request. You must submit this request at least 31 days in advance of the date you'd like the cancellation to take effect.

You'll be responsible for the payment of premiums for any time this policy was in place. We'll refund any premiums paid for the period after the cancellation takes effect.

Request that we reinstate this policy

If this policy ends because you didn't pay the premium on time, you can request we resume your coverage. You must send in the overdue premium within 30 days of the date it was due.

Reinstatement of this policy is subject to our review and isn't guaranteed. We may require that you complete an application before we can consider reinstating the policy. If we require an application, we'll send it to you within 30 days of our receiving the overdue premium.

If we don't send you an application within 30 days of receiving the overdue premium, the policy will be reinstated.

P082.0020

Options C and D

Things we must do

Provide the benefits that we agreed upon

We'll provide insurance coverage to the members and their family members who are eligible, enrolled for coverage and whose premiums have been paid.

The Member Guide explains the details of the members' coverage. This includes:

- When coverage starts
- When coverage ends
- The benefits that are available
- When benefits are payable

Allow a grace period if you're late paying the premium

If you don't pay the premiums on time, we'll give you an extra 45 days to pay us. This is called the grace period. Here's what you need to know about the grace period:

- It can be used for any payment after the first premium has been paid.
- This policy will remain in place during the grace period.
- There will be no interest charged for premiums that are paid during the grace period.
- If you don't pay the premium by the end of the grace period, this policy will end at 11:59 PM Eastern Standard Time on the date the premium was due.
- If you cancel this policy and give us at least 45 days advance written notice, it will end on the date requested, even if it falls within the grace period. See the **Cancel this policy** section for more information.
- You'll be responsible for paying the premiums for any time the policy was in place.

Return unused premium

If you or we cancel this policy, we'll refund any premiums already paid for the period after the cancellation takes effect. If a person insured by this policy dies, we'll return the premium paid for the period after the person's death.

We can issue a refund of the unused premium or apply it as a credit to your next premium payment.

Comply with the law

If any provision in this policy doesn't comply with a state or federal law or regulation, the provision is automatically changed to comply with the requirements of that law or regulation. We may amend this policy to reflect this change.

P082.0022

Things we can do

Deny a claim or rescind this policy

In the **Things you must do** section, we explained that you must give us complete and accurate information when applying for this policy. If you didn't, we have the right to challenge a claim for benefits. This means we can deny a claim that might otherwise be covered.

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

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

- Not issue any policy
- Issue a policy with different coverage or benefit amounts
- Issue a policy with different premium amounts

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

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

If we do rescind the policy or challenge a claim due to missing or inaccurate material information on an application, we'll provide a copy of that application to you.

Review your application for completeness and accuracy. If you find anything is missing or inaccurate, you must immediately notify us in writing at the address listed on the first page of this policy.

Correct minor mistakes

Clerical error

If you notice a mistake in the information you provided, you should notify us immediately. If the error doesn't impact whether this policy is valid, as explained in the **Deny a claim or rescind this policy** section above, we'll update our records accordingly.

If we make a mistake, let us know and we'll correct it as quickly as possible.

If the error results in an underpayment of premium, we'll require the underpaid amount be paid.

If the correction of the error results in us having to return premium, we may require proof that the correction is appropriate. The refund will be limited to the period that begins 90 days prior to the date we receive the proof.

Our mistake won't serve to your disadvantage. Our mistake won't serve to your benefit either. For example, our clerical error won't allow you to keep this policy in place if it was otherwise validly terminated.

Misstatement of age

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

We'll have to cancel the person's coverage if they wouldn't have been eligible for coverage because of their true age. See the **Misstatement of age** section of the Member Guide for more information.

P082.0161

Change the premiums

We can change this policy's premium on the first day of any month.

We'll give you 31 days written notice of any change in premiums.

Rate Guarantee: Premiums won't change during the first 12 months after the effective date unless there's a change in benefits, participation levels or another factor you agreed to in determining the price of this coverage.

Change this policy

We may need to change this policy as explained in the **Comply with the law** section.

Cancel this policy

We can cancel this policy at any time if you don't meet the requirements listed under the **Things you must do** section. We'll give you 31 days written notice if we decide to cancel this policy. We'll refund any premiums paid for the period after the cancellation takes effect.

Pay a third-party administrator

To enhance your administrative experience, you may elect to have a third party of your choice provide administrative services related to this Plan. These services may include integrated enrollment services, maintaining and sending eligibility files, and other administrative items that streamline the process and enhance your experience and the experience of your members.

The third-party administrator must be appropriately licensed and meet the applicable state requirements to perform these administrative services.

If you decide to engage a third party for this purpose, your premium will include the amount needed to cover the cost of these administrative services. Upon the annual renewal of this policy, if we choose not to work with the third party you selected for the upcoming year, we'll advise you accordingly. Any premium adjustment needed will be made at that time. See the **Change the premiums** section for more information.

Pay a dividend

On an annual basis and at their discretion, our Board of Directors will determine whether a portion of any divisible surplus accruing on this policy will be credited to this policy as a dividend on the next policy anniversary.

To be eligible for any such dividend, this policy must remain in force and all premiums must be paid to the next policy anniversary.

Any such dividend will be paid to you in cash or, at your option, can be applied to the premium due on the next policy anniversary. If the dividend is greater than the premium you owe on the policy, any excess will be applied to reduce any premium your members must pay for the same period.

We don't expect that any dividends will be payable under this policy.

P082.0026

Your coverage selections

Classes of members

Members that belong to the following classes may be covered under this Policy.

Class Description:

Class 0001 ALL ELIGIBLE EMPLOYEES ELECTING LOW CRITICAL ILLNESS OR WAIVING CRITICAL ILLNESS

Class 0002 ALL ELIGIBLE EMPLOYEES ELECTING HIGH CRITICAL ILLNESS

P082.0027

Benefit options

Members may select benefits from the following options:

P082.0028

Members of Class 0001:
Option C - Member Critical Illness; Family Critical Illness Insurance

P082.0029

Members of Class 0002:
Option D - Member Critical Illness; Family Critical Illness Insurance

P082.0029

Group critical illness insurance schedule of premium rates

The monthly premiums for your group critical illness insurance Plan are listed below. These premiums can change at any time. We'll give you advance notice of any change in premiums. See the **Things we can do** section of the Policy for more information.

Options C and D — Premium Rates

Voluntary Critical Illness Coverage

P082.0044

Option C Class 0001

The following sets of rates represent the rate per $1,000.00 of coverage.

Non-tobacco Rates

Age From	Age Through	Rate per Member
15	24	$ 0.46
25	29	$ 0.48
30	34	$ 0.52
35	39	$ 0.58
40	44	$ 0.66
45	49	$ 0.79
50	54	$ 0.95
55	59	$ 1.24
60	64	$ 1.63
65	69	$ 2.26
70	99	$ 3.03

Tobacco Rates

Age From	Age Through	Rate per Member
15	24	$ 0.48
25	29	$ 0.51
30	34	$ 0.60
35	39	$ 0.73
40	44	$ 0.88
45	49	$ 1.17
50	54	$ 1.48
55	59	$ 1.99
60	64	$ 2.66
65	69	$ 3.59
70	99	$ 4.66

P082.0047

Option D Class 0002

The following sets of rates represent the rate per $1,000.00 of coverage.

Non-tobacco Rates

Age From	Age Through	Rate per Member
15	24	$ 0.54
25	29	$ 0.62
30	34	$ 0.75
35	39	$ 0.92
40	44	$ 1.14
45	49	$ 1.44
50	54	$ 1.81
55	59	$ 2.32
60	64	$ 2.99
65	69	$ 3.97
70	99	$ 5.00

Tobacco Rates

Age From	Age Through	Rate per Member
15	24	$ 0.59
25	29	$ 0.71
30	34	$ 0.96
35	39	$ 1.34
40	44	$ 1.78
45	49	$ 2.46
50	54	$ 3.17
55	59	$ 4.09
60	64	$ 5.18
65	69	$ 6.56
70	99	$ 7.87

P082.0047

Option C Class 0001

The following set of rates represents the rate per Member based on age for this Plan’s optional benefits.

Non-tobacco Rates

Age From	Age Through	Rate
15	24	$ 0.00
25	29	$ 0.00
30	34	$ 0.00
35	39	$ 0.00
40	44	$ 0.00
45	49	$ 0.00
50	54	$ 0.00

55	59	$ 0.00
60	64	$ 0.00
65	69	$ 0.00
70	99	$ 0.00

Tobacco Rates

Age From	Through	
15	24	$ 0.00
25	29	$ 0.00
30	34	$ 0.00
35	39	$ 0.00
40	44	$ 0.00
45	49	$ 0.00
50	54	$ 0.00
55	59	$ 0.00
60	64	$ 0.00
65	69	$ 0.00
70	99	$ 0.00

P082.0059

Option D Class 0002

The following set of rates represents the rate per Member based on age for this Plan's optional benefits.

Non-tobacco Rates

Age From	Through	
15	24	$ 0.00
25	29	$ 0.00
30	34	$ 0.00
35	39	$ 0.00
40	44	$ 0.00
45	49	$ 0.00
50	54	$ 0.00
55	59	$ 0.00
60	64	$ 0.00
65	69	$ 0.00
70	99	$ 0.00

Tobacco Rates

Age From	Through	
15	24	$ 0.00
25	29	$ 0.00
30	34	$ 0.00
35	39	$ 0.00
40	44	$ 0.00
45	49	$ 0.00
50	54	$ 0.00

55	59	$ 0.00
60	64	$ 0.00
65	69	$ 0.00
70	99	$ 0.00

P082.0059

Options C and D

"Age" means the Member's age in years as of the Policy Issue Date.

P082.0070

Options C and D **Premium Rates**

Spouse Voluntary Critical Illness Coverage

P082.0085

Option C Class 0001

The following sets of rates represent the rate per $1,000.00 of coverage.

Non-tobacco Rates

Age From	Age Through	Rate per Insured Spouse
15	24	$ 0.46
25	29	$ 0.48
30	34	$ 0.52
35	39	$ 0.58
40	44	$ 0.66
45	49	$ 0.79
50	54	$ 0.95
55	59	$ 1.24
60	64	$ 1.63
65	69	$ 2.26
70	99	$ 3.03

Tobacco Rates

Age From	Age Through	Rate per Insured Spouse
15	24	$ 0.48
25	29	$ 0.51
30	34	$ 0.60
35	39	$ 0.73
40	44	$ 0.88
45	49	$ 1.17
50	54	$ 1.48
55	59	$ 1.99
60	64	$ 2.66
65	69	$ 3.59
70	99	$ 4.66

P082.0089

Option D Class 0002

The following sets of rates represent the rate per $1,000.00 of coverage.

Non-tobacco Rates

Age From	Through	Rate per Insured Spouse
15	24	$ 0.54
25	29	$ 0.62
30	34	$ 0.75
35	39	$ 0.92
40	44	$ 1.14
45	49	$ 1.44
50	54	$ 1.81
55	59	$ 2.32
60	64	$ 2.99
65	69	$ 3.97
70	99	$ 5.00

Tobacco Rates

Age From	Through	Rate per Insured Spouse
15	24	$ 0.59
25	29	$ 0.71
30	34	$ 0.96
35	39	$ 1.34
40	44	$ 1.78
45	49	$ 2.46
50	54	$ 3.17
55	59	$ 4.09
60	64	$ 5.18
65	69	$ 6.56
70	99	$ 7.87

P082.0089

Option C Class 0001

The following set of rates represents the rate per spouse based on age for this Plan's optional benefits.

Non-tobacco Rates

		Rate per Insured Spouse
15	24	$ 0.00
25	29	$ 0.00
30	34	$ 0.00
35	39	$ 0.00
40	44	$ 0.00
45	49	$ 0.00
50	54	$ 0.00
55	59	$ 0.00
60	64	$ 0.00

65	69	$ 0.00
70	99	$ 0.00

Tobacco Rates

		Rate per Insured Spouse
15	24	$ 0.00
25	29	$ 0.00
30	34	$ 0.00
35	39	$ 0.00
40	44	$ 0.00
45	49	$ 0.00
50	54	$ 0.00
55	59	$ 0.00
60	64	$ 0.00
65	69	$ 0.00
70	99	$ 0.00

P082.0108

Option D Class 0002

The following set of rates represents the rate per spouse based on age for this Plan's optional benefits.

Non-tobacco Rates

		Rate per Insured Spouse
15	24	$ 0.00
25	29	$ 0.00
30	34	$ 0.00
35	39	$ 0.00
40	44	$ 0.00
45	49	$ 0.00
50	54	$ 0.00
55	59	$ 0.00
60	64	$ 0.00
65	69	$ 0.00
70	99	$ 0.00

Tobacco Rates

		Rate per Insured Spouse
15	24	$ 0.00
25	29	$ 0.00
30	34	$ 0.00
35	39	$ 0.00
40	44	$ 0.00
45	49	$ 0.00
50	54	$ 0.00
55	59	$ 0.00
60	64	$ 0.00
65	69	$ 0.00
70	99	$ 0.00

P082.0108

Options C and D

"Age" means the Member's age in years as of the Policy Issue Date.

P082.0127

Options C and D **Premium Rates**

Child Voluntary Critical Illness Coverage

P082.0137

Option C Class 0001

The following set of rates represents the rate per $1,000.00 of coverage.

Rate per Insured Child

$ 0.00

P082.0131

Option D Class 0002

The following set of rates represents the rate per $1,000.00 of coverage.

Rate per Insured Child

$ 0.00

P082.0131

Options C and D Classes 0001 and 0002

The following set of rates represents the rate per child for this Plan's optional benefits.

Rate Per Child(ren) . . . . $.00

P082.0133

END OF POLICY DOCUMENT