Your Guardian Health Reimbursement Arrangement

A Summary Plan Description for Medicare-Eligible Retired Guardian Home Office Employees and Field Representatives (FRs)

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For Medicare-Eligible Guardian Home Office, Broadshore Capital Partners, LLC, and ReedGroup Employees, Field Representatives (FRs), Career Development Managers (CDMs) and the Field Clerical Employees of the CDMs on Long-Term Disability

Effective: January 2022

The Guardian Life Insurance Company of America

Corporate Benefits Department 10 Hudson Yards New York, NY 10001

(January 2022)

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Introduction

Guardian is pleased to provide you with this Summary Plan Description (SPD) which describes your Health Reimbursement Arrangement (HRA) benefits under the Guardian Life Insurance Company of America Health and Welfare Benefits Plan for Retired Employees and the Guardian Life Insurance Company of America Health and Welfare Benefits Plan for Retired Field Associates (the "Plan") as well as your rights and responsibilities under the Plan as of January 1, 2021. The Plan is intended to qualify as a self-insured medical reimbursement plan for purposes of Sections 105 and 106 of the Internal Revenue Code, as amended ("Code"), as well as a health reimbursement arrangement as defined in IRS Notice 2002-45. The Plan is a self-funded through Company contributions.

Guardian does not provide group-sponsored medical with prescription drugs, dental or vision coverage to Medicare-eligible retirees, individuals on Long-Term Disability (LTD), Board of Directors (BODs) or the Medicare-eligible dependents of these individuals. Instead, they can purchase individual Supplemental Medicare policies through a Medicare exchange. Guardian is committed to supporting these individuals as they transition from group-sponsored to individual health care coverage. Rather than subsidizing the monthly premium for health care coverage, Guardian will make an annual contribution to a Health Reimbursement Arrangement (HRA).

The HRA provides you and your eligible dependents (as defined in this SPD) with the opportunity to receive "eligible medical expense" reimbursements, which are not reimbursed by another plan or policy, from an HRA, established under the Plan, on your behalf.

No individual other than the Plan Administrator has any authority to interpret the Plan or to make any promises to you about any benefits or to change any provision of the Plan. Although Guardian (the Company) intends to continue the Plan indefinitely, Guardian reserves the right to amend, modify or terminate the Plan or any provision at any time and from time to time.

For questions about the Plan, contact the Willis Towers Watson's Via Benefits at the following:
Phone: (888) 427-4164, Mon. through Fri., 8 a.m. to 9 p.m., ET
Website: https://my.viabenefits.com/glic

Eligibility

You are considered a "participant" in the Plan, eligible to have the Company make a contribution to your HRA established under the Plan if you meet the criteria outlined in the sections below.

Note: Upon attaining age 65 you and your eligible spouse/domestic partner will become Medicare-eligible and you will be considered a participant in the Plan. If you and/or your spouse/domestic partner become Medicare-eligible due to disability, you must notify Guardian. Upon becoming Medicare-eligible your eligibility under the Guardian group-sponsored health care plans will end and you will receive an HRA, if you meet the eligibility requirements described in this SPD.

Eligible Retiree

Effective January 1, 2021, Home Office Employees are no longer eligible for the HRA unless the employee satisfies the exceptions as stated below:

- you were an Active participant in the Guardian Retirement Plan for Home Office Employees on December 31, 2020, and you have/will attain age 55 with 10 years of service or age 65 with 5 years of service when you leave Guardian or,
- you were (i) an Active participant in the Guardian Retirement Plan for Home Office Employees, (ii) had attained age 55, age 60 with 20 years of service, or age 65 when you left Guardian and (iii) are rehired or,
- you were an Active participant in the Guardian Retirement Plan for Field Representatives, and you have attained age 55 and 15 years of service or age 65 with 5 years of service, and
- You complete any enrollment forms and procedures required by the Plan Administrator.

If the above exceptions apply to you, you and your eligible dependents may be eligible for the HRA. Assuming you have met the above requirements, you are not required to be enrolled in health care coverage as an active associate/employee to be eligible for this benefit at retirement. If you waive the HRA through Guardian, you will waive your HRA for life. Please note, if you retired before October 1, 2017, you are only eligible for the HRA if you were enrolled in the medical or dental plans immediately prior to the start of your retirement, and your spouse/domestic must also have been enrolled under these plans at that time.

Additionally, your spouse or domestic partner may be eligible for the HRA; however, in addition to meeting Guardian's definition of an eligible dependent, all dependents must:

- have been your eligible dependent as of the date you retired or terminated your employment with Guardian, and
- continue to be your eligible dependent at the time of enrollment and for as long as they remain enrolled in Guardian retiree benefits.

Note: Guardian employees who were hired on or after January 1, 2018 and are a Participant in The Guardian Retirement Investment Plan are not eligible for retiree health benefits, including the HRA. Additionally, Broadshore Capital Partners, LLC ("Broadshore") employees and principals and ReedGroup employees are not eligible for retirement or retiree health care benefits, including the HRA.

Eligible Individual on Long Term Disability

You become an eligible participant if you satisfy all of the following requirements:

- You are a Medicare-eligible Guardian Home Office, Broadshore Capital Partners, LLC, or ReedGroup employee,
- Your employment terminated before January 1, 2021 and you began LTD benefits at that time, and
- You complete any enrollment forms and procedures required by the Plan Administrator.

If you are receiving Long-Term Disability (LTD) benefits and your LTD benefits terminate, you will continue to be eligible for the HRA if your employment terminated before January 1, 2021, you began LTD benefits, and at the time your LTD benefits commenced, you had met the age and service requirements to be considered

retirement-eligible. If you did not meet these requirements and were not considered retirement-eligible, your HRA will terminate.

Eligible Board of Director:

Effective January 1, 2021, Active and Retired Board of Directors are no longer eligible for the HRA unless the Board member satisfies the exceptions as stated below:

- You were an active Board of Director appointed prior to January 1, 2021 and were already receiving the HRA, you will continue to be eligible and will be grandfathered, or
- You were a retired Board of Director prior to January 1, 2021 and were already receiving the HRA, you will continue to be eligible and will be grandfathered.

Board of Directors appointed before January 1, 2021 who are receiving an HRA as a Medicare-eligible active Board of Director, will lose their HRA eligibility upon retirement.

Beginning January 1, 2018, any new Medicare-eligible individuals and existing Medicare-eligible individuals who have already qualified for the HRA contribution will no longer be required to enroll or remain enrolled in a medical policy through Via Benefits to be eligible for the HRA contribution. This means participants can choose to enroll outside of Via Benefits and will remain eligible for the HRA. However, participants may choose to continue their existing plans through Via Benefits and their benefit advisors are available to assist you in finding a Medicare supplement plan.

Eligible Dependent

Associates, employees, retirees, individuals on LTD, and Board of Directors are responsible for ensuring that dependents who are covered under their Guardian health care benefit plans, meet Guardian's definition of eligible dependents. Your dependent is considered an eligible dependent in the Plan, and eligible to have the Company contribute to their HRA established under the Plan, if he or she meets the following criteria:

- He or she must be eligible for Medicare,
- He or she must be an eligible spouse or domestic partner,
- He or she must have been an eligible dependent at the time of your retirement or termination of employment with Guardian, and
- Continue to be your eligible spouse or domestic partner at the time they become eligible for the HRA and for as long as they remain covered under the HRA.

If you are covering a dependent child who becomes Medicare-eligible, they will not be eligible for an HRA. Instead, they will be offered COBRA continuation coverage for the health care plans they were enrolled in prior to becoming Medicare-eligible.

Note: When there are split family situations (e.g., the retiree is Medicare-eligible and the dependents are not or vice versa), the individuals who are non-Medicare-eligible must be enrolled in at least ONE benefit plan in order to be eligible for the HRA when they become Medicare-eligible.

Dependent

A "dependent" under the Plan is one of the following:

- Spouse who is eligible for Medicare;
- Domestic partner who is eligible for Medicare

Your dependent child if the child is a permanently disabled dependent child who prior to January 1, 2013 is covered under your Guardian-sponsored group medical coverage or group dental coverage and is eligible for Medicare Part A and Part B and you retired prior to January 1, 2013. Dependent children who are eligible for Medicare are not eligible for the HRA. Their coverage under the Guardian group-sponsored health care plans will end once they become Medicare-eligible and they will be offered COBRA continuation coverage.

A "spouse" under the Plan is:

- Your spouse as defined under federal law, who is not divorced from you.

A "domestic partner" under the Plan is defined as:

- Two people in a spouse-like relationship who have met all of the following requirements:
- are each other's sole domestic partner and intend to remain so indefinitely;
- have continually resided together in the same permanent residence for 6 months and have not had another domestic partner in the prior 12 months;
- share a committed and mutually dependent relationship with each other that is similar to that of a married couple, but have either chosen not to marry or cannot legally do so;
- neither is married or legally separated to another person nor is the domestic partner of another person;
- are not related by blood closer than would bar marriage under applicable law;
- are both at least 18 years of age and mentally competent to enter into a legal contract; AND
- are financially interdependent on each other

You may also satisfy this definition if you and your domestic partner are legally married under state law.

Note: When there are split family situations (e.g., the retiree is Medicare-eligible and the dependents are not or vice versa), the individuals who are non-Medicare-eligible must be enrolled in at least ONE benefit plan in order to be eligible for the HRA when they become Medicare-eligible.

You will be required to submit documentation (e.g., tax return, marriage certificate, birth certificate) to verify all eligible dependents meet the criteria listed above, before their coverage is approved. Please note, you must enroll yourself and all eligible dependents at the same time, as you will not have the option to add any additional dependents to your retiree health care plans at a later date.

While Guardian's contribution to your HRA is tax-free in most cases, health care expense reimbursements for a retired Board of Director or a domestic partner (unless your domestic partner qualifies as your federal tax dependent) will be taxable. You should discuss the tax treatment of any contribution you receive with a tax advisor. See the *Taxation* section below for more details.

Enrollment

An individual automatically becomes a Participant in the Plan once the above eligibility requirements are met. Guardian will send your information to Via Benefits, Guardian's HRA administrator, in order to initiate the setup of your HRA. Once they receive your information, Via Benefits will send you and your eligible dependent an HRA package in the mail, explaining what the HRA is and how to receive reimbursement. Please call Via Benefits directly if you have questions on the HRA.

Via Benefits also offers a Medicare exchange. For information on enrolling in a supplemental plan through Via Benefits, schedule an enrollment call with a Via Benefits benefit advisor by calling (888) 427 4164. An advisor can assist you with understanding your plan options and costs and processing your enrollment.

You do not need to enroll in a plan through Via Benefits to be eligible for the HRA funds. For information on enrolling in individual supplemental policies outside of their exchange go to www.medicare.gov.

Note: You will need to enroll in Medicare Part B before you can elect an individual Medicare supplemental policy. You can sign up for Medicare Part B by calling the Social Security Office at (800) 772-1213 or Via Benefits can assist you with the enrollment process.

When Coverage Begins

If you become a Participant, your coverage begins, which means you have access to your HRA on the later of the effective date of the Plan, which is January 1, 2013, or the first day of the month coincident with or following your date of Medicare eligibility provided you satisfy the above eligibility requirements.

When Coverage Ends

Participation will end for you, the eligible retiree:

- When you are no longer eligible for an HRA, for any reason;
- On the date you are rehired by Guardian;
- When you are no longer eligible for Medicare;
- When you die;
- On the effective date of any amendment to the Plan terminating your eligibility under the Plan;
- When you are no longer eligible to receive long term disability benefits under Guardian's Group Long Term Disability (LTD) Plan for Employees and Associates unless you otherwise qualify as an Eligible Retiree; or
- On the date the Plan is terminated.

Participation will end for your Eligible Dependent:

- When you are no longer eligible for an HRA for any reason;
- When you are no longer eligible for Medicare;
- When you die and did not otherwise qualify as an eligible retiree;
- In the case of an eligible dependent spouse, the date you divorce or become legally separated from the eligible retiree;
- On the date you are no longer considered an eligible dependent for any reason;
- On the effective date of any amendment to the Plan terminating your eligibility under the Plan; or

- On the date the Plan is terminated.

If you die with no eligible dependents who are Participants in the Plan, your estate or representatives may submit claims for your eligible health care expenses incurred by you and your eligible dependents before your death. Claims must be submitted within 6 months of the eligible retiree's death. All access to any remaining balance is then forfeited.

If you die with one or more eligible dependents who are Participants, your HRA will continue and your eligible dependents who are Participants can continue to submit eligible health care expenses for reimbursement.

Fraud

Notwithstanding the above, the Company may in its sole discretion terminate your coverage or your eligible dependent's coverage, and you will forfeit your remaining HRA balance, if you or your eligible dependent:

Provide false information or makes a misrepresentation in connection with a claim for benefits; or

Obtain or attempt to obtain by means of false, misleading or fraudulent information, acts or omissions; or fails to provide documents request by the Company to verify representations made by you in connection with eligibility or continued eligibility for benefits for you or your dependents

Coverage if Re-Employed by the Company

If you are re-employed by the Company after you retire, you must notify Via Benefits of your status immediately. As an active employee or associate, your retiree medical coverage under the HRA will be suspended and you will be eligible for the medical coverage available to active employees or associates of the same employment class. Contact MyHR if you have further questions on your benefits upon re- employment by the Company.

How the Health Reimbursement Arrangement (HRA) Works

An HRA will be established in your name on your behalf, which can be used to reimburse you and your eligible dependents for eligible health care expenses. See the *HRA Reimbursement* section below for information on what type of expenses can be reimbursed from your HRA. If both you and your eligible dependent are eligible for the HRA, one joint arrangement will be established in your name.

Company Contributions

Guardian, within its sole discretion, will determine the amount of the Company's contribution that it will allocate to your HRA. The Company Contribution will be communicated to you at the time of your initial participation in the Plan. If, for any reason, the Company Contribution changes, you will be notified prior to the effective date of the change. The Company Contribution will be reflected as an opening balance on the first day of each plan year in your HRA. No earnings shall accumulate on the Company contributions made to your HRA.

Your eligible dependent will receive an HRA contribution from the Company that is either equal to yours, or if you retired before October 1, 2017, that is consistent with the Guardian group-sponsored health care plans they were enrolled in prior to becoming an eligible participant under the Plan. While each participant and eligible

dependent will receive a contribution in an HRA, those funds will be commingled in one HRA and can be used to reimburse either party and all covered persons can share in the full contribution – they are not limited to the amount contributed on their behalf.

At any time, you may receive reimbursement for eligible medical expenses up to the amount in your Plan arrangement. By law, you cannot make contributions to your HRA. Only the Company can make contributions to the HRA.

The amount of contributions made by the Company, if any, shall be made by the Company out of its general assets, and no assets will be segregated or earmarked for the purpose of providing benefits under the Plan, nor shall any person have any right, title or claim to such assets prior to their payment hereunder. As such, each HRA established for a Participant under the Plan shall be a notional arrangement which merely reflects a bookkeeping concept and does not represent assets that are actually set aside for the exclusive purpose of providing benefits to the Participant and eligible dependents under the terms of the Plan or that are protected from the reach of the Company's creditors.

Period of Coverage

The funds in your HRA can only be used to reimburse you for eligible health care expenses incurred during your active participation in the Plan. You cannot be reimbursed for expenses incurred prior to the date your participation in the Plan begins or after the date your participation in the Plan ends.

Managing Your Funds and Reimbursements

You can access your HRA online:

Sign into your HRA at: http://my.viabenefits.com/funds. Select the "Login" option. If you are a first-time user, you will need to create a new HRA by following the instructions provided on the website.

Once you have access to your HRA, select "Funds & Reimbursements," where you will see your HRA activity.

Click "Reimbursement Center." This will bring you to your HRA. Once you are in your HRA online, the My Dashboard option shows your HRA balance, claims in need of attention and your next claim payment. You can also file a claim online or print a paper claim form.

You may also contact Via Benefits directly for any question on your HRA.

HRA Reimbursements

Expenses Eligible for Reimbursement

To be eligible for reimbursement from your HRA, an expense must be an eligible health care expense incurred by you or any eligible dependent, provided that you are considered an eligible member as discussed in the *Eligibility Section*.

You may not obtain reimbursement for any eligible health care expenses incurred before your eligibility begins, or after your eligibility ends. However, you will have six months after your eligibility ends to request reimbursement of eligible health care expenses that you incurred prior to your eligibility end date.

Eligible expenses are eligible for reimbursement up to and including the amount credited to your HRA, if any. If your claim for benefits is greater than your balance, any eligible and unreimbursed claims will not be carried forward to the next year and will not be reimbursed with the next annual allocation. However, if you have an balance left over at the end of the year that balance is carried forward to the following year to use for future expenses.

An eligible health care expense is defined under Section 213(d) of the Internal Revenue Code (generally, expenses related to the diagnosis, care, mitigation, treatment or prevention of disease). Please visit the IRS website for more information on eligible health care expenses under the Plan.

Only eligible health care expenses incurred while you and your eligible dependent are participants in the Plan may be reimbursed from your HRA. Eligible health care expenses are "incurred" when the health care is provided, not when you or your eligible dependent are billed, charged or pay for the expense. Thus, an expense that has been paid but not incurred (e.g. pre-payment to a physician) will not be reimbursed until the services or treatment giving rise to the expense has been provided.

For more details on covered services see IRS Publication 502, Medical and Dental Expenses – but be careful in relying on this Publication, however, as it is specifically designed to address what medical expenses are deductible on Form 1040, Schedule A, and not what is reimbursable under an HRA. You can also contact Via Benefits for a complete list of HRA eligible expenses.

Your HRA also cannot reimburse you for any expenses that have been, or will be, taken as a deduction on your Federal income tax return.

Overpayments and Erroneous Reimbursements

If it is determined that you received reimbursement for ineligible expenses or if reimbursement was made in error (e.g., you were reimbursed from your HRA for an expense that is later paid by another medical plan), you will be required to return the payments to the Plan. Failure to return the payment can lead to suspension of future reimbursements from the Plan, or an offset against future reimbursements. If the Plan is unable to recover the improper reimbursement from you, or offset it against future appropriate expenses, the Plan will treat the improper reimbursement like a bad debt, which may have tax implications for you.

Automatic Premium Reimbursement

Automatic premium reimbursement is only available for plans purchased through Via Benefits. While the majority of insurance companies offer this option, some do not. Typically, if you are enrolling in a plan through Via Benefits, automatic reimbursement is activated during your enrollment call with Via Benefits, by the licensed benefit advisor. However, you can also activate Automatic reimbursement through your online member account. This feature allows you to be reimbursed automatically from your HRA (to the extent that HRA funds are available) for your insurance premium payments without having to submit claim forms.

Once automatic reimbursement is turned on, it takes about two to three months to start. You will receive your premium reimbursement monthly and don't have to reapply annually, as it automatically rolls over. However, if you change your plan, you must activate automatic premium reimbursement for your new plan. Via Benefits can assist you in determining whether the plans you are enrolled in offer this feature.

Recurring Reimbursement

When automatic premium reimbursement is not available, you may use a Recurring Reimbursement Form to be reimbursed for your premium payment. You can submit a reimbursement through fax or mail. Be sure to include a copy of your premium receipt with the reimbursement request. All forms have instructions and a check list of what to include.

The Recurring Reimbursement Form has to be filled out annually, regardless of whether you change your plan or not.

Procedures for Filing a Claim

How to File a Claim

To receive a reimbursement for an eligible health care expense, you must complete a reimbursement form along with a copy of your insurance premium bill, an Explanation of Benefits (EOB), or if no EOB is provided, a written statement from the service provider. The written statement from the service provider must contain the following: (a) the name of the patient, (b) the date service or treatment was provided, (c) a description of the service or treatment; and (d) the amount incurred. You can obtain a reimbursement form by contacting the Third-Party Administrator, identified in the *Plan Information* section.

You can send your claim form and documentation via mail or fax to the Claims Administrator at:

Mail: Via Benefits
Via Benefits HRA
P.O. Box 3039
Omaha, NE 68103-3039

Fax: (402) 231-4310

If you prefer to submit your claim online, please follow the instructions below:

- Access your online HRA at My.ViaBenefits.com/glic
- Click "File a Claim" under "Quick Links"
- Enter the following claim information: type of expense, date of expense and amount of expense - to add additional claims, select "Add Another Claim."
- After entering all your claims, click "Next."
- Confirm all expense details, and then click "Next." To make changes, click "Previous."
- Select "Fax" or "Upload" (upload requires claims to be provided in PDF format).
- To fax, click on "Create Coversheet" then print, sign and fax forms (and itemized receipts) to 866-932-2567.
- To upload, use the Browse button to select your receipts in PDF format from your computer.
- To add additional documents, click on "Add Additional Document."
- Check the "Signature box" at the bottom of the page to sign your claim.
- Click "Submit."

If you are submitting a claim for medical or dental expenses and you have medical or dental insurance, you need to submit a claim first to the medical/dental carrier and submit proof of any amount paid by that coverage, such as an Explanation of Benefits (EOB).

If filing a claim for health insurance premiums, you must provide supporting documentation from a third party. A premium statement and a bank statement or both sides of a cancelled check or premium statement showing the amount paid will typically include all the required information.

Your claim is deemed filed when it is received by the Claims Administrator.

If your claim for reimbursement is approved, you will be provided reimbursement as soon as reasonably possible following the determination. Claims are paid in the order in which they are received by the Claims Administrator.

You may establish direct deposit, where available. By using direct deposit, once a claim is submitted, Via Benefits can make a direct deposit from your HRA to your designated checking or savings account. Unless you choose to set up direct deposit, reimbursements will be made by check and mailed to your address on file with Via Benefits. It is your responsibility to ensure that Via Benefits has your current address on file.

Deadline for Filing Claims

Claims for reimbursement for eligible expenses can be submitted at any time. However, if a Participant dies without a surviving Eligible Dependent the HRA will remain open for six months from the date of death for claim submission for expenses incurred prior to the date of death. The six-month claims submission deadline would also apply to any Participant who loses eligibility.

Appeals

If your claim for reimbursement is wholly or partially denied, you will be notified in writing within 30 days after the Claims Administrator receives your claim. If the Claims Administrator determines that an extension of this time period is necessary due to matters beyond the control of the Plan, the Claims Administrator will notify you within the initial 30-day period that an extension of up to an additional 15 days will be required. If the extension is necessary because you failed to provide sufficient information to allow the claim to be decided, you will be notified, and you will have at least 45 days to provide the additional information. The notice of denial will contain:

- the reason(s) for the denial and the Plan provisions on which the denial is based;
- a description of any additional information necessary for you to perfect your claim, why the information is necessary, and your time limits applicable to such procedures,
- a description of the Plan's appeal procedures and the time limits applicable to such procedures, and
- a description of your right to request all documentation relevant to your claim.

If your request for reimbursement under the Plan is denied in whole or in part and you do not agree with the decision of the Claims Administrator, you may file a written appeal. You should file your appeal with the Plan Administrator at the address provided below, no later than 180 days after receipt of the denial notice. You

should submit all information identified in the notice of denial, as necessary, to perfect your claim and any additional information that you believe should support your claim.

Guardian Life Insurance Company
Attn: Benefit Appeals Committee
6255 Sterner's Way; 1W-AK33
Bethlehem, PA 18017

You will be notified in writing of the decision on appeal no later than 60 days after the Plan Administrator receives your request for appeal. The notice will contain the same type of information provided in the first notice of denial provided by the Claims Administrator. The decision of the Plan Administrator will be final and conclusive on all persons claiming benefits under the Plan, subject to applicable law.

Note: You cannot file suit in federal court until you have exhausted these appeals procedures.

Forfeitures

Your HRA balance (minus reimbursement made during the plan year) rolls over from one plan year to the next. Since your HRA balance rolls over from year to year, you will not lose the balance that remains in your HRA at the end of the year, if any, after all claim reimbursements have been made. Only loss of eligibility (subject to COBRA), misrepresentation about eligible dependents, or fraudulent reimbursements will result in forfeiture of the balance. Any forfeited amounts may be used by the Company to offset the administrative costs and expenses of administering the Plan.

Nondiscrimination

If the Company determines during any plan year that the Plan may fail any nondiscrimination requirement imposed on the Plan by law or may exceed any limitation on benefits provided to highly compensated individuals or such other individuals for whom benefits may not be discriminatory under the law, the Company shall have the discretion and authority to take such action as it deems necessary to assure compliance with such nondiscrimination requirement or limitation. Such action may include, without limitation, a modification or limit on benefits reimbursable for any individual for whom benefits may not be discriminatory under the Code or regulations.

Taxation

The Plan is intended to meet certain requirements of existing federal tax laws, under which the benefits you receive under the Plan generally are not taxable. However, the Company cannot guarantee the tax treatment to any given Participant, as individual circumstances may produce different results. If there is any doubt, you should consult your own tax advisor. Specifically, contributions made by the Company to your HRA are excluded from federal income tax if you are an employee/associate or former employee/associate of the Company, which means you do not pay taxes on the money the Company contributes for you when it goes into your HRA or when you use it to pay your health care premiums and other eligible medical care expenses for yourself, your spouse and dependents, each as defined under federal tax law.

However, if you are not considered an employee/associate or former employee/associate or a covered family member is not your spouse or dependent for federal tax purposes (e.g., in most cases your domestic partner is not your tax dependent), the Company may be required to report its contribution to the IRS. Note that certain

self-employed persons are not eligible for tax-free Company contributions or reimbursements from the HRA. You should consult a tax advisor regarding the tax treatment of your HRA benefits.

Continuation Coverage Rights Under COBRA

When your eligible dependent's eligibility for benefits under the Plan ends, they may have the right to COBRA continuation coverage, which is a temporary extension of health coverage under the Plan. This section generally explains COBRA continuation coverage, when it may become available to your eligible dependents and what he/she needs to do to protect their right to receive it. The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 ("COBRA").

COBRA provides a continuation of health coverage when coverage would otherwise end because of a life status change known as a "qualifying event." After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." Your eligible dependent will become a "qualified beneficiary" upon the occurrence of the following "qualifying events":

- if they are your spouse or domestic partner and lose health coverage under the Plan because you die;
- if they are your spouse and lose health coverage under the Plan because you become divorced or legally separated; or
- if they are your domestic partner and lose coverage under the Plan because you terminate your domestic partnership with your domestic partner unless eligible for their own HRA contribution.

In general, to be a qualified beneficiary for the HRA, you must have had a balance in your HRA on the day before the qualifying event occurs. If you do not have a balance in your HRA on the day before a qualifying event occurs, you may not continue the HRA or subsequently join the HRA after the qualifying event occurs.

The Plan will offer COBRA continuation coverage to qualifying beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. When the qualifying event is divorce or termination of the domestic partnership the eligible dependent must notify the Plan Administrator of the qualifying event.

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to the qualified beneficiaries. The qualified beneficiary will have an independent right to elect COBRA continuation coverage.

COBRA continuation coverage is a temporary continuation of coverage. When the qualifying event is a result of a death, divorce, legal separation or termination of a domestic partnership, COBRA continuation coverage for qualified beneficiaries lasts for up to a total of 36 months.

Questions concerning COBRA continuation coverage rights should be addressed to the Plan Administrator. For more information about your rights under COBRA, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration ("EBSA") in your area or visit the EBSA website at www.dol.gov.ebsa. Addresses and phone numbers of EBSA offices are available on EBSA's website.

Notice of Privacy Practices

Original Effective Date April 14, 2003
Updated and Effective January 1, 2021

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

This Notice of Privacy Practices described how the health plan sponsored by The Guardian Life Insurance Company of America in which you participate (the "Health Plan") may use and disclose your protected health information (PHI) in order to carry out treatment, payment and health care operations and for other purposes permitted or required by law.

PHI is individually identifiable information (including demographic information) relating to your health, the health care provided to you and payment for your health care.

The Health Plan is required by law to provide you with this Notice of our legal duties and privacy practices with respect to PHI, and to abide by the terms of this Notice and to protect the privacy of your PHI so long as it remains in effect. However, we may modify the terms of this Notice at any time, and the new notice will be effective for all PHI in our possession at the time of the change, and any received thereafter. Upon request, we will provide you with any revised Notice or you can review the Notice by accessing the Health Plan's webpage – Guardian Home Office, Broadshore and ReedGroup employees may view it on Inside Guardian, under Benefits & Career > Health & Insurance > Benefit Plan Summaries & Notices.

The group health plans sponsored by Guardian which are covered by and referred to individually and collectively in this Notice as the "Health Plan" are:

- The Guardian Life Insurance Company of America Health and Welfare Benefits Plan for Home Office Employees

Broadshore Capital Partners, LLC, Park Avenue Institutional Advisers, and ReedGroup are participating employers in the Guardian medical and certain other plans. Accordingly, employees of those companies are eligible to participate in such. Please note that all participating employers and employees are subject to all rules and regulations of such plans.

Used and Disclosures of Health Information
The Health Plan uses PHI about you for treatment, payment and health care operational purposes. We do not require authorization to use your PHI for these purposes. As described in this Notice, we may also use or disclose your PHI without your authorization for several other reasons. Please note that examples are provided for illustrative purposes only and are not intended to indicate every use or disclosure that may be made for a particular purpose.

Treatment. The Health Plan may use and disclose your PHI to assist your health care providers in your diagnosis and treatment. For example, we may disclose your PHI to providers to provide information about alternative treatments.

Payment. The Health Plan may use and disclose your PHI in order to pay for the services and items you may receive. For example, we may contact your health provider to certify that you receive treatment (and for what

range of benefits), and we may request details regarding your treatment to determine if your benefits will cover, or pay for, your treatment.

Health Care Operations. The Health Plan may use and disclose your PHI to perform health care operations. For example, we may use your PHI for underwriting and premium rating purposes. However, we will not use or disclose your genetic information for underwriting purposes and are prohibited by law from doing so.

In addition to the above mentioned uses of your PHI related to treatment, payment and health care operations, the Health Plan may also use your PHI for the following purposes:

Plan Sponsors. The Health Plan may use or disclose PHI to the plan sponsor (Guardian) of the Health Plan to perform administrative functions. For example, the Health Plan may disclose to the plan sponsor that you are enrolled in, or disenrolled in the Health Plan. The Health Plan will not use or disclose PHI for any employment-related purposes.

Appointment Reminders. Although the Health Plan does not do this, we have the right to use and disclose your PHI to contact you and remind you of appointments.

Business Associates. To administer the Health Plan, third parties may be hired for certain tasks, such as third party administrators (Centivo, Cigna, CVS Caremark), auditors, attorneys, consultants, etc., which are referred to as business associates under HIPAA. Business associates may need to receive PHI to do their jobs. To protect your privacy, business associates must agree in their contract with the Health Plan to safeguard your PHI.

Other Benefits and Services. The Health may use and disclose your PHI to tell you about health-related benefits or services that may be of interest to you.

Release of Information to Family and Friends. The Health Plan may release your PHI to a friend or family member identified by you, that is helping you pay for your health care, or who assists in taking care of you, when you are present and do not object, when you are incapacitated, under certain circumstances during an emergency or when otherwise permitted by law.

Disclosures Required by Law. The Health Plan is required to use and disclose your PHI:

- To you or your personal representative (someone with the legal right to make health care decisions for you);
- To the Secretary of the Department of Health and Human Services, when conducting a compliance investigation, review or enforcement action related to health information privacy or security; and
- when we are otherwise required to do so by federal, state, or local law.

In addition to the above described uses and disclosures of your PHI, the Health Plan may also use and disclose your PHI under the following unique circumstances:

Public Health Risks. The Health Plan may disclose your PHI to public health authorities that are authorized by law to collect information for the purpose of:

- Maintaining vital records, such as births and deaths;
- Reporting child abuse or neglect;
- Preventing or controlling disease, injury or disability;
- public health investigations;
- Notifying appropriate government agencies and authorities regarding the potential abuse or neglect of an adult patient (including domestic violence); however, we will only disclose this information if the covered individual agrees or we are required or authorized by law to disclose this information; and
- Notifying your employer under limited circumstances related primarily to workplace injury or illness or medical surveillance.

Health Oversight Activities. The Health Plan may disclose your PHI to a health oversight agency for activities authorized by law. Oversight activities can include, for example, investigations, inspections, audits, surveys, licensure and disciplinary actions; civil, administrative, and criminal procedures or actions; or other activities necessary for the government to monitor government programs, compliance with civil rights laws and the health care system in general.

Lawsuits and Similar Proceedings. The Health Plan may use and disclose your PHI in response to a court or administrative order, if you are involved in a lawsuit or similar proceeding. We also may disclose your PHI in response to a discovery request, subpoena, or other lawful process by another party involved in the dispute, but only if we have made an effort to inform you of the request or to obtain an order protecting the information the party has requested.

Law Enforcement. We may release PHI to the proper authorities for law enforcement purposes.

Coroners, Medical Examiners, and/or Medical Examiners. We may disclose your PHI to coroners, medical examiners, and/or funeral directors consistent with law.

Organ or Tissue Donation. We may use or disclose your PHI for organ or tissue donation.

Research Purposes. We may use or disclose your PHI for research purposes, but only as permitted by law.
Serious Threats to Health or Safety. The Health Plan may use and disclose your PHI when necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. Under these circumstances, we will only make disclosures to a person or organization able to help prevent the threat.

Military. The Health Plan may use and disclose your PHI if you are a member of United States or foreign military forces (including veterans) and if required by the appropriate military command authorities.

National Security. The Health Plan may use and disclose your PHI to federal officials for intelligence and national security activities authorized by law. We also may disclose your PHI to federal officials in order to protect the President, other officials or foreign heads of state, or to conduct investigations.

Inmates. The Health Plan may disclose your PHI to correctional institutions or law enforcement officials if you are an inmate or under the custody of a law enforcement official. Disclosure for these purposes would be necessary: (a) for the institution to provide health care services to you, (b) for the safety and security of the institution, and/ or (c) to protect your health and safety or the health and safety of other individuals.

Workers' Compensation. The Health Plan may release your PHI for workers' compensation and similar programs.

Breaches of Your Unsecured PHI. Although the Health Plan takes reasonable, industry-standard measures to protect your PHI, should a breach occur, the Health Plan is required by law to notify affected individuals. Under federal medical privacy law, a breach means the acquisition, access, use, or disclosure of unsecured PHI in a manner not permitted by law that compromises the security or privacy of the PHI.

Your Rights

Your Authorization for Other Uses and Disclosures. Other than for the purposes described above, or as otherwise permitted by law, Guardian must obtain your written authorization to use or disclosure your PHI. You have the right to revoke that authorization in writing except to the extent that: (i) we have taken action in reliance upon the authorization prior to your written revocation, or (ii) you were required to give us your authorization as a condition of obtaining coverage, and we have the right, under other law, to contest a claim under the coverage or the coverage itself.

Under federal and state law, certain kinds of PHI may require enhanced privacy protections. These forms of PHI include information pertaining to:

- HIV/AIDS testing, diagnosis or treatment
- Venereal and /or communicable Disease(s)
- Genetic Testing
- Alcohol and drug abuse prevention, treatment and referral
- Psychotherapy notes

We will only disclose these types of delineated information when permitted or required by law or upon your prior written authorization.

The Right to Inspect and Copy. You have the right to inspect and obtain a copy of your PHI that we maintain and have in our possession, including medical records (if we maintain any) and billing records, but not including psychotherapy notes. If you request copies, we will charge you a fee for the costs of copying, mailing, labor and supplies associated with your request. To inspect and copy your PHI, you must submit your request in writing. Under certain circumstances we may deny your request to inspect and copy your PHI. If you are denied access to medical information, you have the right to have that determination reviewed. A licensed health care professional chosen by the Health Plan will review your request and the denial. The person conducting the review will not be the person who denied your request. The Health Plan promises to comply with the outcome of the review.

The Right to Amend Your PHI. If you feel that any PHI we have about you is not correct or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by the Health Plan. To request an amendment, your request must be made in writing and must provide a reason that supports your request. The Health Plan reserves the right to deny your request for an amendment if it is not writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that:

- Was not created by the Health Plan, unless the person or entity that created the information is no longer available to make the amendment;
- Is not part of the medical information kept by or for the Health Plan;
- Is not part of the information which you would be permitted to inspect or copy; or
- Is accurate and complete.

If we deny your request, you may submit a written statement of your disagreement to us, and we will record it with your health information.

The Right to an Account of Disclosures. An accounting of disclosures is a list of the disclosures we have made, if any, of your PHI. You have the right to request an accounting of disclosures. This right applies to disclosures for purposes other than those made to carry out treatment, payment and health care operations as described in this notice. It excludes disclosures made to you, or for those made for notification purposes. Your request must be made in writing and state a time period that cannot be longer than six years prior to the date you make your request. Your request should indicate in what form you want the list (e.g. paper, electronically). We may charge you for the costs of providing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request at the time before any costs are incurred.

The Right to Receive Communications of PHI or Alternative Means or at Alternative Locations. You have the right to request that the Health Plan communicate with you about your health and related issues in a particular manner or at a certain location. For example, you may ask that we contact you at work rather than at home. We will accommodate all reasonable requests made in writing. Your request to receive PHI by alternative means or at an alternative location must clearly state that your life could be endangered by the disclosure of all or part of your PHI.

The Right to Request Restrictions. You have the right to request a restriction or limitation on the PHI we use or disclose about you for treatment, payment or health care operations as described in this Notice. You also have the right to request a limit on the medical information we disclose about you to someone who is involved in your care or the payment for your care (like a family member or friend), or for notification purposes as described in this notice. The Health Plan is not required to agree to your request, however, if we do agree, we will comply with your request until we receive notice from you that you no longer want to restriction to apply (except as required by law or in emergency situations). Any request for a restriction on our use and disclosure of your PHI must be made in writing. Your request must describe in a clear and concise manner: (a) the information you wish restricted; (b) whether you are requesting to limit the Health Plan's use, disclosure or both; and (c) to whom you want the limits to apply.

The Right to Provide an Authorization for Other Uses and Disclosures. The Health Plan will obtain your written authorization for uses and disclosures that are not identified by this Notice or permitted by applicable law. Any authorization you provide to us regarding the use or disclosure of your PHI for purposes may be revoked at any time in writing. After you revoke your authorization, we will no longer use or disclose your PHI for the purposes described in the authorization, except under the following circumstances:

- We have taken action in reliance upon your authorization before we received your written revocation;
- You were required to give us your authorization as a condition of obtaining coverage; or
- If state law gives us the right to contest a claim under your policy.

The Right to Obtain a Paper Copy of This Notice. Upon request, you have a right to a paper copy of this notice, even if you have agreed to accept this notice electronically. You may obtain a paper copy of this notice by sending a request to the contact information listed at the end of this notice.

The Right to File a Complaint. If you believe your privacy rights have been violated, you may file a complaint with the U.S. Secretary of Health and Human Services. If you wish to file a complaint with the Health Plan you may do so using the contact information below. You will not be penalized for filing a complaint.

The Right to be Notified of a Breach. You have the right to be notified in the event the Health Plan (or a business associate of the Health Plan) discovers a breach of unsecured PHI.

How to Contact Us
If you have any complaints or questions about this Notice or you want to submit a written request as required in any of the previous sections of this Notice, please call the toll-free number on the back of your Health Plan ID card, or write to us at the address below:

Attention: Corporate Privacy Officer
Address: The Guardian Insurance Company of America
Corporate Benefits Department
10 Hudson Yards
New York, New York 10001
Phone: (877) 870-6947
Email: myhr@glic.com

Your Rights Under ERISA

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

Receive Information About Your Plan and Benefits

Examine without charge at the Plan Administrator's office and at other specified locations, such as worksites, all documents governing the Plan, including a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor.

Obtain copies of all documents governing the Plan, including copies of the latest annual report (Form 5500 Series) and updated summary plan description upon written request to the Plan Administrator. The Plan Administrator may make a reasonable charge for the copies.

Receive a summary of the Plan's annual financial report, if applicable. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual financial report.

Continue health coverage for your dependents if there is a loss of coverage under the Plan as a result of a qualifying event. Your dependents may have to pay for such coverage. Review this summary plan description governing your COBRA continuation coverage rights.

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 Plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other Plan participants and beneficiaries. No one, including the Company, 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.

Enforce 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 materials from the Plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator.

If you have a claim for benefits, which is denied or ignored, in whole or in part, you may file suit in a state or Federal court after exhausting the Plan's appeal process described in this SPD. In addition, if you disagree with the Plan's decision or lack thereof concerning a medical child support order, you may file suit in Federal court. If it should happen that the 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 have sued to pay these costs and fees. If you are not successful, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance With Your Questions

If you have any questions about your Plan, you should contact the Plan Administrator. If you have any 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 Division of Technical Assistance and Inquiries, 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 publication hotline of the Employee Benefits Security Administration at (866) 444 EBSA, or www.dol.gov/ebsa.

Plan Information

Plan Name:

The Guardian Life Insurance Company of America Health and Welfare Benefits Plan for Home Office Employees
The Guardian Life Insurance Company of America Health and Welfare Benefits Plan for Retired Employees
The Guardian Life Insurance Company of America Health and Welfare Benefits Plan for Field Representatives
The Guardian Life Insurance Company of America Health and Welfare Benefits Plan for Retired Field Associates

Plan Number:
530
537
536
538

Plan Year:
The calendar year

Plan Sponsor:
The Guardian Life Insurance Company of America
10 Hudson Yards
New York, New York 10001
(212) 598-8000

Plan Sponsor's Internal Revenue Identification Number:
13-5123390

Plan Administrator:
The Guardian Life Insurance Company of America
Attn: Benefits Appeal Committee
10 Hudson Yards
New York, NY 10001

You can also contact MyHR:
MyHR, Guardian Human Resources
Email: MyHR@glic.com
Phone (877) 870-6947

Third Party Administrator:
The Plan Administrator has delegated the day-to-day administration and recordkeeping to Via Benefits, Inc.

Via Benefits, Inc.
10975 South Sterling View Drive Suite A-1 South
Jordan, UT 84905
(888) 427-4164
https://medicare.Via Benefits.com/glic

Claims Administrator: Via Benefits
P.O. Box 3039
Omaha, NE 68103-3039
Fax: (402) 231-4310

Type of Administration:

The Plan is self-funded. The Plan Administrator and/or its duly authorized designee(s) has the exclusive right, power, and authority, in its sole and absolute discretion, to administer, apply, construe and interpret the provisions of the Plan, including this SPD, and to decide all matters arising in connection with the operation or administration of the Plan. The Plan Administrator has delegated to the Claims Administrator the discretion to determine Benefits under the Plan and to construe the terms of the Plan with respect to Benefits. All determinations, interpretations or constructions by the Claims Administrator, and the Plan Administrator and/or any duly authorized designees, will be final and binding on all parties.

Funding:

The Plan is funded with employer contributions. Benefits are paid from the Company's general assets. There is no trust or other fund from which benefits are paid.

Agent for Service of Legal Process:

Executive Vice President, General Counsel and Corporate Secretary
The Guardian Life Insurance Company of America
10 Hudson Yards
New York, New York 10001

Service may also be made upon the Plan Administrator.

Plan Amendment & Termination

Although the Company intends to continue the Plan indefinitely, Guardian has the right at any time to discontinue its contributions to the Plan and/or to amend, modify or terminate the Plan or any provision under the Plan and to change or discontinue the type and amount of benefit and eligibility rules at any time for any

reason. If the Plan is terminated, you will have no coverage in the event you or your dependents incur any expenses otherwise covered by the Plan except as provided under the provisions of the Plan for extended benefits and continuation of coverage.

The Plan is not intended to be and may not be construed as forming a contract of employment nor a guarantee of continued employment with Guardian.