MICHIGAN LIFE & HEALTH INSURANCE GUARANTY ASSOCIATION

Guaranty Association Act

The Michigan Life & Health Insurance Guaranty Association Act, Chapter 77 of the Insurance Code of 1956, MCL 500.7701 to 500.7780, details the specific coverage, exemptions and limitations provided to certain policyholders. The general information provided by this summary or the MLHIGA web site does not cover all provisions of the law, nor does it in any way change anyone's rights or obligations under the act or the rights or obligations of MLHIGA. For a definitive statement of the law governing MLHIGA, you must refer to the MLHIGA Act itself. If there is any inconsistency between this summary or the MLHIGA web site and any applicable law, then such law will control.

Coverage

Generally, individuals will be protected by MLHIGA if they reside in Michigan and own a life, health or annuity contract issued by a member insurer licensed in Michigan or if they reside in Michigan and are insured under a group life or health insurance contract issued by a member insurer licensed in Michigan. For owners of unallocated annuity contracts, coverage will be provided if the contract is issued in connection with a specific plan whose sponsor has its principal place of business in Michigan or if the individual is a resident of Michigan and the contract is issued in connection with a government lottery. For payees (or beneficiaries of deceased payees) of structured settlement annuities, coverage will be provided only if the payee is a resident of Michigan. In limited situations, coverage might also be available to certain non-residents.

You may find out if your insurance company is licensed in Michigan by contacting the Department of Insurance and Financial Services at P.O. Box 30220, Lansing, Michigan 48909-7720, telephone number (517) 284-8800 or 877-999-6442. Please be aware, although licensed in Michigan, policies issued by the following entities are not covered by MLHIGA: a nonprofit health care corporation, a health maintenance organization, a fraternal benefit society, a nonprofit dental care corporation (e.g. Delta Dental), a mandatory state pooling plan, a mutual assessment company or similar plan in which the policyholder is subject to future assessments, an insurance exchange, or an organization limited to the issuance of charitable gift annuities.

Protection can be provided in one of several different ways. For example, MLHIGA may provide coverage directly or a financially sound insurer may take over the troubled company's assets and policies and assume responsibilities for continuing coverage and paying covered claims. MLHIGA may also work with other state guaranty associations to develop an overall plan to provide protection for the failed insurer's policyholders. In any case, delays could be necessary to sort out the affairs of the financially troubled insurer.

Limits on Amount of Coverage

The MLHIGA Act limits the amount MLHIGA is obligated to cover for each insolvent company as follows:

1) MLHIGA cannot cover more than what the insurance company would owe under a policy or contract;
2) for any one life, regardless of the number of policies or contracts held with the same company, MLHIGA will cover a maximum of:
   a) $300,000 in life insurance death benefits, but not more than $100,000 in net cash surrender and net cash withdrawal values for life insurance;
   b) $250,000 in the present value of annuity benefits, including net cash surrender and net cash withdrawal values;
   c) for health insurance:
      i) $300,000 in disability income insurance benefits or long-term care benefits;
      ii) $500,000 in basic hospital, medical, and surgical insurance benefits;
      iii) $100,000 in all other health insurance benefits.
   d) In no event is the association obligated to cover more than an aggregate of $300,000 in all benefits (other than basic hospital, medical, and surgical benefits) for any one life.

The limits mentioned above are applied per any "one life" per insolvent company.

As an example of this "one life" limitation, if you own three annuities with the same annuitant from the same insurance company, each worth $100,000 and that company is declared insolvent and ordered liquidated, only $250,000, **in total**, may be protected because that is the maximum amount protected under the MLHIGA Act for all annuities from a single insurer.

Note to benefit plan trustees or other holders of unallocated annuities (GICs, DACs, etc.) covered by the act: for unallocated annuities that fund **governmental retirement plans only** under sections 401(k), 403(b) or 457 of the Internal Revenue Code, the limit is $250,000 in present value of annuity benefits per participating individual; for covered unallocated annuities that fund other plans, benefits are not available on an individual basis and a special limit of $5,000,000 applies to the contract holder, regardless of the number of contracts held with the same company or number of persons covered by the plan. Coverage is dependent on plan sponsor having its principal place of business in Michigan. In all cases, of course, the contract limits also apply.

Exclusions from Coverage

Persons holding policies otherwise covered are not protected by MLHIGA if:

- they are eligible for protection under the laws of another state (this may occur when the insolvent insurer was incorporated in another state whose guaranty association protects insureds who live outside that state); or
- the insurer was not authorized to do business in Michigan.

The Association also does **not** provide coverage for:

- any policy or portion of a policy which is not guaranteed by the insurer or for which the individual has assumed the risk;
- any policy of reinsurance (unless an assumption certificate was issued);
- interest rate yields that exceed an average rate set by formula in the MLHIGA Act;
- dividends;

- obligations not arising from the express written terms of the policy or contract;
- insurer's obligation to provide a book value accounting guaranty for defined contribution benefit plan participants by reference to a portfolio of assets owned by benefit plan;
- interest determined by external reference that has not been credited to the policy or is subject to forfeiture;
- employers' plans that are self-funded (that is, not fully insured by an insurance company, even if an insurance company administers them);
- unallocated annuity contracts, unless they fund a government lottery or a benefit plan of an employer, association or union, however, unallocated annuities issued to employee benefit plans protected by the federal Pension Benefit Guaranty Corporation are not covered. An unallocated annuity contract is an annuity contract or group annuity certificate which is not issued to and owned by an individual, except to the extent of an annuity benefit guaranteed to an individual by an insurer under the contract or certificate. The term shall also include, but not be limited to, guaranteed investment contracts and deposit administration contracts;
- policies issued by the following entities, even though licensed in Michigan: a nonprofit health care corporation, a health maintenance organization, a fraternal benefit society, a nonprofit dental care corporation (e.g. Delta Dental), a mandatory state pooling plan, a mutual assessment company or similar plan in which the policyholder is subject to future assessments, an insurance exchange, or an organization limited to the issuance of charitable gift annuities;
- a portion of a policy or contract to the extent that the assessments required by section 7709 of the MLHIGA Act for the policy or contract are preempted by federal or state law;
- a policy or contract providing any hospital, medical, prescription drug, or other health care benefits under Part C or Part D of Title XVIII of the Social Security Act, 42 USC 1395W-21 to 1395W-29 and 42 USC 1395W-101 to 1395W-152, or under regulations issued under Part C or Part D of Title XVIII of the Social Security Act, 42 USC 1395W-21 to 1395W-29 and 42 USC 1395W-101 to 1395W-152.
- MLHIGA **will not** provide duplicate coverage to **any** individual that is also covered by the laws of another state or another state's guaranty association.

Contact

The intent of this summary and the MLHIGA web site is to briefly explain how MLHIGA provides protection to Michigan policyholders in the event their insurance company becomes insolvent. If you have any questions that are not answered here, you should contact MLHIGA or consult with your attorney.

Disclaimer

The information provided by this summary and the MLHIGA web site is subject to change without notice. The statements made herein are for information purposes only. MLHIGA has not reviewed any specific policy, or verified the information provided regarding residency or other relevant factors. Moreover, whether coverage will be provided to any specific policyholder can only be determined by reference to the statute in effect, at the earliest, at the time that the insurer is declared insolvent. For these reasons, no final determination of coverage can be made until an insurer is declared insolvent and the specific factual and legal circumstances can be reviewed. Nothing contained herein is intended to guarantee coverage for any insured, or to bind MLHIGA in any way. Finally, this summary and the MLHIGA web site are for general information purposes and should not be relied upon as legal advice.

January 14, 2016

Group Critical Illness Insurance Certificate

Megalodon Midco LLC

IMPORTANT NOTICES

GROUP CRITICAL ILLNESS

If you reside in one of the following states, please read the important notice applicable to you.

Arizona residents:

This certificate of insurance may not provide all benefits and protections provided by law in Arizona. Please read this certificate carefully.

California residents:

THIS IS A SUPPLEMENT TO HEALTH INSURANCE. IT IS NOT A SUBSTITUTE FOR ESSENTIAL HEALTH BENEFITS OR MINIMUM ESSENTIAL COVERAGE AS DEFINED IN FEDERAL LAW.

FOR CALIFORNIA RESIDENTS: REVIEW THIS CERTIFICATE CAREFULLY. IF YOU ARE 65 OR OLDER ON THE EFFECTIVE DATE OF THIS CERTIFICATE, YOU MAY RETURN IT TO US WITHIN 30 DAYS FROM THE DATE YOU RECEIVE IT AND WE WILL REFUND ANY PREMIUM YOU PAID. IN THIS CASE, THIS CERTIFICATE WILL BE CONSIDERED TO NEVER HAVE BEEN ISSUED.

Florida residents:

The benefits of the policy providing Your coverage are governed primarily by the laws of a state other than Florida.

To make an inquiry, obtain information about your coverage or to resolve a complaint call 1-800-754-3207

Idaho residents:

30 Day Right To Examine Policy
If a Covered Person does not like the Policy for any reason, it may be returned to Us within 30 days after receipt. We will return any premium that has been paid and the Policy will be void as if it had never been issued.

THIS COVERAGE IS NOT GUARANTEED RENEWABLE

IMPORTANT CANCELLATION INFORMATION – PLEASE READ "POLICY TERMINATION" PROVISION IN THE GENERAL PROVISIONS SECTION

THIS POLICY IS RENEWABLE AT THE OPTION OF THE POLICYHOLDER AND/OR US

Louisiana residents:

THIS CERTIFICATE DOES NOT CONSTITUTE COMPREHENSIVE HEALTH INSURANCE COVERAGE. THIS COVERAGE DOES NOT SATISFY THE INDIVIDUAL MANDATE OF THE AFFORDABLE CARE ACT (ACA).

Maryland residents:

This Certificate may omit some of the benefits required for a Certificate issued and delivered in Maryland.

North Carolina residents:

Notice: This Certificate of Insurance provides all of the benefits mandated by the North Carolina Insurance Code, but is issued under a group master policy located in another state and may be governed by that state's law.

THIS CERTIFICATE IS NOT A MEDICARE SUPPLEMENT CERTIFICATE. IF YOU ARE ELIGIBLE FOR MEDICARE, REVIEW THE GUIDE TO HEALTH INSURANCE FOR PEOPLE WITH MEDICARE, WHICH IS AVAILABLE FROM CIGNA LIFE AND HEALTH INSURANCE COMPANY.

The Policy is a legal contract between the Policyholder and Us.

THIS IS A CRITICAL ILLNESS ONLY POLICY.
BENEFITS PROVIDED ARE NOT INTENDED TO COVER ALL MEDICAL EXPENSES

IMPORTANT CANCELLATION INFORMATION – PLEASE READ "POLICY TERMINATION" PROVISION IN YOUR CERTIFICATE OF INSURANCE

Texas residents:

THE INSURANCE POLICY UNDER WHICH THIS CERTIFICATE IS ISSUED IS NOT A POLICY OF WORKERS' COMPENSATION INSURANCE. YOU SHOULD CONSULT YOUR EMPLOYER TO DETERMINE WHETHER YOUR EMPLOYER IS A SUBSCRIBER TO THE WORKERS' COMPENSATION SYSTEM.

Utah residents:

NOTICE TO BUYER:
This is a specified disease Policy. This Policy provides limited benefits. Benefits provided are supplemental and are not intended to cover all medical expenses. Read your Policy carefully with the Outline of Coverage and the Buyer's Guide.

Vermont residents:

IN THE EVENT OF A CONFLICT BETWEEN THE LAWS OF THE STATE WHERE THE POLICY IS ISSUED AND THE LAWS OF VERMONT, THE LAWS OF VERMONT WILL CONTROL.

THIS POLICY DOES NOT MEET THE MINIMUM COVERAGE REQUIREMENTS OF THE AFFORDABLE CARE ACT. YOU SHOULD NOT PURCHASE THIS POLICY UNLESS YOU ARE ALREADY COVERED BY COMPREHENSIVE MAJOR MEDICAL INSURANCE.

Cigna Health and Life Insurance Company
900 Cottage Grove Road, Bloomfield, Connecticut 06002
A Stock Insurance Company

GROUP CRITICAL ILLNESS CERTIFICATE

THIS CERTIFICATE PROVIDES LIMITED COVERAGE.
PLEASE READ YOUR CERTIFICATE CAREFULLY.

We, the Cigna Health and Life Insurance Company, have issued a Group Policy, CI111745 to Trustee of the Group Insurance Trust for Employers in the Manufacturing Industry.

We certify that We insure all eligible persons who are enrolled according to the terms of the Group Policy. Your coverage will begin according to the terms set forth in the *Effective Date Provisions* section.

This Certificate describes the benefits and basic provisions of Your coverage. It is not the insurance contract and does not waive or alter any terms of the Policy. If questions arise, the Policy language will govern. You may examine the Policy at the office of the Policyholder or the Administrator.

This Certificate replaces all prior Certificates issued to You under the Group Policy.

CIGNA HEALTH AND LIFE INSURANCE COMPANY

Geneva Campbell Brown
Corporate Secretary

Julia M.Huggins
Senior Vice President of US Markets
President CHLIC

30 DAY RIGHT TO EXAMINE CERTIFICATE

Within 30 days of receipt of this Certificate, You can return it to Us for any reason if not satisfied with the insurance provided under this Certificate. We will return any premium that has been paid and this Certificate will be void as if it had never been issued.

THIS IS A CRITICAL ILLNESS ONLY POLICY.
BENEFITS PROVIDED ARE NOT INTENDED TO COVER ALL MEDICAL EXPENSES

THIS CERTIFICATE DOES NOT CONTAIN COMPREHENSIVE ADULT WELLNESS BENEFITS AS DEFINED BY WYOMING LAW.

TABLE OF CONTENTS

SCHEDULE OF BENEFITS

The Schedule of Benefits provides a brief outline of the coverage and benefits including the benefit periods and any limitations applicable to benefits provided in this Policy for each Covered Person, unless otherwise indicated.

This Policy is intended to be read in its entirety. In order to understand all the conditions, exclusions and limitations applicable to its benefits, please read all the Policy provisions carefully.

Covered Classes:

Class 2	All active, Full-Time Hourly Non-Union Employees of the Employer who are regularly working in the United States a minimum of 30 hours per week and regularly residing in the United States and who are United States citizens or permanent resident aliens and their Spouse and Dependent Children who are United States citizens or permanent resident aliens and who are residing in the United States.

The following pages contain a Schedule of Benefits for each class of eligible Employees. For an explanation of these benefits, please see the *Description of Coverages and Benefits* section.

GCI-02-1100-1.00V2

SCHEDULE OF BENEFITS FOR CLASS 2

Subscriber: Megalodon Midco LLC

Effective Date of Subscriber: January 01, 2024

Minimum Subscriber Participation Requirements:
10% of eligible Employees or 10 enrolled Employees, whichever is greater

Eligibility Waiting Period:
There is no Eligibility Waiting Period for this Coverage.

CRITICAL ILLNESS BENEFITS FOR EMPLOYEE

All Employee benefits are payable as shown for the Eligible Employee.

Benefit Type	Benefit Amount
Voluntary Critical Illness Coverage	
Initial Benefit Amounts	$5,000, $10,000, $15,000, $20,000, $25,000, $30,000
Maximum Benefit	$30,000
New Enrollees	
Guaranteed Issue Amount	
Initial Group Enrollment	$30,000
Annual Group Enrollment	$30,000
Life Status Change	$30,000
New Hire	$30,000
Current Insureds	
Guaranteed Issue Amount	
Initial Group Enrollment	$30,000
Annual Group Enrollment	$30,000
Life Status Change	$30,000
Benefit Waiting Period:	None
CONTINUATION OPTION(S):	
Applicable Coverage(s)	Critical Illness Benefits and Optional Benefits for the Employee, His Spouse and Dependent Child(ren)
For Family Medical Leave	
Maximum Benefit Period	up to 12 weeks for family medical leave and up to 26 weeks for military family leave
For Leave of Absence	
Maximum Benefit Period	up to 6 months
For Temporary Layoff	
Maximum Benefit Period	up to 4 weeks
For Furlough	
Maximum Benefit Period	up to 12 weeks

PORTABILITY

Maximum Age of Portability	100 as of the date of porting
Portable Period	Coverage continues to age 100
Amount of Portable Coverage	100% of in force coverage amount
Coverage(s) that may be ported	Employee
Benefit(s) that may be ported	All Voluntary Critical Illness Coverage and Optional Benefits

CRITICAL ILLNESS BENEFITS FOR SPOUSE

Benefit Type	Benefit Amount
Voluntary Critical Illness Coverage	
Initial Benefit Amounts	50% of Employee Benefit Amount
Maximum Benefit	$15,000
New Enrollees	
Guaranteed Issue Amount	
Initial Group Enrollment	$15,000
Annual Group Enrollment	$15,000
Life Status Change	$15,000
New Hire	$15,000
Current Insureds	
Guaranteed Issue Amount	
Initial Group Enrollment	$15,000
Annual Group Enrollment	$15,000
Life Status Change	$15,000
Benefit Waiting Period:	None

PORTABILITY

Maximum Age of Portability	100 as of the date of porting
Portable Period	Coverage continues to age 100
Amount of Portable Coverage	100% of in force coverage amount
Coverage(s) that may be ported	Spouse
Benefit(s) that may be ported	All Voluntary Critical Illness Coverage and Optional Benefits

CRITICAL ILLNESS BENEFITS FOR DEPENDENT CHILD(REN)

Benefit Type	Benefit Amount
Voluntary Critical Illness Coverage	
Initial Benefit Amounts	25% of Employee Benefit Amount
Maximum Benefit	$7,500
New Enrollees	
Guaranteed Issue Amount	
Initial Group Enrollment	$7,500
Annual Group Enrollment	$7,500
Life Status Change	$7,500
New Hire	$7,500

Current Insureds

Guaranteed Issue Amount

Initial Group Enrollment	$7,500
Annual Group Enrollment	$7,500
Life Status Change	$7,500

Benefit Waiting Period: None

PORTABILITY

Maximum Age of Portability	26 as of the date of porting unless otherwise specified
Portable Period	Coverage continues to age 26 unless otherwise specified
Amount of Portable Coverage	100% of in force coverage amount
Coverage(s) that may be ported	Dependent Child
Benefit(s) that may be ported	All Voluntary Critical Illness Coverage and Optional Benefits

CRITICAL ILLNESS COVERAGE - LIST OF COVERED CONDITIONS

Cancer Conditions	**% of Initial Benefit Amount**	**Recurrence % of Initial Benefit Amount**
Invasive Cancer	100%	100%
Carcinoma In Situ	25%	25%
	Benefit Amount	
Skin Cancer	$250 1x per lifetime	Not Available
Vascular Conditions	**% of Initial Benefit Amount**	**Recurrence % of Initial Benefit Amount**
Heart Attack	100%	100%
Stroke	100%	100%
Coronary Artery Disease	25%	25%
Nervous System Conditions	**% of Initial Benefit Amount**	**Recurrence % of Initial Benefit Amount**
Advanced Stage Alzheimer's Disease	25%	Not Available
Amyotrophic Lateral Sclerosis (ALS)	25%	Not Available
Parkinson's Disease	25%	Not Available
Multiple Sclerosis	25%	Not Available
Childhood Conditions	**% of Initial Benefit Amount**	**Recurrence % of Initial Benefit Amount**
Muscular Dystrophy	100%	Not Available
Cystic Fibrosis	100%	Not Available
Cerebral Palsy	100%	Not Available
Poliomyelitis	100%	Not Available

Other Specified Conditions	% of Initial Benefit Amount	Recurrence % of Initial Benefit Amount
Benign Brain Tumor	100%	100%
Blindness	100%	Not Available
Coma	25%	25%
End-Stage Renal (Kidney) Disease	100%	100%
Major Organ Failure	100%	100%
Paralysis	100%	100%

OPTIONAL BENEFITS

HEALTH SCREENING TEST BENEFIT RIDER
All Employee benefits under this Rider are payable at 100% of the Benefit Amount shown for the Eligible Employee.
All Spouse benefits are payable at 100% of the Benefit Amount shown for the Employee.
All Dependent Child(ren) benefits are payable at 100% of the Benefit Amount shown for the Employee.

Voluntary Benefit

Benefit Waiting Period	0 days

EMPLOYEE BENEFITS

Benefit Type	Benefit Amount
Health Screening Test Benefit	
Benefit Amount	$100 per day
Maximum Benefit	1 per year

PREMIUM INFORMATION

INITIAL PREMIUM

Premium:	Refer to your plan and rate confirmation as provided at time of enrollment or application
Contribution(s):	The cost of coverage is paid by the Employee

PREMIUM DUE DATES

The Policy Effective Date and the first day of each succeeding modal period.

Premium rates are subject to change in accordance with the Changes in Premium Rates provision of the *Administrative Provisions* section of this Policy. An Employee's premium is based on His Age and will increase on the Policy Anniversary Date after the Employee enters a new Age bracket.

GCI-02-1100-1.00V2

DESCRIPTION OF COVERAGES AND BENEFITS

This Description of Coverages and Benefits section describes the Critical Illness Coverages and Benefits provided by this Policy. Benefit amounts, benefit periods and any applicable benefit maximums are shown in the *Schedule of Benefits* and may be subject to a Benefit Waiting Period and/or an Elimination Waiting Period before benefits can be paid. The Benefit Amounts shown in the *Schedule of Benefits* will be paid regardless of the actual expenses incurred. Certain words capitalized in the text of these descriptions have special meanings within this Policy and are defined in the *General Definitions* section. Please read these and the *Common Exclusions* sections in order to understand all of the terms, conditions and limitations applicable to these coverages and benefits.

INITIAL CRITICAL ILLNESS BENEFIT

We will pay the Initial Critical Illness Benefit to a Covered Person for the Covered Condition shown in the *Schedule of Benefits* that are diagnosed while coverage is in force, subject to the conditions and limitations set forth below, and the terms, conditions, limitations and exclusions applicable to all coverage under the Policy.

Initial Critical Illness Benefit Amount

The amount of the Initial Critical Illness Benefit is the Initial Benefit Amount shown in the *Schedule of Benefits*. The amount payable per Covered Condition is the Initial Benefit Amount multiplied by the applicable percentage for the diagnosis of the Covered Condition shown in the *Schedule of Benefits*.

Benefit Conditions

The Initial Critical Illness Benefit will only be payable if:

1. The Date of Diagnosis occurs after the Benefit Waiting Period, if applicable;
2. The Date of Diagnosis occurs while the Covered Person's coverage under this Policy is in force;
3. The Critical Illness is a different Covered Condition than any of the Covered Conditions for which an Initial Critical Illness Benefit has been paid;
4. The Date of Diagnosis for the Covered Condition occurs more than 180 days after the Date of Diagnosis for which the last Initial Critical Illness Benefit was paid. This provision will not apply to directly medically related conditions for which an Initial Critical Illness Benefit was paid; however, the second Initial Critical Illness Benefit will be reduced by the amount of the first Initial Critical Illness Benefit;
5. The Covered Condition satisfies the Definition in the Policy; and
6. For Heart Attack and Stroke, the Covered Person has an Inpatient admission.

Benefit Limitations

These limitations apply to payments under the Initial Critical Illness Benefit:

1. No more than one Initial Critical Illness Benefit payment will be made regardless of percentage for each Covered Condition shown in the *Schedule of Benefits*;
2. No more than one Initial Critical Illness Benefit will be paid per Covered Condition per Covered Person; and
3. The Skin Cancer Benefit is not payable as an Initial Critical Illness Benefit.

RECURRENCE CRITICAL ILLNESS BENEFIT

We will pay the Recurrence Critical Illness Benefit to a Covered Person when diagnosed with the Recurrence of an eligible Covered Condition shown in the *Schedule of Benefits* while coverage is in force, subject to the conditions and limitations set forth below, and the terms, conditions, limitations and exclusions applicable to all coverage under the Policy.

Recurrence Critical Illness Benefit Amount

The amount of the Recurrence Critical Illness Benefit payable per Covered Condition is the Initial Benefit Amount shown in the *Schedule of Benefits* multiplied by the applicable Recurrence percentage for each Recurrence diagnosis also shown on the *Schedule of Benefits*.

Benefit Conditions

The Recurrence Critical Illness Benefit will only be payable if:

1. The Date of Diagnosis occurs while the Covered Person's coverage under this Policy is in force;
2. The Covered Condition satisfies the Definition in the Policy;
3. The Covered Condition is the same as a Covered Condition for which an Initial Critical Illness Benefit has been paid;
4. Except for Invasive Cancer, the Date of Diagnosis for the same Covered Condition occurs more than 12 months

after the Date of Diagnosis for which an Initial Critical Illness Benefit was paid. This provision will not apply to directly medically related conditions for which an Initial Critical Illness Benefit was paid; however, the second Initial Critical Illness Benefit will be reduced by the amount of the first Initial Critical Illness Benefit; and

5. For Invasive Cancer the Covered Person has not received treatment for the Covered Condition during the 12 month period between the two Dates of Diagnosis. As used herein, "treatment" does not include medications and follow-up visits to the Covered Person's Physician.

As used herein, "treatment" does not include medications and follow-up visits to the Covered Person's Physician. "Medications" means any form of pharmacotherapy which is primarily used to improve or maintain general physical condition or health, or which is used for routine, long term, or maintenance care that is provided after the resolution of the acute medical problem and where the pharmacotherapy is not expected itself to provide significant therapeutic improvement.

Benefit Limitations
These limitations apply to payments under the Recurrence Critical Illness Benefit:

1. In no event will benefits be paid under the Recurrence Critical Illness Benefit for Major Organ Failure for an Organ for which a benefit was previously paid.

SKIN CANCER BENEFIT
We will pay the Skin Cancer Benefit to a Covered Person as shown in the *Schedule of Benefits* that is diagnosed while coverage is in force, subject to the conditions and limitations set forth below, and the terms, conditions, limitations and exclusions applicable to all coverage under the Policy.

Skin Cancer Benefit Amount
The amount payable for Skin Cancer is the Skin Cancer Benefit Amount shown in the *Schedule of Benefits*.

The Skin Cancer Benefit will not reduce the Initial Critical Illness Benefit Amount(s) available.

If a separate Skin Cancer Benefit Amount is available under the Policy, as shown in the *Schedule of Benefits*, such benefit shall be subject to the Benefit Conditions and Benefit Limitations as provided below.

Benefit Conditions
The Skin Cancer Benefit will only be payable if:

1. The Date of Diagnosis occurs after the Benefit Waiting Period, if applicable;
2. The Date of Diagnosis occurs while the Covered Person's coverage under this Policy is in force; and
3. The Covered Condition satisfies the Definition in the Policy.

Benefit Limitations
These limitations apply to payments under the Skin Cancer Benefit:

1. No more than 1 Skin Cancer Benefit(s) will be paid per Covered Person.

GENERAL DEFINITIONS

Please note that certain words used in this Policy have specific meanings. The words defined below and capitalized within the text of this Policy have the meanings set forth below.

Active Service

An Employee will be considered in Active Service with His Employer on any day that is either:

1. one of the Employer's scheduled work days on which the Employee is performing His regular duties on a Full-time basis, either at one of the Employer's usual places of business or at some other location to which the Employer's business requires the Employee to travel; or
2. a scheduled holiday or holiday period, vacation day or period of Employer-approved paid leave of absence, other than disability or sick leave after 7 days, only if the Employee was in Active Service on the preceding scheduled workday.

A Covered Person other than an Employee is not considered in Active Service if He is:

1. Inpatient in a Hospital, receiving hospice or confined in a rehabilitation or convalescence center or custodial care facility or receiving Outpatient care for chemotherapy or radiation therapy; or
2. confined at home under the care of a Physician for Sickness or Injury;

Advanced Stage Alzheimer's Disease

Meets the criteria described for the diagnosis of Alzheimer's Disease, in addition to the cognitive deficits interfering with independence in completion of Instrumental Activities of Daily Living as needed for Mild Stage Alzheimer's Disease, assistance is also required for completion of at least 2 Physical Activities of Daily Living.

The Date of Diagnosis of the Covered Person's Advanced Stage Alzheimer's disease is the date of the Covered Person's inability to perform at least 2 Physical Activities of Daily Living from this disorder, as confirmed by a Physician.

Age

For purposes of Initial Premium calculations upon initial eligibility unless otherwise stated, a Covered Person's age is His Age attained on the date coverage becomes effective for Him under this Policy.

1. For purposes of increases to coverage, including Enrollment Events and Life Status Changes, a Covered Person's Age, will be His Age as of the effective date of such increase.
2. For purposes of premium calculation for Portability prior to group policy termination, a Covered Person's Age is His Age as of His last birthday.
3. For the purposes of Portability, except as to premium calculations, Extension of Benefits, Waiver of Premium, or Continuation due to Disability, a Covered Person's Age is His Age as of His last birthday.
4. For all other purposes, changes in rates due to age including, age-based terminations, a Covered Person's Age will be His Age on the Policy Anniversary Date coinciding with or following the Covered Person's birthday.

Alzheimer's Disease

A progressive neurodegenerative disorder that is manifested by a significant cognitive decline from previous general functional level in one or more cognitive domains (attention, learning and memory, executive function, language, perceptual-motor, or social cognition).

1. The cognitive deficit is documented by standardized neuropsychological testing (including but not limited to Wechsler Adult Intelligence Scale (WAIS), the Wechsler Memory Scale (WMS), the Halstead/Reitan Neuropsychological Test Battery, Boston Naming Test, the Dellis-Kaplan Executive Function Scale) or, if not available, another quantified clinical assessment (including but not limited to the Mini-Mental state Examination (MMSE) or the Montreal Cognitive Assessment (MoCA);

2. The cognitive deficits interfere with independence in everyday activities, at a minimum requiring assistance with Instrumental Activities of Daily Living;
3. The cognitive deficits do not occur in the context of, nor do they meet the diagnostic criteria generally- recognized in the medical community for, another mental disorder, including but not limited to delirium, major depressive disorder or schizophrenia; and
4. The physical examination (including neurological examination), laboratory testing, brain CT or MRI results, or the results of any other neurodiagnostic studies, do not point to a different cause of the condition than Alzheimer's Disease.

Amyotrophic Lateral Sclerosis (ALS)

A progressive, degenerative motor neuron disease, marked by muscular weakness and atrophy with spasticity and hyperreflexia due to a loss of motor neurons of the spinal cord, medulla and cortex that results in Impairment. ALS is often referred to as Lou Gehrig's disease.

"Impairment" means persistent clinical findings of at least 3 of the following:

1. Trouble swallowing (dysphagia) or choking;
2. Restrictive respiratory distress;
3. Slurring of the speech or dysphonia;
4. Weakness of the extremities;
5. Twitching (fasciculation) of the tongue.

The Date of Diagnosis is the date the Covered Person displays Impairment from this disease as confirmed by a neurologist.

Annual Group Enrollment Period

The period in each calendar year agreed upon by the Employer and Us when an eligible Employee may enroll for or change his or her benefit elections under the Policy as shown in the *Schedule of Benefits*.

Benefit Waiting Period

The period of time, shown in the *Schedule of Benefits*, immediately following the effective date of the Covered Person's coverage, including the effective date of any increase to coverage. No benefits will be paid under the Policy for any Critical Illness Benefits or Optional Benefits for a covered event or a Covered Loss that occurs during the Benefit Waiting Period, as shown in the *Schedule of Benefits*.

Benign Brain Tumor

A localized mass of abnormal cells in the brain that is non-cancerous, non-inflammatory, and non-infectious.

The Date of Diagnosis is the date the tissue specimen is taken on which the diagnosis of Benign Brain Tumor is based.

Blindness

Clinically proven irreversible reduction of sight in both eyes, due to a disease or Sickness resulting in:

1. sight in the better eye reduced to a best corrected visual acuity of less than 6/60 (Metric Acuity) or 20/200 (Snellen or E-Chart Acuity); or
2. visual field restriction to 20^{o} or less in both eyes.

The Date of Diagnosis is the date an ophthalmologist diagnoses an irreversible vision loss.

Cancer

The term includes Invasive Cancer, Carcinoma in Situ and Skin Cancer.

The Date of Diagnosis for Cancer is the date the tissue specimen, blood samples, and/or titer(s) are taken on which a new diagnosis of Cancer is based.

For purposes of the Initial Critical Illness Benefits, the Date of Diagnosis includes the recurrence or spread (metastasis) of a previously existing diagnosed cancer. A diagnosis that reconfirms a presently existing illness will not be considered a new diagnosis.

Carcinoma in Situ

A malignant tumor which has not yet become invasive but is confined only to the superficial layer of cells from which it arose. The term Carcinoma in Situ does not include:

1. pre-malignant conditions or conditions with malignant potential;
2. Skin Cancer; or
3. Invasive Cancer.

For purposes of this Covered Condition, prostate cancer that is classified as T-1a, b, or c, N-0, and M-0 on a TNM classification scale, will be considered Carcinoma in Situ.

Cerebral Palsy

A non-progressive, developmental brain disorder resulting in impaired motor function, muscle tone, or posture caused by a brain injury or abnormal development of the brain that occurs while a child's brain is still developing before, during, or within 24 hours of birth.

The Date of Diagnosis is the date determined by a Physician that the child, while between the ages of 3 and 6, displayed the clinical findings of the disorder and required assistance with walking, including the use of assistive devices such as braces or other orthotics.

Certificate

The Certificate*,* including the Certificate *Schedule of Benefits*, amendments, riders and supplements, if any, is a written statement prepared by Us to set forth a summary of:

1. benefits to which the Covered Person is entitled;
2. to whom the benefits are payable; and
3. limitations or requirements that may apply.

Clinical Diagnosis

A diagnosis that is based on generally accepted medical principles. This type of diagnosis applies only when:

1. a Pathological Diagnosis cannot be made because it is medically inappropriate or life-threatening; and
2. there is medical evidence to support the diagnosis; and
3. a Physician is treating the Covered Person for Invasive Cancer and/or Carcinoma in Situ.

Coma

A profound state of unconsciousness lasting at least 96 continuous hours as the result of disease or Sickness from which the Covered Person cannot be aroused through visual auditory, and noxious physical stimuli. Coma does not mean any state of unconsciousness intentionally or medically induced from which the Covered Person is able to be aroused.

The Date of Diagnosis is the date a Covered Person meets the requirements of a Coma.

Coronary Artery Disease

A narrowing or blockage of the inner lining of the coronary arteries by lipid-bearing plaques. The resulting blockage restricts blood flow to the heart and requires Coronary Artery Bypass Graft (CABG) surgery.

Coronary Artery Disease does not include:

1. Angioplasty (percutaneous coronary intervention)
2. Stent implantation

The Date of Diagnosis is the date the Physician prescribes the CABG surgical procedure for Coronary Artery Disease.

Covered Loss

Is a loss that is:

1. specified in the *Schedule of Benefits* and included in the *Description of Coverages and Benefits* section; and
2. suffered by the Covered Person within the applicable time period described in the *Schedule of Benefits.*

Covered Person

An eligible person, as defined in the *Schedule of Benefits*, who is enrolled and for whom the

Evidence of Insurability, where required, has been accepted by Us, required premium has been paid when due and coverage under this Policy remains in force.

Critical Illness

A disease or Sickness, as diagnosed by a Physician that is specified as a Covered Condition in the Policy where the Date of Diagnosis occurs while coverage is in force. For purposes of the Policy:

Amyotrophic Lateral Sclerosis(ALS), Advanced Stage Alzheimer's Disease, Benign Brain Tumor, Blindness, Carcinoma In Situ, Cerebral Palsy, Coma, Coronary Artery Disease, Cystic Fibrosis, End Stage Renal (Kidney) Disease, Heart Attack, Invasive Cancer, Major Organ Failure, Multiple Sclerosis, Muscular Dystrophy, Paralysis, Parkinson's Disease, Poliomyelitis, Skin Cancer, and Stroke.

Cystic Fibrosis

A progressive disorder characterized by abnormal gene mutations that affects the mucus producing exocrine glands.

The Date of Diagnosis is the date confirmatory IRT Testing via Sweat test is performed.

Date of Diagnosis

The date a Physician renders the Pathological Diagnosis as defined by the Critical Illness. If a Pathological Diagnosis cannot be made, the date a Physician renders a Clinical Diagnosis.

Dependent Child

An Employee's child who meets the following requirements:

1. A child from live birth to the end of the month in which the child reaches age 26;
2. A child who is 26 or more years old, primarily supported by the Employee and incapable of self-sustaining employment by reason of mental or physical handicap.

A child, for purposes of this provision, includes an Employee's:

1. natural child;
2. adopted child, from the earlier of the date the petition for adoption is filed or entry of the child in the adoptive home, or in the case of a child who is in the custody of the state, coverage shall begin at the date of entry of a final decree of adoption. It also means the legally adopted child of the Employee's Spouse provided the child is living with, and is financially dependent upon the Employee;
3. stepchild who resides with the Employee and is financially dependent upon the Employee;
4. child for whom the Employee is the court-appointed legal guardian, as long as the child resides with the Employee and primarily depends on the Employee for financial support. Financial support means that the Employee is eligible to claim the dependent for purposes of Federal and State income tax returns

Eligibility Waiting Period

The cumulative period of time during a continuous period of employment that an Employee must be in Active Service in order to be eligible for coverage under the Policy. It will be extended by the number of days the Employee is not in Active Service.

Employee

For eligibility purposes, an Employee of the Employer who is in one of the Covered Classes.

Employer

The Subscriber and any affiliates, subsidiaries or divisions shown in the *Schedule of Affiliates* and which are covered under this Policy on the date of issue or subsequently agreed to by Us. The term "employer" refers to an employer of a Spouse.

Employer's Plan

A program established and maintained by the Employer to provide benefits to plan participants and their beneficiaries.

End Stage Renal (Kidney) Failure

The chronic irreversible failure of the function of both kidneys, such that regular hemodialysis or peritoneal dialysis is required to sustain life.

The Date of Diagnosis is the date a Physician prescribes that the Covered Person begins dialysis.

Evidence of Insurability Evidence of good health that is submitted by the Eligible Person and is satisfactory to Us before the coverage subject to this requirement becomes effective. An eligible person satisfies the insurability requirement on the day We agree in writing to accept him as insured for the amount subject to this requirement. We may require that the evidence of good health be provided at the eligible person's expense.

Full-time Full-time means the number of hours set by the Subscriber as a regular work week for Employees in the Employee's eligibility class.

Furlough A total or partial temporary suspension of Active Service without a separation from employment, initiated by the Employer for a period of time specified in advance not to exceed the Maximum Benefit Period shown in the *Schedule of Benefits*. A temporary suspension will be considered continuous if the Covered Person returns to Active Service for less than 12 weeks.

Heart Attack An identifiable clinical event that results in ischemic death of a portion of the heart muscle confirmed by diagnostic testing through:

1. electrocardiographic (EKG); and
2. elevation of cardiac enzyme markers of myocardial injury.

In the event of death, an autopsy confirmation and/or death certificate identifying myocardial infarction as the cause of death will be accepted.

The Date of Diagnosis is the date that the ischemic death of a portion of the heart muscle occurred.

He, His, Him, Himself Refers to any individual, male or female.

Hospital An institution that meets all of the following:

1. It is licensed as a Hospital pursuant to applicable law;
2. It is primarily and continuously engaged in providing medical care and treatment to sick and injured persons;
3. It is managed under the supervision of a staff of medical doctors;
4. It provides 24-hour nursing services by or under the supervision of a graduate registered Nurse (R.N.);
5. It has medical, diagnostic and treatment facilities, with major surgical facilities on its premises, or available to it on a prearranged basis.

The term Hospital does not include a clinic, facility, or unit of a Hospital for:

1. rehabilitation, convalescent, custodial, educational, hospice or skilled nursing care;
2. the aged, the treatment of drug addiction or alcoholism; or
3. a facility primarily or solely providing psychiatric services to mentally ill patients.

Initial Open Enrollment Period The period agreed upon by the Employer and Us when an eligible Employee who was hired on or before the Policy Effective Date may enroll for the first time for coverage under this Policy.

Injury Any accidental loss or bodily harm.

Inpatient A Covered Person who is formally admitted and confined to a Hospital or facility under a Physician's order for a period of time requiring at least one overnight stay and is charged for at least one full day's Hospital room and board.

Instrumental Activities of Activities used in measuring levels of personal functioning capacity.

Daily Living

These activities are normally performed without assistance allowing personal independence in everyday living. These activities include the following:

1. assistance with light housekeeping;
2. shopping and meal preparation;
3. laundry;
4. medication management;
5. bill paying; and
6. ability to access needed services outside of the home for medical professional services or rehabilitative care without assistance.

Invasive Cancer

A disease involving an organ of the body which is identified by the presence of malignant cells or a malignant tumor characterized by the uncontrolled and abnormal growth and spread of invasive malignant cells. The term Invasive Cancer does not include:

1. pre-malignant conditions or conditions with malignant potential;
2. Carcinoma in Situ; or
3. Skin Cancer.

For the purpose of the Initial Critical Illness Benefit, the Date of Diagnosis includes the recurrence or spread (metastasis) of a previously diagnosed cancer as long as the Covered Person has not undergone any form of treatment for the previously diagnosed Invasive Cancer for a period of 1 year prior to the Date of Diagnosis for Invasive Cancer that occurs while coverage is in force.

"Treatment" does not include any form of pharmacotherapy which is used to improve or maintain general physical condition or health or which is used for routine, long term, or maintenance care that is provided after the resolution of the acute medical problem and is not expected to provide significant therapeutic improvement. "Treatment" also does not include routine examinations to verify whether cancer has returned.

Major Organ Failure

A life-threatening inability or lack of function of Organs that is the result of Sickness or disease and is not the result of physical Injury or trauma. Major Organ Failure requires a Physician recommend or prescribe that the Covered Person undergo a human to human transplantation of the Organ. If the Covered Person has a combination transplant (i.e. heart and lung), a single benefit amount will be payable.

The Date of Diagnosis is the date when the latter of both of the following occurs:

1. the date the Physician diagnoses, prescribes or recommends that the Covered Person undergo the transplant; and
2. the date the Covered Person is placed on a national registry for organ matching administered by UNOS.

Multiple Sclerosis

A chronic, progressive, inflammatory, demyelinating disease involving damage to cells in the brain and spinal cord, and leading to the following Signs:

'Signs' means:

1. Radiologic findings of plaque upon Magnetic Resonance Imaging (MRI); and
2. Clinical findings of at least 3 of the following motor deficits and 3 of the following sensory deficits:

Motor

1. weakness;
2. spasticity;
3. atrophy;
4. incontinence; or
5. instability of gait

Sensory

1. loss of sensation (hypoesthesia);
2. self-reported pain;
3. visual disturbances;
4. dizziness or vertigo; or
5. numbness and tingling (paresthesia)

The Date of Diagnosis is the date when the latter of both of the following occurs:
1. MRI diagnostic test, or similar diagnostic imagery of the brain; and
2. The Covered Person displays clinical Signs of this disease as confirmed by a Neurologist.

The definition of Multiple Sclerosis includes Neuromyelitis Optica and Transverse Myelitis.

Muscular Dystrophy A progressive disorder characterized by abnormal gene mutations that interfere with the production of proteins needed to form healthy muscle.

The Date of Diagnosis is the date of confirmatory testing with genetic testing or with a combination of EMG and Muscle Biopsy.

Nurse A licensed graduate registered Nurse (R.N.), a licensed practical Nurse (L.P.N.), or a licensed vocational Nurse (L.V.N.) who is not:
1. employed or retained by the Subscriber;
2. living in the Covered Person's household; or
3. a parent, sibling, spouse or child of the Covered Person.

Organ Liver, lung or lungs, pancreas, kidney, heart or bone marrow including blood forming stem cell.

Outpatient A Covered Person who receives medical tests, treatment, or services from an Ambulatory Surgical Center, Hospital, lab, medical clinic, Physician's office, or radiologic center and is not confined for a day's room and board.

Paralysis The complete, irreversible and permanent loss of the use of two or more non-severed limbs, as a result of a disease or Sickness. Paralysis as a result of Stroke, Multiple Sclerosis, and Cerebral Palsy is excluded.

The Date of Diagnosis is the date a Physician makes a diagnosis based on clinical and/or laboratory findings as supported by the Covered Person's medical records.

Parkinson's Disease A progressive, degenerative neurologic disease that is characterized by loss of the neurotransmitter dopamine and leads to the following Signs:

'Signs' means clinical findings of at least 3 of the following:
1. tremors at rest;
2. slowed, physical movement (bradykinesia) or difficulty initiating movement;
3. difficulty with speech (monotone voice, lack of inflection, etc.);
4. muscular rigidity;
5. inexpressive face;
6. festinating gait;
7. rapid, persistent blinking (blepharospasm).

The Date of Diagnosis is the date the Covered Person displays Signs of this disease as confirmed by a Neurologist.

Pathological Diagnosis A diagnosis that is based on a microscopic study of fixed tissue or preparations from the hemic (blood) system. This type of diagnosis must be done by a certified Pathologist whose diagnosis of malignancy is in keeping with the standards set up by the American Board of

Pathology.

Pathologist

A Physician who is licensed to practice pathological anatomy by the American Board of Pathology. Pathologist also means an osteopathic pathologist who is certified by the Osteopathic Board of Pathology.

Physical Activities of Daily Living

Activities used in measuring levels of personal functioning capacity. These activities are normally performed without assistance, allowing personal independence in everyday living. These activities include the following:

1. Transfer and mobility - The ability to move into or out of a bed, chair or wheelchair or to move from place to place, either via walking, a wheelchair, cane, crutches, walker or other equipment;
2. 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 catheter, urostomy, or colostomy bag);
3. Dressing – Putting on and taking off all items of clothing and any necessary braces, fasteners or artificial limbs;
4. Toileting – Getting to and from the toilet, transferring on and off the toilet and performing associated personal hygiene;
5. Eating – Feeding oneself by consuming food or fluids manually from a receptacle (such as a plate, cup or table); or
6. Bathing - Washing oneself by sponge bath; or in either a tub or a shower, including the task of getting into or out of the tub or shower.

Physician

A licensed medical, osteopathic or podiatric practitioner who is practicing within the scope of his license and who is licensed to prescribe and administer medication and to perform surgery that is appropriate for the condition and locality and who is not:

1. employed or retained by the Subscriber;
2. living in the Covered Person's household; or
3. a parent, sibling, spouse or child of the Covered Person.

Poliomyelitis

An acute, infectious disease caused by the poliovirus, characterized by fever, motor paralysis and atrophy of skeletal muscles, marked by inflammation of nerve cells in the anterior horns of the spinal cord, and leading to the following Signs:

"Signs" means:
Flaccid motor weakness or loss of motor function, and two of the following:

1. Muscular weakness;
2. Loss of muscle mass (atrophy);
3. Loss of muscle tone; and
4. Loss of deep tendon reflexes.

Poliomyelitis does not include non-paralytic (abortive) polio or post-polio syndrome.

The Date of Diagnosis is the date when the latter of both of the following occurs:

1. The date the confirmatory sample of throat secretions, stool or cerebrospinal fluid that shows the presence of the poliovirus is taken; and
2. The Covered Person displays clinical Signs of this disease as confirmed by a Physician.

Prior Plan

The plan of insurance providing similar benefits sponsored by the Employer and in effect directly prior to the Policy Effective Date. A Prior Plan will include the plan of an employer in effect on the day prior to:

1. that employer's addition to this policy; or
2. with Our approval, the addition of all employees, or all of a defined group of employees, of an employer, as a result of an agreement to which that employer (or

a parent or shareholder of that employer) is a party with the Subscriber.

Recurrence

For purposes of this policy, means:

1. The return of signs and symptoms of a medical condition or disease with the reappearance of the same histologic pathology.
2. The signs and symptoms of a medical condition or disease that occurs again (reoccurs) with or without a shared or related histologic pathology to a previous disease or condition.

Sickness

A physical or mental illness.

Skin Cancer

An uncontrolled growth of abnormal skin cells that is:

1. basal cell carcinoma or
2. squamous cell carcinoma or
3. melanoma that is diagnosed as Clark's Level I or II or Breslow less than 0.75mm

The Date of Diagnosis is the date the tissue specimen is taken on which the diagnosis of Skin Cancer is based.

Spouse

The Employee's current lawful Spouse who is at least Age 18 for any coverage requiring Evidence of Insurability but not yet Age 100. Except for purposes of determining initial eligibility, the term includes a Spouse who is widowed or divorced or legally separated from an Employee. The term includes a common-law Spouse who is recognized as a common-law Spouse under the laws of the jurisdiction where the common-law marriage was formed.

Stroke

A cerebrovascular event resulting in:

1. damage of brain tissue as a result of ischemia or hemorrhage and confirmed by findings on neuroimaging studies, including Brain CT, MRI, MRA or similar diagnostic study, or a lumbar puncture (spinal tap); and
2. at least 96 hours after the event:
    a. a. clinical evidence of persistent neurological deficits diagnosed by a Physician; or
    b. b. confirmatory findings on neuroimaging studies, including Brain CT, MRI, MRA, or similar diagnostic study, or lumbar puncture (spinal tap) consistent with a cerebrovascular event.

Stroke does not include:

1. transient ischemic attack;
2. brain injury related to trauma or infection;
3. brain injury associated with hypoxia or anoxia;
4. vascular disease affecting the eye or optic nerve; or
5. ischemic disorders of the vestibular system.

In the event of death, an autopsy confirmation and/or death certificate identifying Stroke, as defined in the Policy, as the cause of death will be accepted.

The Date of Diagnosis is the date the cerebrovascular event occurs, and confirmed by:

1. neuroimaging studies or lumbar puncture (spinal tap); or
2. clinical evidence of signs, symptoms, and findings, including neurological deficits, consistent with a cerebrovascular event.

Subscriber

Any participating organization that subscribes to the Trust to which this Policy is issued.

Temporary Layoff

A total temporary suspension of Active Service with a separation from employment, initiated by the Employer for a period of time specified in advance not to exceed the Maximum Benefit Period shown in the *Schedule of Benefits*. Temporary Layoff does not include the permanent termination of Active Service (including but not limited to a job

	elimination), which shall be treated as a termination of employment. A temporary suspension will be considered continuous if the Covered Person returns to Active Service for less than 30 days.
Trust	The Group Insurance Trust for Employers named on the face page of this Policy.
We, Us, Our, Insurance Company	Cigna Health and Life Insurance Company.
You, Your	The person to whom the certificate is issued

ELIGIBILITY

EMPLOYEE
An Employee becomes eligible for coverage under this Policy on the date He meets all of the requirements of one of the Covered Classes and completes any Eligibility Waiting Period, as shown in the *Schedule of Benefits*. The Eligibility Waiting Period will not apply to an Employee, in Active Service on the Policy Effective Date, who was covered under the Prior Plan and satisfied the Eligibility Waiting Period, if any, of that plan. Credit will be given for any time that was satisfied.

Except as noted in the Reinstatement Provision, if an Employee terminates coverage and later wishes to reapply, or if a former Employee is rehired, a new Eligibility Waiting Period must be satisfied as shown in the *Schedule of Benefits*. An Employee is not required to satisfy a new Eligibility Waiting Period if coverage ends because he or she is no longer in a Class of Eligible Employees, but continues to be employed by the Employer, and within one year becomes a member of an eligible class.

SPOUSE AND DEPENDENT CHILDREN
A Spouse and Dependent Children of an eligible Employee become eligible for any dependent coverage provided by this Policy on the later of the date the Employee becomes eligible or the date the Spouse or Dependent Child meets the applicable definition shown in the *General Definitions* section of this Policy. The Employee must be insured under the Policy in order to elect coverage for a Spouse or Dependent Child.

LIMITATIONS ON MULTIPLE ELIGIBILITY
A Covered Person may be insured only once under this Policy even though he or she may be eligible under more than one class of insureds.

ELIGIBLE EMPLOYEE INSURED AS SPOUSE - LOSS OF ELIGIBILITY AS A SPOUSE
If an Employee is eligible and has enrolled as the Spouse of another Employee, but ceases to be eligible to maintain the amount of coverage for which he or she has enrolled as a Spouse, that Employee may, within 31 days, enroll for coverage as an Employee, in an amount equal to the lesser of:

1. The amount of the Spouse's coverage terminating; or
2. The maximum amount of Employee coverage of the class for which he or she is eligible.

Evidence of Insurability is not required. If this amount is not equal to an available Benefit Amount, it will be adjusted to the next higher available Benefit Amount.

An Employee shall not also be eligible for an increase in coverage due to a Life Status Change when eligible under this provision. Premium will be based upon the Employee's Age as of the Effective Date of the Employee's coverage under this provision.

ELIGIBLE SPOUSE INSURED AS EMPLOYEE - LOSS OF ELIGIBILITY AS AN EMPLOYEE
If a Spouse is eligible and has enrolled for coverage as an Employee but ceases to be eligible to maintain the amount of coverage for which he or she has enrolled as an Employee, that Spouse may, within 31 days, be enrolled for coverage as a Spouse in an amount equal to the lesser of:

1. The amount of Employee coverage terminating; or
2. The maximum amount of Spouse coverage for which he or she is eligible.

Evidence of Insurability is not required. If this amount is not equal to an available Benefit Amount, it will be adjusted to the next higher available Benefit Amount.

A Spouse shall not also be eligible for an increase in coverage due to a Life Status Change when eligible under this provision. Premium will be based upon the Employee's Age as of the Effective Date of the Spouse's coverage under this provision.

SPECIAL RULES FOR DEPENDENT CHILDREN
An Employee who is insured will not be insured as a Dependent Child of another Employee.

A Dependent Child of two or more Employees may only be insured once under the Policy. If a Dependent Child of two or

more Employees who have enrolled Dependent Children incurs a claim, then any payable benefit will be divided equally among the Employees who have insured the Dependent Child unless the Employees otherwise agree.

If an Employee who has elected to insure Dependent Children ceases to do so, then the Employee's Spouse may, within 31 days, elect to insure Dependent Children, provided he or she is insured as an Employee.

In all cases, a Dependent Child shall be defined with respect to the Employee who has enrolled Dependent Children.

ENROLLMENT

An Employee may only enroll or apply for coverage at such times, and during such Enrollment Events, as specified in the Policy.

GROUP ENROLLMENT EVENTS

New Enrollees

Subject to the *Deferred Effective Date Provisions*, an Employee who is newly eligible to apply, or has been eligible but did not previously enroll, may apply for coverage for Himself or any eligible Spouse or Dependent Child for an amount shown as Guaranteed Issue without satisfying any Evidence of Insurability, during the Enrollment Events shown in the *Schedule of Benefits*.

Current Insureds

Subject to the *Deferred Effective Date Provisions*, an eligible Employee who is insured under the Prior Plan, or insured under this Policy, may apply for an increase in coverage for Himself or for coverage on any insured Spouse or Dependent Child for an amount shown as Guaranteed Issue without satisfying any Evidence of Insurability, during the Enrollment Events shown in the *Schedule of Benefits*.

An eligible Employee must apply for Himself and be insured for coverage for which He is required to contribute to the cost of coverage in order to apply for coverage for an eligible Spouse or Dependent Child.

EFFECTIVE DATE PROVISIONS

SUBSCRIBER EFFECTIVE DATE

Coverage becomes effective for each Subscriber in consideration of the Subscriber's application, Subscription Agreement and payment of the initial premium when due. Coverage for the Subscriber becomes effective on the Effective date of Subscriber Participation as long as the Minimum Participation Requirements shown in the *Schedule of Benefits* have been satisfied.

EFFECTIVE DATE FOR INDIVIDUALS *(NEWLY ELIGIBLE AND LIFE STATUS)*

Voluntary Benefit

For all Employee coverage, Evidence of Insurability is not required.

If the Employee applies for coverage and agrees to make required contributions within 31 days after the date He becomes eligible and, subject to the *Deferred Effective Date Provisions* section below, coverage becomes effective on the later of:

1. the effective date of the Subscriber's participation under this Policy;
2. the first of the month following the date We or the Employer receive the Employee's completed enrollment form.

For all Spouse coverage, Evidence of Insurability is not required.

If the Spouse is eligible for coverage, and the Employee applies for coverage and agrees to make required contributions within 31 days after the date the Spouse becomes eligible and, subject to the *Deferred Effective Date Provisions* section below, coverage becomes effective on the later of:

1. the effective date of the Subscriber's participation under this Policy;
2. the date the Employee becomes eligible;
3. the date the Employee's coverage becomes effective;
4. the date the dependent meets the definition of Spouse as applicable;
5. the first of the month following the date We or the Employer receive the completed enrollment form.

For all Dependent Child coverage, Evidence of Insurability is not required.

If the Dependent Child is eligible for coverage, and the Employee applies for coverage and agrees to make required contributions within 31 days after the date the Dependent Child becomes eligible and, subject to the Deferred Effective Date Provisions section below, coverage becomes effective on the later of:

1. the effective date of the Subscriber's participation under this Policy;
2. the date the Employee becomes eligible;
3. the date the Employee's coverage becomes effective;
4. the date the dependent meets the definition of Dependent Child as applicable;
5. the first of the month following the date We or the Employer receive the completed enrollment form for Dependent Child coverage.

If coverage for a Dependent Child is in force and another Dependent Child becomes eligible, coverage for that child is effective on the date the child qualifies as a Dependent Child.

EFFECTIVE DATE OF CERTAIN CHANGES

Any increase or decrease in the amount of coverage for the Covered Person resulting from:

1. a change in benefits provided by this Policy; or
2. a change in the Employee's Covered Class,

will take effect on the date of such change and not result in any change in Age for Premium purposes. Increases will take effect subject to any Active Service requirement.

DEFERRED EFFECTIVE DATE PROVISIONS

NOT IN ACTIVE SERVICE

The effective date of coverage will be deferred for any Employee or any eligible Spouse or Dependent Child who is not in Active Service on the date coverage would otherwise become effective. Coverage will become effective on the later of the date He returns to Active Service, or the date coverage would otherwise have become effective.

INDIVIDUAL ENROLLMENT EVENTS

LIFE STATUS CHANGE

A Life Status Change is an event that the Employer has determined qualifies an Employee to apply for coverage or to increase coverage on Himself, His Spouse or Dependent Child due to a Life Status Change under this Policy.

Life Status Changes that qualify an Employee to apply or increase coverage for Himself include:

1. marriage;
2. loss of a Spouse; whether by death, divorce, annulment or legal separation;
3. birth or adoption of a child, or acquiring a child through marriage;
4. a change in the group benefit plan available to the Employee's Spouse;
5. a change in the Employee's employment status that affects eligibility for group benefits for either the Employee or His Spouse;
6. termination of a Spouse's employment; and
7. an event as specified in the Employer's Plan which this Policy insures.

Life Status Changes that qualify an Employee to apply or increase coverage for His eligible Spouse and Dependent Child include:

1. marriage;
2. loss of a Spouse; whether by death, divorce, annulment or legal separation;
3. birth or adoption of a child, or acquiring a child through marriage;
4. a change in the group benefit plan available to the Spouse;
5. a change in the Spouse's employment status that affects eligibility for group benefits for either the Employee or His Spouse;
6. termination of a Spouse's employment; and
7. an event as specified in the Employer's Plan which this Policy insures.

Any coverage elected as a result of a Life Status Change, shall be effective in accordance with the *Effective Date for Individuals Provision*.

GROUP ENROLLMENT EFFECTIVE DATES

Annual Group Enrollment Period

Coverage up to the Guaranteed Issue amount for which an Employee, Spouse and Dependent Child is eligible, will be effective on the effective date of this Policy's anniversary following the enrollment period.

For all Employee and Spouse coverage up to the Guaranteed Issue amount, Evidence of Insurability is not required. For all Employee and Spouse coverage in excess of the Guaranteed Issue amount, Evidence of Insurability is required.

The Employee may apply for an increase in coverage on an insured Spouse or for coverage on a Spouse who is eligible to be insured but was not previously enrolled by the Employee.

For all Dependent Child coverage Evidence of Insurability is not required.

The Dependent Child who is eligible to apply, but was not previously enrolled by the Employee, the Employee may apply or is insured the Employee may apply for an increase for coverage.

TAKEOVER PROVISION

This provision applies only to Employees and the Employee's dependents who were covered for Critical Illness coverage under a Prior Plan provided by the Subscriber or by an entity that has been acquired by the Subscriber on the day prior to the date the Employee would have first become eligible to be insured under this Policy.

A. This section A applies to Employees who are not in Active Service on the day prior to the date the Employee would have first become eligible to be insured under this Policy due to a reason for which the Prior Plan and this Policy both provide for continuation of coverage on a premium paying basis. If the required premium is paid when due, We will insure an Employee and the Employee's dependents, to which this section applies during and for the balance of the period for which coverage would be continued under the Prior Plan that occurs after the effective date of this Policy. This coverage will be provided until the earlier of the date: (a) the Employee, returns to Active Service, or (b) continuation of coverage under the Prior Plan would end but for termination of that plan. The Policy will provide this coverage as follows:

    1. If benefits are payable under the Prior Plan during the period that coverage is continued under this Policy, then no benefits are payable under this Plan.
    2. If benefits are not payable under the Prior Plan during the period that coverage is continued under this Policy, solely because the Prior Plan terminated, benefits payable under this Policy will be the lesser of: (a) the benefits that would have been payable under the Prior Plan; or (b) those provided by this Policy. Credit will be given for partial completion under the Prior Plan of Elimination Periods.

    Notwithstanding this paragraph, all dependent coverage remains subject to the Active Service requirements of the *Deferred Effective Date Provisions* of this Policy.

B. For any benefit offered with this Policy that is subject to an Elimination Period, the Elimination Period under this Policy, if applicable, will be waived while the Employee and the Employee's dependents are insured under this Policy if all of the following conditions are met:

    1. The Covered Loss results from the same or related causes as a Covered Loss for which benefits were payable under the Prior Plan;
    2. Benefits are not payable for the Covered Loss under the Prior Plan solely because it is not in effect;
    3. An Elimination Period would not apply to the Covered Loss if the Prior Plan had not ended;
    4. The Covered Loss occurs within 90 days of the Employee's return to Active Service and the Employee's and the Employee's dependents' coverage under this Policy is continuous from this Policy's Effective Date.

For purposes of paragraph B, benefits will be determined based on the lesser of: (1) the amount of the benefit under the

Prior Plan and any applicable maximums had the Prior Plan remained in force; and (2) those provided by this Policy. If benefits are payable under the Prior Plan for a Covered Loss, no benefits are payable under this Policy.

TERMINATION OF INSURANCE

Coverage on a Covered Person will end on the earliest date below:

1. the date this Policy or coverage for a Covered Class is terminated;
2. the date the Subscriber's participation under this Policy ends.
3. the date the Employee is no longer in Active Service;
4. for a Spouse, the date the Spouse reaches age 100;
5. for a Dependent Child, the end of the month following or coinciding with the date the Dependent Child reaches age 26, unless primarily supported by the Employee and incapable of self-sustaining employment by reason of mental or physical handicap;
6. the date the Employee is no longer in a Covered Class or satisfies eligibility requirements under this Policy;
7. the last day for which premium is paid;
8. with respect to a Spouse or Dependent Child, the date of the death of the covered Employee or the date of divorce from the covered Employee unless the Employee elects to continue coverage, including coverage on any Dependent Child; or
9. the date that the plan of benefits under which the Covered Person is covered is terminated.

Termination will not affect a claim that arises while coverage was in effect.

CONTINUATION OF COVERAGE PROVISIONS

If an Employee is no longer in Active Service, coverage may be continued. The following provisions explain the continuation options available under this Policy. Please see the *Schedule of Benefits*, to determine the applicability of these benefits on a class level.

Notwithstanding any other provision of this Policy, if an Employee's Active Service ends due to termination of employment, or any other termination of the employment relationship, coverage will end and Continuation of Coverage under this section will not apply.

CONTINUATION FOR LAYOFF, LEAVE OF ABSENCE, FAMILY MEDICAL LEAVE OR FURLOUGH
If an Employee's Active Service ends due to personal or family medical leave approved timely by the Employer, coverage will continue for up to the Maximum Benefit Period as shown in the *Schedule of Benefits*. Premiums are required for this coverage and are to be remitted directly to the Subscriber.

If an Employee's Active Service ends due to any other leave of absence approved in writing by the Employer prior to the date the Employee ceases work, coverage will continue up to the Maximum Benefit Period as shown in the *Schedule of Benefits*. Premiums are required for this coverage and are to be remitted directly to the Subscriber. An approved leave of absence does not include Furlough, Temporary Layoff or termination of employment.

If an Employee's Active Service ends due to Furlough, coverage will continue up to the Maximum Benefit Period as shown in the *Schedule of Benefits*. Premiums are required for this coverage and are to be remitted directly to the Subscriber.

If an Employee's Active Service ends due to Temporary Layoff, coverage will continue up to the Maximum Benefit Period shown in the *Schedule of Benefits*. Premiums are required for this coverage and are to be remitted directly to the Subscriber.

PORTABILITY PROVISIONS

Coverage provided by this Policy is portable, except as provided for specific benefits or coverages and except upon termination of the Policy, for an Employee as shown in the *Schedule of Benefits* and satisfies all of the conditions below.

WHOSE INSURANCE IS PORTABLE
A covered Employee who:

1. has not attained the Maximum Age for Portability shown in the *Schedule of Benefits*; and
2. agrees to pay required premiums, may remain covered under this Policy for the Portable Period shown in the *Schedule of Benefits*.

Any Spouse or Dependent Child coverage provided under the covered Employee's Certificate is portable when the Employee ports His coverage.

A covered Spouse or Dependent Child who:
1. has not attained the Maximum Age for Portability shown in the *Schedule of Benefits*; and
2. agrees to pay required premiums, may remain covered under a Certificate issued to Him for the Portable Period shown in the *Schedule of Benefits*.

AMOUNT OF PORTABLE INSURANCE
The amount of portable coverage is shown in the *Schedule of Benefits* and will be subject to the provisions of the Policy that reduce the coverage amount because of a change in class. Any additional coverages and benefits for which the Covered Person was insured are portable only if shown in the *Schedule of Benefits.*

EFFECTIVE DATE OF PORTED INSURANCE
Ported coverage will become effective under this section on the date the Covered Person's coverage under the Policy would otherwise have terminated, as described above, if the Covered Person has agreed to pay required premiums within 31 days of the date He would otherwise have ceased to be eligible. The Covered Person need not show Us He is insurable.

TERMINATION OF PORTED INSURANCE
Coverage will end on the earliest of the following dates:
1. the day after the end of the last period for which premiums are paid;
2. the end of the Portable Period;
3. the date the Covered Person reaches the Maximum Age for Portability shown in the *Schedule of Benefits*;
4. the date the Employee's ported coverage terminates;
5. for a Dependent Child, the date the Dependent Child reaches age 26 unless primarily supported by the Employee and incapable of self-sustaining employment by reason of mental or physical handicap or ceases to qualify as a Dependent Child; or
6. the date the Spouse or Dependent no longer meets the definition of Spouse or Dependent Child.

GCI-02-1400-1.WY

EXCLUSIONS

In addition to any benefit-specific exclusions, benefits will not be paid for any Covered Loss which, directly or indirectly, in whole or in part, is caused by or results from any of the following unless coverage is specifically provided for by name in the *Description of Coverages and Benefits* section:

1. intentionally self-inflicted Injury, suicide or any attempt thereat while sane or insane;
2. commission or attempt to commit a felony or an assault;
3. declared or undeclared war or act of war;
4. a Covered Loss that results from active duty service in the military, naval or air force of any country or international organization. Upon Our receipt of proof of service, We will refund any premium paid for this time. Reserve or National Guard active duty training is not excluded unless it extends beyond 31 days.
5. voluntary ingestion of any narcotic, drug, poison, gas or fumes, unless prescribed or taken under the direction of a Physician and taken in accordance with the prescribed dosage;
6. operating any type of vehicle while under the influence of alcohol or any drug, narcotic or other intoxicant. "Under the influence of alcohol", for purposes of this exclusion, means intoxicated, as defined by the law of the state in which the Covered Loss occurred.
7. a diagnosis not in accordance with generally accepted medical principles prevailing in the United States at the time of the diagnosis.

GCI-02-1500-1.WY

CLAIM PROVISIONS

NOTICE OF CLAIM
Written or authorized electronic, or telephonic notice of claim must be given to Us within 31 days after a Covered Loss occurs or begins or as soon as is reasonably possible. If written or authorized electronic, or telephonic notice is not given in that time, the claim will not be invalidated or reduced if it is shown that written or authorized electronic, or telephonic notice was given as soon as was reasonably possible. Notice can be given to Us at Our Home Office in Bloomfield, Connecticut, such other place as We may designate for the purpose, or to Our authorized agent. Notice should include the Subscriber's name and Policy number and the Covered Person's name, address, Policy and Certificate number.

CLAIM FORMS
We will send claim forms with written instructions for filing proof of loss when We receive notice of a claim. If such forms are not sent within 15 days after We receive notice, the proof requirements will be met by submitting, within the time fixed in this Policy for filing proof of loss, written or authorized electronic proof of the nature and extent of the loss for which the claim is made.

CLAIMANT COOPERATION PROVISION
Failure of a claimant to cooperate with Us in the administration of the claim may result in termination of the claim. Such cooperation includes, but is not limited to, providing any information or documents needed to determine whether benefits are payable or the actual benefit amount due.

PROOF OF LOSS
Written or authorized electronic proof of loss satisfactory to Us must be given to Us at Our office, within 90 days of the loss for which claim is made. If (a) benefits are payable as periodic payments and (b) each payment is contingent upon continuing loss, then proof of loss must be submitted within 90 days after the termination of each period for which We are liable. If written or authorized electronic notice is not given within that time, no claim will be invalidated or reduced if it is shown that such notice was given as soon as was reasonably possible. In any case, written or authorized electronic proof must be given not more than one year after the time it is otherwise required, except if proof is not given solely due to the lack of legal capacity.

TIME OF PAYMENT OF CLAIMS
We will pay benefits due under this Policy for any loss other than a loss for which this Policy provides any periodic payment not more than 60 days upon Our receipt of due written or authorized electronic proof of such loss. Due proof of loss means all essential information needed to make a determination on the claim. Subject to due written or authorized electronic proof of loss, all accrued benefits for loss for which this Policy provides periodic payment will be paid monthly unless otherwise specified in the benefits descriptions and any balance remaining unpaid at the termination of liability will be paid immediately upon receipt of proof satisfactory to Us.

PAYMENT OF CLAIMS
All benefits will be paid in United States currency. All benefits payable under the Policy are payable to the Covered Person, if living, except if the Covered Person is a Dependent Child, then the benefits will be payable to the Employee. If the Covered Person dies while any of these benefits remain unpaid, benefits payable under the Policy will be paid to the Covered Person's Spouse, if living, or otherwise to the executors or administrators of the Covered Person's estate.

Benefits will be reduced by any outstanding premium due.

If We are to pay benefits to the estate or to a person who is incapable of giving a valid release, We may pay $1,000 to a relative by blood or marriage whom We believe is equitably entitled.

Any payment made by Us in good faith pursuant to this provision will fully discharge Us, and release Us from all liability to the extent of such payment.

PHYSICAL EXAMINATION AND AUTOPSY
We, at Our own expense, have the right and opportunity to examine the Covered Person when and as often as We may reasonably require while a claim is pending and to make an autopsy in case of death where it is not forbidden by law.

LEGAL ACTIONS

No action at law or in equity may be brought to recover under this Policy less than 60 days after written or authorized electronic proof of loss has been furnished as required by this Policy. No such action will be brought more than three years after the time such written proof of loss must be furnished.

RECOVERY OF OVERPAYMENT

If benefits are overpaid, We have the right to recover the amount overpaid by either of the following methods.

1. A request for lump sum payment of the overpaid amount;
2. A reduction of any amounts payable under this Policy.

If there is an overpayment due when the Covered Person dies, We may recover the overpayment from the Covered Person's estate.

GCI-02-CE1700.00

ADMINISTRATIVE PROVISIONS

PREMIUMS
All premium rates are expressed in, and all premiums are payable in, United States currency. The premiums for this Policy will be based on the rates determined by written agreement between the Subscriber and Us, the plan and amounts of coverage in effect.

PAYMENT OF PREMIUM
Covered Person
The Covered Person may be responsible for the payment of premium directly to Us, as determined by the Employer from the Policy Effective Date or following the expiration of 60 days from the date coverage is continued for a Covered Person under the *Continuation of Coverage Provisions* section of the Policy. Premium shall be due monthly, unless the Covered Person and We agree on some other period for premium payment. If premium is not paid when due, coverage will end as of the premium due date, except as provided in the Covered Person Grace Period provision below.

GRACE PERIOD
Covered Person
A Grace Period of 31 days will be granted for payment of required premiums under this Policy. A Covered Person's coverage under this Policy will remain in force during the Grace Period. We will reduce any benefits payable for any claims incurred during the Grace Period by the amount of premium due. If no such claims are incurred and premium is not paid during the Grace Period, coverage will end on the last day of the period for which premiums were paid.

REINSTATEMENT OF INSURANCE
If an Employee's Active Service ended due to an Employer-approved leave pursuant to the Family and Medical Leave Act (FMLA) and *Continuation of Coverage* is not applicable, an Employee's coverage may be reinstated at the conclusion of the FMLA leave.

If an Employee's Active Service ends due to the Employer-approved unpaid leave of absence, other than an approved FMLA leave, coverage may be reinstated only:
1. if the reinstatement occurs within 12 weeks from the date coverage ends; or
2. when returning from military service pursuant to the Uniformed Services Employment Act of 1994 (USERRA).

If an Employee's Active Service ends due to Temporary Layoff coverage may be reinstated only if the reinstatement occurs within 31 days from the date coverage ends.
For coverage to be reinstated the following conditions must be met:
1. An Employee must be in a Class of Eligible Employees.
2. The required premium must be paid.
3. We must receive a written request for reinstatement within 31 days from the date an Employee returns to Active Service.

EFFECTIVE DATE OF REINSTATED INSURANCE
Reinstated coverage will be effective on the date the Employee returns to Active Service if Evidence of Insurability is not required. If Evidence of Insurability must be satisfied, the reinstated coverage will be effective as provided in the *Effective Date Provisions* section. If the Employee's coverage ended due to an approved unpaid leave of absence or Temporary Layoff, credit will be given for any time that was satisfied.

GCI-02-CE1800.00

GENERAL PROVISIONS

ENTIRE CONTRACT; CHANGES
This Policy, including the endorsements, amendments and any attached papers constitutes the entire contract of coverage. No change in this Policy will be valid until approved by one of Our executive officers and endorsed on or attached to this Policy. No agent has authority to change this Policy or to waive any of its provisions.

SUBSCRIBER PARTICIPATION UNDER THIS POLICY
An organization may elect to participate under this Policy by submitting a signed Subscriber participation agreement to the Policyholder. No participation by an organization is in effect until approved by Us.

MISSTATEMENT OF AGE AND TOBACCO
If the Covered Person has misstated His Age or tobacco status, all amounts payable under this Policy will be such as the premium paid would have purchased had such fact been correctly stated.

CERTIFICATES
Where required by law, We will provide a Certificate for delivery to the Covered Person. Each Certificate will list the benefits, conditions and limits of this Policy. It will state to whom benefits will be paid.

30 DAY RIGHT TO EXAMINE CERTIFICATE
If a Covered Person does not like the Certificate for any reason, it may be returned to Us within 30 days after receipt. We will return any premium that has been paid and the Certificate will be void as if it had never been issued.

MULTIPLE CERTIFICATES
The Covered Person may have in force only one Certificate at a time under this Policy. If at any time the Covered Person has been issued more than one Certificate, then only the Certificate insuring the Covered Person as an Employee shall be in effect. We will refund premiums paid for the others for any period of time that more than one Certificate was issued.

A Covered Person is not eligible for coverage under more than one Certificate providing similar benefits for Critical Illness coverage under group policies issued by Us. If premium is being paid for more than one such Certificate as an Employee or a Dependent, then coverage will be in effect under the Certificate with the earliest effective date and premiums paid for Certificates which are not in effect will be refunded.

ASSIGNMENT
The rights and benefits provided by this Policy, except as provided herein, may not be assigned. The payee may, after a benefit or series of benefits has become payable, assign only those benefits. Such assignment will be valid only if We receive it before any of those benefits have been paid and only for benefits payable for claims arising from the same Covered Loss. Any other attempt to assign will be void.

INCONTESTABILITY
This Policy or Participation Under This Policy
All statements made by the Subscriber to obtain this Policy or to participate under this Policy are considered representations and not warranties. No statement will be used to deny or reduce benefits or be used as a defense to a claim, or to deny the validity of this Policy or of participation under this Policy unless a copy of the instrument containing the statement is, or has been, furnished to the Subscriber.

After two years from the Policy Effective Date, no such statement will cause this Policy to be contested except for fraud or lack of eligibility for coverage.

A Covered Person's Insurance
All statements made by a Covered Person are considered representations and not warranties. No statement will be used to deny or reduce benefits or be used as a defense to a claim, unless a copy of the instrument containing the statement is, or has been, furnished to the claimant.

After two years from the Covered Person’s effective date of coverage, or from the effective date of increased benefits, no such statement will cause coverage or the increased benefits to be contested except for fraud or lack of eligibility for coverage.

In the event of death or incapacity, the beneficiary or representative shall be given a copy.

POLICY TERMINATION
We may terminate coverage on or after the first anniversary of the Policy Effective Date. We or the Subscriber may terminate coverage on any Premium Due Date. Written or authorized electronic notice by certified mail must be given at least 31 days prior to such Premium Due Date. Failure by the Subscriber to pay premiums when due or within the Grace Period shall be deemed notice to Us to terminate coverage at the end of the period for which premium was paid.

Termination will not affect a claim for a Covered Loss that is the result, directly and independently of all other causes, of a loss that occurs while coverage was in effect.

AGENCY
The Employer is acting as an agent of the Employee for transactions relating to coverage under the Policy. The actions of the Subscriber shall not be considered the actions of Us, and We are not liable for any of their acts or omissions.

CLERICAL ERROR
A Covered Person's coverage will not be affected by error or delay in keeping records of coverage under this Policy. If such an error is found, the premium will be adjusted fairly. A failure to perform, including perform in a timely manner or in a manner prescribed by the Policy, any of the following shall not constitute a clerical error under this provision:

1. enroll or apply for coverage;
2. submit Evidence of Insurability;
3. report notice or provide proof of claim; or
4. pay premiums.

CONFORMITY WITH STATUTES
Any provisions in conflict with the requirements of any state or federal law that apply to this Policy are automatically changed to satisfy the minimum requirements of such laws.

POLICY CHANGES
We may agree with the Subscriber to modify coverage without the Covered Person’s consent.

WORKERS' COMPENSATION INSURANCE
This Policy is not in place of and does not affect any requirements for coverage under any Workers’ Compensation law.

EXAMINATION OF THE POLICY
This Policy will be available for inspection at the Subscriber's or Our office during regular business hours.

EXAMINATION OF RECORDS
We will be permitted to examine all of the Subscriber's records relating to this Policy. Examination may occur at any reasonable time while the Policy is in force. Examination may also occur:

1. at any time for two years after the expiration of this Policy; or, if later,
2. upon the final adjustment and settlement of all claims under this Policy.

OWNERSHIP OF RECORDS
All records maintained by Us are, and shall remain, Our property.

GCI-02-CE1900.00

Cigna Health and Life Insurance Company
900 Cottage Grove Road
Bloomfield, Connecticut 06002

HEALTH SCREENING TEST BENEFIT RIDER

This Rider is attached to and made a part of your group insurance Policy. It is subject to the terms, conditions, limitations and exclusions contained in the Policy as well as those set forth in this Rider.

Rider Effective Date: January 01, 2024

THIS RIDER DOES NOT CONTAIN COMPREHENSIVE ADULT WELLNESS BENEFITS AS DEFINED BY WYOMING LAW.

BENEFITS

The following provisions explain the benefits available under this Rider. Please see the *Schedule of Benefits* for the applicability of these benefits on a class level.

We will pay the per day benefit shown in the *Schedule of Benefits,* if a Covered Person undergoes or receives Health Screening as set forth below, under direction of a Physician while coverage under this Rider is in force. Benefits are subject to any applicable Benefit Waiting Period and Elimination Period.

BENEFIT WAITING PERIOD
The Benefit Waiting Period shown in the *Schedule of Benefits* applies to this Rider.

HEALTH SCREENING TEST
- Mammography;
- Pap Smear for women over Age 18;
- Flexible Sigmoidoscopy;
- Hemoccult Stool Specimen;
- Colonoscopy;
- Prostate Specific Antigen (for prostate cancer);
- Stress test on a bicycle or treadmill;
- Fasting blood glucose test;
- Blood test for triglycerides;
- Serum cholesterol test to determine levels of HDL and LDL;
- Bone marrow testing;
- Breast ultrasound;
- CA 15-3 (blood test for breast cancer);
- CA125 (blood test for ovarian cancer);
- CEA (blood test for colon cancer);
- Chest X-ray;
- Serum Protein Electrophoresis (blood test for myeloma); and
- Thermography

Exclusion(s)
The *Common Exclusions* section of the Policy does not apply to this Rider.

RENEWABILITY/TERMINATION OF COVERAGE
This Rider is renewable. However, this Rider shall automatically terminate on the earliest of the following dates:
1. the date the Covered Person's coverage ends for any reason under the Policy to which this Rider is attached;
2. the last day of the period for which premium is paid for this Rider, subject to the Policy's Grace Period provision; or
3. the end of the period for which premium is paid for coverage under the Policy, to which this Rider is attached,

subject to the Policy's Grace Period provision.

PORTABILITY PROVISION
Coverage under this Rider is portable. Coverage may only be ported if the Covered Person elects to port coverage under the Policy.

REINSTATEMENT
If the Employee applies for reinstatement of insurance under the Policy, the Employee may apply to reinstate this Rider at that time.

CIGNA HEALTH AND LIFE INSURANCE COMPANY

Geneva Campbell Brown
Corporate Secretary

Julia M.Huggins
Senior Vice President of US Markets
President CHLIC

WPB-GCI-02-7000-1.WY

Cigna Health and Life Insurance Company
900 Cottage Grove Road
Bloomfield, Connecticut 06002

MODIFYING PROVISIONS AMENDMENT

Subscriber: Megalodon Midco LLC Policy No.: CI111745

Amendment Effective Date: January 01, 2024

This Amendment is attached to and made part of this Policy. Its provisions are intended to conform the Policy/Certificate to the laws of the state in which the insured resides.

Note: Your policy may not include all said benefits, definitions, terms, conditions, exclusion and limitations outlined below in the state resident section. In such case, disregard the outlined modifications unless your state requires a minimum benefit be provided.

The Policy/Certificate is amended as follows:

Alaska residents:

This Certificate describes the benefits and basic provisions of Your coverage. It is not the insurance contract and does not waive or alter any terms of the Policy. For Alaska residents, the Alaska requirements and this Certificate will govern.

You may contact Cigna at:
Cigna Health and Life Insurance Company
900 Cottage Grove Road, Bloomfield, Connecticut 06002
Telephone: 1-800-754-3207 - www.Cigna.com

1) Under the *Schedule of Benefits* section the following revisions are made:

a) If Heart Attack is not already listed as a Covered Condition, a minimum benefit of $1,000 for Heart Attack will be available. For purposes of this benefit, the definition of Heart Attack is as follows:

An identifiable clinical event that results in ischemic death of a portion of the heart muscle confirmed by diagnostic testing through:

1. electrocardiographic (EKG) changes indicative of myocardial infarction. In the case of myocardial infarction ST wave changes, Q wave changes and/or T wave inversion must be documented and included as one of the criteria on establishing a diagnosis; and, or
2. elevation of cardiac enzyme markers of myocardial injury.

In the event of death, an autopsy confirmation and/or death certificate identifying myocardial infarction as the cause of death will be accepted.

The Date of Diagnosis is the date that the ischemic death of a portion of the heart muscle occurred. In the event of death, the Date of Diagnosis will be the date of death listed on the death certificate.

2) Under the *General Definitions* section, the following changes are made:

a) The definition of Hospital does not require major surgical facilities be on its premises.
b) The definition of No Evidence of Disease, if included, includes the following statement:

For Heart Attack that means the Covered Person:

1. has an absence of hyperkinesis of the non-infarcted myocardium, as demonstrated by a stable ventricular

ejection fraction for a post-myocardial infarction patient; and

2. was discharged from the Inpatient hospital stay for which a(n) Initial Specified Disease Benefit has been paid.

c) The definition of Spouse is replaced as follows:

The Employee's current lawful Spouse. Except for purposes of determining initial eligibility, the term includes a Spouse who is widowed or divorced or legally separated from an Employee. The term includes a common-law Spouse who is recognized as a common-law Spouse under the laws of the jurisdiction where the common-law marriage was formed.

2) Under the *Description of Coverages and Benefits* section, the following is added to the Initial Critical Illness Benefit as an additional Benefit Condition if there is no separation period between Dates of Diagnosis:

a) the Heart Attack the Covered Person has an Inpatient admission.

3) Under the *Eligibility* section, the first paragraph of the Rehabilitation During a Period of Disability the following sentence has been removed:

We have the sole discretion to approve the Employee's participation in a Rehabilitation Plan and to approve a program as a Rehabilitation Plan.

4) The *Claim Provisions* section, the following changes are made:

a) The TIME OF PAYMENT OF CLAIMS has been modified as follows:

We will pay benefits due under this Policy for any loss other than a loss for which this Policy provides any periodic payment not more than 30 days upon Our receipt of due written or authorized electronic proof of such loss. If additional information is required to process the claim, the claim must be paid within 15 days after receiving said information. Due proof of loss means all essential information needed to make a determination on the claim. Subject to due written or authorized electronic proof of loss, all accrued benefits for loss for which this Policy provides periodic payment will be paid monthly unless otherwise specified in the benefits descriptions and any balance remaining unpaid at the termination of liability will be paid immediately upon receipt of proof satisfactory to Us. Failure to pay a claim in accordance with the time periods stated in this provision will require the payment of interest at a rate not to exceed 15% per annum on all benefits due and unpaid.

b) The RECOVERY OF OVERPAYMENT provision is modified as follows:

If benefits are overpaid, We have, within 90 days of the date an overpayment is made, the right to recover the amount overpaid by either of the following methods. We will provide 30 days' notice before seeking recovery of an overpayment.

1. A request for lump sum payment of the overpaid amount.
2. A reduction of any amounts payable under this Policy.

If there is an overpayment due when the Covered Person dies, We may recover the overpayment from the Covered Person's estate.

5) Under the *Administrative Provisions* section of the Policy, the Change in Premium Rates provision is modified to require at least 45 days advance written notice.

6) The *General Provisions* section, the following changes were made:

a) The Entire Contract: Changes is modified as follows:

This Policy, including the endorsements, amendments, Certificate and any attached papers constitutes the entire contract of insurance. No change in this Policy or Certificate will be valid until approved by one of Our executive

officers and endorsed on or attached to this Policy. No agent has authority to change this Policy or Certificate or to waive any of its provisions.

b) The INCONTESTABILITY provision titled This Policy or Participation Under this Policy is modified as follows:

All statements made by the Subscriber to obtain this Policy or to participate under this Policy are considered representations and not warranties. No statement will be used to deny or reduce benefits or be used as a defense to a claim, or to deny the validity of this Policy or of participation under this Policy unless a copy of the instrument containing the statement is, or has been, furnished to the Subscriber. Misrepresentations, omissions, concealment of facts, and incorrect statements may not prevent a recovery under the Policy or Contract unless either
(1) fraudulent;
(2) material either to the acceptance of the risk, or to the hazard assumed by the Insurer; or
(3) the Insurer in good faith would either not have issued the Policy or Contract, or would not have issued a Policy or Contract in as large an amount, or at the same premium or rate, or would not have provided coverage with respect to the hazard resulting in the loss, if the true facts had been made known to the insurer as required either by the Application for the Policy or Contract or otherwise.

After two years from the Policy Effective Date, no such statement will cause this Policy to be contested except for fraud.

c) The POLICY TERMINATION provision is modified as follows:

We may terminate insurance on or after the first anniversary of the Policy Effective Date. The Subscriber may terminate insurance on any Premium Due Date. Written or authorized electronic notice by certified mail must be given at least 45 days prior to such Premium Due Date. Failure by Subscriber to pay premiums when due or within the Grace Period shall be deemed notice to Us to terminate insurance at the end of the period for which premium was paid.

Termination will not affect a claim for a Covered Loss that is the result, directly and independently of all other causes, of a loss that occurs while insurance was in effect.

7) The third paragraph of the Face Page of the Certificate is modified as follows:

This Certificate describes the benefits and basic provisions of Your coverage. It is part of the entire contract of insurance and does not waive or alter any terms of the Policy. If questions arise, the Policy language will govern. You may examine the Policy at the office of the Policyholder or the Administrator.

8) Under the HOSPITAL BENEFIT RIDER the following changes are made:

Not all covered conditions are available in the state. Additional chronic conditions or other mental disorders must be filed prior to use.
Behavioral Health Admission Only Benefit is not available.
Musculoskeletal Admission Only Benefit is not available.

Arkansas residents:

1) Under the *General Definitions* section, items 2 and 3 of the second paragraph of the definition of Dependent Child are replaced with the following:

2. In the case of minor children under an Employee's charge, care and control for whom the Employee has filed a petition to adopt, coverage will be effective:
a. From the date of birth if the petition for adoption is filed and a request for coverage is made within 60 days of the date of birth; or
b. On the date of the filing of the petition for adoption if a request for coverage is made within 60 days of the date of filing.

Coverage shall terminate upon the dismissal of a petition for adoption.

2) Under the *Effective Date Provisions* section, the following paragraph is added to the EFFECTIVE DATE FOR INDIVIDUALS provision:

The Employee must give Us notice of any newborn children within ninety (90) days of the birth or before the next premium due date, whichever is later.

Coverage shall begin on the date of the filing of a petition for adoption if the insured applies for coverage within sixty (60) days after the filing of the petition for adoption. Coverage shall begin from the moment of birth if the petition for adoption and application for coverage is filed within (60) days after the birth of the minor.

3) Under the *General Provisions* section, the following provision is added:

New Entrants
New Employees or their eligible dependents, may be added in accordance with the terms of the Policy.

Florida residents:

1) Under the *General Definitions* section, item 2 of the second paragraph of the *Dependent child* definition includes adopted and foster child as follows:

2. adopted child, beginning with the date of the filing of the petition for adoption. It also means the legally adopted child of the Employee's Spouse or domestic partner/Partner to a Civil Union provided the child is living with, and is financially dependent upon the Employee;

Georgia residents:

1) The Maximum Lifetime per Covered Person cannot exceed $250,000.

2) Under the *General Definitions* section, the following changes have been made:

a) Item 2 of the second paragraph of the Dependent Child definition includes adopted child as follows:

2. adopted child, beginning with the date of the filing of the petition for adoption. It also means the legally adopted child of the Employee's Spouse or domestic partner/Partner to a Civil Union provided the child is living with, and is financially dependent upon the Employee;

b) The definition of Paralysis is replaced with the following:

The complete, irreversible and permanent loss of the use of two or more non-severed limbs, as a result of an accident, disease or Sickness.

The Date of Diagnosis is the date a Physician makes a diagnosis based on clinical and/or laboratory findings as supported by the Covered Person's medical records.

3) Under the *Claim Provisions* section, the Claim Forms provision is replaced with the following:

CLAIM FORMS
We will send claim forms with written instructions for filing proof of loss when We receive notice of a claim. If such forms are not sent within 10 working days after We receive notice, the claimant shall be deemed to have complied with the requirements of the Policy as to proof of loss upon submitting, within the time fixed in this Policy for filing proof of loss, written or authorized electronic proof covering the occurrence, character and extent of the loss for which the claim is made.

4) Under the *Administrative Provision*, the Change in Premium Rates section has been revised to reflect that 60 days advance written notice is required.

5) Under the *Accidental Death and Dismemberment Rider*, no benefits are payable for Paralysis.

6) Under the *Accidental Rider*, no benefits are payable for Paralysis.

Idaho residents:

1) Benefits for the following covered conditions are no longer available:
   Blindness, Coma, Loss of Speech, Loss of Hearing and Paralysis

2) Under the *General Definitions* section, the following changes apply:

   a) The definition of Active Service is replaced with the following:

      An Employee will be considered in Active Service with His Employer on any day that is either:
      1. one of the Employer's scheduled work days on which the Employee is performing His regular duties on a Full Time basis, either at one of the Employer's usual places of business or at some other location to which the Employer's business requires the Employee to travel; or
      2. a scheduled holiday or holiday period, vacation day or period of Employer-approved paid leave of absence, other than disability or sick leave after 7 days, only if the Employee was in Active Service on the preceding scheduled workday.

      A Covered Person is not considered in Active Service if He is:
      1. Inpatient in a Hospital, hospice;
      2. confined at home under the care of Physician for Sickness or Injury.

   b) The definition of Activities of Daily Living has been removed.

   c) The definition for Congenital Anomaly is added:

      Congenital Anomaly
      A condition existing at or from birth that is a significant deviation from the common form or function of the body, whether caused by a hereditary or developmental defect or disease. The term "significant deviation" is defined to be a deviation which impairs the function of the body and includes but is not limited to the conditions of cleft lip, cleft palate, webbed fingers or toes, sixth toes or fingers, or defects of metabolism and other conditions that are medically diagnosed to be congenital anomalies.

      The Date of Diagnosis is the date a Physician makes a diagnosis of Congenital Anomaly that is based on generally accepted principles of medicine at the time the diagnosis is made.

   d) The Dependent Child definition is replaced with the following:

      An Employee's child who meets the following requirements:
      1. A child from live birth to 26 years old;
      2. A child who is 26 or more years old, who is chiefly dependent upon the Employee for support and maintenance and incapable of self-sustaining employment by reason of intellectual disability or physical disability.

      A child, for purposes of this provision, includes an Employee's:
      1. natural child;
      2. adopted child, beginning on the date of the child's birth if Placement occurs within 60 days after the child's birth, or otherwise on the date of Placement for the purpose of adoption. As used in this paragraph, "Placement" means physical placement in the Employee's care. If physical placement is prevented due to the medical needs of the child, Placement means the date the Employee signs an agreement for adoption of such child and assumes financial responsibility for such child;
      3. stepchild who resides with the Employee and is financially dependent upon the Employee;
      4. child, grandchild for whom the Employee is the court-appointed legal guardian, as long as the child resides

with the Employee and primarily depends on the Employee for financial support. Financial support means that the Employee is eligible to claim the dependent for purposes of Federal and State income tax returns;

5. a child of the Employee's domestic partner/Partner to a Civil Union, provided the child is living with, and is financially dependent upon the Employee.

e) The definition of Spouse is replaced with the following:

The Employee's current lawful Spouse who is at least Age 18 for any coverage requiring Proof of Good Health but not yet Age 100. Except for purposes of determining initial eligibility, the term includes a Spouse who is widowed or divorced or legally separated from an Employee.

f) The definition of Totally Disabled or Total Disability is replaced with the following:

Either:

1. the inability of the Covered Person who is currently employed to do any type of work for which he is or may become qualified by reason of education, training or experience; or
2. the inability of the Covered Person who is not currently employed to perform the normal activities of like age and sex without human supervision or assistance.

3) Under the *Effective Date Provisions,* the following changes are made:

a. Under EFFECTIVE DATE FOR INDIVIDUALS, add the following:

If the Dependent Child other than a newborn Dependent Child or a newly adopted Dependent Child, is eligible for Guaranteed Issue coverage, and the Employee applies for coverage and agrees to make required contributions within 31 days after the date the Dependent Child becomes eligible and, subject to the *Deferred Effective Date Provisions* section below, coverage becomes effective on the later of:

1. the effective date of the Policyholder's participation under this Policy;
2. the date the Employee becomes eligible at the end of the Eligibility Waiting Period;
3. the date the Employee's coverage becomes effective;
4. the date the dependent meets the definition of Dependent Child as applicable;
5. the first of the month following the date We or the Employer receive the completed enrollment form for Dependent Child coverage.

If the Dependent Child who is a newborn Dependent Child or a newly adopted Dependent Child, is eligible for Guaranteed Issue coverage, and the Employee applies for coverage and agrees to make required contributions within 31 days after the date the Dependent Child becomes eligible and, subject to the *Deferred Effective Date Provisions* section below, coverage becomes effective on the later of:

1. the effective date of the Policyholder's participation under this Policy;
2. the date the Employee becomes eligible at the end of the Eligibility Waiting Period;
3. the date the Employee's coverage becomes effective;
4. the date the dependent meets the definition of Dependent Child as applicable;
5. the first of the month following the date We or the Employer receive the completed enrollment form for Dependent Child coverage.

b. The following provision is added:

Newborn and Newly Adopted Children

If notice and payment of additional premium are required for dependent coverage under this Policy, the Policy may require notice of birth, placement or adoption and payment of required premium as a condition of coverage for newborn and newly adopted children. The notification period shall be not less than 60 days from the date of birth for a newborn child or, for newly adopted children, 60 days from the earlier of the date of adoption or placement for adoption. The due date for payment of any additional premium, if required, shall be not less than 31 days following receipt by the health plan member of a billing for the required premium.

Coverage for newborns and newly adopted children shall include coverage for Sickness caused by a Congenital Anomaly.

c. Under the GROUP ENROLLMENT EFFECTIVE DATES, the following is added:

The Dependent Child other than a newborn Dependent Child or a newly adopted Dependent Child, who is eligible to apply, but was not previously enrolled by the Employee, the Employee may apply or is insured the Employee may apply for an increase for coverage.

The Dependent Child who is a newborn Dependent Child or a newly adopted Dependent Child, who is eligible to apply, but was not previously enrolled by the Employee, the Employee may apply or is insured the Employee may apply for an increase for coverage.

4) Under the *Termination of Insurance* section, the following is added:

1. for a Dependent Child, the date the Dependent Child, ceases to qualify as a Dependent Child.

5) Under the *Exclusions and Limitations* section, the following changes are made:

a) The list of exclusions is replaced with the following:

1. intentionally self-inflicted Injury, suicide or any attempt thereof while sane or insane;
2. active participation in a felony, riot or insurrection;
3. declared or undeclared war or act of war;
4. a Covered Loss that results from active duty service in the military, naval or air force of any country or international organization. Upon Our receipt of proof of service, We will refund any premium paid for this time. Reserve or National Guard active duty training is not excluded unless it extends beyond 31 days.

b) The Pre-Existing Condition Limitation provision is replaced with the following:

PRE-EXISTING CONDITION LIMITATION
No benefit will be paid for a Covered Loss caused or contributed to by, or resulting from, a Pre-existing Condition, except for a Congenital Anomaly of a covered dependent newborn or newly adopted child, and except for Childhood Conditions listed in the *Schedule of Benefits* for a Dependent Child covered from birth which begins in the first 12 months following the most recent effective date of Covered Person's coverage, and the effective date of any added or increased amount of coverage.

The term "Pre-existing Condition" means any Sickness or Injury for which a Covered Person received medical treatment, advice, care or services including diagnostic measures, took prescribed drugs or medicines within 6 months before the Covered Person's most recent effective date of coverage, and the most recent effective date of any added or increased amount of coverage.

The Pre-Existing Condition Limitation will apply to any added benefits or increases in benefits. This Limitation will not apply to a Covered Loss for which the Date of Diagnosis occurs after the Covered Person is insured under this Policy for at least 12 months after the Covered Person's most recent effective date of coverage, and effective date of any added or increased amount of coverage.

6) Under the *Claims Provisions* section, the TIME OF PAYMENT OF CLAIM provision is replaced with the following:

We will pay benefits due under this Policy for any loss other than a loss for which this Policy provides any periodic payment not more than 30 days upon Our receipt of due written or authorized electronic proof of such loss. Due proof of loss means all essential information needed to make a determination on the claim. Subject to due written or authorized electronic proof of loss, all accrued benefits for loss for which this Policy provides periodic payment will be paid monthly unless otherwise specified in the benefits descriptions and any balance remaining unpaid at the termination of liability will be paid immediately upon receipt of proof satisfactory to Us.

7) Under *Administrative Provision* section, the following *Refund of Unearned Premium* provision has been added:

Refund of Unearned Premium

If the Policyholder cancels this Policy for any reason, We shall refund the pro rata portion of the Unused Collected Premium to the beginning of the next monthly billing cycle. "Unused Collected Premium" as used herein means that portion of any premium collected which is not used, on a pro rata basis to the beginning of the next monthly billing cycle at the time of cancellation, by Us to insure against loss as there is no risk of loss from Covered Persons, or that portion of any collected premium which would have not been collected had the premium been paid monthly.

8) Under *General Provisions* section, the following Consumer Affairs contact information has been added:

Contact Information for the Idaho Department of Insurance
Idaho Department of Insurance
Consumer Affairs
700 W. State Street, 3rd Floor
P.O. Box 83720
Boise, ID 83720-0043
1-800-721-3272 or 208-334-4250 or www.DOI.Idaho.gov

9) The following Rider form(s) is/are not available:

HOSPITAL BENEFIT RIDER
ACCIDENTAL DEATH AND DISMEMBERMENT RIDER
ACCIDENTAL RIDER
DISABILITY INCOME RIDER
HEALTHY LIVING WELLNESS RIDER
TERM LIFE INSURANCE RIDER

Indiana residents:

1) Under the *Claims Provisions*, the Time of Payment of Claims is replaced with the following:

TIME OF PAYMENT OF CLAIMS
We will pay benefits due under this Policy for any loss other than a loss for which this Policy provides any periodic payment immediately after receipt of due written or authorized electronic proof of such loss. Subject to due written or authorized electronic proof of loss, all accrued benefits for loss for which this Policy provides periodic payment will be paid monthly unless otherwise specified in the benefits descriptions and any balance remaining unpaid at the termination of liability will be paid immediately upon receipt of proof satisfactory to Us.

We shall pay or deny each Clean Claim as follows: (1) if the claim is filed electronically, within 30 days after the date We receive the claim; or (2) if the claim is filed on paper, within 45 days after the date We receive the claim. We shall notify a claimant of any deficiencies in a submitted claim not more than: (1) 30 days for a claim that is filed electronically; or (2) 45 days for a claim that is filed on paper; and describe any remedy necessary to establish a Clean Claim. Our failure to notify a claimant as required above establishes the submitted claim as a Clean Claim. If We fail to pay or deny a Clean Claim in the time required above, and We subsequently pay the claim, We shall pay the claimant interest, at the rate prescribed by Indiana law, on the allowable amount of the claim paid. Interest accrues beginning: (1) 31 days after the date the electronic claim is filed; or (2) 46 days after the date the paper claim is filed; and stops on the date the claim is paid.

A "Clean Claim" means a claim submitted for payment that has no defect, impropriety, or particular circumstance requiring special treatment preventing payment.

2) Under the *General Provisions*, the following "Internal and External Grievance Procedures" provision is added:

Internal and External Grievance Procedures

INTERNAL GRIEVANCE PROCEDURE

A "grievance" means any dissatisfaction expressed by or on behalf of a Covered Person regarding matters pertaining to the contractual relationship between:
1. a Covered Person and Us; or
2. the Policyholder and Us;
and for which the Covered Person has a reasonable expectation that action will be taken to resolve or reconsider the matter that is the subject of dissatisfaction.

A Covered Person may file a grievance orally or in writing. We shall make available to Covered Persons a toll free telephone number through which a grievance may be filed. A grievance is considered to be filed on the first date it is received, either by telephone or in writing. We have established procedures to assist Covered Persons in filing grievances. A Covered Person may designate a representative to file a grievance for the Covered Person and to represent the Covered Person in a grievance.

Our grievance procedures include the following:
1. Acknowledgment of the grievance, given orally or in writing, to the Covered Person within 5 business days after receipt of the grievance.
2. Documentation of the substance of the grievance and any actions taken.
3. Notification to the Covered Person of the disposition of the grievance and the right to appeal.
4. Standards for timeliness in:
    a. responding to grievances; and
    b. providing notice to Covered Persons of the disposition of the grievance, and the right to appeal
   that accommodate the clinical urgency of the situation.

A grievance shall be resolved as expeditiously as possible, but not more than 20 business days after We receive all information reasonably necessary to complete the review. If We are unable to make a decision regarding the grievance within the 20 day period due to circumstances beyond Our control, We shall:
1. before the 20th business day, notify the Covered Person in writing of the reason for the delay; and
2. issue a written decision regarding the grievance within an additional 10 business days.

We shall notify a Covered Person in writing of the resolution of a grievance within 5 business days after completing an investigation. The grievance resolution notice must include the following:
1. A statement of the decision reached by Us.
2. A statement of the reasons, policies, and procedures that are the basis of the decision.
3. Notice of the Covered Person's right to appeal the decision.
4. The department, address, and telephone number through which a Covered Person may contact a qualified representative to obtain additional information about the decision or the right to appeal.

Appeals of Grievance Decisions

A Covered Person may file an appeal of a grievance decision orally or in writing. Our appeal procedures include the following:
1. Written or oral acknowledgment of the appeal not more than 5 business days after the appeal is filed.
2. Documentation of the substance of the appeal and the actions taken.
3. Notification to the Covered Person:
   a. of the disposition of an appeal; and
   b. that the Covered Person may have the right to further remedies allowed by law.
4. Standards for timeliness in:
   a. responding to an appeal; and
   b. providing notice to Covered Persons of the disposition of an appeal, and of the right to initiate an external grievance review under IC 27-8-29;
   that accommodate the clinical urgency of the situation.

An appeal of a grievance decision shall be resolved:
1. as expeditiously as possible, reflecting the clinical urgency of the situation; and
2. not later than 45 days after the appeal is filed.

We shall notify a Covered Person in writing of the resolution of an appeal of a grievance decision within 5 business days after completing the investigation. The appeal resolution notice shall include the following:
1. A statement of the decision reached by Us.
2. A statement of the reasons, policies, and procedures that are the basis of the decision.
3. Notice of the Covered Person's right to further remedies allowed by law, including the right to external grievance review by an independent review organization under IC 27-8-29.
4. The department, address, and telephone number through which a Covered Person may contact a qualified representative to obtain more information about the decision or the right to an external grievance review.

EXTERNAL REVIEW OF GRIEVANCES

An external grievance procedure is available for the resolution of external grievances regarding:
1. an adverse determination of appropriateness;
2. an adverse determination of medical necessity;
3. a determination that a proposed service is experimental or investigational; or
4. a denial of coverage based on a waiver described in IC 27-8-5-2.5 or IC 27-8-5-19.2;
made by Us or an agent of Ours regarding a service proposed by the treating health care provider.

Our external grievance procedure shall:
1. allow a Covered Person or a Covered Person's representative to file a written request with Us for an external grievance review of Our:
   a. appeal resolution of a grievance; or
   b. denial of coverage based on a waiver described in IC 27-8-5-2.5 or IC 27-8-5-19.2;
   not more than 45 days after the Covered Person is notified of the resolution; and
2. provide for:
   a. an expedited external grievance review for a grievance related to an illness, a disease, a condition, an injury, or a disability if the time frame for a standard review would seriously jeopardize the Covered Person’s life or health, or ability to reach and maintain maximum function; or
   b. standard external grievance review for a grievance not described in item 2.a. above.

A Covered Person may file not more than one external grievance of Our appeal resolution.

A Covered Person shall not pay any of the costs associated with the services of an independent review organization under this external review procedure. All costs must be paid by Us.

A Covered Person who files an external grievance:
1. shall not be subject to retaliation for exercising the Covered Person's right to an external grievance;
2. shall be permitted to utilize the assistance of other individuals, including health care providers, attorneys, friends, and family members throughout the review process;
3. shall be permitted to submit additional information relating to the proposed service throughout the review process; and
4. shall cooperate with the independent review organization by:
   a. providing any requested medical information; or
   b. authorizing the release of necessary medical information.

We shall cooperate with an independent review organization by promptly providing any information requested by the independent review organization.

An independent review organization shall:
1. for an expedited external grievance, within 3 business days after the external grievance is filed; or
2. for a standard appeal, within 15 business days after the appeal is filed;
make a determination to uphold or reverse Our appeal resolution of a grievance based on information gathered from the Covered Person or the Covered Person's designee, Us, and the treating health care provider, and any additional information that the independent review organization considers necessary and appropriate.

When making the determination, the independent review organization shall apply:
1. standards of decision making that are based on objective clinical evidence; and
2. the terms of the Covered Person's accident and sickness insurance policy.

In an external grievance, We bear the burden of proving that We properly denied coverage for a condition, complication, service, or treatment because the condition, complication, service, or treatment is directly related to a condition for which coverage has been waived under IC 27-8-5-2.5 or IC 27-8-5-19.2.

The independent review organization shall notify Us and the Covered Person of their determination:
1. for an expedited external grievance, within 24 hours after making the determination; and
2. for a standard external grievance, within 72 hours after making the determination.

Upon the request of a Covered Person who is notified that the independent review organization has made a determination, the independent review organization shall provide to the Covered Person all information reasonably necessary to enable the Covered Person to understand the:
1. effect of the determination on the Covered Person; and
2. manner in which We may be expected to respond to the determination.

A determination made under this external review of grievances procedure is binding on Us.

If, at any time during an external review performed, the Covered Person submits information to Us that is relevant to Our resolution of the Covered Person's appeal of a grievance decision and that was not considered by Us:
1. We may reconsider the resolution; and
2. if We choose to reconsider, the independent review organization shall cease the external review process until the reconsideration is completed.

If We reconsider the resolution of an appeal of a grievance decision due to the submission of new information, We shall reconsider the resolution based on the information, and notify the Covered Person of Our decision:
1. within 72 hours after the information is submitted, for a reconsideration related to an illness, a disease, a condition, an injury, or a disability that would seriously jeopardize the Covered Person's life or health, or ability to reach and maintain maximum function; or
2. within 15 days after the information is submitted, for a reconsideration not described in item 1. above.

If the decision reached is adverse to the Covered Person, the Covered Person may request that the independent review organization resume the external review. If We choose not to reconsider Our resolution of a grievance, We shall forward the submitted information to the independent review organization not more than 2 business days after Our receipt of the information.

Louisiana residents:

1) Under the *General Definitions* section, the following changes are made:

   a) The definition of Age does not include the following:

      For the purposes of Portability, except as to premium calculations, Extension of Benefits, Waiver of Premium, or Continuation due to Disability, a Covered Person’s Age is His Age as of His last birthday.

   b) The definition of Dependent Child is replaced with the following:

      An Employee’s child who meets the following requirements:
      1. child from live birth to 26 years old;
      2. Any unmarried child or grandchild who is placed in the home of an Insured Person following execution of an act of voluntary surrender shall be considered the Insured Person’s Dependent Child from the date on which the act of voluntary surrender becomes irrevocable.
      3. A child who is 26 or more years old residing with the Employee and incapable of self-sustaining employment by reason of intellectual or physical disability.

      A child, for purposes of this provision, includes an Employee’s:
      1. natural child;
      2. adopted child, beginning with any waiting period pending finalization of the child’s adoption. It also means

the legally adopted child of the Employee's Spouse or domestic partner/Partner to a Civil Union provided the child is living with, and is financially dependent upon the Employee;
3. stepchild who resides with the Employee and is financially dependent upon the Employee;
4. child, grandchild for whom the Employee is the court-appointed legal guardian, as long as the child resides with the Employee and primarily depends on the Employee for financial support. Financial support means that the Employee is eligible to claim the dependent for purposes of Federal and State income tax returns;
5. a child of the Employee's domestic partner/Partner to a Civil Union, provided the child is living with, and is financially dependent upon the Employee.

c) The definition of Spouse is replaced with the following:

The Employee's legally married husband or wife. Except for purposes of determining initial eligibility, the term includes a Spouse who is widowed or divorced or legally separated from an Employee.

d) A definition of Partner has been included when Domestic Partner is included:

Partner
Any individual who is Your partner in a civil union or domestic partnership, or other relationship as recognized and allowed by applicable federal law, state law, or law of the county, city or local government in Your jurisdiction of residence, if:
1. You provide acceptable evidence that the requirements of the jurisdiction in which they reside for the establishment of the relationship have been met;
2. You submit a written declaration of partnership signed by both parties in a format acceptable to Us; or
3. You and Your partner satisfy the Policyholder's requirements for such partnerships.

2) Under the *Exclusions and Limitations* section, exclusions are replaced with the following:

- voluntary ingestion of narcotic, poison, gas or fumes, unless prescribed or taken under the direction of a Physician and taken in accordance with the prescribed dosage;

- operating any type of vehicle while under the influence of alcohol, narcotic or other intoxicant. "Under the influence of alcohol", for purposes of this exclusion, means intoxicated, as defined by the law of the state in which the Covered Loss occurred.

3) All references to "mental or physical handicap" have been revised to "intellectual or physical disability".

4) Under the *Continuation of Coverage Provisions* section, the following is added:

If an Employee's Active Service ends due to entry into the armed forces, insurance will continue, if the required premium is paid, until the day the Employee fails to return to work as outlined in the Uniform Services Employment and Reemployment Rights Act of 1994.

All of the following will apply when insurance is continued under this provision:
1. any change in benefits that occurs during the period of continuation will apply on the effective date of the change;
2. any Active Service requirement will be waived;
3. the Employee will be given credit for the time He was covered under this Policy prior to the leave.

If an Employee does not continue insurance during such leave and returns to work:
1. the Employee and His enrolled Spouse and Dependent Children will be covered on the date the Employee returns to work from the leave. The Employee must return to work as outlined in the Uniform Services Employment and Reemployment Rights Act of 1994;
2. any portion of an eligibility waiting period that has not been completed will not be credited during the Employee's leave.

A Spouse or Dependent Child, of an Employee, who is covered under the Policy and subsequently called to

service in the armed forces, will continue to be considered a Spouse or Dependent Child under the provisions of the Policy, without any lapse of coverage, provided that all required contributions are paid in accordance with Policy provisions.

5) Under the *Reinstatement of Insurance* section the following has been added:

Your insurance, including insurance for Your dependents who were previously covered, shall be reinstated when You leave employment to perform service in the armed forces, and You reapply for insurance after returning from service pursuant to the Uniformed Services Employment Act of 1994 (USERRA), without any clause or restriction because of a Pre-Existing Condition. An eligible dependent covered under the Policy who is called to service in the armed forces and whose coverage under the Policy is not maintained during such service shall, after release and upon application, have insurance reinstated under the Policy without any clause or restriction because of a Pre-Existing Condition.

The reinstated insurance will include the same coverage amounts that were in force on the date insurance terminated and will be subject to all the terms and provisions of the Policy.

6) Under the *Claim Provisions* section, the following changes are made:

a) The TIME OF PAYMENT OF CLAIMS provision is replaced with the following:

All claims arising under the terms of the Policy shall be paid not more than 30 days from the date upon which written or authorized electronic notice and proof of claim, in the form required by the terms of the Policy, are furnished to Us unless reasonable grounds, such as would put a reasonable and prudent businessman on His guard, exist. Failure to comply with this provision shall subject Us to a penalty payable to the Employee of double the amount of the benefits due under the terms of the Policy during the period of delay, together with attorney's fees to be determined by the court.

b) The following statement in the PAYMENT OF CLAIMS provision has been removed:

Benefits for loss of life will be payable to the Covered Person's beneficiary named under this Policy, if any, in accordance with the BENEFICIARY provision and this *Claim Provisions* section.

7) Under the *Administrative Provisions* section, the following changes are made:

a) Under the Changes in Premium Rates section, a 45 day notice is required for change of premiums.
b) The Reinstatement Provision is modified as follows:
   a. If Your Active Service ends due to the Employer-approved unpaid leave of absence, other than an approved FMLA leave, insurance may be reinstated only if the reinstatement occurs within 12 weeks from the date insurance ends.

8) Under the *General Provisions* section, the following changes are made:

a) The following provision is added:

New Entrants
All new Employees becoming eligible for insurance in one of the Covered Classes shall be added.

b) The first paragraph of the Policy Termination provision is replaced with the following:

We may terminate insurance on or after the first anniversary of the Policy Effective Date. The Policyholder or We may terminate insurance on any Premium Due Date. Written notice with the reason for such termination, by certified mail, must be given at least 60 days prior to such Premium Due Date. Failure by the Policyholder to pay premiums when due or within the Grace Period shall be deemed notice to Us to terminate insurance at the end of the period for which premium was paid.

9) The following Rider form(s) is/are not available:

TERM LIFE INSURANCE RIDER

Maryland residents:

1) Under the *General Definitions* section, item 2 of the second paragraph of the *Dependent child* definition includes adopted child as follows:

    2. adopted child, beginning with the date of the filing of the petition for adoption. It also means the legally adopted child of the Employee's Spouse or Domestic Partner/Partner to a Civil Union provided the child is living with, and is financially dependent upon the Employee.

Massachusetts residents:

1) Under the *Continuation of Insurance Provisions* section, the following provision is added:

    CONTINUATION OF INSURANCE PROVISIONS
    Additional Continuation of Insurance Provisions
    If an Employee leaves the group due to termination of employment resulting from a Plant Closing or Partial Closing, insurance for such Employee will be continued until the earliest of the following dates:
    1. 90 days from the date of the Plant Closing or Partial Closing;
    2. The date the Employee becomes eligible for similar benefits.

    As used in this provision:
    "Plant Closing" means a permanent cessation or reduction of business at a facility which results or will result as determined by the director in the permanent separation of at least 90% of the employees of said facility within a period of six months prior to the date of certification or with such other period as the director shall prescribe, provided that such period shall fall within the six month period prior to the date of certification.

    "Partial Closing" means a permanent cessation of a major discrete portion of the business conducted at a facility which results in the termination of a significant number of the employees of said facility and which affects workers and communities in a manner similar to that of Plant Closings.

    If an Employee leaves the group for a reason other than as a result of a Plant Closing or Partial Closing, insurance for such Employee will be continued until the earliest of the following dates:
    1. 31 days from the date the Employee leaves the group;
    2. The date the Employee becomes eligible for similar benefits.

Minnesota residents:

1) Under the *Exclusions and Limitations* section, the list of exclusions is replaced with the following:

    1. intentionally self-inflicted Injury;
    2. commission or attempt to commit a felony;
    3. declared or undeclared war or act of war;
    4. a Covered Loss that results from active duty service in the military, naval or air force of any country or international organization. Upon Our receipt of proof of service, We will refund any premium paid for this time. Reserve or National Guard active duty training is not excluded unless it extends beyond 31 days;
    5. being under the influence of any narcotic, unless the narcotic is administered on the advice of a Physician;
    6. operating any type of vehicle while under the influence of alcohol or any drug, narcotic or other intoxicant. "Under the influence of alcohol", for purposes of this exclusion, means intoxicated, as defined by the law of the state in which the Covered Loss occurred.

Mississippi residents:

1) Under the *General Definition* section, the following changes are made:

a) The definition of Heart Attack and Stroke have been modified so that in the event of death, confirmation does not need to be by autopsy.

b) Under the *General Definitions* section, item 2 of the second paragraph of the *Dependent child* definition includes adopted child as follows:

2. adopted child, beginning with the date of the filing of the petition for adoption. It also means the legally adopted child of the Employee's Spouse or Domestic Partner/Partner to a Civil Union provided the child is living with, and is financially dependent upon the Employee.

New Hampshire residents:

1) Age Based Reductions will not apply.

2) Under the *General Definitions* section, the following changes are made:

a) The definition of Blindness is revised to include Blindness that is due only to disease;

b) The definition of Dependent Child is replaced with the following:

An Employee's child who meets the following requirements:
1. A child by blood or by law who is under Age 26;
2. A child who is 26 or more years old, primarily supported by the Employee and incapable of self-sustaining employment by reason of mental or physical handicap.

A child, for purposes of this provision, includes an Employee's:
1. natural child;
2. adopted child from the earlier of the date the petition for adoption is filed or entry of the child in the adoptive home, or in the case of a child who is in the custody of the state, coverage shall begin at the date of entry of a final decree of adoption. It also means the legally adopted child of the Employee's Spouse or domestic partner/Partner to a Civil Union provided the child is living with, and is financially dependent upon the Employee;
3. stepchild who resides with the Employee and is financially dependent upon the Employee;
4. child, grandchild for whom the Employee is the court-appointed legal guardian, as long as the child resides with the Employee and primarily depends on the Employee for financial support. Financial support means that the Employee is eligible to claim the dependent for purposes of Federal and State income tax returns.
5. a child of the Employee's domestic partner /Partner to a Civil Union, provided the child is living with, and is financially dependent upon the Employee.

c) The definition of Physical Activities of Daily Living revised as follows:

Activities used in measuring levels of personal functioning capacity. These activities are normally performed without assistance, allowing personal independence in everyday living. These activities include the following:
1. Transfer - The ability to move into or out of a bed, chair or wheelchair with or without the assistance of equipment;
2. Mobility – The ability to move from place to place, either via walking, a wheelchair, cane, crutches, walker or other equipment;
3. 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 catheter, urostomy, or colostomy bag);
4. Dressing - Putting on and taking off all items of clothing and any necessary braces, fasteners or artificial limbs;

5. Toileting - Getting to and from the toilet, transferring on and off the toilet and performing associated personal hygiene;
6. Eating - Feeding oneself by consuming food or fluids manually from a receptacle (such as a plate, cup or table); or
7. Bathing - Washing oneself by sponge bath; or in either a tub or a shower, including the task of getting into or out of the tub or shower.

d) The definition of Spouse is revised as follows:

The Employee's current lawful Spouse. Except for purposes of determining initial eligibility, the term includes a Spouse who is widowed or divorced or legally separated from an Employee. The term includes a common-law Spouse who is recognized as a common-law Spouse under the laws of the jurisdiction where the common-law marriage was formed.

3) Under the *Continuation of Coverage Provisions* section, in the Continuation for Disability for Employees age 60 and Over the definition of Disability/Disabled is revised as follows:

"Disability"/"Disabled" means because of Injury or Sickness the Employee is unable to perform the material duties of His Regular Occupation, as defined below.

4) Under the *Extension of Benefits and Waiver of Premium Provision* section, in the Extension of Benefits provision the definition of Disability/Disabled is revised as follows:

"Disability"/"Disabled" means because of Injury or illness the Employee is continuously unable to perform the material duties of his or her Regular Occupation.

5) Under the *Exclusions and Limitation* section the following changes are made:

a) The felony exclusion is revised to:

commission of a felony;

b) The Pre-Existing Condition Limitation is revised as follows:

We will not pay benefits for a Covered Loss caused or contributed to by, or resulting from, a Pre-existing Condition, except for Childhood Conditions listed in the *Schedule of Benefits* for a Dependent Child covered from birth. The term "Pre-existing Condition" means a condition for which medical advice, diagnosis, care or treatment was recommended by or received from a Physician within the 6-month period preceding the Covered Person's most recent effective date of insurance, and the most recent effective date of any added or increased amount of insurance.

The Pre-Existing Condition Limitation will apply to any added benefits or increases in benefits. This Limitation will not apply to a Covered Loss for which the Date of Diagnosis occurs after the Covered Person is insured under this Policy for 6 months after the Covered Person's most recent effective date of insurance, and effective date of any added or increased amount of insurance.

6) Under the *Claim Provisions* section, the following changes are made:

a) The Proof of Loss provision is replaced with the following:

Written or authorized electronic proof of loss satisfactory to Us must be given to Us at Our office, within 90 days of the loss for which claim is made. If (a) benefits are payable as periodic payments and (b) each payment is contingent upon continuing loss, then proof of loss must be submitted within 90 days after the termination of each period for which We are liable. If written or authorized electronic notice is not given within that time, no claim will be invalidated or reduced if it is shown that such notice was given as soon as was reasonably possible.

b) The Time of PAYMENT OF CLAIMS provision is replaced with the following:

We will pay benefits due under this Policy for any loss other than a loss for which this Policy provides any periodic payment not more than 30 days after receipt of due written or authorized electronic proof of such loss. Subject to due written or authorized electronic proof of loss, all accrued benefits for loss for which this Policy provides periodic payment will be paid monthly unless otherwise specified in the benefits descriptions and any balance remaining unpaid at the termination of liability will be paid immediately upon receipt of proof satisfactory to Us.

c) The PAYMENT OF CLAIMS provision is replaced with the following:

All benefits will be paid in United States currency. All benefits payable under the Policy are payable to the Covered Person, if living, except if the Covered Person is a Dependent Child, then the benefits will be payable to the Employee. If the Covered Person dies while any of these benefits remain unpaid, benefits payable under the Policy will be paid to the Covered Person's Spouse, if living, or otherwise to the executors or administrators of the Covered Person's estate. Benefits for loss of life will be payable to the Covered Person's beneficiary named under this Policy, if any, in accordance with the Beneficiary provision and this *Claim Provisions* section.

Benefits will be reduced by any outstanding premium due.

If We are to pay benefits to the estate or to a person who is incapable of giving a valid release, We may pay up to an amount not exceeding $1,000 to a relative by blood or marriage whom We believe is equitably entitled.

Any payment made by Us in good faith pursuant to this provision will fully discharge Us, and release Us from all liability, to the extent of such payment.

d) The BENEFICIARY provision is replaced with the following:

The beneficiary is the person or persons the Employee names or changes on a form executed by Him and satisfactory to Us. This form may be in writing or by any electronic means agreed upon between Us and the Subscriber. Consent of the beneficiary is not required to affect any changes, unless the beneficiary has been designated as an irrevocable beneficiary.

The Employee may change the beneficiary at any time by giving written notice to the Policyholder. A beneficiary designation or change will become effective on the date the Covered Person executes it. However, We will not be liable for any action taken or payment made before We record notice of the change at our Home Office.

If more than one person is named as beneficiary, the interests of each will be equal unless the Employee has specified otherwise. The share of any beneficiary who does not survive the Covered Person will pass equally to any surviving beneficiaries unless otherwise specified.

If there is no named beneficiary or surviving beneficiary or if the Employee dies while benefits are payable to Him, We may make direct payment to the first surviving class of the following classes of persons:
1. Spouse;
2. Children;
3. parents;
4. siblings;
5. estate of the Covered Person.

e) The RECOVERY OF OVERPAYMENT provision is revised as follows:

RECOVERY OF OVERPAYMENT
If benefits are overpaid, We have the right to recover the amount overpaid by either of the following methods after We identify the reason for the overpayment.
1. A request for lump sum payment of the overpaid amount.
2. A reduction of any amounts payable under this Policy.

Our right to recover is only from amounts that would be payable directly to the Covered Person, and only if the discovery of the overpayment and request for recovery occurs within one year after the overpayment.

If We reduce any amounts payable under this Policy, the Covered Person has the right to appeal the claim adjudication and the amount. If the overpayment is in dispute, the reduction of subsequent claims will be suspended until the dispute is resolved.

7) Under the *General Provisions* section, the following changes are made:

a) The 30 Day Right To Examine Certificate provision does not apply within this section and is added to the Certificate Face Page.

b) The Assignment provision is replaced with the following:

Assignment
The rights and benefits under this Policy may not be assigned and any attempt to assign will be void.

c) The Incontestability provision is replaced with the following:

INCONTESTABILITY
This Policy
All statements made by the Employer to obtain this Policy are considered representations and not warranties. No statement will be used to deny or reduce benefits or be used as a defense to a claim, or to deny the validity of this Policy, unless a signed copy of the instrument containing the statement is, or has been, furnished to the Employer.

After two years from the Policy Effective Date, no such statement will cause this Policy to be contested except for non-payment of premium.

A Covered Person's Insurance
All statements made by a Covered Person are considered representations and not warranties. No statement will be used to deny or reduce benefits or be used as a defense to a claim, unless a signed copy of the instrument containing the statement is, or has been, furnished to the claimant.

After two years from the Covered Person's effective date of insurance, or from the effective date of increased benefits, no such statement will cause insurance or the increased benefits to be contested except for non-payment of premium.

In the event of death or incapacity, the beneficiary or representative shall be given a copy.

d) The Policy Termination provision is replaced with the following:

Policy Termination
The Employer may terminate insurance on any Premium Due Date. We may terminate insurance on or after the first anniversary of the Policy Effective Date.

Written or authorized electronic notice must be given at least 45 days prior to such Premium Due Date. Failure by the Employer to pay premiums when due or within the Grace Period shall be deemed notice to Us to terminate insurance at the end of the period for which premium was paid.

Termination will not affect a claim for a Covered Loss that is the result, directly and independently of all other causes, of a loss that occurs while insurance was in effect.

e) The following provision is added at the end of the section:

Important Notice
The Employer may contact the Insurance Company, using the address or toll-free telephone number given below, with questions or problems with respect to this Policy:

Cigna Health and Life Insurance Company
900 Cottage Grove Road
Bloomfield, Connecticut 06002
Telephone: 1-800-754-3207

A Covered Person may contact the Insurance Company, using the address or toll-free telephone number given below, with questions or problems with respect to the Covered Person's Certificate:

Cigna Health and Life Insurance Company
900 Cottage Grove Road
Bloomfield, Connecticut 06002
Telephone: 1-800-754-3207

8) Under the *Disability Income Rider* the following changes are made:

a) Coverage is only provided for Disability related to a Covered Critical Illness.

b) The definition of Pre-existing Condition revised to mean any Critical Illness for which a Covered Person received medical treatment, advice, care or services including diagnostic measures, took prescribed drugs or medicines.1

9) Under the *Hospital Benefit Rider* the following changes are made:

- The Benefit Waiting Period, Elimination Period and Pre-Existing Condition Limitation do not apply.
- All references to injury are removed.

10) The *Term Life Insurance Rider* is modified as follows:

- The Pre-Existing Condition Limitation does not apply.

11) The following is not available under the *Wellness Treatment, Health Screening Test, and Preventive Care Benefit Rider:*

- Preventative Care benefits are not available.

12) The Health Living Wellness Rider is revised as follows:

- The Pre-Existing Condition Limitation does not apply.
- Preventative Care benefits are not available.

North Carolina residents:

1) Under the *General Definitions* section, the following changes are made:

a) The second statement of the Active Service definition is replaced with the following:

2. a scheduled holiday or holiday period, vacation day or period of Employer-approved paid leave of absence, only if the Employee was in Active Service on the preceding scheduled workday.

b) The Cancer definition includes the following:

If Cancer is not pathologically or clinically diagnosed until after a Covered Person's death, We shall assume liability retroactively beginning with the date of terminal admission to the hospital for not less than 45 days before the Covered Person's date of death. In addition to the required pathological or clinical diagnosis, we may require additional information from the attending physician and hospital.

c) The Dependent Child definition includes adopted child and foster child as follows:

2) adopted child, beginning with the date of the filing of the petition for adoption. It also means the legally adopted child of the Employee's Spouse or domestic partner/Partner to a Civil Union provided the child is living with, and is financially dependent upon the Employee;
3) a foster child placed with you by an authorized placement agency or by judgment, decree or other order of any court of competent jurisdiction;

2) Under the *General Definitions* section, the first paragraph of the Hospital definition is replaced with the following:

An institution or duly licensed State tax-supported institution that meets all of the following:
1. It is licensed as a Hospital pursuant to applicable law;
2. It is primarily and continuously engaged in providing medical care and treatment to sick and injured persons;
3. It is managed under the supervision of a staff of medical doctors;
4. It provides 24-hour nursing services by or under the supervision of a graduate registered Nurse (R.N.);
5. It has medical, diagnostic and treatment facilities, with major surgical facilities on its premises, or available to it on a prearranged basis. The requirement for major surgical facilities does not apply to a duly licensed State tax-supported institution.

3) Under the *Individual Enrollment Events section,* the following are included as reasons for a change under LIFE STATUS CHANGE PROVISION:

- placement of a foster child into the named insured's home;
- issuance of a court order requiring coverage of a child;

4) Under the *Exclusions and Limitations* section the war or act of war exclusion is replaced with the following:

- declared or undeclared war or act of war. This Exclusion does not apply to acts of terrorism;

5) Under the *Claim Provisions* section, the following changes are made:

a) The PROOF OF LOSS is replaced with the following:

PROOF OF LOSS
Written or authorized electronic proof of loss satisfactory to Us must be given to Us at Our office, within 180 days of the loss for which claim is made. If (a) benefits are payable as periodic payments and (b) each payment is contingent upon continuing loss, then proof of loss must be submitted within 180 days after the termination of each period for which We are liable. If written or authorized electronic notice is not given within that time, no claim will be invalidated or reduced if it is shown that such notice was given as soon as was reasonably possible. In any case, written or authorized electronic proof must be given not more than one year after the time it is otherwise required, except if proof is not given solely due to the lack of legal capacity.

b) Under the *Time Payment of Claims* section, the first sentence is replaced by the following:

We will pay benefits due under this Policy for any loss other than a loss for which this Policy provides any periodic payment immediately upon Our receipt of due written or authorized electronic proof of such loss.

6) Under the *Administrative Provisions* section the following changes have been made:

a) The following has been added to the Premiums provision:

Premium rates shall be guaranteed for the first contract year. We will not change the premium rates more than once in any six-month period based on at least 12 months experience. Any rate adjustment shall be preceded by a written 45-day notice.

b) The Reinstatement of Insurance provision changed as, requests for reinstatement must be received within 60 days

7) Under the *General Provisions* section, the Incontestability changed as, fraud cannot be a reason to contest the coverage after 2 years.

8) When the *Wellness Treatment and Health Screening Test Benefit Rider* is included under your plan, the following changes apply:

a) Remove Preventive Care benefits from this title and remove the preventive care coverage section and any reference to Preventive Care in this Rider.

9) When the *Healthy Living Wellness Rider* is included under your plan, the following changes apply:

a) Remove Preventive Care benefits from this title and remove the preventive care coverage section and any reference to Preventive Care in this Rider.

North Dakota residents:

1) Under the *General Definitions* section, item 2 of the second paragraph of the *Dependent child* definition includes adopted child as follows:

2. adopted child, beginning with the date of the filing of the petition for adoption. It also means the legally adopted child of the Employee's Spouse or domestic partner/Partner to a Civil Union provided the child is living with, and is financially dependent upon the Employee;

2) The *Exclusions and Limitation***s** section, the commission or attempt to commit a felony or assault exclusion is revised to be as follows:

- commission or attempt to commit a felony;

Oregon residents:

1) If the Policy provides coverage/benefits to a Spouse, a *Domestic Partner* will be afforded the same coverage/benefits provided to a Spouse.

Domestic Partner means any of the following:

1. A person with whom the Employee has a registered domestic partnership under state law which imposes legal obligations on the parties substantially similar to marriage. Such person will continue to be recognized as a Domestic Partner unless and until: (1) the domestic partnership is dissolved under applicable law; or (2) either the Employee or the Domestic Partner marries another person.

All references in the policy to "Spouse" shall be changed to read "Spouse and Domestic Partner" except as follows:

1. A Domestic Partner shall be deemed eligible to be enrolled for insurance or eligible for Additional Benefits on the latest of:
   a. the date of registration under Item 1 of the definition of Domestic Partner;
   b. the date that the Employee is eligible for insurance under the Policy; or
   c. the effective date of this Rider to the Policy.

2. A child of a Domestic Partner may only be eligible to be insured or eligible for Additional Benefits if:
   a. the child is primarily dependent on the Employee for financial support;
   b. the Employee has a legal obligation of support of the child; or

c. the Employee is the child's legal guardian.

2) The following Rider form(s) is/are not available:

ACCIDENTAL DEATH AND DISMEMBERMENT RIDER
ACCIDENTAL RIDER
DISABILITY INCOME RIDER
HEALTHY LIVING WELLNESS RIDER

3) When the *Hospital Benefit Rider* is included under your plan, the following benefits are not available:

HOSPITAL ADMISSION
HOSPITAL STAY
HOSPITAL INTENSIVE CARE UNIT (ICU) STAY
HOSPITAL OBSERVATION STAY
NEWBORN NEONATAL INTENSIVE CARE (NICU) STAY
HOSPITAL MUSCULOSKELETAL, ENDOCRINE, HEART AND VASCULAR OR RESPIRATORY CONDITION ADMISSION

4) When the *Wellness Treatment, Health Screening Test and Preventive Care Benefit Rider* is included under your plan, the following changes are not available:

Remove Preventive Care benefits from this title and remove the preventive care coverage section and any reference to Preventive Care in this Rider.

South Carolina residents:

1) Under the *General Definitions* section, item 2 of the second paragraph of the *Dependent child* definition includes adopted child as follows:

2. adopted child, beginning with the date of the filing of the petition for adoption. It also means the legally adopted child of the Employee's Spouse or domestic partner/Partner to a Civil Union provided the child is living with, and is financially dependent upon the Employee;

2) Under the *Exclusions and Limitations* section, the list of exclusions is replaced with the following:

- intentionally self-inflicted Injury, suicide or any attempt thereat while sane or insane;
- commission or attempt to commit a felony or an assault;
- declared or undeclared war or act of war;
- a Covered Loss that results from active duty service in the military, naval or air force of any country or international organization. Upon Our receipt of proof of service, We will refund any premium paid for this time. Reserve or National Guard active duty training is not excluded unless it extends beyond 31 days;
- any loss resulting from being Intoxicated or under the influence of alcohol or any drug, narcotic or other intoxicant or under the influence of a narcotic unless taken on the advice of a Physician. "Under the influence of alcohol" or "Intoxicated", for purposes of this exclusion, means intoxicated, as defined by the law of the state in which the Covered Loss occurred;
- diagnosis not in accordance with generally accepted medical principles prevailing in the United States at the time of the diagnosis.

3) Under the *Claim Provisions* section, the following changes are made:

a) The PHYSICAL EXAMINATION AND AUTOPSY provision is replaced with the following:

We, at Our own expense, may examine the Covered Person for whom claim is made as often as reasonably

necessary while a claim is pending and, in the case of death of the Covered Person, We, at Our own expense, also may have an autopsy performed during the period of contestability unless prohibited by law. The autopsy must be performed in South Carolina.

b) The Legal Actions provision is replaced with the following:

No action at law or in equity may be brought to recover under this Policy less than 60 days after written or authorized electronic proof of loss has been furnished as required by this Policy. No such action will be brought more than six years after the time such written proof of loss must be furnished.

4) Under the *General Provisions* section, the following changes are made:

a) The ENTIRE CONTRACT; CHANGES provision is replaced with the following:

This Policy, including the endorsements, amendments, group application form if any and any attached papers constitutes the entire contract of insurance. No change in this Policy will be valid until approved by one of Our executive officers and endorsed on or attached to this Policy. No agent has authority to change this Policy or to waive any of its provisions.

b) The Policy Termination provision is amended to include the following as last paragraph:

However, if the premium is to be collected in weekly, monthly, or other periodic installments by authority of a payroll deduction order executed by the Employee and delivered to Us or the Employer authorizing the deduction of premium installments from the Employee's salary or wages, We may not, during the period for which the Policy is issued and while the Employee remains employed by the authorized Employer, declare forfeited or lapsed the Policy until and unless a written or printed notice of the failure of the Employer to remit the premium or installment thereof, stating the amount or portion thereof due on the Policy and to whom it must be paid, has been duly addressed and mailed to the Employee who is insured under the Policy at least fifteen days before the Policy is terminated or lapsed.

South Dakota residents:

1) Under the *General Definitions* section, the following changes are made:
The Physician definition is replaced with the following:

Physician A licensed health care provider practicing within the scope of His license and rendering care and treatment to a Covered Person that is appropriate for the condition and locality and who is not:

1. living in the Covered Person's household; or
2. a parent, sibling, spouse or child of the Covered Person. However, this restriction of family members does not apply in those areas in which the family member is the only Physician in the area and is acting within His scope of practice.

2) Under the *Exclusions and Limitations* section, the list of exclusions is replaced with the following:

- intentionally self-inflicted Injury, suicide or any attempt thereat while sane or insane;
- commission or attempt to commit a felony or an assault;
- declared or undeclared war or act of war;
- a Covered Loss that results from active duty service in the military, naval or air force of any country or international organization. Upon Our receipt of proof of service, We will refund any premium paid for this time. Reserve or National Guard active duty training is not excluded unless it extends beyond 31 days.
- diagnosis not in accordance with generally accepted medical principles prevailing in the United States at the time of the diagnosis.

3) Under the *Exclusions and Limitations* section, the following changes are made:

a) The following exclusions are removed:

- voluntary ingestion of any narcotic, drug, poison, gas or fumes, unless prescribed or taken under the direction of a Physician and taken in accordance with the prescribed dosage;

- operating any type of vehicle while under the influence of alcohol or any drug, narcotic or other intoxicant. "Under the influence of alcohol", for purposes of this exclusion, means intoxicated, as defined by the law of the state in which the Covered Loss occurred;

b) The Pre-Existing Condition Limitation is revised as follows:

Pre-Existing Condition Limitation
No benefit will be paid for a Covered Loss which is caused, contributed to by, or resulting from a Pre-existing Condition, except for Childhood Conditions listed in the *Schedule of Benefits* for a Dependent Child covered from birth during the first 12 months following the most recent effective date of the Covered Person's coverage, and the effective date of any added or increased amount of coverage.

The term "Pre-existing Condition" means any Sickness or Injury for which a Covered Person received medical treatment, advice, care or services including diagnostic measures, or took prescribed drugs or medicines within 6 months before the Covered Person's most recent effective date of coverage, and the most recent effective date of any added or increased amount of coverage.

The Pre-existing Condition Limitation will apply to any added benefits or increases in benefits.

Texas residents:

1) Under the *General Definitions* section, the following changes are made:

a) The definition of Active Service is replaced with the following:

An Employee will be considered in Active Service with His Employer on any day that is either:
1. one of the Employer's scheduled work days on which the Employee is performing His regular duties on a Full-time basis, either at one of the Employer's usual places of business or at some other location to which the Employer's business requires the Employee to travel; or
2. a scheduled holiday or holiday period, vacation day or period of Employer-approved paid leave of absence, other than disability or sick leave after 7 days, only if the Employee was in Active Service on the preceding scheduled workday.

A Covered Person is not considered in Active Service if He is:
1. Inpatient in a Hospital, receiving hospice or confined in a rehabilitation or convalescence center or custodial care facility;
2. confined at home under the care of a Physician for Sickness or Injury;

b) The definition of Dependent Child is replaced with the following:

An Employee's child who meets the following requirements:
1. A child from live birth to 26 years old;
2. A child who is 26 or more years old, primarily supported by the Employee and incapable of self-sustaining employment by reason of mental or physical handicap.

A child, for purposes of this provision, includes an Employee's:
1. natural child;
2. adopted child, beginning with the date of the filing of the petition for adoption, including where an Employee is a party to a suit in which an Employee seeks to adopt the child. It also means the legally adopted child of

the Employee's Spouse or domestic partner/Partner to a Civil Union;
3. stepchild;
4. child for whom the Employee is the court-appointed legal guardian or for whom the Employee must provide medical support under an order issued under Chapter 154, Family Code, or enforceable by a Texas Court. If an Employee, who is the legal guardian of a foster child, is not a step-parent, grandparent, aunt or uncle, then the child must have resided with the Employee for at least six consecutive months and intend to reside with the Employee for an indefinite period of time.
5. grandchild who is the dependent of the Employee for federal income tax purposes at the time application for coverage of the grandchild is made. Coverage for such grandchild may not be terminated solely because the grandchild is no longer a dependent of the Employee for federal income tax purposes.

c) Under the definition of Physician, the following exclusions are removed:
   1. living in the Covered Person's household; or
   2. a parent, sibling, spouse or child of the Covered Person.

d) The definition of Sickness is replaced with the following:

   A physical or mental illness, including complications of pregnancy.

2) Under the Eligibility section, the following provision is added:

Newborn Child(ren)
Coverage for a newly born child shall be provided without notice for no less than 31 days after the date of birth.

3) Under the *Termination of Insurance* section, item six is replaced with the following:

6. the last day for which premium is paid, subject to the Grace Period;

4) Under the *Extension of Benefits* and *Waiver of Premium Provision* section, the Rehabilitation During a Period of Disability provision is removed.

5) Under the Claim Provisions section, the following changes are made:

a) Under the NOTICE OF CLAIM provision, the first sentence is replaced with the following:

   Written or authorized electronic/telephonic notice of claim must be given to Us within 20 days after a Covered Loss occurs or begins or as soon as is reasonably possible.

b) Under the CLAIM FORMS provision, the first sentence is replaced with the following:

   When We receive notice of a claim, We will send claim forms to claimant of to the Policyholder for delivery to the claimant, with written instructions for filing proof of loss.

c) The CLAIMANT COOPERATION Provision is replaced with the following:

   Failure of a claimant to reasonably cooperate with Us in the administration of the claim may result in termination of the claim. Such cooperation includes, but is not limited to, providing any information or documents needed to determine whether benefits are payable or the actual benefit amount due.

d) Under the TIME OF PAYMENT OF CLAIMS provision, the first sentence is replaced with the following:

   We will pay benefits due under this Policy for any loss other than a loss for which this Policy provides any periodic payment not more than 60 days after Our receipt of due written or authorized electronic proof of such loss

and right of the claimant to the Policy proceeds.

e) Under the PAYMENT OF CLAIMS provision, the second sentence is replaced with the following:

All benefits payable under the Policy are payable to the Covered Person or the Covered Person's assignee, if living, except if the Covered Person is a Dependent Child, then the benefits will be payable to the Employee.

f) Under the PAYMENT OF CLAIMS provision, the following sentence is removed:

Any payment made by Us in good faith pursuant to this provision will fully discharge Us, and release Us from all liability, to the extent of such payment.

g) The following provisions are added:

Payment to Texas Health and Human Services Commission
Upon Our receipt of written notice at Our Home Office, benefits payable on behalf of a Dependent Child must be paid to the Texas Health and Human Services Commission if:
1. the Employee is required to pay child support by a court order or court-approved agreement and:
   a. is a possessory conservator of the child under a court order issued in this state; or
   b. is not entitled to possession of or access to the child;
2. the Texas Health and Human Services Commission is paying benefits on behalf of the child under Chapter 31 or 32, Human Resources Code; and
3. the written notice specifies that the benefits must be paid directly to the Texas Health and Human Services Commission.

Payment to Conservator of Dependent Child
Upon Our receipt of written notice at Our Home Office, benefits payable on behalf of a Dependent Child will be paid to a person who, by court order issued in this state or another state, is appointed as the possessory or managing conservator of such Dependent Child. The conservator must submit to Us:
1. a proper claim form;
2. written notice that the person is a possessory or managing conservator of the Dependent Child on whose behalf the claim is made; and
3. a certified copy of the court order designating the person as possessory or managing conservator of the Dependent Child or other evidence designated by rule of the State Department of Insurance that the person is eligible for the benefits.

6) Under the *General Provisions* section, the following changes are made:

a) The ASSIGNMENT provision is replaced with the following:
We will be bound by an assignment of a Covered Person's coverage under this Policy only when the original assignment or a certified copy of the assignment, signed by the Covered Person and any irrevocable beneficiary, is filed with Us. The assignee may exercise all rights and receive all benefits assigned only while the assignment remains in effect and coverage under this Policy and the Covered Person's Certificate remains in force.

b) The INCONTESTABILITY provision is replaced with the following:

This Policy or Participation Under This Policy
In the absence of fraud, all statements made by the Policyholder to obtain this Policy or to participate under this Policy are considered representations and not warranties. No statement will be used to deny or reduce benefits or be used as a defense to a claim, or to deny the validity of this Policy or of participation under this Policy unless a copy of the written instrument containing the statement is, or has been, furnished to the Policyholder.

After two years from the Policy Effective Date, no such statement will cause this Policy to be contested.

A Covered Person's Insurance

In the absence of fraud, all statements made by a Covered Person are considered representations and not warranties. No statement will be used to deny or reduce benefits or be used as a defense to a claim, unless a copy of the written instrument containing the statement has been signed by the Covered Person, and is, or has been, furnished to the claimant.

After the insurance has been in force before the contest for two years during the individual's lifetime, no such statement will cause the insurance to be contested except for fraud or lack of eligibility for insurance.

In the event of death or incapacity, the beneficiary or personal representative shall be given a copy.

c) The Policy Termination provision is replaced with the following:

We may terminate coverage on or after the first anniversary of the Policy Effective Date. We or the Policyholder may terminate coverage on any Premium Due Date. Written or authorized electronic notice must be given at least 60 days prior to such Premium Due Date. Failure by the Policyholder to pay premiums when due or within the Grace Period shall be deemed notice to Us to terminate coverage at the end of the Grace Period.

Termination will not affect a claim for a Covered Loss that is the result, directly and independently of all other causes, of a loss that occurs while coverage was in effect. Termination of the Policy during a period of disability of the Employee will not affect benefits payable under the coverage for loss of time from work because of the disability, or any specific indemnity required to be provided during a period of Hospital confinement.

7) Under the *Administrative Provisions* section, the first sentence under the CHANGES IN PREMIUM RATES provision is replaced with the following:

The premium rates may be changed by Us from time to time with at least 60 days advance written notice.

Utah residents:

1) The Hospital Benefit Rider includes a minimum Hospital Daily Stay benefit of $50 per day up to 31 days if admitted on an Inpatient basis in a hospital.

2) The following Rider form(s) is/are not available:

ACCIDENTAL RIDER
TERM LIFE INSURANCE RIDER

Vermont residents:

1) To the extent the Policy provides insurance coverage to a spouse, the identical consideration must be applied to same sex marriages and civil unions. The language is as follows:

1. Civil Union Partner means:
   a. A person with whom the Employee has a registered civil union under Vermont law which imposes obligations on the parties substantially similar to marriage. Such person will continue to be recognized as a Civil Union Partner unless and until: (1) the civil union is dissolved under applicable law; or (2) either the Employee or the Civil Union Partner marries another person.

2. Spouse means:
   a. "Lawful spouse" and includes a lawful spouse of the same sex.
   b. This also includes a partner to a civil union recognized under Vermont Law.

2) Portability is replaced with the Continuation for Loss of Eligibility. The Maximum Port Age does not apply.

a) The following Continuation of Loss of Eligibility benefit periods have been added:

Loss of Eligibility

Maximum Benefit Period	
Employee	to age 100
Spouse	to age 100
Dependent Children	to age 26

b) Under the Age definition, all references to Portability language are removed.

c) Portability is not available under the Riders, but Rider benefits can be included in Continuation due to Loss of Eligibility.

3) Under *General Definitions* section, the following changes apply:

1. The definition of Hospital cannot exclude clinics, facilities, or units of a Hospital for drug addicts or alcoholics, and facilities primarily or solely providing psychiatric services to mentally ill patients.

2. The definition of Spouse is replaced with the following:

The Employee's current lawful Spouse who is at least Age 18 for any coverage requiring Evidence of Insurability but not yet Age 100. The term includes a Civil Union Partner recognized under Vermont Law. Except for purposes of determining initial eligibility, the term includes a Spouse who is widowed or divorced or legally separated from an Employee. The term includes a common-law Spouse who is recognized as a common-law Spouse under the laws
of the jurisdiction where the common-law marriage was formed.

4) Under *Exclusions and Limitations* section the Common Exclusions provision is modified as follows:

1. intentionally self-inflicted Injury, suicide or any attempt thereat;
2. commission or attempt to commit a felony;
3. declared or undeclared war or act of war;
4. a Covered Loss that results from active duty service in the military, naval or air force of any country or international organization. Upon Our receipt of proof of service, We will refund any premium paid for this time. Reserve or National Guard active duty training is not excluded unless it extends beyond 31 days.

5) Under the *Claim Provisions* section, the following changes are made:

a) The TIME OF PAYMENT provision is replaced with the following:

We will pay benefits due under this Policy for any loss other than a loss for which this Policy provides any periodic payment immediately upon Our receipt of due written or authorized electronic proof of such loss. Due proof of loss means all essential information needed to make a determination on the claim. Subject to due written or authorized electronic proof of loss, all accrued benefits for loss for which this Policy provides periodic payment will be paid monthly unless otherwise specified in the benefits descriptions and any balance remaining unpaid at the termination of liability will be paid immediately upon receipt of proof satisfactory to Us.

b) The PHYSICAL EXAMINATION AND AUTOPSY provision is replaced with the following:

We, at Our own expense, have the right and opportunity to examine the Covered Person when and as often as We may reasonably require while a claim is pending and to make an autopsy in case of death unless the law of the Covered Person's religion forbids it.

6) Under the *General Provisions section*, the INCONTESTABILITY provision is replaced with the following:

<u>This Policy</u>
All statements made by the Policyholder to obtain this Policy or to participate under this Policy are considered representations and not warranties. No statement will be used to deny or reduce benefits or be used as a defense to a claim, or to deny the validity of this Policy or of participation under this Policy unless a copy of the instrument

containing the statement is, or has been, furnished to the Policyholder.

After two years from the Policy Effective Date, no such statement will cause this Policy to be contested except for fraud.

A Covered Person's Insurance
All statements made by a Covered Person are considered representations and not warranties. No statement will be used to deny or reduce benefits or be used as a defense to a claim, unless a copy of the instrument containing the statement is, or has been, furnished to the claimant.

After three years from the Covered Person's effective date of coverage, or from the effective date of increased benefits, no such statement will cause coverage or the increased benefits to be contested except for fraud or lack of eligibility for coverage.

In the event of death or incapacity, the beneficiary or representative shall be given a copy.

7) Under the *Term Life Rider* the Suicide Exclusion is revised to remove the word "insane".

Washington residents:

1) The following has been added to the first paragraph on the first page:

Any conflict between the terms of the Certificate and the Policy will be decided in favor of the Certificate.

2) If the Policy provides coverage/benefits to a Spouse, a *Domestic Partner* will be afforded the same coverage/benefits provided to a Spouse.

Domestic Partner means any of the following:

1. A person with whom the Employee has a registered domestic partnership under state law which imposes legal obligations on the parties substantially similar to marriage. Such person will continue to be recognized as a Domestic Partner unless and until: (1) the domestic partnership is dissolved under applicable law; or (2) either the Employee or the Domestic Partner marries another person.

All references in the policy to "Spouse" shall be changed to read "Spouse and Domestic Partner" except as follows:

1. A Domestic Partner shall be deemed eligible to be enrolled for insurance or eligible for Additional Benefits on the latest of:
   a. the date of registration under Item 1 of the definition of Domestic Partner;
   b. the date that the Employee is eligible for insurance under the Policy; or;
   c. the effective date of this Rider to the Policy.

2. A child of a Domestic Partner may only be eligible to be insured or eligible for Additional Benefits if:
   a. the child is primarily dependent on the Employee for financial support;
   b. the Employee has a legal obligation of support of the child; or
   c. the Employee is the child's legal guardian.

3) Under the *Schedule of Benefits* section the following revisions are made:

a) If Heart Attack is not already listed as a Covered Condition a minimum benefit of $1,000 for Heart Attacks will be available. For purposes of this benefit, the definition of Heart Attack is as follows:

An identifiable clinical event that results in ischemic death of a portion of the heart muscle confirmed by diagnostic testing through:

1. electrocardiographic (EKG) changes indicative of myocardial infarction. In the case of myocardial infarction ST wave changes, Q wave changes and/or T wave inversion must be documented and included as one of the criteria on establishing a diagnosis; and, or

2. elevation of cardiac enzyme markers of myocardial injury.

In the event of death, an autopsy confirmation and/or death certificate identifying myocardial infarction as the cause of death will be accepted.

The Date of Diagnosis is the date that the ischemic death of a portion of the heart muscle occurred. In the event of death, the Date of Diagnosis will be the date of death listed on the death certificate.

b) the *Schedule of Benefits* section will be updated to include in the Continuation Option(s) continuation up to 6 months for Labor Disputes. The following will then be added to the *Continuation* section:

If an Employee's Active Service ends due to a strike, lockout, or other labor dispute, coverage will continue up to the Maximum Benefit Period as shown in the *Schedule of Benefits*. Premiums are required for this coverage and are to be remitted directly to the Policyholder.

4) Under the *General Definitions* section the following changes are made:

a) Active Service is revised as follows:

An Employee will be considered in Active Service with His Employer on any day that is either:
1. one of the Employer's scheduled work days on which the Employee is performing His regular duties on a Full-time basis, either at one of the Employer's usual places of business or at some other location to which the Employer's business requires the Employee to travel; or
2. a scheduled holiday, vacation day or period of Employer-approved paid leave of absence, other than disability or sick leave after 7 days, only if the Employee was in Active Service on the preceding scheduled workday.

A Covered Person is not considered in Active Service if He is:
1. Inpatient in a Hospital, receiving Hospice Care or confined in a rehabilitation or convalescence center;
2. confined at home under the care of a Physician for Illness or Injury.

b) The definition of Advanced Stage Alzheimer's disease is replaced with the following;

A progressive, degenerative disorder that attacks the brain's nerve cells, or neurons with accumulation and deposition of beta amyloid protein that results in the inability to perform the normal activities for one of like age and sex.

The Date of Diagnosis of the Covered Person's Advanced Stage Alzheimer's disease is the date of the Covered Person's inability to perform the normal activities of like age and sex and who is under the regular care of a Physician as confirmed by a Physician.

c) The definition of Alzheimer's has been revised so that the second bullet is replaced with the following;

- The cognitive deficits interfere with independence in everyday activities.

d) The definition of Blindness is replaced with the following:

Clinically proven irreversible reduction of sight in both eyes, caused by:
- Macular degeneration;
- Diabetic retinopathy;
- Glaucoma, Ischemic;
- optic neuropathy; or
- optic neuritis

The reduction in sight must result in:
1. sight in the better eye reduced to a best corrected visual acuity of less than 6/60 (Metric Acuity) or 20/200 (Snellen or E-Chart Acuity); or

2. visual field restriction to 20o or less in both eyes.

The Date of Diagnosis is the date an ophthalmologist diagnoses an irreversible vision loss.

e) The definition of Coma includes the following:

The Coma must be caused by, but not limited to:

1. Metabolic illness;
2. Cerebral infarction or cerebral hemorrhage;
3. Meningitis or Encephalitis;
4. Hypoxic Ischemic Encephalopathy;
5. Vasculitis.

f) The definition of Dependent Child is revised as follows:

An Employee's child who meets the following requirements:

1. A child from live birth to 26 years old;
2. A child who is 26 or more years old, primarily supported by the Employee and incapable of self-sustaining employment by reason of developmental disability.

A child, for purposes of this provision, includes an Employee's:

1. natural child;
2. adopted child, beginning with any waiting period pending finalization of the child's adoption. It also means the legally adopted child of the Employee's Spouse or Domestic Partner/Partner to a Civil Union provided there is a legal obligation for total or partial support from the Employee;
3. stepchild who resides with the Employee;
4. child for whom the Employee is the court-appointed legal guardian and primarily depends on the Employee for financial support. Financial support means that the Employee is eligible to claim the dependent for purposes of Federal and State income tax returns.
5. a child of the Employee's domestic partner /Partner to a Civil Union, provided the child is living with and is financially dependent upon the Employee;

g) The definition of Loss of Hearing is replaced with the following:

Clinically proven permanent loss of the ability to hear in both ears resulting in a loss of hearing greater than 90dB HL in all tested frequencies, as a result of a disease or Sickness.

Loss of Hearing must be caused by, but not limited to:

1. Otosclerosis;
2. Middle Ear Barotrauma;
3. Tympanic Membrane Perforation;
4. Jugulotympanic Paragangliomas;
5. Presbycusis;
6. Meniere Disease;
7. Paget Disease;
8. Fibrous Dysplasia;
9. Autoimmune Disease (e.g., Rheumatoid Arthritis, Cogan syndrome, Systemic Lupus Erythematosus, Polyarteritis Nodosa, Relapsing Polychondritis, Granulomatosis with polyangiitis);
10. Tertiary Otosyphilis;
11. Multiple Sclerosis;
12. Cerebral infarction or cerebral hemorrhage.

The Date of Diagnosis is the date the latter of both of the following occur:

1. audiometric testing demonstrating greater than 90dB HL;
2. a permanent loss of the ability to hear at greater than 90dB HL as confirmed by a Otolaryngologist.

h) The definition of Loss of Speech is replaced with the following:

Total and permanent loss of oral communication which is irrecoverable by natural, surgical or artificial means caused by:

- Dementia as a result of the following neurodegenerative disorders: Primary progressive aphasia, frontotemporal dementia, progressive supranuclear palsy, and olivo-pronto cerebellar degeneration. Dementia as a result of Alzheimer's, vascular dementia, Huntington disease, prion disease or alcoholic dementia will not be covered;
- Stroke;
- Invasive cancer;
- amyotrophic lateral sclerosis;
- myasthenia gravis;
- multiple sclerosis;
- Parkinson's disease.

The Date of Diagnosis is the date physical exam verifies the inability to communicate orally.

i) The definition of Mild Stage Alzheimer's Disease is replaced with the following:

Meets the criteria described above for the diagnosis of Alzheimer's Disease, but the cognitive deficits interfere with independence in everyday activities for one of like age and sex.

The Date of Diagnosis of the Covered Person's Mild Stage Alzheimer's disease is the date of the Covered Person's inability to perform with independence everyday activities for one of like age and sex who is under the care of a Physician as confirmed by a Physician.

j) The definition of No Evidence of Disease, if included, includes the following statement:

For Heart Attack that means the Covered Person:

1. has an absence of hyperkinesis of the non-infarcted myocardium, as demonstrated by a stable ventricular ejection fraction for a post-myocardial infarction patient; and
2. was discharged from the Inpatient hospital stay for which a(n) Initial Specified Disease Benefit has been paid.

k) The definition of Paralysis includes the following:

Paralysis must be caused by neuromuscular illnesses including, but not limited to:

1. Guillain-Barre;
2. Chronic Inflammatory Demyelinating Polyneuropathy (CIDP).

l) The definition of Totally Disabled or Total Disability has been revised and #2 is replaced with the following:

2. the inability of the Covered Person who is not currently employed to perform the normal activities of like age and sex without human supervision or assistance.

5) Under the DESCRIPTION OF COVERAGES AND BENEFITS section, the following is added to the Initial Critical Illness Benefit as an additional Benefit Condition if there is no separation period between Dates of Diagnosis:

a) the Heart Attack the Covered Person has an Inpatient admission.

6) Under the *Eligibility* section the following Newborn and Adopted Children provision is added:

Newborn and Adopted Child(ren)
Coverage for a newly born or adopted child shall be provided from the moment of birth or placement for adoption. Coverage for a newly born child shall include coverage for any congenital anomaly. If payment of an additional premium is required to provide coverage for such child, notification of the birth or placement of such child and the payment of the required premium must be furnished to Us within 60 days from the date of birth or placement.

7) Under the *Termination of Insurance Provision* and *Termination of Ported Insurance* sections the following replaces the dependent child termination:

- for a Dependent Child, the date the Dependent Child reaches age 26 unless primarily supported by the Employee and incapable of self-sustaining employment by reason of developmental or physical disability;

8) Under the *Extension of Benefits and Waiver of Premium* section, the following has been removed from the Rehabilitation During a Period of Disability:

- We have the sole discretion to approve the Employee's participation in a Rehabilitation Plan and to approve a program as a Rehabilitation Plan.

9) Portability coverage will terminate if the Policy/Subscribers participation under the Policy terminates.

10) Under the *Common Exclusions and Limitations* the following exclusions do not apply:

- voluntary ingestion of any narcotic, drug, poison, gas or fumes, unless prescribed or taken under the direction of a Physician and taken in accordance with the prescribed dosage;
- operating any type of vehicle while under the influence of alcohol or any drug, narcotic or other intoxicant including any prescribed drug for which the Covered Person has been provided a written warning against operating a vehicle while taking it. "Under the influence of alcohol", for purposes of this exclusion, means intoxicated, as defined by the law of the state in which the Covered Injury or Covered Illness occurred.

11) Under the *Claims Provisions* section the following changes are made:

a) The NOTICE OF CLAIM is revised as following:

Written or authorized electronic, or telephonic notice of claim must be given to Us within 31 days after a Covered Loss occurs or begins or as soon as is reasonably possible. If written or authorized electronic, or telephonic notice is not given in that time, the claim will not be invalidated or reduced if it is shown that written or authorized electronic, or telephonic notice was given as soon as was reasonably possible. Notice can be given to Us at Our Home Office in Bloomfield, Connecticut, such other place as We may designate for the purpose, or to Our authorized producer. Notice should include the Policyholder's name and Policy number and the Covered Person's name, address, Policy and Certificate number.

b) The TIME OF PAYMENT OF CLAIMS is revised as follows:

We will pay benefits due under this Policy for any loss other than a loss for which this Policy provides any periodic payment immediately upon Our receipt of due written or authorized electronic proof of such loss. Due proof of loss means all essential information needed to make a determination on the claim. Subject to due written or authorized electronic proof of loss, all accrued benefits for loss for which this Policy provides periodic payment will be paid monthly unless otherwise specified in the benefits descriptions and any balance remaining unpaid at the termination of liability will be paid immediately upon receipt of proof satisfactory to Us.

12) Under the *Administration Provisions*, the first sentence of the Change in Premium Rates has been revised as follows:

The premium rates may be changed by Us with at least 45 days advance written notice.

13) Under the *General Provisions*, the following changes are made:

a) The Entire Contract; Changes section is revised as follows:

This Policy, including the endorsements, amendments, a copy of the application, if any, and any attached papers constitutes the entire contract of coverage. No change in this Policy will be valid until approved by one of Our executive officers and endorsed on or attached to this Policy. No producer has authority to change this Policy or to waive any of its provisions.

b) The Incontestability section is revised as follows:

A Covered Person's Insurance
All statements made by a Covered Person are considered representations and not warranties. No statement will be used to deny or reduce benefits or be used as a defense to a claim, unless a copy of the instrument containing the statement is, or has been, furnished to the claimant or his or her beneficiary, if any.

14) The *Healthy Living Wellness Rider* is retitled Healthy Living Rider.

15) Under the *Wellness Treatment, Health Screening Test and Preventive Care Benefit Rider*, the following changes are made:

a) The rider is retitled to Health Screening Test and Preventive Care Benefit Rider and all listed Wellness Treatment services are available only under Health Screening Test.

b) The following exams are not available:

- Annual routine preventative dental exam
- Annual routine ophthalmological exam including refraction

16) The following Rider form(s) is/are not available:
HOSPITAL BENEFIT RIDER
ACCIDENTAL DEATH AND DISMEMBERMENT RIDER
ACCIDENTAL RIDER
DISIBILITY INCOME RIDER
TERM LIFE INSURANCE RIDER

Wisconsin residents:

1) Under the *General Definitions* section, item 2 of the second paragraph of the *Dependent Child* definition includes adopted child as follows:

a. adopted child, beginning with any waiting period pending finalization of the child's adoption. It also means the legally adopted child of the Employee's Spouse or domestic partner/Partner to a Civil Union provided the child is living with, and is financially dependent upon the Employee;

2) Under the *Claim Provisions*, the TIME OF PAYMENT provision is replaced with the following:
Benefits due shall be paid not more than 30 days after Our receipt of written or authorized electronic proof of loss. Subject to proof of loss, all accrued benefits shall not be paid less frequently than monthly during the continuance of the period for which We are liable, and any balance remaining unpaid at the termination of such period shall be paid as soon as possible after receipt of such proof. A claim shall be overdue if not paid within 30 days after We are furnished written or authorized electronic proof of loss. If such proof is not furnished to Us as to the entire claim, any partial amount supported by written or authorized electronic proof of loss is overdue if not paid within 30 days after proof is furnished to Us. Any part or all of the remainder of the claim that is subsequently supported by written or authorized electronic proof is overdue if not paid within 30 days after such proof is furnished to Us. Any payment shall not be deemed overdue when We have reasonable proof to establish that We are not responsible for the payment, notwithstanding that written or authorized electronic proof of loss has been furnished to Us. For the purpose of calculating the extent to which any claim is overdue, payment shall be treated as being made on the date a draft or other valid instrument which is equivalent to payment was placed in the U.S. mail in a properly addressed, postpaid envelope, or, if not so posted, on the date of delivery.

3) Under the *Administrative Provisions* section, the Change in Premium Rates Provision is revised to show that We may change premium rates with at least 60 days advance written notice if rates are to be increased by 25% or more.

4) Under the *General Provisions* section, the POLICY TERMINATION provision is revised to reflect that 60 days advanced written notice must be provided.

Alabama, Alaska, Arkansas, Arizona, California, Connecticut, Delaware, District of Columbia, Florida, Georgia, Hawaii, Illinois, Indiana, Iowa, Kansas, Kentucky, Maryland, Massachusetts, Michigan, Minnesota, Mississippi, Missouri, Montana, Nebraska, Nevada, New Jersey, North Carolina, North Dakota, Ohio, Oklahoma, Pennsylvania, Puerto Rico, Rhode Island, South Carolina, Tennessee, Virginia, Virgin Islands and Wisconsin Residents:

The Pre-Existing Condition Limitation Period can't exceed 6 months/12 months.

CIGNA HEALTH AND LIFE INSURANCE COMPANY

Geneva Campbell Brown
Corporate Secretary

Julia M.Huggins
Senior Vice President of US Markets
President CHLIC

GCI-00-3000.00 R6/22

SUPPLEMENTAL INFORMATION
for

Megalodon Midco LLC Health & Welfare Benefit Plan ("Plan")

required by the Employee Retirement
Income Security Act of 1974

As a Plan participant in Megalodon Midco LLC's Plan, you are entitled to certain information, rights and protection under the Employee Retirement Income Security Act of 1974 (ERISA).

The benefits described in your Certificate are provided under a group insurance Policy issued by the Insurance Company. The Policy is incorporated into the Plan. The Certificate, along with the following Supplemental Information, makes up the Summary Plan Description as required by ERISA.

IMPORTANT INFORMATION ABOUT THE PLAN

- The Plan is established and maintained by Megalodon Midco LLC, the Plan Sponsor.
- The Employer Identification Number (EIN) is 87-3643212.
- The Plan Number is 501.
- The Insurance Plan is administered directly by the Plan Administrator with benefits provided, in accordance with the provisions of the group insurance contract, CI111745("Policy"), issued by CIGNA HEALTH AND LIFE INSURANCE COMPANY ("Insurance Company").
- The Plan Administrator is: Megalodon Midco LLC
  1780 Pond Run
  Auburn Hills, MI 48326
  248-299-7500
- The Plan Administrator has authority to control and manage the operation and administration of the Plan.
- The Plan Sponsor may terminate, suspend, withdraw or amend the Plan, in whole or in part, at any time, subject to the applicable provisions of the Policy. (Your rights upon termination or amendment of the Plan are set forth in your Certificate.)
- The agent for service of legal process is the Plan Administrator.
- The Plan of benefits is financed by the Employees.
- The date of the end of the Plan Year is December 31.

YOUR RIGHTS AS SET FORTH BY ERISA

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

Receive Information About Your Plan and Benefits

Examine, without charge, at the plan administrator's office and at other specified locations, such as worksites and union halls, all documents governing the plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefit Security Administration.

Obtain, upon written request to the plan administrator, copies of documents governing the operation of the plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The administrator may make a reasonable charge for the copies.

Receive a summary of the plan's annual financial report. The plan administrator is required by law to furnish each participant with a copy of this summary annual report.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for plan participants ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your plan, called "fiduciaries" of the plan, have a duty to do so prudently and in the interest of you and other plan participants and beneficiaries. No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

Enforce Your Rights

If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report from the plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the plan administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court. If it should happen that plan fiduciaries misuse the plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions

If you have any questions about your plan, you should contact the plan administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the plan administrator, you should contact the nearest office of the Employee Benefit Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefit Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefit Security Administration.

WHAT YOU SHOULD DO AND EXPECT IF YOU HAVE A CLAIM

The Plan Administrator designates and names the Insurance Company the named fiduciary for deciding claims and appeals for benefits under the Plan. The Insurance Company shall have the authority, in its discretion, to interpret the terms of the Plan, to decide questions of eligibility for coverage or benefits under the Plan, and to make any related findings of fact. All decisions made by the Insurance Company shall be final and binding on Participants and Beneficiaries to the full extent permitted by applicable law.

Claims for Disability Benefits (applies to all claims filed on or after April 1, 2018)

A disability “claim” is any claim which requires a determination of disability by the Insurance Company regardless of the type of policy under which it arises (for example, short/long term disability, waiver of premium, etc.). A disability claim is “filed” as of the date the Insurance Company first receives, in writing (including electronically) or by telephone (through the Insurance Company’s intake department), notice that a claimant is seeking disability benefits under the Policy. The notice of claim received should provide the date of disability/loss, the claimant’s name and address, and the group Policy

holder's name and address. Properly filed claims will be decided with independence and impartiality.

The Insurance Company has 45 days from the date it receives a claim for disability benefits to determine whether or not benefits are payable in accordance with the terms of the Policy. The Insurance Company may require more time to review the claim if necessary due to matters beyond its control. The review period may be extended for up to two additional 30 day periods. If this should happen, the Insurance Company must provide its extension notice in writing before expiration of the current decision period, explaining the circumstances requiring extension and the date a decision is expected. If the extension is made because additional information must be furnished, the claimant has 45 days within which to provide the requested information and the time for the Insurance Company's decision shall be tolled (stopped) from the date on which the notification of the extension was sent until the date the Insurance Company receives the claimant's response or upon the date the requested information is required to be furnished expires, whichever is sooner.

During the review period, the Insurance Company may require a medical examination of the claimant, at its own expense, or additional information regarding the claim. If a medical examination is required, the Insurance Company will notify the claimant of the date and time of the examination and the physician's name and location. If additional information is required, the Insurance Company will notify the claimant, in writing, stating what information is needed and why it is needed.

If the claim is approved, the Insurance Company will pay the appropriate benefit. If the claim decision is adverse, in whole or in part, the Insurance Company will provide written or electronic notice which will include the following information:

1. The specific reason(s) for the decision;
2. Specific reference to the Policy provision(s) on which the decision was based;
3. A description of any additional information required to perfect the claim, and the reason this information is necessary;
4. A description of the review procedures and the time limits applicable to those procedures, including a statement of the claimant's right to bring a civil action under section 502(a) of ERISA after the claimant appeals and after the claimant receives an adverse decision on appeal;
5. A discussion of the decision, including an explanation of the basis for disagreeing with or not following: (i) the views presented by the claimant to the Insurance Company of the health care professionals treating the claimant and vocational professionals who evaluated the claimant; (ii) the views of medical or vocational experts whose advice was obtained on behalf of the Insurance Company in connection with the claimant's adverse benefit decision, without regard to whether the advice was relied upon in making the benefit decision; and (iii) a disability decision regarding the claimant presented by the claimant to the Insurance Company made by the Social Security Administration;
6. Either the specific internal rules, guidelines, protocols, standards or other similar plan criteria the Insurance Company relied upon in making the decision, or, alternatively, a statement that such rules, guidelines, protocols, standards or other similar plan criteria do not exist;
7. If the adverse decision is based upon medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the decision, applying the terms of the Policy to the claimant's medical circumstances, or a statement that such explanation will be provided free of charge upon request;
8. A statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claim for benefits; and
9. A notice provided in a culturally and linguistically appropriate manner, to the extent required by ERISA.

Appeal of Denied Disability Claims (applies to all claims filed on or after April 1, 2018)

Whenever a claim decision is fully or partially adverse, unless ERISA provides otherwise, the claimant must appeal once to the Insurance Company. As part of the claimant's appeal, the claimant may receive, upon request, free of charge, copies of all documents, records, and other information relevant to the claim for benefits, and the claimant may submit to the Insurance Company, written comments, documents, records, and other information relating to the claim. The review will take into account all comments, documents, records and other information the claimant submits related to the claim, without regard to whether such information was submitted or considered in the initial claim decision. Once an appeal request has been received by the Insurance Company, a full and fair review of the claim appeal will take place.

A written request for appeal must be received by the Insurance Company within 180 days from the date the claimant

received the adverse decision. If an appeal request is not received within that time, the right to appeal will have been waived. The Insurance Company has 45 days from the date it receives a request for appeal to provide its decision. Under special circumstances, the Insurance Company may require more time to review the claim and can extend the time for decision, once, by an additional 45 days. If this should happen, the Insurance Company must provide the extension notice, in writing, before expiration of the initial decision period, indicating the special circumstances and the date a decision is expected. If the extension is made because additional information must be furnished, the claimant has 45 days within which to provide the requested information and the time for the Insurance Company's decision shall be tolled (stopped) from the date on which the notification of the extension was sent until the date the Insurance Company receives the claimant's response or upon the date the requested information is required to be furnished expires, whichever is sooner.

The review will give no deference to the original claim decision. The review will not be made by the person who made the initial claim decision, or a subordinate of that person. When deciding an appeal based in whole or in part upon medical judgment, the Insurance Company will consult with a medical professional having the appropriate training and experience in the field of medicine involved in the medical judgment. Any medical or vocational experts consulted by the Insurance Company for the review will be identified and will not be the expert who was consulted during the initial claim decision or a subordinate of that expert.

During the appeal, the Insurance Company may require a medical examination of the claimant, at its own expense, or additional information regarding the claim. If a medical examination is required, the Insurance Company will notify the claimant of the date and time of the examination and the physician's name and location. If additional information is required, the Insurance Company will notify the claimant, in writing, stating what information is needed and why it is needed.

Before the Insurance Company issues an adverse benefit decision on appeal, if the Insurance Company considered, relied upon, or generated any new or additional evidence in connection with the claim, and/or if the Insurance Company intends to rely on any new or additional rationale in connection with that review, then such evidence and/or rationale will be provided to the claimant, free of charge, as soon as possible and sufficiently in advance of the date that the decision on appeal is required to be made, giving the claimant a reasonable opportunity to respond.

If the claim is approved, the Insurance Company will pay the appropriate benefit. If the claim decision on appeal is adverse, in whole or in part, the Insurance Company will provide written or electronic notice that includes:

1. The specific reason(s) for the decision;
2. Specific reference to the Policy provision(s) on which the decision was based;
3. A statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claim for benefits;
4. A statement describing any voluntary appeal procedures offered, and the claimant's right to obtain the information about those procedures;
5. A statement of claimant's right to bring a civil action under section 502(a) of ERISA, including a description of any applicable contractual limitations period that applies to the claimant's right to bring such an action, and the calendar date on which the contractual limitations period expires for the claim;
6. A discussion of the decision, including an explanation of the basis for disagreeing with or not following: (i) the views presented by the claimant to the Insurance Company of the health care professionals treating the claimant and vocational professionals who evaluated the claimant; (ii) the views of medical or vocational experts whose advice was obtained on behalf of the Insurance Company in connection with the adverse decision, without regard to whether the advice was relied upon in making the adverse decision; and (iii) a disability decision regarding the claimant presented by the claimant to the Insurance Company made by the Social Security Administration;
7. Either the specific internal rules, guidelines, protocols, standards or other similar plan criteria the Insurance Company relied upon in making the decision, or, alternatively, a statement that such rules, guidelines, protocols, standards or other similar plan criteria do not exist;
8. If the adverse decision is based upon medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the decision, applying the terms of the Policy to the claimant's medical circumstances, or a statement that such explanation will be provided free of charge upon request; and
9. A notice provided in a culturally and linguistically appropriate manner, to the extent required by ERISA.

Claims for Non-Disability Benefits (applies to all claims filed on or after April 1, 2018)

A non-disability "claim" is any claim which does not require a determination of disability by the Insurance Company regardless of the type of policy under which it arises (for example, a death claim, an accident claim, etc.). A non-disability claim is "filed" as of the date the Insurance Company first receives, in writing or by telephone (through the Insurance Company's intake department), notice that a claimant is seeking benefits under the Policy. The notice of claim should include the group Policy holder's name, the Policy and Certificate number and the claimant's name and address.

The Insurance Company has 90 days from the date the claim is filed to determine whether or not benefits are payable in accordance with the terms of the Policy. The Insurance Company may require more time to review the claim if special circumstances exist. The review period may be extended for up to one additional 90 day period. If this should happen, the Insurance Company will provide the extension notice in writing, before expiration of the initial decision period, indicating the special circumstances and the date a decision is expected.

During the review period, the Insurance Company may require a medical examination of the claimant, at its own expense, or additional information regarding the claim. If a medical examination is required, the Insurance Company will notify the claimant of the date and time of the examination and the physician's name and location. If additional information is required, the Insurance Company must notify the claimant, in writing, stating what information is needed and why it is needed.

If the claim is approved, the Insurance Company will pay the appropriate benefit. If the claim decision is adverse, in whole or in part, the Insurance Company will provide written or electronic notice which will include the following information:

1. The specific reason(s) for the claim decision;
2. Specific reference to the Policy provision(s) on which the decision was based;
3. A description of any additional information required to perfect the claim, and the reason this information is necessary; and
4. A description of the review procedures and the time limits applicable to those procedures, including a statement of the claimant's right to bring a civil action under section 502(a) of ERISA after the claimant appeals and after the claimant receives an adverse decision on appeal.

Appeal of Denied Non-Disability Claims (applies to all claims filed on or after April 1, 2018)

Whenever a claim decision is fully or partially adverse, the claimant must appeal once to the Insurance Company. As part of the claimant's appeal, the claimant may receive, upon request, free of charge, copies of all documents, records, and other information relevant to the claim for benefits, and the claimant may submit to the Insurance Company, written comments, documents, records, and other information relating to the claim. The review will take into account all comments, documents, records and other information the claimant submits related to the claim, without regard to whether such information was submitted or considered in the initial claim decision. Once an appeal request has been received by the Insurance Company, a full and fair review of the claim appeal will take place.

A written request for appeal must be received by the Insurance Company within 60 days from the date the claimant received the adverse decision. If an appeal request is not received within that time, the right to appeal will have been waived. The Insurance Company has 60 days from the date it receives a request for appeal to provide its decision. Under special circumstances, the Insurance Company may require more time to review the claim and extend the time for decision, once, by an additional 60 days. If this should happen, the Insurance Company will provide the extension notice, in writing, before expiration of the initial decision period, indicating the special circumstances and the date a decision is expected.

If the appeal decision is adverse, in whole or in part, the Insurance Company will provide written or electronic notice that includes:

1. The specific reason(s) for the claim decision;
2. Specific reference to the Policy provision(s) on which the decision was based;
3. A statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claim for benefits;

4. A statement describing any voluntary appeal procedures offered, and the claimant's right to obtain the information about those procedures, and
5. A statement of the claimant's right to bring a civil action under section 502(a) of ERISA.

UNDERWRITTEN BY:
CIGNA HEALTH AND LIFE INSURANCE COMPANY
a Cigna company

Class 2

03/2024