EXHIBIT 5 - Vol. 2

GLOSSARY

This Glossary defines the italicized terms appearing in your booklet.

CGP-3-GLOSS-90 B900.0118-R

Active Appliance means an *appliance* like braces, used in *orthodontic treatment* to move teeth.

CGP-3-GLOSS-90 B750.0192-R

Appliance means any dental device other than a *prosthetic device.*

CGP-3-GLOSS-90 B750.0193-R

Benefit Year with respect to this *plan's* dental expense insurance, means a 12 month period which starts on January 1st and ends on December 31st of each year.

CGP-3-GLOSS-90 B750.0293-R

Close Relative means: (a) a *covered person's* spouse, children, parents, brothers and sisters; and (b) any other person who is part of a *covered person's* household. We don't pay for services and supplies furnished by *close relatives.*

CGP-3-GLOSS-90 B750.0195-R

Covered Person with respect to this *plan's* dental expense insurance, means an *employee* or any of his *covered dependents.*

CGP-3-GLOSS-90 B750.0196-R

Dentist means any dental or medical practitioner we are required by law to recognize who: (a) is properly licensed or certified under the laws of the state where he practices; and (b) provides services which are within the scope of his license or certificate and covered by this *plan.*

CGP-3-GLOSS-90 B750.0198-R

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-R

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

CGP-3-GLOSS-90 B750.0015-R

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-R

Employer means NATIONAL BASKETBALL ASSOCIATION .

CGP-3-GLOSS-90 B900.0051-R

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-R

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 30 hours per week), at his *employer's* place of business.

CGP-3-GLOSS-90 B750.0229-R

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-R

Injury with respect to this *plan's* dental expense insurance, means all damage to a *covered person's* mouth due to an accident, and all complications rising from that damage. But the term *injury* does not include damage to teeth, *appliances* or *prosthetic devices* which results from chewing or biting food or other substances.

CGP-3-GLOSS-90 B750.0199-R

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-R

Orthodontic Treatment means the movement of one or more teeth by the use of *active appliances.* It includes: (a) diagnostic services; (b) the treatment plan; (c) the fitting, making and placement of an *active appliance;* and (d) all related office visits, including post-treatment stabilization.

CGP-3-GLOSS-90 B750.0201-R

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-R

Prosthetic Device means a device which is used to replace missing or lost teeth or tooth structure. It includes all types of dentures, crowns, bridges, pontics and cast restorations.

CGP-3-GLOSS-90 B750.0203-R

Qualified Retiree means is a retired employee of the employer who is under age 65 and A) completed at least 10 years of service or B) is at least 54 years old and has completed 20 years of service or more.

CGP-3-GLOSS-90 B750.0008-R

SECTION I: Guardian Insurance

B115.0003-R

GENERAL PROVISIONS

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-R

Limitation of Authority

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

CGP-3-R-LOA-90 B160.0004-R

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-R

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. If the claim is being made for one of your *covered dependents,* his or her name should also be noted.

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.

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.

Coordination Between Continuation Sections

A covered person may be eligible to continue his group health benefits under this plan's "Federal Continuation Rights" (FCR) section and under other continuation sections of this plan at the same time. If he is: (a) he may elect to continue under FCR; but (b) he may not elect to continue his group health benefits under any other continuation section of this plan.

CGP-3-R-COC-NY-87 B240.0065-R

An Important Notice About Continuation Rights

The following "Federal Continuation Rights" section may not apply to the employer's plan. You must contact your employer to find out if: (a) the employer is subject to the "Federal Continuation Rights" section, and therefore; (b) the section applies to you.

B235.0109-R

YOUR CONTINUATION RIGHTS

Federal Continuation Rights

Important Notice

This section applies only to any dental, out-of-network point-of-service medical, major medical, prescription drug or vision coverages which are part of this plan. In this section, these coverages are referred to as "group health benefits."

This section does not apply to any coverage for loss of income due to disability. This coverage can not be continued under this section.

Under this section, "qualified continuee" means any person who, on the day before any event which would qualify him or her for continuation under this section, is covered for group health benefits under this plan as: (a) an active, covered employee; (b) the spouse of an active covered employee; or (c) the dependent child of an active, covered employee. A child born to, or adopted by, the covered employee during a continuation period is also a qualified continuee. Any other person who becomes covered under this plan during a continuation provided by this section is not a qualified continuee.

Conversion

Continuing the group health benefits does not stop a qualified continuee from converting some of these benefits when continuation ends. But, conversion will be based on any applicable conversion privilege provisions of this plan in force at the time the continuation ends.

If Your Group Health Benefits End

If you are a qualified continuee and your group health benefits end due to your termination of employment or reduction of work hours, you may elect to continue such benefits for up to 18 months, if you were not terminated due to gross misconduct.

The continuation: (a) may cover you or any other qualified continuee; and (b) is subject to "When Continuation Ends".

Extra Continuation for Disabled Qualified Continuees

If a qualified continuee is determined to be disabled under Title II or Title XVI of the Social Security Act on or during the first 60 days after the date his or her group health benefits would otherwise end due to your termination of employment or reduction of work hours, he or she or any member of that person's family who is a qualified continuee may elect to extend his or her 18 month continuation period explained above for up to an extra 11 months.

To elect the extra 11 months of continuation, a qualified continuee must give your employer written proof of Social Security's determination of the disabled qualified continuee's disability before the earlier of: (a) the end of the 18 month continuation period; or (b) 60 days after the date the qualified continuee is determined to be disabled. If, during this extra 11 month continuation period, the qualified continuee is determined to be no longer disabled under the Social Security Act, he or she must notify your employer within 30 days of such determination, and continuation will end, as explained in "When Continuation Ends."

This extra 11 month continuation is subject to "When Continuation Ends".

An additional 50% of the total cost of coverage also may be required from all qualified continuees who are members of the disabled qualified continuee's family by your employer during this extra 11 month continuation period, provided the disabled qualified continuee has extended coverage.

Special Continuance for Retired Employees and their Dependents

If your group health benefits end due to a bankruptcy proceeding under Title 11 of the United States Code involving the employer, you may elect to continue such benefits, provided that:

(a) you are or become a retired employee on or before the date group health benefits end; and

(b) you and your dependents were covered for group health benefits under this plan on the day before the bankruptcy proceeding under Title 11 of the United States Code.

The continuation can last for your lifetime. After your death, the continuation period for a dependent can last for up to 36 months.

For purposes of this special continuance, a substantial elimination of coverage for you and your dependents within one year before or after the start of such proceeding will be considered loss of coverage.

If you die before the bankruptcy proceeding under Title 11 of the United States Code, your surviving spouse and dependent children may elect to continue group health benefits on their own behalf, provided they were covered on the day before such proceedings. The continuation can last for your surviving spouse's lifetime.

This special continuance starts on the later of: (a) the date of the proceeding under Title 11; or (b) the day after the date group health benefits would have ended. It ends as described in "When Continuation Ends", except that a person's entitlement to Medicare will not end such continuance.

B235.0114-R

If You Die While Covered

If you die while covered, any qualified continuee whose group health benefits would otherwise end may elect to continue such benefits. The continuation can last for up to 36 months, subject to "When Continuation Ends".

If Your Marriage Ends

If your marriage ends due to legal divorce or legal separation, any qualified continuee whose group health benefits would otherwise end may elect to continue such benefits. The continuation can last for up to 36 months, subject to "When Continuation Ends".

If a Dependent Child Loses Eligibility

If a dependent child's group health benefits end due to his or her loss of dependent eligibility as defined in this plan, other than your coverage ending, he or she may elect to continue such benefits. However, such dependent child must be a qualified continuee. The continuation can last for up to 36 months, subject to "When Continuation Ends".

Concurrent Continuations

If a dependent elects to continue his or her group health benefits due to your termination of employment or reduction of work hours, the dependent may elect to extend his or her 18 month or 29 month continuation period to up to 36 months, if during the 18 month or 29 month continuation period, either: (a) the dependent becomes eligible for 36 months of continuation due to any of the reasons stated above; or (b) you become entitled to Medicare.

The 36 month continuation period starts on the date the 18 month continuation period started, and the two continuation periods will be deemed to have run concurrently.

Special Medicare Rule

If you become entitled to Medicare before a termination of employment or reduction of work hours, a special rule applies for a dependent. The continuation period for a dependent, after your later termination of employment or reduction of work hours, will be the longer of: (a) 18 months (29 months if there is a disability extension) from your termination of employment or reduction of work hours; or (b) 36 months from the date of your earlier entitlement to Medicare. If Medicare entitlement occurs more than 18 months before termination of employment or reduction of work hours, this special Medicare rule does not apply.

The Qualified Continuee's Responsibilities

A person eligible for continuation under this section must notify your employer, in writing, of: (a) your legal divorce or legal separation from your spouse; or (b) the loss of dependent eligibility, as defined in this plan, of a covered dependent child.

Such notice must be given to your employer within 60 days of either of these events.

B235.0119-R

Your Employer's Responsibilities

Your employer must notify the qualified continuee, in writing, of: (a) his or her right to continue this plan's group health benefits; (b) the payments he or she must make to continue such benefits; and (c) the times and manner in which such payments must be made.

Election of Continuation

To continue his or her group health benefits, the qualified continuee must give your employer written notice that he or she elects to continue. This must be done by the later of: (a) 60 days from the date a qualified continuee receives notice of his or her continuation rights from your employer as described above; or (b) the date coverage would otherwise end. And the qualified continuee must make his or her first payment in a timely manner.

The subsequent payments must be paid to your employer, by the qualified continuee, in advance, at the times and in the manner specified by your employer. No further notice of when payments are due will be given.

The payment will be the total cost of coverage for the group health benefits had the qualified continuee stayed covered under the group plan on a regular basis. It includes any amount that would have been paid by your employer. Except as explained in "Extra Continuation for Disabled Qualified Continuees", an additional charge of two percent of the total cost of coverage may also be required by your employer.

If the qualified continuee fails to give your employer notice of his or her intent to continue, or fails to make any required payments in a timely manner, he or she waives his or her continuation rights.

Grace in Payment

A qualified continuee's payment is timely if, with respect to the first payment after the qualified continuee elects to continue, such payment is made no later than 45 days after such election. In all other cases, such payment is timely if it is made within 31 days of the specified due date. If timely payment is made to the plan in an amount that is not significantly less than the amount the plan requires to be paid for the period of coverage, then the amount paid is deemed to satisfy the requirement for the payment that must be made; unless your employer notifies the qualified continuee of the amount of the deficiency and grants an additional 30 days for payment of the deficiency to be made. Payment is calculated to be made on the date on which it is sent to your employer.

When Continuation Ends

A qualified continuee's continued group health benefits end on the first of the following:

(1) with respect to continuation upon your termination of employment or reduction of work hours, the end of the 18 month period which starts on the date the group health benefits would otherwise end;

(2) with respect to a qualified continuee who has an additional 11 months of continuation due to disability, the earlier of: (a) the end of the 29 month period which starts on the date the group health benefits would otherwise end; or (b) the first day of the month which coincides with or next follows the date which is 30 days after the date on which a final determination is made that the disabled qualified continuee is no longer disabled under Title II or Title XVI of the Social Security Act;

(3) with respect to continuation upon your death, your legal divorce, or legal separation, or the end of a covered dependent's eligibility, the end of the 36 month period which starts on the date the group health benefits would otherwise end;

(4) with respect to a dependent whose continuation is extended due to your entitlement to Medicare while the dependent is on continuation, the end of the 36 month period which starts on the date the group health benefits would otherwise end;

(5) the date the employer ceases to provide any group health plan to any employee;

(6) the end of the period for which the last payment is made;

(7) the date, after the date of election, he or she becomes covered under any other group health plan which does not contain any pre-existing condition exclusion or limitation affecting him or her; or

(8) the date, after the date of election, he or she becomes entitled to Medicare.

Any person whose continued health benefits end as described in (1), (2), (3) or (4) above may elect to convert some of these benefits to an individual insurance policy Guardian normally issues for conversions at the time he or she elects to convert, if conversion is available under this plan.

If conversion is available, the applicant must apply to Guardian in writing and pay the required premium. This must be done within 31 days of the date the applicant's continued group health benefits end. Guardian does not ask for proof of insurability. The converted policy takes effect on the date the applicant's continued group health benefits end. If the applicant is a minor or incompetent, the person who cares for and supports the applicant may apply for him or her.

The converted policy will be renewable and will comply with the laws of the place the applicant lived when he or she applied. But, it will not provide exactly the same benefits the applicant had under the employer's plan. Write to Guardian for details.

The premium for the converted policy will be based on: (a) the policy the applicant selects; and (b) the ages of the people to be covered as of the date the converted policy takes effect.

A covered person may also convert in certain other situations. Read this plan's group health conversion section for details. But, at no time can a person be covered under more than one converted health policy.

B235.0122-R

NEW YORK CONTINUATION RIGHTS

Important Notice

Which Coverages Can Be Continued

This section applies only to those hospital, surgical, out-of-network point-of-service and major medical coverages provided by this plan. These coverages are referred to as "group health benefits." If major medical expense and prescription drug expense coverages are both provided under this plan, they will be treated together as major medical expense coverage.

This section does not apply to any coverages which provide benefits for loss of life, loss of income due to disability, dental expense or prescription drug expense, except as shown above. These coverages, if provided by this plan, cannot be continued under this section.

New York Employee and Dependent Continuation Rights

Conversion

Continuing the group health benefits does not stop a continuee from converting some of these benefits when continuation ends. But, conversion will be based on any applicable conversion privilege provisions of this plan in force at the time the continuation ends.

Important Restriction

No covered person may continue if he: (a) is entitled to Medicare; or (b) is eligible for, or covered by, any other insured or uninsured group health benefit plan which contains no limitation or exclusion with respect to any pre-existing condition of the covered person.

If Your Group Health Benefits End

If your group health benefits end due to termination of your employment or membership in an eligible class of employees, subject to "When Continuation Ends," you may elect to continue such benefits for up to 18 months. The continuation may cover you and any of your then insured dependents whose group health benefits would otherwise end.

Extra Continuation for Disabled Covered Persons

If a covered person is determined to be disabled under Title II or Title XVI of the Social Security Act on the date his group health benefits would otherwise end due to your termination of employment or membership in an eligible class of employees, he may elect to extend his 18 month continuation period explained above for up to an extra 11 months.

To elect the extra 11 months of continuation, the continuee must give the employer written proof of Social Security's determination of his disability before the earlier of: (a) the end of the 18 month continuation period; and (b) 60 days after the date the covered person is determined to be disabled. If, during the extra 11 month continuation period, the continuee is determined to no longer be disabled under the Social Security Act, he must notify the employer within 30 days of such determination, and continuation will end, as explained in "When Continuation Ends."

This extra 11 month continuation: (a) may be elected only by the disabled continuee; and (b) is subject to "When Continuation Ends."

New York Employee and Dependent Continuation Rights (Cont.)

If A Dependent's Group Health Benefits End

A dependent may continue his group health benefits for up to 36 months if such benefits end due to: (a) your death; (b) your legal divorce or legal separation from your spouse; or (c) with respect to a dependent child, his loss of dependent eligibility, as defined in this plan. The continuation is subject to "When Continuation Ends."

The Employer's Responsibilities

The employer must give written notice to a covered person of: (a) his right to continue his group health benefits; (b) the monthly premium he must pay for the continued group health benefits; and (c) the times and manner in which the premiums must be paid. Such written notice must be made within 14 days after a covered person's group health benefits would otherwise end.

Election of Continuation

To continue his group health benefits, the covered person must give the employer written notice that he elects to continue, and pay the first month's premium within 60 days of the later of: (a) the date his group health benefits would otherwise end; and (b) the date the employer gives the covered person his notice of his continuation rights, as explained above.

The subsequent premiums must be paid to the employer, by the continuee, in advance, at the times and in the manner specified by the employer. No further notice of when premiums are due is needed.

The monthly premium will be the total rate which would have been charged for the group health benefits had the covered person stayed insured under the group plan on a regular basis. It includes any amount which would have been paid by the employer. And an additional two percent of the total premium may be charged for the continuation.

A covered person waives his continuations rights if he fails to elect continuation or pay any required premium on time.

The Employer's Liability

The employer will be liable for the continuee's continued group health benefits to the same extent as, and in place of, us, if: (a) he fails to remit a continuee's timely premium payment to us on time, thereby causing the continued group health benefits to end; or (b) he fails to notify the covered person of the continuation rights, as described above.

When Continuation Ends

A continuee's continued group health benefits end on the first of the following:

- with respect to continuation upon your termination of employment or membership in an eligible class of employees, the end of the 18 month period which starts on the date the group health benefits would otherwise end;
- with respect to a disabled continuee who has elected an additional 11 months of continuation, the earlier of (a) the end of the 29 month period which starts on the date the group health benefits would otherwise end; and (b) the first day of the month which next follows the date which is 31 days after the date on which a final determination is made that a disabled continuee is no longer disabled under Title II or Title XVI of the Social Security Act;

New York Employee and Dependent Continuation Rights (Cont.)

- with respect to continuation upon your death or legal divorce or legal separation, or a dependent's loss of dependent eligibility, the end of the 36 month period which starts on the date the group health benefits would otherwise end;
- the date this group plan ends or is amended to end for the class of employees to which you belonged;
- the end of the period for which the last premium payment is made; and
- the date he becomes covered under any other group health plan which contains no limitation or exclusion with respect to any pre-existing condition of the continuee.

CGP-3-R-CC-NY-93 B240.0158-R

ELIGIBILITY FOR LIFE COVERAGES

B264.0002-R

Employee Coverage

Eligible Employees

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

Other Conditions

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

CGP-3-EC-90-1.0 B264.0064-R

When Your Coverage Starts

Employee benefits that don't require *proof* that you are insurable are scheduled to start on the effective date shown on the sticker attached to the inside front cover of this booklet.

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

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

Sometimes, the effective date shown on the sticker or in the endorsement 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 B180.0066-R

When Your Coverage Ends

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

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

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

CGP-3-EC-90-3.0 B264.0034-R

An Employee's Right To Continue Group Life Insurance During A Family Leave Of Absence

Important Notice

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.

Continuation Of Life Coverages

Your loss of life and accidental death and dismemberment coverages may be continued at your *employer's* option. You must contact your *employer* to find out if you may continue these coverages.

If Your Group Insurance Ends

Group insurance may end for you because you cease full-time work due to an approved leave of absence. Such leave of absence must have been granted to allow you to care for a seriously ill spouse, child or parent, or after the birth or adoption of a child, or due to your own serious health condition. If so, your group insurance will be continued at your *employer's option.* You will be required to pay the same share of the premium as before the leave of absence.

When Continuation Ends

Insurance may continue until the earliest of: (a) the date you return to full-time work; (b) the end of a total leave period of 12 weeks in any 12 month period; (c) the date on which your coverage would have ended had you not been on leave; or (d) the end of the period for which the premium has been paid.

CGP-3-EC-90-3.0 B264.0057-R

GROUP TERM LIFE INSURANCE SCHEDULE

Employee Basic Term Life Insurance

Your Basic Term Life Insurance Amount	Insurance Amount	$500,000.00
	CGP-3-R-SCH-90	B265.0011-R

LIFE INSURANCE

B270.0070-R

Employee Group Term Life Insurance

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

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

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

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

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

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

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

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

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

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

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

CGP-3-R-LB-NY-86 B270.0030-R

Converting This Group Term Life Insurance

If Employment or Eligibility Ends

The employee's group life insurance ends if his employment ends, or if he stops being a member of an eligible class of employees. If either happens, he can convert all or part of his group life insurance to an individual life insurance policy.

If the Group Plan Ends or Group Life Insurance is Dropped

The employee's group life insurance also ends if this group plan ends, or if group life insurance is dropped from the group plan for all employees or for his class. But, the amount he can convert is limited to the amount of his group insurance under this plan, less any group life benefits he becomes eligible for in the 45 days after this insurance ends.

If the Group Life Insurance is Reduced

If the employee's group life insurance is reduced for the reasons explained below, the employee can convert the amount by which his group life insurance was reduced to an individual life insurance policy. The employee has this right to convert if his group life insurance is reduced:

(1) on account of age, provided: (i) the first reduction occurs on or after he reached age 60; and (ii) the reduction equals at least 20% of the employee's last in-force pre-reduced group life insurance amount.

(2) due to a change in class which causes a reduction; or

(3) due to an amendment of the group plan which causes a reduction.

The Converted Policy

The employee can convert to one of the policies we normally issue. It can't include disability benefits. And, it can't be a term policy. But, it can be preceded by single premium term insurance for up to one year.

The premium for the converted policy will be based on: (a) the employee's standard or sub-standard risk and rate class under this plan; and (b) his age on the converted policy's effective date. The converted policy will start at the end of the period allowed for conversion.

How and When to Convert

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

But the employer must pay a premium, to us, for the 31 days of extended coverage, if: (1) the employer voluntarily ended the group plan; and (2) the employer replaces the terminated coverage within 6 months of its termination.

Death During the Conversion Period

If an employee dies in the 31 days allowed for conversion under this section, we'll pay his beneficiary the amount he could have converted. We'll pay whether or not he applied for conversion.

Converting This Group Term Life Insurance (Cont.)

Notice of Conversion Right

If the employee is entitled to obtain a converted policy under this section, the employer must give the employee written notice of such right. The employer must give the employee the notice in person, or mail it to his last known address.

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

CGP-3-R-LCON-NY-86 B270.0027-R

Your Extended Life Benefit

Important Notice

This section applies to your basic life benefit.

If You're Totally Disabled

If you meet our standard for total disability, we'll extend your life insurance under this section. We'll extend it for one year from the date your life insurance under the group plan ended. There will be no cost to you.

We'll consider you totally disabled if: (a) you're not able to perform any work for wages or profit due to a sickness or injury; and (b) you became disabled before you reached age 60 and while insured by the group plan.

If You're Permanently Disabled

If you're permanently disabled, you may apply for more one year extensions. We'll consider you permanently disabled if you've been totally disabled for at least nine continuous months. We'll consider you permanently disabled without the nine month wait, if you're totally disabled because: (a) you've lost two limbs by severance at or above the ankles or wrists; or (b) you've lost total and permanent sight in both eyes.

How And When To Apply

To get this extended benefit past the first year, you must send us written medical proof that you're permanently disabled. This must be done before the first one year extension ends. You won't be covered past the first year unless we approve that proof.

Since each extension is only for one year, you must send us proof of your continued disability each year. This must be done in the three months before the prior extension ends. You won't be covered past the date the prior extension ends, unless we approve that proof.

Examination By Our Doctor

We can have you examined by a doctor of our choice as often as we feel necessary during the first two years we've extended your life benefits. But, after two years, we can't have you examined more than once a year.

When This Extension Ends

This extension will end on the date you stop being totally disabled. It will also end if we ask you to be examined by our doctor, and you refuse. And, it will end if you don't give us the proof of disability we require.

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

If You Die While Covered By This Extension

If you die while covered by this extension we'll pay your beneficiary the amount you were covered for. This is the amount you had under the group plan on your last day of active work. It is subject to all reductions which would have applied if you had stayed an active employee.

We'll pay as soon as we receive: (a) written proof of your death; and (b) medical proof that you were continuously disabled until your death.

This must be sent to us within one year of your death.

Until We've Approved You As Permanently Disabled

Your life insurance under the group plan may end after you've become totally disabled but before we've approved you as permanently disabled. If this happens, we suggest you read the section labeled "Converting Your Group Term Life Insurance."

Converting does not stop you from claiming your rights under this section. But, if you convert and we later approve you as permanently disabled, we'll cancel the converted policy. Of course, we'll refund the premiums you paid.

Also, if you convert and then die during the first year of this extension, we'll pay your beneficiary under this section. He won't be paid under the converted policy. But, we'll give him the premiums you paid for that policy.

CGP-3-R-ELB B275.0080-R

ELIGIBILITY FOR MAJOR MEDICAL COVERAGE

B449.0037-R

Employee Coverage

Eligible Employees

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

CGP-3-EC-90-1.0 B489.0131-R

When Your Coverage Starts

Employee benefits are scheduled to start on the effective date shown on the sticker attached to the inside front cover of this booklet.

But you must be actively at work on a *full-time* basis unless you are a *qualified retiree,* 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 an active *full-time employee* and are not actively at work on the date your insurance is scheduled to start, unless you are disabled, we will postpone your coverage until the date you return to active *full-time* work.

If you are a *qualified retiree,* you can not be confined in a health care facility on the scheduled effective date of coverage. If you are confined on that date, we will postpone your coverage until the day after you are discharged. And you must also have met all of the applicable conditions of eligibility and any applicable waiting period in order for coverage to start.

Sometimes, the effective date shown on the sticker or in the endorsement 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 B449.0146-R

When Your Coverage Ends

If you are an active *full-time employee,* your coverage ends on the date your active *full-time* service ends for any reason, other than disability. Such reasons include death, retirement (except for *qualified retirees),* layoff, leave of absence and the end of employment. If you are a *qualified retiree,* your coverage ends at age 65.

If you are an active *full-time employee* or a *qualified retiree,* your coverage also ends on the date you stop being a member of a class of employees eligible for insurance under this plan, or when this plan ends for all *employees.* And it ends when this *plan* is changed so that benefits for the class of *employees* to which you belong ends.

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

CGP-3-EC-90-3.0 B449.0114-R

Continuation 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 insurance may end for you because you cease *full-time* work due to an approved leave of absence. Such leave of absence must have been granted to allow you to care for a seriously ill spouse, child or parent, or after the birth or adoption of a child, or due to your own serious health condition. If so, your group insurance will be continued. You will be required to pay the same share of the premium as before the leave of absence.

Insurance may continue until the earliest of: (a) the date you return to *full-time* work; (b) the end of a total leave period of 12 weeks in any 12 month period; (c) the date on which your coverage would have ended had you not been on leave; or (d) the end of the period for which the premium has been paid.

CGP-3-EC-90-3.0 B449.0036-R

Dependent Coverage

B200.0271-R

Eligible Dependents For Dependent Major Medical Benefits

Your *eligible dependents* are: your legal spouse; your unmarried dependent children who are under age 20; and your unmarried dependent children, from age 20 until their 26th birthday, who are enrolled as full-time students at accredited schools.

CGP-3-DEP-90-2.0 B200.0496-R

Adopted Children And Step-Children

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

The "Pre-Existing Conditions" provision of the major medical portion of this plan, if any, does not apply to an adopted child, if the child: (a) is adopted or placed for adoption prior to his or her 18th birthday; and (b) becomes covered by this plan within 31 days of such placement.

Dependents Not Eligible

We exclude any dependent who is insured by this *plan* as an *employee.* And we exclude any dependent who is on active duty in any armed force.

CGP-3-DEP-91-3.0-NY B200.0611-R

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 coverage and the *plan,* such a child may stay eligible for dependent benefits past this coverage'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 conditions started before he or she reached this coverage's age limit; (b) he or she became insured by this coverage 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 the child 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 yours does.

CGP-3-DEP-90-4.0 B449.0042-R

When Dependent Coverage Starts

In order for your dependent coverage to start you must already be insured for employee major medical coverage, or enroll for employee and dependent major medical coverage at the same time. The date your dependent coverage starts depends on when you elect to enroll your *initial dependents* and agree to make any required payments.

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

If you do this within or after the *enrollment period,* each *initial dependent's* coverage is scheduled to start on the later of the date you sign the enrollment form and the date you become insured for employee coverage.

However, if you do this after the *enrollment period,* each *initial dependent* is considered a *late enrollee.*

Once you have coverage for your *initial dependents,* you must notify us when you acquire any new dependents, and agree to make any additional require payments. The *newly acquired dependent's* major medical coverage will start on the date you sign the enrollment form, if you notify us within 30 days of the date the dependent is acquired. If you fail to notify us within 30 days of the date the dependent is acquired, the dependent is considered a *late enrollee.*

A *late enrollee* is a dependent who the employee fails to enroll for major medical coverage: (a) during the *enrollment period* if the dependent is an *initial dependent;* (b) within 30 days of the date a dependent becomes an *eligible dependent,* if the dependent is not an *initial dependent;* or (c) during a *special enrollment period,* as described below.

However, if you elect to enroll a dependent in this coverage after you previously waived major medical coverage under this *plan* for the dependent, because the dependent was covered under another group plan, and, upon his or her notification by us of this requirement, you stated this in writing at the time of the waiver, we will not consider the dependent to be a *late enrollee,* if the dependent's coverage under the other plan ends due to:

(a) the exhaustion of a COBRA continuation of coverage;

(b) a death, divorce or legal separation;

(c) the end of employment or reduction of work hours; or

(d) the end of employer contributions toward the other plan, or the end of the other plan.

But you must enroll the dependent in this coverage within 30 days of the date his or her coverage under the other plan ends. And the dependent must still be an *eligible dependent.*

Also, a dependent will not be considered a *late enrollee* if he or she is enrolled during a *special enrollment period.* A special enrollment period means a 30 day period which begins on the later of: (a) the date dependent major medical coverage is made available under this *plan;* and (b) the date you acquire an *eligible dependent* through marriage, birth, adoption or placement for adoption. You may enroll an eligible spouse who was previously not enrolled at this time.

And a dependent will not be considered to be a *late enrollee* if he or she is enrolled due to a court order which mandates that you provide this major medical coverage for such dependent.

CGP-3-DEP-90-6.0 B449.0189-R

Newborn And Adopted Children

We cover your newborn child for dependent benefits, from the moment of birth. We also cover your adopted child for dependent benefits from the moment of birth if you take physical custody of the child upon such child's release from the hospital and you file a petition for adoption within 30 days of the child's birth.

We do this only if (a) you are already covered for dependent child coverage when the child is born, adopted or placed for adoption, or (b) the newborn is your first eligible dependent child, and you enroll the child and agree to make any required premium payments within 31 days of the date the child is born, adopted or placed for adoption. If you fail to do this, when enrolled, the child will be considered a *late enrollee.* The child's coverage starts on the date the enrollment form is signed.

CGP-3-DEP-90-8.0 B449.0159-R

When Dependent Coverage Ends

Dependent coverage ends for all of your dependents when your *employee* coverage ends. But if you die while insured, we'll automatically continue dependent benefits for those of your dependents who are insured when you die. We'll do this for six months at no cost, provided: (a) the group *plan* remains in force; (b) the dependents remain *eligible dependents;* and (c) in the case of a spouse, the spouse does not remarry.

If a surviving dependent elects to continue his or her dependent benefits under this *plan's* "Federal Continuation Rights" provision, or under any other continuation provision of this *plan,* if any, this free continuation period will be provided as the first six months of such continuation. Premiums required to be paid by, or on behalf of a surviving dependent will be waived for the first six months of continuation, subject to restrictions (a), (b) and (c) above. After the first six months of continuation, the remainder of the continuation period, if any, will be subject to the premium requirements, and all of the terms of the "Federal Continuation Rights" or other continuation provisions.

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

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

An individual dependent's coverage ends when he or she stops being an *eligible dependent.* This happens to a child at 12:01 a.m. on the date the child attains this coverage's age limit, when he or she marries, when a child covered as a student is no longer an active full-time student, or when a step-child is no longer dependent on you for support and maintenance. It happens to a spouse when a marriage ends in legal divorce or annulment. But, if a child who is enrolled as a full-time student must take a medical leave of absence from school due to sickness, his or her coverage may be continued. Such coverage may be continued for up to one year from the last day the child attended school, but not beyond the date coverage would otherwise end under this *plan* if he or she did not take the medical leave of absence; provided: (a) we receive a *doctor's* certification of the sickness which requires the leave of absence; (b) the group *plan* remains in force; and (c) all required premiums for the child's coverage continue to be paid.

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

CGP-3-DEP-90-9.0 B449.0269-R

CERTIFICATE AMENDMENT

This rider amends the "Dependent Coverage" provisions as follows:

An employee's domestic partner will be eligible for major medical coverage under this plan. Coverage will be provided subject to all the terms of this plan and to the following limitations:

To qualify for such coverage, both the employee and his or her domestic partner must:

- be 18 years of age or older;
- be unmarried, constitute each other's sole domestic partner and not have had another domestic partner in the last 12 months;
- share the same permanent address for at least 12 consecutive months and intend to do so indefinitely;
- share joint financial responsibility for basic living expenses including food, shelter and medical expenses;
- not be related by blood to a degree that would prohibit marriage in the employee's state of residence; and
- be financially interdependent which must be demonstrated by at least four of the following:
  a. ownership of a joint bank account;
  b. ownership of a joint credit account;
  c. evidence of a joint mortgage or lease;
  d. evidence of joint obligation on a loan;
  e. joint ownership of a residence;
  f. evidence of common household expenses such as utilities or telephone;
  g. execution of wills naming each other as executor and/or beneficiary;
  h. granting each other durable powers of attorney;
  i. granting each other health care powers of attorney;
  j. designation of each other as beneficiary under a retirement benefit account; or
  k. evidence of other joint financial responsibility.

The employee must complete a "Declaration of Domestic Partnership" attesting to the relationship.

The domestic partner's dependent children will be eligible for coverage under this plan on the same basis as if the children were the employee's dependent children.

Coverage for the domestic partner and his or her dependent children ends when the domestic partner no longer meets the qualifications of a domestic partner as indicated above. Upon termination of a domestic partnership, a "Statement of Termination" must be completed and filed with the employer. Once the employee submits a "Statement of Termination," he or she may not enroll another domestic partner for a period of 12 months from the date of the previous termination.

And, the domestic partner and his or her children will be not eligible for:

a. survivor benefits upon the employee's death as explained under the "When Dependent Coverage Ends" section;

b. continuation of major medical coverage as explained under the "Federal Continuation Rights" section and under any other continuation rights section of this plan, unless the employee is also eligible for and elects continuation; or

c. conversion of major medical coverage as explained under the "Converting This Group Health Insurance" section of this plan.

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

The Guardian Life Insurance Company of America

Sanford Herman

Vice President, Group Pricing & Standards

CGP-3-A-DMST-96

B210.0014-R

MAJOR MEDICAL HIGHLIGHTS

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

CGP-3-R3-HL-90 B453.0323-R

Benefit Year Cash Deductible

For *covered charges* from a *PPO* provider . . . . . None

For *covered charges* from a non-*PPO* provider $200.00

CGP-3-R3-HL-90 B453.0315-R

Co-Payment

For each visit to a *PPO doctor's* office $10.00

(See the definition of "Co-payment" for a complete explanation.)

CGP-3-R3-HL-90 B453.3700-R

Co-Payments

For most *covered charges* -

For the services of a *preferred provider* . . . . . no *co-payment*

For the services of other providers

Before the Non-*PPO co-payment* cap is met 20%

After the Non-*PPO co-payment* cap is met . . . . . No co-payment

Note: There may be different payment rates for some types of charges. Read all provisions of this plan carefully.

CGP-3-R3-HL-90 B453.6962-R

Co-Payment Cap

Limit on *co-payments,* per *covered person* each *benefit year* $1,000.00

Limit on *co-payments,* per *covered family* each *benefit year* $2,500.00

CGP-3-R3-HL-90 B453.3734-R

Lifetime Limits

Lifetime payment limit for most *sicknesses* or *injuries* . . . . . Unlimited

Note: Some provisions have *benefit year* or treatment period limits. Read all provisions of this *plan* carefully.

CGP-3-R3-HL-90 B453.0343-R

MAJOR MEDICAL EXPENSE INSURANCE

This insurance will pay many of the medical expenses incurred by you and those of your *covered dependents* who are insured for major medical coverage under this *plan.* What we pay and the terms for payment are explained below. All terms in *italics* are defined terms with special meanings. Their definitions are shown in the "Glossary" at the back of this booklet. Other terms are defined where they are used.

CGP-3-R3-1.0 B450.1173-R

LabOne - This Major Medical Plan's Outpatient Laboratory Testing Services Program

This major medical *plan* is designed to provide high quality outpatient laboratory testing services while controlling the cost of such services. To do this, a *covered person* is encouraged to use LabOne, this *plan's* outpatient laboratory testing services program.

Use of the LabOne program is strictly voluntary. We give each *covered person* a LabOne identification card which must be used in the manner described below. If the *covered person* uses the services of LabOne, we pay benefits for the *covered charges* a *covered person* incurs for the outpatient laboratory services, and we waive any of this *plan's* deductible, *co-payment* and *encounter fee* requirements which otherwise would have applied to such charges.

There are two ways for a *covered person* to use the services of LabOne. One way is to take the lab work ordered by a *doctor* directly to a LabOne Patient Service Center. These LabOne Patient Service Centers will determine eligibility through the LabOne ID card, collect specimens, perform testing and deliver the results to your *doctor* upon completion. In addition to an ID card, the *covered person* will periodically be given an up-to-date list of LabOne Patient Service Centers.

The other way for a *covered person* to receive benefits from the LabOne program is to present his or her Guardian ID card to his or her *doctor* and request that the lab specimens, collected in his or her office, be sent to LabOne for processing. LabOne will pick up the specimen, perform the testing and upon completion of the tests, deliver the results to the *covered person's doctor.*

The *covered person* will receive an explanation of any insurance payments made by this *plan.*

If the LabOne program is not used in the manner described above, then benefits will be paid according to all of the other terms of the *plan,* and will be subject to any of this *plan's* deductibles, *encounter fees* and *co-payments.* And the LabOne program does not apply to lab work performed while a *covered person* is an *inpatient* in any health care facility.

What we pay is based on all the terms of this *plan.* The *covered person* should read this material carefully and keep it available when seeking laboratory testing services.

LabOne - This Major Medical Plan's Outpatient Laboratory Testing Services Program (Cont.)

Please refer to the schedule of insurance or highlights for specific benefit levels, payment rates and payment limits.

If a *covered person* has any questions after reading this *plan,* he or she should call The Guardian Group Claim Office at the number shown on his or her ID card.

CGP-3-LAB-PPO-95 B453.5556-R

Private Healthcare Systems, This Plan's Preferred Provider Organization

This *plan* encourages a *covered person* to use services provided by members of Private Healthcare Systems (PHCS), a preferred provider organization (PPO). A PPO is a network of health care providers located in the *covered person's* geographic area. In addition to an identification card, the *covered person* will periodically be given up-to-date lists of PHCS preferred providers.

Use of the network is strictly voluntary, but we generally pay a higher level of benefits for most covered services and supplies furnished to a *covered person* by PHCS. Conversely, we generally pay a lower level of benefits when covered services and supplies are not furnished by PHCS (even if a PHCS *doctor orders the services or supplies). Of course, a covered person* is always free to be treated by any *doctor* or facility, and he or she is free to change *doctors* or facilities at any time.

A *covered person* may use any PHCS provider. He or she just presents his PHCS I.D. card to the PHCS *doctor* or facility furnishing covered services or supplies. Most PHCS *doctors* and facilities will prepare any necessary claim forms for him or her, and submit the forms to us. The *covered person* will receive an explanation of any insurance payments made by this *plan.*

This *plan* also has utilization review features. Under these features, PHCS reviews *hospital* admissions and surgery performed on an *inpatient* basis for us. These features must be complied with whenever a *covered person:* (a) enters a hospital; or (b) is advised to enter a *hospital.* If a *covered person* does not comply with these utilization review features, he or she will not be eligible for full *plan* benefits. See the "Utilization Review Features" section for details.

What we pay is based on all of the terms of this plan. Read this *plan* carefully.

See the Major Medical Highlights for specific benefit levels, co-payments, payment limits and co-insurance.

If the covered person has any questions after reading this plan, he or she should contact The Guardian Group Claim Office.

CGP-3-R3-PHCS-NY B453.2489-R

Utilization Review Features

Important Notice Compliance with this *plan's* utilization review features does not guarantee what we'll pay for *covered charges.* What we pay is based on: (a) the *covered charges* actually incurred; (b) the *covered person* being eligible for coverage under this *plan* at the time the *covered charges* are incurred; and (c) the deductible and *co-insurance* provisions, and all of the other terms of this *plan.*

Definitions

Hospital Admission means admission of a *covered person* to a *hospital* as an *inpatient* for medically necessary care and treatment of a *sickness* or *injury.*

Emergency means a *hospital* admission or surgery if, after an evaluation of the *covered person's* condition, the attending *doctor* determines that failure to make the admission or perform the surgery immediately would pose a serious threat to the *covered person's* life or health. A *hospital* admission or surgery made or performed for the convenience of *doctors* or patients is not an emergency.

Covered Professional Charges for Surgery means the *covered charges* that are: (a) made by a *doctor* for performing surgery; (b) made by a *doctor* or a *nurse* for assisting in the performance of surgery; or (c) made by a *doctor* or a *nurse* for the administration of anesthetics. Any surgical charge which is not a *covered charge* under the terms of this *plan* is not payable under this *plan.*

Regular Working Day means Monday through Friday from 9:00 a.m. to 9:00 p.m. Eastern Time, not including legal holidays.

Required Pre-Hospital Review

Notice of *Hospital* Admission Required We require notice of all *hospital* admissions. The times and the manner in which the notice must be given are described below. When a *covered person* does not comply with the requirements of this section, we reduce what we would otherwise pay for *covered charges* for *hospital* services, as a penalty.

Pre-Hospital Review All non-emergency *hospital* admissions must be reviewed by PHCS before they occur.

The *covered person* or his or her *doctor* must notify PHCS and request a pre-hospital review. PHCS must receive the request at least 48 hours before the admission is scheduled to occur.

When PHCS receives the notice and request, they evaluate: (a) the medical necessity of the *hospital* admission; (b) the anticipated length of stay; and (c) the appropriateness of health care alternatives, like home health care or other outpatient care.

PHCS notifies the *covered person's doctor,* by phone, of the outcome of the review. Then they confirm the outcome of the review in writing.

IF PHCS authorizes a *hospital* admission, the authorization is valid for: (a) the specified *hospital* ; (b) the named attending *doctor;* and (c) the authorized length of stay.

The authorization becomes invalid and the *covered person's* admission must be reviewed by PHCS again if: (a) he or she enters a facility other than the specified facility; (b) he or she changes attending *doctors;* or (c) more than 60 days elapse between the time he or she obtains the authorization and the time he or she enters the *hospital* .

If PHCS determines that the proposed *hospital* admission is not medically necessary, we pay no benefits for the admission.

Pre-Surgical Review

If the *covered person* is being admitted to a *hospital* for surgery, he or she must comply with the "Required Pre-Surgical Review" section. See "Required Pre-Surgical Review" for details.

Emergency Admissions

PHCS must be notified of all emergency admissions by phone. This must be done by the *covered person* no later then the end of the next regular working day after the admission occurs.

When PHCS is notified by phone, they require the following information: (a) the *covered person's* name, social security number and date of birth; (b) the *covered person's* group *plan number; (c) the reason for the admission; (d) the name and location of the hospital;* (e) when the admission occurred; and (f) the name of the *covered person's doctor.*

Continued Stay Review

The *covered person,* or his or her *doctor,* must request a continued stay review for any emergency admission. This must be done at the time PHCS is notified of such admission.

The *covered person,* or his or her *doctor,* must also initiate a continued stay review whenever it is medically necessary to change the authorized length of a *hospital* stay. This must be done before the end of the previously authorized length of stay.

PHCS also has the right to initiate a continued stay review of any *hospital* admission. PHCS will then contact the *covered person's person's doctor* or *hospital* by phone or in writing.

In the case of an emergency admission, the continued stay review evaluates: (a) the medical necessity of the *hospital* admission; (b) the anticipated length of stay; and (c) the appropriateness of health care alternatives. In all other cases, the continued stay review evaluates: (a) the medical necessity of extending the authorized length of stay; and (b) the appropriateness of health care alternatives.

PHCS notifies the *covered person's doctor,* by phone, of the outcome of their review. They then confirm the outcome of the review in writing. The notice always includes any newly authorized length of stay.

Required Pre-Hospital Review (Cont.)

Penalties for Non-Compliance

In the case of each non-emergency *hospital* admission, as a penalty for non-compliance, we reduce what we would have paid for covered *hospital* charges by $500.00, if: (a) the *covered person* or his or her *doctor* does not request a required pre-hospital review; or (b) PHCS is not given at least 48 hours to review and evaluate a proposed *hospital* admission; or (c) PHCS' authorization becomes invalid and the *covered person* or his or her *doctor* does not obtain a new one.

In the case of each emergency admission, as a penalty for non-compliance, we reduce what we would have paid for covered *hospital* charges by $500.00, if: (a) PHCS is not notified of the admission at the times and in the manner described above; or (b) the *covered person* does not request a continued stay review. The penalty applies for covered *hospital* charges incurred after the end of the applicable time limit allowed for giving notice.

For each *hospital* admission, if a *covered person* stays in the *hospital* longer than PHCS authorizes, we reduce what we would have paid for covered *hospital* charges incurred after the end of the authorized length of stay, by $500.00, as a penalty for non-compliance.

Penalties can't be used to meet this *plan's: (a) cash deductibles; or (b) limits on out-of-pocket expenses.*

If a *covered person* or his or her *doctor* disagree with PHCS' decisions, please see the"Appeals Process" section.

Please note that whether or not a *covered person* complies with all of the above required pre-hospital review requirements, we pay no benefits for a *hospital* admission that we or PHCS deem not be medically necessary.

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Required Pre-Surgical Review

When A Review Must Be Done

We require a *covered person* to get a pre-surgical review for any non-emergency procedure performed outside of a *doctor's office. When a covered person* does not comply with the requirements of this section, we reduce what we would otherwise pay for covered professional charges for surgery, as a penalty.

The *covered person* or his or her *doctor* must request a pre-surgical review from PHCS. PHCS must receive the request at least 48 hours before the surgery is scheduled to occur. If the surgery is being done in a *hospital,* on an *inpatient* basis, the pre-surgical review request should be made at the same time as the request for a pre-hospital review.

When PHCS receives the request, they evaluate the medical necessity of the surgery. PHCS notifies the *covered person's doctor,* by phone, of the outcome of the review. They then confirm the outcome of the review in writing. If the review confirms the medical necessity of the proposed surgery, we pay benefits for the surgery, subject to all of the terms of this *plan.* If the review does not confirm the medical necessity of the proposed surgery, we pay no benefits for the surgery and related charges.

If a *covered person* or his or her *doctor* disagree with PHCS' decisions, please see the"Appeals Process" section.

Pre-Hospital Review

If the proposed surgery is to be done on an *inpatient basis,* the "Required Pre-Hospital Review" section must be complied with. See the "Required Pre-Hospital Review" section for details.

Penalties for Non-Compliance

For each surgery, as a penalty for non-compliance, we reduce what we would have paid for covered professional charges for surgery by $500.00, if: (a) the *covered person* does not request a required pre-surgical review; or (b) the *covered person* does not get a second opinion when PHCS has requested one; (c) the *covered person* gets a second opinion from a *doctor* who is not on PHCS' list of specialists; or (d) PHCS is not given at least 48 hours to review and evaluate the proposed surgery.

Penalties can't be used to meet this *plan's:* (a) deductibles; or (b) limits on out-of-pocket expenses.

Please note that whether or not a *covered person* complies with all of the above pre-surgical review requirements, we pay no benefits for surgery and related charges that we or PHCS deem not to be medically necessary.

Appeals Process

If a *covered person* or his or her *doctor* does not agree with the outcome of a review, he or she, or his or her *doctor,* may initiate: (a) an internal appeal under this plan; or (b) under certain conditions, an external appeal through the State. See "Internal Appeal" and "External Appeal" below.

Definitions

As used in this Section:

"Adverse Determination" means a determination, based on a review of information provided, that an admission, extension of stay, or other health care service is not medically necessary.

"Final Adverse Determination" means an adverse determination with respect to a health care service has been upheld following a standard of expedited internal appeal.

Internal Appeal

Internal Appeal Process/Standard Appeal

The *covered person* has at least 45 days from receipt of the notice of the outcome of the initial review to request an internal appeal of the *adverse determination.*

To start the standard appeal, the *covered person:* (a) calls or writes to PHCS for Medical Doctor Review (MDR); and (b) requests an appeal.

PHCS must acknowledge the *covered person's* appeal in writing within 15 days of its receipt.