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 CRITICAL ILLNESS 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

This policy form covers issue age 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

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

GROUP CRITICAL ILLNESS 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.

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

NOTICE TO BUYER: THIS IS A LIMITED BENEFIT HEALTH CERTIFICATE. THIS CERTIFICATE PROVIDES LIMITED BENEFITS. BENEFITS PROVIDED ARE SUPPLEMENTAL AND NOT INTENDED TO COVER ALL MEDICAL EXPENSES.

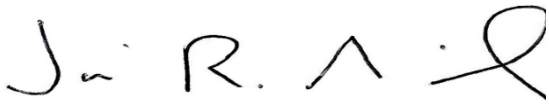
PLEASE READ YOUR CERTIFICATE CAREFULLY.

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).

At the time of enrollment, You may be eligible to select an amount of Critical Illness insurance. We will pay benefits corresponding to the elections You made as shown below. You may change Your or Your Spouse's and Dependent Children's amount of Critical Illness insurance according to the When Can You Make Changes in Insurance provision.

Any limitation applies separately to You, Your Spouse and Dependent Children. Please see Covered Conditions and Exclusions and Limitations for a complete description of benefits, limitations and exclusions.

Classification: Class 1

Insurance Amounts

Employee Insurance	Minimum: $5,000 Maximum: $30,000 Guaranteed Issue Amount – Initial Enrollment only: $30,000 Change Increment Amount: $5,000
Spouse Insurance	Minimum: $2,500 Maximum: $15,000 Guaranteed Issue Amount – Initial Enrollment only: $15,000 Change Increment Amount: $2,500
Dependent Children Insurance	Minimum: $2,500 Maximum: $5,000 Guaranteed Issue Amount – Initial Enrollment only: $5,000 Change Increment Amount: $2,500

The Spouse and Dependent Children Insurance Amount will not be more than 50% of Your Insurance Amount.

If You or Your Spouse or Dependent Children were insured under the Employer's Prior Policy of Critical Illness insurance on the day before the effective date of this Policy for an amount greater than the maximum shown above, You may retain the amount in effect on the day before the effective date of this Policy.

If You or Your Spouse or Dependent Children were insured under the Employer's plan of Critical Illness insurance on the day before the effective date of this Policy for an amount that does not follow the Change Increment Amount shown above, You may retain that amount. If You later elect to change Your or Your Spouse or Dependent Children amount during an annual Enrollment Period, You must elect an amount that conforms to the Insurance Amounts listed above and provide Evidence of Insurability, if required.

Critical Illness If You enrolled in this option, Your insurance will be based on the following.

1. BENEFIT HIGHLIGHTS

Core Conditions Category – Employee, Spouse and Dependent Children Insurance

Covered Condition	Benefit Percentages	Recurrence Benefit Percentages
Heart Attack	**100%**	**25%**
Stroke	**100%**	**25%**
End-stage Heart Failure	**100%**	**25%**
Major Organ Failure	**100%**	**25%**
Occupational Infectious Disease	**100%**	**N/A**
End-stage Kidney Disease	**100%**	**25%**
Coronary Artery Bypass Graft	**25%**	**25%**
Angioplasty	**5%**	**5%**

Cancer Conditions Category – Employee, Spouse and Dependent Children Insurance

Covered Condition	Benefit Percentages	Recurrence Benefit Percentages
Cancer	**100%**	**100%**
Cancer in Situ	**25%**	**25%**
Skin Cancer	**5%**	**5%**

Other Conditions Category – Employee, Spouse and Dependent Children Insurance

Covered Condition	Benefit Percentages	Recurrence Benefit Percentages
Benign Brain Tumor	**100%**	**25%**
Coma	**100%**	**25%**
Complete Blindness	**100%**	**N/A**
Paralysis	**100%**	**N/A**
Loss of Speech	**100%**	**N/A**
Complete Loss of Hearing	**100%**	**N/A**
Advanced ALS/Lou Gehrig's Disease	**100%**	**N/A**
Advanced Alzheimer's Disease	**25%**	**N/A**
Advanced Parkinson's Disease	**25%**	**N/A**
Severe Burns	**100%**	**25%**

Wellness Screening Benefit: $100 per Benefit Year if any one of the wellness screening tests described in this Certificate is performed for You. $100 each Benefit Year if any one of the wellness screening tests described in this Certificate is performed for Your insured Spouse and Dependent Children.

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

2. DEFINITIONS

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.

Activities of Daily Living means:

- Bathing – washing oneself by sponge bath; or in either a tub or shower, including the task of getting into or out of the tub or shower.
- Continence – the ability to maintain control of bowel and bladder function; or, when unable to maintain control of bowel or bladder function, the ability to perform associated personal hygiene (including caring for a catheter or colostomy bag).
- Dressing – putting on and taking off all items of clothing and any necessary braces, fasteners or artificial limbs.
- Eating – feeding oneself by getting food into the body from a receptacle (such as a plate, cup, or table) or by feeding tube or intravenously.
- Toileting – getting to and from the toilet, getting on and off the toilet, and performing associated personal hygiene.
- Transferring – moving into or out of a bed, chair or wheelchair.

The assessment must be made by a medical professional such as an occupational therapist or equivalent.

Benefit Percentage means the percentage that is applied to the Insurance Amount to determine the amount of Critical Illness benefits payable under the Policy.

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

Civil Union means a state sanctioned and/or recognized union of two eligible individuals of the same sex 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 spouses in a marriage, except where prohibited by law.

Clinical Diagnosis means a Diagnosis of Cancer based on observation and history, diagnostic and laboratory studies, and symptoms.

Confined or Confinement means:

- confined to a hospital or similar facility; or
- confined at home due to a sickness or Injury and under the care of a Physician.

Contributory means You pay all of the premium.

Coronary Artery Disease means acute coronary occlusion, coronary atherosclerosis, aneurysm and dissection of the coronary arteries or coronary atherosclerosis due to plaque.

Critical Illness means only the illnesses defined in the Covered Conditions section of this Certificate for which benefits are payable.

Dependent means Your insured Spouse and Dependent Child(ren).

2. DEFINITIONS

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

- Your biological child;
- Your legally adopted child including any child placed with You for adoption;
- Your foster child from the time he or she is placed in the home by a licensed agency;
- Your stepchild;
- The child of Your Civil Union partner;
- The child of Your Domestic Partner; 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;
- 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.

Diagnosed, Diagnosis or Diagnoses means an evaluation of an Insured's medical condition that is performed by a Physician whose specialty is appropriate for the condition being evaluated, and who is board certified in that specialty in accordance with the American Board of Medical Specialties criteria. The evaluation must be consistent with the most current medically accepted diagnostic standards according to Nationally Recognized Authorities. A Diagnosis must be based on conditions, clinical signs on examination, or test results that have changed substantially since becoming insured under the Policy. In addition, if cognitive function is being evaluated, the conclusions must be confirmed with neuropsychological testing conducted by a clinical psychologist at the doctorate level certified through the American Board of Professional Psychology in the area of clinical neuropsychology.

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.

2. DEFINITIONS

Any period of time prior to the Policy Effective Date You were Actively at Work for the Employer as an Employee will count towards completion of the Eligibility Waiting Period.

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 Employees may elect, 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.

Family Member means: (a) Your Spouse and (b) the following relatives of You or Your Spouse: (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, Civil Union or Domestic Partnership;
- Your divorce or dissolution of a Civil Union or 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 child;
- the commencement or termination of employment of Your Spouse or Dependent Child;
- the change from part-time to full-time employment by You, Your Spouse, or Dependent Child;
- the change from full-time to part-time employment by You, Your Spouse, or Dependent Child; or
- the taking of an unpaid Leave of Absence by You or Your Spouse.

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.

Guaranteed Issue Amount means the maximum amount of insurance available to You and Your Dependents under the Policy without having to provide Evidence of Insurability. The Guaranteed Issue Amount is shown in the Benefit Highlights.

Initial Enrollment means the first date You are eligible to enroll for Employee Insurance, Spouse Insurance and Dependent Children Insurance.

Injury means unintentional physical damage or harm caused directly by an accident occurring while insured under the Policy and not due to sickness, disease or any other causes.

Insurance Amount means the amount of insurance available under the Policy as shown in the Benefit Highlights and for which a person covered under the Policy is insured.

Insured means any person covered under the Policy.

Intoxicated means:

- under the influence of alcohol, illegal drugs or prescription drugs other than as prescribed by Your Physician; or
- at or above the minimum blood alcohol level for which You would be considered operating a motorized vehicle under the influence of alcohol in the jurisdiction where the Intoxication occurred.

2. DEFINITIONS

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.

Late Entrant means You apply for any insurance more than 31 days after You first become eligible to enroll in it.

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.

Nationally Recognized Authorities means the American Medical Association (AMA) Council on Scientific Affairs, the AMA Diagnostic and Therapeutic Technology Assessment Project, the AMA Board of Medical Specialties, the American College of Physicians and Surgeons, the Food and Drug Administration, the Centers for Disease Control and Prevention, the Office of Technology Assessment, the National Institutes of Health, the Health Care Finance Administration, the Agency for Health Care Policy and Research, the Department of Health and Human Services, the National Cancer Institute, and any additional organizations We choose which attain similar status.

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.

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 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.

Prior Policy means the group insurance policy(ies) for Critical Illness Insurance issued to the Policyholder that was in effect immediately prior to the Policy.

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

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.

2. DEFINITIONS

Specialist Physician means a medical doctor who is licensed and practicing in the United States and who has completed an accredited specialty training program recognized by the American Board of Medical Specialties and has passed the examination leading to Board Certification in the field most applicable to the condition being evaluated or equivalent certification acceptable to Us.

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.

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.

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 Critical Illness Insurance?

You are initially eligible for Employee Critical Illness 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 Critical Illness 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 Critical Illness Insurance?

For Contributory Employee Critical Illness Insurance
You must enroll within 31 days of the date You are initially eligible for Employee Critical Illness Insurance or within 31 days of the date of a Family Status Change or during any Enrollment Period otherwise You will be considered a Late Entrant.

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 Critical Illness Insurance
Employee Critical Illness Insurance starts on the latest of the date:

- You are eligible; or
- You enroll and 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 Critical Illness Insurance?

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

You may also request a change in Employee Critical Illness 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.

Any amount or increase in Employee Insurance is subject to the Pre-Existing Conditions limitation. A pre-existing condition will be considered to have occurred in relation to the effective date of the change, not the original effective date of Your coverage.

You may only increase or decrease Your Employee Insurance Amount within the limits shown in the Benefit Highlights.

When will Employee Critical Illness Insurance coverage change?

Your Employee Critical Illness 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 Critical Illness Insurance start?

If You are Actively at Work, any increase in Employee Critical Illness 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.

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

Whether or not You are Actively at Work, any reduction in Employee Critical Illness 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 insurance or benefits due to a Family Status Change will start on the latest of:
- the first of the month following the date You apply for such change in Employee Critical Illness 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 Critical Illness 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 Critical Illness Insurance or benefits due to a Family Status Change will start on:
- the first of the month following the date You apply for such change in Employee Critical Illness Insurance and You agree to make any required contribution toward the cost of insurance; or
- the date of Your Family Status Change.

If Evidence of Insurability is required for any increase in Your amount of insurance, the increase in Your insurance will not start until We approve the increase in Writing, but You need to be Actively at Work on that date.

Any change is subject to all the terms of the Policy.

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 a new Pre-existing Condition exclusion for any condition which manifested during the period of time between the date Your employment terminated and the date You are rehired;
- be subject to all the terms and provisions of the Policy.

You will not be subject to a new Pre-existing Condition limitation as of the date You are rehired. You will be given credit for the time You were insured prior to Your termination of employment.

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

3. ELIGIBILITY, EFFECTIVE DATES AND TERMINATION OF EMPLOYEE INSURANCE

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.

You must re-enroll within 31 days of Your rehire date.

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 Critical Illness Insurance end?

Your Employee Critical Illness 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 Critical Illness Insurance or any part of Your insurance;
- the date You notify Us in Writing to cancel Your Employee Critical Illness Insurance;
- the date all benefits paid or payable for You under the Policy reach the maximum amount payable as described herein; or
- the date You die.

Your Employee Critical Illness 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 unless You are eligible for Retired Employee Critical Illness Insurance;
- 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 latest date when all 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 Diagnosis occurring between Your termination date and Your reinstatement effective date will not be considered a Covered Benefit.

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 INSURANCE

When are You eligible for Spouse Critical Illness Insurance?

If You are in an Eligible Class, You are initially eligible for Spouse Critical Illness Insurance on the latest of:

- the Policy effective date;
- the date You are eligible for Employee Critical Illness Insurance; or
- the date You acquire a Spouse.

You are also eligible for Spouse Critical Illness 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.

When must You enroll for Spouse Critical Illness Insurance?

For Contributory Spouse Critical Illness Insurance

You must enroll within 31 days of the date You are initially eligible for Spouse Critical Illness 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 otherwise You will be considered a Late Entrant.

When does Spouse Critical Illness Insurance start?

For Contributory Spouse Critical Illness Insurance

Spouse Critical Illness Insurance starts on the latest of the date:

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

If You are Actively at Work on that date and Your Spouse is not confined on that date.

If You are not Actively at Work on that date, Your Spouse Critical Illness Insurance will not start until You resume being Actively at Work.

What if Your Spouse is Confined?

If Your Spouse is Confined on the date Your Spouse Critical Illness Insurance would normally start, Your Spouse Critical Illness Insurance will not start until Your Spouse is no longer Confined.

When can You make changes in Spouse Critical Illness Insurance?

You may request a change in Your Spouse Critical Illness Insurance Amount or benefit elections during any Enrollment Period while the Policy is in force.

You may also request a change in Spouse Critical Illness 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.

Any amount or increase in Spouse Critical Illness Insurance is subject to the Pre-existing Conditions limitation. A pre-existing condition will be considered to have occurred in relation to the effective date of the change, not the original effective date of Your coverage.

You may only increase or decrease Your Spouse Insurance Amount within the limits shown in the Benefit Highlights.

When will Your Spouse Critical Illness Insurance coverage change?

Your Spouse Critical Illness 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 Critical Illness Insurance start?

4. ELIGIBILITY, EFFECTIVE DATES AND TERMINATION OF SPOUSE INSURANCE

If You are Actively at Work, any increase in Spouse Critical Illness 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 Your Spouse is Confined on that date, Your increase in Spouse Critical Illness Insurance or benefits will not start until Your Spouse is no longer Confined.

If You are not Actively at Work on that date, any increase in Spouse Critical Illness 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 Critical Illness 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; or
- the date of the Policy change.

If You are Actively at Work, any increase in Spouse Critical Illness Insurance or benefits due to a Family Status Change will start on the latest of:

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

If Your Spouse is Confined on that date, Your increase in Spouse Critical Illness Insurance or benefits will not start until Your Spouse is no longer Confined.

If You are not Actively at Work on that date, any increase due to a Family Status Change in Spouse Critical Illness 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 Critical Illness 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 Critical Illness Insurance or benefits and You agree to make any required contribution toward the cost of insurance; or
- the date of Your Family Status Change.

When does Spouse Critical Illness Insurance end?

Spouse Critical Illness 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 Critical Illness Insurance or any part of Your insurance or Your Spouse Critical Illness Insurance;
- the date You notify Us in Writing to cancel Your Spouse Critical Illness Insurance;
- the date You die; or
- the date Your Spouse dies.

Your Spouse Critical Illness Insurance will also end when any of the following occur, but coverage may be

4. ELIGIBILITY, EFFECTIVE DATES AND TERMINATION OF SPOUSE INSURANCE

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 no longer meets the definition of Spouse as described in this Certificate;
- the date Your Spouse 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 Critical Illness Insurance?

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

- The Policy effective date;
- the date You are eligible for Employee Critical Illness Insurance; or
- the date You acquire Your Dependent Children.

You are also eligible for Dependent Children Critical Illness 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 Critical Illness Insurance?

For Contributory Dependent Children Critical Illness Insurance

You must enroll within 31 days of the date You are initially eligible for Dependent Children Critical Illness 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 otherwise You will be considered a Late Entrant.

When does Dependent Children Critical Illness Insurance start?

For Contributory Dependent Children Critical Illness Insurance

Dependent Children Critical Illness Insurance starts on the latest of the date:

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

If You are Actively at Work on that date and Your Dependent Child is not Confined on that date.

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

What if Your Dependent Child is Confined?

If Your Dependent Child is Confined on the date Your Dependent Children Critical Illness Insurance would normally start, Your Dependent Children Critical Illness Insurance will not start until Your Dependent Child is no longer Confined. Confinement does not apply to a newborn child or a newly adopted child.

When can You make changes in Dependent Children Critical Illness Insurance?

You may request a change in Your Dependent Children Critical Illness Insurance or benefit elections during any Enrollment Period at any time while the Policy is in force.

You may also request a change in Dependent Children Critical Illness 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.

Any amount or increase in Dependent Children Critical Illness Insurance is subject to the Pre-existing Conditions limitation. A pre-existing condition will be considered to have occurred in relation to the effective date of the change, not the original effective date of Your coverage.

You may only increase or decrease Your Dependent Children Insurance Amount within the limits shown in the Benefit Highlights.

When will Your Dependent Children Critical Illness Insurance coverage change?

Your Dependent Children Critical Illness 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 Critical Illness Insurance start?

If You are Actively at Work, any increase in Dependent Children Critical Illness 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 Your Dependent Child is Confined on that date, Your increase in Dependent Children Critical Illness Insurance or benefits will not start until Your Dependent Child is no longer Confined.

If You are not Actively at Work on that date, any increase in Dependent Children Critical Illness 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 Critical Illness 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 Dependent Children Critical Illness 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 Critical Illness Insurance and You agree to make any required contribution toward the cost of insurance; or
- the date of Your Family Status Change.

If Your Dependent Child is Confined on that date, Your increase in Dependent Children Critical Illness Insurance or benefits will not start until Your Dependent Child is no longer Confined.

Whether or not You are Actively at Work, any reduction in Dependent Children Critical Illness 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 Critical Illness Insurance or benefits and You agree to make any required contribution toward the cost of insurance; or
- the date of Your Family Status Change.

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

After You 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 Critical Illness 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 Critical Illness Insurance when a newborn child, newly placed foster child or newly adopted child becomes one of Your Dependent

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

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 Critical Illness 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 Critical Illness Insurance.

If You are covered under the Policy and have Dependent Children Critical Illness 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 Critical Illness Insurance end?

Dependent Children Critical Illness 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 Critical Illness 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 Critical Illness Insurance;
- the date You die; or
- the date Your Dependent Child dies.

Your Dependent Children Critical Illness 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. BENEFIT PROVISIONS

What benefits are payable?

We will pay You a lump-sum benefit for the insurance in force when any eligible Insured, on or after the effective date of insurance, is Diagnosed with a Critical Illness condition as defined in the Covered Conditions section of this Certificate.

Any benefits payable are subject to the limitations, exclusions and other conditions stated in the Policy.

How is the amount of the benefit determined?

We will multiply the Insured's Insurance Amount by the Benefit Percentage for the applicable Covered Condition as shown in the Benefit Highlights to determine the benefit to be paid.

If benefits for a particular Critical Illness have been paid, an Insured is not eligible for any additional benefits if the Insured is ever Diagnosed with that Critical Illness again, except as described in Recurrence Benefit.

If an Insured is Diagnosed with more than one Critical Illness on the same date, We will pay only the benefit for the Critical Illness with the largest Benefit Percentage.

Additional Occurrence

When is an additional benefit payable?

If We pay benefits for a particular Critical Illness, We will pay benefits for a different Critical Illness listed in the Benefit Highlights, if there are more than 6 consecutive months between Diagnoses.

Recurrence Benefit

When is a Recurrence Benefit payable?

We will pay a Recurrence Benefit, as shown in the Benefit Highlights, if:

- benefits have been paid under this Policy because an Insured was Diagnosed with a Critical Illness;
- an Insured is Diagnosed with the same Critical Illness more than 12 consecutive months later; and
- the Insured has not received Treatment for the same Critical Illness for 12 consecutive months after the Diagnosis for the Critical Illness. For the purposes of this provision, We will not consider follow-up visits to a Physician or prescription medications other than cytotoxic medications (cancer chemotherapy) to be Treatment.

How is the amount of the Recurrence Benefit determined?

We will multiply the Insured's Insurance Amount by the Recurrence Benefit Percentage for the applicable Covered Condition as shown in the Benefit Highlights to determine the benefit to be paid.

What is the maximum benefit payable under the Recurrence Benefit?

We will pay the Recurrence Benefit for an Insured only once for each applicable Covered Condition.

7. COVERED CONDITIONS

What Critical Illness conditions are covered?

The Critical Illness conditions listed below are covered under the Policy.

CORE CONDITIONS CATEGORY

Heart Attack means, that while insured under the Policy, the Insured has been Diagnosed with Coronary Artery Disease that results in the death of heart muscle due to acute obstruction of a coronary artery that results in a rise and fall of biochemical cardiac markers to levels considered diagnostic of myocardial infarction and includes at least one of the following:

- heart attack symptoms; or
- new electrocardiogram (ECG) changes consistent with a Heart Attack.

The Diagnosis of Heart Attack must be made by a Specialist Physician.

Exclusions:

Heart Attack does not include:

- elevated biochemical cardiac markers as a result of an intra-arterial cardiac procedure including, but not limited to, coronary angiography and coronary angioplasty; or
- silent myocardial infarction, including ECG or imaging changes suggesting a prior myocardial infarction, which do not meet the Heart Attack definition as described above.

Stroke means, that while insured under the Policy, the Insured has been Diagnosed with cerebrovascular disease resulting in a brain tissue infarction or hemorrhage documented by brain imaging in association with acute onset of new neurologic deficits consistent with central nervous system damage.

The Diagnosis of Stroke must be made by a Specialist Physician.

Exclusions:

For the purposes of this Policy, Stroke does not include:

- Transient Ischemic Attacks (TIAs);
- Transient Global Amnesia (TGA); or
- External trauma causing Injury to the brain.

End-stage Heart Failure means, that while insured under the Policy, the Insured has been Diagnosed with severe and irreversible failure of the heart which is not remediable by medical or device therapy or by surgical therapy other than heart transplant. To qualify under End-stage Heart Failure, the Insured must be listed with the United Network of Organ Sharing (UNOS) on a heart transplant waiting list. Severe and irreversible failure of the heart shall be conclusively proven if an Insured has undergone a heart transplant as the recipient while insured under the Policy.

The Diagnosis of End-stage Heart Failure must be made by a Specialist Physician.

Major Organ Failure means, that while insured under the Policy, the Insured is Diagnosed with any end-stage disease as specified by the most current edition of the International Classification of Diseases (ICD) of the heart, liver, lung, small intestine, pancreas or bone marrow that has resulted in the chronic and irreversible failure of the organ to function.

For all organs listed above, a transplant is recommended as soon as an appropriate donor is located, and the Insured is either registered with the:

- United Network of Organ Sharing (UNOS); or
- National Marrow Donor Program (NMDP).

The Diagnosis of Major Organ Failure must be made by a Specialist Physician.

Exclusions:
Major Organ Failure does not include any of the following:

- bone marrow failure that results from the Treatment process for cancer;
- failure of any other organ not listed above; or
- a transplant in which the Insured's own bone marrow is used.

If multiple organs are to be replaced at the same time, only one benefit for Major Organ Failure is payable.

End-Stage Kidney Disease means, that while insured under the Policy, the Insured has been Diagnosed with a renal disease that has resulted in either:

- the chronic and irreversible failure of both kidneys to function and which requires regular dialysis for a minimum of 90 days; or
- the need for a kidney transplant.

The Diagnosis of End-Stage Kidney Disease must be made by a Specialist Physician. In the event a kidney is transplanted at the same time as other organs, only one benefit is payable.

Occupational Infectious Disease means, that while insured under the Policy, the Insured is Diagnosed with Human Immunodeficiency Virus (HIV) infection or Hepatitis B, C and/or D resulting from accidental exposure to HIV or Hepatitis B, C and/or D by contaminated body fluids during the course of performing the Insured's regular occupation for which remuneration is earned. To prove occupational exposure, all of the following must be submitted:

- documentation showing that within five days of the accidental exposure, the exposure was reported and recorded by the appropriate person according to legislation, regulations or standard guidelines that apply to the occupation;
- a negative antibody for HIV or Hepatitis B, C and/or D test, performed by a state certified and licensed laboratory within five days of exposure; and
- a positive antibody for HIV or Hepatitis B, C and/or D test, taken in the 90 to 180 days following the exposure.

Occupational Infectious Disease does not include HIV or Hepatitis B, C and/or D that occurs as a result of IV drug use, sexual transmission or is determined not to be accidental.

The Diagnosis of Occupational Infectious Disease must be made by a Specialist Physician. In order for a benefit to be paid, the Diagnosis of Occupational Infectious Disease must occur while insured under the Policy.

Coronary Artery Bypass Graft means, that while insured under the Policy, an Insured has been Diagnosed with Coronary Artery Disease requiring a procedure to bypass one or more diseased, narrowed or blocked coronary arteries with arterial or venous grafts and is performed by a board certified cardiovascular surgeon.

Exclusions:
No benefit will be payable for diseases requiring other procedures such as percutaneous transluminal coronary angioplasty (PTCA) or laser procedures.

Angioplasty means, that while insured under the Policy, the Insured has been Diagnosed with Coronary Artery Disease requiring a procedure to correct the narrowing or blockage of one or more coronary arteries by balloon. Angioplasty does not include a laser based intra-arterial procedure.

7. COVERED CONDITIONS

CANCER CONDITIONS CATEGORY

Life Threatening Cancer means, that while insured under the Policy, the Insured has been Diagnosed with a malignant neoplasm, which is characterized by the uncontrolled growth and spread of malignant cells and the invasion of neighboring tissue.

The Diagnosis must be:
- made by a Specialist Physician; and
- supported by pathological confirmation or its equivalent.

A Clinical Diagnosis will be accepted only if a pathological confirmation of the Diagnosis cannot be made because it is medically inappropriate or life threatening.

Exclusions:
No benefit will be payable for the following:
- lesions described as benign, pre-malignant, uncertain, borderline, non-invasive, carcinoma in-situ (Tis), or tumors classified as Ta;
- malignant melanoma skin cancer that is less than or equal to 1.0 mm in thickness, unless it is ulcerated or is accompanied by lymph node or distant metastasis;
- any non-melanoma skin cancer, without lymph node or distant metastasis;
- early prostate cancer classified as T1a or T1b (or equivalent staging) without lymph node or distant metastasis; or
- thyroid cancer less than or equal to 1.0 cm in greatest diameter and classified as T1, without lymph node or distant metastasis.

No benefit will be payable under this provision for the non-life threatening cancers listed in the Non-Life Threatening Cancer provision below.

No benefit will be payable for a recurrence or metastasis of an original cancer which was Diagnosed prior to the effective date of insurance.

Cancer in Situ means, that while insured under the Policy, the Insured has been Diagnosed with a cancer wherein the tumor cells still lie within the tissue of origin without having invaded neighboring tissue.

The Diagnosis must be:
- made by a Specialist Physician; and
- supported by pathological confirmation or its equivalent.

A Clinical Diagnosis will be accepted only if a pathological confirmation of the Diagnosis cannot be made because it is medically inappropriate or life threatening.

Cancer in Situ includes, but is not limited to:
- chronic lymphocytic leukemia that has not progressed beyond Rai stage 0;
- Stage 1A (T1a) malignant melanoma (melanoma less than or equal to 1.0 mm in thickness, not ulcerated and without Clark level IV or level V invasion);
- early prostate cancer Diagnosed as T1a or T1b, or equivalent staging without lymph node or distant metastasis;
- thyroid cancer (less than or equal to 1 cm in diameter) and confined to the thyroid and classified as T1a, without lymph node or distant metastasis; and
- ductal carcinoma in situ (DCIS) of the breast.

7. COVERED CONDITIONS

Exclusions:
Non-Life Threatening Cancer does not include any of the following:

- pre-malignant lesions (such as intraepithelial neoplasia);
- Benign tumors or polyps;
- other skin cancer, such as squamous cell or basal cell cancer; or
- Life Threatening Cancer.

No benefit will be payable for a recurrence or metastasis of an original Non-Life Threatening Cancer which was Diagnosed prior to the effective date of insurance.

Skin Cancer means, that while insured under the Policy, the Insured has been Diagnosed with basal cell cancer or squamous cell cancer of the skin.

OTHER CONDITIONS CATEGORY

Advanced Alzheimer's Disease means, that while insured under the Policy, an Insured has:

- been Diagnosed with Functional Assessment Staging Scale (FAST) Stage 6 or higher for Alzheimer's related dementia; and
- demonstrated memory impairment; decreased ability to plan, organize, sequence; language disturbance; or other cognitive disturbance; and
- been unable to perform 3 or more of the Activities of Daily Living without the assistance of another person.

The Diagnosis of Advanced Alzheimer's Disease must be made by a Specialist Physician. In order for a benefit to be paid, the initial Diagnosis of any stage of Alzheimer's disease must occur while insured under the Policy.

Advanced Parkinson's Disease means, that while insured under the Policy, an Insured has:

- been Diagnosed with primary idiopathic Parkinson's disease at stage 4 or higher on the Hoehn and Yahr scale; and
- demonstrated resting tremor, rigidity, bradykinesia and dementia despite a generally accepted drug regimen; and
- been unable to perform 3 or more of the Activities of Daily Living without the assistance of another person.

The Diagnosis of Advanced Parkinson's Disease must be made by a Specialist Physician. In order for a benefit to be paid, the initial Diagnosis of any stage of Parkinson's disease must occur while insured under the Policy.

Advanced ALS or Lou Gehrig's Disease means, that while insured under the Policy, the Insured has:

- been Diagnosed with definite amyotrophic lateral sclerosis (ALS) according to criteria established by the World Federation of Neurology; and
- been determined to require either a feeding tube or non-invasive ventilation; and
- been unable to perform 3 or more of the Activities of Daily Living without the assistance of another person.

The Diagnosis of Advanced ALS or Lou Gehrig's Disease must be made by a Specialist Physician. In order for a benefit to be paid, the Diagnosis of any stage of amyotrophic lateral sclerosis (ALS) or Lou Gehrig's Disease must occur while insured under the Policy.

7. COVERED CONDITIONS

Benign Brain Tumor means, that while insured under the Policy, the Insured is Diagnosed with a non-malignant tumor located in the cranial vault and limited to the brain, meninges, or cranial nerves or pituitary gland. The tumor must require surgical or radiation Treatment or cause irreversible objective neurological deficit(s). The Diagnosis of Benign Brain Tumor must be made by a Specialist Physician.

Exclusions:
No benefit will be payable for the following:

- hematomas, cysts or granulomas; or
- intracranial malformations of the arteries or veins; or
- pituitary tumors, spine or cranial nerves, including pituitary adenomas less than 10 mm. in diameter, acoustic neuroma or craniopharyngioma.

The Diagnosis of Benign Brain Tumor must be made by a Specialist Physician. In order for a benefit to be paid, the Diagnosis of Benign Brain Tumor must occur while insured under the Policy.

No benefit will be payable for a recurrence or metastasis of an original tumor which was Diagnosed prior to the effective date of insurance.

Blindness means, that while insured under the Policy, the Insured has been Diagnosed with an irreversible reduction in sight, lasting at least 180 days, that results in a corrected visual acuity of 20/400 or less or a visual field less than 20 degrees when testing both eyes together. Benefits for Complete Blindness are not payable if the condition is a consequence of another condition for which another Critical Illness benefit has been paid.

The Diagnosis of Blindness must be made by a Specialist Physician.

Coma means a Diagnosis, while insured under the Policy, of a state of unconsciousness with no reaction to external stimuli and which requires an external life support system, both of which have persisted continuously for at least 168 hours.

The Diagnosis of Coma must be made by a Specialist Physician.

Exclusions:
Coma does not include medically induced coma.

Complete Loss of Hearing means, that while insured under the Policy, the Insured has been 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.

Complete 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. Benefits for Complete Loss of Hearing are not payable if the condition is a consequence of another condition for which another Critical Illness benefit has been paid.

The Diagnosis of Complete Loss of Hearing must be made by a Specialist Physician. In order for a benefit to be paid, the initial Diagnosis of Complete Loss of Hearing must occur while insured under the Policy.

Loss of Speech means, that while insured under the Policy, the Insured is Diagnosed with total, permanent and irreversible loss of the ability to speak. The loss must:

- be as a result of Injury or sickness affecting the speech organs; and
- have continued without interruption for a period of at least six (6) consecutive months.

7. COVERED CONDITIONS

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 condition is a consequence of another condition for which another Critical Illness benefit has been paid.

The Diagnosis of Loss of Speech must be made by a Specialist Physician. In order for a benefit to be paid, the Diagnosis of Loss of Speech must occur while insured under the Policy.

Paralysis means, that while insured under the Policy, the Insured has been Diagnosed with total and irreversible loss of use of two or more limbs due to Injury or disease of the spinal cord and that is continuously present for a period of at least 180 days. Limb is defined as the complete arm or the complete leg.

The Diagnosis of Paralysis must be made by a Specialist Physician and shall not include any impairment caused by a Stroke or other sickness.

Severe Burns means, that while insured under the Policy, the Insured is Diagnosed with third-degree burns over at least 18% of the body surface. Severe Burns must occur while the Insured's insurance is in force to be eligible for a benefit. The Diagnosis of Severe Burns must be made by a Specialist Physician.

8. EXCLUSIONS AND LIMITATIONS

What exclusions apply to the benefits payable?

In addition to the exclusions stated in the Covered Conditions section of this Certificate, We will not pay any benefit that is caused by, contributed to in any way, or resulting from any Critical Illness condition Diagnosed outside the United States or Canada without confirmation of the Diagnosis by the type of Specialist Physician specified for each of the Covered Conditions in Section 7 who practices in the United States or Canada.

We will not pay a benefit for any Critical Illness that is due to or results from:

- services or Treatment not included in the Benefit Highlights;
- services or Treatment for which an Insured is not charged, unless there is no charge because the facility is a United States government facility;
- services or Treatment provided by a Family Member;
- Treatment or complications of Treatment not related to a Critical Illness;
- an autologous bone marrow transplant, one in which Your own bone marrow is used;
- intentionally self-inflicted injuries;
- elective plastic or cosmetic surgery;
- active military duty;
- 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);
- Your active Participation in a Riot, Rebellion or Insurrection;
- committing or attempting to commit an assault, felony or other criminal act;
- Your engagement in dangerous conduct or hazardous activity where there is a likelihood of death or serious Injury;
- committing or attempting to commit suicide, whether sane or insane;
- incarceration in a penal institution of any kind;
- being legally Intoxicated or under the influence of any narcotic unless taken on the advice of a Physician and taken as prescribed; or
- improper or illegal use of inhalants or huffing.

What limitations apply to the benefits payable?

In addition to the limitations stated in the Covered Conditions section of this Certificate, We will not pay any benefit for any Critical Illness that is Diagnosed in the first 12 months following the effective date of any Insured's insurance and results from a Pre-Existing Condition.

This provision does not apply on the effective date of the Policy for any amount of Critical Illness insurance for which You, Your Spouse or Dependent Child were insured under the Employer's Prior Policy of insurance on the day before the effective date of the Policy.

Pre-Existing Condition means during the 12 months prior to any Insured's effective date of insurance or the effective date of an increase in any Insured's amount of insurance, any condition for which any Insured:

- sought medical Treatment, consultation, advice, care or services, including diagnostic measures for the condition, or symptoms related to the condition, regardless of whether the condition was Diagnosed or suspected at that time;
- took prescribed drugs or medicines for the condition; or
- had symptoms for which an ordinarily prudent person would have consulted a health care provider for Diagnosis, care or Treatment.

When newborn children, newly placed foster children or newly adopted children are added to Your Dependent Children Insurance within 31 days of the birth, placement or adoption, the Pre-Existing Condition limitation does not apply.

9. WELLNESS SCREENING BENEFIT

What is the wellness screening benefit?

A While Your insurance under the Policy is in force, We will pay You a wellness screening benefit each Benefit Year during which You, Your insured Spouse or Your insured Dependent Child has any one of the following wellness screening tests performed:

- CA15-3 (blood test for breast cancer)
- Breast Cancer Screening (clinical breast exam, mammography, MRI, thermography, ultrasound)
- CA 125 (blood test for ovarian cancer)
- Colorectal Cancer Screening (fecal occult blood test, colonoscopy, sigmoidoscopy)
- CEA (blood test for colon cancer)
- Lipid panel (cholesterol, triglycerides, HDL, LDL)
- Pap smear
- Prostate Cancer Screening (digital rectal exam, PSA blood test)
- Skin Cancer Screening
- Diabetes tests (fasting blood glucose test, hemoglobin A1c)
- Cardiac exercise stress test
- Electrocardiogram (ECG)-resting or stress
- Chest x-ray
- Hemoccult stool analysis
- Serum protein electrophoresis
- Carotid Doppler
- Echocardiogram
- Immunizations
- Interscholastic Sports Physical Exam

What is the amount of the wellness screening benefit?

We will pay You $100 once each Benefit Year if any one of the wellness screening tests described in this Certificate is performed for You regardless of the results of the test. We will pay You $100 each Benefit Year if any one of the wellness screening tests described in this Certificate is performed for Your insured Spouse. We will pay You $100 each Benefit Year if any one of the wellness screening tests described in this Certificate is performed for Your insured Dependent Child. The wellness screening benefit is paid in addition to any other benefits payable under the Policy.

What conditions apply to the wellness screening benefit?

To receive this benefit, You must notify Us of which wellness screening test was performed.

10. 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 date of Diagnosis or within 180 days of the initial Treatment of the Critical Illness.

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 date of Diagnosis or Treatment of the Critical Illness.

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 the individual is legally incompetent.

What is considered Proof of claim?

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

- a description of the Critical Illness;
- the date the Diagnosis and/or Treatment occurred;
- the cause of the Critical Illness; and
- any other information We may require to make a claim determination.

Proof of claim may include, but is not limited to, police accident reports, laboratory results, toxicology results, hospital records, x-rays, narrative reports, or other diagnostic testing materials, as required.

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?

What if Your claim is denied?

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; and
- 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; and
- the identity of any medical or vocational experts whose advice was obtained in connection with the claim, regardless of whether the advice was relied upon to deny the claim.

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; and
- 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?

We will pay You all benefits, 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 Us 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 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, up to a cumulative amount of $5,000; or
- if You have no Spouse, 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.

11. 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:

- Furlough – up to 3 months;
- Layoff – up to 3 months;
- Leave of Absence – up to 3 months;
- Sabbatical – up to 3 months;
- Absence due to Injury or sickness – 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's continuation of insurance end?

Continuation of insurance for Your Spouse 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'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's continuation of insurance;
- the date Your Spouse no longer meets the definition of Spouse as described in this Certificate; or
- the date Your Spouse 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.

Federal Continuance

11. INSURANCE CONTINUATION

Under the provisions of the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), an Insured may have the right to continue Critical Illness insurance coverage beyond the date insurance would otherwise terminate. You should contact Your Employer concerning Your right to continue coverage.

12. 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 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 Diagnosed with a Critical Illness?

If You, Your Insured Spouse or Your Insured Dependent Child is Diagnosed with a covered Critical Illness 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.

13. 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 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.

If You are Diagnosed with a Critical Illness condition as defined in the Covered Conditions section of This Policy, and were never Actively at Work while covered under This Policy, any benefit payable will be the lesser of:

- the benefit payable under This Policy; or
- the benefit payable under the Prior Policy.

What if Your Spouse or Dependent Child is Confined when Your Employer's Prior Policy is replaced with This Policy and You are Actively at Work?

- Your Spouse or Dependent Child was insured under Your Employer's Prior Policy on the day before the Policy effective date;
- You are a member of an Eligible Class for Spouse or Dependent Children coverage;
- You or Your Employer continues to remit premiums for Your Spouse or Dependent Children coverage; and
- Your Spouse or Dependent Child are not receiving or eligible to receive Spouse or Dependent Child benefits under Your Employer's Prior Policy.

Any Spouse or Dependent Child 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.

Does the Pre-Existing Condition limitation 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 Pre-Existing Condition limitation toward the satisfaction of the period of time required by This Policy's Pre-Existing Condition limitation.

14. 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?
You cannot assign any interest in the Policy unless We agree in Writing to such an assignment. We have the right to determine the extent to which any assignment will be honored and the priority of such assignment. We do not assume any responsibility for the validity or sufficiency of any assignment. Any payments made under such assignment after consented to by Us will discharge Our liabilities under the Policy, to the extent of such payments.

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;
- failing to provide any required Evidence of Insurability; 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.

14. GENERAL PROVISIONS

EXAMINATION

What are Our examination rights?

We, at Our expense, have the right to have any person whose Critical Illness is the basis of a claim:

- examined by a Physician, Specialist 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.

INCONTESTABILITY

What is the Incontestability Provision?

Except for non-payment of premium, or fraud, no statement made by any Insured relating to insurability for such insurance will be used to contest the validity 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 all 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.
Any court reviewing Our determination shall uphold such determination unless the claimant proves Equitable Financial Life Insurance Company of America's claim determination is without any rational basis. In any legal proceeding, the Court is limited in its review to the administrative record compiled by Equitable Financial Life Insurance Company of America prior to its final claim determination.

LIMIT OF PREMIUM REFUNDS

Is there a limit on premium refunds?

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.