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 Hospital Indemnity
Insurance Certificate

Megalodon Midco LLC

IMPORTANT NOTICES

GROUP HOSPITAL INDEMNITY

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.

Colorado residents:

THIS IS A SUPPLEMENTAL POLICY THAT IS NOT INTENDED TO PROVIDE THE MINIMUM ESSENTIAL COVERAGE REQUIRED BY THE AFFORDABLE CARE ACT (ACA). UNLESS YOU HAVE ANOTHER PLAN (SUCH AS MAJOR MEDICAL COVERAGE) THAT PROVIDES MINIMUM ESSENTIAL COVERAGE IN ACCORDANCE WITH THE ACA, YOU MAY BE SUBJECT TO A FEDERAL TAX PENALTY. ALSO, THE BENEFITS PROVIDED BY THIS POLICY CANNOT BE COORDINATED WITH THE BENEFITS PROVIDED BY OTHER COVERAGE. PLEASE REVIEW THE BENEFITS PROVIDED BY THIS POLICY CAREFULLY TO AVOID A DUPLICATION OF COVERAGE.

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

Maine residents:

RENEWAL SUBJECT TO CONSENT OF COMPANY: PLEASE READ TERMINATION OF POLICY PROVISION IN THE GENERAL PROVISIONS SECTION.

THIS POLICY IS NOT A MEDICARE SUPPLEMENT POLICY. If you are eligible for Medicare, review the Guide to Health Insurance for People with Medicare available from the company.

Maryland residents:

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

New Hampshire residents:

THIS IS A LIMITED POLICY. READ IT CAREFULLY.

THIS POLICY PROVIDES LIMITED BENEFITS. BENEFITS PROVIDED ARE SUPPLEMENTAL AND ARE NOT INTENDED TO COVER ALL MEDICAL EXPENSES.

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

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.

North Carolina residents:

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

THIS POLICY IS NOT A MEDICARE SUPPLEMENT POLICY.
If you are eligible for Medicare, review the Guide to Health Insurance for People with Medicare, which is available from Us.

UNDER NORTH CAROLINA GENERAL STATUTE SECTION 58-50-40, NO PERSON, EMPLOYER, PRINCIPAL, AGENT, TRUSTEE, OR THIRD PARTY ADMINISTRATOR, WHO IS RESPONSIBLE FOR THE PAYMENT OF GROUP HEALTH OR LIFE INSURANCE OR GROUP HEALTH PLAN PREMIUMS, SHALL: (1) CAUSE THE CANCELLATION OR NONRENEWAL OF GROUP HEALTH OR LIFE INSURANCE, HOSPITAL, MEDICAL, OR DENTAL SERVICE CORPORATION PLAN, MULTIPLE EMPLOYER WELFARE ARRANGEMENT, OR GROUP HEALTH PLAN COVERAGES AND THE CONSEQUENTIAL LOSS OF THE COVERAGES OF THE PERSONS INSURED, BY WILLFULLY FAILING TO PAY THOSE PREMIUMS IN ACCORDANCE WITH THE TERMS OF THE INSURANCE OR PLAN CONTRACT, AND (2) WILLFULLY FAIL TO DELIVER, AT LEAST 45 DAYS BEFORE THE TERMINATION OF THOSE COVERAGES, TO ALL PERSONS COVERED BY THE GROUP POLICY A WRITTEN NOTICE OF THE PERSON'S INTENTION TO STOP PAYMENT OF PREMIUMS. THIS

WRITTEN NOTICE MUST ALSO CONTAIN A NOTICE TO ALL PERSONS COVERED BY THE GROUP POLICY OF THEIR RIGHTS TO HEALTH INSURANCE CONVERSION POLICIES UNDER ARTICLE 53 OF CHAPTER 58 OF THE GENERAL STATUTES AND THEIR RIGHTS TO PURCHASE INDIVIDUAL POLICIES UNDER THE FEDERAL HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT AND UNDER ARTICLE 68 OF CHAPTER 58 OF THE GENERAL STATUTES. VIOLATION OF THIS LAW IS A FELONY. ANY PERSON VIOLATING THIS LAW IS ALSO SUBJECT TO A COURT ORDER REQUIRING THE PERSON TO COMPENSATE PERSONS INSURED FOR EXPENSES OR LOSSES INCURRED AS A RESULT OF THE TERMINATION OF THE INSURANCE.

Ohio residents:

THIS POLICY IS NOT A MEDICARE SUPPLEMENT POLICY. IF YOU ARE ELIGIBLE FOR MEDICARE, REVIEW THE GUIDE TO HEALTH INSURANCE FOR PEOPLE WITH MEDICARE AVAILABLE FROM US.

Oklahoma residents:

NOTICE: The Policyholder has the right to return the Policy within ten (10) days of its delivery and to have the premium refunded if, after examination of the Policy, the Policyholder is not satisfied for any reason. If We do not return any premiums or money paid therefore within thirty (30) days from the date of cancellation, We will pay interest on the proceeds.

WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes a claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

South Dakota residents:

THIS LIMITED HEALTH BENEFITS PLAN DOES NOT PROVIDE FOR COMPREHENSIVE MEDICAL COVERAGE. IT IS A BASIC OR LIMITED BENEFITS POLICY AND IS NOT INTENDED TO COVER ALL MEDICAL EXPENSES. THIS PLAN IS NOT DESIGNED TO COVER THE COSTS OF SERIOUS OR CHRONIC ILLNESS.

Utah residents:

THIS IS NOT A MEDICARE SUPPLEMENT POLICY. IF YOU ARE ELIGIBLE FOR MEDICARE, REVIEW THE GUIDE TO HEALTH INSURANCE FOR PEOPLE WITH MEDICARE AVAILABLE FROM THE COMPANY. WITHIN 30 DAYS OF RECEIPT OF THIS POLICY, YOU CAN RETURN IT TO US FOR ANY REASON IF NOT SATISFIED. WE WILL RETURN ANY PREMIUM THAT HAS BEEN PAID AND THE POLICY VOID.

Virginia residents:

THIS IS A SUPPLEMENT TO HEALTH INSURANCE AND IS NOT A SUBSTITUTE FOR MAJOR MEDICAL COVERAGE. LACK OF MAJOR MEDICAL COVERAGE (OR OTHER MINIMUM ESSENTIAL COVERAGE) MAY RESULT IN AN ADDITIONAL PAYMENT WITH YOUR TAXES.

IMPORTANT NOTICE REGARDING YOUR INSURANCE
In the event You need to contact someone about this insurance for any reason please contact Your agent. If no agent was involved in the sale of this insurance, or if You have any questions you may contact Us at the address above or by calling toll-free 1-800-754-3207.

If you are unable to contact or obtain satisfaction from the company or agent, you may contact the Virginia State Corporation Commission's Bureau of Insurance at the following address and telephone numbers:
P.O. Box 1157
Richmond Virginia 23218-1157
(804) 371-9741 (local)
(800) 552-7945 (VA toll-free)
(877) 310-6560 (national toll-free)

Written correspondence is preferable so that a record of your inquiry is maintained. When contacting your agent, company or Bureau of Insurance, have your policy number available.

West Virginia residents:

THIS POLICY DOES NOT QUALIFY FOR MINIMUM ESSENTIAL COVERAGE

TEN DAY RIGHT TO EXAMINE POLICY
The Policyholder has the right to return this Policy to Us within 10 days of receipt, and to have the premium refunded if, after examination, the Policyholder is not satisfied with this Policy for any reason.

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

GROUP HOSPITAL INDEMNITY CERTIFICATE

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

THIS IS A GROUP HOSPITAL INDEMNITY INSURANCE POLICY. BENEFITS PROVIDED ARE NOT INTENDED TO COVER ALL MEDICAL EXPENSES.

THIS IS NOT A SUBSTITUTE FOR COMPREHENSIVE HEALTH INSURANCE. THIS COVERAGE DOES NOT SATISFY THE INDIVIDUAL MANDATE OF THE AFFORDABLE CARE ACT (ACA).

We, the Cigna Health and Life Insurance Company, have issued a Group Policy, HC111442 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 Subscriber 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 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 maximum benefit amount, 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.

GHIP1.2-1100.00

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.

BENEFIT AMOUNTS PAYABLE
All Employee benefits 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, unless otherwise indicated.
All Dependent Child(ren) benefits are payable at 100% of the Benefit Amount shown for the Employee, unless otherwise indicated

Benefit Waiting Period: 0 days unless otherwise specified

HOSPITAL INDEMNITY BENEFITS
EMPLOYEE BENEFITS

PLAN 1

HOSPITALIZATION BENEFITS

Benefit Type	Benefit Amount
Hospital Admission	
Elimination Period	0 days
Benefit Amount	$500
Maximum Benefit Period	1 day
Hospital Chronic Condition Admission	
Elimination Period	0 days
Benefit Amount	$50
Maximum Benefit Period	1 day
Hospital Stay	
Elimination Period	0 days
Benefit Amount	$200 per day
Maximum Benefit Period	Up to 30 days
Hospital Intensive Care Unit Stay	
Elimination Period	0 days
Benefit Amount	$400 per day
Maximum Benefit Period	Up to 30 days
Hospital Observation Stay	
Elimination Period	24 hours
Benefit Amount	$100 per day
Maximum Benefit Period	Up to 72 hours

CONTINUATION OPTION(S):

Applicable Coverage(s)	Hospital Indemnity Benefits for the Employee, His Spouse and Dependent Child(ren)
For Furlough Maximum Benefit Period	up to 12 weeks
For Temporary Layoff Maximum Benefit Period	up to 4 weeks
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

PORTABILITY

Portable Period	Coverage continues to age 100 for Employee, to age 100 for Spouse, to age 26 for Dependent Child, unless otherwise specified
Amount of Portable Insurance	100%
Coverage(s) that may be ported	Employee, Spouse, Dependent Child
Benefit(s) that may be ported	All
Maximum Age	As of the date of porting, 100 for Employee, 100 for Spouse, 26 for Dependent Child, unless otherwise specified

PREMIUM INFORMATION

INITIAL PREMIUM

Premium:	Refer to your Schedule of Rates or 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.

GHIP1.2-1100.00

DESCRIPTION OF COVERAGES AND BENEFITS

This Description of Coverages and Benefits Section describes the Hospital Indemnity Coverages and Benefits provided by this Policy. Benefit amounts, benefit periods and any applicable aggregate and benefit maximums are shown in the *Schedule of Benefits* and may be subject to a Benefit Waiting Period and/or an Elimination 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.

HOSPITALIZATION BENEFITS

Hospitalization benefits will be paid on a per day basis and we will pay the maximum per day benefit as shown in the *Schedule of Benefits*.

HOSPITAL ADMISSION
We will pay the per day Benefit Amount shown in the *Schedule of Benefits,* subject to the following conditions and limitations, if the Covered Person is admitted to and confined in a Hospital due to a Covered Injury or Covered Illness. This benefit will pay in addition to the Hospital Chronic Condition Admission Benefit, Hospital Stay and Hospital Intensive Care Unit Stay Benefit. Benefits are payable for up to the Maximum Benefit Period shown in the *Schedule of Benefits*.

Benefit Conditions
1. The Hospital stay is as an Inpatient, as defined by the policy.

Benefit Limitation
This benefit will not be payable if:
1. Treatment is given only in the Emergency Room.
2. Treatment is provided on an Outpatient basis.
3. Treatment is for Hospital re-admission for the same Covered Injury or Covered Illness.
4. The benefit is limited to 1 Hospital admission per 90 days for different Covered Injury or Covered Illness.

Exclusion(s) The exclusions that apply to this benefit are in the *Common Exclusions* section.

HOSPITAL CHRONIC CONDITION ADMISSION
We will pay the per day Benefit Amount shown in the *Schedule of Benefits,* subject to the following conditions and limitations, if the Covered Person is admitted to and confined in a Hospital due to a Chronic Condition as specified in the Definitions section of the Policy. This benefit will pay in addition to the Hospital Admission, Hospital Stay or Hospital Intensive Care Unit Stay Benefit. Benefits are payable for up to the Maximum Benefit Period shown in the *Schedule of Benefits*.

Benefit Conditions
1. The Hospital stay is as an Inpatient, as defined by the policy; and
2. Treatment, including an evaluation or consultation, for a Chronic Condition is provided by a specialist in that field of medicine.

Benefit Limitation
This benefit will not be payable if:
1. Treatment is given only in the Emergency Room.
2. Treatment is provided on an Outpatient basis.
3. Treatment is for Hospital re-admission for the same Chronic Condition.
4. The benefit is limited to 1 Hospital admission per 90 days for different Chronic Conditions.

Exclusion(s) The exclusions that apply to this benefit are in the *Common Exclusions* section.

HOSPITAL STAY BENEFIT
We will pay per day the Benefit Amount shown in the *Schedule of Benefits,* subject to the following conditions and limitations, if the Covered Person is confined in a Hospital due to a Covered Injury or Covered Illness. Benefits are payable for up to the Maximum Benefit Period shown in the *Schedule of Benefits*.

Benefit Conditions
The Hospital Stay must meet all of the following:
1. Must be at the direction and under the care of a Physician; and
2. Must be admitted on an Inpatient basis.

The benefit will be paid for each day of a continuous Hospital Stay. If the Hospital Stay begins during the Benefit Waiting Period, the benefit will be paid for each continuous day that extends after the end of the Elimination Period, as shown in the *Schedule of Benefits.* If benefits are calculated on a monthly basis, pro rata payments will be made for confinements of less than one month.

Benefit Limitations
1. The benefit is limited to 1 Hospital Stays within a 90 day period.
2. If a benefit is payable under the Hospital Stay Benefit as well as under the Hospital Intensive Care Unit Stay Benefit, only 1 benefit will be paid for the same Covered Injury or Covered Illness, whichever is the greater amount.
3. If the Covered Person leaves the Hospital and then returns within 90 days for the same or a related Covered Injury or Covered Illness, we will still count that as one Hospital Stay. However, if the Covered Person is out of the Hospital for at least 90 days and then returns for the same or a related Covered Injury or Covered Illness, we will count that as a different Hospital Stay.

Exclusion(s) The exclusions that apply to this benefit are in the *Common Exclusions* section.

HOSPITAL INTENSIVE CARE UNIT (ICU) STAY BENEFIT
We will pay per day the Benefit Amount shown in the *Schedule of Benefits*, subject to the following conditions and limitations, if the Covered Person is confined in an ICU of a Hospital due to a Covered Injury or Covered Illness. Benefits are payable for up to the Maximum Benefit Period shown in the *Schedule of Benefits*.

Benefit Conditions
The Hospital ICU Stay must meet all of the following:
1. Must be at the direction and under the care of a Physician; and
2. Must be admitted on an Inpatient basis.

The benefit will be paid for each day of a continuous Hospital ICU Stay. If the Hospital ICU Stay begins during the Benefit Waiting Period, the benefit will be paid for each continuous day that extends after the end of the Elimination Period, as shown in the *Schedule of Benefits.* If benefits are calculated on a monthly basis, pro rata payments will be made for confinements of less than one month.

Benefit Limitations
1. The benefit is limited to 1 Hospital ICU Stays within a 90 day period.
2. If a benefit is payable under the Hospital Stay Benefit as well as under the Initial Hospital Intensive Care Unit Benefit, only 1 benefit will be paid for the same Covered Injury or Covered Illness, whichever is the greater amount.
3. If the Covered Person leaves the Hospital ICU and then returns within 90 days for the same or a related Covered Injury or Covered Illness, we will still count that as one Hospital ICU Stay. However, if the Covered Person is out of the Hospital ICU for at least 90 days and then returns for the same or a related Covered Injury or Covered Illness, we will count that as a different Hospital ICU Stay.

Exclusion(s) The exclusions that apply to this benefit are in the *Common Exclusions* section.

HOSPITAL OBSERVATION STAY BENEFIT

We will pay the per day Benefit Amount shown in the *Schedule of Benefits,* subject to the following conditions and limitations, if the Covered Person receives treatment for a Covered Injury or Covered Illness in a Hospital, including an observation room, or an Ambulatory Surgical Center, for a period in excess of 24 hours on a non-Inpatient basis and a charge is incurred.

Benefit Conditions
The Hospital Observation Stay must meet all of the following:

1. Be at the direction and under the care of a Physician.

Benefit Limitations

1. This benefit is not payable if a benefit is payable under the Hospital Stay Benefit or Hospital Intensive Care Unit Stay Benefit.

Exclusion(s) The exclusions that apply to this benefit are in the *Common Exclusions* section.

GHIP1.2-2201.00

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, 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 or receiving Outpatient care for chemotherapy or radiation therapy; or
2. confined at home under the care of a Physician for Illness or Injury.

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, a Covered Person's Age is His Age as of His last birthday.
4. For all other purposes, changes in rates due to age and 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.

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.

Benefit Waiting Period

The period of time, shown in the *Schedule of Benefits*, immediately following the effective date of the Covered Person's coverage. No benefits will be paid under the *Schedule of Benefits* for Hospital Indemnity Benefits or any Additional 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*.

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.

Chronic Condition

A condition that:

1. has been diagnosed and treated during a Hospital Stay for which benefits are payable; and
2. Is any of the following conditions:
    1. asthma, chronic obstructive pulmonary disease (COPD), emphysema and chronic bronchitis.

2. low back pain, metabolic syndrome, osteoarthritis, peripheral arterial disease, behavioral: anxiety, bipolar disorder, depression.
3. diabetes mellitus: Type 1, Type 2.
4. cardiac concerns: acute myocardial infarction, angina, congestive heart failure, coronary artery disease, heart disease.

Complications of Pregnancy Whether or not the pregnancy is terminated, any condition:

1. that requires hospital confinement; and
2. whose diagnosis is distinct from pregnancy but is adversely affected or caused by pregnancy.

Examples include: acute nephritis; nephrosis; cardiac decompensation; missed abortion; and similar conditions of comparable severity, non-elective caesarean section; ectopic pregnancy which is terminated; and spontaneous termination of pregnancy which occurs during a period of gestation when a viable birth is not possible.

Complications of pregnancy do not include: false labor; occasional spotting; physician prescribed rest during pregnancy; morning sickness; hyperemesis gravidarum; pre-eclampsia; and similar conditions associated with a difficult pregnancy but not considered a classifiable, distinct complication of pregnancy.

Covered Illness A physical or mental disease or disorder including pregnancy and Complications of Pregnancy, that results in a Covered Loss. A Covered Illness includes medically-necessary quarantine in a Hospital in conjunction with medically-necessary preventive treatment due to an identifiable exposure to a life-threatening contagious and infectious disease.

Covered Injury Any bodily harm that results directly from a Covered Loss.

Covered Loss A loss that is:

1. specified in the *Schedule of Benefits*.
2. suffered by the Covered Person within the applicable time period specified in the *Schedule of Benefits.*

Covered Person An eligible person, as defined in the *Schedule of Benefits*, who is enrolled and has been accepted by Us, required premium has been paid when due and coverage under this Policy remains in force.

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; or
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; or
3. stepchild who resides with the Employee and is financially dependent upon the Employee; or
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.

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.

Elimination Period The continuous period of time that must be satisfied before a benefit shown in the *Schedule of Benefits* is payable. An Elimination Period may be satisfied during the Policy's Benefit Waiting Period.

Emergency Room A designated area in a Hospital that is supervised by Physicians and equipped and staffed to render immediate medical attention on an outpatient basis, 24 hours a day, 7 days a week for the sudden onset of symptoms related to a Covered Injury or Covered Illness. An Emergency Room is not a clinic, an Urgent Care Facility or Physician's office.

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.

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

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 temporary suspension or alteration of Active Service without a separation from employment, initiated by the Employer for a period of time specified in advance not to exceed 12 weeks at a time.

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

Hospice Care Care provided at a designated facility by licensed health care professionals primarily engaged in providing medical services, emotional support, and spiritual resources for people who are in the last stages of a terminal illness.

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.); and
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 or facility for:

1. Rehabilitation, convalescent, custodial, educational, hospice, or skilled nursing care;
2. The aged, drug addiction or alcoholism; or
3. A facility primarily or solely providing psychiatric services to mentally ill patients.

The term Hospital also does not include a unit of a Hospital for rehabilitation, convalescent, custodial, educational, hospice, or skilled nursing care.

Illness A physical or mental disease or disorder including pregnancy. An illness includes medically-necessary quarantine in a Hospital in conjunction with medically-necessary

preventive treatment due to an identifiable exposure to a life-threatening contagious and infectious disease.

Initial Open Enrollment Period — The period during a calendar year 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. This period must be agreed upon by the Employer and Us.

Injury — Any accidental loss or bodily harm.

Inpatient — A Covered Person who is 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.

Insurability Requirement — 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.

Intensive Care Unit (ICU) — A designated area of a hospital that:

1. is for the treatment of patients who are in acute or critical condition;
2. is furnished with emergency life-saving equipment and supplies that are immediately at hand;
3. is staffed 24 hours a day by Nurses who are specially trained to work in an intensive care unit;
4. is equipped and staffed to monitor each patient's vital signs around-the-clock; and
5. is not a recovery room or an area used primarily for post-operative or post-anesthesia care.

An Intensive Care Unit includes a critical care or cardiac care unit.

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.

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.

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.

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.

Spouse

The Employee's current lawful spouse who is at least Age 18 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.

Subscriber

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

Temporary Layoff

A temporary suspension of Active Service with a separation from employment, for a period of time determined in advance by the Employer, other than a Furlough. 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.

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 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. An eligible person may be insured only once as of any given date under the Policy as a Covered Person, even though He may be eligible under more than one class of insureds.

LIMITATIONS ON MULTIPLE ELIGIBILITY
A Covered Person may be insured only once as of any given date under the Policy as a Covered Person, even though He 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 eligible Employee may apply for coverage, subject to the *Deferred Effective Date Provisions* section of this Policy, for Himself or any eligible Spouse or Dependent Child or to increase coverage for any Covered Person under this Policy during the Initial Open Enrollment Period as agreed to by Us and the Subscriber.

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 Policy.

Current Insureds

Subject to the *Deferred Effective Date Provisions*, an eligible Employee 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 *Policy.*

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

During the Initial Open Enrollment Period, an Employee and His eligible Spouse or Dependent Child may become insured under the coverage provided by this Policy without satisfying any Evidence of Insurability.

Any Employee who is not in Active Service on the date His coverage would otherwise become effective under this Policy may not become covered under this Policy until He returns to Active Service.

If an Employee's eligible dependent is not in Active Service on the date the coverage would otherwise be effective, it will be effective on the date the dependent returns to Active Status.

EFFECTIVE DATE PROVISIONS

SUBSCRIBER EFFECTIVE DATE

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. 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 insurance 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

ANNUAL RE-ENROLLMENT AND LIFE STATUS CHANGE

An Annual Re-Enrollment is a period of time once per year, no more than twice per year as agreed to by Us and the Subscriber when an Employee can apply for coverage or to increase coverage on Himself, Spouse or Dependent Child under this Policy.

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. 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. as specified in the Employer's Plan which this Policy insures.

ANNUAL RE-ENROLLMENT

An Employee who is eligible to apply, but did not previously enroll, may apply or is insured may apply for an increase for coverage. Changes to coverage for an Employee who applies during the enrollment period and agrees to make required contributions 31 days after enrollment period ends are as follows:

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.

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.

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

Coverage 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.

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.

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 Hospital Indemnity 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. 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, 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, 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.

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. A Elimination Period would not apply to the Covered Loss if the Prior Plan had not ended;
4. The Covered Loss begins 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 gross benefit under the Prior Plan and any applicable maximums; and (2) those provided by this Policy, including Optional Benefits. If benefits are payable under the Prior Plan for a Covered Loss confinement, then 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.
9. the date that the plan of benefits under which the Covered Person is covered is terminated.

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

CONTINUATION OF INSURANCE 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 terminate and Continuation of Insurance 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* for Furlough. 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* for Temporary Layoff. 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 or Subscriber's participation under this Policy ends, for an Employee for whom all eligibility ends under this Policy 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*;
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*;
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 insurance 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 applied and 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 that 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;
6. the date the Spouse or Dependent no longer meets the definition of Spouse or Dependent Child.

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COMMON EXCLUSIONS

In addition to any benefit-specific exclusions, benefits will not be paid for any Covered Injury or Covered Illness which is caused by or results from any of the following unless coverage is specifically provided for by name in the *Description of Coverage 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 Injury or Covered Illness 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 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.
7. elective or cosmetic surgery. This does not include reconstructive, cosmetic surgery: a) incidental to or following surgery for trauma, infection or other disease of the involved part; or b) due to congenital disease or anomaly of a Covered Dependent child which has resulted in a functional defect.
8. dental surgery, unless the surgery is the result of an accidental injury;
9. services or treatment rendered by a Physician, Nurse or any other person who is:
    a. employed or retained by the Subscriber;
    b. providing homeopathic, aroma-therapeutic or herbal therapeutic services
    c. living in the Covered Person's household;
    d. a parent, sibling, spouse or child of the Covered Person.

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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 your 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 You, Your Spouse and Dependent Child 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 You or the Covered Person dies, We may recover the overpayment from Your or the Covered Person's estate.

GHIP1.2-CE1600.00

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 insurance in effect.

PAYMENT OF PREMIUM
Covered Person
You, Your Spouse and Dependent Child 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 You, Your Spouse and Dependent Child under the *Continuation of Insurance Provisions* section of the Policy. Premium shall be due monthly, unless You, Your Spouse and Dependent Child 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. Your, Your Spouse and Dependent Child'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 Your Active Service ended due to an approved leave pursuant to the Family and Medical Leave Act (FMLA) and Continuation of Insurance is not applicable, Your coverage may be reinstated at the conclusion of the FMLA leave.

If Your 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 insurance ends; or
2. when returning from military service pursuant to the Uniformed Services Employment Act of 1994 (USERRA).

If Your 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. You 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 You return to Active Service. If Your coverage ended due to an approved unpaid leave of absence or Temporary Layoff, credit will be given for any time that was satisfied.

GHIP1.2-CE1700.00

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.

MISSTATEMENT OF AGE OR SEX
If the Covered Person's age or sex has been misstated, the benefits payable under this Policy will be reduced under the Payment of Claims provision of the Policy.

CERTIFICATES
Where required by law, We will provide a Certificate for delivery by the Subscriber 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.

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 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 insurance.

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 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 Injury or Covered Illness that is the result, directly of a Covered Loss that occurs while coverage was in effect.

AGENCY
The Employer is acting as an agent of the Employee for transactions relating to insurance under the Policy. The actions of the Subscriber shall not be considered the actions of the Insurance Company, 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;
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.

GHIP1.2-CE1800.00

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

MODIFYING PROVISIONS AMENDMENT

Subscriber: Megalodon Midco LLC Policy No.: HC111442

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, exclusions 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) A minimum benefit of $50 per day for Hospital Stay benefits will be payable.

2) Under the *General Definitions* section, the definition of Spouse has been 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.

3) The *Claim Provisions* section, the Recovery of Overpayment provision has been modified as follows:

We have the right, upon 30 days written notice and within 365 days of the overpayment, to recover from the Covered Person or the recipient of benefits any amount that We determine to be an overpayment. The Covered Person or the recipient of benefits has the obligation to refund to Us any such amount. If benefits are overpaid on any claim, the Covered Person or the recipient of benefits must either reimburse Us within 90 days or notify us in writing that the Covered Person wishes to challenge the recovery of an overpayment. If the Covered Person challenges the recovery of an overpayment, We will notify the Covered Person in writing of our final decision within 30 days of receipt of the Covered Person's written challenge. If reimbursement is not made in a timely manner, We have the right to:

1. recover such overpayments from the Covered Person, any other person to or for whom payment was made, or the Covered Person's estate;
2. reduce or offset against any future benefits payable to the Covered Person or the Covered Person's survivors until full reimbursement is made;
3. refer the unpaid balance to a collection agency; and

4. pursue and enforce all legal and equitable rights in court.

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

Arkansas residents:

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

a) The word "external" is removed from the definition of Covered Accident.

b) Items 2 of the second paragraph of the definition of Dependent Child is 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 *Claim Provisions* section, the first sentence of the *Time 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 immediately upon Our receipt of due written or authorized electronic proof of such loss.

4) Under the General Provisions section, the Incontestability provision is revised under A Covered Person's Insurance to state a copy of the instrument containing the statement must also be furnished to the Covered Person.

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;

2) Under the *Term Life Insurance Rider,* the following changes are made:

a) Whose Insurance May Be Converted section is replaced with the following:

Each Covered Person's insurance or any portion of it may be converted if it ends for any of the following reasons:
1.employment or membership ends;
2.termination of membership in an eligible class under the Policy.

b) The Amount of Conversion Insurance section is replaced with the following:

The Covered Person may apply for an amount of insurance that is not greater than the coverage amount terminating under the Policy; or

Apply for more than $10,000 of insurance if the Policy is terminated or amended to terminate the insurance for any class of Insureds, or the Employer cancels participation under the Policy.

Conversion in these cases is only permitted if you have been covered by the Policy or, any group life insurance policy issued to the Employer which the Policy replaced, for at least 3 years.

Idaho residents:

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

a) Tier 1 benefits are not available. Tier 2 benefits will always be paid.

b) The Benefit Waiting Period does not apply.

c) The Maximum Benefit Period for the Hospital Stay will not be less than 31 days and will not exceed 180 days

d) The Maximum Benefit Period for the ICU Stay will not be less than 31 days and will not exceed 180 days

e) The Maximum Benefit Period for the Newborn Nursery Care Stay Benefits will not be less than 31 days and will not exceed 180 days

f) The Maximum Benefit for Skilled Nursing Stay Benefits will not be less than 31 days.

g) The Maximum Benefit for Mental Illness and Nervous Disorder Facility Care will not be less than 31 days.

h) The Maximum Benefit for Substance Abuse Facility Care will not be less than 31 days.

i) Elimination Periods will not apply. Under the Hospital Observation Stay Benefit, the Elimination Period is referred to as the Observation Period.

2) Under the Definitions section the following changes are made:

a) The definition of Congenital Anomaly has been 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 in the United States at the time the diagnosis is made.

b) The definition of Dependent Child has been 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, , 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 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 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.

c) Under the definition of Spouse the following sentence is removed:

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.

d) Under the definition of Complications of Pregnancy, the second paragraph is replaced with the following:

Examples include: acute nephritis; nephrosis; cardiac decompensation; missed abortion; and similar conditions of comparable severity caesarean section; ectopic pregnancy which is terminated; and spontaneous termination of pregnancy which occurs during a period of gestation when a viable birth is not possible.

e) The definition of Aircraft is removed.

3) Under the *Effective Date Provision* section, the follow changes have been made:

a) The following has been added to the Effective Date for Individuals provision:

In this Effective Date for Individuals provision, references to an Employee applying for coverage for a Spouse or Dependent Child, do not apply before the end of a 60-day period that begins on the date of marriage, birth or placement for adoption, as applicable.

b) The following has been added to the Effective Date for Individuals provision:

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 plan member, of a billing for the required premium.

4) Under the *Common Exclusions* section, the following changes are made:

a) Modify the following exclusions as shown:
- active participation in a felony, riot or insurrection
- Elective or cosmetic surgery. This does not include reconstructive, cosmetic surgery: a) incidental to or following surgery for trauma, infection or other disease of the involved part; or b) due to congenital disease or Congenital Anomaly of a Covered Dependent child.

b) Remove the following exclusions:
- 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.

5) Under *Administrative Provision* section, the following changes have been made:

a) Add the following *Refund of Unearned Premium* provision:

Refund of Unearned Premium
If the Subscribercancels 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.

6) The following Rider form(s) is/are not available:
ACCIDENTAL DEATH AND DISMEMBERMENT RIDER
CRITICAL ILLNESS INSURANCEA RIDER
DISABILITY INCOME RIDER
TERM LIFE INSURANCE RIDER
WELLNESS TREATMENT, HEALTH SCREENING AND PREVENTIVE CARE BENEFIT RIDER

Indiana residents:

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

a) The Notice of Claim must be received within 90 days after a Covered Loss occurs or begins.

b) The following language added to the Payment of Claims Provision:

Indemnities payable under this Policy for any loss other than loss for which this policy provides any periodic payment will be paid immediately upon receipt of due written proof of such loss. If We are unable to immediately pay due to deficiencies in Your claim, We will notify You within 30 days if Your claim was filed electronically or within 45 days if Your claim was filed on paper of those deficiencies and how they can be remedied. Our failure to notify You of any deficiencies within the stated time frames will establish the submitted claim as a clean claim. We will pay or deny a clean claim:

1. If filed electronically, within 30 days after the date We receive the claim;
2. If the claim is filed on paper, within 45 days after the date We receive the claim.

Louisiana residents:

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

2) Under the *Hospital Observation Stay Benefit* section, cannot require a charge be incurred for benefits to be payable.

3) Under the *Description of Benefits* section, the following benefit condition does not apply to the Substance Abuse Facility
Care Benefit:

- The facility charges room and board for treatment services; and

4) 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 Dependent Child definition is replaced by the following:

An Employee's child who meets the following requirements:
1. A 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 first paragraph of the Hospital definition is replaced by the following:

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.); and
5. It has medical, diagnostic and treatment facilities, with major surgical facilities on its premises, or available to it on a prearranged basis.

d) The following Physical Therapy definition has been added:

Physical Therapy Manipulation by physical and mechanical means including heat treatment or diathermy, ultrasonic, microtherm, manipulation, adjustment, massage therapy and acupuncture as performed by a licensed Physical Therapist, licensed chiropractor or licensed podiatrist.

5) Under the *Administrative Provisions* section, the first paragraph of the Changes in Premium Rates provision is updated as follows:

Changes in Premium Rates:
The premium rates may be changed by Us from time to time with at least 31 days advance written notice, and 45 days advance written notice for rates increase of 20% or more. No change in rates will be made until 24 months after the Effective Date. An increase in rates will not be made more often than once in a 12 month period. However, We reserve the right to change the rates even during a period for which the rate is guaranteed, if any of the following events take place:

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

a) Under the Incontestability provision, the time limit changed from two years to three years and removal of fraud as shown below:

<u>This Policy or Participation Under This Policy</u>

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

A Covered Person's Insurance
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 lack of eligibility for coverage.

b) The Policy Termination provision is replaced by 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 notice 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 coverage at the end of the period for which premium was paid

7) The following Rider form(s) is/are not available:
TERM LIFE INSURANCE RIDER

Maine residents:

1) Under the *Schedule of Benefits,* the Hospital Stay, Hospital Intensive Care Unit Stay and Newborn Nursery Care Stay Maximum Benefit Period will not be less than 31 days.

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

a) The Dependent Child definition is replaced by 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 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;
3. stepchild;
4. child for whom the Employee is the court-appointed legal guardian;
5. a child of the Employee's domestic partner /Partner to a Civil Union.

b) The Covered Accident definition is replaced with the following:

An accidental bodily injury sustained by the Covered Person that is the direct cause of the condition for which benefits are provided and that occurs while the insurance is in force.

3) The *Extension of Benefits* section is added:

Extension of Benefits
If coverage ends while a Covered Person is confined to a Hospital as an Inpatient as the result of a Covered Accident, We will continue to pay benefits for confinement that become payable after the date coverage otherwise ends if the Covered Person meets the following requirements:
1. the confinement must be continuous after the date of termination; and
2. coverage must not have ended as a result of the Covered Person's voluntary termination of coverage.

This Extension of Benefits terminates upon the earliest of the following:

1. the date the Covered Person is no longer confined to a Hospital as an Inpatient;
2. the date the Covered Person receives the maximum benefit for Hospital Stay; or
3. six (6) months following the effective date of discontinuance.

If coverage ends and it is subsequently determined that the Covered Person was Totally Disabled on the date the group Policy is discontinued, We will provide an extension of the Benefits available under the coverage for 6 months where the Benefits are directly related to the condition causing Total Disability.

4) Under the *Claims Provisions*, the first sentence under the Time of Payment of Claims provisions 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.

5) Under the *Administrative Provisions* section, the Third Party Notice of Cancellation provision is added:

Third Party Notice of Cancellation
You have the right:
1. to designate a third party to receive notice of cancellation of Your Certificate;
2. to change such designation; and
3. of Certificate reinstatement, if You suffer from Cognitive Impairment or Functional Incapacity and the grounds for cancellation was nonpayment of premium or other lapse or default on Your part.

We will send You a Third Party Notice Request Form. We will do this within 10 days of receiving Your request. Any time after completion of this form You may change this designation by written request.

After We have received Your completed Third Party Notice Request Form, at least 10 days prior to cancellation of Your Certificate, We will give notice of the pending cancellation to Your designated third party, if any, at the address You provided. This notice will give the reason for the cancellation. It will also give the date the Certificate is to end. Cancellation may be due to nonpayment of premium. If so, the notice will include the amount of unpaid premium and the date by which it must be paid. The cancellation may be due to some other lapse or default on Your part. If so, the notice will include an explanation of how to cure the default and the time You have to do this.

6) Under the *General Provisions* section, under Incontestability provision, the sentences referencing the time limit changed from two years to three years and reference to fraud removed as shown below:

<u>This Policy or Participation Under This Policy</u>
After three years from the Policy Effective Date, no such statement will cause this Policy to be contested except for lack of eligibility for coverage.

<u>A Covered Person's Insurance</u>
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 lack of eligibility for coverage.

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 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;

Massachusetts residents:

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

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 *Common Exclusions and Limitations* section, the following exclusions are revised:
   - intentionally self-inflicted Injury;
   - commission or attempt to commit a felony;
   - operating any type of vehicle while under the influence of alcohol or any drug or narcotic unless administered on the advice of a Physician and taken in accordance with the prescribed dosage 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;

Mississippi 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 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* section, the following changes apply:

   a) The Time of Payment of Claims provision is replaced by the following:

      All benefits payable under this Certificate for any loss, other than loss for which this policy provides any periodic payment, will be paid within twenty-five (25) days after receipt of due written proof of such loss in the form of a clean claim where claims are submitted electronically, and will be paid within thirty-five (35) days after receipt of

due written proof of such loss in the form of clean claim where claims are submitted in paper format. Benefits due under the policies and claims are overdue if not paid within twenty-five (25) days or thirty-five (35) days, whichever is applicable, after We receive a clean claim containing necessary medical information and other information essential for Us to administer preexisting condition, coordination of benefits, and subrogation provisions. A "clean claim" means a claim received by an Us for adjudication and which requires no further information, adjustment, or alteration by the provider of the services or any Insured in order to be processed and paid by Us. A claim is clean if it has no defect or impropriety, including any lack of substantiating documentation, or particular circumstance requiring special treatment that prevents timely payment from being made on the claim under this provision. A clean claim includes resubmitted claims with previously identified deficiencies corrected. Errors, such as system errors, attributable to Us, do not change the clean claim status. A clean claim does not include any of the following:

1. a duplicate claim, which means an original claim and its duplicate when the duplicate is filed within thirty (30) days of the original claim;
2. claims which are submitted fraudulently or that are based upon material misrepresentations;
3. claims that require information essential for Us to administer preexisting condition, coordination of benefits, or subrogation provisions; or
4. claims submitted by a provider more than thirty (30) days after the date of service; if the provider does not submit the claim on behalf of the Insured, then a claim is not clean when submitted more than thirty (30) days after the date of billing by the provider to the Insured.

Not later than twenty-five (25) days after the date We actually receive an electronic claim, We will pay the appropriate benefit in full, or any portion of the claim that is clean, and notify the provider (where the claim is owed to the provider) or the Insured (where the claim is owed to the Insured) of the reasons why the claim or portion thereof is not clean and will not be paid and what substantiating documentation and information is required to adjudicate the claim as clean. Not later than thirty-five (35) days after the date We actually receive a paper claim, We will pay the appropriate benefit in full, or any portion of the claim that is clean, and notify the provider (where the claim is owed to the provider) or the Insured (where the claim is owed to the Insured) of the reasons why the claim or portion thereof is not clean and will not be paid and what substantiating documentation and information is required to adjudicate the claim as clean. Any claim or portion thereof resubmitted with the supporting documentation and information requested by Us will be paid within twenty (20) days after receipt.

For purposes of this provision, the term "pay" means that We will either send cash or a cash equivalent by United States mail, or send cash or a cash equivalent by other means such as electronic transfer, in full satisfaction of the appropriate benefit due the provider (where the claim is owed to the provider) or the Insured (where the claim is owed to the Insured). To calculate the extent to which any benefits are overdue, payment shall be treated as made on the date a draft or other valid instrument was placed in the United States mail to the last known address of the provider (where the claim is owed to the provider) or the Insured (where the claim is owed to the Insured) in a properly addressed, postpaid envelope, or, if not so posted, or not sent by United States mail, on the date of delivery of payment to the provider or insured.

If the claim is not denied for valid and proper reasons by the end of the applicable time period prescribed in this provision, We will pay the provider (where the claim is owed to the provider) or the Insured (where the claim is owed to the Insured) interest on accrued benefits at the rate of three percent (3%) per month accruing from the day after payment was due on the amount of the benefits that remain unpaid until the claim is finally settled or adjudicated. Whenever interest due pursuant to this provision is less than One Dollar ($1.00), such amount shall be credited to the account of the person or entity to whom such amount is owed.

In the event We fail to pay benefits when due, the person entitled to such benefits may bring action to recover such benefits, any interest which may accrue as provided in subparagraph 3 of this paragraph (h) and any other damages as may be allowable by law. If it is determined in such action that We acted in bad faith as evidenced by a repeated or deliberate pattern of failing to pay benefits and/or claims when due, the person entitled to such benefits (health care provider or insured) shall be entitled to recover damages in an amount up to three (3) times the amount of the benefits that remain unpaid until the claim is finally settled or adjudicated.

b) Physician Examination and Autopsy is replaced by the following:

Physical Examination
While a claim is pending, We have the right at Our expense to have the Covered Person who has a loss examined by a Physician when and as often as We reasonably require.

3) Under the Administrative Provision section, the Change 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.

4) Under the *General Provisions* section, Misstatement of Age or Sex provision is replaced by the following:

Misstatement of Age
If the Covered Person's age has been misstated, the benefits payable under this Policy shall be as such as the premium paid would have purchased had such fact been correctly stated.

New Hampshire residents:

1) The *Schedule of Benefits* is modified as follows:

a) The Benefit Waiting Period will not apply.

b) The *Hospitalization Benefits* are revised as follows:

i) Elimination Periods do not apply.
ii) A $50 per day minimum benefit is payable even if Age Based Reductions apply.
iii) For Hospital Stay, Hospital Intensive Care Unit Stay and Newborn Nursery Care Stay, if included, up to 31 days of benefits are available.
iii) All references to "Treatment" are replaced with "Visit" for the Additional Inpatient and Outpatient Care Benefits.
iv) Prescription Drug Benefit will pay Generic and Mail Order at the Brand-Retail benefit amounts.

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

a) The definition of Covered Accident is revised to remove "external" event.

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 ho is under age 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 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 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 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 provided the child is living with, ,and is financially dependent upon the Employee.

c) Definition of *Hospital* is revised so that the first two paragraphs read as follows:

An institution that meets all of the following:

1. It is operated 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 Physicians;
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 shall include a Veteran's Administration Hospital or Federal Government Hospital, and the requirement that a patient must incur an expense as an Inpatient at such a facility shall be waived.

d) Definition of *Inpatient* also includes the following:

The requirement that a person be charged for room and board shall not apply to confinement in a Veteran's Administration Hospital or Federal Government Hospital and in such case, the term "Inpatient" shall mean a Covered Person who is required to be confined for a period of at least a full day as determined by the Hospital.

e) Definition of *Skilled Nursing* is revised to include the following:

The term "skilled nursing facility" includes swing bed, but only when the hospital or critical hospital has entered into a swing-bed agreement with the Department of Health and Human Services, under which the facility can "swing" its beds and provide either Skilled Nursing Facility care, as needed.

f) Definition of *Spouse* is revised so that the first sentence reads as follows:

The Employee's current lawful spouse.

3) Section C of The *Takeover Provision* section does not apply. Section C changed to B.

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

a) Modify the exclusions as shown:

- commission of a felony;
- a Covered Injury or Covered Illness that occurs while on 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) Remove the following exclusion:

- Pregnancy, including childbirth, occurring within the first 9 months of the Covered Person's effective date of coverage. This Exclusion does not apply to Complications of Pregnancy.

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

Pre-Existing Condition Limitation
We will not pay benefits for a Covered Injury or Covered Illness caused, contributed to by, or resulting from a Pre-existing Condition. The term "Pre-existing Condition" means any Illness 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 Injury or Covered Illness that occurs after the Covered Person is insured under this Policy for at least 6 continuous months after the Covered Person's most recent effective date of coverage, and effective date of any added or increased amount of coverage.

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

a) Proof of Loss must be given within 90 days or when reasonably possible. A one year maximum is not permitted.

b) The Recovery of Overpayment provision is revised as follows:

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

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

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

a) Under the Grace Period provision it is revised to state that All premiums due under the policy must be remitted by the employer of the persons insured, therefore optional language permitting payment of premium directly to the Us by the employee is not permitted.

b) The following provisions is added:

Policy Reinstatement
This Policy may be reinstated within 45 days of lapse if it lapsed for nonpayment of premium. Requirements for reinstatement are written application of the Policyholder satisfactory to Us and payment of all overdue premiums. Any premiums accepted in connection with a reinstatement will be applied to a period for which premium was not previously paid, but not to any period more than 60 days prior to the date of reinstatement.

c) The Payment of Premium provision is revised as follows:

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 *Portability 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.

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

a) The 30 Day Right to Examine Certificate is revised as follows:

The Certificate may, at any time within 30 days after its receipt by the certificate holder, be returned by delivering it or mailing it to the Company or the agent through whom it was purchased. Immediately upon such delivery or mailing, the Certificate will be deemed void from the beginning, and any premium paid on it will be refunded.

b) The Assignment provision is revised and includes the statement "The rights and benefits under this Policy may not be assigned to a healthcare provider".

c) The Incontestability provision the second paragraph under This Policy or Participation Under This Policy is replaced by the following:

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

d) The Policy Termination provision is revised to require a minimum of 45 days is required for notice of policy termination.

e) The following *Important Notice* must be included:

Important Notice
The Policyholder 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

8) The following is not available under the *Wellness Treatment and Health Screening Test Benefit and Preventative Care Rider*:

a) Preventative Care benefits are not available

9) Under the *Accidental Death and Dismemberment Rider*

a) For Employee, Spouse and children, the minimum benefit amount payable for Paralysis and Coma is $5,000 and $1,000 for dismemberment of finger or toe

b) The exclusions are modified as follows:
1. flight in, boarding or alighting from an Aircraft or any craft designed to fly above the Earth's surface:
a. except as a fare-paying passenger on a regularly scheduled commercial airline;
b. being flown by the Covered Person or in which the Covered Person is a member of the crew.

10) The *Domestic Partner/Civil Union Partner Coverage Amendment* is modified to include Domestic Partners who are 16 years of age.

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

CRITICAL ILLNESS INSURANCE RIDER

North Carolina residents:

1) Under the *General Definitions* section, the definition of Dependent Child is replaced by 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, 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, foster child, beginning with any waiting period pending finalization of the child's adoption. It also means the legally adopted child or foster 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 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.

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

a) Modify the following exclusion:
- declared or undeclared war or act of war. This Exclusion does not apply to acts of terrorism;

b) Remove the following exclusion:
- dental surgery, unless the surgery is the result of an accidental injury.

3) 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 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) 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 immediately upon Our receipt of due written or authorized electronic proof of such loss.

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

a) Misstatement of Age or Sex provision is replaced with the following:

Misstatement of Age
If the Covered Person's age has been misstated, the benefits payable under this Policy shall be such as the premium paid would have purchased at the correct age.

b) The Termination provision is revised to require minimum notice of 45 days.

c) The Incontestability provision is revised so fraud cannot be a reason to contest the coverage after 2 years.

5) Under the *Critical Illness Insurance Rider,* the Date of Diagnosis definition also included the following:

A Clinical Diagnosis that can only be made postmortem will also be accepted.

North Dakota residents:

1) Benefits are not available for Travel and Lodging.

2) The Benefit Waiting Period does not apply.

3) The Elimination Periods do not apply.

4) Under the Schedule of Benefits section:
   a) A minimum benefit of $50 per day for Hospital Stay and Hospital Intensive Care Unit Stay will be available for up to 10 days.
   b) the Elimination Period under the Observation Benefit is referred to as the Observation Period
   c) Tier 1 is not available. Tier 2 benefits will always be paid.

5) The Lifetime Maximum does not apply to Substance Abuse Facility Care or Mental Illness and Nervous Disorder Facility Care.

6) 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;

7) Under the *Description of Benefits* section, the following change is made to the Skilled Nursing Facility limitation #2

   If the Covered Person leaves the Skilled Nursing Facility and then returns within 180 days for the same or a related Covered Injury or Covered Illness, we will still count that as one period of confinement for purposes of the Maximum Benefit Periods. However, if the Covered Person is out of the Skilled Nursing Facility for at least 180 days and then returns for the same or a related Covered Injury or Covered Illness, we will count that as a different period of confinement.

8) Under the *Common Exclusions and Limitations* section, the following changes are made to the exclusions:

   a) Modify the following exclusion as shown:

      - commission or attempt to commit a felony;

   b) The following exclusion is removed:

      - dental surgery, unless the surgery is the result of an accidental injury;

9) Under the *Administrative Provisions* section, Effective Date of Reinstated Insurance is replaced by the following:

   Effective Date of Reinstated Insurance
   Reinstated coverage will be effective on the date the Employee returns to Active Service if satisfaction of the Insurability Requirement is not required. If the Insurability Requirement must be satisfied, the reinstated coverage will be effective as provided in the *Effective Date Provisions* section. If the Employee did not fully satisfy the Pre-Existing Condition Limitation (if any, as shown in the *Schedule of Benefits* and *Description of Coverages*) before coverage ended due to an approved unpaid leave of absence or Temporary Layoff, credit will be given for any time that was satisfied.

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

   a) The Misstatement of Age or Sex provision is replaced by the following:

      Misstatement of Age or Sex
      If the Covered Person's age or sex has been misstated, We will adjust all benefits to the amounts that would have been purchased for the correct age or sex.

b) The 30 Day Right to Examine Certificate provisions is replaced by the following:

10 Day Right To Examine Certificate
If a Covered Person does not like the Certificate for any reason, it may be returned to Us within 10 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.

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

ACCIDENTAL DEATH AND DISMEMBERMENT RIDER
DISABILITY INCOME RIDER
TERM LIFE INSURANCE RIDER

Oregon residents:

NOTICE: MUST PROVIDE DOMESTIC PARTNER COVERAGE FOR OREGON RESIDENTS

1) Under the *Schedule of Benefits* section, Tier 1 benefits are not available. Tier 2 benefits will always be paid.

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

ACCIDENTAL DEATH AND DISMEMBERMENT RIDER
CRITICAL ILLNESS INSURANCE RIDER
DISABILITY INCOME RIDER

3) 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 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* section, make the following changes:

a) 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 have an autopsy performed at Our expense, in case of death where it is not forbidden by law. The autopsy must be performed in South Carolina.

b) The Legal Action provision as 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 at all unless brought within six years after the time such written proof of loss is required to be furnished.

3) 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 applications 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.

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 *Description of Coverage and Benefits* section under the Hospital Intensive Care Unit ICU Stay Benefit, the Benefit Condition stating the person must be admitted on an Inpatient basis is removed.

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

a) The Inpatient definition is revised as follows:
A Covered Person who is formally admitted and confined to a Hospital or facility under a Physician's order.

b) The Physician definition is revised as follows:

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

The exclusion of treatment by family members does not apply in those areas in which the family member is the only Physician in the area and is acting within their scope of practice.

3) Under the *Common 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 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.

b) The following exclusion is modified as shown below:
- services or treatment rendered by a Physician, Nurse or any other person who is:
  a. employed or retained by Policyholder;
  b. providing homeopathic, aroma-therapeutic or herbal therapeutic services.

c. living in the Covered Person's household;
d. a parent, sibling, spouse or child of the Covered Person.

- Treatment by family members does apply in those areas in which the family member is the only Physician in the area and is acting within their scope of practice.

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

No benefit will be paid for a Covered Injury or Covered Sickness which is caused, contributed to by, or resulting from a Pre-existing Condition 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.

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

a) the Pre-Existing Condition Limitation is replaced with the following:

Coverage under this Rider is subject to a Pre-existing Condition Limitation.

No benefit will be paid for a Disability caused, or contributed to by, or resulting from a Pre-existing Condition 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.

b) The Exclusions are revised as follows:

Injuries or illnesses that occur in the workplace or during the course of any employment for pay, benefit, or profit.

5) Under the *Critical Illness Insurance Rider* the following changes are made:

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

Coverage under this Rider is subject to a Pre-existing Condition Limitation.

No benefit will be paid for a Covered Injury or Covered Illness caused, contributed to by, or resulting from a Pre-existing Condition 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 Illness 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 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.

b) The word "initial" is removed from Critical Illness Benefit and the benefit payment conditions.

c) 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 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.

Texas residents:

1) Benefits are not available for Skilled Nursing Facility.

2) Benefits are not available for any At-Home Care, Hospice Facility Care or Additional Inpatient and Outpatient Care Benefits except benefits will be available for Inpatient Surgery.

3) Under the Descriptions of Benefits section, if the Newborn Nursery Care Benefit(s) are included, the following Benefit Limitation is added to the Hospital Admission, Hospital Chronic Condition Admission, Hospital Stay and Hospital Intensive Care Unit (ICU) Stay benefits:

If a Covered Person is eligible for the Newborn Nursery Care Admission Benefit for the same Covered Injury or Covered Illness regardless of the date of service, this benefit will only be paid if it is the greater amount.

4) Under the *General Definitions* section, make the following changes:

a) Under the Age definition, item 3 is replaced with the following:
3. For the purposes of Portability, except as to premium calculations, Extension of Benefits, Waiver of Premium Continuation due to Disability a Covered Person's Age is His Age as of His last birthday.

b) Under the Complications of Pregnancy definition:

i) Item 2 is replaced with the following:

2. whose diagnosis is distinct from pregnancy but is or caused by pregnancy.

ii) The last paragraph is replaced with the following:
Complications of pregnancy do not include: false labor; occasional spotting; physician prescribed rest during pregnancy; morning sickness; and similar conditions associated with a difficult pregnancy but not considered a classifiable, distinct complication of pregnancy.

c) 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 any waiting period pending finalization of the child's 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, including where the Spouse or Domestic Partner/Partner to a Civil Union is a party to a suit in which He seeks to adopt the child;
3. stepchild;
4. a 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 stepparent, 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.

d) Under the definition of Illness, the first sentence is replaced with the following:

   A physical or mental disease or disorder including complications of pregnancy.

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

   A licensed graduate registered Nurse (R.N.), a licensed practical Nurse (L.P.N.), or a licensed vocational Nurse (L.V.N.).

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

   The Employee's current lawful spouse who is at least Age 18 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.

5) Under the Eligibility section, 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.

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

Extension of Benefits
If the Policy terminates while a Covered Person is Totally Disabled as the result of a Covered Injury or Illness, We will continue to pay benefits for that Covered Person until the earliest of:
1. 90 days after the Policy terminates; or
2. the date the Covered Person is no longer Totally Disabled.

7) Under the *Claim Provisions* section, make the following changes:

a) The Claim Forms provision is replaced with the following:

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

b) 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.

c) The Time of Payment of Claims provisions are 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 the right of the claimant to the Policy proceeds. 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.

If payment is delayed beyond the time period after receiving satisfactory proof of loss, We will be liable to pay the insured or the beneficiary making the claim under the policy, in addition to the amount of the claim, interest on the amount of the claim at the rate of 18 percent a year as damages, together with reasonable attorney's fees.

8) 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:
   is a possessory conservator of the child under a court order issued in this state; or
   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.

9) Under the *General Provisions* section, make the following changes:

a) The Misstatement of Age or Sex provision is replaced with the following:

Misstatement of Age or Sex
If the Covered Person's age or sex has been misstated, the premiums due and benefits payable under this Policy will be adjusted to conform to the correct age and/or sex.

b) 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.

c) 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/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 written instrument containing the statement is, or has been, furnished to the Policyholder/Subscriber.

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

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 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 personal representative shall be given a copy.

d) Under the Policy Termination provision, the second paragraph is replaced with the following:

Termination will not affect a claim for a Covered Injury or Covered Illness that is the result, directly and independently of all other causes, of a Covered 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 any specific indemnity required to be provided during a period of Hospital confinement.

Utah residents:

1) Portability is always included. The Maximum Port Age does not apply.

2) Throughout the contract wherever there is reference to Physician, it also includes healthcare provider acting within the scope of their license.

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

a) A minimum benefit of $50 per day for Hospital Stay benefits will be payable.

b) The Benefit Waiting Period does not apply.

c) the Elimination Periods do not apply to the Hospitalization Benefits and Additional Medical Facility and Home Care Benefits are revised to remove the Elimination Period and Observation Period.

4) Under the *Description of Coverages and Benefits* section the following changes are made:

a) The Hospital Stay and Hospital Intensive Care Unit Benefit Limitations which specifies the number of days in which a return to the hospital will be considered the same stay is revised as follows:

If the Covered Person leaves the Hospital and then returns within 180 days for the same or a related Covered Accident, We will still count that as one Hospital Stay. However, if the Covered Person is out of the Hospital for at least 180 days and then returns for the same or a related Covered Accident, We will count that as a different Hospital Stay.

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

a) The definition of Active Service is revised:

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, 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 other than an Employee is not considered in Active Service if He is:
1. receiving Hospice Care.

b) The definition of Dependent Child is revised:

An Employee's unmarried child who meets the following requirements:
1. A newborn child from the moment of birth to 26 years old;
2. A child who is 26 or more years old, primarily dependent on the Employee for support and maintenance and incapable of self-sustaining employment by reason of mental or physical impairment.

A child, for purposes of this provision, includes an Employee's:
1. natural child;
2. adopted child, beginning from the moment of birth, if placement for adoption occurs within 30 days of the child's birth, or beginning from the date of placement, if placement for adoption occurs more than 30 days after the child's birth. "Placement for adoption" means the assumption and retention by a person of a legal obligation or total or partial support of a child in anticipation of the adoption of the child. It also means the legally adopted child of the Employee's Spouse or Domestic Partner/Partner to a Civil Union;
3. Child for whom the Employee is required by a court order or administrative order to provide health insurance coverage for a child regardless of whether it is the custodial or non-custodial parent;
4. stepchild;
5. child for whom the Employee is the court-appointed legal guardian;
6. a child of the Employee's domestic partner /Partner to a Civil Union.

c) The definition of Nurse is revised:

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 Policyholder/Subscriber;
2. a parent, sibling, spouse or child of the Covered Person.

d) The definition of Physician is revised:

A licensed medical, healthcare provider who is practicing within the scope of his license issued within the United States who is not:
1. employed or retained by the Policyholder/Subscriber;
2. a parent, sibling, spouse or child of the Covered Person.

e) The definition of Spouse is revised:

The Employee's current lawful spouse who is at least Age 18 but under Age 100 on the coverage effective date. Except for purposes of determining initial eligibility, the term includes a Spouse who is widowed, divorced, legally separated from, or annulled 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.

f) The definition of Complications of Pregnancy is revised to add pre-eclampsia as an example.

g) The 1st sentence of the definition of Hospital is revised as follows: "A facility that is licensed and operating within the scope of such license" and the following is added:

The term Hospital shall include a Veteran's Administration Hospital or Federal Government Hospital, and the requirement that a patient must incur an expense as an Inpatient at such a facility shall be waived.

6) The *Termination of Insurance* section is revised as follows:

a) The following does not apply:
- for a Spouse, the date the Spouse reaches age 100;
- 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;

b) The following has been revised as shown:
- for a Dependent Child, the first day of the month following 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 impairment or otherwise ceases to meet the definition of a Dependent Child;

7) The *Extension of Benefits and Waiver of Premium Provision* section is revised as follows:

a) The 1st paragraph of the Extension of Benefits is revised as follows:

If an Employee's Active Service ends due to a Disability, and the Employee becomes Disabled while less than age 60, coverage for the Hospital Indemnity Benefits shown in the *Schedule of Benefits* will be extended without premium payment when the Employee submits satisfactory proof that He has been continuously Disabled for the Extension Elimination Period shown in the *Schedule of Benefits* until the earlier of the following dates:
1. the date the Employee is no longer Disabled;
2. 12 months after the end of Active Service; or
3. the date the Policy terminates.

b) The *Waiver of Premium* section, the Termination of Waiver provision is revised as follows:

i) The following does not apply:

The date He refuses to participate in a Rehabilitation plan for which We determine him or her to be eligible;

ii) The definition of Disability is revised as follows:

"Disability/Disabled" means because of Injury or Illness an Employee is unable to perform the material duties of his or her Regular Occupation, or is receiving disability benefits under the Employer's plan, during the initial 12 months of continuous Disability. Thereafter, the Employee must be continuously unable to engage in

employment or occupation for which He may reasonably become qualified based on education, training or experience.

iii) The following have been added:
Failure to submit satisfactory proof of Disability or continued Disability within the time periods specified above does not invalidate the claim if the Employee can show that it was not reasonably possible to submit such proof within the prescribed time limit.

8) The *Portability section* is revised as follows:

Coverage provided by this Policy is portable for an Employee for whom all eligibility ends under this Policy as shown in the *Schedule of Benefits* and satisfies all of the conditions below.

WHOSE INSURANCE IS PORTABLE
A covered Employee who applies and agrees to pay required premiums within 60 days of the loss of eligibility of coverage 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 who applies and agrees to pay required premiums within 60 days of the loss of eligibility of coverage may remain covered under a Certificate issued to Him while this Policy remains in force for the Portable Period shown in the *Schedule of Benefits*.

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

A covered Dependent Child who:
1. has been covered under the Employee's or Spouse's Certificate that remains in force; and
2. applies and agrees to pay required premiums within 60 days of the loss of eligibility of coverage, may remain covered under a Certificate issued to Him while this Policy remains in force for the Portable Period shown in the *Schedule of Benefits*.

A Policyholder must provide an Employee who is (a) current on His premium payment for ported insurance, or (b) eligible to elect portable insurance during the Grace Period, the opportunity to make changes to their ported coverage benefits, subject to the options made available by the Policyholder, if such opportunity is available to regular Employees during an Annual Enrollment Period.

PORTED INSURANCE PREMIUM
The premium for portable insurance may not exceed 102% of the group rate in effect for a group member, including a Policyholder's contribution, if any, for a group insurance policy. We may not charge an Employee an additional fee, an additional premium, interest, or any similar charge for electing portable insurance.

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 age, retirement, or a change in class.

EFFECTIVE DATE OF PORTED INSURANCE
Ported insurance 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 applied and agreed to pay required premiums within 60 days of the date, He would otherwise have ceased to be eligible. The Covered Person need not show Us that 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 Employee's ported coverage terminates;
4. for a Dependent Child, the first day of the month following 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 impairment or ceases to quality as a Dependent Child;
5. the date the Spouse no longer meets the definition of Spouse;
6. the date the Covered Person is considered to reside outside the United States. The Covered Person will be considered to reside outside the United States when the Covered Person has been outside the United States for a total period of 4 months during any 4 consecutive months.

9) Under the *Common 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 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.

b) The following exclusion is modified as shown below:

- voluntary commission or attempt to commit a felony;
- voluntary participant in the commission of or active participation in riot, insurrection, rebellion or unlawful police action;
- services or treatment rendered by a Physician, Nurse or any other person who is:
  a) employed or retained by the Policyholder/Subscriber;
  b) providing homeopathic, aroma-therapeutic or herbal therapeutic services;
  c) a parent, sibling, spouse or child of the Covered Person;

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

a) The Proof of Loss provision is revised as follows:

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 a claim is or could have been 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 if it is shown that such notice was given as soon as was reasonably possible. Failure to give notice or file proof of loss as required by the provision does not bar recovery under the Policy if the Insurer fails to show it was prejudiced by failure.

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 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. 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 10% per annum on all benefits due and unpaid.

c) The Payment of Claims provision is revised to not permit reduction of benefits by outstanding premium due as well as paying $1,000 to a relative.

d) The Recovery of Overpayment the first sentence is revised as follows:

If benefits are overpaid, We have the right to recover the amount overpaid by either of the following methods, due to fraud, or within 12 months of the overpayment for any other reason.

e) The following Grievance Procedure is added:

Grievance Procedure
When a claim is denied, the claimant will receive a written statement containing the exact reason(s) for the claim denial.

If the claimant wishes to contest Our decision, He must contact the Appeals Department and inform Us, orally or in writing, that He wishes to contest Our decision. If the decision is upheld, the claimant has the right to a second level appeal review. The Appeals Department contact information is:

Cigna Supplemental Health Solutions
PO Box 22000
Chattanooga, TN 37421-9702
Cigna-Supplemental-benefit-appeals@cigna.com
Fax: 866-304-4326

Appeal determination will be made in writing no later than 30 calendar days after Our receipt of the written request unless We need more time to obtain additional information to make a determination. If more time is needed to obtain the additional information, We may extend Our response time an additional 30 days. However, this response time may be suspended while We are waiting for additional information requested from the claimant as permitted under Our grievance procedures. We will keep the claimant regularly advised of the status of Our response to the complaint.

Throughout this procedure and at any time during this procedure the claimant may, by written request, appoint another person to act as His agent or representative.

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

a) The Change in Premium Rates provision is revised so that the first two sentences read as follows:

No change in rates will be made until 24 months after the Effective Date. The premium rates may be changed by Us with at least 31 days advance written notice. Item # 5 our right to change premium under the events during a rate guarantee period if "Other changes occur in the nature of the risk that would affect our original risk assessment" is removed.

b) A refund of Unearned Premium is 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.

c) The Grace Period provision is revised as follows:

Policy
A Policy Grace Period of 31 days will be granted for payment of required premiums under this Policy. This Policy will be in force during the Policy Grace Period. The Policyholder is liable to Us for any unpaid premium for the time this Policy was in force. If the premium is not paid before the grace period ends, the coverage provided by this policy will terminate as of the last day of the 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. If the premium is not paid before the grace period ends, the coverage provided by this policy will terminate as of the last day of the grace period.

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

a) The Incontestability provision is revised as follows:

This Policy or Participation Under This Policy
All statements made by the Policyholder/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 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/Subscriber.

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 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.

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

b) The Policy Termination provision is revised as follows:

We may terminate coverage on or after the first anniversary of the Policy Effective Date. We or the Policyholder may terminate coverage on any renewal date. Written notice must be given at least 90 days prior to such renewal date. Failure by the Policyholder to pay premiums when due or within the Grace Period shall be deemed notice to Us to terminate coverage as of the last day of the Grace Period. The Policyholder is obligated to give 30 days prior written notice of termination to each Covered Person and to notify each Covered Person of their rights to continue coverage upon termination.

13) Under the *Optional Riders,* the Portability Provision is revised to read as follows:

Coverage under this Rider is portable.

14) Under the *Critical Illness Insurance Rider* the following changes are made:

a) The date of diagnosis for Amyotrophic Lateral Sclerosis, Blindness, Loss of Hearing, Multiple Sclerosis, Myasthenia Gravis and Parkinson's Disease is revised to state that diagnosis must be made by a health care provider.

b) The felony and riot exclusions are revised to add "voluntary" commission.

c) The Pre-Existing Condition Limitation Period can't exceed 6 months/6 months.

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

a) The following Elimination Period definition is added:

Elimination Period
The continuous period of time that must be satisfied before a benefit shown in the *Schedule of Benefits* is payable.

16) Under the *Amendatory Rider for Domestic Partner /Civil Union Partner Coverage* the following does not apply:

A child of a Domestic Partner/Civil Union Partner may only be eligible to be insured 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.

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

TERM LIFE INSURANCE RIDER

Vermont residents:

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

a) Portability provision has been removed from this schedule and has been replaced with the Continuation for Loss of Eligibility.

The following Continuation for 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

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

a) 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 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 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.

b) The Hospital definition is replaced with the following:

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.); and
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 rehabilitation, convalescent, custodial, educational, hospice, or skilled nursing care.

**As a result, a clinic, facility, or unit of a Hospital for the aged, drug addicts or alcoholics; and a facility primarily or solely providing psychiatric services to mentally ill patients will be treated as any other Hospital Admission or Hospital Stay.*

c) The Injury definition is replaced with the following:

Accidental bodily injury sustained by the insured person and directly caused by an accident which is not the result of disease or bodily infirmity.

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

a) Add the following two paragraphs under Spouse and Dependent Children:

Newborn Child(ren)
Coverage for a newly born child shall be provided without notice or additional premium for no less than 60 days after the date of birth.

Adopted Child(ren)
Coverage for a child under 18 due to adoption or placement of adoption for adoption of the child shall be provided as of the date of the adoption or placement for adoption. Placement for adoption means the assumption and retention by a person of a legal obligation for total or partial support of a child in anticipation of the adoption of the child. The child's placement with a person terminates the "placement of adoption" legal obligations.

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

For Continuation for Loss of Eligibility, the coverage on a Covered Person will end of the earliest date below due to a Qualifying Event:

The date the Covered Person is considered to reside outside of the United States. The Covered Person will be considered to reside outside the United States when the Covered Person has been outside the United States for a total period of 4 months or more during any 4 consecutive months.

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

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. Premiums are required for this coverage and are to be remitted in accordance with the *Payment of Premium* provision.

Continuation for Loss of Eligibility

If an Employee's coverage ends due to Loss of Eligibility from a qualifying event as defined in this section, coverage will continue up to the Maximum Benefit Period as shown in the *Schedule of Benefits*. The qualifying event means:

1. loss of employment, including a reduction in hours that results in ineligibility for employer-sponsored coverage;
2. divorce, dissolution, or legal separation of the covered employee from the employee's spouse or civil union partner;
3. a dependent child ceasing to qualify as a dependent child under the generally applicable requirements of the policy; or
4. death of the covered employee or member.

The Provisions of this section will not apply if

1. the deceased person or Employee was not insured under the group policy on the date of the qualifying event;
2. the person is covered by Medicare;
3. the person is covered by any other group insured or uninsured arrangement which provides dental coverage or hospital and medical coverage for individuals in a group and under which the person was not covered immediately prior to such qualifying event, and no preexisting condition exclusion applies.

6) Remove *Portability Provisions* section entirely.

7) Under the *Common Exclusions and Limitations* section, remove the following exclusion:

- voluntary ingestion of any narcotic, drug, poison, gas or fumes, unless prescribed or taken under the direction a Physician and taken in accordance with the prescribed dosage;
- Pregnancy, including childbirth, occurring within the first 9 months of the Covered Person's effective date of coverage. This Exclusion does not apply to Complications of Pregnancy.

8) Under the *Claims Provision* section, 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 or the Covered Person's religion forbids it.

9) Under the *General Provisions* section, the Incontestability provision is revised as follows:

<u>This Policy or Participation Under 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 three years from the Policy Effective Date, no such statement will cause this Policy to be contested except for fraud.

<u>A Covered Person's Insurance</u>

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.

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

a) The Death Benefit provision is replaced with the following:

We will pay the benefit shown in the Schedule of Benefits if a Covered Person dies. The death benefits will include interest from the date of death to the date of payment at a rate equal to the greater of 6% or the rate applicable to proceeds left on deposit with the insurer.

b) Remove the following sentence in the Whose Insurance May Be Converted provision:

The Covered Person must be under Age 70 to be eligible for a converted policy.

11) The *Critical Illness Rider* is modified to remove the following exclusion:

- 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.

Washington 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) Under the *Schedule of Benefits* the following changes are made:

a) A minimum benefit of $50 per day for Hospital Stay and Hospital Intensive Care Unit Stay will be available for up to 10 days.

b) Under the Hospitalization Benefits, the Hospital Intensive Care Unit Stay Additional ICU Admission benefit will not be payable, and Day 1 benefit will always pay at Day 2+ benefit levels.

3) Under the *Description of Coverage and Benefits* the Substance Abuse Facility Care Benefit Exclusions are revised as follows:

Exclusions The exclusions that apply to this benefit are in the *Common Exclusions* Section.

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 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.

5) 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.

6) Under the *Common Exclusions and Limitations* section 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.
- Pregnancy, including childbirth, occurring within the first 9 months of the Covered Person's effective date of coverage. This Exclusion does not apply to Complications of Pregnancy.

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

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

a) The Notice of Claim is replaced with the 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.

9) Under the *Administrative Provisions* section, the Effective Date of Reinstated Insurance is revised as follows:

Reinstated coverage will be effective on the date the Employee returns to Active Service. If the Employee did not fully satisfy the Eligibility Waiting Period, Benefit Waiting Period, or the Pre-Existing Condition Limitation (if any), as provided in the *Schedule of Benefits* before coverage ended due to an approved unpaid leave of absence, Temporary Layoff, credit will be given for any time that was satisfied.

10) Under the *General Provisions* section, the following is revised as follows:

a) The Misstatement of Age or Sex provision is replaced with the following:

Misstatement of Age or Sex
If the Covered Person's age or sex has been misstated, We will adjust all premiums and benefits to the amounts that would have been purchased for the correct age or sex.

b) The Incontestability, 1st paragraph is revised as follows:

<u>This Policy or Participation Under This Policy</u>
All statements made by the Policyholder/Subscriber to obtain this Policy or to participate under this Policy are considered representations and not warranties. A copy of the application, if any, is attached to the Policy when issued. 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/Subscriber

11) 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

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

ACCIDENTAL DEATH AND DISMEMBERMENT RIDER
DISABILITY INCOME RIDER
CRITICAL ILLNESS INSURANCE 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:

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;

2) Under the *Disability Income Rider,* the Pre-existing Condition Limitation is revised to include the following:

However, if the Covered Person discloses a Sickness on the enrollment form and coverage is issued without specifically excluding that Sickness, the Pre-existing Condition limitation does not apply to that Sickness.

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, Utah, 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

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, HC111442("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

02/2024