



National Guardian Life Insurance Company

Two East Gilman Street, PO Box 1191, Madison, WI 53701

ENDORSEMENT

The policy and certificate to which this endorsement is attached are amended as follows:

1. Under Part 1. Definitions, the definition of Eligible Dependent is hereby deleted and the following definition is added:

Eligible Dependent - Means a person listed below:

1. Your spouse or lawful Domestic Partner;
2. Your unmarried dependent child under age 21, who is your natural or adopted child, step-child, foster child, or child for whom you are a legal guardian and who is primarily dependent on You for support and maintenance.
3. Your unmarried child age 21 or older but less than age 23 who is:
 - a. Not regularly employed on a full-time basis;
 - b. Primarily dependent upon You for support and maintenance; and
 - c. Enrolled as a full-time student in an accredited educational institution or licensed trade school.
4. Your unmarried child who has reached age 21 and who is:
 - a. primarily dependent upon You for support and maintenance; and
 - b. incapable of self-sustaining employment by reason of mental or physical handicap.Proof of the child's incapacity or dependency must be furnished to Us for an already enrolled child who reaches the age limitation, or when You enroll a new disabled child under the plan.

2. Under Part III. Individual Effective Dates, the following paragraph is added:

If an application or other form of enrollment is required in order to continue coverage beyond the thirty-one-day period after the date of birth of a newborn child and You have notified Us of the birth, either orally or in writing, We will, upon such notification, provide You with all forms and instructions necessary to enroll the newborn child. You will then have an additional ten days from the date such forms and instructions are provided in which to enroll the newborn child.

3. Under Part VIII. Claim Provisions the provisions entitled Proof of Loss, Payment of Claims and Time of Payment of Claims are hereby deleted and the following provisions are added:

PROOF OF LOSS: Written proof of loss must be given to Us in case of claim for loss for which this Policy provides any periodic payment contingent upon continuing loss within 90 days after the termination of the period for which We are liable, and in case of claim for any other loss within 90 days after the date of such loss. Failure to furnish such proof within the time required will not invalidate or reduce any claim if it was not reasonably possible to give proof within such time. However, such proof must be furnished as soon as reasonably possible and in no event (except in the absence of legal capacity) later than 12 months from the time of proof is otherwise required. If You are legally incapable of submitting such proof, You may submit it at any time that it is reasonably possible for You to do so.

TIME OF PAYMENT OF CLAIMS: Benefits payable under this policy will be paid within 30 days following Our receipt of written proof of loss. Any balance remaining unpaid at the end of Our liability will be paid immediately upon receipt of written proof of loss.

PAYMENT OF BENEFITS: All benefits will be payable to You unless assigned by You or by operation of law. Any accrued benefits unpaid at Your death will be paid to Your estate. If benefits are payable to the estate, We can pay benefits up to \$1,000 to someone related to You by blood or marriage whom We consider to be entitled to the benefits. We will be discharged to the extent of any such payment made in good faith. If You utilizes a public hospital or clinic, and such hospital or clinic submits a claim for benefits, whether or not You have made an assignment of benefits, We will pay the benefits provided by this Policy directly to such hospital or clinic. If, however, a claim for benefits provided by this Policy is paid and then such public hospital or clinic files a claim for benefits, We will not be liable for the duplicate payment of such benefits to such hospital or clinic.

4. Under Part VIII. Claim Provisions, the following paragraph is added to Recovery of Overpayments provision: "Except in cases of fraud or misrepresentation by a health care provider, Our right to recover or otherwise offset an overpayment will be limited to a period of 12 months beginning on the date on which the overpayment is made."
5. Part X. Grievance Procedures is hereby deleted and the following Part is added:

PART X. RIGHT TO FILE A GRIEVANCE: When We make a determination on a claim for benefits, We will notify you immediately of Our decision. In the event that You disagree with Our determination, You, or Your authorized representative, will have the right to file a grievance and request a hearing before Our Grievance Review Committee.

The following levels of review are available to You or Your Health Care Provider acting on Your behalf:

1. First-Level Grievance Review.

- (a) You, or Your Health Care Provider acting on Your behalf, may submit a Grievance. Not later than the 5th business day after receiving a Grievance, We will provide You with confirmation of receipt of the Grievance, documentation of the substance of the Grievance and any actions taken and investigate the substance of the Grievance, including any aspects involving clinical care.
- (b) We will issue a written decision in clear terms to You, and if applicable, to Your Health Care Provider, not more than twenty (20) days after receiving a Grievance. If We cannot make a decision within twenty (20) days due to circumstances beyond Our control, We may take up to an additional ten (10) days to issue a written decision if We provide written notice to You of the extension and the reasons for the delay. The person or persons reviewing the Grievance will not be the same person or persons who initially handled the matter that is the subject of the Grievance and, if the issue is a clinical one, at least one of whom shall be a medical Doctor with appropriate expertise to evaluate the matter. If the decision is not in Your favor, the written decision shall contain:
 - (1) the professional qualifications and licensure of the person or persons reviewing the Grievance;
 - (2) a statement of the reviewers' understanding of the Grievance;
 - (3) the reviewers' decision in clear terms and the contractual basis or medical rationale in sufficient detail for You or Your Health Care Provider to respond further to Our position;
 - (4) a reference to the evidence or documentation used as the basis for the decision;
 - (5) a statement advising You of Your right to request a Second-Level Grievance Review and a description of the procedure for submitting a Second-Level Grievance; and
 - (6) the address of the Department of Insurance through which You may contact a qualified representative to obtain additional information about the decision or the right to appeal.

We must notify You, or the Health Care Provider acting on Your behalf, within five (5) business after completion of an investigation.

2. Second-Level Grievance Review.

A Second-Level Grievance review process is available if You are dissatisfied with the first-level Grievance review decision. The Covered Person or the Health Care Provider acting on the Covered Person's behalf may submit a Second-Level Grievance.

- (a) We shall, not later than the 5th business day after receiving a request for a second-level Grievance review, confirm, orally or in writing, receipt of the Grievance and make known to You the name, address, and telephone number of a person designated to coordinate the Grievance review for Us.

- (b) The panel shall be comprised of persons who were not previously involved in any matter giving rise to the Second-Level Grievance, are not Company employees, and do not have a financial interest in the outcome of the review. A person who was previously involved in the matter may appear before the panel to present information or answer questions. The panel may also include other enrollees. All of the persons reviewing a Second-Level Grievance involving shall be Providers who have appropriate expertise.
- (c) We will issue a written decision in clear terms to You, and if applicable, to Your Health Care Provider, not more than twenty (20) days after receiving a Grievance. If We cannot make a decision within twenty (20) days due to circumstances beyond Our control, We may take up to an additional ten (10) days to issue a written decision, if We provide written notice to You of the extension and the reasons for the delay. The person or persons reviewing the Grievance will not be the same person or persons who initially handled the matter that is the subject of the Grievance and, if the issue is a clinical one, at least one of whom shall be a medical Doctor with appropriate expertise to evaluate the matter. If the decision is not in Your favor, the written decision shall contain:
 - (1) the professional qualifications and licensure of the members of the review panel;
 - (2) a statement of the review panel's understanding of the nature of the Grievance and all pertinent facts;
 - (3) the review panel's recommendation to Us and the rationale behind that recommendation;
 - (4) a description of or reference to the evidence or documentation considered by the review panel in making the recommendation;
 - (5) a written statement of the clinical rationale used by the review panel to make the recommendation;
 - (6) the rationale for Our decision if it differs from the review panel's recommendation;
 - (7) a statement that the decision is Our final determination in the matter; and
 - (8) notice of the availability of the Commissioner of Insurance.

We must notify You, or the Care Provider acting on Your behalf, with five (5) business after completion of the investigation.

Expedited Second-Level Grievance Review.

An expedited appeal of a Grievance may be requested by You or a Health Care Provider acting on Your behalf only when a non-expedited appeal would reasonably appear to seriously jeopardize Your life or health or seriously jeopardize Your ability to regain maximum function. We may require documentation of the medical justification for the expedited appeal. We will, in consultation with a Doctor, provide expedited review, and will communicate Our decision in writing to You and Your Health Care Provider as soon as possible, but not later than seventy-two (72) hours after receiving the all necessary information to complete the review. The written decision will contain the information outlined in item (c) under the Second-Level Grievance Review.

3. For Purposes of this Right to File a Grievance:

Adverse Determination means a determination by Us that the health care services furnished or proposed to be furnished to You are:

- (a) not Medically Necessary, as determined by us; or
- (b) Experimental/Investigational, as determined by Us; and
- (c) benefit coverage is therefore denied, reduced or terminated.

Authorized Representative: An individual who the Covered Person willingly acknowledges to represent his or her interests during an appeal process. The Covered Person may be required to submit written verification of his or her consent to be represented. If the Covered Person has been determined by a Doctor to be incapable of assigning the right of representation, the appeal may be filed by a family member or a legal representative.

Grievance: Any dissatisfaction expressed by or on behalf of a Covered Person regarding:

- (a) a determination that a service or proposed service is not appropriate or Medically Necessary;
- (b) a determination that a service or proposed service is experimental or investigational;
- (c) the availability of participating providers;
- (d) the handling or payment of claims for health care services; or
- (e) the contractual relationship between a Covered Person and Us.

Health Care Provider: A Doctor; health care professional who is licensed, registered, to provide Health Care Services in the ordinary care of business or practice; a health care facility as defined by the laws of the state to operate as a health care facility; or a pharmacy.

Health Care Services: Services provided for the diagnosis, prevention, treatment, cure or relief of a Sickness or Injury.

This Endorsement is effective on the later of the policy effective date or the certificate effective date to which it is attached.

There are no other changes to the policy or certificate.

In witness whereof We have caused this Endorsement to be signed by Our President and Secretary.



Sherri Kliczak, Secretary



John Larson, President