

## CERTIFICATE OF COVERAGE

**The Guardian Life Insurance Company of America**

7 Hanover Square  
New York, New York 10004

The group long term disability income coverage described in this Certificate is attached to the group Policy effective January 1, 2015.

### GROUP LONG TERM DISABILITY INCOME COVERAGE

### LIMITED BENEFIT – PLEASE READ CAREFULLY

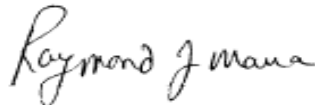
Guardian certifies that the Member to whom this Certificate is issued is entitled to the benefits described herein. However, the Member must: (a) satisfy all of this Plan's eligibility and effective date requirements; (b) be listed in Our and/or the Policyholder's records as a validly covered Member under this Plan; and (c) all required premium payments must have been made by or on behalf of the Member.

The Member is not covered by any part of this Plan for which he or she has waived coverage. Such a waiver of coverage is shown in Our and/or the Policyholder's records.

**Policyholder:** Financial Services Institute Inc.

**Group Policy Number:** G-00502443

**The Guardian** Life Insurance Company of America



Vice President, Group Products

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## DEFINITIONS

This section defines certain terms appearing in Your Certificate.

**CPI-W:** This term means that part of the United States Department of Labor Consumer Price Index that measures the relative value of the cost of a typical urban wage earner's purchase of certain goods and services. If the Department of Labor stops publishing the CPI-W, We have the right to use some other similar standard.

### **Disability or Disabled:**

These terms mean You meet either the occupation test or the earnings test shown below.

- **Occupation Test:** You meet this test if: (1) You are not working in any occupation; and (2) You have a current Sickness or Injury which causes impairment to such a degree that You are not able to perform, on a Full-Time basis, the major duties of Your Own Occupation.

You will not meet this test, if You are able to perform the major duties of Your Own Occupation with Reasonable Accommodation.

- **Earnings Test:** For any month in which You are working, You may meet this test, if: (1) You have a current Sickness or Injury which causes impairment; and (2) such impairment causes You to be unable to earn more than this Plan's maximum allowable Disability Earnings.

Neither loss of a professional or occupational license due to misconduct or unlawful activity or receipt of, or entitlement to, Social Security disability benefits in and of themselves constitute Disability under this Plan.

**Disability Earnings:** This term means the monthly income You earn from working while Disabled. It includes salaries, wages, commissions, bonuses and any other compensation earned or accrued while working including pension, profit sharing contributions, sick pay, paid time off, holiday and vacation pay. When You have an ownership interest in the business, Disability Earnings also includes business profits, attributable to You, whether received or not. It includes any income You earn while Disabled and return to the employer, partnership, or any other similar business arrangement to cover any business or overhead expenses. If You have the ability to work on a Part-Time or Full-Time basis, Disability Earnings also includes Maximum Capacity Earnings beginning with the earlier of the date You: (1) have been terminated from employment with the employer; (2) have been Disabled for 12 months in a row; or (3) have been offered a job or workplace modification by the employer and You do not return to work.

**Doctor:** Any medical practitioner We are required by law to recognize. He or she must: (1) be properly licensed or certified by the laws of the state where he or she practices; and (2) provide services that are within the lawful scope of his or her practice.

**Eligibility Date:** This term means the earliest date You are eligible for coverage under this Plan.

**Elimination Period:** This term means the period of time You must be Disabled, due to a covered Disability, before this Plan's benefits are payable.

Any days during which You return to work on a Full-Time basis performing the major duties of Your Own Occupation, will not count toward the Elimination Period. If You are or become eligible under any other similar group income replacement plan while You are working during the Elimination Period, You will not be entitled to benefits from this Plan.

We do not require You to complete an Elimination Period if: (1) You were covered under a similar income replacement plan the Policyholder had with another carrier on the day before this Plan starts; and (2) Your Disability would have been a Recurring Disability under the prior plan had it remained in effect.

**Financial Lending Institution:** This term means an organization: (1) duly chartered and licensed by the state or federal government; and (2) regularly engaged in the lending of funds.

**Full-Time:** This term means You regularly work at least the number of hours in the normal work week set by the employer (but not less than 30 hours per week).

**Government Plan:** This term means any of the following: (1) the United States Social Security Act; (2) the Railroad Retirement Act; (3) the Canadian Pension Plan; or (4) any other plan provided under the laws of a state, province or any other political subdivision. It also includes: (a) any public employee Retirement Plan; or (b) any plan provided in place of the above named plan or acts. It does not include: (i) any Workers' Compensation Act

or similar law; (ii) the Jones' Act; (iii) the Longshoreman's and Harbor Workers' Compensation Act; or (iv) the Maritime Doctrine of Maintenance, Wages, or Cure.

**Gross Monthly Benefit:** This term means this Plan's Monthly Benefit before it is integrated with other income and earnings.

**Injury:** This term means a bodily Injury due to an accident that occurs, independent of all other causes, while You are covered by this Plan. Subject to all other requirements, We will cover a Disability caused by an Injury when the Disability starts within 90 days of the date of such Injury.

**Insured Earnings:** Only Your earnings from the employer will be included as Insured Earnings.

Your Gross Monthly Benefit may be limited due to Proof of Insurability requirements. In this case, only the part of Your Insured Earnings that applies to the amount of Your limited Gross Monthly Benefit is used to calculate premiums due under this Plan. We calculate benefit amounts and limits based on the amount of Your Insured Earnings on record with Us as of the Redetermination date immediately prior to the start of Your Disability. See the "Redetermination" and "Proof of Insurability" sections of this Plan.

- **For Partners and S Corporation Shareholders:** Insured Earnings means the sum of the amounts listed below, divided by 12.
  - (1) Your compensation as an employee or S Corporation shareholder, as reported on Your Federal Income Tax Return(s), Form 1040, for the prior calendar year, less the gross total of unadjusted employee business expenses as included on the corresponding Schedule A-Itemized Deductions.
  - (2) Your non-passive income (loss) from trade of business as reported on Schedule E - Part II of Your Federal Income Tax Return(s), Form 1040, for the prior calendar year, less any expenses incurred and reported elsewhere on Your Return; and
  - (3) Your contributions during the prior calendar year, deposited into a: (a) cash or deferred compensation plan, or salary reduction plan, qualified under IRC section 401(k), 403(b), 457 or similar plan; and (b) elective employee pre-tax deferrals to a Section 125 plan or flexible spending account.

You may not have been a partner or S Corporation shareholder for the full prior calendar year. In that case, Your earnings are based on the monthly average of the sum of the listed amounts averaged for the full number of months that You were a partner or S Corporation shareholder during that calendar year.

- **For Sole Proprietors and LLC members:** Insured Earnings means the sum of the amounts listed below.
  - (1) Your average monthly net profit as determined from Schedule C - Part II of Your Federal Income Tax Return(s), Form 1040 for the prior calendar year.
  - (2) Your average monthly contribution during the prior calendar year deposited into a: (a) cash or deferred compensation plan, or salary reduction plan, qualified under IRC section 401(k), 403(b), 457 or similar plan; and (b) elective employee pre-tax deferrals to a Section 125 plan or flexible spending account.

Monthly net profit is calculated as gross income less total expenses.

You may not have been a sole proprietor for the prior calendar year. In that case, We calculate average monthly net profit and average monthly contributions using the full number of months that You were a sole proprietor during such time.

- **For All Others:** Insured Earnings means Your rate of monthly earnings received from the employer. We include as earnings: (a) taxable earned income, including: (i) bonuses and commissions averaged for the prior 12 months; and (ii) overtime pay; (b) elective employee pre-tax deferrals to a Section 125 plan or flexible spending account; and (c) contributions to a cash or deferred compensation plan, or a salary reduction plan, qualified under IRC Section: 401(k); 403(b); or 457; as reported on Your W-2 form. We do not include as earnings: (1) expense accounts and other extra compensation; (2) stock options exercised; or (3) employer contributions to a cash or deferred compensation plan or salary reduction plan. If You were not employed by the employer for the entire prior calendar year, Insured Earnings are based on the monthly average of the sum of the listed amounts, averaged for the full number of months that You were employed by the employer, during such calendar year.

**Maximum Capacity Earnings:** this term means the income You could earn if working to the fullest extent to which You are able in Your Own Occupation. We decide the fullest extent of work You are able to do based on objective data provided by any or all of the following sources: (1) Your treating Doctor; (2) impartial medical or vocational exams; (3) peer review specialists; (4) functional capacities exams; and (5) other medical and vocational specialists whose area of expertise is appropriate to Your Disability.

**Maximum Payment Period:** This term means the longest time that benefits are paid by this Plan, subject to all terms, limitations and exclusions.

**Member:** This term means a Financial Advisor who is reported by the Policyholder as a member in good standing.

**Mental Illness:** This term means any mental disorder, regardless of cause, listed in the Diagnostic and Statistical Manual of Mental Disorders (DSM) currently in use by the American Psychiatric Association (APA). If the APA stops publishing the DSM, We have the right to use some other similar source. A Mental Illness may be (1) caused by; (2) be contributed to by; or (3) result in physical, biological or chemical factors or symptoms. For purposes of this Plan, Mental Illness does not include: (1) irreversible dementia caused by Alzheimer's disease, stroke, trauma or viral infection; or (2) any other condition not typically treated by a psychiatrist, clinical psychologist or other qualified mental health professional.

**Monthly Benefit:** This term means this Plan's Gross Monthly Benefit reduced by other income. If You are working while Disabled, Your Monthly Benefit will be further reduced based on the amount of Your Disability Earnings.

**No-Fault Motor Vehicle Coverage:** This term means a motor vehicle plan that pays disability or medical benefits no matter who was at fault in an accident.

**Objective Medical Evidence:** This term includes, but is not limited to: (1) diagnostic testing; (2) laboratory reports; and (3) medical records of a Doctor's exam documenting clinical signs, presence of symptoms and test results consistent with generally accepted medical standards supported by nationally recognized authorities in the health care field.

**Objective Proof of Your Restrictions and Limitations:** During the Own Occupation period this term means objective proof of Your inability to perform the duties of Your Own Occupation, and including all restrictions and limitations relating to Your inability to work. After the Own Occupation period, this term means objective proof of Your inability to perform the duties of any Gainful Work and including all restrictions and limitations relating to Your inability to work.

**Own Occupation:** This term means the occupation(s): (1) You are routinely performing immediately prior to Disability; (2) which is Your primary source of income prior to Disability; and (3) for which You are covered under this Plan. Occupation includes any employment, trade or profession that are related in terms of similar tasks, functions, skills, abilities, knowledge, training and experience required by employers from those engaged in a particular occupation in the general labor market in the national economy. Occupation is not specific to a certain employer or a certain location.

**Plan:** This term means the group long term disability income coverage described in the Policy and this Certificate.

**Policyholder:** This term means Financial Services Institute Inc.

**Proof of Insurability:** This term means the completion of an evidence of insurability form, acceptable to Us, which shows that a person is insurable.

**Recurring Disability:** This term means a later Disability that: (1) is related to an earlier Disability for which this Plan paid benefits; and (2) meets the conditions described in the Recurring Disability section of this Plan.

**Regular and Appropriate Care:** This term means, with respect to Your disabling condition(s) and any other condition(s) which, if left untreated, would adversely affect Your disabling condition, You: (1) visit a Doctor as frequently as medically required, according to generally accepted medical standards, to effectively manage these conditions; and (2) are receiving the most appropriate treatment, according to generally accepted medical standards, designed to achieve maximum medical improvement in these conditions. Treatment must be provided by a Doctor or Doctors whose specialty is most appropriate according to generally accepted medical standards for Your: (a) Disability; and (b) any other conditions which left untreated would adversely affect Your disabling condition. Generally accepted medical standards are those supported by nationally recognized authorities in the health care field including: (i) the American Medical Association (AMA); (ii) the AMA Board of Medical Specialties; (iii) the Food and Drug Administration; (iv) the Centers for Disease Control; (v) the National Cancer Institute; (vi)

the National Institutes of Health; (vii) the Department of Health and Human Services; and (viii) any other agency of similar repute.

**Rehabilitation Agreement:** This term means a formal agreement between: (1) You; (2) Us; and (3) Your employer, if needed. It outlines the Rehabilitation Program in which You agree to take part.

**Rehabilitation Program:** This term means a program of work or job-related training for You that We approve in writing. Its aim is to restore Your wage earning abilities.

**Retirement Plan:** This term means a defined benefit or defined contribution plan funded wholly or in part by the employer's deposits for Your benefit. The term does not include: (1) profit sharing plans; (2) thrift plans; (3) non-qualified deferred compensation plans; (4) individual retirement accounts; (5) tax sheltered annuities; (6) 401(k), 403(b), 457 or similar plans; or (7) stock ownership plans.

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

**Sickness:** This term means an illness or disease. Pregnancy is treated as a Sickness under this Plan.

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

**You or Your:** These terms mean the covered Member.

## GENERAL PROVISIONS

### Limitation of Authority

No person, except by a writing signed by the President, a Vice President or a Secretary of Guardian, has the authority to act for Us to: (1) determine whether any contract, Plan or certificate is to be issued; (2) waive or alter any provisions of any contract or plan, or any of Our requirements; (3) bind Us by any statement or promise relating to the contract issued or to be issued; or (4) accept any information or representation which is not in a signed application. No agent or broker has the authority to change the contract or plan or waive any provisions of the same.

### Incontestability

This Plan is incontestable, except for a fraudulent statement, after two years from its date of issue, except for non-payment of premiums.

No statement in any application, except a fraudulent statement, made by You will be used to contest the validity of Your insurance or to deny a claim for a loss incurred after such insurance has been in force for two years during Your lifetime.

If this Plan replaces a plan Your Policyholder had with another insurer, We may rescind this Plan based on misrepresentations or omissions made by the Policyholder or a Member in a signed application for up to two years from the effective date of this Plan.

In the event Your insurance is rescinded, We will refund premiums paid for the periods such insurance is void. The premium paid by You will be sent to Your last known address on file with Your Policyholder or Us.

## Examination and Autopsy

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

## Long Term Disability Claim Provisions

Your right to make a claim for long term disability benefits provided by this Plan is governed as follows:

**Notice:** You must send Us written notice of an injury or sickness for which a claim is being made within 20 days after the occurrence or commencement of any loss covered by this Plan. This notice should include Your name and the Policy number.

**Claim Forms:** We will furnish You with forms for filing proof of loss within 15 days of receipt of notice. If We do not furnish the forms on time, We will accept a written description and adequate proof of the injury or sickness that is the basis of the claim as proof of loss. You must detail the nature and extent of the loss for which the claim is being made.

**Proof of Loss:** Written proof of loss must be furnished to Us in case of claim for loss for which this policy provides any periodic payment contingent upon continuing loss within 90 days after the termination of the period for which We are liable and in case of claim for any other loss within 90 days after the date of such loss. Failure to furnish such proof within the time required shall not invalidate nor reduce any claim if it was not reasonably possible to give proof within such time, provided such proof is furnished as soon as reasonably possible and in no event, except in the absence of legal capacity, later than 1 year from the time proof is otherwise required.

**Payment of Benefits:** We will pay long term disability benefits as soon as We receive written proof of loss.

**Legal Actions:** No legal action against this Plan shall be brought until 60 days from the date proof of loss has been given as shown above. No legal action shall be brought against this Plan after three years from the date of the final benefit determination.

**Workers' Compensation:** The long term disability benefits provided by this Plan are not in place of and do not affect requirements for coverage by Workers' Compensation.

## ELIGIBILITY FOR LONG TERM DISABILITY INCOME COVERAGE

### Eligible Members

Subject to the conditions of eligibility set forth below, and to all of the other conditions of this Plan, You are eligible if You are in an eligible class of Members.

### Conditions of Eligibility

You are eligible for long term disability income coverage if You are in an eligible class of Members.

**Enrollment Requirement:** If You must pay all or part of the cost of Your coverage, We will not cover You until You enroll and agree to make the required payments.

**Proof of Insurability:** If You: (1) do not meet this Plan's enrollment requirement within 30 days after You first become eligible; or (2) enroll after You previously had coverage which ended because You failed to make a required payment, We will require Proof of Insurability. And, You will not be covered until We approve that proof in writing.

Part or all of Your insurance amounts may be subject to Proof of Insurability. The Schedule of Benefits explains if and when We require proof. You will not be covered for any amount that requires such proof until You give the proof to Us and We approve that proof in writing.

### **When Member Coverage Starts**

Whether You must pay all or part of the cost of Your coverage, You must elect to enroll and agree to make the required payments before Your coverage will start. If You do this on or before Your Eligibility Date, Your coverage is scheduled to start on Your Eligibility Date. If You do this within 30 days after Your Eligibility Date, Your coverage is scheduled to start on Your Eligibility Date. If You elect to enroll and agree to make the required payments more than 30 days after Your Eligibility Date, Your coverage will not start until You send Us Proof of Insurability. Once We have approved such proof, Your coverage is scheduled to start on Your approved effective date.

Any part of Your coverage which is subject to Proof of Insurability will not start unless You send such proof to Us, and We approve it in writing. Once We have approved it, that part of Your coverage is scheduled to start on Your approved effective date.

### **When Member Coverage Ends**

Your coverage will end on the first of the following dates:

- The date Your active Full-Time service ends for any reason.
- The date You stop being an eligible Member under this Plan.
- The date You are no longer 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 the group Plan ends, or is discontinued for a class of Members to which You belong.
- The last day of the period for which required payments are made for You.

### **LONG TERM DISABILITY INCOME COVERAGE**

This coverage replaces part of Your income if You become Disabled due to a covered Sickness or Injury. What We pay is governed by all the terms of this Plan.

This Certificate includes form(s) GC-SCH-LTD-11-DC which are this Plan's Schedule(s) of Benefits. Your class and benefit options are shown in the Schedule of Benefits that applies to You. See form(s) GC-SCH-LTD-11-DC.

Terms with special meanings are defined. See the definitions section of this Plan. Other terms with special meanings are defined where they are used.

### **Benefit Provisions**

**How Payments Start:** To start getting payments from this Plan, You must meet all of the conditions listed below.

- You must: (1) become Disabled while covered by this Plan; and (2) remain Disabled and covered for this Plan's Elimination Period.
- You must provide proof of loss, as described in Claim Provisions.

Benefits accrue as of the first day after the end of the Elimination Period, subject to all Plan terms.

You can satisfy the Elimination Period while working, provided You are Disabled.

**Waiver of Premium:** We waive Your premiums for this coverage while You are entitled to receive a Monthly Benefit payment from this Plan.

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

- The date You are no longer Disabled.
- The date You fail to provide proof of loss as required by this Plan.
- The date You have been outside the United States and/or a country or region approved by Us for more than two months in a 12 month period.
- The date You die.



- The end of the Maximum Payment Period.
- The date no further benefits are payable under any provision in this Plan that limits the Maximum Payment Period.
- The date You are no longer receiving Regular and Appropriate Care from a Doctor.
- The date payments end in accordance with a Rehabilitation Agreement.

**Maximum Payment Period:** The Maximum Payment Period is shown in the Schedule of Benefits. But, it may be less than that shown due to: (1) the nature of Your Disability; (2) the date You were first treated for the cause of Your Disability; and (3) the length of time You have been covered by this Plan. See Disabilities With A Limited Maximum Payment Period and Pre-Existing Conditions.

**Recurring Disability:** Benefits from this Plan end if You cease to be Disabled. But, a later Disability may be treated as a Recurring Disability, if all of the terms listed below are met:

- You must return to Active Work right after Your benefits end.
- The Disability must recur less than six months after You were last entitled to benefits.
- The later Disability must be due to the same or related cause of Your earlier Disability.
- You must not become covered under any other similar group income replacement plan during the time You return to Active Work.
- During the time You return to Active Work, You must: (a) stay covered by this Plan; and (b) premium payments must be made on Your behalf.
- Your benefits must not have ended because You have used up the Maximum Payment Period.

If the later Disability is a Recurring Disability, You will not need to satisfy a new Elimination Period. The Recurring Disability will be subject to all the terms of this Plan in effect on the date the earlier Disability began.

If all of the terms listed above are not met, the later Disability will be treated as a new period of Disability. You will be required to satisfy a new Elimination Period. The new period of Disability will be subject to all the terms of this Plan in effect on the date the new period of Disability starts.

**Calculation of Monthly Benefit:** Your benefit is governed by the terms of this Plan in effect on the date Disability starts. Any changes to this Plan that take place: (1) while You are Disabled; or (2) during a period of Active Work that occurs between an initial period of Disability and a Recurring Disability; will not affect Your benefit.

We calculate Your Gross Monthly Benefit according to the Schedule of Benefits. This Plan includes Proof of Insurability requirements that may affect the amount of Your Gross Monthly Benefit. The Schedule of Benefits explains these requirements.

From Your Gross Monthly Benefit, subtract the amount of any income listed in Other Income Benefits that You receive or are entitled to receive. The result is Your Monthly Benefit.

This Plan includes Proof of Insurability requirements that may affect the amount of Your Gross Monthly Benefit. The Schedule of Benefits explains these requirements.

Your Monthly Benefit is equal to the lesser of the amounts determined by Method 1 or Method 2 shown below.

**Method 1:**

- From Your Insured Earnings subtract the amount of any income listed in Other Income Benefits that You receive or are entitled to receive.
- From the result in step (a) subtract Your current Disability Earnings.

**Method 2:**

- Calculate Your Gross Monthly Benefit according to the Schedule of Benefits.
- From the result in step (a) subtract the amount of any income listed in Other Income Benefits that You receive or are entitled to receive.

**Redetermination:** This Plan redetermines Your Insured Earnings on the date a change in Your Insured Earnings occurs. The plan sponsor must report updates to all Members' Insured Earnings as they occur. Changes to Your Insured Earnings are subject to any Proof of Insurability requirements of this Plan. As of this Plan's

redetermination date, We use Your Insured Earnings on record with Us to: (1) set rates; (2) project benefit amounts and limits; and (3) calculate premium payable under this Plan. You must be actively-at-work on a Full-Time basis on that date. If You are not, We do not do this until the date You return to Active Work on a Full-Time basis. But, changes in earnings will not apply to a Recurring Disability.

**Other Income Benefits:** You may receive, or be entitled to receive, income shown in the list below. We will reduce Your Gross Monthly Benefit by such other income benefits to determine Your Monthly Benefit from this Plan.

- Disability benefits from any mandated benefit act or law. This includes all temporary disability or state disability benefits required by law.
- Disability benefits from all group plans of the employer. This includes payments made by a group life insurance plan due to Your Disability. This does not include payments made from a group life insurance plan's: (1) accelerated death benefit; or (2) like provision that allows payment of such plan's proceeds due to terminal illness.
- Disability benefits from any other group plan; but, if the other group plan was in force prior to this Plan, and the other group plan also deducts for disability benefits from any other group plan, We will not deduct these other group disability benefits.
- Income from a sick leave, salary continuance or paid time off plan, but only to the extent that such income plus the amount of Your Gross Monthly Benefit is more than 100% of Your Insured Earnings. This applies whether such plan is sponsored on a formal or informal basis. This includes: (1) donated; (2) lump sum; and (3) recurrent payments of accrued sick leave benefits. But, if You are working while Disabled, We will account for such income as described in Adjustment of Monthly Benefit for Disability Earnings.
- Benefits as shown below from: (1) the United States Social Security Act; (2) the Railroad Retirement Act; or (3) any other like U.S. or Canadian plan or act.
  - (a) All disability benefits for which: (i) You are entitled; and (ii) Your spouse and children are entitled due to Your Disability;
  - (b) All unreduced retirement benefits for which: (i) You are entitled; and (ii) Your spouse and children are entitled due to Your entitlement; and
  - (c) All reduced retirement benefits paid to: (i) You; and (ii) Your spouse and children due to Your receipt of such benefits.

We do not reduce Your Gross Monthly Benefit by the retirement benefits described in (b) and (c) above, to the extent that You and Your dependents were entitled to receive such income prior to the start of Disability. We will reduce the Gross Monthly Benefit by marginal increases in such income You and Your dependents were entitled to receive after Disability begins.

We will reduce Your Gross Monthly Benefit by benefits referred to in (a), (b) and (c) above, net of attorney fees, approved by the Social Security Administration.

We will reduce Your Gross Monthly Benefit by Your dependents' benefits described in (a), (b) and (c) above if: (i) the dependents' benefits are provided to You by the Social Security Administration; (ii) at the time that the Social Security Administration makes its first payment of the dependent benefits described in (a), (b), and (c) above, the dependent child remains a minor dependent or an adult Disabled dependent, and (iii) the dependent benefits under entitlement to You are greater than any dependent benefit being received under entitlement by another person, not You. If true, We will reduce Your Gross Monthly Benefit by the difference.

We do not reduce Your Gross Monthly Benefit by the benefits to which You are entitled, as described in (a), (b), and (c) above unless such benefits are greater than any widow/widower benefit You are receiving. And then We reduce Your Gross Monthly Benefit by the difference.

- Disability benefits from any: (1) No-Fault Motor Vehicle Coverage; (2) motor vehicle financial responsibility act; or (3) like law.
- Payment or settlement, with or without admission of liability, from: (1) a Workers' Compensation law; (2) an occupational disease law; or (3) any other act or law of like intent. This includes: (a) the Jones' Act; (b) the Longshoreman's and Harbor Workers' Compensation Act; or (c) any Maritime doctrine of

Maintenance, Wages or Cure. If You receive a payment net of attorney fees approved by the Workers' Compensation Board or similar authority, We reduce Our benefit by the net payment.

- Disability benefits from any third party when Your Disability is the result of the negligence or intentional tort liability of that third party.
- Unemployment compensation benefits.

We integrate Your Gross Monthly Benefit with income shown above that You are entitled to receive without regard to the reason You are entitled to receive it.

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

**Other Income Not Subject to Deduction:** We will not reduce Your Gross Monthly Benefit by any income You receive or are entitled to receive from the list below.

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

**Lump Sum Payments of Other Income:** Income with which We integrate may be paid in a lump sum. In this case, We take the equivalent monthly rate stated in the award into account when We determine Your Monthly Benefit. If no monthly rate is given, We pro-rate the lump sum over the lesser of: (1) 60 months; or (2) the expected remaining number of months for which You would be entitled to benefits from this Plan based on the proof of loss submitted to Us.

**Cost of Living Freeze:** You may receive a cost of living increase in other income with which We integrate. In this case, We do not further reduce Your Monthly Benefit by the amount of such increase.

**Application for Other Income:** You must apply for other income benefits to which You may be entitled. If these benefits are denied, You must appeal until: (1) all possible appeals have been made; or (2) We notify You that no further appeals are required.

If We feel You are entitled to receive such income benefits, We will estimate the amount due to You and Your spouse and children. We will take this estimated amount into account when We determine Your Monthly Benefit. But, We will not take this estimated amount into account if You sign Our reimbursement agreement. In this agreement You promise: (1) to apply for any benefits for which You may be eligible; (2) to appeal any denial of such benefits until all possible appeals have been made; and (3) to repay any amount We overpaid due to an award of such benefits.

If We do reduce Your Gross Monthly Benefit by an estimated amount, We will adjust Your Monthly Benefit when We receive written proof: (1) of the amount awarded; or (2) that the other income benefits have been denied; and no further appeals are possible. If We underpaid You, We pay the full amount of the underpayment in a lump sum.

We will assist You in applying for other income benefits.

**Adjustment of Monthly Benefit for Disability Earnings:** We adjust the Monthly Benefit for Disability Earnings as follows.

For each of the first 24 months after the date You first have Disability Earnings, add Your Gross Monthly Benefit and Your Disability Earnings.

- If the sum is not more than 100% of Your indexed Insured Earnings, We do not reduce Your Monthly Benefit.
- If the sum is more than 100% of Your indexed Insured Earnings, We reduce Your Monthly Benefit by the amount over 100% of Your indexed Insured Earnings.

For each month after that, We pay the greater of the amount calculated under Method 1 or Method 2:

Method 1:

- If Your Disability Earnings are less than 20% of Your indexed Insured Earnings, We do not reduce Your Monthly Benefit.
- If Your Disability Earnings are 20% or more of Your indexed Insured Earnings, We reduce Your Monthly Benefit by 50% of Your Disability Earnings.

Method 2:

- (1) Subtract Your Disability Earnings from Your indexed Insured Earnings.
- (2) Divide the result in (1) above by Your indexed Insured Earnings.
- (3) Multiply the result in (2) above by Your Monthly Benefit. This is the amount We pay.

If Your Disability Earnings fluctuate widely from month to month, We may adjust Your Monthly Benefit using an average Disability Earnings amount. The average Disability Earnings amount will be computed using Your most current month's Disability Earnings and the prior two months Disability Earnings.

**Maximum Allowable Disability Earnings:** This Plan limits the amount of income You may earn, or may be able to earn, and still be considered Disabled.

If Your Disability Earnings are more than the limit shown below, payments from this Plan will end. Payments from this Plan will also end if You are able to earn more than the limit shown below:

- During the first 24 months of payments the limit is 80% of Your indexed Insured Earnings.
- After this Plan has paid benefits for 24 months in a row, the limit is 80% of Your indexed Insured Earnings if You are working, or 80% of Your indexed Insured Earnings if You are not working.

**Indexing:** We apply an indexing factor to Your Insured Earnings on the date You have received 12 monthly payments in a row and each anniversary after that. This factor increases the amount of income You may earn and still be considered Disabled. This adjustment does not increase Your Gross Monthly Benefit, Monthly Benefit, or any other benefit under this Plan.

To make the first adjustment, We multiply Your Insured Earnings by the indexing factor for that year. To make adjustments in each later year, We multiply the amount of Your last indexed Insured Earnings by the indexing factor.

The indexing factor is the lesser of: (1) 10%; or (2) one-half of the average CPI-W from the prior calendar year.

**Minimum Payment:** The minimum monthly payment for Disability under this Plan is \$100.00.

## Limitations and Exclusions

**Disabilities with a Limited Maximum Payment Period:** We limit the Maximum Payment Period, if You are Disabled due to a Mental Illness, or drug or alcohol abuse. If You have a coexistent condition(s), which is not subject to the limits in this section, and is disabling in and of itself, We will not limit benefits as described below.

The Maximum Payment Period for all periods of Disability due to a Mental Illness, drug or alcohol abuse is 24 months. This is a combined maximum for all such conditions and all periods of Disability.

No benefits will be paid for Disability due to a Mental Illness or drug or alcohol abuse if You are not receiving treatment for the cause of the Disability from a provider, or in a facility that is: (1) licensed by the state to provide treatment for such condition; and (2) accredited or approved by the Joint Commission on the Accreditation of Health Care Facilities or Medicare.

If payments under this Plan would end due to the limits in this section, We may extend such payments, as shown below. But, You must meet all of the following conditions: (1) You must be Disabled due to a condition named above; (2) You must be an inpatient in a qualified institution because of Your Disability; and (3) You must have been treated as an inpatient for at least 14 days in a row. In such case, We extend payments until the earliest of: (a) 90 days from the date of Your discharge; (b) the end of this Plan's Maximum Payment Period; and (c) the date Your Disability ends.

As used here, "qualified institution" means a legally operated hospital or other public or private facility licensed to provide inpatient medical care and treatment for the cause of Your Disability.

**Pre-Existing Conditions:** A pre-existing condition is an Injury or Sickness, whether diagnosed or misdiagnosed, and any symptoms of it, for which, in the "look back period", You: (1) receive advice or treatment from a Doctor; (2) undergo diagnostic procedures other than routine screening in the absence of symptoms or suspicion of disease process by a Doctor; (3) are prescribed or take prescription drugs; or (4) receive other medical care or treatment, including consultation with a Doctor.

The "look back period" is the 12 months before the latest of: (1) the effective date of Your coverage under this Plan; (2) the effective date of a change that increases the benefits payable by this Plan; and (3) the effective date of a change in Your benefit election that increases the benefit payable by this Plan.

No benefits are payable for Disability caused by, contributed to by or resulting from a pre-existing condition; unless the Disability starts after the date You have been covered under this Plan for 24 months in a row.

Your Disability caused by, contributed to by or resulting from; a pre-existing condition may begin after: (1) a change which provides for an increase in the benefits payable by this Plan; or (2) a change in Your benefit election which increases the benefit payable by this Plan. In this case, Your benefit will be limited to the amount that would have been payable had the change not taken place. But, this limit does not apply if Your Disability starts after the date the change has been in force for 24 months in a row.

We do not cover any Disability that starts before Your coverage under this Plan.

**Prior Coverage Credit:** If this Plan replaces a similar disability income replacement plan the Policyholder had with another insurer, the pre-existing condition provision may not apply to You, if coverage under this Plan starts immediately after the termination of coverage under the prior disability income replacement plan. This Plan must start right after the prior plan ends.

The pre-existing condition provision will be waived for You if You: (1) are Actively Working on the effective date of this Plan; and (2) have fulfilled the requirements of any pre-existing condition provision of the prior plan.

You may have been covered under the prior plan when it ended, but have not met the requirements of any pre-existing condition provision of the prior plan. In that case, We credit any time used to meet the prior plan's pre-existing condition provision toward meeting this Plan's pre-existing conditions provision. You must: (1) enroll for coverage under this Plan on or before this Plan's effective date; and (2) be Actively Working on the effective date of this Plan.

But, We limit Your maximum Monthly Benefit under this Plan if: (1) it is more than the maximum Monthly Benefit for which You were covered under the prior plan; (2) You become Disabled due to a pre-existing condition; and (3) this Plan pays benefits for such Disability because We credit time as explained above. In this case, We limit the maximum Monthly Benefit to the amount to which You would have been entitled under the prior plan.

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

**Exclusions:** This Plan does not pay benefits for Disability caused by, or related to:

- Declared or undeclared war, act of war, or armed aggression;
- Service in the armed forces, National Guard, or military reserves of any state or country;
- Your taking part in a riot or civil disorder;
- Your commission of, or attempt to commit a felony;
- Your voluntary use of any poison, chemical, prescription or non-prescription drug or controlled substance unless: (1) it was prescribed for You by a Doctor; and (2) it was used as prescribed. In the case of a non-prescription drug, We do not pay for any loss resulting from or contributed to by Your use in a manner inconsistent with package instructions. A controlled substance is anything called a controlled substance

in Title II of the Comprehensive Drug Abuse Prevention and Control Act of 1970, as amended from time to time;

This Plan does not pay any benefits for any period of Disability:

- During which You are confined to a facility as a result of Your conviction of a crime;
- During which You are receiving medical treatment or care outside the United States or Canada unless expressly authorized by Us;
- Which starts before You are covered by this Plan; or
- During which Your loss of earnings is not solely due to Your Disability.

## Services

**Social Security Assistance:** If You are Disabled, We require You to apply for Social Security benefits. See Application for Other Income. If We believe You to be eligible for such benefits, We may offer to assist You in applying for them. Receiving Social Security benefits will protect Your earnings record for retirement and enable You to qualify for Medicare coverage after 24 months.

Services We can provide include:

- Help in completing Your application for such benefits, and any related forms;
- Assistance finding suitable legal counsel; and
- Copies of medical and vocational data needed to file Your claim.

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

You must apply for all income benefits for which You may be eligible, whether or not You use Our help. Using Our help does not cancel Your duties shown in Application for Other Income.

**Rehabilitation and Case Management:** We will review Your Disability to see if certain services are likely to help You return to Gainful Work. If needed, We may ask for more medical or vocational information.

When Our review is complete, We may offer You a Rehabilitation Program.

The Rehabilitation Program will start when a written Rehabilitation Agreement is signed by: (1) You; (2) Us; and (3) Your employer, if needed. The program may include, but is not limited to:

- Vocational assessment of Your work potential;
- Coordination and transition planning with an employer for Your return to work;
- Consulting with Your Doctor on Your return to work and need for accommodations;
- Training in job seeking skills and resume preparation; and
- Retraining.

We have the right to determine which services are appropriate.

If You accept the Rehabilitation Agreement, We will pay an enhanced benefit. The enhanced benefit will be 110% of the Monthly Benefit that would otherwise be paid. This enhanced benefit will be payable as of the first Monthly Benefit after the Rehabilitation Program starts.

We stop paying the enhanced benefit on the earliest of:

- The date Your benefits from this Plan end;
- The date You violate the terms of the Rehabilitation Agreement;
- The date You end the Rehabilitation Program; and
- The date the Rehabilitation Agreement ends.

If You end a Rehabilitation Program without Our consent, You must repay any enhanced benefits paid.

**Dependent Care Expenses:** While You are participating in a Rehabilitation Program, We will pay a dependent care expense benefit, when all of the following conditions are met:

- You incur expense to provide care for a qualified dependent; and
- The care is provided by a licensed provider other than a family member.

The dependent care expense benefit will be the lesser of: (1) \$350.00 per month per qualified dependent; not to exceed \$1,000.00 per month for all qualified dependents combined; and (2) the actual monthly day care expense incurred by You.

We will stop paying the dependent care expense benefit on the earlier of the date You are no longer: (1) incurring dependent care expenses for a qualified dependent; (2) participating in a Rehabilitation Program; or (3) entitled to receive a Monthly Benefit from this Plan.

As used here, "qualified dependent" means a person who is: (1) dependent upon You for main support and maintenance; and (2) under the age of fourteen; and (3) Your biological child, lawfully adopted child, stepchild or any other child who is living with You in a regular parent-child relationship. The term also means a family member age fourteen or over who is physically or mentally incapable of caring for him or herself.

**Worksite Modification:** In order to accommodate Your Disability, an employer may incur a cost to modify his or her worksite. We may reimburse the employer, up to \$2,500.00 for the cost of the worksite modification. We make this payment if We agree that the modification will enable You to: (1) return to work; or (2) remain at work.

**Early Intervention Services:** This Plan includes early intervention services as part of Our disability management program. The intent of these services is to: (1) assist Disabled persons in achieving higher levels of functionality; and (2) support the employer's absence management goals by promoting stay-at work and return-to work agendas where possible.

The key to success of an early intervention program is prompt notification of work absences which have the potential to exceed this Plan's Elimination Period. With prompt notification, We are able to more effectively manage the potential claim.

When You are Disabled from one of the conditions listed below, a long term disability claim form should be completed as soon as possible following the date of Disability. To facilitate an immediate intervention, the form should be submitted to Us within one week of the date Your Disability begins.

- Chronic fatigue conditions, including Epstein-Barr syndrome.
- Mental Illness.
- Repetitive motion syndromes or injuries.
- Fibromyalgia.
- Back pain or strain.
- Neck pain or strain.
- Chronic pain.
- Diabetes.
- Cardiovascular conditions.

On receipt of the completed claim form, We will determine whether the claim is appropriate for early intervention services. You will be notified of Our decision. Examples of services, which We may provide, at Our discretion, include, but are not limited to: (1) job accommodation; (2) ergonomic adjustments to workstations; (3) proactive case management consultations with Your Doctor or other providers of medical care.

## **Claim Provisions**

**Administration:** We, as part of our routine operations, apply the terms of this Plan for making decisions, including making determinations regarding eligibility, receipt of benefits and claims, or explaining our administrative policies, procedures, and processes. All such determinations are conclusive and binding, except that they may be modified or reversed by a court or regulatory agency with appropriate jurisdiction.

**Notice:** You must send Us written notice of Your intent to file a claim under this Plan as described in the Certificate's General Provisions. For details, You can call Us at 1-800- 538-4583.

**Proof of Loss:** When We receive Your notice, We will provide You with a claim form for filing proof of loss. This form requires data from the Policyholder, You, and the Doctor(s) treating Your Sickness or Injury. Proof of loss must be given to Us within the time stated in the Certificate's General Provisions. If You do not receive a claim form within 15 days of the date You sent Your notice, You should send Us written proof of loss without waiting for the form.

Proof of loss, provided at Your expense, consists of the following. Failure to provide this information may delay, suspend, reduce or terminate Your benefits.

- The date Disability began.
- Your last day of Active Work.
- The cause of Disability.
- The extent of Disability, including limitations and restrictions preventing You from performing the major duties of Your Own Occupation.
- If Your occupation requires that You carry liability or malpractice insurance, any changes to such insurance that become effective on or after the date of Disability
- Objective Medical Evidence in support of Your limitations and restrictions, beginning with the date Disability began.
- Objective Proof of Your Restrictions and Limitations, beginning with the date Disability began.
- The prognosis of Disability.
- The name and address of all Doctors, hospitals and health care facilities where You have been treated for Your Disability since the date Disability began.
- Proof that You are currently receiving Regular and Appropriate Care from a Doctor.
- Proof that You have been receiving Regular and Appropriate Care from a Doctor, from the date Disability began.
- Proof of Insured Earnings.
- Proof of Disability Earnings.
- Payroll or absence data from the employer for the three months prior to the date Disability began, or other period We specify.
- Proof of application for all other sources of income to which You may be entitled, that may affect Your payment from this Plan.
- Proof of receipt of other income that may affect Your payment from this Plan .

You must provide Objective Medical Evidence from a Doctor who is not Yourself, Your spouse, child, parent, sibling or business associate.

Proof of Insured Earnings and Disability Earnings may consist of: (1) copies of Your W-2 forms; (2) payroll records from Your employer(s); (3) copies of Your U.S. Individual Income Tax Returns; (4) copies of the U.S. income tax returns from any business in which You hold an ownership or shareholder interest; (5) a statement from a certified public accountant; (6) copies of any income records accepted or required by the IRS; or (7) any other records We deem necessary.

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

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

**Authorization Required:** You must provide Us with written, unaltered authorizations to obtain medical, financial, vocational, occupational, and governmental information required to determine Our liability under this Plan. You



must provide Us with such authorizations as often as We may require, in order that they remain current. Failure to provide such authorizations may delay, suspend or terminate Your benefits.

**Right to Request Medical, Financial or Vocational Assessment:** We may ask You to take part in a medical, financial, vocational or other assessment that We feel is necessary to determine whether the terms of this Plan are met. We may require this as often as We feel is reasonably necessary. We will pay for all such assessments. But, if You postpone a scheduled assessment without Our approval, You will be responsible for any rescheduling fees. If You do not take part in or cooperate with the assessment, We have the right to stop or suspend Your payments under this Plan.

**Ongoing Proof of Loss:** To continue to receive payments from this Plan, You must give Us current proof of loss as often as We may reasonably require. Ongoing proof of loss must be provided to Us within 30 days of the date We request it.

**Payment of Benefits:** We pay benefits to You, if You are legally competent. If You are not, We pay benefits to the legal representative of Your estate. Benefits are paid in US dollars.

We pay benefits once each month at the end of the period for which they are payable.

No benefits are payable for this Plan's Elimination Period.

Benefits to which You are entitled may remain unpaid at Your death. Such benefits may be paid at Our discretion to: (1) Your estate; or (2) Your spouse, parents, children, or brothers and sisters.

**Partial Month Payment:** You may be Disabled for only part of a month. In this case, We compute Your payment as 1/30<sup>th</sup> of the benefit to which You would be entitled for the full month times the number of days You are Disabled. Payment will not be made for more than 30 days in any month.

**Overpayment Recovery:** If We overpaid You, You must repay Us in full. We have the right to reduce Your payment or apply any benefits payable, including the minimum payment, toward recovery of the overpayment.

## **SUBROGATION AND RIGHT OF RECOVERY**

**Purpose:** When You have the right to recover amounts paid by this Plan, We also have certain rights. These are explained below.

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

- **Guardian:** This term means a person who has the care of the person or property of another.
- **Insurance Coverage:** This term means any insurance which provides coverage for: (1) medical expense payments; or (2) liability. This includes, but is not limited to: (a) uninsured motorist coverage; (b) underinsured motorist coverage; (c) personal umbrella coverage; (d) medical payments coverage; (e) workers compensation coverage; (f) no-fault automobile insurance coverage; or (g) any first party insurance.
- **Third Party:** This term means any party actually, possibly, or potentially responsible for making any payment to You due to Your Injury, Sickness or condition. This term also means such party's: (1) liability insurer; or (2) any insurance coverage. But, this term does not mean: (a) Us; or (b) You.
- **You:** This term means the covered Member. It also includes Your parent or guardian if You are a minor or incompetent.

**Subrogation:** When this Plan pays a benefit, We will immediately be subrogated to Your rights of recovery from any third party to the full extent of benefits paid.

**Recovery:** If You receive a payment from any third party or insurance coverage due to an Injury, Sickness or condition, We have the right to recover from, and be repaid by, You for all amounts this Plan has paid due to that Injury, Sickness or condition, up to and including the full amount You receive from any third party or insurance coverage.

**Constructive Trust:** You must serve as a constructive trustee over the funds that constitute payment from any third party or insurance coverage due to Your Injury, Sickness or condition. If You fail to hold such funds in trust, it will be deemed a breach of Your fiduciary duty to Us.

**Lien Rights:** We will have a lien to the extent of benefits We paid due to Your Injury, Sickness or condition for which the third party is liable. The lien will be imposed on any recovery, whether by settlement, judgement, or

otherwise, including from any insurance coverage, that You receive due to Your Injury, Sickness or condition. The lien may be enforced against any party who holds funds or proceeds which represent the amount of benefits paid by Us. This includes, but is not limited to: (1) You; (2) Your representative or agent; (3) the third party; (4) the third party's insurer, representative or agent; and (5) any other source who holds such funds.

**First Priority Claim:** This Plan's recovery rights are a first priority claim against all third parties and are to be paid to Us before any other claim for Your damages. This Plan will be entitled to full repayment on a first dollar basis from any third party's payments, even if such payment to the plan will result in a recovery to You which is not sufficient: (1) to make You whole; or (2) to compensate You in part or in whole for the damages sustained. This Plan is not required to participate in or pay court costs or attorney fees to the attorney hired by You to pursue Your damage claim.

**Applicable to All Settlements and Judgements:** We are entitled to full recovery regardless of whether: (1) any liability for payment is admitted by a third party; or (2) the settlement or judgement received by You identifies the benefits the plan paid. This Plan is entitled to recover from any and all settlements or judgements, even those designated as: (a) pain and suffering; or (b) non-economic damages only.

**Cooperation:** You must fully cooperate with Our efforts to recover the benefits paid under this Plan. You must notify Us within 30 days of the date when any notice is given to any party, including an insurance company or attorney, of Your intention to pursue or investigate a claim to recover damages or obtain compensation due to Injury, Sickness or condition sustained by You. You and Your agents, must provide all information requested by Us or Our representative. This includes, but is not limited to, completing and submitting any applications or other forms or statements as We may reasonably request. Failure to do this may result in the termination of benefits or the instigation of legal action against You.

You must do nothing: (1) to prejudice Our rights as described in this section; or (2) to prejudice Our ability to enforce the terms of this section. This includes, but is not limited to, refraining from making any settlement or recovery that attempts to reduce or exclude the full amount of all benefits paid by this Plan.

We have the right to conduct an investigation regarding the Injury, Sickness or condition to identify any third party. We reserve the right to notify the third party and his or her agents of Our lien. Agents include, but are not limited to: (1) insurance companies; and (2) attorneys.

**Interpretation:** In the event that any claim is made that any part of this section is ambiguous, or questions arise as to the meaning or intent of any of its terms, We have the sole authority and discretion to resolve all disputes regarding the interpretation of this section.

**Jurisdiction:** Any legal action or proceeding with respect to this section may be brought in any court of competent jurisdiction as We may choose. You must submit to each such jurisdiction and waive whatever rights may correspond to You by reason of Your present or future domicile.

### **Grievance Procedures – External Review**

If You or Your representative does not agree with the handling of a claim or has any other grievance, You may file a request for an external review. Requests should be sent to the Commissioner. This must be done within 30 business days after the date of receipt of a grievance decision rendered in a formal review. If the request is accepted by the Commissioner, an external review will be conducted by an Independent Review Organization (IRO). Within 5 business days of Our receipt of the IRO's recommendation, a written report will be submitted to You or Your representative and the Commissioner indicating Our decision with respect to the IRO's recommendation.

The Commissioner may refer matters not within his or her jurisdiction to any other appropriate federal or District government agency for disposition or resolution.

If You are dissatisfied with the resolution reached through the insurer's internal grievance system regarding medical necessity, You may contact the Director, Office of the Health Care Ombudsman and Bill of Rights at the following:

For Medical Necessity cases, District of Columbia Department of Health Care Finance Office of the Health Care Ombudsman and Bill of Rights

899 North Capital Street, N.E.

6<sup>th</sup> Floor

Washington, D.C. 20002

Phone: 1-877-685-6391

Fax: 1-202-478-1397

If You are dissatisfied with the resolution reached through the insurer's internal grievance system regarding all other grievances, You may contact the Commissioner at the following

For Non-Medical Necessity cases:

Commissioner

Department of Insurance, Securities and Banking

810 First Street, NE 7<sup>th</sup> Floor

Washington, D.C. 20002

Phone: 1-202-727-8000

Fax: 1-202-354-1085

### **Definitions**

"Commissioner" means the Commissioner of Insurance.

"Grievance" means a written request by You or a person on Your behalf for review of Guardian's decision to deny, reduce, limit, terminate or delay Your covered health care services.

"Grievance Decision" means a determination accepting or denying the basis or requested remedy of the grievance.

"Independent Review Organization (IRO)" means an impartial, certified health entity engaged by the Commissioner or the Director to review any adverse grievance decision made by Guardian.

## LONG TERM DISABILITY INCOME COVERAGE SCHEDULE OF BENEFITS

Effective on the later of January 1, 2015, or your effective date under this Plan, this Schedule of Benefits is attached to the Certificate. This Schedule of Benefits replaces any previously issued Schedule of Benefits.

**Initial Election** When You first become eligible for this Plan You must choose to become covered for one of the Plans described below and pay the required premium.

You may request to switch to another plan at any time. But, We will require Proof of Insurability before You switch to another plan which provides greater benefits. You must notify the Policyholder of any desired switch and pay the required premium.

**Own Occupation Period** The Maximum Payment Period.

**Elimination Period** For Disability due to Injury ..... 90 days  
For Disability due to Sickness ..... 90 days

Maximum Payment Period	Age When Disability Starts	Maximum Payment Period
	61 or younger	To age 65, or to Social Security Normal Retirement Age (SSNRA), or 3 years 6 months, whichever is longest
	62	To SSNRA, or 3 years 6 months, whichever is longer
	63	To SSNRA, or 3 years, whichever is longer
	64	To SSNRA, or 2 years 6 months, whichever is longer
	65	2 years
	66	1 year 9 months
	67	1 year 6 months
	68	1 year 3 months
	69 or older	1 year

**Gross Monthly Benefit** 60% of Your Insured Earnings to a maximum benefit of:

Plan A: \$ 2,500.00  
Plan B: \$ 5,000.00  
Plan C: \$ 7,500.00  
Plan D: \$10,000.00

The benefit will be rounded to the nearest \$1.00, if not already a multiple of that amount.

**Note:** We integrate Your Gross Monthly Benefit with certain other income You may receive. Read all of the terms of this Plan to see: (1) the other income with which We integrate; and (2) how We integrate.

## CERTIFICATE RIDER

### Limited Benefits – Please Read Carefully

Effective January 1, 2015, or the effective date of the Employee's Certificate, whichever is later, this rider amends this Plan by the addition of the following:

#### Cost of Living Benefit

We apply a cost of living adjustment to Your Monthly Benefit each year, if the terms listed below are met. This allows Your Monthly Benefit to change with inflation. The cost of living benefit supplements this Plan's Monthly Benefit after it is adjusted for Disability Earnings.

This benefit begins on the first of the month that follows or coincides with the date You are entitled to receive 48 monthly payments in a row from this Plan.

It ends when 10 cost of living adjustments have been made.

When We make a cost of living adjustment, We add a cost of living benefit to Your Monthly Benefit after it is adjusted for Disability Earnings. How We do this is shown below.

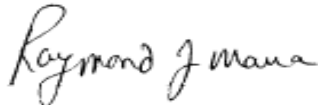
- (1) Take Your Monthly Benefit for the month before You are first entitled to a cost of living adjustment; and adjust it for Disability Earnings.
- (2) Multiply the amount in (1) by the current cost of living factor.
- (3) Add the result in (2) to the Monthly Benefit, after it is adjusted for Disability Earnings that is currently payable.

The cost of living factor is 3%.

The cost of living adjustments may cause Your benefit to be more than the maximum Monthly Benefit.

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

**The Guardian** Life Insurance Company of America



Vice President, Group Products

## CERTIFICATE RIDER

### Limited Benefits – Please Read Carefully

Effective October 1, 2014, or the effective date of the Member's Certificate, whichever is later, this rider amends this Plan by the addition of the following:

#### Critical Disability Supplement Benefit

We pay an added benefit if You have a Functional Disability. What We pay is subject to the terms shown below and to all the terms of the Plan.

**Definitions:** As used in this rider, the terms listed below have the meanings shown below. Additional terms, not listed here, are defined in the Plan.

- **Activities of Daily Living:** This term means the ability to perform the following, with or without equipment or adaptive devices:
  1. **Bathing:** wash in a tub or shower; or take a sponge bath; and towel dry.
  2. **Dressing:** put on and take off all clothes; and those medically necessary braces or prosthetic limbs usually worn; and fasten or unfasten them.
  3. **Toileting:** get to and from and on and off the toilet; to maintain personal hygiene; and care for clothes.
  4. **Transferring:** move in and out of a chair or bed.
  5. **Continence:** control bowel and bladder function; or, in the event of incontinence, maintain personal hygiene.
  6. **Eating:** get food into the body by any means once it has been prepared and made available.
- **Cognitive Impairment or Cognitively Impaired:** This term means a decline or loss in intellectual aptitude. Such loss may result from: (1) Injury; (2) Sickness; (3) Alzheimer's disease, or (4) like forms of senility or irreversible dementia. It must be supported by clinical proof and standardized tests that precisely measure decline in the areas of: (a) short term memory; (b) orientation to time, place and person; (c) deductive or abstract reasoning; and (d) judgment as it relates to awareness of safety. Cognitive impairment does not include decline or loss due to a Mental Illness.
- **Functional Disability or Functionally Disabled:** These terms mean, due to Sickness or Injury, You are: (1) not able to perform two or more Activities of Daily Living on a routine basis, without help; or (2) Cognitively Impaired and in need of verbal cueing to protect yourself or others.

**When Critical Disability Supplement Coverage Starts:** You will be covered on the later of: (1) the effective date of this benefit; or (2) the date You become covered under the Plan.

**When and How Critical Disability Supplement Benefit Payments Start:** To start getting payments, You must:

- Become Disabled while covered by the Plan;
- Remain Disabled for the Plan's Elimination Period;
- Have a Functional Disability: (1) while entitled to receive a Monthly Benefit from the Plan; and (2) that lasts at least 30 days in a row; and
- Be receiving Regular and Appropriate Care from a Doctor.

We may use an independent entity to assess Your Functional Disability. You must take part in this assessment and any reassessments when We request them.

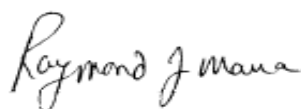
**What We Pay:** If You meet the conditions stated above, We pay 20% of Your Insured Earnings. The benefit will be rounded to the nearest \$1.00, if not already a multiple of that amount. Any \$.50 increment that is not a multiple of \$1.00 will be rounded to the next higher \$1.00 multiple. The monthly maximum for this benefit is \$5,000.00.

**When Critical Disability Supplement Benefit Payments End:** We stop paying this benefit on the earlier of: (1) the date Your Monthly Benefits from the Plan end; or (2) the date You are no longer Functionally Disabled.

**When Critical Disability Supplement Benefit Coverage Ends:** Your coverage ends on the earlier of: (1) the date the Plan is amended to end this benefit; or (2) the date Your coverage under the Plan ends.

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

**The Guardian** Life Insurance Company of America

A handwritten signature in cursive script that reads "Raymond J. Mana".

Vice President, Group Products