Equitable's Employee Benefits Group
8501 IBM Dr., Ste. 150-B
Charlotte, NC 28262

Toppan Interamerica, Inc.
1131 Highway 155 S
Mcdonough, GA 30253

WELCOME PACKET

important information about your benefits

EQUITABLE

Equitable Financial Life Insurance Company of America

2999 North 44th Street, Suite 250
Phoenix, Arizona 85018
(800) 777-6510
https://equitable.com/customer-service/life-insurance

GROUP ACCIDENT INSURANCE POLICY

Non-Participating

Policy Number:	017246
Policy Effective Date:	January 01, 2024
Policyholder:	Toppan Interamerica, Inc.
Issue State:	Georgia

READ YOUR POLICY CAREFULLY.

We agree to provide the rights and benefits of this Policy according to its conditions and provisions.

This Policy is issued to the Policyholder shown above in consideration of the Policyholder's application and payment of premiums. The Policyholder must pay premiums to Equitable Financial Life Insurance Company of America at Our home office or at another location chosen by Us. The first premium is due on the effective date. Subsequent premiums are due on the first day of each month ("Premium Due Date").

This Policy is delivered in and governed by the laws of the Issue State shown above unless otherwise preempted by the federal Employee Retirement Income Security Act (“ERISA”), where applicable.

Signed at Phoenix, Arizona.

Mark Pearson, Chairman of the Board and Chief Executive Officer

Jose Ramon Gonzalez,
Senior Executive Vice President, Secretary and General Counsel

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1. ENTIRE CONTRACT

The following are made part of this Policy:

- any Policy provisions, amendments, endorsements or riders;
- the application of the Policyholder;
- any certificate of coverage and any amendments, endorsements or riders; and
- for Contributory insurance, the Insured's Signed enrollment forms.

This Policy is the entire contract.

2. PREMIUMS

Payment of Premiums

The premiums due under this Policy on each Premium Due Date are based upon the premium rates in effect for the coverage provided. The premiums due are the sum of the monthly premiums for all Insureds.

Premiums payable to Us will be paid in United States dollars on the Premium Due Date.

Premium Rates

We determine initial or any subsequent monthly premium rates on the basis of the insurance being provided. After the initial monthly premium rates have been in effect for 36 months from the Policy Effective Date, We have the right to recalculate any premium rate. However, We have the right to recalculate the initial or any subsequent monthly premium rate when any of the following occurs:

- a change occurs in the Policy plan design;
- a new division or subsidiary or affiliated Company is added to or deleted from this Policy;
- the number of Employees covered under this Policy changes by more than 25% from the number on the Policy Effective Date or any anniversary of the Policy Effective Date thereafter; or
- one or more classes are added to or deleted from this Policy.

We will provide Written notification of any increases in the premium rates to the Policyholder at least 60 days prior to the effective date of the increase. Premium rate increases may take effect on an earlier date when both the Policyholder and We agree.

Grace Period

The grace period means the 60-day period of time following the Premium Due Date during which premium payment may be made. If the Policyholder does not pay the required premium before the end of the grace period, this Policy will automatically cease at the end of the grace period. If the Policyholder gives Us advance Written notice that this Policy will cease on an earlier date, then this Policy will cease on that date; but no such termination will take effect during any period for which the required premium has been paid to Us.

The Policyholder is responsible for the premium that is due during that part of the grace period that the insurance remains in force or the entire grace period if Written notice is not received prior to the end of the grace period.

3. TERMINATION

Amending or Terminating the Policy

This Policy can be cancelled:

- by Equitable Financial Life Insurance Company of America; or
- by the Policyholder.

We may amend or terminate this Policy if:

- the Policyholder fails to pay any portion of the premium within the grace period;
- the termination date requested by the Policyholder is in writing but no earlier than the last date for which premium has been paid;
- We specify the date in advance by Written notice to the Policyholder. We may give this notice at any time, but not less than 60 days in advance of such date. Occasions on which We may give this notice include but are not limited to the following:

    - when less than 10% of all Eligible Employees are insured for Contributory insurance;
    - at any time when the Policyholder fails:
        -- to furnish promptly any information that We may reasonably require; or
        -- to perform any other obligations pertaining to this Policy;
    - at any time when the Policyholder ceases to qualify for insurance coverage under this Policy in accordance with Our then current standard underwriting rules and practices.

- any date the Policyholder does not have at least 5 Employees insured under this Policy; or
- any date the Policyholder is not actively engaged in the business that We agreed to insure.
- We determine that there is 25% change in the number of lives, or a significant change in the occupation or age of the eligible classes as a result of a corporate transaction such as a merger, divestiture, acquisition, sale, or reorganization of the Policyholder and/or its Employees.

We reserve the right to review and terminate all classes under the Policy if any class ceases to be covered.

We have the right to terminate this Policy on the first day of any month after We give the Policyholder at least 60 days notice of Our intent to terminate.

Once this Policy terminates, the insurance it provides will end automatically.

4. GENERAL PROVISIONS

Agency
For all purposes of this Policy, the Policyholder acts on its own behalf or as an agent of the Employee. Under no circumstances will the Policyholder be deemed an agent of Equitable Financial Life Insurance Company of America.

Certificate of Insurance
We will provide the Policyholder with a certificate of insurance to be given to each Employee. The certificate will explain the important features of this Policy and to whom We will pay benefits.

Incontestability
The validity of this Policy shall not be contested, except for nonpayment of premium or fraud, after it has been in force for two years from the Policy Effective Date.

Information We May Need
The Policyholder must give Us, on Our forms, any information that We may need to compute premiums, provide insurance coverage and keep records. Such information as to any individual will be binding upon that individual, and We will rely on it as such. At all reasonable times while this Policy is in force and until We resolve all rights and duties under it, We can inspect any of the Policyholder's records that would, in Our judgment, have any effect on the insurance provided under this Policy.

Insurer's Authority
Equitable Financial Life Insurance Company of America has discretionary authority to make all final determinations regarding claims for benefits under this Policy. This discretionary authority includes, but is not limited to, the right to determine eligibility for benefits and the amount of any benefit due and to construe the terms of the Policy.

This does not prohibit an insured from seeking legal redress.

Policy Changes
This Policy may be changed in whole or in part. Only an officer of Equitable Financial Life Insurance Company of America is authorized to make a change which must be endorsed on or attached to this Policy.

Any other person, including an agent, may not change this Policy or waive any part of it.

Statements
All statements made in any Application are considered representations and not warranties. No representation by the Policyholder in applying for this Policy will render it void unless the representation is contained in the Application.

No representation by any Employee in applying for insurance under this Policy, will be used to reduce or deny a claim unless a copy of the Employee's Written application for insurance is or has been given to the Employee or the Employee's beneficiary, if any.

Time Periods
For the purpose of effective dates and termination date under this Policy, all days begin at 12:00 midnight and end at 11:59:59 PM at the Policyholder's location.

Workers' Compensation
This Policy is not in lieu of, and does not affect, any requirement for coverage by Workers' Compensation Insurance.

Attached are the certificates for the policies in the state of Georgia

Equitable Financial Life Insurance Company of America

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https://equitable.com/customer-service/life-insurance

GROUP ACCIDENT CERTIFICATE OF INSURANCE

Non-Participating

Equitable Financial Life Insurance Company of America certifies that it has issued and delivered a Group Insurance Policy to the Policyholder shown below insuring the classes of Employees of the Employer shown below.

Policy Number:	017246
Policy Effective Date:	January 01, 2024
Policyholder:	Toppan Interamerica, Inc.
Issue State:	Georgia

NOTICE TO BUYER. THIS IS A LIMITED BENEFIT CERTIFICATE. THIS CERTIFICATE PROVIDES ACCIDENT ONLY COVERAGE AND DOES NOT PAY BENEFITS FOR LOSS FROM SICKNESS.

PLEASE READ YOUR CERTIFICATE CAREFULLY.

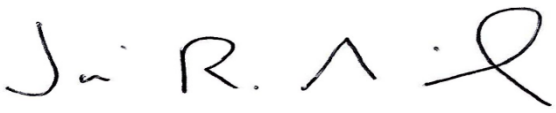
NOTICE: The laws of the State of Georgia prohibit insurers from unfairly discriminating against any person based upon his or her status as a victim of family violence.

This Certificate contains the terms of the Group Insurance Policy that affect Your insurance. This Certificate is part of the Group Insurance Policy.

This Certificate is governed by the laws of the Issue State shown above unless preempted by the federal Employee Retirement Income Security Act.

Signed at Phoenix, Arizona.

Mark Pearson, Chairman of the Board and Chief Executive Officer



Jose Ramon Gonzalez,
Senior Executive Vice President, Secretary and General Counsel

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1. BENEFIT HIGHLIGHTS

Eligible Classes: All Active Full Time Employees working at least 30 hours per week.

Eligibility Waiting Period: If You are working for the Policyholder on the effective date - the waiting period is 0 continuous day(s).
If You are working for the Policyholder after the effective date - the waiting period is the first of the month following 30 continuous day(s).

Classification: Class 1

Benefit Plan: Accident Plan

If You enrolled for this option, accident insurance for all Insureds You elect to enroll will be based on the following plan design You elected to enroll in:

Benefit Coverage Type: 24-Hour Coverage

Covered Benefits

Unless otherwise specified, the following benefits will be payable only once for each Covered Accident as applicable. Refer to the Covered Accident Benefits section of this Certificate for additional benefit details.

Life and Dismemberment Losses	Amount of Benefit		
	Employee	Spouse or Domestic Partner	Child
Accidental Death	$50,000	$50,000	$25,000
Accidental Death Common Carrier	$100,000	$100,000	$50,000
Catastrophic Loss: Loss of Arm or Loss of Hand—both arms or both hands, Loss of Leg or Loss of Foot—both legs or both feet, Loss of Hand and Loss of Foot or Loss of Arm and Loss of Leg—one hand and one foot or one arm and one leg, Loss of an Ear—both ears, irrecoverable Loss of Hearing—both ears, Loss of an Eye—both eyes, irrecoverable Loss of Sight—both eyes, irrecoverable Loss of Speech or ability to speak, or any combination equaling two or more losses from: Loss of Arm, Loss of Hand, Loss of Leg, Loss of Foot, Loss of an Ear or Loss of an Eye	$15,000	$15,000	$7,500
Accidental Dismemberment:			
Loss of Hand--one hand, Loss of Foot—one foot, Loss of Leg—one leg or Loss of Arm—one arm	$7,500	$7,500	$3,750
Loss of a Finger or Loss of a Toe—two or more fingers or toes	$1,500	$1,500	$750
Loss of a Finger or Loss of a Toe--one	$750	$750	$375

finger or one toe			
Loss of Hearing or Loss of an Ear—one ear	$7,500	$7,500	$3,750
Loss of Sight or Loss of an Eye--one eye	$7,500	$7,500	$3,750
Dislocations Open Reduction			
Hip	$6,000	$6,000	$6,000
Knee, ankle or bones of the foot	$2,000	$2,000	$2,000
Elbow or wrist	$800	$800	$800
Shoulder	$1,000	$1,000	$1,000
Collarbone or bones of the hand	$1,600	$1,600	$1,600
Finger(s) or toe(s)	$200	$200	$200
Lower jaw	$800	$800	$800
Dislocations Closed Reduction			
Hip	$3,000	$3,000	$3,000
Knee, ankle or bones of the foot	$1,000	$1,000	$1,000
Elbow or wrist	$400	$400	$400
Shoulder	$500	$500	$500
Collarbone or bones of the hand	$800	$800	$800
Finger(s) or toe(s)	$100	$100	$100
Lower jaw	$400	$400	$400
Incomplete Dislocation or a Dislocation that requires reduction without Anesthesia	25% of the applicable Closed Reduction		
Fractures Open Reduction			
Hip or thigh	$4,000	$4,000	$4,000
Skull-depressed	$8,000	$8,000	$8,000
Skull-simple	$3,000	$3,000	$3,000
Vertebral processes	$700	$700	$700
Bones of face or nose	$700	$700	$700
Leg (tibia or fibula)	$2,000	$2,000	$2,000
Vertebrae (body of) or sternum	$1,600	$1,600	$1,600
Pelvis (excluding coccyx)	$1,600	$1,600	$1,600
Upper jaw or upper arm	$750	$750	$750
Lower jaw	$650	$650	$650
Knee cap	$650	$650	$650
Ankle	$650	$650	$650
Foot	$650	$650	$650
Collarbone	$650	$650	$650
Shoulder	$650	$650	$650
Forearm	$650	$650	$650
Hand	$650	$650	$650
Wrist	$650	$650	$650
Elbow	$650	$650	$650
Heel	$650	$650	$650
Rib, finger, toe or coccyx	$350	$350	$350
Multiple ribs	$1,000	$1,000	$1,000
Fractures Closed Reduction			
Hip or thigh	$2,000	$2,000	$2,000
Skull-depressed	$4,000	$4,000	$4,000
Skull-simple	$1,500	$1,500	$1,500
Vertebral processes	$350	$350	$350

1. BENEFIT HIGHLIGHTS

Bones of face or nose	$350	$350	$350
Leg (tibia or fibula)	$1,000	$1,000	$1,000
Vertebrae (body of) or sternum	$800	$800	$800
Pelvis (excluding coccyx)	$800	$800	$800
Upper jaw or upper arm	$375	$375	$375
Lower jaw	$325	$325	$325
Knee cap	$325	$325	$325
Ankle	$325	$325	$325
Foot	$325	$325	$325
Collarbone	$325	$325	$325
Shoulder	$325	$325	$325
Forearm	$325	$325	$325
Hand	$325	$325	$325
Wrist	$325	$325	$325
Elbow	$325	$325	$325
Heel	$325	$325	$325
Rib, finger, toe or coccyx	$175	$175	$175
Multiple ribs	$500	$500	$500

Chip Fractures and other Fractures not reduced by Open or Closed Reduction	25% of the applicable Closed Reduction

Additional Injuries			
Eye Injury	$250	$250	$250
Gunshot wound	$500	$500	$500
Brain Injury	$150	$150	$150
Paralysis - monoplegia	$1,000	$1,000	$1,000
Paralysis - diplegia	$5,000	$5,000	$5,000
Paralysis - hemiplegia	$5,000	$5,000	$5,000
Paralysis - paraplegia	$25,000	$25,000	$25,000
Paralysis - quadriplegia	$50,000	$50,000	$50,000
Coma	$10,000	$10,000	$10,000
Concussion	$200	$200	$200
Concussion Lifetime Maximum Benefit	$2,000	$2,000	$2,000
Lacerations			
Laceration(s) with no sutures and treated by Physician	$35	$35	$35
Single Laceration under 5 centimeters with sutures	$65	$65	$65
Lacerations 5 – 15 centimeters with sutures (total of all Lacerations)	$250	$250	$250
Lacerations greater than 15 centimeters with sutures (total of all Lacerations)	$500	$500	$500
Burns			
21 – 40 square centimeters 2nd degree	$400	$400	$400
21 – 40 square centimeters 3rd degree	$1,000	$1,000	$1,000
41 – 65 square centimeters 2nd degree	$800	$800	$800
41 – 65 square centimeters 3rd degree	$2,000	$2,000	$2,000
66 – 160 square centimeters 2nd degree	$1,200	$1,200	$1,200
66 – 160 square centimeters 3rd degree	$6,000	$6,000	$6,000
161 – 225 square centimeters 2nd degree	$1,600	$1,600	$1,600
161 – 225 square centimeters 3rd degree	$14,000	$14,000	$14,000
More than 225 square centimeters 2nd degree	$2,000	$2,000	$2,000
More than 225 square centimeters 3rd degree	$20,000	$20,000	$20,000

Skin Graft	50% of the applicable Burn Benefit

1. BENEFIT HIGHLIGHTS

Medical Services			
Diagnostic Exam (1 time per Benefit Year):			
Arteriogram, angiogram, CT, CAT, EKG, EEG, or MRI	$200	$200	$200
X-ray (once per Covered Accident)	$30	$30	$30
Accident Emergency Treatment (non- Emergency Room or non-Urgent Care Facility) (1 time per Covered Accident)	$100	$100	$100
Physician's follow-up Treatment office visit (per visit, up to 10 times per Covered Accident)	$25	$25	$25
Physical and Occupational Therapy (per visit up to (10 times per Covered Accident)	$35	$35	$35
Medical Devices	$125	$125	$125
Epidural Pain Management (up to 2 times per Covered Accident)	$50	$50	$50
Prescription drug	$25	$25	$25
Prosthesis (one)	$750	$750	$750
Prosthesis (two)	$1,500	$1,500	$1,500
Anesthesia	$50	$50	$50
Blood, plasma or platelet transfusion	$200	$200	$200
Hospital			
Hospital admission (once per Benefit Year)	$1,500	$1,500	$1,500
Hospital Confinement (per day up to 30 days per Covered Accident)	$400	$400	$400
Intensive Care Unit admission (once per Benefit Year; payable instead of Hospital admission benefit if Confined immediately to ICU)	$3,000	$3,000	$3,000
Intensive Care Unit Confinement (per day up to 15 days; payable in addition to any Hospital Confinement benefit)	$800	$800	$800
Ambulance (Ground)	$600	$600	$600
Ambulance (Air)	$4,000	$4,000	$4,000
Emergency Room admission or Urgent Care Facility	$150	$150	$150
Family lodging Maximum Lodging Night Stays: 1 benefit per day, 30 days per Benefit Year	$100	$100	$100
Transportation (100 or more miles up to 3 times per Covered Accident)	$500	$500	$500
Rehabilitation Unit (per day up to 30 days per Covered Accident)	$100	$100	$100
Surgery			
Miscellaneous Surgery requiring general Anesthesia that is not otherwise listed (once per 24-hour period even though multiple surgical procedures may be performed)	$300	$300	$300
Open Surgery	$1,250	$1,250	$1,250
Exploratory Surgery or debridement	$250	$250	$250
Laparoscopic Surgery or hernia repair	$300	$300	$300

1. BENEFIT HIGHLIGHTS

Tendon/Ligament/Rotator cuff tear	$750	$750	$750
Torn Knee Cartilage	$750	$750	$750
Ruptured / herniated disc	$750	$750	$750
Emergency Dental			
Emergency dental extraction	$65	$65	$65
Emergency dental crown	$200	$200	$200
Wellness Screening Benefit			
(once per Benefit Year)	$100	$100	$100

Contributions: The cost of Your insurance is paid entirely by You. This is Your Contributory Insurance.

2. DEFINITIONS

24-Hour Coverage means coverage is provided under the Policy for Injuries resulting from Covered Accidents incurred on and off the job.

Accident or Accidental means an external event that an average person would consider sudden and unforeseeable and:

- that results, directly and independently of all other causes;
- is independent of any illness, disease, or other bodily malfunction; and
- occurs while coverage is in force under the Policy for the Insured.

Accident or Accidental does not mean an unintentional accident caused by or during medical Treatment or surgery for Sickness or Injury.

Actively at Work or Active Work means that the Employee is performing all of the usual and customary duties of his or her job. This may be done at the Policyholder's place of business, an alternate place approved by the Policyholder, or a place to which the Policyholder's business requires the Employee to travel. An Employee will be deemed to be Actively at Work on weekends or Policyholder approved vacations, holidays or business closures if the Employee was Actively at Work on the last scheduled work day preceding such time off, and You are neither Confined nor disabled due to an Injury or Sickness.

Anesthesia means a general or spinal anesthetic. It does not include injection of local anesthetic or peripheral nerve blocks.

Benefit Year means a calendar year beginning on January 1 of any year and ending on December 31 of that year.

Chip Fracture means a bone Fracture diagnosed by a Physician interpreting an x-ray or other imaging test showing that part of the bone close to a joint has broken-off at a ligament attachment point.

Civil Union means a state sanctioned and/or recognized union of two eligible individuals of the same or Opposite sex. Parties to a Civil Union will receive the same benefits and protections under this Certificate and be subject to the same responsibilities as Spouse or Domestic Partners in a marriage, except where prohibited by law.

Coma means that while insured under the Policy, an Insured has been diagnosed by a Physician with a condition from which the Insured cannot be aroused and which requires an external life support system, both of which have persisted continuously for at least 168 hours. Coma does not include: (1) a medically induced coma; or (2) a coma that results from any alcohol or drug use.

Common Carrier means commercial airplanes, trains, buses, trolleys, subways, ferries and boats that operate on a regularly scheduled basis between predetermined points or cities. Privately chartered vehicles and taxis are not Common Carriers.

Confined or Confinement means on the advice of a Physician, the assignment of a person to a bed as a resident Inpatient in a Hospital for not less than 24 continuous hours. There must be a charge for room and board.

Contributory means You pay all of the premium.

Covered Accident means an Accident that:

- occurs while the Policy and the Insured's coverage is in force;
- occurs on or after the effective date of insurance; and
- is not excluded by the Policy or applicable riders or endorsements attached to it.

Dependent means Your insured Spouse or Domestic Partner and Dependent Child(ren).

2. DEFINITIONS

Dependent Child(ren) means an unmarried individual who is under age 26 and is:

- The Employee's biological child from live birth to under age 26;
- The Employee's legally adopted child including any child placed with You for adoption;
- The Employee's foster child from the time he or she is placed in the home by a licensed agency;
- The Employee's stepchild;
- The child of the Employee's Civil Union partner;
- The child of the Employee's Domestic Partner's child; or
- A child under a court appointed guardianship.

In addition to the Children described above, any other child over whom the Employee has legal custody or legal guardianship or with whom the Employee has a legal relationship or a blood relationship may be covered to the same extent as a Child under this Certificate, provided the child depends on the Employee for most of his or her support and maintenance and resides in the Employee's household. A Child also includes any child required to be recognized as a Child under the laws of the state where the Policy and/or Certificate is delivered. We reserve the right to require that the Employee provide proof of legal custody, legal guardianship, support and maintenance, residency in the Employee's household, blood relationship or legal relationship.

A Dependent Child also includes any child, regardless of age, who is incapable of self-sustaining employment by reason of mental or physical disability and became so incapacitated prior to age 26. Proof of disability must be sent to Us within 31 days after the child attains age 26, and at reasonable intervals at Our request, but not more often than annually after the two-year period following the child's 26th birthday.

Any coverage provided to Dependent Children under this Certificate shall continue after age 26 while such child remains incapable of self-sustaining employment because of the disability and otherwise continues to meet the definition of Dependent Child.

No person may be considered to be a Dependent Child of more than one Employee.

Dependent Child does not include:

- any person who is insured as an Employee;
- Your married child whose Employer sponsors Accident Insurance and/or a medical plan ; or
- any person residing outside the United States. This exclusion does not apply to a Dependent Child who:
- resides with You while You are on a temporary work assignment outside the United States; or
- is a Full-time Student attending school outside of the United States.

Dislocation means a completely separated joint.

- Open Reduction of Dislocation means a surgical procedure.
- Closed Reduction of Dislocation means a non-surgical procedure.

The joint Dislocations covered under the Policy are shown in the Benefit Highlights.

Domestic Partner means an individual who is age 18 or older who is the same or opposite sex as the Employee and has established a domestic partnership with the Employee by filing an affidavit of domestic partnership or obtaining a Certificate of domestic partnership from his or her local registrar.

Eligibility Waiting Period means the length of time You must be a member in an Eligible Class before You can apply for insurance. The Eligibility Waiting Period is shown in the Benefit Highlights. Any period of time prior to the Policy Effective Date You were Actively at Work for the Employer as a full-time Employee will count towards completion of the Eligibility Waiting Period.

Emergency Room means a specified area within a Hospital that is designated for the emergency care of Accidental injuries. This area must:

- be staffed and equipped to handle trauma;

- be supervised and provide Treatment by Physicians; and
- provide 24-hours a day service by registered graduate nurses (RNs).

Employee means for eligibility purposes a person who is an Employee of the Employer in one of the "Classes of Eligible Employees".

Employer means the Employer named on the cover page of this Certificate and includes any subsidiary or affiliated company named in the application.

Enrollment Period means the period of time each year not to exceed 30 days during which eligible Employee may elect, or change, or cancel insurance under the Policy. The Enrollment Period cannot exceed 30 days or occur more than once in any 12-month period unless We agree in Writing.

Exploratory Surgery means an operation performed for diagnostic purposes.

Family Member means: (a) Your Spouse or Domestic Partner and (b) the following relatives of You or Your Spouse or Domestic Partner: (1) parent; (2) grandparent; (3) child; (4) grandchild; (5) brother; (6) sister; (7) aunt; (8) uncle; (9) first cousin; (10) nephew or niece. This includes adopted, in-law and step-relatives.

Family Status Change means one of the following events:
- Your marriage, or Civil Union or acquiring a Domestic Partner;
- Your divorce or dissolution of a Civil Union or termination of a Domestic Partnership;
- the birth of Your child;
- the adoption of a child by You;
- the placement of a child with You, pending adoption;
- the death of Your Spouse or Domestic Partner or child;
- the commencement or termination of employment of Your Spouse or Domestic Partner or Dependent Child;
- the change from part-time to full-time employment by You or Your Spouse or Domestic Partner or Dependent Child;
- the change from full-time to part-time employment by You or Your Spouse or Domestic Partner or Dependent Child; or
- the taking of an unpaid Leave of Absence by You or Your Spouse or Domestic Partner.

Fracture means a broken bone which can be seen by x-ray.
- Open Reduction of Fracture means a surgical procedure.
- Closed Reduction of Fracture means a non-surgical procedure.

The bone Fractures covered under the Policy are shown in the Benefit Highlights.

Furlough means that for a period of time, You have been instructed by Your Employer in Writing to temporarily not report to work and You are not receiving income from Your Employer. Your normal vacation time is not considered a Furlough.

Hospital means a facility licensed in the applicable jurisdiction that provides medical care and Treatment to sick and injured persons on an Inpatient basis with 24-hour nursing service by or under the supervision of a Physician. Hospital does not include: (1) a rest home; (2) a skilled nursing facility; (3) an extended care facility; (4) a place of convalescence; (5) rehabilitative care; (6) custodial care; or (7) a place primarily for the Treatment of drug addiction or alcoholism.

Hospital Intensive Care Unit (ICU) means:
- a specifically designated part of a Hospital called an intensive care unit that provides the highest level of medical care and is restricted to patients who are critically ill or injured and who require intensive comprehensive observation and care, including a neonatal intensive care unit specializing in the care of ill or premature newborn infants.;

- separate and apart from the surgical recovery room and from rooms, beds and wards customarily used for patient Confinement;
- permanently equipped with special lifesaving equipment for the care of the critically ill or injured;
- under constant and continuous observation by a specially trained nursing staff assigned exclusively to the intensive care unit on a 24-hour basis; and
- has an assigned Physician on a full-time basis.

A hospital intensive care unit is not any of the following step-down units:
- a progressive care unit;
- an intermediate care unit;
- a private monitored room;
- sub-acute intensive care unit; or
- an Observation Unit.

Incomplete Dislocation means a Dislocation in which the joint is not completely separated.

Injury means Accidental body injury that is the direct result of a Covered Accident. Injuries must be independent of Sickness, disease, bodily infirmity, and other causes.

Inpatient or Inpatient Treatment means the Insured who receives Treatment as a resident patient using and being charged for the room and board facilities of a Hospital.

Insured means any person covered under the Policy.

Intoxicated or Intoxication means at or above the minimum blood alcohol level for which the Insured would be considered operating a motorized vehicle under the influence of alcohol in the jurisdiction where the Accident or Injury occurred.

For the purposes of this definition, “operating” includes allowing the engine to run even if not seated in the vehicle and "motorized vehicle" includes, but is not limited to, automobiles, motorcycles, boats and snowmobiles.

Laceration means a cut.

Laparoscopic Surgery means the use of a laparoscope to perform surgical procedures inside the body.

Layoff means that You are temporarily not Actively at Work for a period of time Your Employer agreed to in Writing. Your normal vacation time is not considered a temporary Layoff.

Leave of Absence means that You are temporarily not Actively at Work for a period of time Your Employer agreed to in Writing. Your normal vacation time is not considered a temporary Leave of Absence.

Loss of Arm, Ear, Eye, Finger, Foot, Hand, Leg, Toe, Hearing, Sight or Speech
- Loss of Arm means that the arm is completely cut off at or above the elbow.
- Loss of an Ear means the irreversible loss of at least 75% of the visible part of the ear due to Injuries received in a Covered Accident.
- Loss of an Eye means the permanent removal of the eyeball.
- Loss of a Finger means that the finger is completely cut off at the joint proximate to the first interphalangeal joint where it is attached to the hand.
- Loss of Foot means the loss of at least four toes of the same foot or that the foot is completely cut off at or above the ankle joint or the use of the foot is permanently lost.
- Loss of Hand means the loss of at least two fingers and a thumb of the same hand or the permanent and irrecoverable loss of use of the hand.
- Loss of Leg means that the leg is completely cut off at or above the knee.

2. DEFINITIONS

- Loss of a Toe means that the toe is completely cut off at the joint proximate to the first interphalangeal joint where it is attached to the foot
- Loss of Hearing means that the Insured has been initially diagnosed with a condition that results in the total and irreversible loss of hearing in both ears to a point that an Insured is unable to hear sounds at or below 70 decibels. The diagnosis must be confirmed using audiometric testing. Loss of Hearing does not include loss of hearing that can be corrected to above 70 decibels by the use of any hearing aid or device
- Loss of Sight of an eye means best corrected vision of the eye is 20/200 or worse, or a visual field of 20 degrees or less. The degree of visual loss must be permanent with no realistic expectation of improvement.
- Loss of Speech means the Insured is initially diagnosed with total, permanent, and irreversible loss of the ability to speak. The loss must have continued without interruption for a period of at least 30 day. Loss of Speech does not include any loss that could be restored, totally or partially, by use of a device or implant. Benefits for Loss of Speech are not payable if the loss of speech is due to a stroke.

Observation Unit means a specified area within a Hospital, apart from the Emergency Room, where a patient can be monitored following Outpatient surgery or Treatment in the Emergency Room by a Physician and which:

- is under the direct supervision of a Physician or registered nurse;
- is staffed by nurses assigned specifically to that unit; and
- provides care seven days per week, 24-hours per day.

Open Surgery means surgery involving direct visualization of the impacted area. Open Surgery requires Anesthesia.

Outpatient or Outpatient Treatment means Treatment received by the Insured at a Hospital or licensed ambulatory care facility and there is no charge for room and board.

Paralysis means the Insured has been diagnosed by a Physician with total and irreversible loss of voluntary movement in muscles due to Injury of associated nerves that is consecutively present for 90 days, but shall not include any paralysis caused by a stroke.

- Monoplegia is the complete and irreversible Paralysis of one arm or one leg.
- Hemiplegia is the complete and irreversible Paralysis of one arm and one leg on the same side.
- Diplegia is the complete and irreversible Paralysis of both arms.
- Paraplegia is the complete and irreversible Paralysis of both legs.
- Quadriplegia is the complete and irreversible Paralysis of both arms and both legs.

Participation in a Riot, Rebellion or Insurrection, the words "Participation" and "Riot" in this phrase mean:
Participation includes promoting, inciting, conspiring to promote or incite, aiding, abetting, and all forms of taking part in, but will not include actions taken in defense of public or private property, or actions taken in Your own defense, if such actions of defense are not taken against persons seeking to maintain or restore law and order including but not limited to police officers and firefighters.

Riot includes all forms of public violence, disorder, or disturbance of the public peace, by three or more persons assembled together, whether or not acting with a common intent and whether or not damage to person or property or unlawful act or acts is the intent or the consequence of such disorder.

Physical or Occupational Therapist means a person who:

- is licensed by the state or province to practice physical or occupational therapy;
- performs services which are allowed by their license; and
- performs services for which benefits are provided under the Policy; and
- practices according to the Code of Ethics of the American Physical Therapy Association.

The Physical or Occupational Therapist cannot be You, a business associate, or any Family Member.

2. DEFINITIONS

Physician means a person who is operating within the scope of his or her license and is either:

- licensed in the United States as a medical doctor and authorized to practice medicine and prescribe and administer drugs or to perform surgery; or
- any other duly licensed medical practitioner who is deemed by applicable state or provincial law to have the same authority as a legally qualified medical doctor.

The Physician cannot be You, a business associate, or any Family Member.

Policy means the group insurance policy under which this Certificate is issued.

Policyholder means the entity to which the Policy is issued.

Proof means any medical, financial or other information that We require to make a claim determination.

Prosthesis means the replacement of a missing part by an artificial substitute, such as an artificial extremity, an artificial organ or part but does not include cosmetic prosthesis.

Rehabilitation Unit means an appropriately licensed facility that provides rehabilitation care services on an Inpatient basis. Rehabilitation care services consist of the combined use of medical, social, educational, and vocational services to enable patients disabled by Accidental Injury to achieve the highest possible functional ability. Services are provided by or under the supervision of an organized staff of Physicians. The rehabilitation unit may be part of a Hospital or a freestanding facility.
A rehabilitation unit is not:

- a nursing home;
- an extended care facility;
- a skilled nursing facility;
- a rest home or home for the aged;
- a hospice care facility;
- a place for alcoholics or drug addicts; or
- an assisted living facility.

Sickness means disease or illness including diseases or infections resulting from bug bites, stings or infestations by microorganisms, mental illness, drug illness, abuse or addiction, and alcohol illness, abuse or addiction, or pregnancy.

Signed means any symbol or method executed or adopted by a person with the present intention to authenticate a record, and which is on or transmitted by paper, electronic or telephonic media, and which is consistent with applicable law.

Spouse means the person to whom the Insured is legally married. Any person insured as an Employee under the group Policy may not also be insured as a Spouse. For the purposes of this definition the term Spouse may also include a Civil Union contract.

Treatment means a Physician's consultation, care or services; diagnostic measures; or the prescription, refill or taking of prescribed drugs or medicines.

Urgent Care Facility means a facility or place other than a Physician’s office, Hospital, or an Emergency Room that provides emergency or urgent care and Treatment to Injured people. Such facility may be a 24-hour clinic.

We, Us, Our means Equitable Financial Life Insurance Company of America or an affiliate company.

Written or Writing means a record which is on or transmitted by paper, electronic or telephonic media, and which is consistent with applicable law.

2. DEFINITIONS

You, Your means an Employee who is eligible for insurance under the Policy.

3. ELIGIBILITY, EFFECTIVE DATES AND TERMINATION OF EMPLOYEE INSURANCE

When are You eligible for Employee Accident Insurance?

You are initially eligible for Employee Accident Insurance on the latest of:

- the policy effective date;
- the first of the month following the date Your Eligibility Waiting Period ends; or
- the date You first are Actively at Work in an Eligible Class.

You are also eligible for Employee Accident Insurance during any Enrollment Period or as a result of a Family Status Change, provided You are Actively at Work and in an Eligible Class.

When must You enroll for Employee Accident Insurance?

For Contributory Employee Accident Insurance
You must enroll within 31 days of the date You are initially eligible for Employee Accident Insurance or within 31 days of the date of a Family Status Change or during any Enrollment Period.

If You do not enroll for insurance during Your initial Enrollment Period, You will not be insured for any Contributory Employee Accident Insurance.

If You refuse Your insurance and do not enroll when You are eligible, then You will not be allowed to enroll until the next Enrollment Period.

For Contributory Employee Accident Insurance
Employee Accident Insurance starts on the latest of the date:

- You are eligible;
- You enroll; and
- You agree to make any required contribution toward the cost of insurance;

if You are Actively at Work on that date.

If You are not Actively at Work on that date, Your insurance will not start until You resume being Actively at Work.

When can You make changes in Employee Accident Insurance?

You may request a change in Your Employee Accident Insurance benefit elections during any Enrollment Period while the Policy is in force.

You may also request a change in Employee Accident Insurance at any time due to a Family Status Change. Such request must be made within 31 days of the date the Family Status Change occurred.

When will Employee Accident Insurance coverage change?

Your Employee Accident Insurance coverage under the Policy may change if:

- You enroll for a different coverage option;
- You transfer to another class under the Policy; or
- there is a Policy change.

When does a change in Employee Accident Insurance start?

If You are Actively at Work, any increase in Employee Accident Insurance or benefits, for reasons other than a Family Status Change, will start the latest of:

- the first of the month following the date of change, when You apply for a different coverage option and You agree to make any required contribution toward the cost of insurance;
- the first of the month following the date of change, when You transfer to a different class of eligible
- Employees;
- the date specified during the Enrollment Period;
- the date of the Policy change.

3. ELIGIBILITY, EFFECTIVE DATES AND TERMINATION OF EMPLOYEE INSURANCE

If You are not Actively at Work on that date, any increase in Employee Accident Insurance will not start until You resume being Actively at Work.

Whether or not You are Actively at Work, any reduction in Employee Accident Insurance or benefits for reasons other than a Family Status Change will start immediately on:

- the first of the month following the date of change, when You apply for a different coverage option;
- the first of the month following the date of change, when You transfer to a different class of eligible Employees;
- the date specified during the Enrollment Period;
- the date of the Policy change.

If You are Actively at Work, any increase in Employee Accident Insurance or benefits due to a Family Status Change will start on the later of:

- the first of the month following the date You apply for such change in Employee Accident Insurance and You agree to make any required contribution toward the cost of insurance; or
- the date of Your Family Status Change.

If You are not Actively at Work on that date, any increase due to a Family Status Change in Employee Accident Insurance or benefits will not start until You resume being Actively at Work.

Whether or not You are Actively at Work, any reduction in Employee Accident Insurance or benefits due to a Family Status Change will start immediately on:

- the first of the month following the date You apply for such change in Employee Accident Insurance and You agree to make any required contribution toward the cost of insurance; or
- the date of Your Family Status Change.

Any change in Employee Accident Insurance will only affect benefits for a Covered Accident that occurs after the effective date of the change.

What happens if You are rehired by Your Employer?

If You are rehired by Your Employer within 6 months of the date Your employment ends, Your insurance may be reactivated. Your reactivated insurance will:

- be the same insurance for which You were insured prior to termination of employment;
- be subject to all the terms and provisions of the Policy.

If You had partially satisfied Your Eligibility Waiting Period prior to Your termination of employment, Your previous time employed with Your Employer will count towards completion of Your Eligibility Waiting Period. Your Eligibility Date will be the later of the date You are rehired or the day after You complete the Eligibility Waiting Period.

If You are rehired by Your Employer 6 months or later after the date Your employment terminates, Your coverage will not be reactivated. You will be eligible for insurance on the day after You complete a new Eligibility Waiting Period.

Coverage will not be reactivated for any amount of insurance which You continued under the Portability Provision, unless You cancel such coverage.

When does Employee Accident Insurance end?

Your Employee Accident Insurance under the Policy will end on the earliest of the following to occur:

- the date the Policy terminates;
- the last day of the period for which any required premium has been paid for Your Employee Accident Insurance or any part of Your insurance;
- the date You notify Us in Writing to cancel Your Employee Accident Insurance; or

- the date You die.

Your Employee Accident Insurance will also end when any of the following occur, but coverage may be extended subject to any allowed continuation as specified in the Insurance Continuation section:

- the date You are no longer in an Eligible Class;
- the date You enter active duty in any armed service;
- the date You retire;
- the date Your class is no longer included for insurance; or
- the last day You are Actively at Work, subject to any applicable Waiver of Premium Benefit or Portability provisions provided.

If Your coverage has ended, can it be reinstated?

If Your insurance ends for any reason other than You have voluntarily terminated Your insurance, then Your insurance may be reinstated within 12 months from when Your insurance ended. To reinstate Your insurance, You must submit a Written request within 31 days after You return to being Actively at Work in an Eligible Class. Reinstatement will be effective on the later date when both of the following have occurred:

- You agree to make any required contribution toward the cost of Your insurance; and
- You return to being Actively at Work.

Any Accident occurring between Your termination date and Your reinstatement effective date will not be considered a Covered Accident.

A new Eligibility Waiting Period will not apply.

Your reinstated insurance will be subject to all the terms and provisions of the Policy.

Coverage will not be reinstated for any amount of insurance which You continued under the Portability provision, unless You cancel such coverage.

4. ELIGIBILITY, EFFECTIVE DATES AND TERMINATION OF SPOUSE OR DOMESTIC PARTNER INSURANCE

When are You eligible for Spouse or Domestic Partner Accident Insurance?

If You are in an Eligible Class, You are initially eligible for Spouse or Domestic Partner Accident Insurance on the latest of:

- the policy effective date;
- the date You are eligible for Employee Accident Insurance; or
- the date You acquire a Spouse or Domestic Partner.

You are also eligible for Spouse or Domestic Partner Accident Insurance during any Enrollment Period or as a result of a Family Status Change, provided You are in an Eligible Class and have a Spouse or Domestic Partner.

When must You enroll for Spouse or Domestic Partner Accident Insurance?

For Contributory Spouse or Domestic Partner Accident Insurance
You must enroll within 31 days of the date You are initially eligible for Spouse or Domestic Partner Accident Insurance as long as You are Actively at Work on that date, or within 31 days of the date of a Family Status Change or during any Enrollment Period.

When does Spouse or Domestic Partner Accident Insurance start?

For Contributory Spouse or Domestic Partner Accident Insurance starts on the latest of the date:

- You are eligible for Spouse or Domestic Partner Accident Insurance;
- You are insured under the Policy for Employee Accident Insurance;
- You enroll for Spouse or Domestic Partner Accident Insurance; and
- You agree to make any required contribution toward the cost of insurance;

if You are Actively at Work on that date.

If You are not Actively at Work on that date, Your Spouse or Domestic Partner Accident Insurance will not start until You resume being Actively at Work.

When can You make changes in Spouse or Domestic Partner Accident Insurance?

You may request a change in Your Spouse or Domestic Partner Accident Insurance benefit options during any Enrollment Period while the Policy is in force.

You may also request a change in Spouse or Domestic Partner Accident Insurance at any time due to a Family Status Change. Such request must be made within 31 days of the date the Family Status Change occurred.

When will Your Spouse or Domestic Partner Accident Insurance coverage change?

Your Spouse or Domestic Partner Accident Insurance coverage under the Policy may change if:

- You enroll for a different coverage option;
- You transfer to another class under the Policy; or
- there is a Policy change.

When does a change in Spouse or Domestic Partner Accident Insurance start?

If You are Actively at Work, any increase in Spouse or Domestic Partner Accident Insurance or benefits, for reasons other than a Family Status Change, will start on the latest of:

- the first of the month following the date of change, when You apply for a different coverage option and You agree to make any required contribution toward the cost of insurance;
- the first of the month following the date of change, when You transfer to a different class of eligible Employees;
- the date specified during the Enrollment Period;
- the date of the policy change.

4. ELIGIBILITY, EFFECTIVE DATES AND TERMINATION OF SPOUSE OR DOMESTIC PARTNER INSURANCE

If You are not Actively at Work on that date, any increase in Spouse or Domestic Partner Accident Insurance or benefits will not start until You resume being Actively at Work.

Whether or not You are Actively at Work, any reduction in Spouse or Domestic Partner Accident Insurance or benefits for reasons other than a Family Status Change will start on:

- the first of the month following the date of change, when You apply for a different coverage option;
- the first of the month following the date of change, when You transfer to a different class of eligible Employees;
- the date specified during the Enrollment Period;
- the date of the Policy change.

If You are Actively at Work, any increase in Spouse or Domestic Partner Accident Insurance or benefits due to a Family Status Change will start on the later of:

- the first of the month following the date You apply for such change in Spouse or Domestic Partner Accident Insurance and You agree to make any required contribution toward the cost of insurance; or
- the date of Your Family Status Change.

If You are not Actively at Work on that date, any increase due to a Family Status Change in Spouse or Domestic Partner Accident Insurance or benefits will not start until You resume being Actively at Work.

Whether or not You are Actively at Work, any reduction in Spouse or Domestic Partner Accident Insurance or benefits due to a Family Status Change will start immediately on:

- the first of the month following the date You apply for such change in Spouse or Domestic Partner Accident Insurance and You agree to make any required contribution toward the cost of insurance; or
- the date of Your Family Status Change.

Any change in Spouse or Domestic Partner Accident Insurance will only affect benefits for a Covered Accident that occurs after the effective date of the change.

When does Spouse or Domestic Partner Accident Insurance end?

Spouse or Domestic Partner Accident Insurance under the Policy will end on the earliest of the following to occur:

- the date the Policy terminates;
- the last day of the period for which any required premium has been paid for Your insurance or Your Spouse or Domestic Partner Accident Insurance or any part of Your insurance or Your Spouse or Domestic Partner Accident Insurance;
- the date You notify Us in Writing to cancel Your Spouse or Domestic Partner Accident Insurance;
- the date You die; or
- the date Your Spouse or Domestic Partner dies.

Your Spouse or Domestic Partner Accident Insurance will also end when any of the following occur, but coverage may be extended subject to any allowed continuation as specified in the Insurance Continuation section:

- the date You are no longer in an Eligible Class;
- the date You are no longer insured under the Policy;
- the date Your Spouse or Domestic Partner no longer meets the definition of Spouse or Domestic Partner as described in this Certificate;
- the date Your Spouse or Domestic Partner enters active duty in any armed service;
- the date You retire;
- the date Your class is no longer included for insurance; or
- the last day You are Actively at Work, subject to any Portability provision provided.

5. ELIGIBILITY, EFFECTIVE DATES AND TERMINATION OF DEPENDENT CHILDREN INSURANCE

When are You eligible for Dependent Children Accident Insurance?

If You are in an Eligible Class, then You are initially eligible for Dependent Children Accident Insurance on the latest of:

- The policy effective date;
- the date You are eligible for Employee Accident Insurance; or
- the date You acquire Your Dependent Children.

You are also eligible for Dependent Children Accident Insurance during any Enrollment Period or as a result of a Family Status Change, provided You are in an Eligible Class and have one or more Dependent Children.

When must You enroll for Dependent Children Accident Insurance?

For Contributory Dependent Children Accident Insurance
You must enroll within 31 days of the date You are initially eligible for Dependent Children Accident Insurance as long as You are Actively at Work on that date or within 31 days of the date of a Family Status Change or during any Enrollment Period.

When does Dependent Children Accident Insurance start?

For Contributory Dependent Children Accident Insurance
Dependent Children Accident Insurance starts on the latest of the date:

- You are eligible for Dependent Children Accident Insurance;
- You are first insured under the Policy, for Employee Accident Insurance;
- You enroll for Dependent Children Accident Insurance; and You agree to make any required contribution toward the cost of insurance;

if You are Actively at Work on that date.

If You are not Actively at Work on that date, Your Dependent Children Accident Insurance will not start until You resume being Actively at Work.

When can You make changes in Dependent Children Accident Insurance?

You may request a change in Your Dependent Children Accident Insurance benefit options during any Enrollment Periodat any time while the Policy is in force.

You may also request a change in Dependent Children Accident Insurance at any time due to a Family Status Change. Such request must be made within 31 days of the date the Family Status Change occurred.

When will Your Dependent Children Accident Insurance coverage change?

Your Dependent Children Accident Insurance coverage under the Policy may change if:

- You enroll for a different coverage option;
- You transfer to another class under the Policy; or
- there is a Policy change.

When does a change in Dependent Children Accident Insurance start?

If You are Actively at Work, any increase in Dependent Children Accident Insurance or benefits, for reasons other than a Family Status Change, will start on the latest of:

- the first of the month following the date of change, when You apply for a different coverage option and You agree to make any required contribution toward the cost of insurance;
- the first of the month following the date of change, when You transfer to a different class of eligible Employees;
- the date specified during the Enrollment Period;
- the date of the Policy change.

If You are not Actively at Work on that date, any increase in Dependent Children Accident Insurance or benefits will not start until You resume being Actively at Work.

5. ELIGIBILITY, EFFECTIVE DATES AND TERMINATION OF DEPENDENT CHILDREN INSURANCE

Whether or not You are Actively at Work, any reduction in Dependent Children Accident Insurance or benefits for reasons other than a Family Status Change will start immediately on:

- the first of the month following the date of change, when You apply for a different coverage option;
- the first of the month following the date of change, when You transfer to a different class of eligible Employees;
- the date specified during the Enrollment Period;
- the date of the Policy change.

If You are Actively at Work, any increase in Dependent Children Accident Insurance or benefits due to a Family Status Change will start on the later of:

- the first of the month following the date You apply for such change in Dependent Children Accident Insurance and You agree to make any required contribution toward the cost of insurance; or
- the date of Your Family Status Change.

If You are not Actively at Work on that date, any increase due to a Family Status Change in Dependent Children Accident Insurance or benefits will not start until You resume being Actively at Work.

Whether or not You are Actively at Work, any reduction in Dependent Children Accident Insurance or benefits due to a Family Status Change will start immediately on:

- the first of the month following the date You apply for such change in Dependent Children Accident Insurance and You agree to make any required contribution toward the cost of insurance; or
- the date of Your Family Status Change.

Any change in insurance for Your Dependent Children will only affect benefits for a Covered Accident that occurs after the effective date of the change.

How can You add a child or children to Your Dependent Children Accident Insurance?

After You or Your Spouse or Domestic Partner and a Dependent Child are covered under the Policy, and You are Actively at Work, any child who becomes one of Your Dependent Children will automatically be covered.

How does Dependent Children Accident Insurance apply to newborn children, newly placed foster children or newly adopted children?

If You are insured under the Policy but do not have Dependent Children Accident Insurance when a newborn child, newly placed foster child, or newly adopted child becomes one of Your Dependent Children, then such child will automatically be covered for 31 days from the date he or she becomes Your Dependent Child. To continue coverage beyond 31 days, You must:

- enroll for Dependent Children Accident Insurance within 31 days from the date the newborn child, newly placed foster child or newly adopted child becomes Your Dependent Child; and
- pay the required premium to continue Your Dependent Children Accident Insurance.

If You are covered under the Policy and have Dependent Children Accident Insurance when a newborn, newly placed foster child or newly adopted child becomes one of Your Dependent Children, then such child will automatically be covered.

When does Dependent Children Accident Insurance end?

Dependent Children Accident Insurance under the Policy will end on the earliest of the following to occur:

- the date the Policy terminates;
- the last day of the period for which any required premium has been paid for Your insurance or Your Dependent Children Accident Insurance, or any part of the insurance;
- the date Your Employer's participation in the trust and under the Policy terminates;

- the date You notify Us in Writing to cancel Your Dependent Children Accident Insurance;
- the date You die; or
- the date Your Dependent Child dies.

Your Dependent Children Accident Insurance will also end when any of the following occur, but coverage may be extended subject to any allowed continuation as specified in the Insurance Continuation section:

- the date You are no longer in an Eligible Class;
- the date You are no longer insured under the Policy;
- the date Your Dependent Child no longer meets the definition of Dependent Child as described in this Certificate, but only with respect to that person;
- the date Your Dependent Child enters active duty in any armed service;
- the date You retire;
- the date Your class is no longer included for insurance; or
- the last day You are Actively at Work, subject to any Portability provision provided.

6. COVERED ACCIDENT BENEFITS

What benefits are payable under the Policy?

The following are the Covered Accident Benefits covered under the Policy. Eligible benefit payments for a Covered Accident Benefit will be payable in a lump sum as shown in the Benefit Highlights. Each Covered Accident Benefit can be claimed only once for each Covered Accident, unless otherwise specified. We will pay benefits for multiple Injuries sustained in the same Covered Accident up to the benefit amount shown in the Benefit Highlights for such Injuries. Diagnosis and Treatment for Injuries sustained by Covered Accidents must be made within 12 months to qualify for benefits under the Policy unless otherwise specified.

Accident Emergency Treatment (non-Emergency Room, non-Urgent Care Facility) Benefit

The Accident Emergency Treatment (non-Emergency Room, non-Urgent Care Facility) Benefit is payable for each Insured who receives Treatment from a Physician as the result of Injuries received in a Covered Accident, provided the Treatment is received within 15 days after the date of the Covered Accident. This benefit is payable only once per Insured for each Covered Accident and not more than once per 24-hour period. If the Insured receives Treatment for the same Injuries in an Emergency Room or Urgent Care Facility within the same 15 day period, We will pay only the Emergency Room Treatment Benefit or the Urgent Care Facility Benefit.

Accidental Death Benefit

An Accidental Death Benefit is payable if an Insured dies within 365 days of the date of the Covered Accident as a result of Injuries received from that Accident. If We pay this benefit for an Insured, We will not pay the Accidental Death Common Carrier Benefit for the same Insured.

Accidental Death Common Carrier Benefit

An Accidental Death Common Carrier Benefit is payable if an Insured dies within 365 days of the date of the Covered Accident as a result of Injuries received from that Covered Accident, while a fare paying passenger on a Common Carrier. If We pay this benefit for an Insured, We will not pay the Accidental Death Benefit for the same Insured.

Accidental Dismemberment Benefit

An Accidental Dismemberment Benefit is payable if an Insured sustains the following:

- Loss of Hand—one hand;
- Loss of Foot—one foot;
- Loss of Leg—one leg;
- Loss of Arm—one arm;
- Loss of a Finger or Loss of a Toe—one or more fingers or toes;
- Loss of an Eye—one eye; or
- irrecoverable Loss of Sight—one eye;
- Loss of an Ear—one ear; or
- irrecoverable Loss of Hearing—one ear;

due to Injuries received in a Covered Accident, and the loss occurs within 365 days after the date of the Covered Accident.

If the Insured loses a finger or a toe and later loses a hand, foot, arm or leg on the same side of the body within 365 days after the date of the Covered Accident as the result of the same Covered Accident, We will subtract the amount We paid for the loss of the finger or toe from the benefit We pay for the loss of the hand, foot, arm or leg.

For multiple Dismemberments resulting from the same Covered Accident that occur within 365 days after the date of the Covered Accident, We will pay 100% of each benefit amount listed in the Benefit Highlights for the applicable dismembered body part. If the Insured loses one arm or one leg and later loses the other arm or leg within 365 days of the Covered Accident as the result of the same Covered Accident, We will subtract the amount We paid for that loss of an arm or leg from the benefit We pay for the Catastrophic Accident Benefit. If the Insured loses one arm and one leg or one hand and one foot within 365 days of the Covered Accident as the result of the same Covered Accident, We will pay for the Catastrophic Accident Benefit. No

6. COVERED ACCIDENT BENEFITS

Accidental Dismemberment Benefit will be paid in addition to the Catastrophic Accident Benefit.

Ambulance Benefit (Air)

An Ambulance Benefit is payable for a licensed professional air ambulance company to transport an Insured to or from a Hospital, or between medical facilities for Treatment of Injuries received in a Covered Accident. The air ambulance must provide the transportation services to the Insured within 72 hours after the date of the Covered Accident.

Ambulance Benefit (Ground)

An Ambulance Benefit is payable for a licensed professional ambulance company to transport an Insured by ground, to or from a Hospital or between medical facilities for Treatment of Injuries received in a Covered Accident. The ambulance must provide transportation services to the Insured within 72 hours after the date of the Covered Accident.

Anesthesia Benefit

An Anesthesia Benefit is payable for each Insured who requires Anesthesia as a result of Injuries received in a Covered Accident. The Anesthesia must be prescribed by a Physician and administered in a Hospital or Physician's office within 90 days after the date of the Covered Accident.

Blood/Plasma/Platelet Transfusion Benefit

A Blood/Plasma/Platelet Transfusion Benefit is payable for each Insured who requires a transfusion, administration, cross matching, typing and processing of blood, plasma or plateletas a result of Injuries received in a Covered Accident. The blood, plasma or platelet transfusion must be administered within 90 days after the date of the Covered Accident.

Brain Injury Benefit

A Brain Injury Benefit is payable for each Insured who sustains a brain Injury as a result of a Covered Accident. The brain Injury must be diagnosed within 72 hours of the Covered Accident. Brain Injury includes the following:

- amnesia;
- loss of consciousness;
- temporary and complete blindness;
- seizures; or
- other disruptions of the various chemical processes of the brain;

when incurred as a result of a Covered Accident. It does not include neurological disorders diagnosed as a coma or a concussion. If the Injury is diagnosed as temporary blindness and then results in permanent irrecoverable Loss of Sight of both eyes within 365 days of the Covered Accident as a result of the same Covered Accident, We will subtract from the Catastrophic Accident Benefit the amount We paid for the for the Brain Injury Benefit if the sole reason for paying the Brain Injury Benefit was due to blindness. Only one Brain Injury Benefit is payable for all brain Injuries sustained in the same Covered Accident.

Burn Benefit

A Burn Benefit is payable for each Insured who sustains covered burns shown in the Benefit Highlights as the result of Injuries received in a Covered Accident. The Insured must be treated by a Physician within 72 hours after the date of the Covered Accident. If the Insured meets more than one of the burn classifications, We will pay only the greater benefit amount as shown in the Benefit Highlights.

Catastrophic Accident Benefit

A Catastrophic Accident Benefit is payable if an Insured sustains the following:

- Loss of Hand—both hands;
- Loss of Foot—both feet;
- Loss of Arm or Loss of Leg—both arms or both legs;
- Loss of Hand and Loss of Foot—one hand and one foot;
- Loss of Arm and Loss of Leg—one arm and one leg;
- Loss of an Eye—both eyes; or

- irrecoverable Loss of Sight—both eyes;
- Loss of an Ear—both ears;
- irrecoverable Loss of Hearing—both ears;
- irrecoverable Loss of Speech or the ability to speak; or
- any combination equaling two or more losses from: Loss of Arm, Loss of Hand, Loss of Leg, Loss of Foot, Loss of an Ear or Loss of an Eye;

due to Injuries received in a Covered Accident and occurs within 365 days after the date of the Covered Accident. Loss of Arm and Loss of Hand or Loss of Leg and Loss of Foot on the same side of the body are counted as one loss. If the Insured loses one arm or one leg and later loses the other arm or leg within 365 days of the Covered Accident as the result of the same Covered Accident, We will subtract the amount We paid for that loss of an arm or leg from the benefit We pay for the Catastrophic Accident Benefit. If the Injury is diagnosed as temporary blindness and then results in permanent irrecoverable Loss of Sight of both eyes within 365 days of the Covered Accident as a result of the same Covered Accident, We will subtract from the Catastrophic Accident Benefit the amount We paid for the Brain Injury Benefit if the sole reason for paying the Brain Injury Benefit was due to blindness.

Coma Benefit

A Coma Benefit is payable for each Insured who is in a Coma as the result of Injuries received in a Covered Accident.

Concussion Benefit

A Concussion Benefit is payable for each Insured who sustains a concussion as the result of a Covered Accident up to the Lifetime Maximum Benefit shown in the Benefit Highlights. The concussion must be diagnosed by a Physician within 72 hours of the Covered Accident.

Diagnostic Exam Benefit

A Diagnostic Exam Benefit is payable for each Insured who requires a diagnostic examination to determine the extent of Injuries received in a Covered Accident. The Insured must schedule an examination and the examination must be performed within 90 days after the date of the Covered Accident. Diagnostic exams include arteriogram, angiogram, Computed Tomographies (CT Scan), Computerized Axial Tomography (CAT), Electrocardiography (EKG), Electroencephalogram (EEG), and Magnetic Resonance Imagings (MRIs) and x-rays. This benefit is payable only once per Benefit Year for each Insured except for x- rays, which are payable only once per covered accident.

Dislocation Benefit

A Dislocation Benefit is payable for each Insured who sustains a Dislocation as the result of Injuries received in a Covered Accident. The Dislocation must be diagnosed by a Physician within 90 days after the date of the Covered Accident. Treatment of the Dislocation must require Anesthesia by a Physician.

It can be corrected by open (surgical) reduction or closed (non-surgical) reduction, and it must be a complete Dislocation.

If the Dislocation requires reduction without Anesthesia by a Physician or a Physician diagnoses the Dislocation as an Incomplete Dislocation, We will pay 25% of the applicable benefit amount shown in the Benefit Highlights for a Closed Reduction of the joint involved.

Benefits will only be payable for the first Dislocation of a joint sustained in a Covered Accident. Subsequent Dislocations of the same joint are not payable for the same Covered Accident.

Emergency Dental Benefit

An Emergency Dental Benefit is payable for each Insured who requires dental work as the result of Injuries received in a Covered Accident. The dental work must occur within 90 days after the date of the Covered Accident. This benefit is only payable for broken teeth repaired with crown(s) or broken teeth requiring extraction, regardless of the number of teeth involved.

Emergency Room Treatment Benefit

6. COVERED ACCIDENT BENEFITS

An Emergency Room Treatment Benefit is payable for each Insured who requires examination and Treatment by a Physician in an Emergency Room as the result of Injuries received in a Covered Accident. The Emergency Room examination and Treatment must occur within 72 hours after the date of the Covered Accident.

Epidural Pain Management Benefit

An Epidural Pain Management Benefit is payable for each Insured who receives an Epidural Injection administered for pain management for Injuries received in a Covered Accident. Epidural Injection means injection of drugs through a catheter placed into the epidural space. The epidural must be prescribed by a Physician and administered in a Hospital or Physician's office within 90 days after the date of the Covered Accident. This benefit is payable up to 2 times per Insured per Covered Accident. This benefit is not payable for an Epidural Injection administered during a surgical procedure and does not include epidural steroid injections.

Eye Injury Benefit

An Eye Injury Benefit is payable for each Insured who incurs an eye Injury as a result of a Covered Accident. The eye Injury must require surgery or the removal of a foreign object by a Physician and must be performed within 90 days of the Covered Accident. Only one Eye Injury Benefit is payable for all eye Injuries sustained in the same Covered Accident.

Family Lodging Benefit

A Family Lodging Benefit is payable for one companion to accompany the Insured who is Confined in a Hospital as a result of Injuries received in a Covered Accident. The Hospital must be more than 100 miles from the residence of the Insured. The place of lodging must be a motel or hotel room. The expenses for such lodging must occur within 90 days of the Covered Accident. Subject to the Maximum Lodging Night Stays shown in the Benefit Highlights, benefits will be paid as long as:

- the companion accompanies the Insured; and
- the Insured remains Confined.

Fracture Benefit

A Fracture Benefit is payable for each Insured who sustains Fractures as the result of Injuries received in a Covered Accident. The Fracture must:

- be a Fracture covered under the Policy as shown in the Benefit Highlights;
- be diagnosed by a Physician within 90 days after the date of the Covered Accident; and
- require open (surgical) reduction or closed (non-surgical) reduction by a Physician.

A partial benefit is payable for each Insured who sustains a Chip Fracture or other Fractures not reduced by open or closed reduction.

Gunshot Wound Benefit

A Gunshot Wound Benefit is payable for each Insured who sustains a gunshot wound as a result of a Covered Accident. The gunshot wound must be caused by:

- a bullet; or
- other object fired by rifle or pistol using gunpowder.

The gunshot wound must be treated by a Physician at a Hospital within 24 hours of the shooting. Only one Gunshot Wound Benefit is payable for all gunshot Injuries sustained in the same Covered Accident.

Hospital Admission Benefit

A Hospital Admission Benefit is payable for each Insured admitted to a Hospital as a result of Injuries received in a Covered Accident. Admission to the Hospital must occur within 30 days after the date of the Covered Accident. If the Insured is Confined immediately to the Intensive Care Unit, We will pay only the Hospital Intensive Care Unit Admission Benefit and not the Hospital Admission Benefit. This benefit is payable only once per Benefit Year for each Insured.

This benefit will not be paid for:
- Emergency Room Treatment;
- Outpatient Treatment; or
- a stay of less than 24 hours in an Observation Unit.

Hospital Confinement Benefit

A Hospital Confinement Benefit is payable for each Insured Confined in a Hospital as a result of Injuries received in a Covered Accident. The Hospital Confinement must begin within 30 days after the date of the Covered Accident.

We will pay benefits for only one period of Confinement at a time even if it is caused by more than one Covered Accident. If the Insured is Confined in a Hospital, and is Confined once again within 90 days for Injuries received in the same Covered Accident or by a related condition, We will treat that Confinement as a continuation of the prior Confinement. If more than 90 days have passed between the periods of Hospital Confinement, We will treat the Confinement as a new Confinement.

The maximum benefit paid will not exceed number of days for the Hospital Confinement Benefit as shown in the Benefit Highlights.

This benefit will not be paid for:
- Emergency Room Treatment;
- Outpatient Treatment; or
- Confinement of less than 24 hours to an Observation Unit.

Hospital Intensive Care Unit Admission Benefit

A Hospital Intensive Care Unit Admission Benefit is payable for each Insured who is admitted to the Hospital's Intensive Care Unit due to Injuries sustained in a Covered Accident. Admission to the Hospital's Intensive Care Unit must occur within 30 days after the date of the Covered Accident. This benefit is payable only once per Benefit Year for each Insured.

Hospital Intensive Care Unit Confinement Benefit

A Hospital Intensive Care Unit Confinement Benefit is payable for each Insured Confined in an Intensive Care Unit as a result of Injuries received in a Covered Accident. Confinement in a Hospital Intensive Care Unit must begin within 30 days after the date of the Covered Accident.

If the Insured is Confined in a Hospital Intensive Care Unit, and is Confined once again within 90 days for Injuries received in the same Covered Accident or by a related condition, We will treat this Confinement as a continuation of the prior Confinement. If more than 90 days have passed between the periods of Confinement in a Hospital Intensive Care Unit, We will treat the Confinement as a new Confinement.

If the Insured is Confined to a Hospital Intensive Care Unit that does not meet the definition of a Hospital Intensive Care Unit, We will pay the Hospital Confinement Benefit. The Hospital Intensive Care Unit Confinement Benefit is paid in addition to the Hospital Confinement Benefit for the first 15 days of Confinement in the Hospital Intensive Care Unit. If the Insured is Confined in a Hospital Intensive Care Unit for more than 15 days, benefits will continue to be paid under the Hospital Confinement Benefit beginning on the 16th day. The maximum benefits paid will not exceed the number of days for the Hospital Confinement Benefit and the number of days for the Hospital Intensive Care Unit Confinement Benefit as shown in the Benefit Highlights.

Laceration Benefit

A Laceration Benefit is payable for each Insured who sustains Lacerations as the result of Injuries received in a Covered Accident. The Laceration must be repaired by a Physician within 72 hours after the date of the Covered Accident. The benefit payable will be based on the total length of all Lacerations received in any one Covered Accident which requires repair. This benefit is payable only once for each Covered Accident.

Loss of Hearing/Ear Benefit

A Loss of Hearing Benefit is payable if an Insured sustains the irrecoverable Loss of Hearing of one ear or the Loss of an Ear due to Injuries received in a Covered Accident, and the loss occurs within 365 days after the date of the Covered Accident.

Loss of Sight/Eye Benefit

A Loss of Sight Benefit is payable if an Insured sustains the irrecoverable Loss of Sight of one eye or the Loss of an Eye due to Injuries received in a Covered Accident, and the loss occurs within 365 days after the date of the Covered Accident.

Medical Device Benefit

A Medical Device Benefit is payable for the use of a medical device as an aid in personal locomotion or mobility. The medical device must be prescribed by a Physician for the Insured as a result of Injuries received in each Covered Accident. Medical devices include wheelchairs, crutches, walkers, back braces, leg braces, neck braces and walking boots. The use of a medical device must begin within 90 days after the date of the Covered Accident. This benefit is payable only once for each Covered Accident.

Paralysis Benefit

A Paralysis Benefit is payable for each Insured who becomes paralyzed as a result of Injuries received in a Covered Accident. The Paralysis must occur within 90 days of the Covered Accident. The Paralysis must be confirmed by a Physician and based on documented evidence that the Paralysis was caused by Injury. The duration of the Paralysis must be at least 30 days and expected to be permanent.

Physical and Occupational Therapy Benefit

A Physical and Occupational Therapy Benefit is payable for each Insured who requires physical or occupational therapy Treatment as the result of Injuries received in a Covered Accident. The therapy must begin within 90 days after:

- the date of the Covered Accident; or
- the date on which the Physician prescribes physical or occupational therapy following surgery or other medical Treatment required and provided for Treatment of the Injuries sustained in a Covered Accident.

The therapy must be rendered by a Physical or Occupational Therapist.

This benefit is limited to the maximum number of visits per Insured per Covered Accident as shown in the Benefit Highlights

Physician Follow-Up Treatment Benefit

A Physician Follow-Up Treatment Benefit is payable for each Insured who receives follow-up Treatment for Injuries incurred from a Covered Accident when such follow-up Treatment is recommended or advised by a Physician. The follow-up Treatment must:

- be within 90 days after the date of the Covered Accident;
- be due to Injuries received as the result of a Covered Accident;
- occur after initial Treatment by a Physician; and
- not be for routine examinations or preventive testing.

This benefit includes follow-up Treatment provided by a licensed or certified chiropractor. This benefit is limited to the number of times per Insured per Covered Accident, as shown in the Benefit Highlights.

Prescription Drug Benefit

A Prescription Drug Benefit is payable once per Covered Accident for each Insured who requires medication to treat an Injury sustained as a direct result of a Covered Accident. The medication must be prescribed by a Physician within 30 days of the Covered Accident.

Prosthesis Benefit

A Prosthesis Benefit is payable for an Insured who sustains:

- Loss of Hand, Loss of Foot, Loss of Arm, Loss of Leg or Loss of an Eye as a result of Injuries received in a Covered Accident; and
- requires a prosthetic device, artificial limb or eye which is prescribed by a Physician.

The prosthetic device/artificial limb or eye must be received within 365 days after the date of the Covered Accident.

This benefit is not payable for joint replacement such as an artificial hip or knee.

Rehabilitation Unit Benefit

A Rehabilitation Unit Benefit provides a daily benefit if the Insured is Confined in a Rehabilitation Unit for physical, occupational or speech therapy Treatment of Injuries incurred from a Covered Accident. The Rehabilitation Unit Confinement must begin within 90 days after the date of the Covered Accident and be preceded by Confinement in a Hospital. This benefit is limited to the maximum number of days per Insured per Covered Accident as shown in the Benefit Highlights. The Rehabilitation Unit benefit will not be paid if the Hospital Confinement Benefit is paid for the same day; only the highest eligible benefit will be paid.

Skin Graft Benefit

A Skin Graft Benefit is payable for each Insured who receives a skin graft within 90 days after the date of the Covered Accident for a burn for which a benefit was received under the Burn benefit. This benefit is payable once per Insured per Covered Accident.

Surgery Benefit

A Surgery Benefit is payable for each Insured who undergoes a surgical procedure listed in the Benefit Highlights for repair of internal Injuries received as the result of a Covered Accident. Treatment must be first provided by a Physician within 90 days and the Injury repaired through surgery within 180 days of the date of the Covered Accident. The surgery may be provided in a Hospital on an Inpatient or Outpatient basis or in a licensed ambulatory surgical facility. Benefits will be payable for Exploratory Surgery or other specified surgery without repair as shown in the Benefit Highlights.

Debridement Benefit

A Debridement Benefit is payable for each Insured who undergoes debridement as the result of an Injury received in a Covered Accident. Treatment must be first provided by a Physician within 90 days and the Injury must be repaired through surgery by a Physician within 180 days after the date of the Covered Accident.

Exploratory Surgery Benefit

An Exploratory Surgery Benefit is payable for each Insured who undergoes an operation performed for diagnostic purposes only as the result of an Injury received in a Covered Accident. Treatment must be first provided by a Physician within 90 days and the surgery must be performed by a Physician within 180 days after the date of the Covered Accident.

Hernia Repair Benefit

A Hernia Repair Benefit is payable for each Insured who sustains a hernia as the result of direct Injuries in a Covered Accident. The hernia must be diagnosed by a Physician within 90 days and must be repaired through surgery by a Physician within 180 days after the date of the Covered Accident.

Laparoscopic Surgery Benefit

A Laparoscopic Surgery Benefit is payable for each Insured who undergoes Laparoscopic Surgery for Injuries sustained in a Covered Accident. The Laparoscopic Surgery must occur within 180 days after the date of the Covered Accident.

Miscellaneous Surgery Benefit

A Miscellaneous Surgery Benefit is payable for each Insured who undergoes a surgery requiring Anesthesia received as the result of a Covered Accident that is not covered by any other Injury benefit in the Benefit Highlights. Treatment must be first provided by a Physician within 90 days and the Injury must be repaired

through surgery by a Physician within 180 days after the date of the Covered Accident. Only one Miscellaneous Surgery Benefit is payable per 24-hour period even though multiple surgical procedures may be performed.

Open Surgery Benefit
An Open Surgery Benefit is payable for each Insured who undergoes open abdominal, cranial or thoracic surgery to repair internal Injuries received as the result of a Covered Accident. Treatment must be first provided by a Physician within 90 days and the Injury must be repaired through surgery by a Physician within 180 days after the date of the Covered Accident. We will pay this benefit once per Covered Accident.

Ruptured/Herniated Disc Benefit
A Ruptured/Herniated Disc Benefit is payable for each Insured who sustains a ruptured or herniated disc in the spine as the result of Injuries received in a Covered Accident. Treatment must be first provided by a Physician within 90 days and the Injury repaired through surgery by a Physician within 180 days after the date of the Covered Accident.

Tendon/Ligament /Rotator Cuff Benefit
A Tendon/Ligament/Rotator Cuff Benefit is payable for each Insured who injures a tendon, ligament, or rotator cuff as the result of Injuries received in a Covered Accident. The tendon, ligament, or rotator cuff must be torn, ruptured, or severed. Treatment must be first provided by a Physician within 90 days and the Injury repaired through surgery by a Physician within 180 days after the date of the Covered Accident. If exploratory arthroscopic surgery is performed and no repair is done, the applicable amount payable is shown in the Benefit Highlights.

Torn Knee Cartilage Benefit
A Torn Knee Cartilage Benefit is payable for each Insured who sustains a torn knee cartilage (meniscus) as the result of direct Injuries in a Covered Accident. Treatment must be first provided by a Physician within 90 days and the Injury repaired through surgery by a Physician within 180 days after the date of the Covered Accident. If exploratory arthroscopic surgery is performed and no repair is done, or if the cartilage is shaved (debridement), the applicable benefit payable is shown in the Benefit Highlights.

Transportation Benefit
A Transportation Benefit is payable for each Insured who is required to travel more than 100 miles one way from the Insured's residence to:
- receive special Treatment; or
- be Confined in a Hospital;

if prescribed by a Physician for the Treatment of Injuries resulting from a Covered Accident when such Treatment or Confinement is not available locally. Such transportation must occur within 90 days of the date of the Covered Accident.

This benefit is not payable for transportation by ground ambulance or air ambulance.

Urgent Care Facility Benefit
An Urgent Care Facility Benefit is payable for each Insured who requires emergency or urgent Treatment at an Urgent Care Facility for Injuries sustained in a Covered Accident. The Treatment must occur within 72 hours after the date of the Covered Accident.

Wellness Screening Benefit
A Wellness Screening Benefit is payable for each Insured who has any one of the following wellness screening tests performed:

- Breast Cancer Screening (clinical breast exam, mammography, MRI, thermography, ultrasound)
- CA15-3 (blood test for breast cancer)
- CA125 (blood test for ovarian cancer)
- Cardiac Exercise Stress Test
- Fasting Blood Glucose Test

6. COVERED ACCIDENT BENEFITS

- Colorectal Cancer Screening (fecal occult blood test, colonoscopy, sigmoidoscopy)
- Hemoccult Stool Analysis
- CEA (blood test for colon cancer)
- Chest x-ray
- Lipid panel (cholesterol, triglycerides, HDL, LDL)
- Pap smear
- Prostate Cancer Screening (digital rectal exam, PSA blood test)
- Serum Protein Electrophoresis
- Skin Cancer Screening
- Diabetes tests (fasting blood glucose test, hemoglobin A1c)
- Carotid Doppler
- Echocardiogram
- Electrocardiogram (ECG)-resting or stress
- Immunizations
- Interscholastic Sports Physical Exam

To receive this benefit, You must notify Us of which wellness screening test was performed. The benefit is payable once per Insured per Benefit Year.

7. EXCLUSIONS

What exclusions apply to the benefits payable?

No benefits will be payable for any loss that is the result of a Covered Accident that is due to or results from:

- war or any act of war or Your active duty in any armed service during a time of war (this does not include acts of terrorism);
- active participation in a war (declared or undeclared);
- active military duty;
- riding in or driving any motor-driven vehicle in a race, stunt show, speed test or driving while Intoxicated;
- Intoxication;
- operating, learning to operate, serving as a crew member of, jumping or falling from any aircraft, including those which are not motor-driven. This does not include:
  1. flying as a fare paying passenger in a scheduled or chartered flight operated by a commercial airline;
  2. flying as a passenger with no duties on board an aircraft operated by a private business to transport its personnel or guests;
  3. flying in Your Employer's corporate aircraft as a passenger or crew member; or
  4. flying in a life-saving medevac or similar medical air transport service;
- Injuries sustained from any aviation activities, other than riding as a fare paying passenger;
- operating a taxi or any other delivery service for any kind of compensation or profit;
- engaging in hang-gliding, bungee jumping, parachuting, sail gliding, parasailing, parakiting or mountaineering;
- participating in or practicing for any semi-professional or professional competitive athletic contest in which any compensation is received, including coaching or officiating;
- committing of or attempting to commit a felony or engaging in an illegal occupation;
- active Participation in a Riot, Rebellion or Insurrection;
- committing or attempting to commit suicide, whether sane or insane, or injuring oneself intentionally;
- voluntary use of any controlled substance as defined in Title II of the Comprehensive Drug Abuse Prevention and Control Act of 1970, as now or hereafter amended, unless administered on the advice of a Physician and used as directed;
- use of any drug, unless used as prescribed by a Physician or as directed;
- improper or illegal use of inhalants or huffing;
- a Sickness or infection including physical or mental condition which is not caused solely by or as a direct result of a Covered Accident;
- incarceration in a penal institution of any kind;
- An Injury arising out of or in the course of any work for pay or profit. This exclusion will not apply to an Insured who is enrolled for 24-Hour Coverage.

No benefits will be payable relating to or resulting from services or Treatment rendered or Confinement outside the United States.

8. CLAIM PROVISIONS

How is a claim submitted?

To submit a claim, You or someone on Your behalf must send Us Written notice and Proof of claim on Our form within the time limits specified. Your Employer has the notice and Proof of claim forms.

NOTICE OF CLAIM

When does Written notice of claim have to be submitted?

Written notice of claim must be given to Us no later than 90 days after the Insured's date of loss.

If notice cannot be given within the applicable time period, We must be notified as soon as it is reasonably possible.

When We receive Written notice of claim, We will send the forms for Proof of claim. If the forms are not received within 10 days after Written notice of claim is sent, Proof of claim may be sent to Us without waiting to receive the Proof of claim forms.

PROOF OF CLAIM

When does Written Proof of claim have to be submitted?

Written Proof of claim must be given to Us no later than 180 days after the Insured's date of loss.

If Proof cannot be given within the time limit, Proof must be given as soon as reasonably possible. Proof of claim may not be given later than one year after the time Proof is otherwise required unless You are legally incompetent.

What is considered Proof of claim?

Proof of claim must consist of at least the following information:

- a description of the loss;
- the date the loss occurred;
- the cause of the loss;
- hospital records, physician records, x-rays, narrative reports, or lab, toxicology or other diagnostic testing materials as appropriate for the Treatment of the Injury;
- police accident reports; and
- any other information We may require to make a claim determination.

We may require as part of the Proof, authorizations to obtain medical and non-medical information. Proof must be satisfactory to Us.

PAYMENT OF BENEFITS

When are benefits payable?

Benefits are payable upon Our receipt of satisfactory Proof of claim that establishes benefit eligibility according to the provisions of the Policy.

When will a decision on Your claim be made?

For approved claims, We will pay any benefits due within 15 working days after receipt of an electronic claim, or 30 calendar days after receipt of a paper claim. We will pay an interest rate required by Georgia at the time on the benefits due until the claim is paid.

What if Your claim is denied?

8. CLAIM PROVISIONS

If We deny all or any part of Your claim, You will receive a Written notice of denial stating:

- the specific reason(s) for the denial;
- the specific Policy provision(s) on which the denial is based;
- Your right to receive, upon request and free of charge, copies of all documents, records, and other information relevant to Your claim for benefits;
- a description of any additional material or information needed to prove entitlement to benefits and an explanation of why such material or information is necessary;
- a description of the appeal procedures and time limits; and
- Your right to bring a civil action under ERISA, §502(a), if applicable, following an adverse determination on review.

Can You request a review of a claim denial?

If all or part of Your claim is denied, You may request in Writing a review of the denial within 60 days after receiving notice of denial.

You may submit Written comments, documents, records or other information relating to Your claim for benefits, and may request free of charge copies of all documents, records, and other information relevant to Your claim for benefits.

We will review the claim on receipt of the Written request for review, and will notify You of Our decision within a reasonable time but not later than 60 days after the request has been received. If an extension of time is required to process the claim, We will notify You in Writing of the special circumstances requiring the extension and the date by which We expect to make a determination on review. The extension cannot exceed a period of 60 days from the end of the initial period.

If a period of time is extended because You failed to provide information necessary to decide Your claim, the period for making the decision on review is tolled from the date We send notice of the extension to You until the date on which You respond to the request for additional information. You will have at least 45 days to provide the specified information.

What if Your claim is denied on review?

If We deny all or any part of Your claim on review, You will receive a Written notice of denial stating:

- the specific reasons for the denial;
- the specific Policy provisions on which the denial is based;
- Your right to receive, upon request and free of charge, copies of all documents, records, and other information relevant to Your claim for benefits;
- Your right to bring a civil action under ERISA, §502(a), if applicable; and
- the following statement: “You and Your plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact Your local U.S. Department of Labor Office and Your State Insurance regulatory agency.”

To whom are benefits payable?

Benefits payable for loss of life will be payable in accordance with the beneficiary designation (other than Your Employer). Unless You otherwise specify, if more than one beneficiary survives You, all surviving beneficiaries will share equally. If there is no beneficiary designation, the benefit will be payable to Your estate. The beneficiary designation must be in Writing, Signed by You and in a form acceptable to Us. If no beneficiary is alive on the date of Your death or You do not elect a beneficiary, We, at Our option, may make payments as follows:

- to Your Spouse or Domestic Partner, if living; or
- if there is no surviving Spouse or Domestic Partner, to Your surviving children in equal shares; or
- if there is no surviving Spouse or Domestic Partner or children, to Your surviving parents in equal shares; or
- if there is no surviving Spouse or Domestic Partner, children or parents, to Your surviving brothers and sisters in equal shares; or

- if there is no surviving Spouse or Domestic Partner, children, parents, brothers or sisters, to Your surviving grandparents in equal shares; or
- if none of the above, to Your estate.

Benefits payable for loss of life of Your Spouse or Domestic Partner or a Dependent Child will be payable to You. If You are not living or are disqualified by operation of law, We will pay the deceased Dependent's estate.

For other benefits, We will pay You if Your Proof of claim is satisfactory to Us, except in the following situations:

- You are a minor. In such case, claim may be made by Your duly appointed guardian, conservator or committee and We will pay to such person or persons;
- due to physical or mental incapacity, You cannot, in Our judgment, give a valid receipt for payments.
- In such case, claim may be made as described above; or
- You die before We pay You. In such case, claim may be made by Your executor or the administrator of Your estate and We will pay to such person or persons.

If a benefit is payable to Your estate, if You are a minor, or You are not competent, We have the right to pay an amount of the benefit up to $5,000 to any of Your relatives that We consider entitled. If We pay benefits in good faith to a relative, We will not have to pay those benefits again.

If Your beneficiary is a minor or is not competent, We have the right to pay up to $1,000 to the person or institution that appears to have assumed custody and main support for the minor, until the appointed legal representative makes a formal claim. If We pay benefits in good faith to a person or institution, We will not have to pay those benefits again.

If We do not pay You and claim is not made by the appropriate person designated above, We may, at Our option, make payments under either or both Methods A or B below. Any decision to pay any benefits prior to the appointment of the appropriate person designated (as shown above), is solely at Our discretion, and We may choose to pay no amounts under any circumstances until such appropriate person is formally appointed.

Method A: We may pay up to the sum of $5,000 to any individual or entity We determine has incurred or paid expenses as a result of funeral services provided to or on Your behalf. If We pay such a benefit, We will not have to pay that benefit amount again and the total benefit due under the Policy shall be reduced by the amount paid under this provision.

Method B: We may pay the whole or any part of such benefit:

- to Your Spouse or Domestic Partner, up to a cumulative amount of $5,000; or
- if You have no Spouse or Domestic Partner, up to a cumulative amount of $5,000 to any one or more of the following relatives in the following order of priority:
  - first, Your child or children;
  - then, Your mother or father; or
  - Your estate.

9. INSURANCE CONTINUATION

Are there any conditions under which Your Employer can continue Your insurance?

While the Policy is in force and subject to the conditions stated in the Policy, Your Employer may continue Your insurance that was in force on the date immediately before the date You ceased to be Actively at Work by paying the required premium to Us for any of the following reasons and durations:

- Sickness or Injury – up to 12 months;
- Furlough – up to 3 months;
- Layoff – up to 3 months;
- Leave of Absence – up to 6 months;
- sabbatical – up to 6 months;
- labor dispute – up to 6 months;

You should contact Your Employer for more details.

While the Policy is in force, You may be eligible to continue Your insurance pursuant to the Family and Medical Leave Act of 1993, as amended or continue coverage pursuant to a state required continuation period (if any). You should contact Your Employer for more details.

While the Policy is in force, You may be eligible to continue Your insurance coverage pursuant to the Uniformed Services Employment and Reemployment Rights Act (USERRA), as amended. You should contact Your Employer for more details.

When does Your continuation of insurance end?

Your continuation of insurance will end on the earliest of the following to occur:

- the date the Policy terminates;
- the last day for which any required premium has been paid for Your continuation of insurance;
- the date You request in Writing to end Your continuation of insurance;
- the date You reside outside the United States;
- the date You die; or
- the date You become insured again under the Policy.

When does Your Spouse or Domestic Partner's continuation of insurance end?

Continuation of insurance for Your Spouse or Domestic Partner will end on the earliest of the following to occur:

- the date the Policy terminates;
- the last day for which any required premium has been paid for Your continuation of insurance or Your Spouse or Domestic Partner's continuation of insurance;
- the date You are no longer insured for continuation of insurance under the Policy;
- the date You request in Writing to end Your Spouse or Domestic Partner's continuation of insurance;
- the date Your Spouse or Domestic Partner no longer meets the definition of Spouse or Domestic Partner as described in this Certificate; or
- the date Your Spouse or Domestic Partner dies.

When does Your Dependent Children's continuation of insurance end?

Your Dependent Children's continuation of insurance will end on the earliest of the following to occur:

- the date the Policy terminates;
- the last day for which any required premium has been paid for Your continuation of insurance or Your Dependent Children's continuation;
- the date You are no longer insured for continuation of insurance under the Policy;
- the date You request in Writing to end Your Dependent Children's continuation of insurance;
- the date Your Dependent Child no longer meets the definition of a Dependent Child as described in this Certificate, but only with respect to that person; or
- the date Your Dependent Child dies.

10. PORTABILITY

PORTABILITY UNDER THIS CERTIFICATE

When can You port Your coverage to a different Eligible Class?

You may port Your coverage under this Certificate to a different Eligible Class if:

- You are no longer Actively at Work or the Policy terminates; and
- You are under age 70 on the day the portability coverage would take effect; and
- the first premium is paid within 31 days of the earlier of the date You are no longer Actively at Work or the Policy termination date.

To whom will premiums be paid?

Premiums due will be paid directly to Our administrative office and will include any portion previously paid by the Policyholder. Premiums will be billed directly to You at Your last known address.

What is the amount of portable insurance?

Only the insurance that was in effect under this Certificate may be ported.

Can You port Your Dependents Coverage?

You may port Dependent coverage if:

- You are porting insurance and
- Your Dependent was covered under the Group Policy and continues to meet the definition of Spouse or Domestic Partner or Child; and
- Your Dependent is under age 70 on the day the Portability coverage would take effect; and
- the first premium is paid within 31 days of the date You are no longer Actively at Work.

What happens if You or Your Insured Dependents are injured as a result of a Covered Accident?

If You or Your Insured Dependents are injured as a result of a Covered Accident within 31 days after Your insurance ends, but before You have applied to port, We will pay any benefits as if You had ported. However, You must pay any premium due.

Is Coverage under the Portability provision subject to a new Certificate? Coverage under the Portability Provision is subject to the terms of the new Certificate, and ends according to the termination provision in the new Certificate, including when the Policy terminates.

11. CONTINUITY OF COVERAGE

What happens if Your Employer replaces other group insurance with this Certificate and the Policy?

If Your Employer replaces group insurance provided by another insurance company ("Prior Policy") with the insurance provided by this Certificate and the Policy ("This Policy"), the Continuity of Coverage benefits set forth in this Section may be available to You. These benefits will be available if the insurance and level of benefits under the Prior Policy were substantially similar to the insurance provided by This Policy.

What if You are not Actively at Work when Your Employer replaces Your Prior Policy with This Policy?

You and Your Spouse or Domestic Partner and Dependent Children will be covered under This Policy if You are not Actively at Work on the policy effective date if:

- You were insured under the Prior Policy on the day before the Policy Effective Date;
- You are a member of an Eligible Class;
- Your Employer continues to remit premiums for Your coverage; and
- You are not receiving or eligible to receive benefits under the Employer's Prior Policy.

Any benefit payable will be the lesser of:

- the benefit payable under This Policy; or
- the benefit payable under Your Employer's Prior Policy.

Does the Eligibility Waiting Period apply when Your Employer's Prior Policy is replaced with This Policy?

We will apply any period of time satisfied under the Prior Policy to meet the requirements of the Eligibility Waiting Period toward the satisfaction of the period of time required by This Policy's Eligibility Waiting Period.

12. GENERAL PROVISIONS

AGENCY

Can the Policyholder, Employer, or third party administrator act as Our agent?
For all purposes of the Policy, the Policyholder, Employer or third party administrator acts on its own behalf or as Your agent. Under no circumstances will the Policyholder, Employer or third party administrator be deemed Our agent.

ALTERATION

Who can alter the Policy?
The only persons with the authority to alter or modify the Policy or to waive any of its provisions are Our president, actuary, secretary or one of Our vice presidents and any such changes must be in Writing.

ASSIGNMENT

Can benefit payments be assigned?
An Insured cannot assign any of the group accident insurance benefits.

BENEFICIARY

How can You change Your Beneficiary?
You can change Your beneficiary at any time by giving Us Written notice. The beneficiary's consent is not required for this or any other change in this Certificate, unless the designation of the beneficiary is irrevocable.

CLERICAL ERROR

What happens when there is a clerical error in the administration of the Policy?
Clerical errors in the administration of the Policy or delays in keeping records for the Policy whether by Us, the Policyholder, or the Employer:

- will not terminate insurance that would otherwise have been effective.
- will not continue insurance that would otherwise have ceased or should not have been in effect.

If appropriate, a fair adjustment of premium will be made to correct the error, subject to the "Limit of Premium Refunds" section.

This provision does not apply to benefit administration errors by the Policyholder or the Employer which results in an Employee:

- not enrolling for insurance within required time limits;
- failing to request increased amounts of insurance within required time limits; or
- failing to exercise any available Insurance Continuation or Portability options.

CONFORMITY WITH STATUTES

What is the effect of Conformity with Statutes?
If any provision of the Policy conflicts with any applicable law, the provision will be automatically amended to meet the minimum requirements of the law, except as otherwise pre-empted by federal law.

DISCHARGE OF OUR RESPONSIBILITY

What is the effect of payments under the Policy?
Payment made under the terms of the Policy will, to the extent of such payment, release Us from all

further obligations under the Policy. We will not be obligated to see to the application of such payment.

EXAMINATION AND AUTOPSY

What are Our examination and autopsy rights?

We, at Our expense, have the right to have any person with respect to whom a claim has been filed:

- examined by a Physician, other health professional or vocational expert of Our choice; and/or
- interviewed by an authorized representative.

This right may be used as often as We determine necessary. Unless authorized by the examining Physician, the examination may not be recorded nor may another person be present during the examination.

We, at Our expense, may have an autopsy made unless prohibited by law.

INCONTESTABILITY

What is the Incontestability Provision?

Except for non-payment of premium, fraud or any claims incurred within two years of the effective date of an Insured's initial, increased, additional or reinstated insurance, no statement made by any Insured relating to insurability for such insurance will be used to contest the claims of that insurance after the insurance has been in force for a period of two years during that individual's lifetime. The statement must be contained in a form Signed by that individual.

This provision shall not preclude the assertion at any time of a defense to a claim based upon the Insured's eligibility for insurance.

INSURER'S AUTHORITY

What is Our authority?

Equitable Financial Life Insurance Company of America has discretionary authority to make final determinations regarding claims for benefits under the Policy. This discretionary authority includes, but is not limited to, the right to determine eligibility for benefits and the amount of any benefits due and to construe the terms of the Policy.

This does not prohibit an Insured from seeking legal redress.

LEGAL PROCEEDINGS

What are the time limits for legal proceedings?

No legal action may start:

- until 60 days after Proof of claim has been given; nor
- more than 3 years after the time Proof of claim is required.

The claimant must exhaust all internal appeal/administrative remedies prior to filing any legal proceeding. If the claimant fails to exhaust all administrative remedies prior to initiating any legal action, We shall be entitled to legal fees in defense of the action. For claims subject to ERISA, if a claimant files state law causes of action that are later determined by a court to be preempted by ERISA, We shall be entitled to legal fees in defense of those causes of action.

LIMIT OF PREMIUM REFUNDS

Is there a limit on premium refunds?

12. GENERAL PROVISIONS

Whether premiums were paid in error or otherwise, We will refund only that part of the excess premium that was paid during the 12-month period that preceded the date We learned of such overpayment.

MISSTATEMENT OF FACTS

What happens if there is a misstatement of facts in the administration of the Policy?

If relevant facts about the Employer or Employee relating to this insurance are determined not to be accurate:

- a fair adjustment of premium will be made, subject to the "Limit of Premium Refunds" section; and
- the actual facts will decide whether, and in what amount, and for what duration insurance is valid under the Policy.

NON-PARTICIPATING

Does the Policy participate in dividends?

The Policy is non-participating and will not share in any profits or surplus earnings of Equitable Financial Life Insurance Company of America, and, therefore, no dividends are payable.

PREMIUM PAYMENTS AS EVIDENCE OF INSURANCE

Does the payment of premiums guarantee coverage under the Policy?

The receipt of premiums by Us is not a guarantee of insurance. Eligibility for benefits will be determined at the time of claim submission and in order to receive a benefit under the Policy, all Policy requirements must be satisfied.

If We determine that You or Your Dependents are not eligible for coverage, You should contact Your Employer regarding the refund of premiums due, if any.

REIMBURSEMENT

What if a benefit is underpaid or overpaid?

Reimbursement will be made to Us for any overpayments that We may make due to any reason. You must repay Us within 60 days unless We agree to a longer time period. Deductions may be made from future benefit payments to recover any such overpayments.

If We have underpaid a benefit for any reason, We will make a lump sum payment for that amount.

Interest does not accrue on any underpaid or overpaid benefit unless required under the applicable law.

STATEMENTS

Are statements warranties?

In the absence of fraud, all statements made in any application are considered representations and not warranties. No representation by You in enrolling for insurance under the Policy will be used to reduce or deny a claim unless a copy of Your Written application for insurance is or has been given to You, Your beneficiary, if any, or Your estate representative.

TIME PERIODS

What time periods apply to this Certificate?

For the purpose of effective dates and termination dates under this Certificate, all days begin at 12:00, midnight and end at 11:59:59 PM at the Policyholder's location.

EQUITABLE

Privacy notice

What does Equitable do with your personal information?

Why?

Financial companies choose how they share your personal information. Federal law gives consumers the right to limit some, but not all, sharing. Federal law also requires us to tell you how we collect, share and protect your personal information. **Please read this notice carefully to understand what we do.**

What?

The types of personal information we collect and share depend on the product or service you have with us. When you open an account, we will use this information to verify your identity to comply with laws. This information can include:

- Social Security number and date of birth
- Financial information
- Medical information
- Demographic information
- Contact information (e.g., residential address, phone number)
- Other information specific to you (e.g., driver's license number, passport number, employment status)

When you are no longer our customer, we continue to share your information as described in this notice.

How?

All financial companies need to share customers' personal information to run their everyday business. In the section below, we list the reasons financial companies can share their customers' personal information, the reasons Equitable chooses to share and whether you can limit this sharing.

Reasons we can share your personal information	Does Equitable share?	Can you limit this sharing?
For our everyday business purposes, and those of your financial professional — such as processing your transactions, maintaining your account(s), responding to court orders and legal investigations, or reporting to credit bureaus	Yes	No
For our marketing purposes — to offer you our products and services	Yes	Yes
For joint marketing with other financial companies	No	We don't share
For our affiliates' everyday business purposes — information about your transactions and experiences	Yes	No
For our affiliates' everyday business purposes — information about your creditworthiness	Yes	Yes
For our affiliates to market to you	Yes	Yes
For nonaffiliated companies to market to you	No[1]	We don't share

1 For clients of Equitable Advisors: If your financial professional (FP) moves to another brokerage or investment advisory firm, your FP is permitted to take certain basic contact information about you to the new firm so your FP may inform you of the move; you always have the option of keeping your investments at Equitable Advisors or moving them to another firm.

Who we are...

Who is providing this notice?	Equitable, on behalf of itself, and those of its affiliates listed in the **Other important information** section.

What we do...

How does Equitable protect my personal information?	To protect your personal information from unauthorized access and use, we use security measures that comply with federal law, including computer safeguards, and secured files and buildings. We also comply with applicable state laws and regulations regarding protection of personal information.
How does Equitable collect my personal information?	We collect your personal information, for example, when you: • Open an account • Purchase products • Request information about a product or marketing materials • Make a financial transaction • Make a claim Your personal information may be collected from persons other than you (e.g., credit bureaus, Medical Information Bureau, payment processors), and may be disclosed in certain circumstances to third parties without your authorization; however, you do have the right to access and correct any and all personal information we have collected about you.
Why can't I limit all sharing?	Federal law gives you the right to limit only: • Sharing for affiliates' everyday business purposes — information about your creditworthiness • Affiliates from using your information to market to you • Sharing for nonaffiliated companies to market to you State laws and individual companies may give you additional rights to limit sharing.

Definitions

Affiliates	Companies related by common ownership or control. They can be financial and nonfinancial companies (e.g., distribution entities, investment managers, reinsurers).
Nonaffiliated companies	Companies not related by common ownership or control. They can be financial and nonfinancial companies (e.g., print vendors, payment processors, third-party administrators).
Joint marketing	A formal agreement between nonaffiliated financial companies that together market financial products or services to you.

Questions?

Call (877) 806-4573 or visit equitable.com/about-us/privacy-security-and-fraud.

Other important information:

This privacy notice applies to Equitable Holdings, Inc. and its following affiliates: Equitable Financial Life Insurance Company; Equitable Financial Life and Annuity Company (Equitable Financial Life Insurance and Annuity Company in CA); Equitable Financial Life Insurance Company of America; Equitable Advisors, LLC; Equitable Distributors, LLC; and Equitable Network, LLC (Equitable Network Insurance Agency of Utah, LLC in UT; Equitable Network Insurance Agency of California, LLC in CA; Equitable Network of Puerto Rico, Inc. in PR).

Equitable is the brand name of the retirement and protection subsidiaries of Equitable Holdings, Inc., including Equitable Financial Life Insurance Company (Equitable Financial) (NY, NY); Equitable Financial Life Insurance Company of America (Equitable America), an AZ stock company; and Equitable Distributors, LLC. Equitable Advisors is the brand name of Equitable Advisors, LLC (member FINRA, SIPC) (Equitable Financial Advisors in MI & TN).

 | G2290558 | Cat. #134310 (Revised 8/23)

EQUITABLE

Group Employee Benefits
Producer Compensation Notice

Regular Mail:
Equitable
Employee Benefits Group
P.O. Box 4728
Syracuse, NY 13202

Express Mail:
Equitable
Employee Benefits Group
(34-1)
100 Madison Street
Syracuse, NY 13202

EQUITABLE

Equitable Financial Life Insurance Company*
Equitable Financial Life Insurance Company of America*

For Assistance Call (866) 274-9887

PRODUCER COMPENSATION NOTICE

Equitable[1] utilizes the services of brokers, advisors, and consultants (collectively, "Producers") in connection with the sale of our Employee Benefits products. We believe that the expertise of these Producers is valuable to our customers, and so Equitable provides compensation to these Producers for their services. A Producer may receive one or more of the compensationtypes listed below in connection with the sale of Equitable Employee Benefits products to you and/or your employees.[2]

Base Compensation – this compensation, which varies by product, is payable as a percentage of annual premium on a pre-defined flat commission scale or on a graded schedule under which the commission percentage decreases as the annual premium increases.

Supplemental Compensation – this compensation, which is payable only in connection with sales of certain Equitable Employee Benefits products, is payable to all Producers other than advisors who meet certain pre-defined annual sales thresholds. This compensation is also payable as a percentage of annual premium on a pre-defined flat commission scale or on a graded schedule; however, unlike base compensation, under the supplemental compensation graded schedule, the commission percentage increases as the annual premium increases. Persistency Bonus – Producers may also qualify for an additional bonus payment based on the persistency of their in-force block. Persistency is the percentage of in-force business that is retained year over year.

The payment of supplemental compensation as to any particular sale does not affect the cost of the product purchased because the cost of supplemental compensation is considered part of the overhead expenses for all of Equitable's Employee Benefits products.

For more information about Equitable's Producer Compensation Program for its Employee Benefits products, please email ebappointments@equitable.com.

1 Equitable is the brand name of Equitable Holdings, Inc. and its family of companies, including Equitable Financial Life Insurance Company (Equitable Financial) (NY, NY) and Equitable Financial Life Insurance Company of America (Equitable America), an AZ stock company. Equitable's Employee Benefits products are issued by either Equitable Financial or Equitable America. Equitable Financial or Equitable America are each responsible for their respective obligations, which are backed solely by each company's respective claims-paying abilities.

2 Note that Producers or their affiliates may have other relationships with Equitable unrelated to the sale of Equitable Employee Benefits products as to which those Producers may receive separate compensation from Equitable.

3 Advisors may be eligible to receive supplemental compensation on a case-by-case basis.