



Welcome to Workplace benefits

Everyone deserves a Guardian

Every day, Guardian gives 26 million Americans the security they deserve through our insurance and wealth management products and services.

We've partnered with your organization to offer you a range of employee benefits. Inside this pack, you'll find the plans your employer thinks you might benefit from.

Your coverage options



Critical illness insurance

Taking care of the expenses if you're critically ill



Accident insurance

Helping you cover expenses after an accident



Hospital indemnity insurance

Covering some of your hospital stay costs

Know your benefits

Your benefits support your physical and financial wellbeing, to help keep you and your loved ones protected.

With Guardian, you're in good hands. We've been delivering on our promises for over 150 years, and we're looking forward to doing the same for you too.

1

Read through this information.

2

Find out more about your benefits.

3

Talk to your employer if you need help or have any questions.

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Critical illness insurance

Critical illness insurance may help you cover expenses not covered by your health insurance.

It's a cash payment you receive if you ever experience a serious illness like cancer, a heart attack, or a stroke, giving you the financial support to focus on recovery.

Who is it for?

Critical illness insurance is a supplemental policy for people who already have health insurance. It provides you with an additional payment to cover expenses like deductibles, treatments, and living costs.

What does it cover?

Critical illnesses include strokes, heart attacks, Parkinson's disease and cancer. Our policies can cover over 30 major illnesses, helping you stay financially stable by paying you a lump sum if you're diagnosed with one of them.

Why should I consider it?

Health coverage is becoming more expensive, with higher co-pays, premiums, and deductibles. Critical illness insurance is an affordable way to supplement and pay for additional expenses that your health insurance doesn't cover. Our policies typically provide payments for the first and second time you're diagnosed with a covered illness.

Plus, critical illness insurance is portable and payments are made directly to you.

You will receive these benefits if you meet the conditions listed in the policy.



Critical costs

John is hospitalized after a heart attack, and has to cover the cost of five days as an inpatient.

Average heart attack hospitalization expense: **\$53,000**

Average Major Medical deductible: **\$1,500**

Major Medical covers 80% of the cost after the deductible is met, but John's still responsible for 20%: **\$10,300**.

Total out-of-pocket amount for John (deductible + coinsurance): **\$11,800**.

John has a **\$10,000** Guardian Critical Illness policy, which covers the majority of these out-of-pocket expenses.

This example is for illustrative purposes only. Your plan's coverage may vary. See your plan's information on the following pages for specific amounts and details.



Your critical illness coverage

CRITICAL ILLNESS

Benefit Amount(s)	Employee may choose a lump sum benefit of \$5,000 to \$20,000 in \$5,000 increments.	
CONDITIONS		
Cancer	1st OCCURRENCE	2nd OCCURRENCE
Invasive Cancer	100%	50%
Carcinoma In Situ	30%	0%
Benign Brain Tumor	75%	0%
Skin Cancer	\$250 per lifetime	Not Covered
Vascular		
Heart Attack	100%	50%
Stroke	100%	50%
Heart Failure	100%	50%
Coronary Arteriosclerosis	30%	0%
Other		
Organ Failure	100%	50%
Kidney Failure	100%	50%
ADDITIONAL CONDITIONS		1st OCCURRENCE ONLY
Addison's Disease		30%
ALS (Lou Gehrig's Disease)		100%
Alzheimer's Disease		50%
Coma		100%
Huntington's Disease		30%
Loss of Hearing		100%
Loss of Sight		100%
Loss of Speech		100%
Multiple Sclerosis		30%
Parkinson's Disease		100%
Permanent Paralysis	50% for 1 limb, 100% for 2 limbs	
Severe Burns		100%
Childhood Conditions		1st OCCURRENCE ONLY
Cerebral Palsy		100%
Cleft Lip/Palate		100%
Club Foot		100%
Cystic Fibrosis		100%
Down's Syndrome		100%
Muscular Dystrophy		100%
Spina Bifida		100%
Type I Diabetes		100%



Your critical illness coverage

CRITICAL ILLNESS

Spouse Benefit	May choose a lump sum benefit of \$5,000 to \$20,000 in \$5,000 increments up to 100% of the employee's lump sum benefit.
Child Benefit- children age Birth to 26 years	25% of employee's lump sum benefit
Benefit Reductions: Benefits are reduced by a certain percentage as an employee ages	50% at age 70
Guarantee Issue: The 'guarantee' means you are not required to answer health questions to qualify for coverage up to and including the specified amount, when you sign up for coverage during the initial enrollment period.	<p>We Guarantee Issue up to: Less than age 70 \$20,000</p> <p>For a spouse: Less than age 70 \$20,000</p> <p>For a child: All Amounts</p> <p>Health questions are required if the elected amount exceeds the Guarantee Issue, as well as for all applicants age 70+ regardless of elected amount.</p>
Portability: Allows you to take your Critical Illness coverage with you if you terminate employment.	Included
Pre-Existing Condition Limitation: A pre-existing condition includes any condition for which you, in the specified time period prior to coverage in this plan, consulted with a physician, received treatment, or took prescribed drugs.	3 months prior, 12 months after

WELLNESS BENEFIT

Employee Per Year Limit	\$50
Spouse Per Year Limit	\$50
Child Per Year Limit	\$50

Condition Definitions

- **Stroke:** Stroke must be severe enough to cause neurological deficits at least 30 days after the event.
- **Heart Failure:** An insured must be placed on an organ transplant list in order to be eligible for the Heart failure benefits.
- **Coronary Arteriosclerosis:** Coronary Arteriosclerosis must be severe enough to require a coronary artery bypass graft.
- **Organ Failure:** Organ failure includes both lungs, liver, pancreas or bone marrow and requires the insured to be placed on an organ transplant list.
- **Kidney Failure:** An insured must be placed on an organ transplant list in order to be eligible for the Kidney failure benefits.

Critical Illness Cost Illustration

To determine the most appropriate level of coverage, you should consider your current basic monthly expenses and expected financial needs during a Critical Illness.

Spouse coverage premium is based on Employee age

Child cost is included with employee election.

	Bi-weekly Premiums Displayed Election Cost Per Age Bracket					
	< 30	30-39	40-49	50-59	60-69	70+†
Employee						
\$5,000	\$0.58	\$0.90	\$1.92	\$4.02	\$7.50	\$13.25
\$10,000	\$1.15	\$1.80	\$3.83	\$8.03	\$15.00	\$26.49
\$15,000	\$1.73	\$2.70	\$5.75	\$12.05	\$22.50	\$39.74
\$20,000	\$2.31	\$3.60	\$7.66	\$16.06	\$30.00	\$52.99
Benefit Amount Up To 100% of Employee Amount to a Maximum of \$20,000						
Spouse						
\$5,000	\$0.58	\$0.90	\$1.92	\$4.02	\$7.50	\$13.25
\$10,000	\$1.15	\$1.80	\$3.83	\$8.03	\$15.00	\$26.49
\$15,000	\$1.73	\$2.70	\$5.75	\$12.05	\$22.50	\$39.74
\$20,000	\$2.31	\$3.60	\$7.66	\$16.06	\$30.00	\$52.99

†Benefit reductions may apply. See plan details.

EXCLUSIONS AND LIMITATIONS

A SUMMARY OF PLAN LIMITATIONS AND EXCLUSIONS FOR CRITICAL ILLNESS:

We will not pay benefits for the First Occurrence of a Critical Illness if it occurs less than 3 months after the First Occurrence of a related Critical Illness for which this Plan paid benefits. By related we mean either: (a) both Critical Illnesses are contained within the Cancer Related Conditions category; or (b) both Critical Illnesses are contained within the Vascular Conditions category. We will not pay benefits for a Second occurrence (recurrence) of a Critical Illness unless the Covered Person has not exhibited symptoms or received care or treatment for that Critical Illness for at least 12 months in a row prior to the recurrence. For purposes of this exclusion, care or treatment does not include: (1) preventive medications in the absence of disease; and (2) routine scheduled follow-up visits to a Doctor.

We do not pay benefits for claims relating to a covered person: taking part in any war or act of war (including service in the armed forces) committing a felony or taking part in any riot or other civil disorder or intentionally injuring themselves or attempting suicide while sane or insane.

Employees must be legally working in the United States in order to be eligible for coverage. Underwriting must approve coverage for employees on temporary assignment: (a) exceeding 1 year; or (b) in an area under travel warning by the US Department of State, subject to state specific variations.

If the plan is new (not transferred): During the exclusion period, this Critical Illness plan does not pay charges relating to a pre-existing condition. If this plan is transferred from another insurance carrier, the time an insured is covered

under that plan will count toward satisfying Guardian's pre-existing condition limitation period. A pre-existing condition includes any condition for which an employee, in a specified time period prior to coverage in this plan, consults with a physician, receives treatment, or takes prescribed drugs. Please refer to the plan documents for specific time periods. State variations may apply.

Guardian's Critical Illness plan does not provide comprehensive medical coverage. It is a basic or limited benefit and is not intended to cover all medical expenses. It does not provide "basic hospital," "basic medical," or "medical" insurance as defined by the New York State Insurance Department.

Health questions are required on 1) late enrollees and 2) enrollees over age 69 (not applicable in FL). This coverage will not be effective until approved by a Guardian underwriter.

This policy will not pay for a diagnosis of a listed critical illness that is made before the insured's Critical Illness effective date with Guardian.

The policy has exclusions and limitations that may impact the eligibility for or entitlement to benefits under each covered condition. See your certificate booklet for a full listing of exclusions & limitations..

If Critical Illness insurance premium is paid for on a pre tax basis, the benefit may be taxable. Please contact your tax or legal advisor regarding the tax treatment of your policy benefits..

Contract # GP-1-CI-14

Guardian's Critical Illness Insurance is underwritten and issued by The Guardian Life Insurance Company of America, New York, NY. Products are not available in all states. Policy limitations and exclusions apply. Optional riders and/or features may incur additional costs. Plan documents are the final arbiter of coverage. This policy provides limited benefits health insurance only. It does not provide basic hospital, basic medical or major medical insurance as defined by the New York State Department of Financial Services.
Policy Form # GP-1-LAH-12R; GP-1-CI-14

GUARDIAN® is a registered trademark of The Guardian Life Insurance Company of America

Minnesota Urology P.A.

ALL ELIGIBLE PART-TIME

Kit created 10/12/2023
Group number: 00056204

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Accident insurance

Accidents happen. With accident insurance, you can help them hurt a bit less.

Accident insurance is an extra layer of protection that gives you a cash payment to help cover out-of-pocket expenses when you suffer an unexpected, qualifying accident.

Who is it for?

Nobody can predict when an accident might happen. That's why accident insurance is an important add-on policy for people who want to supplement the health and disability insurance coverage they already have individually or through an employer.

What does it cover?

Accident Insurance pays you lump sum of benefits after you suffer an accident. This could be more than 40 different circumstances, including: emergency treatment, ambulance, burns, dislocations, fractures, hospital confinement, and surgery.

Why should I consider it?

Health coverage may become more expensive, with higher co-pays, premiums, and deductibles. Accident insurance can be a simple, affordable way to help supplement and cover additional expenses your health and disability insurance may not cover, including x-rays, ambulance services, deductibles, and even things like rent or groceries.

Plus, accident insurance is portable and payments are made directly to you.

You will receive these benefits if you meet the conditions listed in the policy.



Added support during recovery

Amanda breaks her leg falling off her bike and needs emergency treatment.

Average non-surgical broken leg treatment expense: **\$2,500**

Average Major Medical deductible: **\$1,500**

Major Medical covers 80% of the surgical cost after the deductible is met, but Amanda's still responsible for 20%: **\$200**

Total out-of-pocket amount for Amanda (deductible + coinsurance): **\$1,700**

Amanda's Guardian Accident policy pays her a benefit of **\$1,700**, which covers all of her out-of-pocket expenses.

This example is for illustrative purposes only. Your plan's coverage may vary. See your plan's information on the following pages for specific amounts and details.



Your accident coverage

ACCIDENT	
COVERAGE - DETAILS	
Your Bi-weekly premium	\$4.46
You and Spouse	\$6.88
You and Child(ren)	\$8.50
You, Spouse and Child(ren)	\$10.93
Accident Coverage Type	Off Job
Portability - Allows you to take your Accident coverage with you if you terminate employment.	Included
ACCIDENTAL DEATH AND DISMEMBERMENT	
Benefit Amount(s)	Employee \$100,000 Spouse \$50,000 Child \$25,000
Catastrophic Loss	Quadriplegia, Loss of speech & hearing (both ears), Loss of Cognitive function: 100% of AD&D Hemiplegia & Paraplegia: 50% of AD&D
Common Carrier	200% of AD&D benefit
Common Disaster	200% of Spouse AD&D benefit
Dismemberment - Hand, Foot, Sight	Single: 50% of AD&D benefit Multiple: 100% of AD&D benefit
Dismemberment - Thumb/Index Finger Same Hand, Four Fingers Same Hand, All Toes Same Foot	25% of AD&D benefit
Seatbelts and Airbags	Seatbelts: \$10,000 & Airbags: \$15,000
Reasonable Accommodation to Home or Vehicle	\$2,500
Child(ren) Age Limits	Children age birth to 26 years
RAINY DAY FUND	Benefit Amount: \$500 Rollover Maximum: \$250 Fund Maximum: \$1,000
FEATURES	
Air Ambulance	\$1,500
Ambulance	\$300
Blood/Plasma/Platelets	\$300
Burns (2nd Degree/3rd Degree)	9 sq inches To 18 sq inches: \$0/\$2,000 18 sq inches To 35 sq inches: \$1,000/\$4,000 Over 35 sq inches: \$3,000/\$12,000
Burns - Skin Graft	50% of burn benefit
Child Organized Sport - Benefit is paid if the covered accident occurred while your covered child, age 18 years or younger, is participating in an organized sport that is governed by an organization and requires formal registration to participate.	25% increase to child benefits
Chiropractic Visits	\$50/visit, up to 6 visits



Your accident coverage

FEATURES (Cont.)

Coma	\$12,500
Concussion Baseline Study	\$25
Concussions	\$300
Diagnostic Exam (Major)	\$300
Dislocations	Schedule up to \$7,000
Doctor Follow-Up Visits	\$75, up to 6 treatments
Emergency Dental Work	\$400/Crown, \$100/Extraction
Emergency Room Treatment	\$250
Epidural Anesthesia Pain Management	\$100, 2 times per accident
Eye Injury	\$300
Family Care—Benefit is payable for each child attending a Child Care center while the insured is confined to a hospital, ICU or Alternate Care or Rehabilitative facility due to injuries sustained in a covered accident.	\$30/day, up to 30 days
Fractures	Schedule up to \$8,000
Gun Shot Wound	\$1,000
Hospital Admission	\$1,500
Hospital Confinement	\$300/day - up to 1 year
Hospital ICU Admission	\$3,000
Hospital ICU Confinement	\$600/day - up to 15 days
Initial Dr. Office/Urgent Care Facility Treatment	\$125
Joint Replacement (Hip/Knee/Shoulder)	\$3,500/\$1,750/\$1,750
Knee Cartilage	\$750
Laceration	Schedule up to \$500
Lodging - The hospital stay must be more than 50 miles from the insured's residence.	\$150/day, up to 30 days for companion hotel stay
Medical Appliance—Wheelchair, motorized scooter, leg or back brace, cane, crutches, walker, walking boot that extends above the ankle or brace for the neck.	Schedule up to \$600
Outpatient Therapies	\$50/day, up to 10 days
Post-Traumatic Stress Disorder	\$500
Prosthetic Device/Artificial Limb	1: \$1,000 2 or more: \$2,000
Rehabilitation Unit Confinement	\$150/day, up to 15 days
Ruptured Disc With Surgical Repair	\$750
Surgery (Cranial, Open Abdominal, Thoracic, Hernia) Max	Schedule up to \$1,500 Hernia: \$300
Surgery (Exploratory or Arthroscopic)	\$500
Tendon/Ligament/Rotator Cuff	1: \$750 2 or more: \$1,500
Transportation - Benefit is paid if you have to travel more than 50 miles one way to receive special treatment at a hospital or facility due to a covered accident.	\$0.50 per mile, limited to \$600/round trip, up to 3 times per accident
Traumatic Brain Injury — A nondegenerative, noncongenital Injury to the brain from an external nonbiological force, requiring Hospital Confinement for 48 hours or more and resulting in a permanent neurological deficit with significant loss of muscle function and persistent clinical symptoms.	\$5,000

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MINNESOTA UROLOGY P.A.

ALL ELIGIBLE PART-TIME

Kit created 10/12/2023 11

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Your accident coverage

FEATURES (Cont.)

X - Ray

\$50

UNDERSTANDING YOUR BENEFITS:

- **Common Carrier** – Benefit is paid if an insured's death occurs due to an accident while riding as a fare-paying passenger in a public conveyance. If this is paid, we do not pay the Accidental Death benefit.
- **Common Disaster** – Benefit is paid if both you & your spouse die in a covered accident or separate covered accidents within the same 24 hour period.
- **Reasonable Accommodation** – Benefit is payable if a modification is required to an insured's place of residence or vehicle due to an Accidental Dismemberment or Catastrophic loss.
- **Emergency Room Treatment** – Benefit is paid only when an insured is examined or treated within 72 hours of a covered accident.
- **Rainy Day Fund** – Can pay benefits when a claimant has exhausted a frequency limitation that applies to a particular benefit. Rainy Day Fund will apply to the following benefits Air Ambulance, Ambulance, Blood/Plasma/Platelets, Chiropractic visits, Diagnostic Exam (Major), Doctor Follow-Up visits, Emergency Dental Work, Epidural Anesthesia Pain Management, Eye Injury, Family Care, Fractures, Gun Shot Wound, Hospital Confinement, Hospital ICU Confinement, Joint Replacement, Knee Cartilage, Lodging, Outpatient Therapies, Rehabilitation Unit Confinement, Ruptured Disc with Surgical Repair, Surgery (Cranial, Open Abdominal, Thoracic, Hernia), Surgery (Exploratory and Arthroscopic), Transportation and X-Ray, if they are included on your plan.

LIMITATIONS AND EXCLUSIONS:

A SUMMARY OF ACCIDENT LIMITATIONS AND EXCLUSIONS:

Employees must be working in the United States in order to be eligible for coverage. Underwriting must approve coverage for employees on temporary assignment: (a) exceeding 1 year; or (b) in an area under travel warning by the US Department of State, subject to state specific variations.

This proposal summarizes the major features of the Guardian Accident benefit plan. It is not intended to be a complete representation of the proposed plan. For full plan features, including exclusions and limitations, please refer to your Policy.

This proposal is hedged subject to satisfactory financial evaluation.

We don't pay benefits for any Injury caused by or related to directly or indirectly: Sickness, disease, mental infirmity or medical or surgical treatment; 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; 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

policyholder, 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, sail gliding, parasailing, parakiting, ballooning, parachuting, zorbing or skydiving; an accident that occurred before the covered person is covered by this plan; injuries to a dependent child received during birth; 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. Job related or on the job injuries for the employee are excluded if Accident coverage is off job only.

Contract # GP-I-ACC-18

If Accident insurance premium is paid for on a pre tax basis, the benefit may be taxable. Please contact your tax or legal advisor regarding the tax treatment of your policy benefits.



Your accident coverage

Guardian's Accident Insurance is underwritten and issued by The Guardian Life Insurance Company of America, New York, NY. Products are not available in all states. Policy limitations and exclusions apply. Optional riders and/or features may incur additional costs. Plan documents are the final arbiter of coverage. This policy provides Accident insurance only. It does not provide basic hospital, basic medical or major medical insurance as defined by the New York State Department of Financial Services.

IMPORTANT NOTICE –THIS POLICY DOES NOT PROVIDE COVERAGE FOR SICKNESS.

Policy Form # GP-1-AC-BEN-12, et al., GP-1-LAH-12R; GP-1-ACC-18

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Hospital indemnity insurance

Hospital indemnity insurance can cover some of the cost associated with a hospital stay, letting you focus on recovery.

Being hospitalized for illness or injury can happen to anyone, at any time. While medical insurance may cover hospital bills, it may not cover all the costs associated with a hospital stay. That's where hospital indemnity coverage can help.

Who is it for?

Hospital indemnity insurance is for people who need help covering the costs associated with a hospital stay if they suddenly become sick or injured.

What does it cover?

If you are admitted to a hospital for a covered sickness or injury, you'll receive payments that can be used to cover all sorts of costs, including:

- Deductibles and co-pays.
- Travel to and from the hospital for treatment.
- Childcare service assistance while recovering.

Why should I consider it?

Health coverage is becoming more expensive, with higher co-pays, premiums, and deductibles. Hospital indemnity insurance can help pay for out-of-pocket costs associated with being hospitalized, giving you more of a financial safety net for unplanned expenses brought on by a hospital stay.

Plus, hospital indemnity insurance is portable and payments are made directly to you – even if you didn't incur any out-of-pocket expenses.

You will receive these benefits if you meet the conditions listed in the policy.



Be prepared

John is hospitalized after a heart attack, and has to cover the cost of five days as an inpatient.

Average heart attack hospitalization expense: **\$53,000**

Average Major Medical deductible: **\$1,500**

Major Medical covers 80% of the cost after the deductible is met, but John's still responsible for 20%: **\$10,300.**

Total out-of-pocket amount for John (deductible + coinsurance): **\$11,800.**

John's Guardian Hospital Indemnity policy pays him **\$1,000** for hospital admission.

The policy gives him a total payment of **\$1,000** to help cover the out-of-pocket amount.

This example is for illustrative purposes only. Your plan's coverage may vary. See your plan's information on the following pages for specific amounts and details.



Your hospital indemnity coverage

Hospital Indemnity	
Option I	
Coverage Details	
Your Bi-weekly premium	\$4.94
You and Spouse	\$8.37
You and Child(ren)	\$7.02
You, Spouse and Child(ren)	\$12.47
Benefits	
Hospital/ICU Admission	\$1,000 per admission, limited to 2 admission(s) per insured and 3 admission(s) per covered family per benefit year.
Hospital/ICU Confinement	\$100/\$200 per day, limited to 15 day(s) per insured per benefit year.
Pre-Existing Conditions Limitation - A pre-existing condition includes any condition for which you, in the specified time period prior to coverage in this plan, consulted with a physician, received treatment, or took prescribed drugs.	3 months prior, 12 months after
Portability - Allows you to take your Hospital Indemnity coverage with you if you terminate employment.	Included
Child(ren) Age Limits	Children age birth to 26 years

UNDERSTANDING YOUR BENEFITS – HOSPITAL INDEMNITY

Hospital Admission & Hospital ICU Admission benefits are not payable on the same day.

Premium will be waived if you are hospitalized for more than 30 days.

Hospital admission or confinement benefits are not payable for a newborn unless the child is admitted to the Neonatal ICU.

Hospital/ICU confinement benefits are not payable on the same day as Hospital/ICU admission benefit.

After initial enrollment, Hospital Indemnity coverage will continue as long as an insured is actively at work.



Your hospital indemnity coverage

LIMITATIONS AND EXCLUSIONS:

In order to be eligible for coverage: Employees must be legally working: (a) in the United States or (b) outside the United States, for a US based employer, in a country or region approved by Guardian.

An applicant must enroll within 31 days of the coverage effective date. An open enrollment will occur each year during a 30 day time period specified by the policyholder. If an applicant does not enroll during their initial enrollment period, he/she may not enroll until the next open enrollment period.

This Plan will not pay benefits for:

- Treatment relating to a covered person: taking part in any war or act of war (including service in the armed forces), commission of or attempt to commit a felony, an act of terrorism, or participating in an illegal occupation, riot or insurrection.

- Suicide or any intentionally self-inflicted injury

Elective surgery;

Surgery to correct vision or hearing, unless medically necessary surgery for glaucoma, cataracts or other sickness or injury;

Dental care, dental xrays, or dental treatment;

Gastric or intestinal bypass services including lap banding, gastric stapling, and other similar procedures to facilitate weight loss; the reversal, or revision of such procedures; or services required for the treatment of complications from such procedures. This exclusion does not apply to completion of a weight reduction program that may be payable under the Health Screening benefit ;

Rest cures or custodial care, or treatment of sleep disorders;

Cosmetic surgery. This Exclusion does not apply to reconstructive surgery:

(a) on an injured part of the body following infection or disease of the involved part;

(b) of a congenital disease or anomaly of a covered dependent newborn or adopted infant; or

(c) on a nondiseased breast to restore and achieve symmetry between two breasts following a covered Mastectomy;

Treatment or removal of warts, moles, boils, skin blemishes or birthmarks, bunions, acne, corns, calluses, the cutting and trimming of toenails, care for flat feet, fallen arches or chronic foot strain;

Service, treatment or loss related to alcoholism or drug addiction, except for drugs prescribed by the Covered Person's Doctor and taken as prescribed;

Care or treatment for mental or nervous disorders;

Services, treatment or loss rendered in any Veterans Administration or Federal Hospital, except if there is a legal obligation to pay;

Services or treatment Provided by a Doctor, Nurse or any other person who is employed or retained by a Covered Person or who is a Covered Person's Spouse, parent, brother, sister, child, Domestic Partner or partner in a civil union.

Surgery and treatment, procedures, products or services that are experimental or investigative.

Treatment of a Covered Dependent Child's Children;

Sickness or Injury sustained while on active duty in the armed forces of any country. This does not include Reserve or National Guard duty for training.

GP-1-HI-15

Guardian Hospital Indemnity Insurance is underwritten by The Guardian Life Insurance Company of America, New York, NY and will not be effective until approved by a Guardian underwriter. Products are not available in all states. Policy limitations and exclusions apply. Optional riders and/or features may incur additional costs. Plan documents are the final arbiter of coverage. This policy provides limited hospital insurance only. It does not provide basic medical or major medical insurance as defined by the New York State Department of Financial Services.
Policy Form # GP-1-HI-15, GP-1-LAH-12R

GuidanceResources® - Employee Assistance Program

Sometimes life can feel overwhelming.
It doesn't have to.

Guardian's Employee Assistance Program provides confidential counseling, expert guidance, and valuable resources to help you handle any of life's challenges, big or small.

How it can help



Confidential emotional support

- Anxiety, depression, stress



Work and lifestyle support

- Child, elder and pet care



Financial resources and legal guidance

- Retirement planning, taxes
- Wills, trusts and estate planning

**This service is only available if you purchase qualifying lines of coverage.
See your plan administrator for more details.**

Legal/financial assistance and resources services are not available in the state of New York.

The Employee Assistance Program is a suite of services solely created and offered by ComPsych. Guardian is not responsible or liable for care or advice given by any provider or any service offering within the Employee Assistance Program. This information is for informational purposes only. It is not a contract. Only the plan service agreement can provide the actual terms, services, limitations and exclusions. Guardian and ComPsych reserve the right to discontinue the Employee Assistance Program at any time without notice. Legal services provided through the Employee Assistance Program will not be provided in connection with or any action against Guardian, ComPsych, or your employer. The Employee Assistance Program, or any individual service offering within the Program, is not an insurance benefit and may not be available in all states.



How to access 24/7 live assistance



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Visit
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App: GuidanceNowSM
Organization web ID: Guardian
Note: First-time users will need to register first with the organization web ID: Guardian.

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2023-159687 (8/25)



Our commitment to you

Please read the documentation referenced below carefully. The notices are intended to provide you important information about our insurance offerings and to protect your interests. Certain ones are required by law.

Important information



Notice Informing Individuals about Nondiscrimination and Accessibility Requirements

Guardian notice stating that it complies with applicable Federal civil rights laws and does not discriminate based on race, color, national origin, age, disability, sex, or actual or perceived gender identity. The notice provides contact information for filing a nondiscrimination grievance. It also provides contact information for access to free aids and services by disabled people to assist in communications with Guardian.

Visit <https://www.guardiananytime.com/notice48> to read more.

No Cost Language Services

Guardian provides language assistance in multiple languages for members who have limited English proficiency.

Visit <https://www.guardiananytime.com/notice46> to read more.

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Guardian Life, P.O. Box 14319,
Lexington, KY 40512

Please print clearly and mark carefully.

Employer/Planholder Name: Minnesota Urology P.A.	Group Plan Number: 00056204	Benefits Effective: _____
PLEASE CHECK APPROPRIATE BOX <input type="checkbox"/> Initial Enrollment <input type="checkbox"/> Add Employee/Member Dependents/Family Members <input type="checkbox"/> Drop/Refuse Coverage <input type="checkbox"/> Information Change		
<p>In this form, you will be referred to as an Employee/Member. Members of your family will be referred to as Dependents/Family Members. There will also be times, when referring to Dependents/Family Members, this form will distinguish between your spouse and your children. Depending on the type of plan your Planholder selected, other plan documents may refer to you as an employee, a member, or a similar term, and, to members of your family, as family members, dependents, eligible dependents, or a similar term. Please refer to the group policy, certificate of coverage, (sometimes called a member guide), to see how terms are defined and to determine which members of your family are eligible for coverage. Plan documents such as the group policy, certificate of coverage, (sometimes called a member guide), control if there is any dispute concerning the meaning of terms used in this form.</p>		

Class: ALL ELIGIBLE PART-TIME	Division: _____	Subtotal Code: _____	(Please obtain this from your Employer/Planholder)
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About You: Full Legal Name-First, MI, Last Name: _____ What is the name you go by? (optional) _____	Employer/Planholder Provided Identification: _____	Social Security Number _____ - _____ - _____ Your Social Security Number must be provided if enrolling for Life Coverage. Short Term Disability Coverage and/or Long Term Disability Coverage.	
Address _____	City _____	State _____	Zip _____
Gender Identity: <input type="checkbox"/> M <input type="checkbox"/> F Date of Birth (mm-dd-yy): ____ - ____ - ____			
Phone (indicate primary): <input type="checkbox"/> Home (____) ____ - ____ <input type="checkbox"/> Work (____) ____ - ____ <input type="checkbox"/> Mobile (____) ____ - ____			
Email Address (indicate primary) <input type="checkbox"/> Home _____ <input type="checkbox"/> Work _____			
Are you married or in a civil union? <input type="checkbox"/> Yes <input type="checkbox"/> No Date of marriage/civil union: ____ - ____ - ____ Do you have children or other dependents? <input type="checkbox"/> Yes <input type="checkbox"/> No Placement date of adopted child: ____ - ____ - ____			

About Your Job:	Job Title: _____
Work Status: <input type="checkbox"/> Active <input type="checkbox"/> Retired <input type="checkbox"/> COBRA/State Continuation Hours worked per week: _____	Date of full time hire: ____ - ____ - ____

About Your Family: Please include the names of the dependents you wish to enroll for coverage. Your dependent's Social Security Number must be provided if enrolling for Life Coverage. Additional information may be required for dependents.				
Spouse (wherever the term "Spouse" appears on this form, it also includes "Civil Union Partner").	Gender Identity: <input type="checkbox"/> M <input type="checkbox"/> F	Social Security Number ____ - ____ - ____	Date of Birth (mm-dd-yyyy) ____ - ____ - ____	
Address/City/State/Zip: _____				
Phone: () - _____				
Child/Dependent 1:	<input type="checkbox"/> Add <input type="checkbox"/> Drop	Gender Identity: <input type="checkbox"/> M <input type="checkbox"/> F	Social Security Number ____ - ____ - ____	Status (check as applicable) <input type="checkbox"/> Student (post high school) <input type="checkbox"/> Disabled <input type="checkbox"/> Non standard dependent
Address/City/State/Zip: _____			Date of Birth (mm-dd-yyyy) ____ - ____ - ____	
Phone: () - _____				

Child/Dependent 2: Address/City/State/Zip: Phone: () - -	<input type="checkbox"/> Add <input type="checkbox"/> Drop	Gender Identity: <input type="checkbox"/> M <input type="checkbox"/> F	Social Security Number ____ - ____ - ____ Date of Birth (mm-dd-yyyy) ____ - ____ - ____	Status (check as applicable) <input type="checkbox"/> Student (post high school) <input type="checkbox"/> Disabled <input type="checkbox"/> Non standard dependent
Child/Dependent 3: Address/City/State/Zip: Phone: () - -	<input type="checkbox"/> Add <input type="checkbox"/> Drop	Gender Identity: <input type="checkbox"/> M <input type="checkbox"/> F	Social Security Number ____ - ____ - ____ Date of Birth (mm-dd-yyyy) ____ - ____ - ____	Status (check as applicable) <input type="checkbox"/> Student (post high school) <input type="checkbox"/> Disabled <input type="checkbox"/> Non standard dependent
Child/Dependent 4: Address/City/State/Zip: Phone: () - -	<input type="checkbox"/> Add <input type="checkbox"/> Drop	Gender Identity: <input type="checkbox"/> M <input type="checkbox"/> F	Social Security Number ____ - ____ - ____ Date of Birth (mm-dd-yyyy) ____ - ____ - ____	Status (check as applicable) <input type="checkbox"/> Student (post high school) <input type="checkbox"/> Disabled <input type="checkbox"/> Non standard dependent

Critical Illness Coverage: You must be enrolled to cover your dependents/family members <i>Benefit reductions apply. Please see plan administrator.</i> Employee/Member Insurance Amount: <input type="checkbox"/> \$5,000 <input type="checkbox"/> \$10,000 <input type="checkbox"/> \$15,000 <input type="checkbox"/> \$20,000 <input type="checkbox"/> I do not want this coverage.	
Spouse Insurance Amount: Up to 100% of the employee/member's amount to a maximum of \$20,000 <input type="checkbox"/> \$5,000 <input type="checkbox"/> \$10,000 <input type="checkbox"/> \$15,000 <input type="checkbox"/> \$20,000 <input type="checkbox"/> I do not want this coverage.	
Dependent/Child(ren) Insurance Amount: <input type="checkbox"/> 25% of the employee/member's amount <input type="checkbox"/> I do not want this coverage.	

Employee/Member Only - Name your beneficiaries: (Primary beneficiary percentages must total 100%) If electing different beneficiaries that are not the same as those named for Basic Life or Voluntary Term Life, please name below.

If additional space is needed, please attach a separate sheet of paper with this information along with your enrollment form. Be sure to sign and date (mm-dd-yyyy) the paper and keep a copy for your records

Primary Beneficiaries:

Name: _____ Social Security Number: _____ - _____ - _____ % _____

Date of Birth (mm-dd-yy): _____ - _____ - _____ Address/City/State/Zip: _____

Phone: () - _____ Relationship to Employee/Member: _____

Name: _____ Social Security Number: _____ - _____ - _____ % _____

Date of Birth (mm-dd-yy): _____ - _____ - _____ Address/City/State/Zip: _____

Phone: () - _____ Relationship to Employee/Member: _____

Contingent Beneficiary: _____ Social Security Number: _____ - _____ - _____

Date of Birth (mm-dd-yy): _____ - _____ - _____ Address/City/State/Zip: _____

Phone: () - _____ Relationship to Employee/Member: _____

(In the event the primary beneficiaries are deceased, the contingent beneficiary will receive the benefit. Employer/Planholder maintains beneficiary information.)

Spouse and dependent/child(ren) – If the intended beneficiary is to be someone other than the Employee/Member, please complete the Beneficiary Designation form.

Attention: If any of the beneficiaries named above is a minor (a person under the age of 18 or 21, depending on their state of residency), state law may limit Guardian's ability to pay life insurance proceeds directly to them for as long as they remain a minor. State Uniform Transfers to Minors Act (UTMA) laws, where applicable, may allow for the normal course of payment of these proceeds, or a portion thereof, to the minor beneficiary's designated Custodian to manage on the minor's behalf until they reach adult age. At that time, the proceeds are turned over to the adult child, who can use the proceeds in any way he or she chooses.

Are any of the beneficiaries identified above considered a minor in the state in which they reside? Check one box only. ☐ Yes ☐ No

If you answered "Yes", please name the legally designated UTMA Custodian for all minor beneficiaries you have designated:

Custodian to Minor Beneficiaries:

Name: _____ Social Security Number (or FEIN/TIN # if a corporate entity): _____ - _____

Date of Birth (mm-dd-yyyy) (if an individual): _____ - _____ - _____ Address/City/State/Zip: _____

Phone: () - _____

Accident Coverage You must be enrolled to cover your family members.

Your Bi-weekly premium	Employee/Member Only	Employee/Member & Spouse	Employee/Member & Dependent/Child(ren)	Employee/Member, Spouse & Dependent/Child(ren)
	<input type="checkbox"/> \$4.46	<input type="checkbox"/> \$6.88	<input type="checkbox"/> \$8.50	<input type="checkbox"/> \$10.93

☐ I do not want this coverage.

Employee/Member Only Name your beneficiaries: (Primary beneficiary percentages must total 100%) If electing different beneficiaries that are not the same as those named for Basic Life or Voluntary Term Life, please name below.

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Primary Beneficiaries:

Name: _____ Social Security Number: _____ - _____ - _____ % _____

Date of Birth (mm-dd-yy): _____ - _____ - _____ Address/City/State/Zip: _____

Phone: () - _____ Relationship to Employee/Member: _____

Name: _____ Social Security Number: _____ - _____ - _____ % _____

Date of Birth (mm-dd-yy): _____ - _____ - _____ Address/City/State/Zip: _____

Phone: () - _____ Relationship to Employee/Member: _____

Contingent Beneficiary: _____ Social Security Number: _____ - _____ - _____

Date of Birth (mm-dd-yy): _____ - _____ - _____ Address/City/State/Zip: _____

Phone: () - _____ Relationship to Employee/Member: _____

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Spouse and dependent/child(ren) – If the intended beneficiary is to be someone other than the Employee/Member, please complete the Beneficiary Designation form.

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If you answered "Yes", please name the legally designated UTMA Custodian for all minor beneficiaries you have designated:

Custodian to Minor Beneficiaries:

Name: _____ Social Security Number (or FEIN/TIN # if a corporate entity): _____ - _____

Date of Birth (mm-dd-yyyy) (if an individual): _____ - _____ - _____ Address/City/State/Zip: _____

Phone: () - _____

Hospital Indemnity Coverage

You must be enrolled to cover your dependents/family members.

Check only one box.

Your Bi-weekly premium

Employee/Member Only

Employee/Member & Spouse

Employee/Member &
Child(ren)

Employee/Member, Spouse &
Child(ren)

☐ \$4.94

☐ \$8.37

☐ \$7.02

☐ \$12.47

☐ I do not want this coverage.

☐ I do not want this coverage.

☐ I do not want this coverage.

☐ I do not want this coverage.

Signature

- HOSPITAL INDEMNITY ONLY: This is a limited plan of Hospital Indemnity insurance. It is a supplement to health insurance. It is not a substitute for hospital or medical expense insurance, a health maintenance organization (HMO) contract, or major medical expense insurance.
- I understand that insurance coverage for an adopted child begins on the date of placement for adoption.
- I understand that insurance coverage, other than life insurance coverage, for a newborn child begins at the moment of birth.
- If coverage is waived and you later decide to enroll, late entrant penalties may apply. You may also have to provide, at your own expense, proof of each person's insurability. Guardian or its designee has the right to reject your request.
- Your coverage will not be effective until approved by a Guardian or its designated underwriter.
- I hereby apply for the group benefit(s) that I have chosen above.
- I understand that I must meet eligibility requirements for all coverages that I have chosen above.
- Submission of this form does not guarantee coverage. Among other things, coverage is contingent upon underwriting approval and meeting the applicable eligibility requirements.
- I agree that my employer/planholder may deduct premiums from my pay if they are required for the coverage I have chosen above.
- I state that the information provided above is true and correct to the best of my knowledge or belief.

Any person who with intent to defraud any insurance company or other person files an application for insurance or statements of claim containing any materially, false information or conceals for purpose of misleading information concerning any fact material hereto, may be guilty of committing a fraudulent insurance act as determined by a court of law, which may be a crime, and may also be subject to civil penalties, or denial of insurance benefits.

The state in which you reside may have a specific state fraud warning. Please refer to the attached Fraud Warning Statements page.

The following section applies to these coverage(s): Accident Coverage, Cancer Coverage, Critical Illness Coverage, Hospital Indemnity Coverage:

NOTICE TO CONSUMER: THIS COVERAGE IS A SUPPLEMENT TO HEALTH INSURANCE AND IS NOT A SUBSTITUTE FOR MAJOR MEDICAL COVERAGE. LACK OF MAJOR MEDICAL COVERAGE (OR OTHER MINIMUM ESSENTIAL COVERAGE) MAY RESULT IN AN ADDITIONAL PAYMENT WITH YOUR TAXES. ALSO, THE BENEFITS PROVIDED BY THIS POLICY CANNOT BE COORDINATED WITH THE BENEFITS PROVIDED BY OTHER COVERAGE. PLEASE REVIEW THE BENEFITS PROVIDED BY THIS POLICY CAREFULLY TO AVOID A DUPLICATION OF COVERAGE.

SIGNATURE OF EMPLOYEE/MEMBER X _____

DATE _____

Fraud Warning Statements

The laws of several states require the following statements to appear on the enrollment form:

Alabama: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or who knowingly presents false information in an application for insurance is guilty of a crime and may be subject to restitution fines or confinement in prison, or any combination thereof.

California: For your protection California law requires the following to appear on this form: Any person who knowingly presents false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

Colorado: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policy holder or claimant for the purpose of defrauding or attempting to defraud the policy holder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

Delaware, Indiana and Oklahoma: WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

District of Columbia: WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits, if false information materially related to a claim was provided by the applicant.

Florida: Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

Kentucky: Any person who knowingly and with intent to defraud any insurance company or other person files a statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

Louisiana and Texas: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit is guilty of a crime and may be subject to fines and confinements in state prison.

Maryland : Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

New Jersey: Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

New Mexico: ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR KNOWINGLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO CIVIL FINES AND CRIMINAL PENALTIES.

Ohio: Any person who with intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

Rhode Island: Any person who knowingly and willfully presents a false or fraudulent claim for payment of a loss or benefit or knowingly and willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Virginia: Any person who with intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may have violated state law.