



# **YOUR GROUP INSURANCE PLAN BENEFITS**

**JEFF DAVIS COUNTY BOARD OF EDUCATION  
CLASS 0001  
CANCER BENEFITS**

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

**The Guardian Life Insurance Company of America**

10 Hudson Yards  
New York, New York 10001  
(212) 598-8000  
[www.GuardianAnytime.com](http://www.GuardianAnytime.com)

If Your Group Certificate includes any of the following coverages: Guardian Insured: Group Accident, Group Cancer, Group Critical Illness, Group Hospital Indemnity, Group Dental or Group Vision, the following consumer complaint notice is applicable. (Employer Funded Coverages, if any, are excluded from this Rider.)

**New Mexico Residents**  
**Consumer Complaint Notice**

**If You are a resident of New Mexico, Your coverage will be administered in accordance with the minimum applicable standards of New Mexico law. If You have concerns regarding a claim, premium, or other matters relating to this coverage, You may file a complaint with the New Mexico Office of Superintendent of Insurance (OSI) using the complaint form available on the OSI website and found at:**

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

CCN-2019-NM

B999.0042



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**CERTIFICATE OF COVERAGE**

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**The Guardian**  
10 Hudson Yards  
New York, New York 10001

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

Group Policy No.	Certificate No.	Effective Date
Issued To		

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

**The Guardian** Life Insurance Company of America

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

CGP-3-R-STK-90-3

B110.0023



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All Options

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**GENERAL PROVISIONS**

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As used in this booklet:

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

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

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

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

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

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

CGP-3-R-GENPRO-90

B160.0002

All Options

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**Limitation of Authority**

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

CGP-3-R-LOA-90

B160.0004

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### **Incontestability**

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

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

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

CGP-3-R-INCY-90

B160.0003

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### **Examination and Autopsy**

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

CGP-3-R-EA-90

B160.0006

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### **Accident and Health Claims Provisions**

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

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

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

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

## Accident and Health Claims Provisions (Cont.)

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

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

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

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

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

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

CGP-3-R-AHC-90

B160.0014

All Options

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**ELIGIBILITY FOR CANCER INSURANCE**

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**Employee Coverage**

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

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

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

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

CGP-3-EC-90-1.0

B477.0054

All Options

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

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

CGP-3-EC-90-2.0

B476.3878

All Options

**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.

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

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

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

### Group Cancer Insurance Coverage During a Family Leave of Absence

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

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

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

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

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

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

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

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

## Employee Coverage (Cont.)

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

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

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

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

CGP-3-EC-90-3.0

B477.0058

**All Options**

**Dependent Coverage**

CGP-3-DEP-90-1.0

B473.0009

**All Options**

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

CGP-3-DEP-90-2.0

B477.0070

**All Options**

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

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

**Dependents Not Eligible** *We exclude any dependent who is insured by this plan as an employee. And, we exclude any dependent who is on active duty in any armed force. Upon notice of entry into service, pro rata unearned premiums will be refunded.*

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

CGP-3-DEP-90-3.0

B477.0071

**All Options**

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

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

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

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

CGP-3-DEP-90-4.0

B477.0073

## All Options

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

CGP-3-DEP-90-5.0

B477.0075

## All Options

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

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

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

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

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

CGP-3-DEP-90-6.0

B477.0074

## All Options

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

CGP-3-DEP-90-7.0

B477.0076



## All Options

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

If *you* are required to pay part or all of the cost 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 or she stops being an eligible dependent. This happens to a child: (a) at 12:01 A.M. Standard Time at the child's place of residence on the date the child attains this *plan's* age limit; (b) when the child marries; or (c) when a step-child is no longer dependent on *you* for most of his or her support and maintenance. This happens to a spouse when a marriage ends in legal divorce or annulment.

CGP-3-DEP-90-9.0

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**SCHEDULE OF INSURANCE**

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**Cancer Benefit**

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

<b>Immunotherapy:</b>	\$500.00 per month. \$2,500.00 per lifetime.
<b>Intensive Care Unit Confinement:</b>	\$600.00 for first 30 days per confinement. \$800.00 for 31st day and thereafter confinement.
<b>Inpatient Special Nursing:</b>	\$150.00 per day. Limited to 30 days per <i>benefit year</i> .
<b>Medical Imaging:</b>	\$200.00 per image. Limited to 2 images per <i>benefit year</i> .
<b>Outpatient and Family Member Lodging:</b>	\$100.00 per day. Limited to 90 days per <i>benefit year</i> .
<b>Outpatient or Ambulatory Surgical Center:</b>	\$350.00 per day. Limited to 3 days per procedure.
<b>Physical or Speech Therapy:</b>	\$50.00 per visit. Limited to 4 visits per month. Limited to \$1,000.00 per lifetime.
<b>Surgically Implanted Prosthetic Devices:</b>	\$3,000.00 per device. Limited to \$6,000.00 per lifetime.
<b>Non-Surgically Implanted Prosthetic Devices:</b>	\$300.00 per device. Limited to \$600.00 per lifetime.
<b>Radiation Therapy and Chemotherapy:</b>	\$15,000.00 per <i>benefit year</i> .
Injected cytotoxic meds	\$1,200.00 per week.
Pump dispensed cytotoxic meds (first prescription then per week for refills)	\$1,200.00 per week.
Oral cytotoxic meds	\$600.00 per prescription up to \$1,800.00 per month.
Cytotoxic meds administration by any other method	\$1,200.00 per week.
External radiation therapy	\$1,000.00 per week.
Insertion of interstitial or intracavity admin of radioisotopes or radium	\$1,250.00 per week.
Oral or I.V. radiation	\$1,000.00 per week.
<b>Reconstructive Surgery:</b>	
Breast TRAM flap	\$3,000.00
Breast reconstruction	\$700.00
Breast symmetry	\$350.00
Facial reconstruction	\$700.00
<b>Reproductive Benefits:</b>	\$1,500.00 for egg harvesting \$500.00 for egg storage. \$500.00 for sperm storage. \$2,000.00 lifetime limit for all reproductive benefits.

**Second Surgical Opinion:** \$300.00  
 Limited to one per surgical procedure.

**Skin Cancer:**

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

**Surgical Benefits:**

<b>Surgery</b>	<b>Surgical Benefit</b>
Abdomen - Cholecystectomy	\$770.00
Abdomen - Exploratory laparotomy	\$580.00
Abdomen - Paracentesis	\$150.00
Bladder - (TUR) transurethral resection bladder tumors	\$580.00
Bladder - Cystectomy (complete)	\$1,980.00
Bladder - Cystectomy (partial)	\$990.00
Bladder - Cystectomy (with ureteroileal conduit)	\$3,960.00
Bladder - Cystoscopy	\$150.00
Brain - Burr holes not followed by surgery	\$770.00
Brain - Excision brain tumor	\$3,850.00
Brain - Exploratory craniotomy	\$1,650.00
Brain - Ventriculoperitoneal shunt	\$770.00
Brain - Hemispherectomy	\$5,500.00
Breast - lumpectomy	\$380.00
Breast - mastectomy partial	\$580.00
Breast - mastectomy radical	\$1,150.00
Breast - mastectomy simple	\$770.00
Chest - Bronchoscopy	\$330.00
Chest - Lobectomy	\$1,650.00
Chest - Mediastinoscopy	\$330.00
Chest - Pneumonectomy	\$2,310.00
Chest - Thoracentesis	\$150.00
Chest - Thoracostomy	\$330.00
Chest - Thoracotomy	\$770.00
Chest - Wedge resection	\$1,320.00

Esophagus - Esophagogastrectomy	\$1,650.00
Esophagus - Esophagoscopy	\$300.00
Esophagus - Resection of esophagus	\$2,200.00
Eye - Enucleation	\$550.00
Eye - P32 uptake	\$270.00
Female Reproductive - Abdominal hysterectomy/uterus only	\$990.00
Female Reproductive - Colposcopy	\$190.00
Female Reproductive - D&C	\$190.00
Female Reproductive - Oophorectomy	\$580.00
Female Reproductive - Uterus, tubes & ovaries	\$1,920.00
Female Reproductive - Uterus, tubes & ovaries with exenteration	\$5,500.00
Female Reproductive - Vaginal hysterectomy/uterus only	\$580.00
Intestines - Abdominal-perineal resection	\$2,750.00
Intestines - Colectomy	\$990.00
Intestines - Colonoscopy (does not include virtual or CT Colonography)	\$300.00
Intestines - Colostomy/or revision of	\$380.00
Intestines - ERCP	\$380.00
Intestines - Excesional on rectum for biopsy	\$300.00
Intestines - Ileostomy	\$380.00
Intestines - Proctosigmoidoscopy	\$150.00
Intestines - Resection of small intestine	\$2,310.00
Intestines - Sigmoidoscopy	\$150.00
Kidney - Nephrectomy (radical)	\$3,960.00
Kidney - Nephrectomy (simple)	\$2,310.00
Liver - Resection of liver	\$2,750.00
Lymphatic - Axillary node dissection	\$770.00
Lymphatic - Excision of lymph nodes	\$190.00
Lymphatic - Lymphadenectomy (bilateral)	\$990.00
Lymphatic - Lymphadenectomy (unilateral)	\$770.00
Lymphatic - Splenectomy	\$770.00
Mandible - Mandibulectomy	\$1,540.00
Misc - Bone marrow aspiration	\$150.00
Misc - Pathological hip fracture (chemo)	\$960.00

Misc - Venous-Catheters/venous port (chemo)	\$150.00
Misc - Peripherally inserted central catheter (PICC)	\$150.00
Misc - Pathological fracture (chemo)	\$440.00
Mouth - Glossectomy	\$770.00
Mouth - Hemiglossectomy	\$380.00
Mouth - Resection of palate	\$770.00
Mouth - Tonsil/Mucous membranes	\$580.00
Pancreas - Jejunostomy	\$990.00
Pancreas - Pancreatectomy	\$2,310.00
Pancrease - Whipple procedure	\$3,960.00
Penis - amputation, complete	\$770.00
Penis - amputation, partial	\$380.00
Penis - amputation, radical	\$990.00
Prostate - (TUR) transurethral resection prostate	\$580.00
Prostate - Cystoscopy	\$150.00
Prostate - Radical Prostatectomy	\$1,540.00
Radium Implants - Insertion	\$1,100.00
Radium Implants - Removal	\$550.00
Salivary glands - Parotidectomy	\$770.00
Salivary glands - Radical neck dissection	\$1,980.00
Spine - Cordotomy	\$580.00
Spine - Laminectomy	\$990.00
Stomach - Gastrectomy (complete)	\$1,540.00
Stomach - Gastrectomy (partial)	\$990.00
Stomach - Gastrojejunostomy	\$990.00
Stomach - Gastroscopy	\$330.00
Testis - Orchiectomy (bilateral)	\$530.00
Testis - Orchiectomy (unilateral)	\$380.00
Throat - Laryngectomy (w/out neck dissection)	\$990.00
Throat - Laryngectomy (with neck dissection)	\$1,980.00
Throat - Laryngoscopy	\$330.00
Throat - Tracheostomy	\$330.00
Thyroid - Thyroidectomy (partial: one lobe)	\$580.00
Thyroid - Thyroidectomy (total: both lobes)	\$770.00

Vulva - Vulvectomy (partial)	\$580.00
Vulva - Vulvectomy (radical)	\$1,540.00
<b>Transportation/Companion Transportation:</b>	\$0.50 per mile. Limited to \$1,500 per round trip.
CGP-3-SI	B477.0366

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**SCHEDULE OF INSURANCE**

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**Cancer Benefit**

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



<b>Intensive Care Unit Confinement:</b>	\$400.00 for first 30 days per confinement. \$600.00 for 31st day and thereafter confinement.
<b>Inpatient Special Nursing:</b>	\$100.00 per day. Limited to 30 days per <i>benefit year</i> .
<b>Medical Imaging:</b>	\$100.00 per image. Limited to 2 images per <i>benefit year</i> .
<b>Outpatient and Family Member Lodging:</b>	\$75.00 per day. Limited to 90 days per <i>benefit year</i> .
<b>Outpatient or Ambulatory Surgical Center:</b>	\$250.00 per day. Limited to 3 days per procedure.
<b>Physical or Speech Therapy:</b>	\$25.00 per visit. Limited to 4 visits per month. Limited to \$400.00 per lifetime.
<b>Surgically Implanted Prosthetic Devices:</b>	\$2,000.00 per device. Limited to \$4,000.00 per lifetime.
<b>Non-Surgically Implanted Prosthetic Devices:</b>	\$200.00 per device. Limited to \$400.00 per lifetime.
<b>Radiation Therapy and Chemotherapy:</b>	\$10,000.00 per <i>benefit year</i> .
Injected cytotoxic meds	\$800.00 per week.
Pump dispensed cytotoxic meds (first prescription then per week for refills)	\$800.00 per week.
Oral cytotoxic meds	\$400.00 per prescription up to \$1,200.00 per month.
Cytotoxic meds administration by any other method	\$800.00 per week.
External radiation therapy	\$650.00 per week.
Insertion of interstitial or intracavity admin of radioisotopes or radium	\$800.00 per week.
Oral or I.V. radiation	\$650.00 per week.
<b>Reconstructive Surgery:</b>	
Breast TRAM flap	\$2,000.00
Breast reconstruction	\$500.00
Breast symmetry	\$250.00
Facial reconstruction	\$500.00
<b>Second Surgical Opinion:</b>	\$200.00 Limited to one per surgical procedure.
<b>Skin Cancer:</b>	
Biopsy only	\$100.00
Reconstructive surgery following excision of a skin cancer	\$250.00

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

**Surgical Benefits:**

<b>Surgery</b>	<b>Surgical Benefit</b>
Abdomen - Cholecystectomy	\$575.00
Abdomen - Exploratory laparotomy	\$435.00
Abdomen - Paracentesis	\$110.00
Bladder - (TUR) transurethral resection bladder tumors	\$435.00
Bladder - Cystectomy (complete)	\$1,485.00
Bladder - Cystectomy (partial)	\$740.00
Bladder - Cystectomy (with ureteroileal conduit)	\$2,970.00
Bladder - Cystoscopy	\$110.00
Brain - Burr holes not followed by surgery	\$575.00
Brain - Excision brain tumor	\$2,885.00
Brain - Exploratory craniotomy	\$1,235.00
Brain - Ventriculoperitoneal shunt	\$575.00
Brain - Hemispherectomy	\$4,125.00
Breast - lumpectomy	\$285.00
Breast - mastectomy partial	\$435.00
Breast - mastectomy radical	\$860.00
Breast - mastectomy simple	\$575.00
Chest - Bronchoscopy	\$245.00
Chest - Lobectomy	\$1,235.00
Chest - Mediastinoscopy	\$245.00
Chest - Pneumonectomy	\$1,730.00
Chest - Thoracentesis	\$110.00
Chest - Thoracostomy	\$245.00
Chest - Thoracotomy	\$575.00
Chest - Wedge resection	\$990.00
Esophagus - Esophagogastrectomy	\$1,235.00
Esophagus - Esophagoscopy	\$225.00
Esophagus - Resection of esophagus	\$1,650.00
Eye - Enucleation	\$410.00
Eye - P32 uptake	\$200.00

Female Reproductive - Abdominal hysterectomy/uterus only	\$740.00
Female Reproductive - Colposcopy	\$140.00
Female Reproductive - D&C	\$140.00
Female Reproductive - Oophorectomy	\$435.00
Female Reproductive - Uterus, tubes & ovaries	\$1,440.00
Female Reproductive - Uterus, tubes & ovaries with exenteration	\$4,125.00
Female Reproductive - Vaginal hysterectomy/uterus only	\$435.00
Intestines - Abdominal-perineal resection	\$2,060.00
Intestines - Colectomy	\$740.00
Intestines - Colonoscopy (does not include virtual or CT Colonography)	\$225.00
Intestines - Colostomy/or revision of	\$285.00
Intestines - ERCP	\$285.00
Intestines - Excisional on rectum for biopsy	\$225.00
Intestines - Ileostomy	\$285.00
Intestines - Proctosigmoidoscopy	\$110.00
Intestines - Resection of small intestine	\$1,730.00
Intestines - Sigmoidoscopy	\$110.00
Kidney - Nephrectomy (radical)	\$2,970.00
Kidney - Nephrectomy (simple)	\$1,730.00
Liver - Resection of liver	\$2,060.00
Lymphatic - Axillary node dissection	\$575.00
Lymphatic - Excision of lymph nodes	\$140.00
Lymphatic - Lymphadenectomy (bilateral)	\$740.00
Lymphatic - Lymphadenectomy (unilateral)	\$575.00
Lymphatic - Splenectomy	\$575.00
Mandible - Mandibulectomy	\$1,155.00
Misc - Bone marrow aspiration	\$110.00
Misc - Pathological hip fracture (chemo)	\$720.00
Misc - Venous-Catheters/venous port (chemo)	\$110.00
Misc - Peripherally inserted central catheter (PICC)	\$110.00
Misc - Pathological fracture (chemo)	\$330.00
Mouth - Glossectomy	\$575.00
Mouth - Hemiglossectomy	\$285.00

Mouth - Resection of palate	\$575.00
Mouth - Tonsil/Mucous membranes	\$435.00
Pancreas - Jejunostomy	\$740.00
Pancreas - Pancreatectomy	\$1,730.00
Pancrease - Whipple procedure	\$2,970.00
Penis - amputation, complete	\$575.00
Penis - amputation, partial	\$285.00
Penis - amputation, radical	\$740.00
Prostate - (TUR) transurethral resection prostate	\$435.00
Prostate - Cystoscopy	\$110.00
Prostate - Radical Prostatectomy	\$1,155.00
Radium Implants - Insertion	\$825.00
Radium Implants - Removal	\$410.00
Salivary glands - Parotidectomy	\$575.00
Salivary glands - Radical neck dissection	\$1,485.00
Spine - Cordotomy	\$435.00
Spine - Laminectomy	\$740.00
Stomach - Gastrectomy (complete)	\$1,155.00
Stomach - Gastrectomy (partial)	\$740.00
Stomach - Gastrojejunostomy	\$740.00
Stomach - Gastroscopy	\$245.00
Testis - Orchiectomy (bilateral)	\$395.00
Testis - Orchiectomy (unilateral)	\$285.00
Throat - Laryngectomy (w/out neck dissection)	\$740.00
Throat - Laryngectomy (with neck dissection)	\$1,485.00
Throat - Laryngoscopy	\$245.00
Throat - Tracheostomy	\$245.00
Thyroid - Thyroidectomy (partial: one lobe)	\$435.00
Thyroid - Thyroidectomy (total: both lobes)	\$575.00
Vulva - Vulvectomy (partial)	\$435.00
Vulva - Vulvectomy (radical)	\$1,155.00

**Transportation/Companion Transportation:** \$0.50 per mile.  
Limited to \$1,000 per round trip.

CGP-3-SI B477.0368

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## CANCER COVERAGE

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

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

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

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

CGP-3-CAN-IC-12

B477.0002

### Option B

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#### Benefits

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

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

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

## Benefits (Cont.)

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- Ambulance** We will pay the amount shown in the schedule of insurance if a licensed professional ambulance is used to transport a *covered person* to a *hospital* where a *covered person* is confined as an *inpatient* for *internal cancer* treatment. We limit what we pay to two one-way trips per *period of hospital confinement*.
- Anesthesia** If general anesthesia is provided to a *covered person* in connection with a surgical procedure covered under the Surgical Benefits section, we will pay 25% of the amount shown in the schedule of insurance for the surgical procedure.
- Anti-Nausea Medication** We will pay the amount shown in the schedule of insurance if a *doctor* prescribes a *covered person* drugs to control nausea related to chemotherapy or radiation for *internal cancer* treatments. We limit what we pay each month to the amount shown in the schedule of insurance.
- Attending Doctor** We will pay the amount shown in the schedule of insurance if a *covered person* is visited by a *doctor* for the treatment of *internal cancer* while confined in a *hospital* . We don't pay for visits by the operating surgeon. We limit what we pay per *period of hospital confinement* to the number of days shown in the schedule of insurance.
- Blood, Plasma and Platelets** We will pay the amount shown in the schedule of insurance for each day a *covered person* receives blood, plasma and/or platelets for the treatment of *internal cancer*. We pay whether the blood, plasma and/or platelets is received as an *inpatient* in a *hospital* or as an outpatient in a *doctor's* office, *hospital* or *ambulatory surgical center*. We don't pay for blood, plasma and/or platelets for any other reason, including replacement of blood during surgery. And we limit what we pay in the 12 months which starts on the date of the first treatment to the amount shown in the schedule of insurance.
- Bone Marrow and Stem Cells** We will pay the amount shown in the schedule of insurance if a *covered person* receives a *bone marrow transplant* or *stem cell transplant* to treat *internal cancer*.
- Cancer Screening** Once per *benefit year*, we will pay the amount in the schedule of insurance if you provide *proof* satisfactory to us that a *covered person* received at least one of the following tests for *internal cancer* : (1) bone marrow testing; (2) BRCA testing; (3) breast ultrasound; (4) breast MRI; (5) colonoscopy or virtual colonoscopy; (6) CA 125 test (blood test for ovarian *cancer* ); (7) CA 15-3 test (blood test for breast *cancer* ); (8) CEA (blood test for colon *cancer* ) (9) chest x-ray; (10) CT scans or MRI scans; (11) flexible sigmoidoscopy; (12) hemocult stool specimen (lab confirmed); (13) mammogram; (14) pap smear; (15) PSA (blood test for prostate *cancer* ); (16) Serum Protein Electrophoresis (test for myeloma); (17) testicular ultrasound; (18) thermography; or (19) ThinPrep.
- We will pay this benefit once per *benefit year* for each *covered person* regardless of whether multiple tests are performed. We will pay this benefit whether or not *cancer* is *diagnosed*.

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

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

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

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

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

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

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

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

## Benefits (Cont.)

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

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

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

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

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

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

CGP-3-CAN-BEN-12

B477.0003

### Option A

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## Benefits

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

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

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



- Anti-Nausea Medication** We will pay the amount shown in the schedule of insurance if a *doctor* prescribes a *covered person* drugs to control nausea related to chemotherapy or radiation for *internal cancer* treatments. We limit what we pay each month to the amount shown in the schedule of insurance.
- Attending Doctor** We will pay the amount shown in the schedule of insurance if a *covered person* is visited by a *doctor* for the treatment of *internal cancer* while confined in a *hospital* . We don't pay for visits by the operating surgeon. We limit what we pay per *period of hospital confinement* to the number of days shown in the schedule of insurance.
- Blood, Plasma and Platelets** We will pay the amount shown in the schedule of insurance for each day a *covered person* receives blood, plasma and/or platelets for the treatment of *internal cancer*. We pay whether the blood, plasma and/or platelets is received as an *inpatient* in a *hospital* or as an outpatient in a *doctor's* office, *hospital* or *ambulatory surgical center*. We don't pay for blood, plasma and/or platelets for any other reason, including replacement of blood during surgery. And we limit what we pay in the 12 months which starts on the date of the first treatment to the amount shown in the schedule of insurance.
- Bone Marrow and Stem Cells** We will pay the amount shown in the schedule of insurance if a *covered person* receives a *bone marrow transplant* or *stem cell transplant* to treat *internal cancer*.
- Cancer Screening** Once per *benefit year*, we will pay the amount in the schedule of insurance if you provide *proof* satisfactory to us that a *covered person* received at least one of the following tests for *internal cancer* : (1) bone marrow testing; (2) BRCA testing; (3) breast ultrasound; (4) breast MRI; (5) colonoscopy or virtual colonoscopy; (6) CA 125 test (blood test for ovarian *cancer* ); (7) CA 15-3 test (blood test for breast *cancer* ); (8) CEA (blood test for colon *cancer* ) (9) chest x-ray; (10) CT scans or MRI scans; (11) flexible sigmoidoscopy; (12) hemocult stool specimen (lab confirmed); (13) mammogram; (14) pap smear; (15) PSA (blood test for prostate *cancer* ); (16) Serum Protein Electrophoresis (test for myeloma); (17) testicular ultrasound; (18) thermography; or (19) ThinPrep.
- We will pay this benefit once per *benefit year* for each *covered person* regardless of whether multiple tests are performed. We will pay this benefit whether or not *cancer* is *diagnosed*.
- Cancer Screening Follow-Up** Once per *benefit year*, we will pay the amount shown in the schedule of insurance for an additional invasive diagnostic procedure provided to a *covered person*. We will pay this benefit only if the procedure is recommended by a *doctor* as necessary due to the results of the initial *cancer* screening procedure.
- Experimental Treatment** We pay the amount shown in the schedule of insurance if a *doctor* prescribes experimental treatment for a *covered person* for the purpose of destroying or changing abnormal tissue, and the treatment is administered by medical personnel in a *doctor's* office, *clinic* or *hospital*. All treatment must be *NCI-listed* as viable experimental treatment for *internal cancer*.

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

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

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

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

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

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

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

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

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

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

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

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

CGP-3-CAN-BEN-12

B477.0005

**Option B**

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

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

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

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

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

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

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

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

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

**Outpatient or  
Ambulatory Surgical  
Center**

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

**Physical or Speech  
Therapy**

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

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

**Prosthetic Devices**

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

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

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

**Radiation Therapy  
or Chemotherapy**

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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**Option A**

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

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

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

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

- Medical Imaging** We will pay the amount shown in the schedule of insurance if a covered person receives a medical imaging procedure related to a diagnosed internal cancer. We limit what we pay each benefit year to the number of images shown in the schedule of insurance.
- Outpatient and Family Member Lodging** We pay the amount in the schedule of insurance per day for lodging as described below. We limit what we pay for lodging to the number of days shown in the schedule of insurance.
- We pay a daily lodging benefit when a covered person stay in a hotel, motel or other commercial accommodation in conjunction with receiving treatment of internal cancer. Such treatment must be ordered by a doctor and must not be able to be obtained locally. Lodging must occur more than 50 miles from the covered person's home.
- We pay a daily lodging benefit for one adult family member who stays in a hotel, motel or other commercial accommodation in order to be near the covered person while confined in a hospital for internal cancer treatment. The hospital must be at least 50 miles from the covered person's home.
- We don't pay for any day that a stay begins more than 24 hours prior to treatment or more than 24 hours after treatment.
- Outpatient or Ambulatory Surgical Center** We will pay the amount shown in the schedule of insurance when a covered person uses an outpatient or ambulatory surgical center for a surgical procedure covered under this plan's surgical benefits section. We limit what we pay to three days per surgical procedure.
- Physical or Speech Therapy** We will pay the amount shown in the schedule of insurance for physical or speech therapy provided to a covered person for restoration of normal body function following treatment of internal cancer. Such therapy must be provided by a licensed or certified physical or speech therapist.
- We limit what we pay combined for physical and speech therapy to the number of visits per month shown in the schedule of insurance. We limit what we pay for physical and speech therapy combined to the lifetime limit shown in the schedule of insurance.
- Prosthetic Devices** We will pay the amount shown in the schedule of insurance for prosthetic devices provided to a covered person as a direct result of treatment of internal cancer. There are separate amounts shown in the schedule of insurance for surgically implanted prosthetic devices and non-surgically implanted prosthetic devices. We limit what we pay for prosthetic devices in a covered person's lifetime to the amounts shown in the schedule of insurance.
- Surgically implanted prosthetic devices must be the direct result or consequence of the surgical treatment of internal cancer.
- The prosthetic device coverage does not include coverage for a Breast Transverse Rectus Abdominis Myocutaneous (TRAM) Flap procedure as listed under the Reconstructive Surgery benefit.

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

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

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

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

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

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

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

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

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

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



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

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

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

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Option B

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**DEFINITIONS**

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- Accredited Practitioner** This term means a *naturopathic doctor, ayurvedic practitioner, bio-feedback practitioner or hypnotherapist* who is licensed (if applicable) under the laws of the state where treatment is received as qualified to treat the type of condition for which a claim is being made. If licensed, the practitioner must be practicing within the scope of his or her license.
- Ayurvedic Medicine** This term means a practice of health promotion, disease prevention, and personal growth that includes physical, psychological and spiritual aspects. ayurvedic practices are intended to promote well being and reduce stress and may include yoga, meditation, massage, dietary changes and herbs.
- Ayurvedic Practitioner** This term means an *accredited practitioner* who has been certified through the American Association of Drugless Accredited Practitioners for Ayurvedic Medicine.
- Ambulatory Surgical Center** This term means a facility in which outpatient surgery is done. It must meet all of the requirements shown below:
- have a medical staff of *doctors*, nurses, and licensed anesthesiologist;
  - maintain at least two operating rooms; and one recovery room;
  - maintain diagnostic lab and x-ray facilities;
  - be staffed and equipped to give emergency care;
  - have a blood supply;
  - maintain medical records;
  - have agreements with *hospitals* for immediate acceptance of patients who need *inpatient* confinement; and
  - be licensed in accord with the laws of the appropriate legally authorized agency. A facility is not an *ambulatory surgical center* if it is part of a *hospital*.
- Benefit Year** This term means each period of 12 months in a row which starts on starts on January 1st and ends on December 31st.
- Bio-Feedback** This term means a therapy that trains and uses the mind to control body functions that are typically regulated automatically such as muscle tension, heart rate, blood pressure or temperature.
- Bio-Feedback Practitioner** This term means an *accredited practitioner* who has a bachelor's degree in a health related profession, such as a degree in medicine, osteopathy or naturopathic medicine and who has received certification from the Biofeedback Society of America and is currently licensed in the state where he or she practices.
- Board Certified** This term means a *doctor* who has been certified in the appropriate medical specialty by a member board of the American Board of Medical Specialties.

- Bone Marrow Transplant** This term means a procedure in which a patient's bone marrow is replaced with cellular elements to reconstitute the bone marrow. It may be preceded by chemotherapy, radiotherapy, or other treatments which cause residual bone marrow to be destroyed. The collection of stem cells or other peripheral blood cells and their reinfusion is not a *bone marrow transplant*.
- Cancer** This term means *you* have been *diagnosed* with a disease manifested by the presence of a malignant tumor characterized by the uncontrolled growth and spread of malignant cells in any part of the body. This includes leukemia, Hodgkin's disease, lymphoma, sarcoma, malignant tumors and melanoma. *Cancer* includes carcinomas in- situ (in the natural or normal place, confined to the site of origin, without having invaded neighboring tissue). Pre-malignant conditions or conditions with malignant potential, such as myelodysplastic and myeloproliferative disorders, carcinoid, leukoplakia, hyperplasia, actinic keratosis, polycythemia, and nonmalignant melanoma, moles or similar diseases or lesions will not be considered *cancer*.
- Clinic** This term means an institution, building or part of a building where outpatients receive treatment for Diagnoses.
- Covered Person** This term means *you*, if *you* are covered under this *plan* and *your* covered dependents.
- Diagnosed or Diagnosis** These terms mean the establishment of *cancer* by a *doctor* through the use of clinical and/or lab findings. Diagnosis of *cancer* must be based on microscopic (histologic) exam of: (a) fixed tissues; or (b) preparations of blood or bone marrow. Such exam must be documented in a written report by a *doctor* who is *board certified* in pathology. If, however, in the opinion of the attending *doctor*, a pathological diagnosis is medically inappropriate, a clinical diagnosis of *cancer* will be accepted.
- Doctor** This term means any practitioner of the healing arts that: (a) is properly licensed or certified by the laws of the state in which he or she practices; and (b) provides services that are within the lawful scope of his or license.
- Extended Care Facility or Skilled Nursing Facility** This term means a facility which mainly provides full-time *inpatient* skilled nursing care for sick or injured people who do not need to be in a *hospital*. This *plan* recognizes such a place if it carries out its stated purpose under all relevant state and local laws, and it is: (a) accredited for its stated purpose by the Joint Commission of Healthcare Organizations; or (b) approved for its stated purpose by Medicare. In some places an extended care facility is called: (a) a rehabilitation facility; or (b) a skilled nursing facility; or (c) a sub-acute facility.
- Family Member** This term means *your* spouse, brother or sister (including stepbrother or stepsister), children (including stepchildren), parents (including stepparents), grandchildren, father or mother-in-law, and spouses, if applicable, of any of these.
- Hospice** This term means a licensed facility or program which provides a coordinated set of services at home or in a facility for persons who are certified by a *doctor* as terminally ill.

- Hospital** This term means a short-term, acute care general facility, which:
- (1) is primarily engaged in providing, by or under the continuous supervision of *doctors*, to *inpatients*, diagnostic services and therapeutic services for diagnosis, treatment and care of sick or injured persons;
  - (2) has organized departments of medicine and major surgery;
  - (3) has a requirement that every patient must be under the care of a *doctor* or *dentist*;
  - (4) provides 24 hour nursing service by or under the supervision of a registered professional nurse (R.N.);
  - (5) is duly licensed by the agency responsible for licensing such *hospitals*; and
  - (6) is not, other than incidentally: (a) a place of rest; (b) a place primarily for the treatment of tuberculosis; (c) a place for the aged; (d) a place for drug addicts or alcoholics; or (e) a place for convalescent, custodial, educational or rehabilitative care.
- Hypnotherapist** This term means an *accredited practitioner* who has been certified by the American Board of Hypnotherapy or the American Clinical Board of Hypnotherapy.
- Hypnotherapy** This term means a change in a person's conscious awareness, induced by another person, which may alter memory and consciousness, increase susceptibility to suggestions, and bring about responses and ideas that may be considered unusual.
- Immunotherapy** This term means treatments intended to improve the immune system by providing antibodies, colony stimulating factors, or immunoglobulins for the purpose of treating *cancer*.
- Inpatient** This term means: (a) a *covered person* who is physically confined as a registered bed patient in a *hospital* or other recognized health care facility; or (b) the confinement itself.
- Intensive Care Unit** This term means a *hospital* area of special care, which at the time of admission is separate and apart from the surgical recovery room, other rooms, beds or wards normally used for patient confinement. In addition, the unit must provide the following: (a) 24 hour continuous nursing care attended by nurses assigned to the unit on a full-time basis; (b) direction and/or supervision by a full time doctor director or a standing "intensive care" committee of the medical staff; and (c) special medical apparatus used to treat the critically ill.
- Internal Cancer** This term means a *cancer* contained within the body. *Internal cancers* do not include skin *cancer* except for melanomas classified as Clark's level III and higher or a Breslow level greater than or equal to 1.5mm.

## Definitions (Cont.)

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- Naturopathic Doctor** This term means an *accredited practitioner* who has graduated from a four year naturopathic medical school, which is accredited by the Council on Naturopathic Medical Education.
- NCI-Listed** This term means a *cancer* treatment protocol that is listed in the National Cancer Institute's (NCI) Physician Data Query (PDQ). The PDQ is an on-line database that contains *cancer* information summaries, listings of clinical trials, and directories of *doctors* and organization involved in *cancer* care.
- Palliative Care** This term means treatment or services designed to reduce the severity of a condition or symptoms without curing the underlying disease.
- Period of Hospital Confinement** This term means *hospital* confinement for a continuous and uninterrupted period of time while under the regular care and attendance of a *doctor*. A new period of *hospital* confinement will begin if a new *hospital* confinement occurs 30 or more days after the end of the previous *hospital* confinement or if the *hospital* confinement results from a completely independent cause from the previous *hospital* confinement.
- Plan** This term means the group *cancer* coverage described in the *plan* and this certificate.
- Pre-Existing Condition** A pre-existing condition is a *cancer*, whether diagnosed or misdiagnosed, for which in the 12 months before a person becomes covered by this *plan*, he or she: (1) received advice or treatment from a *doctor*; (2) underwent diagnostic procedures; (3) was prescribed or took prescription drugs; or (4) received other medical care or treatment, including consultation with a *doctor*.
- Proof or Proof Of Insurability** These terms mean an application for coverage showing that a person is insurable.
- Stem Cell Transplant** This term means the delivery of autologous or allogeneic stem cells to a person who has received chemotherapy or radiology to treat *internal cancer*. This definition does not include allogeneic or autogeneic bone marrow collection and infusion of bone marrow under general anesthesia.
- We, Us and Our** These terms mean The Guardian Life Insurance Company of America.
- You or Your** These terms mean the insured *employee*.

CGP-3-CAN-DEF-12

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Option A

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**DEFINITIONS**

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- Ambulatory Surgical Center** This term means a facility in which outpatient surgery is done. It must meet all of the requirements shown below:
- have a medical staff of *doctors*, nurses, and licensed anesthesiologist;
  - maintain at least two operating rooms; and one recovery room;
  - maintain diagnostic lab and x-ray facilities;
  - be staffed and equipped to give emergency care;
  - have a blood supply;
  - maintain medical records;
  - have agreements with *hospitals* for immediate acceptance of patients who need *inpatient* confinement; and
  - be licensed in accord with the laws of the appropriate legally authorized agency. A facility is not an *ambulatory surgical center* if it is part of a *hospital*.
- Benefit Year** This term means each period of 12 months in a row which starts on starts on January 1st and ends on December 31st.
- Board Certified** This term means a *doctor* who has been certified in the appropriate medical specialty by a member board of the American Board of Medical Specialties.
- Bone Marrow Transplant** This term means a procedure in which a patient's bone marrow is replaced with cellular elements to reconstitute the bone marrow. It may be preceded by chemotherapy, radiotherapy, or other treatments which cause residual bone marrow to be destroyed. The collection of stem cells or other peripheral blood cells and their reinfusion is not a *bone marrow transplant*.
- Cancer** This term means *you* have been *diagnosed* with a disease manifested by the presence of a malignant tumor characterized by the uncontrolled growth and spread of malignant cells in any part of the body. This includes leukemia, Hodgkin's disease, lymphoma, sarcoma, malignant tumors and melanoma. *Cancer* includes carcinomas in- situ (in the natural or normal place, confined to the site of origin, without having invaded neighboring tissue). Pre-malignant conditions or conditions with malignant potential, such as myelodysplastic and myeloproliferative disorders, carcinoid, leukoplakia, hyperplasia, actinic keratosis, polycythemia, and nonmalignant melanoma, moles or similar diseases or lesions will not be considered *cancer*.
- Clinic** This term means an institution, building or part of a building where outpatients receive treatment for Diagnoses.
- Covered Person** This term means *you*, if *you* are covered under this *plan* and *your* covered dependents.

- Diagnosed or Diagnosis** These terms mean the establishment of *cancer* by a *doctor* through the use of clinical and/or lab findings. Diagnosis of *cancer* must be based on microscopic (histologic) exam of: (a) fixed tissues; or (b) preparations of blood or bone marrow. Such exam must be documented in a written report by a *doctor* who is *board certified* in pathology. If, however, in the opinion of the attending *doctor*, a pathological diagnosis is medically inappropriate, a clinical diagnosis of *cancer* will be accepted.
- Doctor** This term means any practitioner of the healing arts that: (a) is properly licensed or certified by the laws of the state in which he or she practices; and (b) provides services that are within the lawful scope of his or license.
- Extended Care Facility or Skilled Nursing Facility** This term means a facility which mainly provides full-time *inpatient* skilled nursing care for sick or injured people who do not need to be in a *hospital*. This *plan* recognizes such a place if it carries out its stated purpose under all relevant state and local laws, and it is: (a) accredited for its stated purpose by the Joint Commission of Healthcare Organizations; or (b) approved for its stated purpose by Medicare. In some places an extended care facility is called: (a) a rehabilitation facility; or (b) a skilled nursing facility; or (c) a sub-acute facility.
- Family Member** This term means *your* spouse, brother or sister (including stepbrother or stepsister), children (including stepchildren), parents (including stepparents), grandchildren, father or mother-in-law, and spouses, if applicable, of any of these.
- Hospice** This term means a licensed facility or program which provides a coordinated set of services at home or in a facility for persons who are certified by a *doctor* as terminally ill.
- Hospital** This term means a short-term, acute care general facility, which:
- (1) is primarily engaged in providing, by or under the continuous supervision of *doctors*, to *inpatients*, diagnostic services and therapeutic services for diagnosis, treatment and care of sick or injured persons;
  - (2) has organized departments of medicine and major surgery;
  - (3) has a requirement that every patient must be under the care of a *doctor* or *dentist*;
  - (4) provides 24 hour nursing service by or under the supervision of a registered professional nurse (R.N.);
  - (5) is duly licensed by the agency responsible for licensing such *hospitals*; and
  - (6) is not, other than incidentally: (a) a place of rest; (b) a place primarily for the treatment of tuberculosis; (c) a place for the aged; (d) a place for drug addicts or alcoholics; or (e) a place for convalescent, custodial, educational or rehabilitative care.

## Definitions (Cont.)

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- Immunotherapy** This term means treatments intended to improve the immune system by providing antibodies, colony stimulating factors, or immunoglobulins for the purpose of treating *cancer*.
- Inpatient** This term means: (a) a *covered person* who is physically confined as a registered bed patient in a *hospital* or other recognized health care facility; or (b) the confinement itself.
- Intensive Care Unit** This term means a *hospital* area of special care, which at the time of admission is separate and apart from the surgical recovery room, other rooms, beds or wards normally used for patient confinement. In addition, the unit must provide the following: (a) 24 hour continuous nursing care attended by nurses assigned to the unit on a full-time basis; (b) direction and/or supervision by a full time doctor director or a standing "intensive care" committee of the medical staff; and (c) special medical apparatus used to treat the critically ill.
- Internal Cancer** This term means a *cancer* contained within the body. *Internal cancers* do not include skin *cancer* except for melanomas classified as Clark's level III and higher or a Breslow level greater than or equal to 1.5mm.
- NCI-Listed** This term means a *cancer* treatment protocol that is listed in the National Cancer Institute's (NCI) Physician Data Query (PDQ). The PDQ is an on-line database that contains *cancer* information summaries, listings of clinical trials, and directories of *doctors* and organization involved in *cancer* care.
- Palliative Care** This term means treatment or services designed to reduce the severity of a condition or symptoms without curing the underlying disease.
- Period of Hospital Confinement** This term means *hospital* confinement for a continuous and uninterrupted period of time while under the regular care and attendance of a *doctor*. A new period of *hospital* confinement will begin if a new *hospital* confinement occurs 30 or more days after the end of the previous *hospital* confinement or if the *hospital* confinement results from a completely independent cause from the previous *hospital* confinement.
- Plan** This term means the group *cancer* coverage described in the *plan* and this certificate.
- Pre-Existing Condition** A pre-existing condition is a *cancer*, whether diagnosed or misdiagnosed, for which in the 12 months before a person becomes covered by this *plan*, he or she: (1) received advice or treatment from a *doctor*; (2) underwent diagnostic procedures; (3) was prescribed or took prescription drugs; or (4) received other medical care or treatment, including consultation with a *doctor*.
- Proof or Proof Of Insurability** These terms mean an application for coverage showing that a person is insurable.



## Definitions (Cont.)

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

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

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

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### All Options

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## Limitations

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

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

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

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

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

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

CGP-3-CAN-LIMIT-12

B477.0028

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**Exclusions**

This *plan* will not pay benefits for:

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

CGP-3-CAN-EXC-12

B477.0030

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**Waiver of Premium**

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

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

CGP-3-CAN-WP-12

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**PORTABILITY**

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**Note** This section does not apply to residents of Kansas, Maine, or South Dakota.

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

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

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

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

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

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

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

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

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

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

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**CERTIFICATE AMENDMENT - ELIGIBILITY FOR CANCER COVERAGE**

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

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

**Conditions of Eligibility**

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

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

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

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

**When Employee Coverage Starts** *Your* eligibility date is the date *you* have met all of the conditions of eligibility.

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

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

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

## DEPENDENT COVERAGE

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

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

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

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

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

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

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

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

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

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

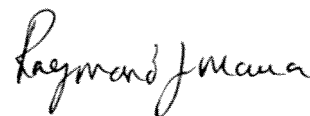
Once *you* have dependent child coverage for *your initial dependent* child(ren) any *newly acquired dependent* children will be covered as of the date he or she is first eligible.

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

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

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

**The Guardian** Life Insurance Company of America



Senior Vice President, Group and Worksite Markets

B477.0479

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**CERTIFICATE AMENDMENT**

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The certificate is amended to add the following:

**Initial Diagnosis Benefit**

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

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

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

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

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

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

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

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

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

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

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

**The Guardian** Life Insurance Company of America

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

CGP-3-A-CAN-IDB-12

B477.0036



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**CERTIFICATE AMENDMENT**

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The certificate is amended to add the following:

**Initial Diagnosis Benefit**

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

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

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

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

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

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

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

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

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

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

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

**The Guardian** Life Insurance Company of America

Stuart J Shaw

Vice President, Risk Mgt. & Chief Actuary

CGP-3-A-CAN-IDB-12

B477.0036

All Options

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**GLOSSARY**

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This Glossary defines the italicized terms appearing in your booklet.

CGP-3-GLOSS-90

B900.0118

All Options

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

CGP-3-GLOSS-90

B900.0003

All Options

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

CGP-3-GLOSS-90

B750.0015

All Options

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

CGP-3-GLOSS-90

B750.0006

All Options

**Employer** means JEFF DAVIS COUNTY BOARD OF EDUCATION .

CGP-3-GLOSS-90

B900.0051

All Options

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

CGP-3-GLOSS-90

B900.0004

All Options

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

CGP-3-GLOSS.1

B750.0230

All Options

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

CGP-3-GLOSS-90

B900.0006

**All Options**

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

CGP-3-GLOSS-90

B900.0008

**All Options**

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

CGP-3-GLOSS-90

B900.0039

## All Options

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

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## STATEMENT OF ERISA RIGHTS

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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.

## Statement of Erisa Rights (Cont.)

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

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

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

B800.0093

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## Group Health Benefits Claims Procedure

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

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

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

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

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

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

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

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

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

**Adverse Benefit Determination** If a claim is denied, Guardian will provide a notice that will set forth:

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



## Group Health Benefits Claims Procedure (Cont.)

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

### **Appeal of Adverse Benefit Determinations**

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

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

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

In reviewing an appeal, Guardian will:

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

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

## Group Health Benefits Claims Procedure (Cont.)

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

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

B752.0052

### All Options

### Termination of This Group Plan

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

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

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

B800.0086

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## **YOUR BENEFITS INFORMATION - ANYTIME, ANYWHERE**

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**[www.GuardianAnytime.com](http://www.GuardianAnytime.com)**

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

[GuardianAnytime.com](http://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](http://www.GuardianAnytime.com)



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

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