



# **YOUR GROUP INSURANCE PLAN BENEFITS**

**NATIONAL SEATING & MOBILITY  
CLASS 0001  
ACCIDENT 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.

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**CERTIFICATE OF COVERAGE**

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**The Guardian**

*7 Hanover Square  
New York, New York 10004*

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

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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## 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

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## 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

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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

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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

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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.

**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.



## Accident and Health Claims Provisions (Cont.)

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**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

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## ELIGIBILITY FOR ACCIDENT 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.

CGP-3-EC-90-1.0

B476.1228

**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 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, 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-90-6.0

B476.1230

**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 Accident 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 Accident 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 Accident 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.

**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*.

## **Employee Coverage (Cont.)**

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**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

B476.1232

## Dependent Coverage

CGP-3-DEP-90-1.0

B473.0009

**Eligible Dependents For Dependent Accident 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

B476.1242

**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 accident benefits by only one employee at a time.*

CGP-3-DEP-90-3.0

B476.1244

**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 accident 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

B476.1246

**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.*

## Dependent Coverage (Cont.)

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

B476.1247

**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

B476.1248

**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-90-7.0

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## Schedule of Benefits

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### Employee And Dependent Accident Coverage

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For limitations regarding the number of benefit payments per covered accident please refer to the BENEFIT section.

#### Benefits

Accident Emergency Room Treatment	\$175.00
Accident Follow-Up Visit - Doctor	\$50.00 up to 6 treatments
Air Ambulance	\$1,000.00
Ambulance	\$150.00
Appliance	\$125.00
Blood/Plasma/ Platelets	\$300.00
Burn	<u>2nd Degree</u> 18 to 35 square inches: \$1,000.00 over 35: \$3,000.00  <u>3rd degree</u> 9 to 18 square inches: \$2,000.00 18 to 35 square inches: \$4,000.00 over 35: \$12,000.00
Burn - Skin Graft	50% of burn benefit
Child Organized Sport	Additional 20% of payable benefits
Chiropractic Visits	\$25.00 per visit
Coma	\$10,000.00
Concussions	\$75.00
Dislocations	<u>Closed/Open</u>
Hip	\$2,200.00/\$4,400.00
Knee	\$1,100.00/\$2,200.00
Shoulder	\$330.00/\$660.00
Collar bone (sternoclavicular)	\$550.00/\$1,100.00
Collar bone (acromioclavicular and separation)	\$110.00/\$220.00
Ankle or foot	\$880.00/\$1,760.00
Lower jaw	\$330.00/\$660.00
Wrist or elbow	\$330.00/\$660.00
Toe or finger	\$110.00/\$220.00
Bones of the hand	\$330.00/\$660.00

## Employee And Dependent Accident Coverage (Cont.)

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Diagnostic Exam (Major)	\$150.00
Emergency Dental Work	Crown: \$300.00 Extraction: \$75.00
Epidural Anesthesia Pain Management	\$100.00
Eye Injury	\$300.00
Family Care	\$20.00 per day
Fracture	<u>Closed/Open</u>
Skull (depressed)	\$2,750.00/\$5,500.00
Skull (non-depressed)	\$1,100.00/\$2,200.00
Hip, Thigh (femur)	\$1,650.00/\$3,300.00
Vertebrae, body of (excluding vertebrae processes)	\$825.00/\$1,650.00
Pelvis	\$825.00/\$1,650.00
Leg	\$825.00/\$1,650.00
Bones of the face or nose	\$385.00/\$770.00
Upper jaw, maxilla	\$385.00/\$770.00
Upper arm (humerous)	\$385.00/\$770.00
Lower jaw, mandible	\$330.00/\$660.00
Shoulder blade	\$330.00/\$660.00
Vertebral process	\$330.00/\$660.00
Forearm	\$330.00/\$660.00
Kneecap	\$330.00/\$660.00
Foot (except toes)	\$330.00/\$660.00
Ankle	\$330.00/\$660.00
Rib	\$275.00/\$550.00
Coccyx	\$220.00/\$440.00
Finger, toe	\$110.00/\$220.00
Hospital Admission	\$1,000.00
Hospital Confinement	\$225.00 per day
Hospital ICU Admission	\$2,000.00
Hospital ICU Confinement	\$450.00 per day
Initial Physician's office/Urgent care facility treatment	\$75.00
Knee Cartilage	\$500.00



## Employee And Dependent Accident Coverage (Cont.)

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Joint Replacement	Hip: \$2,500.00 Knee: \$1,250.00 Shoulder: \$1,250.00
Laceration	No sutures required: \$25.00 Lacerations less than 5 cm: \$50.00 Lacerations at least 5 cm but less than 15 cm: \$200.00 Lacerations at least 15 cm or more: \$400.00
Lodging	\$125.00 per day
Occupational or Physical Therapy	\$25.00 per day
Prosthetic Device/Artificial Limb	1: \$500.00 2 or more: \$1,000.00
Rehabilitation Unit Confinement	\$150.00 per day
Ruptured Disc With Surgical Repair	\$500.00
Surgery	Cranial, open-abdominal or thoracic: \$1,250.00 Hernia \$150.00
Surgery - Exploratory or Arthroscopic	\$250.00
Tendon/Ligament/Rotator Cuff	1: \$500.00 2 or more: \$1,000.00
Transportation	\$500.00
Wellness Benefit	\$50.00 per year
X - Ray	\$30.00
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## ACCIDENT COVERAGE

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Subject to all of this *plan's* terms, this *plan* will pay the benefits described below if a *covered person* sustains an injury or incurs a loss as a result of a covered accident which occurs on or after the date he or she becomes insured by this *plan*. This *plan* pays no benefits other than what is specifically listed below.

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.

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### Benefits

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| <b>Accident<br/>Emergency Room<br/>Treatment</b> | <i>We pay the amount shown in the Schedule of Insurance if a covered person is examined or treated by a doctor in a hospital emergency room for the initial treatment of injuries sustained in a covered accident within 72 hours after the covered accident. This benefit is payable once per covered person per covered accident. We will not pay the Accident Emergency Room Treatment benefit and the Initial Doctor's Office/Urgent Care Facility benefit for the same covered accident.</i> |
| <b>Accident Follow-Up<br/>Visit</b>              | <i>We pay the amount shown in the Schedule of Insurance if a covered person requires additional follow up treatments (not including occupational, speech or physical therapy or chiropractic treatment) after initial emergency room treatment or doctor's office/urgent care facility treatment. We pay up to 6 treatments per covered person per covered accident. Treatment must begin within 60 days of a covered accident and be completed within 365 days.</i>                              |
| <b>Air Ambulance</b>                             | <i>We pay the amount shown on the Schedule of Insurance if a covered person is transported by air ambulance to or from a hospital or between medical facilities for treatment of injuries sustained as the result of a covered accident within 48 hours of a covered accident. This benefit is payable once per covered person per covered accident.</i>  |
| <b>Ambulance</b>                                 | <i>We pay the amount shown on the Schedule of Insurance if a licensed ambulance company transports a covered person by ground to or from a hospital or between medical facilities for treatment of injuries sustained as a result of a covered accident within 90 days of covered accident. This benefit is payable once per covered person per covered accident.</i>   |
| <b>Appliance</b>                                 | <i>We pay the amount shown on the Schedule of Insurance if a covered person uses an appliance prescribed by a doctor as necessary due to an injury sustained as a result of a covered accident. An appliance includes wheelchairs, leg or back braces, crutches, walkers, walking boot that extends above the ankle, and brace for the neck. Use of the appliance must begin within 90 days of covered accident. This benefit is payable once per covered person per covered accident.</i>        |

- Blood/Plasma/  
Platelets** We pay the amount shown in the Schedule of Insurance if as the result of a *covered accident* a *covered person* receives a transfusion, administration, cross matching, typing and processing of blood/plasma/platelets within 90 days of the *covered accident*. This benefit is payable once per *covered person* per *covered accident*.
- Burn** We pay the amount shown in the Schedule of Insurance if a *covered person* receives burns as a result of a *covered accident* and is treated by a *doctor* within 72 hours of the *covered accident*. If a *covered person* meets more than one of the burn classifications, we pay the higher amount. This benefit is payable once per *covered person* per *covered accident*.
- Burn - Skin Graft** We pay the amount shown in the Schedule of Insurance when medically necessary grafting of the skin is received by a *covered person* for a burn that was payable under the Burn benefit. This benefit is payable once per *covered person* per *covered accident*.
- CGP-3-AC-BEN-12 B476.0004
- Child Organized  
Sport** We pay the additional amount shown on the Schedule of Insurance if the *covered accident* occurred while an *employee's* covered dependent child is participating in an *organized sport*. The child must be insured by this plan on the date the *accident* occurred. The covered child must be 18 years of age or younger.
- Chiropractic visits** We pay the amount shown in the Schedule of Insurance if as the result of a *covered accident* a *covered person* suffers a structural imbalance and receives *chiropractic care services* by a chiropractor in a chiropractor's office. Treatment must begin within 60 days after a *covered accident* and be completed within 180 days of the *covered accident*. We will pay for up to 6 visits per *covered person* per *covered accident* but no more than 12 visits per calendar year.
- Coma** We pay the amount shown in the Schedule of Insurance if as the result of a *covered accident* a *covered person* is in a *coma* lasting at least 7 consecutive days characterized by the absence of eye opening, verbal response, and motor response. The condition must require intubation for respiratory assistance, be diagnosed or treated by a *doctor* within 90 days of the *covered accident*. This benefit is not payable for a medically induced *coma*.
- Concussions** We pay the amount shown in the Schedule of Insurance if a *covered person* sustains a concussion as the result of a *covered accident* and is diagnosed within 72 hours of the *covered accident*. This benefit is payable once per *covered person* per *covered accident*.
- Dislocations** We pay the amount shown in the Schedule of Insurance if a *covered person* is injured and suffers a *dislocation* as the result of a *covered accident*. A *dislocation* must be diagnosed by a *doctor* within 90 days of the *covered accident*. The *dislocation* must be corrected by open (surgical) or closed (non-surgical) reduction.
- For multiple *dislocations* due to the same *covered accident*, we will pay no more than two times the benefit amount for the joint involved with the highest benefit amount.

For partial *dislocations*, we will pay 25% of the benefit shown in the Schedule of Insurance for a closed reduction.

- Diagnostic Exam (Major)** We pay the amount shown in the Schedule of Insurance if a *covered person* receives one of the following imaging studies due to a *covered accident*: Computerized Tomography (CT scan), computerized axial tomography (CAT), magnetic resonance imaging (MRI) or electroencephalography (EEG). The imaging study must be prescribed by a *doctor* and performed in a *doctor's* office or in a *hospital* on an *inpatient* or *outpatient* basis. This benefit is payable once per *covered person* per *covered accident*.
- Emergency Dental Work** We pay the amount shown in the Schedule of Insurance if a *covered person* suffers a broken tooth as the result of a *covered accident* and it is repaired by a *dentist* with a dental crown and/or dental extraction. The dental services must begin within 60 days of the *covered accident*. One dental crown and one dental extraction is payable per *covered person* per *accident*.
- Epidural Anesthesia Pain Management** We pay the amount shown in the Schedule of Insurance if a *covered person* is prescribed and receives an epidural administered for pain management for injuries received as a result of a *covered accident*. The epidural must be administered in a *hospital* or *doctor's* office and is payable twice per *covered person* per *accident*. This benefit is not payable for an epidural administered during a surgical procedure.
- Eye Injury** We pay the amount shown in the Schedule of Insurance if a *covered person* is injured as the result of a *covered accident* and suffers an eye *injury*. The eye *injury* must require surgery or the removal of a foreign object by a *doctor* within 90 days of a *covered accident*. This benefit is payable once per *covered person* per *covered accident*.
- Family Care** We pay the amount shown in the Schedule of Insurance if a *covered person* is injured as the result of a *covered accident* and is confined in a *hospital*, ICU or *alternate care* or *rehabilitative facility* and an *employee* has a child or children attending a *child care center*. The benefit is payable for each child attending a *child care center* while the *covered person* is confined. The child attending the *child care center* does not need to be insured under this Policy for Accident coverage but must meet the eligibility requirements found in the Dependent Eligibility section. This benefit is payable for up to 30 days within 365 days of the *covered accident*. This benefit is payable once per child per *covered accident*.
- Fracture (Bone)** We pay the amount shown in the Schedule of Insurance if a *covered person* suffers a *fracture* as a result of a *covered accident* and it is diagnosed within 90 days of the *covered accident*. The *fracture* must require open (surgical) or closed (non-surgical) reduction by a *doctor*. This benefit is payable for up to two *fractures* per *covered person* per *covered accident*. If there are more than two *fractures*, we will pay the highest two benefit amounts per *covered person* per *covered accident*. We pay 25% of the amount shown in the Schedule of Insurance for the closed reduction of a bone with a chip *fracture* that was a result of a *covered accident*.

**Hospital Admission** We pay the amount shown in the Schedule of Insurance if a *covered person* is admitted to a *hospital* within 180 days of a *covered accident* as a result of injuries sustained in a *covered accident*. This benefit is payable once per *covered person* per *covered accident*. This benefit is not payable for *emergency room* treatment, *outpatient treatment*, or a *hospital* stay less than 20 hours in an observation unit. We will not pay the Hospital Admission and Hospital Intensive Care Unit Admission benefits for the same *covered accident*.

**Hospital Confinement** We pay the amount shown in the Schedule of Insurance if a *covered person* is confined to a *hospital* within 180 days of a *covered accident* as a result of injuries sustained in a *covered accident*. This benefit is payable up to 365 days per *covered accident*. This benefit is not payable for a *hospital* stay less than 20 hours. We pay either the Hospital Confinement or the Hospital Intensive Care Unit Confinement benefits for each day.

**Hospital Intensive Care Unit Admission** We pay the amount shown in the Schedule of Insurance if a *covered person* is admitted directly to a *hospital intensive care unit* within 30 days of a *covered accident* as a result of injuries sustained in a *covered accident*. This benefit is payable once per *covered person* per *covered accident*. This benefit is not payable for *emergency room* treatment, *outpatient treatment*, or a *hospital* stay less than 20 hours in an observation unit. We will not pay the Hospital Admission and the Hospital Intensive Care Unit Admission benefits for the same *covered accident*.

**Hospital Intensive Care Unit Confinement** We pay the amount shown in the Schedule of Insurance if a *covered person* is confined to a *hospital intensive care unit* within 30 days of a *covered accident* as a result of injuries sustained in a *covered accident*. This benefit is payable up to 15 days per *covered accident*. This benefit is not payable for a *hospital intensive care unit* stay less than 20 hours. We pay either the Hospital Confinement or the Hospital Intensive Care Unit Confinement for each day.

**Initial Doctor's Office/Urgent Care Facility Treatment** We pay the amount shown in the Schedule of Insurance if a *covered person* is examined or treated by a *doctor* in a *doctor's office* or *urgent care facility* for the initial treatment of a *covered accident* within 30 days after the *covered accident*. This benefit is payable once per *covered person* per *covered accident*. We will not pay the Accident Emergency Room Treatment benefit and the Initial Doctor's Office/Urgent Care Facility Treatment benefit for the same *covered accident*.

**Knee Cartilage** We pay the amount shown in the Schedule of Insurance if a *covered person* tears, ruptures or severs knee cartilage (meniscus) as the result of a *covered accident* and requires surgical repair. The *injury* must be treated by a *doctor* within 60 days after the *covered accident* and repaired through surgery within 365 days.

**Joint Replacement** We pay the amount shown in the Schedule of Insurance if due to an *injury* sustained in a *covered accident* a *covered person* requires a hip, knee, or shoulder joint replacement. The joint replacement must be performed by a *doctor* within 90 days of a *covered accident* and is payable once per *covered person* per *covered accident*.

<b>Laceration</b>	<i>We pay the amount shown in the Schedule of Insurance if a covered person sustains a laceration as a result of a covered accident and it is repaired by a doctor within 72 hours of the covered accident. The amount we pay will be based on the total length of all lacerations received in any one covered accident which require repair. This benefit is payable once per covered person per covered accident for a laceration with no sutures and once per covered person per covered accident for a laceration which required sutures.</i>
<b>Lodging</b>	<i>We pay the amount shown in the Schedule of Insurance for a companion's hotel/motel stay during the period of time a covered person is confined to the hospital as the result of a covered accident. This benefit is payable up to 30 days per covered person per covered accident and is only payable while the insured is confined to the hospital. The hospital must be more than 50 miles from the residence of the covered person.</i>
<b>Occupational or Physical Therapy</b>	<i>We pay the amount shown in the Schedule of Insurance if a covered person requires occupational or physical therapy due to injuries sustained in a covered accident. Treatment must begin within 60 days of the covered accident, be completed within 6 months, and be performed by a licensed occupational or physical therapist. This benefit is payable up to 10 treatments per covered person per covered accident.</i>
<b>Prosthetic Device/Artificial Limb</b>	<i>We pay the amount shown in the Schedule of Insurance if due to injuries sustained in a covered accident a covered person receives one or more prosthetic devices/artificial limbs as prescribed by a doctor for functional use due to the loss of a hand, foot or sight of an eye. The device or limb must be prescribed within 365 days of the covered accident and is payable once per covered person per covered accident. This benefit is not payable for hearing aids, dental aids (including false teeth), eyeglasses, or cosmetic prostheses such as hair wigs.</i>
<b>Rehabilitation Unit Confinement</b>	<i>We pay the amount shown in the Schedule of Insurance if a covered person is confined to rehabilitation unit due to injuries sustained in a covered accident. This benefit is payable up to 15 days per covered person per covered accident but cannot exceed 30 days per calendar year. We will not pay the Rehabilitation Unit Confinement and the Hospital Confinement benefits for the same day.</i>
<b>Ruptured Disc With Surgical Repair</b>	<i>We pay the amount shown in the Schedule of Insurance if a covered person receives a ruptured disc in his spine as a result of injuries sustained in a covered accident. The injury must be treated by a doctor within 60 days of the covered accident and surgically repaired within 365 days of the covered accident. This benefit is payable once per covered person per covered accident.</i>
<b>Surgery (cranial, open-abdominal, thoracic, hernia)</b>	<i>We pay the amount shown in the Schedule of Insurance if a covered person undergoes cranial, open-abdominal, thoracic, or hernia surgery due injuries sustained to a covered accident. Cranial, open-abdominal, and thoracic surgery must be performed within 72 hours of the covered accident. Hernia surgery must be diagnosed within 30 days of covered accident and surgery must be performed within 60 days. If more than one surgery is performed, we pay the benefit with the highest dollar amount. This benefit is payable once per covered person per covered accident.</i>

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<b>Surgery (Exploratory and Arthroscopic)</b>	<i>We pay the amount shown in the Schedule of Insurance if a covered person undergoes exploratory or arthroscopic surgery as a result of injuries sustained in a covered accident and the surgery takes place within 60 days of the covered accident. This benefit is payable once per covered person per covered accident. Hernia repair is not covered under this benefit. This benefit is not payable if the Surgery or Tendon/Ligament/Rotator Cuff benefits are payable for the same surgery.</i>
<b>Tendon/Ligament/Rotator Cuff</b>	<i>We pay the amount shown in the Schedule of Insurance if a covered person receives a torn, ruptured or severed tendon, ligament, or rotator cuff as the result of injuries sustained in a covered accident. The injury must be treated within 60 days of the covered accident and repaired through surgery within 365 days of the covered accident. This benefit is payable once per covered person per covered accident.</i>
<b>Transportation</b>	<i>We pay the amount shown in the Schedule of Insurance if a covered person must travel more than 50 miles one way to receive special treatment at a hospital or free standing treatment facility due to a covered accident. The treatment must be prescribed by a doctor and not available locally. This benefit is payable up to three times per covered person per covered accident and is not payable if transportation is provided by ambulance or air ambulance.</i>
<b>Wellness Benefit</b>	<i>We pay the amount shown in the Schedule of Insurance for one wellness benefit per calendar year per covered person if such person has a wellness test performed while coverage is in force. Wellness tests are</i> <ul style="list-style-type: none"><li>● Abdominal aortic aneurysm ultrasonography</li><li>● Blood test for triglycerides</li><li>● Bone marrow testing</li><li>● Bone density screening</li><li>● Breast ultrasound</li><li>● CA 15-3 (blood test for breast cancer)</li><li>● CA125 (blood test for ovarian cancer)</li><li>● Carotid ultrasound</li><li>● CEA (blood test for colon cancer)</li><li>● Chest x-ray</li><li>● Colonoscopy</li><li>● Completion of a smoking cessation program</li><li>● Completion of a weight reduction program</li><li>● Double contrast barium enema</li><li>● EKG</li><li>● Fasting blood glucose test</li></ul>

- Flexible sigmoidoscopy
- Hemoccult stool analysis
- Immunizations
- Mammography
- Pap smear
- PSA (blood test for prostate cancer)
- Routine/annual physicals
- Serum cholesterol test to determine level of HDL and LDL
- Serum Protein Electrophoresis (blood test for myeloma)
- Skin cancer biopsy
- Stress test on a bicycle or treadmill
- Thermography
- ThinPrep pap test
- Virtual colonoscopy.

**X - Ray** We pay the amount shown in the Schedule of Insurance if a *covered person* receives an x-ray as the result of injuries sustained in a *covered accident*. The test must be prescribed by a *doctor* and performed in a *doctor's office* or a *hospital* on an *inpatient* or *outpatient* basis and performed within 90 days of the *covered accident*. This benefit is payable once per *covered person* per *covered accident*.

**Payment of Benefits** For covered loss of life, we pay *your* beneficiary described below.

For all other covered losses, we pay *you*, if *you* are living. If not, we pay *your* beneficiary described below.

We pay all benefits in a lump sum, as soon as we receive proof of loss which is acceptable to *us*. This should be sent to *us* as soon as possible.

**The Beneficiary** *You* decide who gets this benefit if *you* die. *You* should have named a beneficiary on *your* enrollment form. *Your* beneficiary designation should be maintained by *your employer*. *You* can change *your* beneficiary at any time by giving *us* written notice, unless *you* have assigned this insurance. But the change will not take effect until the *employer* gives *you* written confirmation of the change.

If *you* named more than one person, but didn't tell *us* what their shares should be, they will share equally. If someone *you* named dies before *you*, that person's share will be divided equally by the beneficiaries still alive, unless *you* have specified otherwise.

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



## Exclusions

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This *plan* will not pay benefits for any injury caused by or related to, directly or indirectly:

- Sickness, disease, mental infirmity or medical or surgical treatment.
- Voluntary use of any poison, chemical, prescription or non-prescription drug or controlled substance unless: (1) it was prescribed for a *covered person* by a *doctor*, and (2) it was used as prescribed. In the case of a non-prescription drug, this *plan* does not pay for any *accident* resulting from or contributed to by use in a manner inconsistent with package instructions. "Controlled substance" means anything called a controlled substance in Title II of the Comprehensive Drug Abuse Prevention and Control Act of 1970, as amended from time to time.
- The *covered person* being legally intoxicated.
- Declared or undeclared war, act of war, or armed aggression.
- Service in the armed forces, National Guard, or military reserves of any state or country.
- Taking part in a riot or civil disorder.
- Commission of, or attempt to commit a felony.
- Treatment rendered or *hospital confinement* outside the United States or Canada.
- Intentionally self inflicted injury, while sane or insane.
- Suicide or attempted suicide, while sane or insane.
- Travel or flight in any kind of aircraft, including any aircraft owned by or for the *employer* except as a fare-paying passenger on a common carrier.
- Participation in any kind of sporting activity for compensation or profit, including coaching or officiating.
- Riding in or driving any motor-driven vehicle in a race, stunt show or speed test.
- Participation in hang gliding, bungee jumping, sailgliding, parasailing, parakiting ballooning, parachuting, or skydiving.
- An accident that occurred before the *covered person* is covered by this *plan*.
- Injuries to a dependent child received during birth.

CGP-3-AC-EXC-12

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## PORTABILITY PRIVILEGE

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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 *accident* 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*: (1) 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 *accident* coverage, *your* spouse may port the dependent *accident* 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 *accident* 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: (1) *your* rate class under this *plan*; and (2) *your* or *your* surviving spouse's age bracket as shown in the Accident 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.

CGP-3-AC-PORT-12

B476.0020

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## DEFINITIONS

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<b>Accident</b>	This term means an event or occurrence that was not reasonably foreseeable, or that could not have been reasonably expected or anticipated. The term <i>accident</i> does not include a <i>sickness</i> .
<b>Alternate Care Facility</b>	This term means a facility that is licensed according to state and/or local laws to provide skilled care, intermediate care, intermingled care, custodial care, or rehabilitative care as an alternative to care at a <i>hospital</i> .
<b>Child Care Center</b>	This term means a program of child care which: (1) is provided in a facility that is licensed as a day care center or is operated by a licensed day care provider; and (2) charges a fee for the care of children. The term does not include child care provided by a: (a) parent; (b) stepparent; (c) grandparent; (d) sibling; (e) aunt; or (f) uncle.
<b>Chiropractic Care Services</b>	This term means spinal manipulation by a licensed chiropractor to correct a structural imbalance caused by a <i>covered accident</i> . This does not include services for massage therapy or treatment of chronic conditions or other injuries not related to structural imbalance.
<b>Covered Accident</b>	This term means an <i>accident</i> that: <ul style="list-style-type: none"><li>● Occurs while <i>your</i> coverage or <i>your</i> dependent's coverage under this policy is in effect.</li><li>● Results in a bodily <i>injury</i> and</li><li>● Is not otherwise excluded under the terms of this policy.</li></ul>
<b>Covered Person</b>	This term means an <i>employee</i> or dependent insured by this <i>plan</i> .
<b>Coma</b>	This term means a state of complete mental unresponsiveness, due to <i>injury</i> , with no evidence of appropriate responses to stimulation, as diagnosed by a <i>doctor</i> .
<b>Companion</b>	This term means a spouse, domestic partner, civil union partner, sibling, child, parent, grandparent, or any primary care giver.
<b>Dentist</b>	This term means a licensed <i>doctor</i> of dentistry, operating within the scope of his or her license, in the state in which he or she is licensed.
<b>Dislocation</b>	This term means a completely separated joint due to an <i>injury</i> . A partial <i>dislocation</i> means the joint is misaligned but not completely dislocated, as diagnosed by a <i>doctor</i> .
<b>Doctor</b>	This term means any medical practitioner We are required by law to recognize. He or she must: (1) be properly licensed or certified by the laws of the state where he or she practices; and (2) provide services that are within the lawful scope of his or her practice.
<b>Emergency Room</b>	This term means a department of the <i>hospital</i> that is designated for emergency care of accidental injuries. This area must be staffed and equipped to handle trauma, be supervised and provide treatment by <i>doctors</i> , and provide care seven days per week, 24 hours per day.

**Epidural Anesthesia** This term means a form of regional anesthesia involving injection of drugs through a catheter placed into the epidural space. The epidural must be administered due to a *covered accident*, and does not include treatment for childbirth or diseases.

**Fracture** This term means a broken bone that can be determined by a diagnostic exam. A chip *fracture* is a *fracture* in which a piece of the bone is broken off near a joint at a place where a ligament is usually attached.

**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.

**Hospital Intensive Care Unit** This term means a designated area of a *hospital* that

- (1) provides the highest quality of medical care and is restricted to patients who are critically ill or injured and who require intensive comprehensive observation and care;
- (2) is separate and apart from the surgical recovery room and from rooms, beds, wards, and units customarily used for patient confinement
- (3) is permanently equipped with special lifesaving equipment for the care of the critically ill or injured;
- (4) is under continuous observation by a specially trained nursing staff assigned exclusively to the intensive care unit on a 24 hour basis and is assigned a *doctor* on a full-time basis.

**Hospital Confinement** This term means admission to a *hospital* as an *inpatient* for at least 24 consecutive hours by a *doctor* for an *injury*.

**Injury** This term means unintentional physical damage or harm caused directly by an *accident* and not due to *sickness*, disease or any other causes. The *injury* must occur while you or your covered dependent are insured under this *plan*.

**Inpatient** This term means a patient who is admitted to a *hospital* for an *injury*.

## Definitions (Cont.)

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<b>Occupational Therapy</b>	This term means the treatment of a physically disabled person by means of constructive activities designed and adapted to promote the restoration of the <i>covered person's</i> ability to satisfactorily accomplish the ordinary tasks of daily living and those tasks required by the <i>covered person's</i> particular occupational role. Occupational therapy does not include diversional, recreational, vocational therapies(i.e. hobbies, arts and crafts).
<b>Occupational Therapist</b>	This term means a person, other than you or a family member, who: 1) possesses the designation "Occupational Therapists Registerd(OTR)", 2) is licensed by the state to practice <i>occupational therapy</i> , 3) performs services which are allowed by his licenses; and 4) performs services for which benefits are provided by this <i>plan</i> .
<b>Organized Sport</b>	This term means a sport activity that is governed by an organization and requires formal registration to participate. Proof of registration will be required at claim time.
<b>Outpatient Treatment</b>	This term means medical services that a <i>covered person</i> receives when not confined as an <i>inpatient</i> in a <i>hospital</i> .
<b>Physical Therapy</b>	This term means treatment by physical means, hydrotherapy, heat, or similar modalities, physical agents, bio-mechanical and neuro-physiological principles and devices. Such therapy is given to relieve pain, restore function, and to prevent disability following <i>injury</i> or loss of a body part.
<b>Physical Therapist</b>	This term means a person, other than you or a family member, who: 1) is licensed by the state to practice <i>physical therapy</i> ; 2) performs services which are allowed by his or her license; 3) performs services for which benefits are provided by this Policy and 4) practices according to the code of ethics of the American Physical Therapy Association.
<b>Rehabilitative Unit</b>	This term means an appropriately licensed facility or separate section of a <i>hospital</i> that provides rehabilitation care services on an <i>inpatient</i> basis and is designated, staffed and equipped to provide restorative services under the supervision of a trained and experienced rehabilitation <i>doctor</i> . A rehabilitation unit is not: a nursing home; an extended care facility; a skilled nursing facility; a rest home or home for the aged; a hospice care facility; a place for alcoholics or drug addicts; or an assisted living facility.
<b>Sickness</b>	This term means a disease, illness or other condition not related to <i>injury</i> including diseases or infections except when the due to an accidental cut or wound.
<b>Urgent Care Facility</b>	This term means a health care facility that is organizationally separate from a <i>hospital</i> and whose primary purpose is the offering and provision of immediate, short term medical care, without appointment, for urgent care.
<b>We, Us and Our</b>	These terms mean The Guardian Life Insurance Company of America.
<b>You or Your</b>	These terms mean the insured <i>employee</i> .

CGP-3-AC-DEF-12

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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

**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

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

CGP-3-GLOSS-90

B750.0015

**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

**Employer** means NATIONAL SEATING & MOBILITY .

CGP-3-GLOSS-90

B900.0051

**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

**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

**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

**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

**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

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## SUMMARY PLAN DESCRIPTION SUPPLEMENT TO CERTIFICATE

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You participate in a single or multiple employer insured Welfare Plan. This supplement and your certificate of insurance together may constitute the Summary Plan Description as required by the Employee Retirement Income Security Act of 1974 (ERISA). This supplement should be retained with your certificate.

- **Name of Plan:**

NATIONAL SEATING & MOBILITY Plan

- **Employer's Name:** (Plan Sponsor)

NATIONAL SEATING & MOBILITY

**Address:** 320 PREMIER COURT  
FRANKLIN TN 37067

**Phone Number:** 423-756-2268

- If you participate in a multiple employer insured Welfare Plan, you may obtain a complete list of the employers sponsoring the plan upon written request to the plan administrator. You may also receive information as to whether a particular employer is a plan sponsor, and if the employer is a plan sponsor, the sponsor's address.

- **IRS Employer Identification Number (EIN):**621400785

- **Plan Number:** 509

- **Type of Administration:**contract administration

- **Plan Administrator:** (if other than Plan Sponsor)

NATIONAL SEATING & MOBILITY

**Address:** 320 PREMIER COURT  
FRANKLIN TN 37067

**Phone Number:** 423-756-2268

- **Agent for the Service of Legal Process:**

NATIONAL SEATING & MOBILITY

**Address:** 320 PREMIER COURT  
FRANKLIN TN 37067

**Phone Number:** 423-756-2268

(Legal process may also be served on the Plan Administrator.)

- If the plan is maintained pursuant to one or more collective bargaining agreements, the following information may be obtained by participants and beneficiaries upon written request to the plan administrator, and is available for examination by participants and beneficiaries: a copy of any such collective bargaining agreement; a complete list of the employers and employee organizations sponsoring the plan; and information as to whether a particular employer or employee organization is a sponsor of the plan, and if so, the sponsor's address. For the purpose of this paragraph, a plan is maintained pursuant to a collective bargaining agreement if such agreement controls any duties, rights or benefits under the plan, even though such agreement has been superseded in part for other purposes.
- **Date of End of Record Year:** January 1st .
- **Sources of Contribution:**Contributions to the plan are provided by:
  - the Employer
  - the Employee
  - Both the Employer and the Employee (assuming there are situations where both contribute).
- A class or classes of full-time employees are eligible to apply for insurance provided they have completed the service waiting period established by the employer, if any. Qualified dependents of these employees may also be eligible for insurance. (Your certificate provides details.)
- Participants and beneficiaries under this Plan can obtain, without charge, a copy of procedures governing qualified domestic relations order (QDRO) determinations from the plan administrator.
- **Termination/Amendment/Elimination:**Conditions may exist in the Group Policy where the plan sponsor or others have the authority to terminate the plan, amend or eliminate benefits under the plan. Please see the Plan Administrator for more information regarding these specific conditions and to request a copy of the Group Policy.
- **Assistance:** For information regarding rights under ERISA, contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in the telephone directory, or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, D.C. 20210.

B055.0083-R



**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.

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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;
- 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;

## Group Health Benefits Claims Procedure (Cont.)

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- 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:

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## 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.

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## 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.

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**The Guardian Life Insurance  
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