YOUR GROUP INSURANCE
PLAN BENEFITS

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

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

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

Vice President, Group Products

CGP-3-R-STK-90-3   B110.0023-R
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COMPLAINT NOTICE

This notice is to advise you that should any complaints arise regarding this insurance you may contact the Guardian at the following address or phone number:

The Guardian Sales Office  
88 Kearny Street, Suite 1900  
San Francisco, California 94108  
Telephone: (415) 788-4440  
(800) 832-9555  
Fax: (415) 788-4412

If you feel your complaints have not been resolved after contacting the Guardian you may contact the California Department of Insurance at the following address or phone number:

Department of Insurance  
300 South Spring St.  
Los Angeles, CA 90013

Consumer Hotline: 1-800-927-4357
GENERAL PROVISIONS

As used in this booklet:

“Covered person” means an employee 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.

Limitation of Authority

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

Incontestability

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

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

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

Examination and Autopsy

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

**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.
ELIGIBILITY FOR DISABILITY COVERAGE

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. Other parts of this coverage explain 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.

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.

When Your Coverage Ends
Your long term disability 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 replace certain group benefits with converted policies.
LONG TERM DISABILITY HIGHLIGHTS

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

Elimination Period
For disability due to injury ........................................... 90 days.
For disability due to sickness ................................. 90 days.

Gross Monthly Benefit .................................................. $1,500.00.

Note: We integrate your gross monthly benefit with certain other income you may receive. Read all of the terms of this plan to see what income we integrate with, and how.

Maximum Payment Period
See the following table.

<table>
<thead>
<tr>
<th>Age When Disability Starts</th>
<th>Maximum Payment Period</th>
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<td>Age 69 or older</td>
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</tbody>
</table>

Loan Payoff
$175,000 lifetime benefit

Maximum Benefit
$85,000 lifetime benefit
LONG TERM DISABILITY INCOME INSURANCE

This insurance replaces part of your income when it is reduced by disability. 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 at the end of this section. Other terms are defined where they are used.

Claim Provisions

**Filing A Claim For Benefits**

You must send us written notice of an *injury* or *sickness* for which you intend to file a long term disability claim within 30 days of the *injury* or start of the *sickness* for which a claim is being made. This notice should include your name and Social Security number and the *plan* number.

We will furnish you with claim forms for filing proof of *disability* within 15 days of our receipt of the initial notice of your intent to file a claim. The completed claim forms must be returned to us within a reasonable period of time. If we do not furnish the forms within the time stated, we will accept a written description of the *injury* or *sickness* that is the basis for the claim in place of our form. You must detail the nature and extent of the *disability* for which the claim is being made. If necessary to determine our liability, as part of proof of loss, we may require:

(a) certification of the extent and nature of your *disability* from all *doctors* who have treated you for the cause of your *disability*;

(b) certification of income from any other sources of income to which you may be entitled which may affect our benefit payments;

(c) satisfactory evidence that you have applied for all benefits and payments from other income sources to which you may be entitled; and

(d) proof of any income from other sources that you have received.

We may require you to authorize release of medical and income data by the sources of such data, including the providers of medical and/or dental services. Any information not furnished or for which the release of authorization to obtain data is not obtained can result in suspension or delay of long term disability benefit payments until such information or authorization is received by us.

**Time Limit For The Filing Of A Claim**

Any claim not filed within a reasonable period of time following the end of the elimination period will be denied and no long term disability benefits will be payable unless we receive written proof that you lacked the legal capacity to file the claim or that it was not reasonably possible for you to file the claim. In no event will benefits be payable for more than one year retroactively from the date the claim is filed.

**Continued Proof Of Disability**

Additional proof will be required. Written proof of your continued *disability* and *doctor’s* care must be provided to us within 30 days of each date we make such request.
Payment Of Benefits
Benefits for the long term disability income insurance are payable once every month, provided you continue to submit periodic written proof of loss and any current earnings as required by us. We pay all long term disability benefits to you, if legally competent. If you are not legally competent, we will pay all benefits to which you are entitled to the legal representative of your estate. We have the right to pay any benefits to which you are entitled which remain unpaid at your death to one of the following: (a) your estate; or (b) your spouse, parents, children or brothers and sisters.

Examination
If you make a claim for benefits, we have the right to require that you be examined by a doctor as often as we feel is necessary. And we have the right to terminate or suspend your net monthly payments if you fail to attend such an examination. In such case, your net monthly payments may be resumed, provided that: (a) the required examination occurs within a reasonable period of time; and (b) you continue to be entitled to net monthly payments under all other provisions of this plan. We will pay for all such examinations.

For other information on filing a claim, see this plan's "Accident and Health Claims Provisions."

How This Plan Works

When And How This Plan's Net Monthly Payments Start
To start getting net monthly payments under this plan, you must meet all of the following conditions:

- you must: (a) become disabled while insured by this plan; and (b) stay both disabled and insured by this plan continuously throughout the elimination period.

- you must be: (a) under a doctor’s regular care for the cause of your disability; and (b) receiving appropriate medical care for the cause of your disability and for any other sickness or injury which exists before, or occurs during, the period you are disabled under the plan.

- you must send us acceptable written proof of: (a) your disability; (b) your prior monthly earnings; and (c) any current monthly earnings.

We reserve the right to determine when you meet the above conditions.

Failure to pass your regular occupational physical checkup does not constitute disability under this plan. We do not accept, as proof of disability, certification from a doctor who is: (a) yourself; or (b) your business associate, spouse, parent, child, brother or sister.

Once we approve your initial proofs of disability and earnings we start to make net monthly payments. The first net monthly payment is made one month after the end of the elimination period.

The Elimination Period
The elimination period is the period of time you must be continuously disabled before long term disability benefits are payable.

- For disability due to injury, the elimination period is 90 days.
For disability due to sickness, the elimination period is 90 days.

Any days of disability which result from a disability for which this plan does not pay benefits will not count toward the elimination period. Any days during which you are not disabled will not count toward the elimination period.

The elimination period will be considered continuous if you return to work in your regular occupation for not more than 45 consecutive days during the elimination period. The elimination period will be extended by one day for each day you temporarily return to work. This interruption of the elimination period will not apply if you become eligible under any other group long term disability plan.

Continued Payment Of This Plan's Net Monthly Payments

To continue to be entitled to net monthly payments under this plan, you must continue to provide adequate proof of:

(a) your continued disability;
(b) continued regular doctor's care for the cause of the disability;
(c) any current monthly earnings; and
(d) any other income we integrate with that you are entitled to receive.

In addition, we may, at any time, require you to be examined by a doctor or medical professional of our choosing.

Your net monthly payments under this plan can be terminated or suspended if at any time you fail to comply with any of the above requirements.

See "Accident and Health Claims Provisions" for how often we can require continued proof of the items shown above.

How long we continue to make net monthly payments under this plan will be subject to all the terms of this plan.

When Disability Ends

Your disability under this plan ends on the earliest of: (a) the date you earn or we determine you are able to earn at a rate of at least 80% of your prior monthly earnings; or (b) the date we determine you are able to perform the major duties of your regular occupation or employment on a full-time basis, even if you choose not to perform such duties; or (c) after you have been disabled for 24 consecutive months, the date we determine you are able to perform the major duties of any suitable occupation or employment (other than rehabilitative work, as allowed under this plan) even if you choose not to perform such duties.

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CGP-3-LTD94-B-3.0
When This Plan’s Payments End

This plan’s net monthly payments end on the earliest of:

(a) the date your disability ends;
(b) the date you die;
(c) the end of the maximum payment period;
(d) the date you fail to give us any proof of disability we require;
(e) the date you refuse to allow any physical exam we require;
(f) the date you are no longer under the regular and continuing care of a doctor.

Maximum payment period

See the following table.

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<thead>
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<th>Age when disability starts</th>
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Recurring Disability

Benefits for disability cease when your disability ends, as described above. If your benefit ceased because your disability ended, and you become disabled again under this plan we will consider the later period of disability to be a recurring disability if:

(a) you return to active, full-time work right after a period of disability for which this plan has paid benefits;
(b) your disability recurs less than six months after the end of the period for which you were last entitled to a net monthly payment under this plan;
(c) your later disability is due to the same sickness or injury that caused the earlier period of disability;
(d) you do not become covered under any other group long term disability income plan during the period you are performing active full-time work;
(e) this plan does not terminate during the time that you are performing active full-time work; and
(f) you remain insured under this plan and the employer resumes premium payment for the coverage during any time you are performing active full-time work.
How This Plan Works (Cont.)

If we consider the disability to be a recurring disability, the disability will be treated as a continuation of the earlier disability. This means you will not be required to satisfy a new elimination period before benefits will be payable under this plan for the later disability. It also means that if, during any period of time you are receiving benefits under this plan, or during the period of active work that separates an earlier disability and a recurring disability: (a) any of the benefit provisions under this plan change; or (b) your basic monthly earnings or class change; those changes will not apply to the recurring disability. The benefits payable for the recurring disability will be based on the terms of the plan that applied to the earlier disability.

If the later period of disability:

(a) is due to an unrelated cause;

(b) begins six months or more after the end of the period for which disability benefits were payable under this plan; or

(c) begins after the date this plan ends;

the disability will not be considered recurring and will be treated like a new period of disability.

You must provide all proof of loss required by this plan for disability before benefits will be payable for a recurring disability.

Application For Other Income Required

You must apply for any disability or retirement benefits we integrate with, which we feel, you may be entitled to receive. If such benefits are denied we require you to apply for them again. You are required to continue to appeal all denials until: (a) you receive written notification from the Guardian that no further appeals are necessary; or (b) all possible appeals have been exhausted.

If we feel that you are entitled to any of the benefits shown above, we will: (a) assume you are receiving such benefits; and (b) integrate the gross monthly benefit with the estimated amount of such benefits payable to you and any applicable dependents on behalf of your disability. But we do not do this if you sign our agreement concerning benefits under which you promise: (a) to apply for any benefits we integrate with; and (b) at our request, to reapply for such benefits or appeal any denial of such benefits until no further appeals can be made; and (c) repay any overpayment due to an award of such benefits.

If we do estimate them, we adjust your net monthly payments when we receive written proof: (a) of the amount awarded; or (b) that such benefits are denied after any reapplications or appeals we require. In the case of (b), if such adjustment shows we underpaid you, we pay you the full amount of the underpayment in a lump sum.

The Guardian will assist you in applying for other income benefits.

Computing Your Net Monthly Payment From This Plan

Your net monthly payment under this plan is your net monthly benefit determined above, reduced by 50% of any current monthly earnings you earn while disabled.
How This Plan Works (Cont.)

If, during any month for which this plan pays benefits, the sum of the following:

(a) your net monthly payment, as figured above;
(b) the total amount of all other income with which this plan integrates that you are entitled to receive; and
(c) the amount of your current monthly earnings;

is greater than the amount of your prior monthly earnings, your net monthly payment for that month will be further reduced by that portion in excess of 100% of your prior monthly earnings.

Cost Of Living Freeze

After we compute the first net monthly benefit, we do not reduce your benefit due to cost of living increases in social security benefits or other income benefits with which we integrate. We do adjust net monthly payments if: (a) your current monthly earnings change; or (b) your social security benefits or other income benefits with which we integrate change due to a recalculation of the benefit when updated information is received after the initial benefit is calculated.

Minimum Net Monthly Payment

This plan’s minimum net monthly payment is $100.00.

Payments For Partial Months

When disability lasts part of a month, we pay 1/30 of the net monthly payment for each day for which we are liable. In no event will benefits be paid for any more than 30 days for any one month.

Waiver Of Premium

We waive all premiums for your long term disability income insurance which fall due while you are entitled to receive a net monthly payment from this plan.

If This Plan Ends

This insurance ends when the group plan ends. It also ends when this insurance is dropped from the group plan for all employees, or for your class. If either happens while you are disabled, we pay you benefits as if your insurance did not end. But what we pay will be based on all of the terms of this plan.

Overpayments - Our Recovery Rights

If we determine that we overpaid you, you must reimburse us in full. In addition, we have the right to stop paying benefits until the overpayment is satisfied. We have the right to recover overpayments made for any reason, including those that result from lump sum awards by any of the income benefits we integrate with.

Loan Payoff Benefit

We provide a loan payoff benefit if you become functionally disabled, as defined by this plan. The loan payoff benefit is explained below. But, what we pay is subject to all the terms of this plan.

To be eligible for a loan payoff benefit, you must meet all of the following conditions:
How This Plan Works (Cont.)

(a) you must be disabled, according to the terms of this plan, and be entitled to receive net monthly payments under this plan;

(b) you must meet the definition of functional disability for a period of 12 consecutive months; and

(c) you must have an eligible loan(s).

Once we approve your proofs of disability and eligible loan(s), we start to repay your eligible loan(s). If the terms of an eligible loan(s) change after the onset of disability, loan payoff benefit payments will be based on the lesser of the loan re-payment requirements. We have the right to repay eligible loan(s) in installments. Payments will be made to the financial lending institution that made the loans.

To be eligible for payoff (an "eligible loan"), a loan:

(1) must have been made to the employee/resident by a financial lending institution;

(2) must have been made to cover educational expenses for college and/or medical school, including tuition, fees, textbooks, and equipment;

(3) must have been made prior to the onset of disability;

(4) must have been made prior to the date the resident graduated from medical school; and

(5) must not be a loan which the resident is not required to repay.

The resident must provide proof of eligible debt.

Loan payoff benefits end on the earliest of:

(a) the date you are no longer functionally disabled;

(b) the date you fail to provide continued proof of disability as required by this plan;

(c) the date you are no longer entitled to net monthly payments from this plan;

(d) the end of the maximum payment period; or

(e) the date the maximum loan payoff benefit is reached.

Special Limitations

Mental Or Emotional Conditions, Alcohol Abuse And Drug Abuse

If you are disabled, as defined by this plan, by a mental or emotional condition, alcohol abuse or drug abuse, we limit the duration of this plan's benefits. For the long term disability income coverage of this plan, a mental or emotional condition will include, but is not limited to, any of the following:

- bipolar affective disorder (manic depressive syndrome).
- schizophrenia.
- delusional (paranoid) disorders.
- psychotic disorders.
• depressive disorders.
• anxiety disorders.
• somatoform disorders (psychosomatic illness).
• eating disorders.
• mental illness.

For each disability due to a mental or emotional condition, alcohol or drug abuse, our payments stop at the earliest of: (a) the date during any one period of disability that you have received 24 net monthly payments; (b) the end of the maximum payment period; or (c) the date disability ends.

Benefits will be limited to a total of 24 months of benefits in your lifetime for all disabilities contributed to, or caused by, any combination of the conditions shown above.

But, if at the end of benefit payments as shown above, you are being treated for the cause of your disability as an inpatient in a qualified institution for at least 14 consecutive days, we extend our payments. We extend them until the earliest of: (a) 90 days from the date of your discharge; (b) the end of the maximum payment period; or (c) the date disability ends.

By "qualified institution," we mean a legally operated hospital or other public or private facility licensed to provide inpatient medical care and treatment for the cause of your disability.

Pre-Existing Conditions
A pre-existing condition is a sickness or injury, including all related conditions and complications, for which, in the three months before your insurance under this plan starts, you: (a) receive advice or treatment from a doctor; take prescribed drugs; or receive other medical care or treatment, including consultation with a doctor; or (b) exhibit symptoms which would cause an ordinarily prudent person to seek medical advice, diagnosis, care or treatment.

A pregnancy which exists on the date your insurance under this plan starts is also a pre-existing condition.

We do not pay benefits for disability caused by such a condition, unless it starts after you complete at least one full day of active work after the date you are insured under this plan for 12 consecutive months.

We do not cover any disability which begins before your insurance under this plan starts.

If This Plan Replaces Another Plan
The pre-existing condition limitation shown above will not apply if you: (a) were insured on the day before this plan started under a long term disability plan the employer had with another insurer; and (b) meet the requirements shown below. But, this plan must start right after the old plan ends.

The pre-existing condition limitation will be waived if you: (a) are actively working on a full-time basis on the effective date of this plan; and (b) have fulfilled the requirements of any pre-existing condition exclusion or limitation of the old plan.
If you: (a) are actively working on a full-time basis on the effective date of this plan; but (b) have not fulfilled the requirements of any pre-existing condition limitation or exclusion of the old plan; then we will apply any period of time credited toward the satisfaction of the pre-existing condition limitation or exclusion under the old plan toward satisfaction of this plan’s pre-existing condition limitation.

We will deduct all payments made by the old plan under an extension provision. Any benefits for a disability caused by a pre-existing condition that we agree to pay will be subject to all other terms of this plan.

Exclusions

- We do not cover any period of disability caused, directly or indirectly, by: (a) declared or undeclared war or act of war or armed aggression; (b) your service in the armed forces, National Guard, or military reserves of any state or country; (c) your taking part in a riot or other civil disorder; (d) your commission of, or attempt to commit, a felony; (e) your unlawful use or threat of force on another person without his or her consent; (f) intentional self injury or attempted suicide while sane or insane; (g) job-related or on-the-job injury; or (h) conditions for which benefits are payable by Workers’ Compensation or like laws.

- We do not pay benefits for any period during which you are confined to any facility as a result of your conviction of a crime or public offense.

- We do not pay benefits for any period during which you are not under the regular care and treatment of a doctor.

- We do not pay benefits for any period of disability which starts before you are insured by this plan.

In addition, no benefits will be payable for any period during which your loss of earnings is not solely due to your disability.

Definitions

**Active Work** For The Long Term Disability Income Insurance “active work” means you are physically able to perform and are performing all of the regular duties of your work for the employer in the usual way and on a full-time basis, either at one of the employer’s usual places of business or at some location to which the employer’s business requires you to travel. Any changes in your long term disability benefits that are scheduled to occur on a date you are not actively working will not take place until the date you return to active work. However, if your return to active work is followed by a later period of disability which is considered a recurring disability, as described in this plan, changes which occur before or during that period of active work will not take place.
Disability means, solely due to your sickness or injury:

(1) For the first 24 months of your disability:
   (a) you are completely unable to perform the major duties of your regular occupation on a full-time basis; and
   (b) your current monthly earnings, if any, are less than 80% of your prior monthly earnings.

(2) After you have been disabled for 24 consecutive months, the definition of disability changes. For the duration of the disability, "disability" means:
   (a) you are completely unable to perform on a full-time basis the major duties of any occupation or work for which you are, or could become, qualified for by training, education or experience; and
   (b) your current monthly earnings, if any, are less than 80% of your prior monthly earnings.

While you are disabled, you can engage in: (i) any other occupation full or part-time; (ii) some, but not all, of the major duties or your regular occupation full or part-time; or (iii) all of the major duties of your regular occupation part-time.

This plan only covers disability that starts while you are insured by this plan.

You will not be considered disabled under this plan if you are not under the regular care and treatment of a doctor.

In no event will the loss of a professional or occupational license, in itself, constitute disability.

If you are employed as an airline pilot, co-pilot, or crew member, disability will not be determined to exist unless you, because of sickness or injury, are completely unable to perform the major duties of any occupation for which you are, or could become, qualified by training, education or experience.

Doctor means any medical practitioner we’re required by law to recognize, who: (a) is properly licensed or certified as such by the laws of the state where he or she practices; and (b) provides services that are within the lawful scope of his or her practice.

Earnings has the following meanings for this plan’s long term disability income insurance:
"Basic monthly earnings" are based on the amount of your earnings received from the employer as reported to us. These earnings are used in determining the amount of premiums due for the coverage and for projecting your gross monthly benefit under this plan. Basic monthly earnings means an employee's rate of monthly earnings. Bonuses, commissions, expense accounts, overtime pay and any other extra compensation are excluded. But, any employee compensation which is deposited into a cash or deferred compensation plan, or a salary reduction plan, qualified under IRC Section 401(k) is included. Any employee compensation based on excluded income listed above and any employer contributions deposited into such 401(k) is excluded. In case of weekly earnings, it refers to those earnings for a normal work week not exceeding forty hours. Such weekly earnings are multiplied by 4.333. Subject to any of this plan's proof of insurability requirements each September 1st, we use the employee's then current monthly earnings to set rates and to project the employee's gross monthly benefit for billing purposes. But the employee must be actively at work on a full-time basis on that date. If he is not, we do this on the date he returns to active full-time work.

"Current monthly earnings" are the exact amount of monthly earnings you earn from working while disabled. Your current monthly earnings will include any income you earn while disabled but which is returned to your employer, partnership or any other similar business arrangement to cover any business or overhead expenses. Your current monthly earnings are used in determining your net monthly payment.

"Prior monthly earnings" means your rate of basic monthly earnings as last reported to us prior to the start of your disability. Your prior monthly earnings are used in determining your gross monthly benefit under this plan.

As part of proof of loss that we require, you must give us acceptable proof of your earnings. If you do not, we will not pay any benefits. Such proof must consist of: (a) copies of your U.S. Individual Tax Returns; (b) a statement from a certified public accountant; or (c) any other records we agree to accept.

Employer means UNIVERSITY OF CALIFORNIA SAN FRANCISCO SCHOOL OF MEDICINE.

Government Plan means: (a) the United States Social Security Act; (b) the Railroad Retirement Act; (c) the Canadian Pension Plan; or (d) any other plan provided under the laws of a state, province or any other political subdivision. It also includes any public employee retirement plan; or any plan provided as an alternative to the above plan or acts. It does not include: (i) any Workers’ Compensation Act or similar law; (ii) the Jones’ Act; (iii) the Longshoreman’s and Harbor Workers’ Compensation Act; or (iv) the Maritime Doctrine of Maintenance, Wages or Cure.

Gross Monthly Benefit means this plan's monthly benefit before it is integrated with other income and earnings.
Injury means: (a) all bodily injury due to an accident that occurs, independent of all other causes, while you are insured by this plan; and (b) all complications thereof. Disability will be considered caused by an injury only if that disability: (a) is directly caused by the injury; and (b) begins within 90 days of the date of such injury.

Maximum Payment Period means the longest period that benefits are paid by this plan for continuous disability.

Net Monthly Benefit means this plan’s monthly benefit after the gross monthly benefit is integrated with other income but before it is reduced by any current monthly earnings.

Net Monthly Payment means this plan’s net monthly benefit less any reduction by current monthly earnings. See “How We Compute Net Monthly Payments” for details.

No-Fault Motor Vehicle Coverage means a motor vehicle plan that pays disability or medical benefits without considering who was at fault in any accident.

Plan means the Guardian group long term disability income insurance plan the employer bought.

Regular Occupation means your occupation as performed in the general labor market in the national economy. When determining the duties of your regular occupation we use both the job description provided for you by the employer as well as the duties of that occupation as shown in the most recent version of the Dictionary of Occupational Titles, published by the U.S. Department of Labor.

Retirement Plan means a defined benefit or a defined contribution plan funded wholly or in part by the employer’s deposits for your benefit. The term does not include: (a) profit sharing plans; (b) thrift plans; (c) non-qualified deferred compensation plans; (d) individual retirement accounts; (e) tax sheltered annuities; or (f) stock ownership plans.

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

Sickness means: (a) any illness or disease; (b) all related conditions; and (c) all complications and recurrences thereof. This plan treats pregnancy like a sickness.

We, Us, Our, and Guardian mean the Guardian Life Insurance Company of America.

Other terms with special meanings are defined where they are used.
Converting This Group Long Term Disability Insurance

**Eligibility for Conversion**
An employee’s long term disability coverage ends if his active employment ends. If this happens, subject to the conditions below, he can obtain a converted disability income plan if he’s been insured under this plan (or a prior plan sponsored by the same employer, which this plan replaced) for at least 12 consecutive months immediately prior to the date his group coverage ends.

But the employee cannot convert if his group long term disability coverage ends due to: (1) the end of group coverage for all active employees or an employee’s class; (2) the employee’s failure to make a required contribution; (3) the employee’s retirement; or (4) the employee changing to a class of employees which is not eligible for group long term disability coverage.

And the employee will not be able to convert if he: (a) becomes eligible for long term disability insurance under another group plan within 31 days of the date his coverage under this plan ends; (b) has other insurance which would result in overinsurance by our standards or; (c) is disabled under the terms of this group long term disability plan.

**To Obtain a Converted Plan**
The employee must apply to us in writing and pay any required premium to obtain a converted disability income plan. He must do this within 31 days of the date his group long term disability coverage ends. If he fails to apply to us in writing and pay any required premium within 31 days of the date his group long term disability coverage ends, he is no longer eligible to obtain a converted disability income plan.

**The Converted Plan**
The converted disability income plan will be renewable and will comply with the laws of the State where the employee lives when he applies. There is no proof of insurability required to obtain the converted disability income plan.

The benefits, terms and conditions of the converted plan will be those offered for conversion at the time the employee applies to convert. The converted plan will not provide all the same benefits as the employee’s group long term disability coverage. The benefit periods and levels of coverage of the converted plan are more limited than those of this group long term disability plan.

The premium for the converted plan will be based on: (a) the plan for which the employee is eligible; (b) the risk and the rate class of the employee; and (c) the employee’s attained age.

The employee’s converted plan starts on the date his group long term disability coverage ends.

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This Glossary defines the italicized terms appearing in your booklet.

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

Employer means UNIVERSITY OF CALIFORNIA SAN FRANCISCO SCHOOL OF MEDICINE.

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

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

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

Receive Information About Your Plan and Benefits

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

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

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

Prudent Actions By Plan Fiduciaries

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

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

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

Assistance with Questions

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

**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.

Guardian will provide a benefit determination not later than 45 days from the date of receipt of a claim. This period may be extended by up to 30 days if Guardian determines that an extension is necessary due to matters beyond the control of the plan, and so notifies the claimant before the end of the initial 45-day period. Such notification will include the reason for the extension and a date by which the determination will be made. If prior to the end of the 30-day period Guardian determines that an additional extension is necessary due to matters beyond the control of the plan, and so notifies the claimant, the time period for making a benefit determination may be extended for up to an additional period of up to 30 days. Such notification will include the special circumstances requiring the extension and a date by which the final determination will be made.

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

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 45 days after receipt of the claim.

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.
Disability Benefits Claims Procedure (Cont.)

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;
- references to the specific plan provision on which the determination is based;
- a description of any additional material or information necessary to make the claim valid and an explanation of why such material or information is needed;
- a description of the plan's claim review procedures which a claimant may follow to have a claim for benefits reviewed 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;
- 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; and
- in the case of an adverse benefit determination based on medical necessity or experimental treatment, notice will either include an explanation of the scientific or clinical basis for the determination, or a statement that such explanation will be provided 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
Disability Benefits Claims Procedure (Cont.)

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

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

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.

Termination of This Group Plan

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

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

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