Elective Life Insurance

YOUR GROUP INSURANCE PLAN BENEFITS

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

The Guardian
7 Hanover Square
New York, New York 10004

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

<table>
<thead>
<tr>
<th>Group Policy No.</th>
<th>Certificate No.</th>
<th>Effective Date</th>
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Issued To

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

Vice President, Group Products

CGP-3-R-STK-90-3

B110.0023
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GENERAL PROVISIONS

As used in this booklet:

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

"Employer" means the employer who purchased this plan.


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

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

Limitation of Authority

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

Incontestability

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

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

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

Examination and Autopsy

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

Eligible Employees

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

Other Conditions

You must:

(a) be legally working in the United States.

(b) be regularly working at least the number of hours in the normal work week set by your employer (but not less than 20 hours per week), at:
   
   (i) your employer’s place of business;
   
   (ii) some place where your employer’s business requires you to travel; or
   
   (iii) any other place you and your employer have agreed upon for performance of occupational duties.

Note: If you are working outside the United States on a temporary assignment and you meet all other conditions of eligibility, you will be covered by this plan, provided that: you are on an assignment, not exceeding one year, in a country or region that is not under a travel warning issued by the US Department of State. Coverage may be available when you are: (1) on a longer temporary assignment; or (2) assigned in a region that is under a travel warning; however, coverage must be approved in writing.

If you must pay all or part of the cost of employee coverage, we won’t insure you until you enroll and agree to make the required payments. If you do this: (a) more than 31 days after you first become eligible; or (b) after you previously had coverage which ended because you failed to make a required payment, we also ask for proof that you’re insurable. And you won’t be covered until we approve that proof in writing.

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

If your active full-time service ends before you meet any proof of insurability requirements that apply to you, you’ll still have to meet those requirements if you’re later re-employed.

When Your Coverage Starts

Employee benefits that don’t require proof that you are insurable are scheduled to start on the effective date shown on the sticker attached to the inside front cover of this booklet.
Employee Coverage (Cont.)

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

But you must be fully capable of performing the major duties of your regular occupation for your employer on a full-time basis at 12:01 AM Standard Time for your place of residence on the scheduled effective date or dates. And you must have met all of the applicable conditions explained above, and any applicable waiting period. If you are not fully capable of performing the major duties of your occupation on any date part of your insurance is scheduled to start, we will postpone that part of your coverage until the date you are so capable and are working your regular number of hours.

Sometimes, the effective date shown on the sticker or in the endorsement 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; or during an approved leave of absence, not due to sickness or injury, of 90 days or less; and if you were performing the major duties of your regular occupation and working your regular number of hours on your last regularly scheduled work day, your coverage will start on the scheduled effective date. However, any coverage or part of coverage for which you must elect and pay all or part of the cost, will not start if you are on an approved leave and such coverage or part of coverage was not previously in force for you under a prior plan which this plan replaced.

Delayed Effective Date For Employee Optional Life Coverage

With respect to this plan’s employee optional group term life insurance, if an employee is not actively at work on a full-time basis on the date his or her coverage is scheduled to start, due to sickness or injury, we’ll postpone coverage for an otherwise covered loss due to that condition. We’ll postpone such coverage until he or she completes 10 consecutive days of active full-time service without missing a work day due to the same condition.

Coverage for an otherwise covered loss due to all other conditions will start on the date the employee returns to active full-time service.

When Your Coverage Ends

Your coverage ends on the date your active full-time service ends for any reason. Such reasons include disability, death, retirement, layoff, leave of absence and the end of employment.

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

It ends on the date you are no longer working in the United States, unless you are on a temporary assignment: (1) not exceeding one year in a country or region that is not under a travel warning by the US Department of State; or (2) for which we have agreed, in writing, to provide coverage.
Employee Coverage (Cont.)

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

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

Important Notice

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

Continuation of Coverage

Life insurance may be continued at your employer’s option. You must contact your employer to find out if you may continue this insurance.

If Your Group Coverage Would End

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

When Continuation Ends

Insurance may continue until the earliest of the following:

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

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

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

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

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

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

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

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

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**Dependent Life Coverage**

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**Dependent Coverage**

** Eligible Dependents For Optional Dependent Life Benefits**

Your *eligible dependents* are: your legal spouse who is under age 70; and your unmarried dependent children who are 14 or more days old, until they reach age 23 and your unmarried dependent children, from age 23 until they reach age 25, who are enrolled as full-time students at accredited schools.

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**Adopted Children And Step-Children**

Your "unmarried dependent children" include your legally adopted children and, if they depend on you for most of their support and maintenance, your step-children. We treat a child as legally adopted from the time the child is placed in your home for the purpose of adoption. We treat such a child this way whether or not a final adoption order is ever issued.
Dependent Coverage (Cont.)

Dependents Not Eligible

We exclude any dependent who is on active duty in any armed force.

CGP-3-DEP-90-3.0

Proof Of Insurability

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

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

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

CGP-3-DEP-90-5.0

When Dependent Coverage Starts

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

If you do this on or before your eligibility date, the dependent's coverage is scheduled to start on the later of the first of the month which coincides with or next follows your eligibility date and the date you become insured for employee coverage.

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

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

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

A newly acquired dependent will be covered for those dependent benefits not subject to proof of insurability from the date the newly acquired dependent is first eligible, if you notify us and agree to make any additional payments within 31 days after the date the dependent becomes eligible. If you do this more than 31 days after the date the dependent becomes eligible, a newly acquired dependent will be covered from the date you notify us and agree to make any additional payments.
If proof of insurability is required for dependent benefits as explained above, those benefits are scheduled to start, subject to the "Exception" stated below, on the effective date shown in the "Endorsement" section of your application, provided that you send us the proof we require and we approve that proof in writing. A copy of the approved application is furnished to you.

**Exception**

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

**When Dependent Coverage Ends**

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

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

An individual dependent’s coverage ends when he stops being an eligible dependent. This happens to a child at 12:01 a.m. on the date the child attains this plan’s age limit, when he marries, or when a step-child is no longer dependent on the employee for support and maintenance. It happens to a spouse when a marriage ends in legal divorce or annulment, and with respect to optional life coverage, it happens at 12:01 a.m. on the date the spouse reaches age 70.

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

Optional Life Enrollment Period
You may choose to be insured under one of the plans of optional term life insurance shown below. You may only be insured under one plan at a time. You must notify the employer of your election and pay the required premium.

You may switch to another plan of optional term life insurance during the optional life enrollment period. Each year, the optional life enrollment period starts on August 1st and ends on August 31st. We may require proof of insurability before you become insured under the new plan of benefits. See below for details. If we do not require proof, you will become insured under the new plan of benefits as of the September 1st which coincides with or next follows the end of the optional life enrollment period.

Your Optional Term Life Insurance Amount
Plan A
You may elect amounts of optional term life insurance in increments of $50,000.00, but your amount may not be less than $50,000.00 and may not exceed $500,000.00.

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

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

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

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

Proof of Insurability Requirements
Proof of insurability requirements apply to your optional term life insurance. Such requirements may apply to your full benefit amount or just part of it. When proof of insurability requirements apply, it means you must submit to us proof that you’re insurable, and we must approve your proof in writing before your insurance, or the specified part becomes effective.

We require proof as follows:
Employee Optional Contributory Term Life Insurance (Cont.)

We require proof before an employee switches from his or her current increment of optional term life insurance to an increment which provides a greater amount of insurance.

We require proof before we will insure any employee who enrolls for optional term life insurance after the time allowed for enrolling as specified in this plan.

We require proof for amounts of optional term life insurance in excess of $200,000.00.

We require proof for amounts of optional term life insurance in excess of $10,000.00, if an employee's scheduled optional term life effective date is after he or she reaches age 65.

CGP-3-R-SCH-90 B265.0697

We require proof for all amounts of optional term life insurance, if an employee's scheduled optional term life effective date is after he or she reaches age 70.

CGP-3-R-SCH-90 B265.0702

Annual Election

After you initially enroll for Employee Optional Term Life Insurance benefits you may elect to increase the elected insurance amount by selecting the next higher plan from the amounts shown above. This option is available during the Optional Life Enrollment Period, as determined by your employer. Proof of insurability will not be required for increases provided the insurance amount does not exceed the amount of Employee Optional Term Life Insurance for which proof of insurability is required.

In the event proof of insurability is required and has been submitted and approved by us, proof for additional increases will be required on the second anniversary of the approval date.

If proof of insurability was required and you were declined, you will no longer be eligible for additional increases without submitting subsequent proofs of insurability.

Dependent Optional Term Life Insurance will not automatically increase and will require proof of insurability.

CGP-3-R-SCH-90 B265.1242

Dependent Optional Term Life Insurance

You may choose the plan of dependent spouse optional term life insurance, and the plan of dependent child optional term life insurance shown below. You must notify the employer of your elections and pay the required premium.

CGP-3-R-SCH-90 B265.0800
**Dependent Optional Term Life Insurance (Cont.)**

### Your Optional Dependent Spouse Term Life Insurance Amount

**Plan A**

An amount equal to 50% of your optional term life insurance amount, to a maximum of $250,000.00.

CGP-3-R-SCH-90  
B265.0511

### Your Optional Dependent Child Insurance Amount

**Plan A**

**Child's Age At Death**

<table>
<thead>
<tr>
<th>Benefit Amount</th>
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<tr>
<td><strong>At least 14 days but less than 6 months</strong></td>
</tr>
<tr>
<td><strong>At least 6 months but less than 23 years</strong></td>
</tr>
<tr>
<td><strong>At least 23 years but less than 25 years if a full-time student</strong></td>
</tr>
</tbody>
</table>

CGP-3-R-SCH-90  
B265.1247

In no event may the insurance amount of a dependent spouse exceed 0% of the insurance amount of an employee.

In no event may the insurance amount of a dependent child exceed 10% of the insurance amount of an employee.

CGP-3-R-SCH-90  
B265.1253

### Proof of Insurability Requirements

Proof of insurability requirements apply to your dependent optional term life insurance. Such requirements may apply to the full benefits amount or just part of them. When proof of insurability requirements apply, it means you must submit to us proof that a dependent is insurable, and we must approve the proof in writing before the insurance, or the specified part becomes effective.

We require proof as follows:

CGP-3-R-SCH-90  
B265.0536

We require proof before we will insure any spouse who is enrolled for dependent optional term life insurance after the time allowed for enrolling as specified in this plan.

CGP-3-R-SCH-90  
B265.0540

We require proof for any increase in the amount of dependent optional term life insurance, including increases due to an employee's annual election, with respect to a dependent spouse.

CGP-3-R-SCH-90  
B265.1237
Dependent Optional Term Life Insurance (Cont.)

We require proof for any amount of dependent optional term life insurance in excess of $50,000.00 with respect to your dependent spouse.

CGP-3-R-SCH-90 B265.0542

We require proof for any amount of dependent optional term life insurance in excess of $5,000.00 with respect to your dependent spouse, if your dependent spouse’s scheduled dependent optional term life effective date is after he or she reaches age 65.

CGP-3-R-SCH-90 B265.0864

We require proof before we will insure any child who is enrolled for dependent optional term life insurance after the time allowed for enrolling as specified in this plan.

CGP-3-R-SCH-90 B265.0549

We require proof for any increase in the amount of dependent optional term life insurance, including increases due to an employee’s annual election, with respect to a dependent child.

CGP-3-R-SCH-90 B265.1239
Your Optional Group Term Life Insurance

Life Benefit
Subject to the limitations and exclusions below, if you die while insured for this benefit, we'll pay your beneficiary the amount shown in the schedule for the plan of benefits you have elected. Your life benefit may be subject to reductions based on your age. These reductions are also shown in the schedule. Your benefit amount, a portion thereof, or increases in such amount may not become effective until you submit proof of insurability to us, and we approve it in writing. These requirements are also shown in the schedule.

Proof of Death
Subject to all of the terms of this plan, we'll pay this insurance as soon as we receive written proof of death which is acceptable to us. This should be sent to us as soon as possible.

Suicide Exclusion
We pay no benefits if your death is due to suicide, if such death occurs within two years from your employee optional group term life insurance effective date under this plan. Also, we pay no increased benefit amount if your death is due to suicide, if such death occurs within two years from the effective date of the increase.

Seatbelt and Airbag Benefits
If you die as a direct result of an automobile accident while properly wearing a seatbelt, we will increase your benefit amount by $10,000.00. And if you die as a direct result of an automobile accident while both properly wearing a seatbelt, and sitting in a seat equipped with an airbag, we'll increase your benefit amount by an additional $5,000.00, for a total increase of $15,000.00.

Your Beneficiary
You decide who gets this insurance if you die. You should have named your beneficiary on your enrollment form. You can change your beneficiary at any time by giving your employer written notice, unless you've assigned this insurance. But the change won't take effect until your employer gives you written confirmation of the change.

If you named more than one person, but didn't tell us what their shares should be, they'll share equally. If someone you named dies before you do, his or her share will be divided equally by the beneficiaries still alive, unless you've told us otherwise.

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

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

We will recognize an assignee as the owner of the rights assigned only if: (a) the assignment is in writing and signed by you; and (b) a signed or certified copy of the written assignment has been received and approved by us.
Your Optional Group Term Life Insurance (Cont.)

We will not be responsible for legal, tax or other effects of any assignment, or for any benefits we pay under this plan before we receive and approve any assignment.

We suggest you speak to a lawyer before you make any assignment. If you decide you want to assign this insurance, write to us for details.

Payment to a Minor or Incompetent

If your beneficiary is a minor or incompetent, we have the option of paying this insurance in monthly installments. We would pay them to the person who cares for and supports your beneficiary.

Payment of Funeral or Last Illness Expense

We have the option of paying up to $250.00 of this insurance to any person who incurs expenses for your funeral or last illness.

Settlement Option

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

CGP-3-R-EOPT-96

Portability Privilege

Applicability

This provision applies only to this plan's employee and dependent Optional group term life insurance. It does not apply to supplemental life insurance, if any is included in this plan. And it does not apply to Accidental Death and Dismemberment Insurance.

Important Restriction

You must provide proof of insurability satisfactory to us.

Portability Of Optional Group Term Life Insurance

You may elect to continue all or part of your employee Optional group term life insurance and dependent Optional group term life insurance, by choosing a portable certificate of coverage, subject to the following terms.

You may port your coverage if coverage under this plan ends because you: (a) have terminated employment, or (b) stop being a member of an eligible class of employees.

You may not port your coverage or coverage for any of your dependents, if you: (a) have reached your 70th birthday on the day coverage under this plan ends; or (b) are eligible for this plan's Optional Group Term Life Insurance Extended Life Benefit.

You may not port your coverage or coverage for any of your dependents if coverage under this plan ends due to: (a) failure to pay any required premium; or (b) the end of this group plan.

You may port: (a) the full amount(s) of your Optional term life insurance as of the day your coverage under this plan ends, or (b) 50% of such amount, if such amount under this plan is at least $50,000.00.
You may port: (a) the full amount(s) of your dependent Optional term life insurance as of the day your coverage under this plan ends; or (b) 50% of such amount(s), if: (i) your dependent spouse amount under this plan is at least $20,000.00; and (ii) your dependent child amount under this plan is at least $4,000.00. However, if you port the full amount of your insurance, any dependent amount(s) ported must be a full amount. And, if you elect to port 50% of your insurance, any dependent amount(s) ported must be 50% of such amount(s).

You may port: (a) your insurance only; (b) your insurance and insurance of your covered spouse; (c) your insurance and the insurance of all of your covered dependents; or (d) if you are a single parent, your insurance and the insurance of all of your covered dependent children. No other combinations will be allowed.

To be eligible to port, a dependent must be insured as of the day your coverage under this plan ends.

**If You Die While Insured**

If you die while insured for dependent Optional term life insurance, your spouse may port the insurance of your dependents as described above. But, your spouse and dependents must be insured on the date of death. No dependents will be allowed to port if: (a) there is no surviving spouse; or (b) your surviving spouse has reached his or her 70th birthday on the day you die.

**The Portable Certificate Of Coverage**

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

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

**How To Port**

To get a portable certificate of coverage, you or your surviving spouse must: (a) apply to us in writing; and (b) pay the required premium. You have 31 days from the date your coverage under this plan ends to do this. We require proof of insurability satisfactory to us.

**Defined Term**

As used in this provision, the term "port" means to choose a portable certificate of coverage which provides group term life insurance.
Information About Conversion and Portability

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

THE FOLLOWING PROVISION APPLIES TO YOUR OPTIONAL GROUP TERM LIFE INSURANCE:

Converting This Group Term Life Insurance

If Employment or Eligibility Ends

Your group life insurance ends if: (a) your employment ends; or (b) you stop being a member of an eligible class of employees. If either happens, you can convert your group life insurance to an individual life insurance policy. Conversion choices are based on your disability status.

If you are not disabled, as defined in the section labeled "Extended Life Benefit With Waiver of Premium", you can convert to a permanent life insurance policy. You can convert the amount for which you were covered under this plan, less any group life benefits you become eligible for in the 31 days after this insurance ends.

If you: (a) are disabled, as defined in the section labeled "Extended Life Benefit With Waiver of Premium"; and (b) have not yet been approved for the Extended Life Benefit, you can convert to: (a) a permanent life insurance policy; or (b) an interim term insurance policy, as explained in the section labeled "Interim Term Insurance". You can convert the full amount for which you were covered under this plan.

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

If The Group Plan Ends or Group Life Insurance Is Dropped

Your group life insurance also ends if: (a) this group plan ends; or (b) life insurance is dropped from the group plan for all employees or for your class. If either happens, you may be eligible to convert as explained below. Conversion choices are based on your disability status.

If you: (a) are not disabled, as defined in the section labeled "Extended Life Benefit With Waiver of Premium", when this coverage ends; and (b) you have been insured by a Guardian group life plan for at least five years, you can convert to a permanent life insurance policy. But, the amount you can convert is limited to the lesser of: (a) $2,000.00; or (b) the amount of your insurance under this plan, less any group life benefits you become eligible for in the 31 days after this insurance ends.

If you: (a) are disabled, as defined in the section labeled "Extended Life Benefit With Waiver of Premium"; and (b) have not yet been approved for the Extended Life Benefit, you can convert to: (a) a permanent life insurance policy; or (b) an interim term insurance policy. You can convert the full amount for which you were covered under this plan.
If you are later approved for the Extended Life Benefit, then the converted policy, if any, is cancelled as of our approval date.

**The Converted Policy**

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

**Interim Term Insurance**

If you: (a) are disabled, as defined in the section labeled "Extended Life Benefit With Waiver of Premium"; and (b) have not yet been approved for the Extended Life Benefit, you have the option to convert your coverage to an individual term life insurance policy. The individual term policy requires lower premiums than an individual permanent insurance policy.

This Interim term policy is available for only one year from the date you become disabled. During this year, if you are approved for the Extended Life Benefit, the interim term insurance is cancelled, as of our approval date. If, after one year, you have not been approved for the Extended Life Benefit, you must convert to an individual permanent life insurance policy, or coverage will end. Premiums for the individual permanent life insurance policy will be based on your age as of the date you convert from the interim term insurance policy.

**How and When to Convert**

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

**Death During the Conversion Period**

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

**Notice of Conversion Right**

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

This notice should be given at least 15 days before the end of the 31 day period allowed for conversion as described in "How and When to Convert." If the notice is not given at least 15 days before the end of such period, you will have an additional period of 15 days from the date notice is given to apply for the converted policy and pay the required premium. But, in no event shall the additional period extend more than 60 days beyond the 31 day period allowed for conversion as described above.
Your Accelerated Life Benefit

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

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

Accelerated Life Benefit

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

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

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

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

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

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

Maximum Benefit Amount

The amount of the Accelerated Life Benefit for which you may apply is based on the amount of group term life insurance for which you are insured on the day before you apply for the benefit. The minimum benefit amount is the lesser of: (a) $10,000.00; or (b) 50% of the inforce amount. The maximum benefit amount is the lesser of: (a) $250,000.00; or (b) 50% of the inforce amount.

Discount

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

A detailed statement of the method of computing the amount of the Accelerated Life Benefit is filed with each state insurance department. This statement is available from The Guardian upon request.
Your Accelerated Life Benefit (Cont.)

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

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

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

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

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

Even if you are receiving an Extended Life Benefit under this plan, you can still apply for an Accelerated Life Benefit. However, once you convert your group term life insurance, the terms of the converted life policy will apply. Any amount to which you could otherwise convert is permanently reduced by the gross amount of the Accelerated Life Benefit paid to you.

Please read "Your Remaining Group Term Life Insurance" provision for restrictions that may apply.

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

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

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

The premium cost of your remaining coverage is based on the amount of group term life insurance for which you are insured on the day before you apply for the Accelerated Life Benefit.
Your Accelerated Life Benefit (Cont.)

You may be required to provide proof of insurability for increased amounts. If you are, we must approve that proof in writing before you are covered for the new amount.

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

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

Restrictions  We will not pay an Accelerated Life Benefit to you if you:

- are required by law to use the payment to meet the claims of creditors, whether or not you are in bankruptcy; or
- are required by court order to pay all or part of the benefit to another person; or
- are required by a government agency to use the payment to apply for, to receive or to maintain a governmental benefit or entitlement; or
- lose your coverage under the group plan for any reason after you elect the Accelerated Life Benefit but before we pay such benefit to you.

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Your Extended Life Benefit With Waiver Of Premium

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

If You Are Disabled  You are disabled if you meet the definition of total disability, as stated below.

If you meet the requirements in the "How and When to Apply" provision, we'll extend your optional life insurance under this section without payment of premiums from you or the employer.

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

(a) not able to perform any work for wages or profit; and

(b) you are receiving regular doctor's care appropriate to the cause of disability.

How And When To Apply  To apply for this extension, you must submit satisfactory written medical proof of your total disability. You must provide this proof within one year of the onset of that disability. Any claim filed after one year from the onset of total disability will be denied. We will deny the claim unless we receive written proof that: (a) you lacked the legal capacity to file the claim; or (b) it was not reasonably possible for you to file the claim.
Your Extended Life Benefit With Waiver Of Premium (Cont.)

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

(a) become totally disabled before you reach age 60 and while insured by the group plan; and

(b) remain totally disabled for nine continuous months.

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

Continued Eligibility For Extended Life Benefit

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

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

Until You've Been Approved For This Extended Life Benefit

Your life insurance under the group plan may end after you've become totally disabled, but before we've approved you for this extension. During this time period, you may either:

(a) continue group premium payments, including any portion which would have been paid by the employer, until you are approved or declined for this extension; or

(b) convert to an individual permanent or term policy. Please read the section labeled "Converting This Group Term Life Insurance" for details on how to convert.

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

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

When This Extension Begins

Once approved by us, your extended benefit will be effective on the later of:

(a) nine continuous months from the date active full-time service ends due to total disability; or

(b) the date we approve you for this benefit.

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

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

(a) the date you are no longer disabled;

(b) the date we ask you to be examined by our doctor, and you refuse;

(c) the date you do not give us the proof of disability we require;

(d) the date you are no longer receiving regular doctor’s care appropriate to the cause of disability; or

(e) the day before the date you reach age 65.

If the extension ends, and you are not insured by the group plan again as an active full-time employee, you can convert as if your employment just ended. Read the section labeled “Converting This Group Term Life Insurance”.

If You Die While Covered By This Extension
If you die while covered by this extension we’ll pay your beneficiary the amount for which you were covered as of your last day of active full-time work, subject to all reductions which would have applied had you stayed an active employee.

Proof Of Death
We’ll pay as soon as we receive

(a) written proof of your death, that is acceptable to us; and

(b) medical proof that you were continuously disabled until your death. This must be sent within one year of your death.

CGP-3-R-LW-TD-99-2 B275.0059

LifeAssist
If you are eligible for this plan’s Optional Life Extended Life Benefit you may also be eligible for the LifeAssist benefit.

When And How The LifeAssist Benefit Begins
You become eligible for LifeAssist benefits when all of the following conditions are met:

(a) you are eligible for this plan’s Optional Life Extended Life Benefit; and

(b) you are functionally disabled, as defined below; and

(c) you have been insured under this Optional Life plan for at least 12 consecutive months, prior to the start of your disability.
Functional Disability or Functionally Disabled means, due to sickness or injury, you are:

(a) not able to perform 2 or more activities of daily living on a routine basis, without help; or
(b) cognitively impaired and need verbal cueing to protect yourself or others; and

you are:
(c) receiving regular doctor’s care appropriate to the cause of disability; and
(d) not working for wage or profit.

Activities of Daily Living means:

(1) Bathing: the ability to wash in a tub or shower; or by taking a sponge bath; and to towel dry, with or without adaptive equipment or adaptive devices.

(2) Dressing: the ability to put on and take off all clothes; and those medically necessary braces or prosthetic limbs usually worn; and also to fasten or unfasten them.

(3) Toileting: the ability to get to and from and on and off the toilet; to maintain personal hygiene; and to care for clothes.

(4) Transferring: the ability to move in and out of a chair or bed with or without equipment such as: canes; walkers; crutches; grab bars; or any other support devices.

(5) Continence: the ability to control bowel and bladder function; or, in the event of incontinence, the ability to maintain personal hygiene.

(6) Eating: the ability to get food into the body by any means once it has been prepared and made available.

Cognitively impaired means a decline or loss in intellectual aptitude. Such loss may result from: (a) injury; (b) sickness; (c) Alzheimer’s disease; or (d) similar forms of senility or irreversible dementia. It must be supported by clinical proof and standardized tests that precisely measure decline in the areas of: (i) short term memory; (ii) orientation to time, place and person; (iii) deductive or abstract reasoning; and (iv) judgement as it relates to awareness of safety.

**Payment Of Benefits**

We pay this benefit monthly, in arrears. We pay benefits to you if you are legally competent. If you are not, we pay benefits to the legal representative of your estate.

**What We Pay**

Subject to all the terms of this plan, the monthly LifeAssist benefit is equal to 1% of your Optional Life Extended Life Benefit, to a monthly maximum of $2,000.00.

Payments are made based on a 30 day month. You may be eligible for the LifeAssist benefit for only part of a month. In such case, we compute the benefit payable as 1/30th of the monthly benefit times the number of days you are eligible for this benefit.
While you are approved for the Optional Life Extended Life Benefit, if your insurance coverage is reduced under the extension, the amount of the LifeAssist benefit is reduced accordingly.

**Continued Eligibility For The LifeAssist Benefit**

We may require periodic written proof that you remain functionally disabled. This written proof of your continued disability and regular doctor’s care must be provided to us within 30 days of the date we make each such request.

We can require that you take part in a medical assessment, with a medical professional of our choice, as often as we feel is reasonably necessary.

**When The LifeAssist Benefit Ends**

We stop paying this benefit on the earliest of the following dates:

(a) the date you are no longer functionally disabled;
(b) the date you are no longer eligible for this Optional Life plan’s Extended Life Benefit;
(c) the date we ask you to take part in a medical assessment and you refuse;
(d) the date you do not give us proof of disability that we require;
(e) the date you are no longer receiving regular doctor’s care appropriate to the disability; and
(f) the date the lifetime maximum LifeAssist benefit is reached.

The lifetime maximum LifeAssist benefit payments to be made to you by this plan are 100 months of benefit payments.

CGP-3-R-LSUPP-99

**Your Dependent Spouse and Child Optional Term Life Insurance**

**The Benefit**

Subject to the limitations and exclusions shown below, if one of your dependents dies while insured for this benefit, we pay the amount shown in the schedule for the plan you have elected. We pay this in a lump sum when we receive written proof of death which is acceptable to us. Send the proof to us as soon as possible.

We pay you, if you’re living. If you’re not, and the dependent was your child, we pay your spouse. If your spouse is not living, we pay the child’s living brothers and sisters in equal shares. If there are none, we pay the child’s estate. If the dependent was your spouse, we pay your spouse’s estate.

**Suicide Exclusion**

We pay no benefits if the dependent’s death is due to suicide, if such death occurs within two years from the effective date of the dependent’s optional term life insurance under this plan. Also, we pay no increased benefit amount if the dependent’s death is due to suicide, if such death occurs within two years from the effective date of the increase.
Your Dependent Spouse and Child Optional Term Life Insurance (Cont.)

Seatbelt and Airbag Benefits

If a dependent dies as a direct result of an automobile accident while properly wearing a seatbelt, we will increase the benefit amount by $5,000.00. And if a dependent dies as a direct result of an automobile accident while both properly wearing a seatbelt, and sitting in a seat equipped with an airbag, we’ll increase the benefit amount by an additional $2,500.00, for a total increase of $7,500.00.

Payment to a Minor or Incompetent

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

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Converting This Dependent Term Life Insurance

If Your Group Life Insurance Ends or You Stop Being Eligible

Dependent term life insurance ends for all of your dependents when your group life insurance ends. Your insurance ends when: (a) your active full-time employment ends; (b) you stop being a member of a class of employees eligible for employee group life insurance; (c) your group life insurance is extended under the Extended Life Benefit provision; or (d) you die.

Dependent term life insurance also ends when you stop being a member of a class of employees eligible for dependent term life insurance.

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

If This Plan Ends or Life Insurance is Dropped

Dependent term life insurance also ends for all of your dependents when this plan ends. And it ends if either employee or dependent term life insurance is dropped from this plan for all employees or for your class.

If one of the above happens, and your dependents have been insured by a Guardian group plan for at least five years, they can convert. But we limit the amount each dependent can convert to the lesser of: (a) $2,000.00; and (b) the amount of his or her insurance under this plan less any group life benefits for which he or she becomes eligible in the 31 days after this insurance ends.

If a Dependent Stops Being Eligible

A dependent's term life insurance ends when he or she stops being an eligible dependent as defined by this plan. If a dependent stops being eligible, that dependent can convert all or part of his or her insurance.

The Converted Policy

The dependent can convert to one of the individual life insurance policies we normally issue. That policy can't include disability benefits. And it can't be a term policy.

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

Write to us for details.
Converting This Dependent Term Life Insurance (Cont.)

How and When to Convert

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

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

Death During the Conversion Period

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

Notice of Conversion Right:

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

The notice should be given at least 15 days before the end of the 31 day period allowed for conversion as described in "How and When to Convert." If the notice is not given at least 15 days before the end of such period, the dependent will have an additional period of 15 days from the date notice is given to apply for the converted policy and pay the required premium. But, in no event shall the additional period extend more than 60 days beyond the 31 day period allowed for conversion as described above.

CGP-3-R-DEPL-03-N

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GLOSSARY

This Glossary defines the italicized terms appearing in your booklet.

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

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

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

Employer  
means CARNEGIE INSTITUTION OF WASHINGTON.

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

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

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

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

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

Proof or Proof of Insurability  
means an application for insurance showing that a person is insurable.
STATEMENT OF ERISA RIGHTS

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

Receive Information About Your Plan and Benefits

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

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

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

Prudent Actions By Plan Fiduciaries

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

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

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

Assistance with Questions

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

Claim forms and instructions for filing claims may be obtained from the Plan Administrator.

Guardian is the Claims Fiduciary with discretionary authority to determine eligibility for benefits and to construe the terms of the plan with respect to claims.

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

(a) If a claim is wholly or partially denied, the claimant will be notified of the decision within 90 days after Guardian received the claim.

(b) If special circumstances require an extension of time for processing the claim, written notice of the extension shall be furnished to the claimant prior to the termination of the initial 90-day period. In no event shall such extension exceed a period of 90 days from the end of such initial period. The extension notice shall indicate the special circumstances requiring an extension of time and the date by which The Guardian expects to render the final decision.

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

(1) the specific reason(s) the claim was denied;
(2) specific references to the pertinent plan provision on which the denial is based;
(3) a description of any additional material or information needed to make the claim valid, and an explanation of why the material or information is needed;
(4) an explanation of the plan’s claim review procedure.

A claimant must file a request for review of a denied claim within 60 days after receipt of written notification of denial of a claim.

(d) Guardian will notify the claimant of its decision within 60 days of receipt of the request for review. If special circumstances require an extension of time for processing, The Guardian will render a decision as soon as possible, but no later than 120 days after receiving the request. The Guardian will notify the claimant about the extension.

If you apply for an extension of life insurance benefits due to total disability under an Extended Life Benefit under this plan, these claim procedures will apply to such request:
Guardian will make a determination of whether you meet the plan’s standard for total disability not later than 45 days after the date of receipt of a claim. This period may be extended by up to 30 days if Guardian determines that an extension is necessary due to matters beyond the control of the plan, and so notifies you before the end of the initial 45-day period. Such notification will include the reason for the extension and a date by which the determination will be made. If prior to the end of the 30-day period Guardian determines that an additional extension is necessary due to matters beyond the control of the plan, and so notifies you, the time period for making a benefit determination may be extended for an additional period of up to 30 days. Such notification will include the special circumstances requiring the extension and a date by which the final determination will be made.

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

If you fail to provide all information needed to make a benefit determination, Guardian will notify you of the specific information that is needed as soon as possible but no later than 45 days after receipt of your application for an extension of benefits.

If Guardian extends the time period for making a benefit determination due to your failure to submit information necessary to make the determination, you will be given at least 45 days to provide the requested information. The extension period will begin on the date on which you respond to the request for additional information.

If an application for an extension of benefits is denied, Guardian will provide a notice that will set forth:

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

If an application is denied, you will have up to 180 days to make an appeal.

Guardian will conduct a full and fair review of an appeal which includes providing to claimants the following:
Life Insurance Claims Procedure (Cont.)

- the opportunity to submit written comments, documents, records and other information relating to the claim;
- the opportunity, upon request and free of charge, for reasonable access to, and copies of, all documents, records and other information relating to the claim; and
- a review that takes into account all comments, documents, records and other information submitted by the claimant relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination. In reviewing an appeal, Guardian will
- provide for a review conducted by a named fiduciary who is neither the person who made the initial adverse determination nor that person’s subordinate;
- in deciding an appeal based upon a medical judgment, consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment;
- identify medical or vocational experts whose advice was obtained in connection with an adverse benefit determination; and
- ensure that a health care professional engaged for consultation regarding an appeal based upon a medical judgment shall be neither the person who was consulted in connection with the adverse benefit determination, nor that person’s subordinate.

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

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

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

Termination of This Group Plan

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

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

When this plan ends, you may be eligible to continue or convert your insurance coverage. Your rights upon termination of the plan are explained in this booklet.
YOUR BENEFITS INFORMATION - ANYTIME, ANYWHERE

www.GuardianAnytime.com

Insured employees and their dependents can access helpful, secure information about their Guardian benefits(s) online at:

GuardianAnytime.com - 24 hours a day, 7 days a week.

Anytime, anywhere you have an internet connection you will be able to:

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

To register, go to www.GuardianAnytime.com