



**TRUIST FINANCIAL CORPORATION
EMPLOYEE BENEFIT PLAN**

Summary Plan Description

**Basic Term Life
Supplemental Dependent Life
Supplemental Term Life
Standalone Accidental Death & Dismemberment**

As of August 1, 2024

FOREWORD

Introduction

Truist Financial Corporation ("Truist") maintains the Life and Accidental Death and Dismemberment Insurance Plan ("Plan") for eligible employees.¹ The purpose of the Plan is to provide certain benefits to eligible employees as specified in this document.

Purpose of this Document

The Plan is an employee welfare benefit plan subject to certain requirements of the Employee Retirement Income Security Act of 1974 ("ERISA"), as amended. ERISA requires that you receive a Statement of ERISA Rights, a description of Claim Procedures, and other specific information about the Plan.

This document, together with the certificate of insurance booklet (the "Certificate of Insurance") issued by Insurance Company, is the Summary Plan Description ("SPD") for the Plan as of August 1, 2024.² The benefits described in this SPD are provided under a group insurance policy issued by the Insurance Company. The Insurance Company is designated and named the claims fiduciary for benefits provided under the Plan. Benefits under the Plan are described in the Certificate of Insurance, a copy of which is attached to this SPD as Appendix A.

We encourage plan participants to read this SPD carefully. If you have any questions regarding the information in the SPD, contact the Plan Administrator whose name and address are listed below. It is your responsibility to become familiar with the SPD (that is, this document and the attached Certificate of Insurance) and to ask questions if you do not understand how the requirements impact you.

REQUESTS FOR PLAN DOCUMENTS

Requests for plan documents must be in writing and sent to:

Chairman, Employee Benefits Committee
Truist Financial Corporation
214 N Tryon Street, 45th Floor
Charlotte NC 28202

Failure to send a written request to the address above will not constitute a request for plan documents.

¹ The Plan is a component benefit of the Truist Financial Corporation Employee Benefit Plan. This SPD should be read in conjunction with the SPD for the Truist Financial Corporation Employee Benefit Plan.

² This SPD only summarizes the provisions of the formal plan document and does not attempt to cover all of the details contained in the plan document. The operation of the Plan and the benefits to which you (or your beneficiaries) may be entitled will be governed solely by the terms of the official plan document. To the extent that any of the information contained in this SPD or any information you receive orally is inconsistent with the official plan document, the provisions set forth in the Plan document will govern. If you wish to review the Plan document, please contact the Plan Administrator.

ELIGIBILITY AND PARTICIPATION REQUIREMENTS

Except as provided otherwise in the attached Certificate of Insurance, you are eligible to participate in this Plan if you are an Employee of Truist Financial Corporation ("Truist") or a Participating Employer³ (collectively, "Employer") and are scheduled to work 20 or more hours per week. For more information regarding whether you are eligible to participate in the Plan and /or when coverage begins and ends, please read the eligibility information contained in the attached Booklet.

Employee means any common-law employee of an Employer who is paid by an Employer and is treated by an Employer as an Employee for federal payroll tax withholding purposes.

The term "Employee" does not include:

- 1) Any individual who is performing services for the Employer (i) under an independent contractor or consultant agreement or arrangement with the Employer; (ii) pursuant to an agreement between the Employer and a third party; or (iii) who is treated for payroll purposes as other than an Employee of the Employer even if a court, the Internal Revenue Service, or any other entity determines that such individual is a common law employee;
- 2) Any individual who performs services pursuant to a services agreement between an Employer and a staffing firm under which the staffing firm has agreed to provide medical coverage;
- 3) Any individual covered by a collective bargaining agreement that does not provide for coverage under the Plan, provided that the type of benefits provided under the Plan were the subject of good faith bargaining between the individual's bargaining representative and an Employer;
- 4) Any individual who is not defined as an Employee in a Program Document for that particular Benefit Plan;
- 5) Any individual who is categorized by any Employer as a temporary or contract employee.

If an individual is engaged in an independent contractor or similar capacity and is subsequently classified by an Employer, a governmental body, or the judiciary as an Employee, such person, for purposes of the Plan, shall be deemed to be an Employee from the actual (and not effective) date of such classification by Employer or the date as of which such classification by the governmental body or judiciary is final and not appealable.

³ Participating employers are listed below.

SUMMARY OF PLAN BENEFITS

A summary of the benefits provided under the Plan is set forth in the attached Certificate of Insurance.

Earnings under this Plan are based on your Benefits Annual Rate ("BAR"). The BAR reflects your total annual cash compensation⁴, not just your annual base pay.⁵ Your BAR is calculated for you in Workday so the rates in annual enrollment reflect your individual BAR. Generally, BAR is recalculated annually at September 30th. For example, your benefits for the 2025 Plan Year would be based off the following BAR calculation:

Regular pay (annualized) as of Sept. 30, 2024	+	Eligible cash bonuses, compensation, incentives, overtime, and premium pay + from Oct. 1, 2023 – Sept. 30, 2024	=	Your Benefits Annual Rate
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Special BAR Rules:

- In the case of employees in highly-incented positions (positions where more than 50% of compensation is expected to be from payments other than base salary), a special recalculation of BAR may be required. For example, if a highly-incented employee becomes eligible for a benefit and less than 12 months of compensation history was included in the last BAR calculation, BAR will be recalculated at the time of death to determine the appropriate BAR by looking at actual earnings.
- For new hires, your BAR is your base pay alone.
- Employees on a Leave of Absence⁶ with pay through date of September 30 or greater are recalculated annually.
- Employees on Leave of Absence without pay at the time of the BAR calculation are not updated and the BAR will not be recalculated until the next annual enrollment period
- If an employee's calculated BAR is less than \$1000, it is automatically updated to \$40,000.

For more information regarding how your BAR is calculated, please contact the Plan Administrator.

⁴ Your total annual cash compensation does not include equity grants (e.g., stock options, RSUs, etc.). The determination regarding whether an item of compensation is included in your total annual compensation shall be made by the Plan Administrator, in its sole and absolute discretion, and shall apply uniformly to all persons similarly situated. The decision of the Plan Administrator shall be final and conclusive upon all interested persons.

⁵ Base pay is a fixed amount of money paid to you in return for work performed. Base pay does not include benefits, bonuses, or other potential compensation you might receive in addition to your base pay.

⁶ Leave of Absence means a period of Employer-approved absence from service that is not treated as a termination of employment in accordance with the Employer's employment policies, including an absence under the FMLA or to perform Uniformed Service protected under USERRA.

HOW THE PLAN IS ADMINISTERED

Plan Operations

Because benefits are provided through an insurance contract, the Plan is administered by both the Plan Sponsor and the Insurance Company.

Plan Administration

The Plan Sponsor has named the Truist Employee Benefits Plan Committee (the "Committee") as the Plan Administrator of the Plan. The Committee shall be the Plan Administrator, and the Chairman of the Committee shall be the agent for service of legal process on the plan.

The Committee shall consist of a Chairman, designated in the Committee's charter and not less than three (3) individuals appointed by the Chairman. The Chairman may appoint a secretary who will not be a Committee member. Any member of the Committee may resign, and his successor, if any, shall be appointed by the Chairman.

The Committee has the authority to require eligible individuals to furnish it with such information as it determines is necessary for the proper administration of the Plan.

The Plan Administrator, or its delegate, has the exclusive discretionary authority to construe and to interpret the Plan, to decide all questions of eligibility for benefits and to determine the amount of such benefits, and its decisions on such matters are final and conclusive. If any exercise of this discretionary authority is reviewed by a court, arbitrator, or any other tribunal, it will be reviewed under the arbitrary and capricious standard (i.e., the abuse of discretion standard). Benefits under the Plan will be paid only if the Plan Administrator or Claims Administrator decides in its discretion that the applicant is entitled to them.

Power and Authority of Claims Administrator

The Plan is fully insured. Benefits are provided under a group insurance contract entered into between the Plan Sponsor and the Insurance Company. Claims for benefits are sent to the Insurance Company. The Insurance Company, not the Plan Sponsor, is responsible for determining and paying claims.

The Insurance Company is the named fiduciary for administering claims (i.e., Claims Administrator) and is responsible for:

- Determining eligibility for a benefit and the amount of any benefits payable under the Plan; and
- Providing the claims procedures to be followed and the claims forms to be used by eligible individuals pursuant to the Plan.

The Insurance Company also has the authority to require eligible individuals to furnish it with such information as it determines is necessary for the proper administration of the Plan.

ALLOCATION OF RESPONSIBILITIES AMONG NAMED FIDUCIARIES

Duties of Named Fiduciaries

The named fiduciaries with respect to the plan and the fiduciary duties and other responsibilities allocated to each, which shall be carried out in accordance with the other applicable terms and provisions of the plan, shall be as follows:

1) Plan Administrator:

- a) To interpret the provisions of the Plan and determine the rights of participants under the Plan, except to the extent such powers are delegated to another named fiduciary or other person or persons as provided in this SPD;
- b) To administer the Plan in accordance with its terms, except to the extent such powers are delegated to another named fiduciary or other person or persons as provided in this SPD;
- c) To file such reports as may be required with the United States Department of Labor, the Internal Revenue Service and any other government agency to which reports may be required to be submitted from time to time;
- d) To comply with requirements of the law for disclosure of plan provisions and other information relating to the plan to participants and other interested parties; and
- e) To administer the claims procedure to the extent allocated to it in this SPD.

2) Claims Fiduciary:

- a) To adjudicate claims for benefits under the Plan;
- b) To administer the claims procedures to the extent allocated to it in this SPD.

3) Compensation and Human Capital Committee:

- a) The Compensation and Human Capital Committee of the Board will be responsible for approving the Charter of the Employee Benefits Plan Committee; and
- b) The Compensation and Human Capital Committee of the Board may delegate its responsibilities to the appropriate officers of Truist.

Co-fiduciary Liability

Except as otherwise provided in ERISA, a named fiduciary shall not be responsible or liable for any act or omission of another named fiduciary with respect to fiduciary responsibilities allocated to such other named fiduciaries. A named fiduciary of the plan shall be responsible and liable only for its own acts or omissions with respect to fiduciary duties specifically allocated to it and designated as its responsibility.

CLAIMS PROCEDURES

The Plan has designated and named the Insurance Company as the Claims Administrator under the Plan. The Claims Administrator has full discretion and authority to determine eligibility for benefits and to construe and interpret all terms and provisions of the Plan, to the extent permitted by applicable state law.

Benefit Claim

The Claims Administrator will decide your claim in accordance with its reasonable claims procedures, as required by ERISA and other applicable law. See the attached Certificate of Insurance issued by the Claims Administrator for information about how to file a claim and for details regarding the Claims Administrator's claims procedures.

Appealing Denied Claim

If your claim is denied (that is, not paid in part or in full), you will be notified and you may appeal to the Claims Administrator for a review of the denied claim. The Claims Administrator will decide your appeal in accordance with its reasonable claims procedures, as required by ERISA and other applicable law. See the attached Certificate of Insurance issued by the Claims Administrator for information about how to file a claim and for details regarding the Claims Administrator's claims procedures.

Important Appeal Deadlines

If you do not appeal on time, you will lose your right to file suit in court, as you will not have exhausted your internal administrative appeal rights (which generally is a condition for bringing suit in court). See the attached Certificate of Insurance for information about how to appeal a denied claim, and for details regarding the Claims Administrator's appeals procedures.

Exhaustion of Administrative Remedies; Limitations of Actions

Claimants shall not be entitled to challenge the Committee's or Claims Administrator's determinations in judicial or administrative proceedings without first complying with the administrative claims procedures set forth in this SPD, as appropriate. All such claims must be brought within the timeframes set forth above for the Claimant's type of claim. The decisions made pursuant to applicable administrative claims procedures are final and binding on the Claimant and any other party.

If the Claimant has complied with and exhausted the appropriate claims procedures and intends to exercise his right to bring civil action under ERISA Section 502(a), the Claimant must bring such action within 12 months following the date on which he submitted the last required appeal (or voluntary appeal, if offered and the Claimant files a voluntary appeal) under such procedures. If the Claimant does not bring such action within such 12-month period, the Claimant shall be barred from bringing an action related to his claim.

Incompetency

If any person entitled to payments under the Plan is a minor or under other legal disability or otherwise incapacitated so as to be unable to manage his financial affairs or is otherwise incapable of giving a valid receipt and discharge for any payment, the following provision shall apply. If the payment is to be made by a Claims Administrator, such payment shall be made in accordance with the terms of the contract under which such benefit is payable. If the payment is to be otherwise made, the Committee, in its discretion, may direct that all or any portion of such payment be made:

- (i) to such person;
- (ii) to such person's legal guardian or conservator; or
- (iii) to such person's Spouse or to any other person,

in any manner the Committee considers advisable, to be expended for his benefit. The decision of the Committee (or, where applicable, that of the Claims Administrator) shall, in each case, be final and binding upon all persons.

LEGAL INFORMATION

No legal action to recover benefits may be brought later than one year from the date your claim for benefits is denied at the end of the appeals process. If you choose to pursue a second level appeal, the one-year period for bringing a legal action will begin to run once that final second- level decision has been issued.

Beneficiary Designations

In the event that the Plan Administrator, Insurer, or Claim Administrator is unable to determine the identity of your beneficiary under circumstances of competing claims or otherwise, the Plan Administrator, Insurer, or Claim Administrator, as applicable may, in its sole discretion, file an interpleader action seeking an order of the court as to the determination of the beneficiary. The Plan Administrator, Insurer, or Claim Administrator may act in reliance upon any proper order issues in maintaining, distributing or otherwise disposing of your benefit under the terms of the Benefit Plan, to any beneficiary specified in the court order.

Plan Amendment/Termination

Truist has reserved the right to modify, amend or terminate the Plan at any time. Except as otherwise provided in the Plan, the right to modify, amend or terminate the Plan will not in any way affect your right to claim benefits, or diminish or eliminate any claims for benefits under the Plan to which you may have become entitled to claim prior to such termination or amendment. The Plan is not a contract, and Truist does not guarantee and makes no promise to offer a specific level of benefits in the future. The right to future benefits under the Plan will never vest. Neither the Plan nor the benefits provided under this Plan can be orally amended. All oral statements and representations shall be without force or effect even if such statements and representations are made by the Plan Administrator, the Claims Administrator, by any delegate of the Plan Administrator or Claims Administrator, or by other party. Only written statements that are consistent with the terms of the Plan and made by the Plan Administrator and /or Claims Administrator can bind the Plan.

No Contract of Employment

The Plan is not intended to be, and may not be construed as constituting, a contract or other arrangement between you and any employer to the effect that you will be employed for any specific period of time.

Intentional Misrepresentations

If you commit fraud or make an intentional misrepresentation of a material fact about your participation in the health care plans, the plans have the right to retroactively terminate coverage permanently for you and all of your eligible dependents. Also, the plan may seek financial damages caused by the misrepresentations and may pursue legal action against you. Material misrepresentation includes, but is not limited to, submitting falsified claims or covering a dependent who is ineligible (for instance, adding a spouse before you are married or after you are divorced, or adding a child who doesn't meet the plan qualifications of an eligible dependent).

Governing Law and Venue

This Plan is governed by and will be construed in accordance with ERISA, and to the extent not preempted by ERISA, by the laws of the state of North Carolina, without regard for any choice of law principles thereof. Unless otherwise provided in this SPD, any legal action related to this Plan shall be brought only in the United States District Court for the Western District of North Carolina and of any court situated in Charlotte, North Carolina.

Impact on other Benefit Plans

It is not the responsibility of any other party, including, but not limited to, Truist Financial Corporation, the Plan Administrator, the Insurance Company, or any other party to advise you how your eligibility under this Plan and / or the component Benefit Plans may affect your eligibility for any other benefits, plans, or programs that you are or may become eligible for and no such party shall be liable for providing or failing to provide you with such advice.

Right to Convert or Port

If your coverage or any portion of it under the Plan ends for any reason, except nonpayment of premium, you may be able to elect to convert or port your life insurance coverage to an individual policy without providing evidence of insurability. You must request an application to convert or port your coverage within 31 days of the date your employment ended. Contact Teammate Care at 800-716-2455, option 1, for the application.

To convert or port your coverage you must: 1) request and complete a Notice of Conversion Right form; and 2) have Truist sign the form. The Insurance Company must receive this within: 1) 31 days after Life Insurance terminates; or 2) 15 days from the date Truist signs the form; whichever is later. Contact Teammate Care at 800-716-2455, option 1, for the application. More details regarding this option are

provided in the attached Certificate of Insurance.

QUESTIONS

If you have any general questions regarding the Plan (including, for example, whether you are eligible to participate in the Plan), please contact the Committee.

If you have questions regarding eligibility for a benefit and/or the amount of any benefits payable under the Plan, please contact the Claims Administrator.

PARTICIPATING EMPLOYERS

As of August 1, 2024, the list of Participating Employers is provided below. This list may be updated at any time without formal amendment to this SPD.

AFCO Acceptance Corporation
AFCO Credit Corporation
BB&T Collateral Service Corporation
BB&T Real Estate Funding, LLC
CB Finance, Inc.
GFO Advisory Services, LLC
Grandbridge Real Estate Capital, LLC
Prime Rate Premium Finance Corporation, Inc.
Regional Acceptance Corporation
Service Finance Holdings, LLC
SunTrust Equity Funding, LLC
Truist Commercial Equity
Truist Advisory Services, Inc.
Truist Bank
Truist CIG, LLC
Truist Community Capital, LLC
Truist Delaware Trust Company
Truist Equipment Finance Corp
Truist Investment Services, Inc.
Truist Leasing Corp
Truist Merchant Services LLC
Truist Securities, Inc.

CERTIFICATE OF INSURANCE
LIFE INSURANCE

Maryland

The group insurance policy providing coverage under this certificate was issued in a jurisdiction other than Maryland and may not provide all of the benefits required by Maryland law.

State Notices

IMPORTANT INFORMATION FOR RESIDENTS OF CERTAIN STATES: There are state-specific requirements that may change the provisions described in the group insurance certificate. If you live in a state that has such requirements, those requirements will apply to your coverage. State-specific requirements that may apply to your coverage are summarized below. In addition, updated state-specific requirements are published on our website. You may access the website at www.thehartford.com. If you are unable to access this website, want to receive a printed copy of these requirements, or have any questions or complaints regarding any of these requirements or any aspect of your coverage, please contact your Employee Benefits Manager; or you may contact us as follows:

The Hartford
Group Benefits Division, Customer Service
P.O. Box 2999
Hartford, CT 06104-2999
1-800-523-2233
<https://www.thehartford.com/>

If you have a complaint and contacts between you, us, your agent, or another representative have failed to produce a satisfactory solution to the problem, some states require we provide you with additional contact information. If your state requires such disclosure, the contact information is listed below with the other state requirements and notices.

We are providing notice that Hartford Life and Accident Insurance Company is subject to economic and trade sanctions laws and regulations. These laws and regulations, including the laws and regulations administered and enforced by the United States Department of the Treasury's Office of Foreign Assets Control ("OFAC"), prevent Hartford Life and Accident from providing coverage to, and from paying benefits to, entities and individuals where prohibited by applicable law. In addition, these laws and regulations prohibit certain activities with respect to certain countries.

We have included this information to make you aware of the existence and potential impact of these economic and trade sanctions programs on your benefit program.

The Hartford complies with applicable Federal civil rights laws and does not unlawfully discriminate on the basis of race, color, national origin, age, disability, or sex. The Hartford does not exclude or treat people differently for any reason prohibited by law with respect to their race, color, national origin, age, disability, or sex.

If your policy is governed under the laws of Maryland, any of the benefits, provisions or terms that apply to the state you reside in as shown below will apply only to the extent that such state requirements are more beneficial to you.

Alaska:

1. If notice of Your **Conversion Right** is not received by You on the date Your or Your Dependent's coverage terminates, You have 15 days from the date You receive the notice.
2. The **Policy Interpretation** provision, if shown in the **General Provisions** section of the Certificate, is not applicable.
3. The **Spouse** definition will always include domestic partners, civil unions, and any other legal union recognized by state law.

Arizona:

1. **NOTICE:** The Certificate may not provide all benefits and protections provided by law in Arizona. Please read the Certificate carefully.

Arkansas:

1. **NOTICE:** You have the right to file a complaint with the Arkansas Insurance Department (AID). You may call AID to request a complaint form at (800) 852-5494 or (501) 371-2640 or write the Department at:
Arkansas Insurance Department
1 Commerce Way, Suite 102
Little Rock, AR 72202

California:

1. The **Policy Interpretation** provision, if shown in the General Provisions section of the Certificate, does not apply to you. The following requirement applies to you:

Eligibility Determination: *How will We determine Your or Your Dependent's eligibility for benefits?*

We, and not Your Employer or plan administrator, have the responsibility to fairly, thoroughly, objectively and timely investigate, evaluate and determine Your or Your Dependent's eligibility for benefits for any claim You or Your beneficiaries make on The Policy. We will:

- 1) obtain with Your or Your beneficiaries' cooperation and authorization if required by law, only such information that is necessary to evaluate Your or Your beneficiaries' claim and decide whether to accept or deny Your or Your beneficiaries' claim for benefits. We may obtain this information from Your or Your beneficiaries' Notice of Claim, submitted proofs of loss, statements, or other materials provided by You or others on Your behalf; or, at Our expense We may obtain necessary information, or have You or Your Dependent's physically examined when and as often as We may reasonably require while the claim is pending. In addition, and at Your or Your beneficiaries' option and at Your or Your beneficiaries' expense, You or Your beneficiaries may provide Us and We will consider any other information, including but not limited to, reports from a Physician or other expert of Your or Your beneficiaries' choice. You or Your beneficiaries should provide Us with all information that You or Your beneficiaries want Us to consider regarding Your or Your beneficiaries' claim;
- 2) As part of Our routine operations, We will apply the terms of The Policy for making decisions, including decisions on eligibility, receipt of benefits and claims or explaining policies, procedures and processes;
- 3) if We approve Your claim, We will review Our decision to approve Your or Your beneficiaries claim for benefits as often as is reasonably necessary to determine Your or Your Dependent's continued eligibility for benefits;
- 4) if We deny Your or Your beneficiaries' claim, We will explain in writing to You or Your beneficiaries the basis for an adverse determination in accordance with The Policy as described in the provision entitled **Claim Denial**.

In the event We deny Your or Your beneficiaries' claim for benefits, in whole or in part, You or Your beneficiaries can appeal the decision to Us. If You or Your beneficiaries choose to appeal Our decision, the process You or Your beneficiaries must follow is set forth in The Policy provision entitled **Claim Appeal**. If You or Your beneficiaries do not appeal the decision to Us, then the decision will be Our final decision.

2. **For Your Questions and Complaints:**

State of California Insurance Department
Consumer Communications Bureau
300 South Spring Street, South Tower
Los Angeles, CA 90013
Toll Free: 1(800) 927-HELP
TDD Number: 1(800) 482-4833
Web Address: www.insurance.ca.gov

Colorado:

1. The **Suicide** provision will only exclude amounts of life insurance in effect within the first year of coverage or within the first year following an increase in coverage.
2. The **Dependent Child(ren)** definition will always include children related to You by civil union.
3. The **Spouse** definition will always include civil unions.
4. Entering a civil union, terminating a civil union, the death of a party to a civil union or a party to a civil union losing employment, which results in a loss of group insurance, will all constitute as a **Change in Family Status**.
5. The **Claim Appeal** provision will always include the following:

In addition, if a claim for benefits is wholly or partially denied and all administrative remedies have been exhausted, You are entitled to pursue such claim anew, from the beginning, in a court with jurisdiction and entitled to a trial by jury.

Florida:

1. **Legal Actions** cannot be taken against Us more than 5 years after the date Proof of Loss is required to be furnished according to the terms of The Policy.

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| <ol style="list-style-type: none">2. NOTICE: The benefits of the policy providing you coverage may be governed primarily by the laws of a state other than Florida. |
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Georgia:

1. **NOTICE:** The laws of the state of Georgia prohibit insurers from unfairly discriminating against any person based

upon his or her status as a victim of family abuse.

Idaho:

1. **For Your Questions and Complaints:**

Idaho Department of Insurance

Consumer Affairs

700 W State Street, 3rd Floor

PO Box 83720

Boise, ID 83720-0043

Toll Free: 1-800-721-3272

Web Address: www.DOI.Idaho.gov

Illinois:

1. **For Your Questions and Complaints:**

Illinois Department of Insurance

Consumer Services Station

Springfield, Illinois 62767

Consumer Assistance: 1(866) 445-5364

Officer of Consumer Health Insurance: 1(877) 527-9431

Web Address: <http://insurance.illinois.gov/>

2. In accordance with Illinois law, insurers are required to provide the following **NOTICE** to applicants of insurance policies issued in Illinois.

STATE OF ILLINOIS
The Religious Freedom Protection and Civil Union Act
Effective June 1, 2011

The Religious Freedom Protection and Civil Union Act ("the Act") creates a legal relationship between two persons of the same or opposite sex who form a civil union. The Act provides that the parties to a civil union are entitled to the same legal obligations, responsibilities, protections and benefits that are afforded or recognized by the laws of Illinois to spouses. The law further provides that a party to a civil union shall be included in any definition or use of the terms "spouse," "family," "immediate family," "dependent," "next of kin," and other terms descriptive of spousal relationships as those terms are used throughout Illinois law. This includes the terms "marriage" or "married," or variations thereon. Insurance policies are required to provide identical benefits and protections to both civil unions and marriages. If policies of insurance provide coverage for children, the children of civil unions must also be provided coverage. The Act also requires recognition of civil unions or same sex civil unions or marriages legally entered into in other jurisdictions.

For more information regarding the Act, refer to 750 ILCS 75/1 *et seq.* Examples of the interaction between the Act and existing law can be found in the Illinois Insurance Facts, Civil Unions and Insurance Benefits document available on the Illinois Department of Insurance's website at <http://insurance.illinois.gov/>.

Indiana:

1. **For Your Questions and Complaints:**

Public Information/Market Conduct

Indiana Department of Insurance

311 W. Washington St. Suite 300

Indianapolis, IN 46204-2787

1(317) 232-2395

Louisiana:

1. The age limit stated in the **Continuation for Dependent Child(ren)** with Disabilities provision is increased to 21, if less than 21.
2. The following requirement applies to you:

Reinstatement after Military Service: *Can coverage be reinstated after return from active military service?*

If Your or Your Dependents' coverage ends because You or Your Dependents enter active military service, coverage may be reinstated, provided You request such reinstatement upon Your or Your Dependents' release from active military service.

The reinstated coverage will:

- 1) be the same coverage amounts in force on the date coverage ended;
- 2) not be subject to any Eligibility Waiting Period for Coverage or Evidence of Insurability; and
- 3) be subject to all the terms and provisions of The Policy.

Maine:

1. **NOTICE:** The laws of the State of Maine require notification of the right to designate a third party to receive notice of cancellation, to change such a designation and, to have the Policy reinstated if the insured suffers from cognitive impairment or functional incapacity and the ground for cancellation was the insured's nonpayment of premium or other lapse or default on the part of the insured.

Within 10 days after a request by an insured, a Third Party Notice Request Form shall be mailed or personally delivered to the insured.

Massachusetts:

1. The definition of **Terminal Illness or Terminally Ill** shown in the **Accelerated Benefit** cannot exceed 24 months.
2. **NOTICE: As of January 1, 2009, the Massachusetts Health Care Reform Law requires that Massachusetts residents, eighteen (18) years of age and older, must have health coverage that meets the Minimum Creditable Coverage standards set by the Commonwealth Health Insurance Connector, unless waived from the health insurance requirement based on affordability or individual hardship. For more information call the Connector at 1-877-MA-ENROLL or visit the Connector website (www.mahealthconnector.org).**

This plan is not intended to provide comprehensive health care coverage and **does not meet Minimum Creditable Coverage standards**, even if it does include services that are not available in the insured's other health plans.

If you have questions about this notice, you may contact the Division of Insurance by calling (617) 521-7794 or visiting its website at www.mass.gov/doi.

Michigan:

1. The **Policy Interpretation** provision, if shown in the **General Provisions** section of the Certificate, is not applicable.

Minnesota:

1. You or Your Dependents must be on a documented military leave of absence in order to qualify for the Military Leave of Absence continuation shown in the **Continuation Provisions**.
2. If there are 25 or more residents of Minnesota who are covered under The Policy, or there are fewer than 25 residents and those residents constitute 25% or more of the total number of people covered under The Policy, the Lay Off continuation shown in the **Continuation Provisions** shall not apply to you. The following requirement applies to you:

Minnesota Coverage Continuation: If You are voluntarily or involuntarily terminated or Laid Off by the Employer, You may elect to continue Your Life Insurance coverage (including Dependent Life coverage) by making premium payments to the Employer for the cost of continued coverage. Continued coverage will take effect on the date Your coverage would otherwise have ended and must be elected within 60 days from:

- 1) the date Your coverage would otherwise terminate; or
 - 2) the date You receive a written notice of Your right to continue coverage from the Employer;
- whichever is later.

The amount of premium charged may not exceed 102% of the premium paid for other similarly situated employees who are Actively at Work. The Employer will inform You of:

- 1) Your right to continue coverage;
- 2) the amount of premium; and
- 3) how, where and by when payment must be made.

Upon request, the Employer will provide You Our written verification of the cost of coverage.

Coverage will be continued until the earliest of:

- 1) the date You are covered under another group policy;
- 2) the date the required premium is due but not paid; or
- 3) the last day of the 18th month following the date of termination or Lay Off.

Upon the termination of continued coverage, You may:

- 1) exercise Your Conversion Right; or
- 2) continue coverage under a group Portability policy; and
- 3) qualify for Retiree coverage.

Minnesota law requires that if Your coverage ends because the Employer fails to notify You of Your right to continue coverage or fails to pay the premium after timely receipt, the Employer will be liable for benefit payments to the extent We would have been liable had You still been covered.

3. If the following paragraph appears in the **Accelerated Benefit** provision, it does not apply to you:

In the event:

- 1) You are required by law to accelerate benefits to meet the claims of creditors; or
- 2) if a government agency requires You to apply for benefits to qualify for a government benefit or entitlement;

You will still be required to satisfy all the terms and conditions herein in order to receive an Accelerated Benefit

4. If there are 25 or more residents of Minnesota who are covered under The Policy and those 25 residents constitute 25% or more of the total number of people covered under The Policy, You are not required to be insured under The Policy for a specified period of time in order to exercise the **Conversion Right**.

Missouri:

1. The period in which You must remain Disabled to qualify for **Waiver of Premium** cannot exceed 180 days.
2. If Waiver of Premium is approved and You have completed the elimination period, We will retroactively refund to You, or to Your estate if You have died, any premiums paid during the period You have been continuously Disabled.
3. The **Suicide** provision will only exclude amounts of life insurance in effect within the first year of coverage or within the first year following an increase in coverage.

Montana:

1. The time period in which You are required to be insured under The Policy in order to exercise the **Conversion Right** cannot exceed 3 years.
2. If You are eligible to receive the **Felonious Assault Benefit**, We will not exclude for losses that result from a Felonious Assault committed by a member of Your family or a member of the household in which You live.
3. **NOTICE:** Conformity with Montana statutes: The provisions of the certificate conform to the minimum requirements of Montana law and control over any conflicting statutes of any state in which the insured resides on or after the effective date of the certificate.

New Hampshire:

1. Your Spouse may be eligible to continue his or her Life Insurance coverage in the event of divorce or separation as shown in the **Spouse Continuation** below:

Spouse Continuation: *Can coverage for my Spouse be continued in the event of divorce or separation?*

If:

- 1) You are a resident of New Hampshire;
- 2) You get a divorce or legal separation from a Spouse that is covered under The Policy; and
- 3) the final decree of divorce or legal separation does not expressly prohibit it;

Your former Spouse may continue his or her coverage.

We must receive Your Spouse's written request and the required premium to continue his or her coverage within 30 days of the final decree of divorce or legal separation.

Solely for the purpose of continuing the coverage, Your Spouse will be considered the insured person. However, Your former Spouse's coverage will not continue beyond the earliest of:

- 1) the 3-year anniversary of the final decree of divorce or legal separation;
- 2) the remarriage of the former Spouse;
- 3) Your death;
- 4) an earlier time as provided by the final decree of divorce or legal separation; or
- 5) a date the coverage would otherwise have ended under the Dependent Termination Provision.

New Mexico:

1. **For Your Questions and Complaints:**

Office of Superintendent of Insurance
Consumer Assistance Bureau
P.O. Box 1689
Santa Fe, NM 87504-1689
1(855) 427-5674

New York:

1. If the definition of **Spouse** requires the completion of a domestic partner affidavit, the requirement applies to you: The domestic partner affidavit must be notarized and requires that You and Your domestic partner meet all of the following criteria:
 - 1) you are both legally and mentally competent to consent to contract in the state in which you reside;
 - 2) you are not related by blood in a manner that would bar marriage under laws of the state in which you reside;
 - 3) you have been living together on a continuous basis prior to the date of the application;
 - 4) neither of you have been registered as a member of another domestic partnership within the last six months; and
 - 5) you provide proof of cohabitation (e.g., a driver's license, tax return or other sufficient proof).

The domestic partner affidavit further requires that You and Your domestic partner provide proof of financial interdependence in the form of at least two of the following:

- 1) a joint bank account;
- 2) a joint credit card or charge card;
- 3) joint obligation on a loan;
- 4) status as an authorized signatory on the partner's bank account, credit card or charge card;
- 5) joint ownership of holdings or investments, residence, real estate other than residence, major items of personal property (e.g., appliances, furniture), or a motor vehicle;
- 6) listing of both partners as tenants on the lease of the shared residence;
- 7) shared rental payments of residence (need not be shared 50/50)
- 8) listing of both partners as tenants on a lease, or shared rental payments, for property other than residence;
- 9) a common household and shared household expenses (e.g., grocery bills, utility bills, telephone bills, etc. and need not be shared 50/50);
- 10) shared household budget for purposes of receiving government benefits;
- 11) status of one as representative payee for the other's government benefits;
- 12) joint responsibility for child care (e.g., school documents, guardianship);
- 13) shared child-care expenses (e.g., babysitting, day care, school bills, etc. and need not be shared 50/50);
- 14) execution of wills naming each other as executor and/or beneficiary;
- 15) designation as beneficiary under the other's life insurance policy;
- 16) designation as beneficiary under the other's retirement benefits account;
- 17) mutual grant of durable power of attorney;
- 18) mutual grant of authority to make health care decisions (e.g., health care power of attorney);
- 19) affidavit by creditor or other individual able to testify to partners' financial interdependence;

- 20) other item(s) of proof sufficient to establish economic interdependency under the circumstances of the particular case.

North Carolina:

1. **NOTICE:** UNDER NORTH CAROLINA GENERAL STATUTE SECTION 58-50-40, NO PERSON, EMPLOYER, FINANCIAL AGENT, TRUSTEE, OR THIRD PARTY ADMINISTRATOR, WHO IS RESPONSIBLE FOR THE PAYMENT OF GROUP LIFE INSURANCE, GROUP HEALTH OR GROUP HEALTH PLAN PREMIUMS, SHALL:
 - 1) CAUSE THE CANCELLATION OR NONRENEWAL OF GROUP LIFE INSURANCE, GROUP HEALTH 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 PERSON 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 WRITTEN NOTICE OF THE PERSON'S INTENTION TO STOP PAYMENT OF PREMIUMS. 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.

IMPORTANT TERMINATION INFORMATION

YOUR INSURANCE MAY BE CANCELLED BY THE COMPANY. PLEASE READ THE TERMINATION PROVISION IN THE CERTIFICATE.

THE CERTIFICATE OF INSURANCE PROVIDES COVERAGE UNDER A GROUP MASTER POLICY. THE CERTIFICATE PROVIDES ALL OF THE BENEFITS MANDATED BY THE NORTH CAROLINA INSURANCE CODE, BUT YOU MAY NOT RECEIVE ALL OF THE PROTECTIONS PROVIDED BY A POLICY ISSUED IN NORTH CAROLINA AND GOVERNED BY ALL OF THE LAWS OF NORTH CAROLINA.

North Dakota:

1. The **Suicide** provision will only exclude amounts of life insurance in effect within the first year of coverage or within the first year following an increase in coverage.

Ohio:

1. Any references to the **Accelerated Benefit** shall be changed to the **Accelerated Death Benefit**.

Oregon:

1. The **Spouse** definition will include Your domestic partner provided You have registered as domestic partners with a government agency or office where such registration is available. You will not be required to provide proof of such registration.
2. The **Dependent Child(ren)** definition will include children related to You by domestic partnership.
3. The following Jury Duty continuation applies for Employers with 10 or more employees:

Jury Duty: If You are scheduled to serve or are required to serve as a juror, Your coverage may be continued until the last day of Your Jury Duty, provided You:

- 1) elected to have Your coverage continued; and
- 2) provided notice of the election to Your Employer in accordance with Your Employer's notification policy.

Rhode Island:

1. The **Policy Interpretation** provision, if shown in the **General Provisions** section of the Certificate, is not applicable.

South Carolina:

1. The dollar amount stated in the third paragraph of the **Claims to be Paid** provision is changed to \$2,000, if greater than \$2,000.
2. If the **Continuity from a Prior Policy for Disability Extension** provision is included in the Certificate and You qualify for continued coverage, Your Amount of Insurance will be the greater of the amount of life insurance and

accidental death and dismemberment principal sum that You had under the Prior Policy or the amount shown in the Schedule of Insurance. This Amount of Insurance will be reduced by any coverage amount that is in force, paid or payable under the Prior Policy or that would have been payable under the Prior Policy had timely election been made.

3. If The Policy Terminates or Your Employer ceases to be a Participating Employer and You have been approved for the **Waiver of Premium**, Your coverage under the terms of this provision will not be affected. Your Dependent coverage will continue for a period of 12 months from the date of Policy termination and will be subject to the terms and conditions of The Policy.
4. If The Policy Terminates or Your Employer ceases to be a Participating Employer and You have been approved for the **Disability Extension**, Your and Your Dependent's coverage will be continued for a period of up to 12 months from the date The Policy terminated or Your Employer ceased to be a Participating Employer, as long as premiums are paid when due. Coverage during this period will be subject to the other terms and conditions of the **Disability Extension Ceases** provision. When this extension period is exhausted, You may be eligible to exercise the **Conversion Right** for You and Your Dependent's coverage. **Portability Benefits** will not be available

South Dakota:

1. The definition of **Physician** can include You or a person Related to You by blood or marriage in the event that the Physician is the only one in the area and is acting within the scope of their normal employment.

Texas:

1. The **Policy Interpretation** provision, if shown in the **General Provisions** section of the Certificate, is not applicable.
2. **NOTICE:**

Have a complaint or need help?

If you have a problem with a claim or your premium, call your insurance company first. If you can't work out the issue, the Texas Department of Insurance may be able to help.

Even if you file a complaint with the Texas Department of Insurance, you should also file a complaint or appeal through your insurance company. If you don't, you may lose your right to appeal.

Hartford Life and Accident Insurance Company

To get information or file a complaint with your insurance company:

Call: Customer Service at 860-547-5000

Toll-free: 1-800-523-2233

Online: <https://www.thehartford.com/contact-the-hartford>

Email: GBD.Customerservice@hartfordlife.com

Mail: The Hartford, Group Benefits Division, P.O. Box 2999, Hartford, CT 06104-2999

The Texas Department of Insurance

To get help with an insurance question or file a complaint with the state:

Call with a question: 1-800-252-3439

File a complaint: www.tdi.texas.gov

Email: ConsumerProtection@tdi.texas.gov

Mail: MC 111-1A, P.O. Box 12030, Austin, TX 78711-2030

¿Tiene una queja o necesita ayuda?

Si tiene un problema con una reclamación o con su prima de seguro, llame primero a su compañía de seguros. Si no puede resolver el problema, es posible que el Departamento de Seguros de Texas (Texas Department of Insurance, por su nombre en inglés) pueda ayudar.

Aun si usted presenta una queja ante el Departamento de Seguros de Texas, también debe presentar una queja a través del proceso de quejas o de apelaciones de su compañía de seguros. Si no lo hace, podría perder su derecho para apelar.

Hartford Life and Accident Insurance Company

Para obtener información o para presentar una queja ante su compañía de seguros:

Llame a: servicio al cliente al 860-547-5000

Teléfono gratuito: 1-800-523-2233

En línea: <https://www.thehartford.com/contact-the-hartford>

Correo electrónico: GBD.Customerservice@hartfordlife.com

Dirección postal: The Hartford, Group Benefits Division, P.O. Box 2999, Hartford, CT 06104-2999

El Departamento de Seguros de Texas

Para obtener ayuda con una pregunta relacionada con los seguros o para presentar una queja ante el estado:

Llame con sus preguntas al: 1-800-252-3439

Presente una queja en: www.tdi.texas.gov

Correo electrónico: ConsumerProtection@tdi.texas.gov

Dirección postal: MC 111-1A, P.O. Box 12030, Austin, TX 78711-2030

Utah:

1. We will send **Claim Forms** within 15 days of receiving a Notice of Claim. If We do not send the forms within 15 days, any other written proof which fully describes the nature and extent of the claim may be submitted.
2. If the **Sending Proof of Loss** provision provides a timeframe in which proof must be submitted before it affects Your claim, this time limitation shall not apply to You.
3. When We determine that benefits are payable, We will make **Claim Payments** within no more than 45 days after **Proof of Loss** is received.
4. Any reference to fraud within the **Incontestability** provision does not apply to You.
5. A Sickness or Injury continuation of at least 6 months must be included in the **Continuation Provisions**.

Vermont:

1. The following requirement applies:

Purpose: This requirement is intended to provide benefits for parties to a civil union. Vermont law requires that insurance contracts and policies offered to married persons and their families be made available to parties to a civil union and their families. In order to receive benefits in accordance with this requirement, the civil union must have been established in the state of Vermont according to Vermont law.

General Definitions, Terms, Conditions and Provisions: The general definitions, terms, conditions or any other provisions of the policy, contract, certificate and/or riders and endorsements are hereby superseded as follows:

- 1) Terms that mean or refer to a marital relationship or that may be construed to mean or refer to a marital relationship: such as "marriage", "spouse", "husband", "wife", "dependent", "next of kin", "relative", "beneficiary", "survivor", "immediate family" and any other such terms include the relationship created by a civil union.
- 2) Terms that mean or refer to a family relationship arising from a marriage such as "family", "immediate family", "dependent", "children", "next of kin", "relative", "beneficiary", "survivor" and any other such terms include the family relationship created by a civil union.
- 3) Terms that mean or refer to the inception or dissolution of a marriage, such as "date of marriage", "divorce decree", "termination of marriage" and any other such terms include the inception or dissolution of a civil union.
- 4) "Dependent" means a spouse, a party to a civil union, and/or a child or children (natural, stepchild, legally adopted or a minor who is dependent on the insured for support and maintenance) who is born to or brought to a marriage or to a civil union.

- 5) "Child or covered child" means a child (natural, step-child, legally adopted or a minor who is dependent on the insured for support and maintenance) who is born to or brought to a marriage or to a civil union.

Cautionary Disclosure: THIS NOTICE IS ISSUED TO MEET THE REQUIREMENTS OF VERMONT LAW AS EXPLAINED IN THE "PURPOSE" PARAGRAPH OF THE NOTICE. THE FEDERAL GOVERNMENT OR ANOTHER STATE GOVERNMENT MAY NOT RECOGNIZE THE BENEFITS GRANTED UNDER THIS NOTICE. YOU ARE ADVISED TO SEEK EXPERT ADVICE TO DETERMINE YOUR RIGHTS UNDER THIS CONTRACT

2. Interest on a **Claim Payment** is payable from the date of death until the date payment is made at an interest rate of 6% annually or Our corporate interest rate, whichever is greater.

Virginia:

1. **For Your Questions and Complaints:**
State Corporation Commission
Life and Health Division
Bureau of Insurance
P.O. Box 1157
Richmond, VA 23218
1(804) 371-9691 (inside Virginia)
1(877) 310-6560 (outside Virginia)

Washington:

1. The following **Disputed Diagnosis** requirement applies to You:

Disputed Diagnosis: *What happens if a dispute occurs over whether I am Terminally Ill or my Dependent is Terminally Ill?*

If Your or Your Dependent's attending Physician, and a Physician appointed by Us, disagree on whether You or Your Dependent are Terminally Ill, Our Physician's opinion will not be binding upon You or Your Dependent. The two parties shall attempt to resolve the matter promptly and amicably. If the disagreement is not resolved, You or Your Dependent have the right to mediation or binding arbitration conducted by a disinterested third party who has no ongoing relationship with either You or Your Dependent or Us. Any such arbitration shall be conducted in accordance with the laws of the State of Washington. As part of the final decision, the arbitrator or mediator shall award the costs of the arbitrator to one party or the other, or may divide the costs equally or otherwise.

2. A Labor Dispute continuation of at least 6 months must be included in the **Continuations Provisions**.
3. The **Dependent Child(ren)** definition will always include children related to You by domestic partnership.
4. The definition of **Spouse** will always include domestic partners.
5. The provision titled **Suicide** does not apply to you.

Wisconsin:

1. **For Your Questions and Complaints:**
To request a Complaint Form:
Office of the Commissioner of Insurance
Complaints Department
P.O. Box 7873
Madison, WI 53707-7873
1(800) 236-8517 (outside of Madison)
1(608) 266-0103 (in Madison)



HARTFORD LIFE AND ACCIDENT INSURANCE COMPANY

One Hartford Plaza
Hartford, Connecticut 06155
(A stock insurance company)

CERTIFICATE OF INSURANCE

Policyholder: TRUIST FINANCIAL CORP.

Policy Number: GL-674861

Policy Effective Date: January 1, 2004

Policy Anniversary Date: January 1, 2025

We have issued The Policy to the Policyholder. The Policy is a legal contract between the Policyholder and Us. Our name, the Policyholder's name and the Policy Number are shown above. The provisions of The Policy, which are important to You, are summarized in this certificate consisting of this form and any additional forms which have been made a part of this certificate. This certificate replaces any other certificate We may have given to You earlier under The Policy. The Policy alone is the only contract under which payment will be made. Any difference between The Policy and this certificate will be settled according to the provisions of The Policy on file with Us at Our home office. The Policy may be inspected at the office of the Policyholder.

Signed for the Company

A handwritten signature in dark ink, appearing to read "Kevin Barnett".

Kevin Barnett, Secretary

A handwritten signature in dark ink, appearing to read "Jonathan R. Bennett".

Jonathan Bennett, President

A note on capitalization in this Certificate:

Capitalization of a term, not normally capitalized according to the rules of standard punctuation, indicates a word or phrase that is a defined term in The Policy or refers to a specific provision contained herein.

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GBD-1100 A01 (10/08)	

SCHEDULE OF INSURANCE

The benefits described herein are those in effect as of August 1, 2024.

Cost of Coverage:

Non-Contributory Coverage: Basic Life Insurance

Contributory Coverage: Supplemental Life Insurance
Supplemental Dependent Life Insurance

Disclosure of Fees:

We may reduce or adjust premiums, rates, fees and/or other expenses for programs under The Policy.

Disclosure of Services:

In addition to the insurance coverage, We may offer noninsurance benefits and services to Active Teammates.

Eligible Class(es) For Coverage: All Full-time and Part-time Regular Active Teammates who are citizens or legal residents of the United States, its territories and protectorates; excluding teammates covered by Crestar Executive Life Insurance, temporary, leased or seasonal teammates as follows:

Class 1: All Full-time and Part-time Regular Active Teammates enrolled in the Supplemental Dependent Life Insurance plan prior to January 1, 2014.

Class 2: All Full-time and Part-time Regular Active Teammates enrolled in the Supplemental Dependent Life Insurance plan on or after January 1, 2014.

Regular Employment: regularly scheduled to work at least 20 hours weekly

Class 3: All Teammates on special contract assignments that confirm their eligibility for Truist health and welfare benefits during the assignment

Regular Employment: regularly scheduled to work at least 1 hour weekly

Annual Enrollment Period: as determined by Your Employer on a yearly basis.

Eligibility Waiting Period for Coverage:

The first day of the month following the date You were hired.

The time period(s) referenced above are continuous. The Eligibility Waiting Period for Coverage will be reduced by the period of time You were a Full-time or Part-time Active Teammate with the Employer under the Prior Policy.

Life Insurance Benefit

Amount of Life Insurance:

Basic Amount of Life Insurance

Maximum Amount

1 times Your annual Earnings, subject to a maximum of \$1,000,000 rounded to the next higher \$1,000 if not already a multiple of \$1,000.

However, in no event will Your Basic Amount of Life Insurance be less than \$10,000.

Supplemental Amount of Life Insurance

Guaranteed Issue Amount

1, 2, 3, 4, 5, 6, 7, or 8 times Your annual

Maximum Amount

1, 2, 3, 4, 5, 6, 7, or 8 times Your annual

Earnings, subject to a maximum of \$750,000 rounded to the next higher \$1,000 if not already a multiple of \$1,000.

Earnings, subject to a maximum of \$4,000,000 rounded to the next higher \$1,000 if not already a multiple of \$1,000.

However, in no event will Your Supplemental Amount of Life Insurance be less than \$10,000.

Combined Basic and Supplemental Amount of Life Insurance

Maximum Amount

\$4,000,000

If Your amount of Combined Basic and Supplemental Life Insurance exceeds the Combined Maximum Amount, the Supplemental Amount of Life Insurance will be reduced, followed by a reduction in the Basic Amount of Life Insurance, if necessary.

Dependent Life Insurance Benefit

With respect to Class 1:

Supplemental Amount of Dependent Life Insurance

Maximum Amount

Spouse	\$10,000
Dependent Children: Live birth but under age 26 years(s)	\$7,500

The amount of Spouse Supplemental coverage may never exceed 100% of the Basic Amount of Life Insurance in force for the Teammate.

With respect to Class 2:

Supplemental Amount of Dependent Life Insurance

	Guaranteed Issue Amount	Maximum Amount
Spouse	The amount You elect in increments of \$10,000, subject to a minimum of \$10,000 and a maximum of \$100,000.	The amount You elect in increments of \$10,000, subject to a minimum of \$10,000 and a maximum of \$300,000.

Maximum Amount

Dependent Children: live birth but under age 26 year(s)	Option 1: \$7,500 Option 2: \$10,000 Option 3: \$15,000
--	---

The amount of Spouse Supplemental coverage may never exceed 50% of the Combined Basic and Supplemental Amount of Life Insurance the teammate is eligible for.

Reduction in Amount of Life Insurance

We will reduce the Amount of Life Insurance for You and Your Dependents by any Amount of Life Insurance in force, paid or payable:

- 1) in accordance with the Conversion Right;
- 2) under the Portability provision; or
- 3) under the Prior Policy.

GBD-1100 B02 (10/08) (Rev-1)

ELIGIBILITY AND ENROLLMENT

Eligible Persons: *Who is eligible for coverage?*

All persons in the class or classes shown in the Schedule of Insurance will be considered Eligible Persons.

GBD-1100 D01 (10/08)

Eligibility for Coverage: *When will I become eligible?*

You will become eligible for coverage on the latest of:

- 1) the Policy Effective Date;
- 2) the date You become a member of an Eligible Class; or
- 3) the date You complete the Eligibility Waiting Period for Coverage shown in the Schedule of Insurance, if applicable.

GBD-1100 D02 (10/08)

Eligibility for Dependent Coverage: *When will I become eligible for Dependent Coverage?*

You will become eligible for Dependent coverage on the later of:

- 1) the date You become eligible for teammate coverage; or
- 2) the date You acquire Your first Dependent.

GBD-1100 D03 (10/08) (Rev-1)

Enrollment: *How do I enroll for coverage?*

For Non-Contributory Coverage, Your Employer will automatically enroll You for coverage. However, You will be required to complete a beneficiary designation form.

To enroll for Contributory Coverage, You must:

- 1) complete and sign a group insurance enrollment form which is satisfactory to Us, for Your and Your Dependent's coverage; and
- 2) deliver it to Your Employer.

You have the option to enroll electronically. Your Employer will provide instructions.

If You do not enroll for Your coverage and/or Your Dependent's coverage within 31 days after becoming eligible under The Policy, or if You were eligible to enroll under the Prior Policy and did not do so, and later choose to enroll You may enroll for Your coverage and/or Your Dependent's coverage only:

- 1) during an Annual Enrollment Period designated by the Policyholder; or
- 2) within 31 days of the date You have a Change in Family Status.

Enrollment may be subject to the Evidence of Insurability Requirements provision.

GBD-1100 D04 (10/08) (Rev-1)

Evidence of Insurability Requirements: *When will I first be required to provide Evidence of Insurability?*

We require Evidence of Insurability for initial coverage, if You:

- 1) enroll more than 31 days after the date You are first eligible to enroll, for an amount greater than one level, including electing initial coverage after a Change in Family Status;
- 2) enroll for an Amount of Life Insurance greater than the Supplemental Guaranteed Issue Amount, regardless of when You enroll for coverage; or
- 3) were eligible for any coverage under the Prior Policy, but did not enroll and later choose to enroll for that coverage under The Policy for an amount greater than one level.

If Your Evidence of Insurability is not satisfactory to Us:

- 1) Your Amount of Life Insurance will equal the amount for which You were eligible without providing Evidence of Insurability, provided You enrolled within 31 days of the date You were first eligible to enroll; and
- 2) You will not be covered under The Policy if You enrolled more than 31 days after the date You were first eligible to enroll.

GBD-1100 D05 (10/08) (Rev-1)

Dependent Evidence of Insurability Requirements: *When will my Dependents first be required to provide Evidence of Insurability?*

We require Evidence of Insurability, for initial coverage, if You:

- 1) enroll for Your Dependents' coverage more than 31 days after the date You are first eligible to enroll, for an amount greater than the Guaranteed Issue Amount, including electing initial coverage after a Change in Family Status;
- 2) enroll for an Amount of Dependent Life Insurance greater than the Dependent Guaranteed Issue Amount, regardless of when You enroll for coverage; or
- 3) were eligible for any coverage under the Prior Policy, but did not enroll and later choose to enroll for that coverage under The Policy for an amount greater than the Guaranteed Issue Amount.

However, no Evidence of Insurability will be required if the Amount of Life Insurance for Your Dependent Child(ren) is \$15,000 or less.

If Your Dependents' Evidence of Insurability is not satisfactory to Us:

- 1) Your Dependents' Amount of Life Insurance will equal the amount for which Your Dependents were eligible without providing Evidence of Insurability, provided You enrolled within 31 days of the date You were first eligible to enroll;
- 2) Your Dependents will not be covered under The Policy if You enrolled more than 31 days after the date You were first eligible to enroll.

GBD-1100 D06 (10/08)

Evidence of Insurability: *What is Evidence of Insurability?*

Evidence of Insurability must be satisfactory to Us and may include, but will not be limited to:

- 1) a completed and signed application approved by Us;
- 2) a medical examination;
- 3) an attending Physician's statement; and
- 4) any additional information We may require.

Evidence of Insurability will be furnished at Our expense except for Evidence of Insurability due to late enrollment. We will then determine if You or Your Dependents are insurable for initial coverage or an increase in coverage as described in the Increase in Amount of Life Insurance provision.

You will be notified in writing of Our determination of any Evidence of Insurability submission.

GBD-1100 D07 (10/08)

Change in Family Status: *What constitutes a Change in Family Status?*

A Change in Family Status occurs when:

- 1) You get married;
- 2) You and Your spouse divorce or legally separate (recorded through the Clerk of Court);
- 3) Your child is born or You adopt or become the legal guardian of a child or a child is placed with You for foster care;
- 4) Your spouse or child dies;
- 5) Your spouse's loss or commencement of employment;
- 6) Your spouse moves into or out of a country with socialized medicine;
- 7) Your or Your spouse's start or end a military leave of absence;
- 8) Your loss of coverage under Medicare or Medicaid;
- 9) Your COBRA coverage expires or COBRA subsidiary expires;
- 10) You or Your spouse have a significant change in health care costs under Your spouse's plan;
- 11) You lose your eligibility under your parent's health care plan; or
- 12) You have a change in day care coverage for your child (Dependent Care FSA only).

GBD-1100 D08 (10/08)

PERIOD OF COVERAGE

Effective Date: *When does my coverage start?*

Non-Contributory Coverage will start on the date You become eligible.

Contributory Coverage, for which Evidence of Insurability is not required, will start on the latest to occur of:

- 1) the date You become eligible, if You enroll on or before that date;

- 2) the January 1st on or next following the last day of the Annual Enrollment Period, if You enroll during an Annual Enrollment Period; or
- 3) the date You enroll, if You do so within 31 days from the date You are eligible.

Any coverage for which Evidence of Insurability is required, will become effective on the later of:

- 1) the date You become eligible; or
- 2) the date We approve Your Evidence of Insurability.

All Effective Dates of coverage are subject to the Deferred Effective Date provision.

GBD-1100 E01 (10/08)

Deferred Effective Date: *When will my effective date for coverage or a change in my coverage be deferred?*

If, on the date You are to become covered:

- 1) under The Policy; or
- 2) for a new benefit;

You are not Actively at Work due to a physical or mental condition, such coverage will not start until the date You are Actively at Work.

GBD-1100 E03 (10/08)

Continuity from a Prior Policy: *Is there continuity of coverage from a Prior Policy?*

Your initial coverage under The Policy will begin, and will not be deferred if, on the day before the Policy Effective Date, You were:

- 1) insured under the Prior Policy; and
- 2) Actively at Work or on an authorized family and medical leave;

but on the Policy Effective Date, You were not Actively at Work, and would otherwise meet the Eligibility requirements of The Policy. However, Your Amount of Insurance will be the lesser of the amount of life insurance:

- 1) You had under the Prior Policy; or
- 2) shown in the Schedule of Insurance;

reduced by any coverage amount:

- 1) that is in force, paid or payable under the Prior Policy; or
- 2) that would have been so payable under the Prior Policy had timely election been made.

Such amount of insurance under this provision is subject to any reductions in The Policy and will not increase.

Coverage provided through this provision ends on the first to occur of:

- 1) the last day of a period of 12 consecutive months after the Policy Effective Date;
- 2) the date Your insurance terminates for any reason shown under the Termination provision;
- 3) the last day You would have been covered under the Prior Policy, had the Prior Policy not terminated; or
- 4) the date You are Actively at Work.

However, if the coverage provided through this provision ends because You are Actively at Work, You may be covered as an Active Teammate under The Policy.

GBD-1100 E05 (10/08) (Rev-1)

Dependent Effective Date: *When does Dependent coverage start?*

Coverage, for which Evidence of Insurability is not required, will start on the latest to occur of:

- 1) the date You become eligible for Dependent coverage, if You have enrolled on or before that date; or
- 2) the January 1st on or next following the last day of the Annual Enrollment Period, if You enroll during an Annual Enrollment Period; or
- 3) the date You enroll, if You do so within 31 days from the date You are eligible for Dependent coverage.

Coverage for which Evidence of Insurability is required, will become effective on the later of:

- 1) the date You become eligible for Dependent coverage; or
- 2) the date We approve Your Dependents' Evidence of Insurability.

In no event will Dependent coverage become effective before You become eligible.

GBD-1100 E07 (10/08)

Dependent Deferred Effective Date: *When will the effective date for Dependent coverage or a change in coverage be deferred?*

If, on the date Your Dependent, other than a newborn, is to become covered:

- 1) under The Policy;
- 2) for increased benefits; or
- 3) for a new benefit; and

he or she is:

- 1) confined in a hospital; or
- 2) Confined Elsewhere;

such coverage will not start until he or she:

- 1) is discharged from the hospital; or
- 2) is no longer Confined Elsewhere;

and has engaged in all the normal and customary activities of a person of like age and gender, in good health, for at least 15 consecutive days.

This Deferred Effective Date provision will not apply to disabled children who qualify under the definition of Dependent Child(ren).

Confined Elsewhere means Your Dependent is unable to perform, unaided, the normal functions of daily living, or leave home or other place of residence without assistance.

GBD-1100 E09 (10/08)

Dependent Continuity from a Prior Policy: *Is there continuity of coverage from a Prior Policy for my Dependents?*

If on the day before the Policy Effective Date, You were covered with respect to Your Dependents under the Prior Policy, the Deferred Effective Date provision will not apply to initial coverage under The Policy for such Dependents. However, the Dependent Amount of Insurance will be the lesser of the amount of life insurance:

- 1) Your Dependents had under the Prior Policy; or
- 2) shown in the Schedule of Insurance;

reduced by any coverage amount:

- 1) that is in force, paid or payable under the Prior Policy; or
- 2) that would have been so payable under the Prior Policy had timely election been made.

GBD-1100 E11 (10/08)

Change in Coverage: *When may I change my coverage or coverage for my Dependents?*

After Your initial enrollment You may increase or decrease coverage for You or Your Dependents, or add a new Dependent to Your existing Dependent coverage:

- 1) during any Annual Enrollment Period designated by the Policyholder; or
- 2) within 31 days of the date of a Change in Family Status.

GBD-1100 E12 (10/08)

Effective Date for Changes in Coverage: *When will changes in coverage become effective?*

Any decrease in coverage will take effect on the date of the change.

Any increase in coverage will take effect on the latest of:

- 1) the date of the change;
- 2) the date requirements of the Deferred Effective Date provision are met;
- 3) the date Evidence of Insurability is approved, if required; or
- 4) the January 1st on or next following the last day of the Annual Enrollment Period, except for an increase as a result of a Change in Family Status.

GBD-1100 E13 (10/08)

Increase in Amount of Life Insurance: *If I request an increase in the Amount of Life Insurance for myself, must I provide Evidence of Insurability?*

If You or Your Dependents are already enrolled for an Amount of Supplemental Life Insurance under The Policy, then You and Your Dependents must provide Evidence of Insurability for any increase that would result in an Amount of Life Insurance that is greater than the Guaranteed Issue Amount.

If Your Evidence of Insurability is not satisfactory to Us, the Amount of Life Insurance You had in effect on the date immediately prior to the date You requested the increase will not change.

If Your Dependents' Evidence of Insurability is not satisfactory to Us, the Amount of Life Insurance they had in effect on the date immediately prior to the date You requested the increase will not change.

GBD-1100 E15 (10/08) (Rev-1)

Termination: *When will my coverage end?*

Your coverage will end on the earliest of the following:

- 1) the last day of the month following the date The Policy terminates;
- 2) the last day of the month following the date You are no longer in a class eligible for coverage, or The Policy no longer insures Your class;
- 3) the last day of the month following the date the premium payment is due but not paid;
- 4) the 15th of the month in which Your employment terminates if Your employment terminates from the 1st to the 15th of the month; or the last day of the month in which Your employment terminates if Your employment terminates from the 16th through the last day of the month; or
- 5) the last day of the month following the date You are no longer Actively at Work;

unless continued in accordance with any one of the Continuation Provisions.

GBD-1100 E17 (10/08)

Dependent Termination: *When does coverage for my Dependent end?*

Coverage for Your Dependent will end on the earliest to occur of:

- 1) the last day of the month following the date Your coverage ends;
- 2) the last day of the month following the date the required premium is due but not paid;
- 3) the last day of the month following the date You are no longer eligible for Dependent coverage;
- 4) the 15th of the month in which Your employment terminates if Your employment terminates from the 1st to the 15th of the month; or the last day of the month in which Your employment terminates if Your employment terminates from the 16th through the last day of the month; or
- 5) the last day of the month following the date the Dependent no longer meets the definition of Dependent;

unless continued in accordance with the Continuation Provisions.

GBD-1100 E21 (10/08)

Continuation Provisions: *Can my coverage and coverage for my Dependents be continued beyond the date it would otherwise terminate?*

Coverage can be continued by Your Employer beyond a date shown in the Termination provision, if Your Employer provides a plan of continuation which applies to all teammates the same way.

The amount of continued coverage applicable to You or Your Dependents will be the amount of coverage in effect on the date immediately before coverage would otherwise have ended. Continued coverage:

- 1) is subject to any reductions in The Policy;
- 2) is subject to payment of premium;
- 3) may be continued up to the maximum time shown in the provisions; and
- 4) terminates if The Policy terminates.

In no event will the amount of insurance increase while coverage is continued in accordance with the following provisions. The Continuation Provisions shown below may not be applied consecutively.

In all other respects, the terms of Your coverage and coverage for Your Dependents remain unchanged.

Leave of Absence: If You are on a documented leave of absence, other than Family and Medical Leave or Military Leave of Absence, Your coverage (including Dependent Life coverage) may be continued for 36 month(s) after the month in which the leave of absence commenced. If the leave terminates prior to the agreed upon date, this continuation will cease immediately.

Military Leave of Absence: If You enter active full-time military service and are granted a military leave of absence in writing, Your coverage (including Dependent Life coverage) may be continued for up to 5 year(s). If the leave ends prior to the agreed upon date, this continuation will cease immediately.

Lay Off: If You are temporarily laid off by the Employer due to lack of work, all of Your coverage (including Dependent Life coverage) may be continued until the last day of the month following the month in which the lay off commenced. If the lay off becomes permanent, this continuation will cease immediately.

Disability Insurance: If You are working for the Policyholder and:

- 1) are covered by; and
- 2) meet the definition of disabled under;

a group long term disability insurance policy, issued by Us to Your Employer, Your coverage (including Dependent Life coverage) may be continued for a period of 12 consecutive month(s) from the date You were last Actively at Work while You remain disabled.

Sickness or Injury: If You are not Actively at Work due to sickness or injury, all of Your coverages (including Dependent Life coverage) may be continued:

- 1) for a period of 12 consecutive month(s) from the date You were last Actively at Work; or
- 2) if such absence results in a leave of absence in accordance with state or federal family and medical leave laws, then the combined continuation period will not exceed 12 consecutive month(s).

Family and Medical Leave: If You are granted a leave of absence, in writing, according to the Family and Medical Leave Act of 1993, or other applicable state or local law, Your coverage(s) (including Dependent Life coverage) may be continued for up to 12 weeks, or 26 weeks if You qualify for Family Military Leave, or longer if required by other applicable law, following the date Your leave commenced. If the leave of absence ends prior to the agreed upon date, this continuation will cease immediately.

Severance: If Your employment terminates and continuation of life insurance is available to You and Your Dependents in a severance plan sponsored by the Employer, all of Your coverage (including Dependent Life coverage) may be continued. Your coverage will continue until the earliest of:

- 1) the date The Policy terminates;
- 2) the date You become covered under another group life insurance policy;
- 3) the date specified in Your severance plan; or
- 4) for up to 2 month(s) from the date Your employment terminated.

Coverage for Your Dependents will continue until the earliest of:

- 1) the date Your Dependents no longer meet the definition of Dependents;
- 2) the date We or Your Employer terminate Dependent coverage; or
- 3) the date Your coverage terminates.

GBD-1100 E23 (10/08) (Rev-1)

Continuation for Dependent Child(ren) with Disabilities: *Will coverage for Dependent Child(ren) with disabilities be continued?*

If Your Dependent Child(ren) reach the age at which they would otherwise cease to be a Dependent as defined, and they are:

- 1) age 26 or older; and
- 2) disabled; and
- 3) primarily dependent upon You for financial support;

then Dependent Child(ren) coverage will not terminate solely due to age. However:

- 1) You must submit proof satisfactory to Us of such Dependent Child(ren)'s disability within 31 days of the date he or she reaches such age; and
- 2) such Dependent Child(ren) must have become disabled before attaining age 26.

Coverage under The Policy will continue as long as:

- 1) You remain insured;
- 2) the child continues to meet the required conditions; and
- 3) any required premium is paid when due.

However, no increase in the Amount of Life Insurance for such Dependent Child(ren) will be available.

We have the right to require proof, satisfactory to Us, as often as necessary during the first two years of continuation, that the child continues to meet these conditions. We will not require proof more often than once a year after that.

GBD-1100 E26 (10/08)

Disability Extension: *Does coverage continue if I am Disabled?*

If You become Disabled, You may qualify for Disability Extension for You and Your Dependents. To qualify for Disability Extension, You must be Disabled prior to Normal Retirement Age. If You qualify for Disability Extension, You may continue Your coverage while You are Disabled provided the required premium payments are made.

If You qualify for Disability Extension, the amount of continued coverage:

- 1) will be the amount in force on the date You cease to be an Active Teammate or the date You became insured under The Policy if You were never an Active Teammate under The Policy;
- 2) will be subject to any reductions provided by The Policy; and

3) will not increase.
GBD-1100 E29 (10/08)

Eligible Coverages: *What coverages are eligible under this provision?*

This provision applies only to:

- 1) Your Basic Life Insurance;
- 2) Your Supplemental Life Insurance; and
- 3) Dependent Life Insurance.

You are not eligible to apply for both the Portability Benefit and Disability Extension for the same coverage amount for You or Your Dependents.

GBD-1100 E31 (10/08) (Rev-1) (NC)

Disabled: *What does Disabled mean?*

Disabled means You are prevented by injury or sickness from doing any work for which You are, or could become, qualified by:

- 1) education;
- 2) training; or
- 3) experience.

In addition, You will be considered Disabled if You have been diagnosed with a life expectancy of 24 months or less.

GBD-1100 E32 (10/08)

Conditions for Qualification: *What conditions must I satisfy before I qualify for this provision?*

To qualify for Disability Extension You must:

- 1) be covered under The Policy and be under Normal Retirement Age when You become Disabled;
- 2) be Disabled and provide Proof of Loss that You have been Disabled; or
- 3) Your coverage must have been continued under a Disability Extension provision of the Prior Policy.

In any event, You must have been Actively at Work under The Policy to qualify for Disability Extension.

GBD-1100 E34 (10/08) (Rev-1) (NC)

Disability Extension Ceases: *When will the Disability Extension cease?*

We will continue Your coverage while You remain Disabled until the earliest of the date:

- 1) The Policy terminates;
- 2) the required premium for coverage is due but not paid;
- 3) You attain Normal Retirement Age; or
- 4) You are no longer in an Eligible Class, or the class is cancelled.

What happens when the Disability Extension ceases?

When the Disability Extension ceases:

- 1) if You return to work in an Eligible Class, as an Active Teammate, then You may again be eligible for coverage as long as premiums are paid when due; or
- 2) if You do not return to work in an Eligible Class, coverage will end and You may be eligible to exercise the Conversion Right if You do so within the time limits described in such provision. The Amount of Life Insurance that may be converted will be subject to the terms and conditions of the Conversion Right. Portability will not be available.

GBD-1100 E40 (10/08)

BENEFITS

Life Insurance Benefit: *When is the Life Insurance Benefit payable?*

If You or Your Dependents die while covered under The Policy, We will pay the deceased person's Life Insurance Benefit after We receive Proof of Loss, in accordance with the Proof of Loss provision.

The Life Insurance Benefit will be paid according to the General Provisions of The Policy.

GBD-1100 F01 (10/08)

Suicide: *What benefit is payable if death is a result of suicide?*

If You or Your Dependent commit suicide while sane or insane, We will not pay any Supplemental Amount of Life Insurance or Supplemental Amount of Dependent Life Insurance for the deceased person which was elected within the 2 year period immediately prior to the date of death. This applies to initial coverage and elected increases in coverage. It does not apply to benefit increases that resulted solely due to an increase in Earnings.

This 2 year period includes the time group life insurance coverage was in force under the Prior Policy.

Any premium paid by You during this 2 year period for initial amounts of Supplemental Life Insurance or elected increases in Supplemental Life Insurance, will be returned to Your beneficiary.

GBD-1100 F03 (10/08)

Accelerated Benefit: *What is the benefit?*

In the event that You or Your Dependent are diagnosed as Terminally Ill while the Terminally Ill person is:

- 1) covered under The Policy for an Amount of Life Insurance of at least \$10,000; and
- 2) under age 80;

We will pay the Accelerated Benefit in a lump sum amount as shown below, provided We receive proof of such Terminal Illness.

The Accelerated Benefit will not be available to You unless You have been Actively at Work under The Policy.

You must request in writing that a portion of the Terminally Ill person's Amount of Life Insurance be paid as an Accelerated Benefit.

The Amount of Life Insurance payable upon the Terminally Ill person's death will be reduced by any Accelerated Benefit Amount paid under this benefit. Any premium required will be based on the amount of Your life insurance remaining after the Accelerated Benefit is paid under this benefit.

You may request a minimum Accelerated Benefit amount of \$3,000, and a maximum of \$500,000. However, in no event will the Accelerated Benefit Amount exceed 80% of the Terminally Ill person's Amount of Life Insurance. This option may be exercised only once for You and only once for each of Your Dependents.

For example, if You are covered for a Life Insurance Benefit Amount under The Policy of \$100,000 and are Terminally Ill, You can request any portion of the Amount of Life Insurance Benefits from \$3,000 to \$80,000 to be paid now instead of to Your beneficiary upon death. However, if You decide to request only \$3,000 now, You cannot request the additional \$77,000 in the future.

Any benefits received under this benefit may be taxable. You should consult a personal tax advisor for further information.

In the event:

- 1) You are required by law to accelerate benefits to meet the claims of creditors; or
- 2) if a government agency requires You to apply for benefits to qualify for a government benefit or entitlement;

You will still be required to satisfy all the terms and conditions herein in order to receive an Accelerated Benefit.

If You have executed an assignment of rights and interest with respect to Your or Your Dependent's Amount of Life Insurance, in order to receive the Accelerated Benefit, We must receive a release from the assignee before any benefits are payable.

Terminal Illness or Terminally Ill means a life expectancy of 24 months or less.

GBD-1100 F06 (10/08) (Rev-1)

Proof of Terminal Illness and Examinations: *Must proof of Terminal Illness be submitted?*

We reserve the right to require satisfactory Proof of Terminal Illness on an ongoing basis. Any diagnosis submitted must be provided by a Physician.

If You or Your Dependents do not submit proof of Terminal Illness satisfactory to Us, or if You or Your Dependents refuse to be examined by a Physician, as We may require, then We will not pay an Accelerated Benefit.

GBD-1100 F07 (10/08)

Conversion Right: *If coverage under The Policy ends, do I have a right to convert?*

If Life Insurance coverage or any portion of it under The Policy ends for any reason, except nonpayment of premium, You and Your Dependents may have the right to convert the coverage that terminated to an individual conversion policy without providing Evidence of Insurability. Conversion is not available for any Amount of Life Insurance for which You or Your Dependents were not eligible and covered under The Policy.

If coverage under The Policy ends because:

- 1) The Policy is terminated; or,
- 2) coverage for an Eligible Class is terminated;

then You or Your Dependent must have been insured under The Policy for 5 years or more, in order to be eligible to convert coverage. The amount which may be converted under these circumstances is limited to the lesser of:

- 1) \$10,000; or
- 2) the Life Insurance Benefit under The Policy less any Amount of Life Insurance for which You or Your Dependent may become eligible under any group life insurance policy issued or reinstated within 31 days of termination of group life coverage.

If coverage under The Policy ends for any other reason, except nonpayment of premium, the full amount of coverage which ended may be converted.

Insurer, as used in this provision, means Us or another insurance company which has agreed to issue conversion policies according to this Conversion Right.

GBD-1100 F09 (10/08) (Rev-1)

Conversion: *How do I convert my coverage or my Dependents' coverage?*

To convert Your coverage or coverage for Your Dependents, You must:

- 1) complete a Notice of Conversion Right form; and
- 2) have Your Employer sign the form.

The Insurer must receive this within:

- 1) 31 days after Life Insurance terminates; or
- 2) 15 days from the date Your Employer signs the form;

whichever is later. However, We will not accept requests for Conversion if they are received more than 91 days after Life Insurance terminates.

After the Insurer verifies eligibility for coverage, the Insurer will send You a Conversion Policy proposal. You must:

- 1) complete and return the request form in the proposal; and
- 2) pay the required premium for coverage;

within the time period specified in the proposal.

Any individual policy issued to You or Your Dependents under the Conversion Right:

- 1) will be effective as of the 32nd day after the date coverage ends; and
- 2) will be in lieu of coverage for this amount under The Policy.

GBD-1100 F10 (10/08)

Conversion Policy Provisions: *What are the Conversion Policy provisions?*

The Conversion Policy will:

- 1) be issued on any one of the Life Insurance policy forms the Insurer is issuing for this purpose at the time of conversion; and
- 2) base premiums on the Insurer's rates in effect for new applicants of Your class and age at the time of conversion.

The Conversion Policy will not provide:

- 1) the same terms and conditions of coverage as The Policy;
- 2) any benefit other than the Life Insurance Benefit; and
- 3) term insurance.

However, Conversion is not available for any Amount of Life Insurance which was, or is being, continued:

- 1) under a certificate of insurance issued in accordance with the Portability provision; or
- 2) in accordance with the Continuation Provisions;

until such coverage ends.

GBD-1100 F11 (10/08)

Death within the Conversion Period: *What if I or my Dependents die before coverage is converted?*

We will pay the deceased person's Amount of Life Insurance You would have had the right to apply for under this provision if:

- 1) coverage under The Policy terminates; and
- 2) You or Your Dependent die within 31 days of the date coverage terminates; and
- 3) We receive Proof of Loss.

If the Conversion Policy has already taken effect, no Life Insurance Benefit will be payable under The Policy for the amount converted.

GBD-1100 F12 (10/08)

Portability Benefits: *What is Portability?*

Portability is a provision which allows You and Your Dependents to continue coverage under a group Portability policy when coverage would otherwise end due to certain Qualifying Events.

GBD-1100 F14 (10/08)

Qualifying Events: *What are Qualifying Events?*

Qualifying Events for You are:

- 1) Your employment terminates for any reason prior to Normal Retirement Age; or
- 2) Your membership in an Eligible Class under The Policy ends;
provided the Qualifying Event occurs prior to Normal Retirement Age.

Qualifying Events for Your Dependents are:

- 1) Your employment terminates, for any reason prior to Normal Retirement Age;
- 2) Your death;
- 3) Your membership in a class eligible for Dependent coverage ends; or
- 4) He or she no longer meets the definition of Dependent, however, a Dependent Child(ren) who reaches the limiting age under The Policy is not eligible for Portability;
provided the Qualifying Event occurs prior to Normal Retirement Age.

In order for Dependent Child(ren) coverage to be continued under this provision, You or Your Spouse must elect to continue coverage due to your own Qualifying Event.

GBD-1100 F15 (10/08)

Electing Portability: *How do I elect Portability?*

You may elect Portability for Your coverage after Your Basic and Supplemental Life Insurance coverage ends due to a Qualifying Event. You may also elect Portability for Your Dependent coverage if Your Dependent coverage ends due to a Qualifying Event. The Policy must still be in force in order for Portability to be available. Portability will not be available to You or Your Dependents unless You have been Actively at Work under The Policy.

To elect Portability for You or Your Dependents, You must:

- 1) complete and have Your Employer sign a Portability application; and
- 2) submit the application to Us, with the required premium.

This must be received within:

- 1) 31 days after Life Insurance terminates; or
- 2) 15 days from the date Your Employer signs the application;

whichever is later. However, Portability requests will not be accepted if they are received more than 91 days after Life Insurance terminates.

After We verify eligibility for coverage, We will issue a certificate of insurance under a Portability policy. The Portability coverage will be:

- 1) issued without Evidence of Insurability;
- 2) issued on one of the forms then being issued by Us for Portability purposes; and
- 3) effective on the day following the date Your or Your Dependent's coverage ends.

The terms and conditions of coverage under the Portability policy will not be the same terms and conditions that are applicable to coverage under The Policy.

GBD-1100 F16 (10/08) (NC)

Limitations: *What limitations apply to this benefit?*

You may elect to continue 50%, 75%, or 100% of the Amount of Life Insurance which is ending for You or Your Dependent. This amount will be rounded to the next higher multiple of \$1,000, if not already a multiple of \$1,000. However, the Amount of Life Insurance that may be continued will not exceed:

- 1) \$1,000,000 for You;
- 2) \$50,000 for Your Spouse; or
- 3) \$10,000 for Your Dependent Child(ren).

If You elect to continue 50% or 75% now, You may not continue any portion of the remaining amount under this Portability provision at a later date. In no event will You or Your Dependents be able to continue an Amount of Life Insurance which is less than \$5,000.

Portability is not available for any Amount of Life Insurance for which You or Your Dependents were not eligible and covered.

In addition Portability is not available if You or Your Dependents are entering active military service.

GBD-1100 F17 (10/08)

Effect of Portability on Other Provisions: *How does Portability affect other Provisions?*

Portability is not available for any Amount of Life Insurance that You have exercised under the Conversion Right.

Portability is also not available to You while Your coverage is being continued under a Continuation Provision under The Policy. However, if:

- 1) You elect to continue only a portion of terminated coverage under this Portability Benefit; or
- 2) the Amount of Life Insurance exceeds the maximum Portability amount;

then the Conversion Right may be available for the remaining amount.

GBD-1100 F18 (10/08) (Rev-1)

GENERAL PROVISIONS

Notice of Claim: *When should I notify the Company of a claim?*

You, or the person who has the right to claim benefits, must give Us, written notice of a claim within 30 days after the date of death.

If notice cannot be given within that time, it must be given as soon as reasonably possible after that. Such notice must include the claimant's name, address, and the Policy Number.

GBD-1100 H01 (10/08)

Claim Forms: *Are special forms required to file a claim?*

We will send forms to the claimant to provide Proof of Loss, within 15 days of receiving a Notice of Claim. If We do not send the forms within 15 days, the claimant may submit any other written proof which fully describes the nature and extent of the claim.

GBD-1100 H02 (10/08) (NC)

Proof of Loss: *What is Proof of Loss?*

Proof of Loss may include, but is not limited to, the following:

- 1) a completed claim form;
- 2) a certified copy of the death certificate (if applicable);
- 3) Your Enrollment form;
- 4) Your Beneficiary Designation (if applicable);
- 5) documentation of:
 - a) the date Your disability began;
 - b) the cause of Your disability; and
 - c) the prognosis of Your disability;
- 6) any and all medical information, including x-ray films and photocopies of medical records, including histories, physical, mental or diagnostic examinations and treatment notes;
- 7) the names and addresses of all:
 - a) Physicians or other qualified medical professionals You have consulted;
 - b) hospitals or other medical facilities in which You have been treated; and
 - c) pharmacies which have filled Your prescriptions within the past three years;

- 8) Your signed authorization for Us to obtain and release medical, employment and financial information (if applicable); or
- 9) any additional information required by Us to adjudicate the claim.

All proof submitted must be satisfactory to Us.

GBD-1100 H03 (10/08)

Sending Proof of Loss: *When must Proof of Loss be given?*

Written Proof of Loss should be sent to Us or Our representative within 365 day(s) after the loss. However, all claims should be submitted to Us within 90 days of the date coverage ends.

If proof is not given by the time it is due, it will not affect the claim if:

- 1) it was not reasonably possible to give proof within the required time; and
- 2) proof is given as soon as reasonably possible; but
- 3) not later than 1 year after it is due unless You, or the person who has the right to claim benefits, are not legally competent.

GBD-1100 H04 (10/08) (Rev-1)

Physical Examination and Autopsy: *Can We have a claimant examined or request an autopsy?*

While a claim is pending We have the right at Our expense:

- 1) to have the person who has a loss examined by a Physician when and as often as We reasonably require; and
- 2) to have an autopsy performed in case of death where it is not forbidden by law.

GBD-1100 H05 (10/08)

Claim Payment: *When are benefit payments issued?*

When We determine that benefits are payable, We will pay the benefits in accordance with the Claims to be Paid provision, but not more than 30 days after such Proof of Loss is received.

Benefits may be subject to interest payments as required by applicable law.

GBD-1100 H06 (10/08)

Claims to be Paid: *To whom will benefits for my claim be paid?*

Life Insurance Benefits will be paid in accordance with the life insurance Beneficiary Designation provided it does not contradict the Claim Payment provision.

If no beneficiary is named, or if no named beneficiary survives You, We may, at Our option, pay:

- 1) the executors or administrators of Your estate;
- 2) all to Your surviving spouse;
- 3) if Your spouse does not survive You, in equal shares to Your surviving children;
- 4) if no child survives You, in equal shares to Your surviving parents; or
- 5) if no parent survives You, in equal shares to Your surviving siblings.

In addition, We may, at Our option, pay a portion of Your Life Insurance Benefit up to \$250 to any person equitably entitled to payment by reason of having incurred expenses on Your behalf or because of expenses from Your burial. Payment to any person, as shown above, will release Us from liability for the amount paid.

If any beneficiary is a minor, We may pay his or her share, until a legal guardian of the minor's estate is appointed, to a person who at Our option and in Our opinion is providing financial support and maintenance for the minor. We will pay:

- 1) \$200 at Your death; and
- 2) monthly installments of not more than \$200.

Payment to any person as shown above will release Us from all further liability for the amount paid.

We will pay the Life Insurance Benefit at Your Dependent's death to You, if living. Otherwise, it will be paid, at Our option, to Your surviving spouse or the executor or administrator of Your estate.

We will make any payments, other than for loss of life, to You. We may make any such payments owed at Your death to Your estate. If any payment is owed to:

- 1) Your estate;
- 2) a person who is a minor; or
- 3) a person who is not legally competent,

then We may pay up to \$1,000 to a person who is related to You and who, at Our sole discretion, is entitled to it. Any such payment shall fulfill Our responsibility for the amount paid.
GBD-1100 H07 (10/08) (Rev-1) (NC)

Beneficiary Designation: *How do I designate or change my beneficiary?*

You may designate or change a beneficiary by doing so in writing on a form satisfactory to Us and filing the form with the Employer. Only satisfactory forms sent to the Employer prior to Your death will be accepted.

Beneficiary designations will become effective as of the date You signed and dated the form, even if You have since died. We will not be liable for any amounts paid before receiving notice of a beneficiary change from the Employer.
GBD-1100 H08 (10/08)

Claim Denial: *What notification will my beneficiary or I receive if a claim is denied?*

If a claim for benefits is wholly or partly denied, You or Your beneficiary will be furnished with written notification of the decision. This written notification will:

- 1) give the specific reason(s) for the denial;
- 2) make specific reference to the provisions upon which the denial is based;
- 3) provide a description of any additional information necessary to perfect a claim and an explanation of why it is necessary; and
- 4) provide an explanation of the review procedure.

GBD-1100 H10 (10/08)

Claim Appeal: *What recourse do my beneficiary or I have if a claim is denied?*

On any claim, the claimant or his or her representative may appeal to Us for a full and fair review. To do so, he or she:

- 1) must request a review upon written application within:
 - a) 180 days of receipt of claim denial if the claim requires Us to make a determination of disability; or
 - b) 60 days of receipt of claim denial if the claim does not require Us to make a determination of disability; and
- 2) may request copies of all documents, records, and other information relevant to the claim; and
- 3) may submit written comments, documents, records and other information relating to the claim.

We will respond in writing with Our final decision on the claim.

GBD-1100 H11 (10/08)

Policy Interpretation: *Who interprets the terms and conditions of The Policy?*

We have full discretion and authority to determine eligibility for benefits and to construe and interpret all terms and provisions of The Policy. This provision applies where the interpretation of The Policy is governed by the Employee Retirement Income Security Act of 1974, as amended (ERISA).

GBD-1100 H12 (10/08)

Incontestability: *When can the Life Insurance Benefit of The Policy be contested?*

Except for non-payment of premiums, Your or Your Dependent's Life Insurance Benefit cannot be contested after two years from its effective date.

No statement made by You or Your Spouse relating to Your or Your Spouse's insurability will be used to contest Your insurance for which the statement was made after Your insurance has been in force for two years. In order to be used, the statement must be in writing and signed by You and Your Spouse.

No statement made relating to Your Dependents being insurable will be used to contest their insurance for which the statement was made after their insurance has been in force for two years. In order to be used, the statement must be in writing and signed by You or Your representative.

All statements made by the Policyholder, the Employer or You or Your Spouse under The Policy will be deemed representations and not warranties. No statement made to affect this insurance will be used in any contest unless it is in writing and a copy of it is given to the person who made it, or to his or her beneficiary or Your representative.

GBD-1100 H13 (10/08) (NC)

Assignment: *Are there any rights of assignment?*

You have the right to absolutely assign all of Your rights and interest under The Policy including, but not limited to the following:

- 1) the right to make any contributions required to keep the insurance in force;

- 2) the right to convert; and
- 3) the right to name and change a beneficiary.

We will recognize any absolute assignment made by You under The Policy, provided:

- 1) it is duly executed; and
- 2) a copy is acknowledged and on file with Us.

We and the Policyholder assume no responsibility:

- 1) for the validity or effect of any assignment; or
- 2) to provide any assignee with notices which We may be obligated to provide to You.

You do not have the right to collaterally assign Your rights and interest under The Policy.

GBD-1100 H14 (10/08)

Legal Actions: *When can legal action be taken against Us?*

Legal action cannot be taken against Us:

- 1) sooner than 60 days after the date written Proof of Loss is furnished; or
- 2) more than 6 years after the date Proof of Loss is required to be furnished according to the terms of The Policy.

GBD-1100 H15 (10/08)

Workers' Compensation: *How does The Policy affect Workers' Compensation coverage?*

The Policy does not replace Workers' Compensation or affect any requirement for Workers' Compensation coverage.

GBD-1100 H16 (10/08)

Insurance Fraud: *How does the Company deal with fraud?*

Insurance fraud occurs when You, Your Dependents and/or the Employer provide Us with false information or file a claim for benefits that contains any false, incomplete or misleading information with the intent to injure, defraud or deceive Us. It is a crime if You, Your Dependents and/or the Employer commit insurance fraud. We will use all means available to Us to detect, investigate, deter and prosecute those who commit insurance fraud. We will pursue all available legal remedies if You, Your Dependents and/or the Employer perpetrate insurance fraud.

GBD-1100 H17 (10/08)

Misstatements: *What happens if facts are misstated?*

If material facts about You or Your Dependents were not stated accurately:

- 1) the premium may be adjusted; and
- 2) the true facts will be used to determine if, and for what amount, coverage should have been in force.

GBD-1100 H18 (10/08)

DEFINITIONS

Active Teammate means a teammate who works for the Employer on a regular basis in the usual course of the Employer's business. This must be at least the number of hours shown in the Schedule of Insurance.

PA-9221 C01 (10/08)

Actively at Work means at work with Your Employer on a day that is one of Your Employer's scheduled workdays. On that day, You must be performing for wage or profit all of the regular duties of Your job:

- 1) in the usual way; and
- 2) for Your usual number of hours.

We will also consider You to be Actively At Work on any regularly scheduled vacation day, paid time off day, personal day or holiday, only if You were Actively At Work on the preceding scheduled work day.

PA-9221 C02 (10/08)

Bonuses means the weekly average of bonuses You received from the Employer over:

- 1) the 12 calendar month period beginning on October 1st and ending on September 30th immediately prior to the anniversary date You became Disabled; or
- 2) the total period of time You worked for the Employer, if less than the above period.

PA-9221 C05 (10/08)

Contributory Coverage means coverage for which You are required to contribute toward the cost. Contributory Coverage is shown in the Schedule of Insurance.
PA-9221 C10 (10/08)

Dependent Child(ren) means:

Your children, stepchildren, legally adopted children, or any other children related to You by blood or marriage or domestic partnership provided such children are:

- 1) from live birth to age 26; or
- 2) age 26 or older and disabled. Such children must have become disabled before attaining age 26. You must submit proof, satisfactory to Us, of such children's disability.

PA-9221 C13 (10/08) (Rev-1)

Dependents means Your Spouse and Your Dependent Child(ren). A dependent must be a citizen or legal resident of the United States of America, its territories and protectorates.

PA-9221 C14 (10/08)

Earnings means the annual earnings calculated by the Employer.

PA-9221 C15 (10/08)

Employer means the Policyholder.

PA-9221 C18 (10/08)

Guaranteed Issue Amount means the Amount of Life Insurance for which We do not require Evidence of Insurability. The Guaranteed Issue Amount is shown in the Schedule of Insurance.

PA-9221 C20 (10/08)

Non-Contributory Coverage means coverage for which You are not required to contribute toward the cost. Non-Contributory Coverage is shown in the Schedule of Insurance.

PA-9221 C26 (10/08)

Normal Retirement Age means the Social Security Normal Retirement Age under the most recent amendments to the United States Social Security Act. It is determined by Your date of birth, as follows:

Year of Birth	Normal Retirement Age	Year of Birth	Normal Retirement Age
1937 or before	65	1955	66 + 2 months
1938	65 + 2 months	1956	66 + 4 months
1939	65 + 4 months	1957	66 + 6 months
1940	65 + 6 months	1958	66 + 8 months
1941	65 + 8 months	1959	66 + 10 months
1942	65 + 10 months	1960 or after	67
1943 through 1954	66		

PA-9221 C27 (10/08)

Physician means a person who is:

- 1) a doctor of medicine, Osteopathy, Psychology or other legally qualified practitioner of a healing art that We recognize or are required by law to recognize;
- 2) licensed to practice in the jurisdiction where care is being given;
- 3) practicing within the scope of that license; and
- 4) not You or Related to You by blood or marriage.

PA-9221 C31 (10/08)

Prior Policy means the group life insurance policy carried by the Employer on the day before the Policy Effective Date and will only include the coverage which is transferred to Us.

PA-9221 C33 (10/08)

Related means Your Spouse, or someone in a similar relationship in law to You, or other adult living with You, or Your sibling, parent, step-parent, grandparent, aunt, uncle, niece, nephew, son, daughter, or grandchild.

PA-9221 C34 (10/08)

Spouse means Your spouse who:

- 1) is not legally separated or divorced from You; and
- 2) is not in active full-time military service.

Spouse will include Your domestic partner provided You:

- 1) have executed a domestic partner affidavit satisfactory to Us, establishing that You and Your partner are domestic partners for purposes of The Policy; or
- 2) have registered as domestic partners with a government agency or office where such registration is available and provide proof of such registration unless requiring proof is prohibited by law.

You will continue to be considered domestic partners provided You continue to meet the requirements described in the domestic partner affidavit or required by law.

PA-9221 C37 (10/08)

The Policy means the Policy which We issued to the Policyholder under the Policy Number shown on the face page.

PA-9221 C38 (10/08)

We, Us, or Our means the insurance company named on the face page of The Policy.

PA-9221 C41 (10/08)

You or Your means the person to whom this Certificate of Insurance is issued.

PA-9221 C42 (10/08)

**THE LIFE AND ACCIDENTAL DEATH AND
DISMEMBERMENT BENEFIT (AD&D)
CERTIFICATES OF INSURANCE
FOLLOW IMMEDIATELY AFTER THIS PAGE**

CERTIFICATE OF INSURANCE
ACCIDENTAL DEATH AND DISMEMBERMENT BENEFIT (AD&D)

Maryland

The group insurance policy providing coverage under this certificate was issued in a jurisdiction other than Maryland and may not provide all of the benefits required by Maryland law.

State Notices

IMPORTANT INFORMATION FOR RESIDENTS OF CERTAIN STATES: There are state-specific requirements that may change the provisions described in the group insurance certificate. If you live in a state that has such requirements, those requirements will apply to your coverage. State-specific requirements that may apply to your coverage are summarized below. In addition, updated state-specific requirements are published on our website. You may access the website at <https://www.thehartford.com/>. If you are unable to access this website, want to receive a printed copy of these requirements, or have any questions or complaints regarding any of these requirements or any aspect of your coverage, please contact your Employee Benefits Manager; or you may contact us or one of our contracted administrators as follows:

The Hartford
Group Benefits Division, Customer Service
P.O. Box 2999
Hartford, CT 06104-2999
1-800-523-2233

If you have a complaint and contacts between you, us, your agent, or another representative have failed to produce a satisfactory solution to the problem, some states require we provide you with additional contact information. If your state requires such disclosure, the contact information is listed below with the other state requirements and notices.

We are providing notice that Hartford Life and Accident Insurance Company is subject to economic and trade sanctions laws and regulations. These laws and regulations, including the laws and regulations administered and enforced by the United States Department of the Treasury's Office of Foreign Assets Control ("OFAC"), prevent Hartford Life and Accident from providing coverage to, and from paying benefits to, entities and individuals where prohibited by applicable law. In addition, these laws and regulations prohibit certain activities with respect to certain countries.

We have included this information to make you aware of the existence and potential impact of these economic and trade sanctions programs on your benefit program.

The Hartford complies with applicable Federal civil rights laws and does not unlawfully discriminate on the basis of race, color, national origin, age, disability, or sex. The Hartford does not exclude or treat people differently for any reason prohibited by law with respect to their race, color, national origin, age, disability, or sex.

If your policy is governed under the laws of Maryland, any of the benefits, provisions or terms that apply to the state you reside in as shown below will apply only to the extent that such state requirements are more beneficial to you.

Alaska:

4. The **Policy Interpretation** provision if shown in the **General Provisions** section is not applicable.
5. The **Spouse** definition will always include domestic partners, civil unions, and any other legal union recognized by state law.

Arizona:

1. **NOTICE:** The Certificate may not provide all benefits and protections provided by law in Arizona. Please read the Certificate carefully.

Arkansas:

1. **NOTICE:** You have the right to file a complaint with the Arkansas Insurance Department (AID). You may call AID to request a complaint form at (800) 852-5494 or (501) 371-2640 or write the Department at:
Arkansas Insurance Department
1 Commerce Way, Suite 102
Little Rock, AR 72202

California:

1. The **Policy Interpretation** provision if shown in the **General Provisions** section is replaced by the following:

Eligibility Determination

We, and not Your Employer or plan administrator, have the responsibility to fairly, thoroughly, objectively and timely investigate, evaluate and determine the Covered Person's eligibility for benefits for any claim the Covered Person or the Covered Person's estate make on the Policy. We will:

- (a) obtain with the Covered Person's cooperation and authorization if required by law, only such information that is necessary to evaluate his/her claim and decide whether to accept or deny his/her claim for benefits. We may obtain this information from the Covered Person's Notice of Claim, submitted proofs of loss, statements, or other materials provided by the Covered Person or others on the Covered Person's behalf; or, at Our expense. We may obtain necessary information, or have the Covered Person physically examined when and as often as We may reasonably require while the claim is pending. In addition, and at the Covered Person's option and at his/her expense, the Covered Person may provide Us and We will consider any other information, including but not limited to, reports from a Physician or other expert of the Covered Person's choice. The Covered Person should provide Us with all information that he/she want Us to consider regarding his/her claim;
- (b) as a part of Our routine operations, We will apply the terms of the Policy for making decisions, including decisions on eligibility, receipt of benefits and claims, or explaining policies, procedures and processes;
- (c) if We approve the Covered Person's claim, We will review Our decision to approve his/her claim for benefits as often as is reasonably necessary to determine his/her continued eligibility for benefits;
- (d) if We deny the Covered Person's claim, We will explain in writing to the Covered Person the basis for an adverse determination in accordance with the Policy as described in the provision entitled Claim Denial.

In the event We deny the Covered Person's claim for benefits, in whole or in part, he/she can appeal the decision to Us. If the Covered Person chooses to appeal Our decision, the process he/she must follow is set forth in the Policy provision entitled **Claim Appeal**. If the Covered Person does not appeal the decision to Us, then the decision will be Our final decision.

2. **For Your Questions and Complaints:**

State of California Insurance Department
Consumer Communications Bureau
300 South Spring Street, South Tower
Los Angeles, CA 90013
Toll Free: 1(800) 927-HELP
TDD Number: 1(800) 482-4833
Web Address: www.insurance.ca.gov

Colorado:

1. Dependent Child coverage if shown in the **Dependent Termination** provision of the **Period of Coverage** section will not terminate if the Dependent Child is enrolled in a postsecondary education institution and takes a medical leave of absence before the earlier of:
 - a) one year after the first day of the Medically Necessary Leave of Absence; or
 - b) the date the coverage would otherwise terminate under the terms of coverage.

Medically Necessary Leave of Absence means a leave of absence from a postsecondary educational institution or a change in enrollment of the Dependent Child at the institution that:

- a) begins while the Dependent Child is suffering from a serious illness;
 - b) is medically necessary; and
 - c) causes the Dependent to lose student status for the purpose of Dependent Child coverage.
2. The definition of **Dependent Child(ren)** includes children related to You by a civil union and domestic partnership.
3. The definition of **Spouse** includes Your partner in a civil union or domestic partnership.
4. The list of changes in the **Change in Family Status** provision, if shown in the **Eligibility and Enrollment** also applies to coverage for civil unions and domestic partnership.
5. **The following eligibility and enrollment requirements apply to you:**

Newlywed Coverage:

If You marry or enter into a civil union or You execute a domestic partner affidavit while covered under The Policy, Your Spouse or party to a civil union or domestic partner shall automatically become covered under The Policy for 31 days of the date of marriage or civil union or domestic partnership. Benefits and amounts will be the minimum amount for those We are providing for Spouse coverage under The Policy at that time.

Coverage of Your Spouse or party to a civil union or domestic partnership will cease after 31 days of the date of marriage or civil union or domestic partnership unless You:

- a) request in writing that coverage for Your Spouse or party to a civil union or domestic partner be continued; and
- b) pay the additional required premium.

Newborn/New Child Coverage:

If, while covered under The Policy, You:

- a) have a newborn child; or
- b) adopt or receive a foster or stepchild;

the child will become covered under The Policy for 31 days of the date of birth or the date of financial dependence on You. Benefits and amounts will be the minimum amount for those We are providing for Dependent Children under The Policy at that time.

Coverage of the new child will cease after 31 days of the date of birth or financial dependence unless You:

- a) request in writing that coverage for Your child be continued; and
- b) pay the additional required premium.

6. The **Claim Appeal** provision will always include the following:

In addition, if a claim for benefits is wholly or partially denied and all administrative remedies have been exhausted, You are entitled to pursue such claim anew, from the beginning, in a court with jurisdiction and entitled to a trial by jury.

7. The **Policy Interpretation** provision, if shown in the **General Provisions** section of the Certificate, is not applicable.

Florida:

- | |
|--|
| 1. NOTICE: The benefits of the policy providing you coverage may be governed primarily by the laws of a state other than Florida. |
|--|

Idaho:

1. **For Your Questions and Complaints:**

Idaho Department of Insurance

Consumer Affairs

700 W. State Street, 3rd Floor

PO Box 83720

Boise, ID 83720-0043

Toll Free: 1(800) 721-3272

Web Address: www.DOI.Idaho.gov

2. **Notice to Buyer: This is an accident-only certificate and it does not pay benefits for loss from sickness. Review Your certificate carefully.**
3. **Notice to Buyer: This certificate provides limited benefits. Benefits provided are supplemental and are not intended to cover all medical expenses.**

Illinois:

1. The **Policy Interpretation** provision if shown in the **General Provisions** section is not applicable.

2. **For Your Questions and Complaints**

Illinois Department of Insurance

Consumer Services Station

Springfield, IL 62767

Consumer Assistance: 1(866) 445-5364

Officer of Consumer Health Insurance 1(877) 527-9431

Web Address: <http://insurance.illinois.gov/>

3. In accordance with Illinois law, insurers are required to provide the following **NOTICE** to applicants of insurance policies issued in Illinois.

STATE OF ILLINOIS
The Religious Freedom Protection and Civil Union Act
Effective June 1, 2011

The Religious Freedom Protection and Civil Union Act ("the Act") creates a legal relationship between two persons of the same or opposite sex who form a civil union. The Act provides that the parties to a civil union are entitled to the same legal obligations, responsibilities, protections and benefits that are afforded or recognized by the laws of Illinois to spouses. The law further provides that a party to a civil union shall be included in any definition or use of the terms "spouse," "family," "immediate family," "dependent," "next of kin," and other terms descriptive of spousal relationships as those terms are used throughout Illinois law. This includes the terms "marriage" or "married," or variations thereon. Insurance policies are required to provide identical benefits and protections to both civil unions and marriages. If policies of insurance provide coverage for children, the children of civil unions must also be provided coverage. The Act also requires recognition of civil unions or same sex civil unions or marriages legally entered into in other jurisdictions.

For more information regarding the Act, refer to 750 ILCS 75/1 *et seq.* Examples of the interaction between the Act and existing law can be found in the Illinois Insurance Facts, Civil Unions and Insurance Benefits document available on the Illinois Department of Insurance's website at www.insurance.illinois.gov.

Kansas:

1. The **Policy Interpretation** provision if shown in the **General Provisions** section is replaced by the following:

Policy Interpretation. Pursuant to the Employee Retirement Income Security Act of 1974, as amended (ERISA), Your Employer has delegated to Us the fiduciary responsibility to determine eligibility for benefits and to construe and interpret all terms and provisions of The Policy. Therefore, We are fiduciary for The Policy and We have the continuing duty to act prudently and in the interest of You, Your beneficiaries and the other plan participants. If You have a claim for benefits which is denied or ignored, in whole or in part, then You may file suit in state or federal court for a review of Your eligibility or entitlement to benefits under The Policy. This provision only applies where the interpretation of The Policy is governed by ERISA.

Louisiana:

1. The following requirements apply to the definition of **Dependent Child(ren)** :
 - a) an unmarried Child who is placed in your home pursuant to an adoption placement agreement; executed with a licensed adoption agency (from the date of placement in your home);
 - b) an unmarried Child who is placed in your home following execution of an act of voluntary surrender (as of the date on which the act of voluntary surrender becomes irrevocable);
 - c) your unmarried grandchild who is in your legal custody;
 - d) a limiting age of 21 years, or 24 years if a student, if less than such ages;
 - e) an unmarried Child to age 24, if a student and deemed to be unable to attend school full-time due to a mental or nervous condition, problem or disorder; and
 - f) an unmarried Child who is subsequently called to military service and any required premium is paid.

2. The following requirement applies to you:

Reinstatement after Military Service: *Can my coverage be reinstated after return from active military service?*

If:

- a) Your coverage terminates because You enter active military service; and
- b) You are rehired within 12 months of the date You return from active military service;

then coverage may be reinstated, provided You request such reinstatement within 31 days of the date you return to work.

The reinstated coverage will:

- a) be the same coverage amounts in force on the date coverage terminated; and
- b) not be subject to any Waiting Period for Coverage, Evidence of Insurability or Pre-existing Conditions Limitations; and
- c) be subject to all the terms and provisions of The Policy.

Maine:

1. **NOTICE:** The laws of the State of Maine require notification of the right to designate a third party to receive notice of cancellation, to change such a designation and, to have the Policy reinstated if the insured suffers from cognitive impairment or functional incapacity and the ground for cancellation was the insured's nonpayment of premium or other lapse or default on the part of the insured.

Within 10 days after a request by an insured, a Third Party Notice Request Form shall be mailed or personally delivered to the insured.

2. The time period stated in the **Notice of Claim** provision shown in the **General Provisions** section is changed to 30 days if not already 30 days.
3. The time period stated in the **Claim Forms** provision shown in the **General Provisions** section is changed to 15 days if not already 15 days.
4. The time periods stated in the **Sending Proof of Loss** provision shown in the **General Provisions** section are changed to 90 days and 1 year if not already 90 days and 1 year, respectively.
5. The time period stated in the **Claim Payment** provision shown in the **General Provisions** section is changed to 30 days if not already 30 days.
6. The dollar amount stated in the **Claims to be Paid** provision shown in the **General Provisions** section is changed to \$2,000 if not already \$2,000.
7. The phrase "In the absence of Insurance Fraud" in the **Misstatements** provision does not apply to you.

Michigan:

1. The **Policy Interpretation** provision if shown in the **General Provisions** section is not applicable.

Minnesota:

1. The definition of **Disabled or Total Disability** in the **Permanent Total Disability** Benefit is replaced by the following:

Disabled or Total Disability, for the purpose of this Benefit, means Your or Your Spouse's:

- a) inability during the first two years of disability to perform the Essential Duties of Your or Your Spouse's Occupation; and
- b) after that, Your or Your Spouse's inability to engage in Any Occupation for which you are suited by education, training and experience; or
- c) with respect to a Spouse who is unemployed, his or her inability to engage in the normal and customary activities of a person of like age and gender in good health.

Your unemployed Spouse must be:

- a) regularly attended by Physician; and
- b) continuously confined within his or her house or Hospital, provided such house or Hospital confinement will not preclude transportation of Your Spouse to or from a Hospital or Physician's office for necessary treatment at the direction of his or her Physician.

Montana:

2. The time period stated in the **Conversion Right** provision is changed to 3 years, if greater than 3 years.
3. The dollar amount stated in the **Conversion Right** provision is changed to \$10,000, if less than \$10,000.
4. The 2nd paragraph of the **Conversion Policy Provisions** does not apply to you.
5. The dollar amount stated in the second paragraph of the **Claims to be Paid** provision shown in the **General Provisions** section is changed to \$500, if not \$500.
6. The following requirement applies to you:

Payable Interest: *Is interest payable on death claims?*

Claims payable for loss of life will be paid within 60 days of the date due proof is received. If the claim is paid more than 30 days after the date due proof is received, the amount payable will include interest. Interest will be paid at the discount rate, on 90-day commercial paper, in effect at the Federal Reserve Bank in the Ninth Federal Reserve District on the date due proof is received.

7. The definition of **Physician** in the **Definitions** section will include the following freedom of choice language:
You have full freedom of choice in the selection of any health care provider for the treatment of any injury related to an Accident within the scope and limitations of his or her practice, including a licensed physician, physician assistant, dentist, osteopath, chiropractor, optometrist, podiatrist, psychologist, licensed social worker, licensed professional counselor, licensed marriage and family therapist, acupuncturist, naturopathic physician, physical therapist or advanced practice registered nurse.

New Hampshire:

1. Item 1 of the definitions of **Disabled** and **Disabled or Disability** if shown in the **Definitions** section is replaced by the following:
 - 1) performing any work or occupation for wage or profit for which You are, or become, reasonably qualified by reason of education, training or experience.

2. Item 3 of the last paragraph of the **Sending Proof of Loss** provision shown in the **General Provisions** section does not apply to you.
3. Item 3 of the **Conditions for Qualification** provision is replaced by the following:
 - 3) provide such proof in accordance with the Sending Proof of Loss provision.
4. Item 1 of the definition of **Extended Care Facility** in the **Extended Care Facility Benefit** is replaced by the following:
 - 1) Operates pursuant to law;
5. The following continuation requirement applies to you:
Spouse Continuation: *Can coverage be continued for a divorced Spouse?*
 If You are legally separated or divorced from Your Spouse, coverage for Your former Spouse may continue under The Policy until the earliest of:
 - 1) the last day of the third year following the anniversary of a final divorce or legal separation;
 - 2) the date You remarry;
 - 3) the date Your former Spouse remarries;
 - 4) a date specified in the final divorce decree;
 - 5) the date Your former Spouse fails to pay any premiums that may be due; or
 - 6) the date You die.
6. The time period stated for legal action to start in the **Legal Actions** provision shown in the **General Provisions** section can not be less than 3 years after the time **Proof of Loss** is required to be given.
7. An initial period of Confinement and any subsequent periods of Confinement for the same Injury occurring within 90 days of the initial Confinement discharge date will be considered one **Period of Confinement** up to a maximum of 180 days, if an **Accident Hospital Income Benefit** is included in Your certificate.
8. Reference to the terms wholly and continuously or reasonably within the definition of **Disabled or Disability** do not apply to You if either a **Waiver of Premium** or an **Extended Care Facility Benefit** are included in Your certificate.
9. "Injury sustained while Intoxicated" or "Injury sustained while driving while Intoxicated" are revised to "Injury sustained while driving feloniously while Intoxicated" when referenced in the **Exclusions** provision.
10. **Notice: The Policy does not insure against loss resulting from sickness.**
11. **Notice:** You have a 30 day right from Your original Certificate Effective Date to examine Your certificate. If You are not satisfied, You may return it to Us within 30 days of Your original Certificate Effective Date. In that event, We will consider it void from its Effective Date and any premiums paid will be refunded. Any claims paid under The Policy during the initial 30 day period will be deducted from the refund.
12. We will refund the pro rata portion of any premium paid for You or Your covered Dependents while You or Your covered Dependents are in the armed forces on full-time active duty, if coverage is excluded during this period.
13. **Notice: This is a Limited Policy - Read it Carefully**
14. Termination of coverage will not affect benefits otherwise payable for a claim incurred while The Policy is in force.
15. The following **Extension of Coverage While Disabled** provision is added to the **Continuation Provisions** section of the Certificate:

Extension of Coverage While Disabled

If You are Disabled when coverage would otherwise terminate because:

- 1) You are no longer eligible for insurance or are no longer in an Eligible Class; or
 - 2) the Policy terminated and You are not eligible for coverage under a replacing policy;
- Your and Your Dependents coverage will be extended for 90 days after it would otherwise terminate, while:
- 1) Disability continues; and
 - 2) the required premium for coverage is paid.

In no event will coverage under this provision be extended beyond 90 days. Benefit payment is subject to any applicable limitations, maximums, and terms of The Policy.

Disabled or Disability, for the purpose of this benefit, means You are prevented from performing any work or occupation for wage or profit for which You are or become reasonably qualified by reason of education, training or experience.

16. **Notice:** This is an ancillary health certificate. This certificate provides limited benefits. Benefits provided are supplemental and are not intended to cover all medical expenses.
17. The **Accidental Death and Dismemberment Principal Sum Amount** under The Policy at the time of issue shall be at least \$10,000 per covered person and paid without regard to whether benefits are provided under other

insurance. The amount payable for the Loss of one limb, in whole or in part, shall be at least \$5,000 per covered person. The amount payable for Loss of a thumb and index finger shall be at least \$2,000 per covered person.

New Mexico:

1. We cannot require that You prove that Your child was born in wedlock, living with You, or claimed as a dependent on Your or Your Spouse's tax return in order for Your child to be eligible for **Dependent** coverage.
2. Benefits paid on behalf of You or Your Dependent under this certificate shall be paid to the human services department when:
 - 1) the human services department has paid or is paying benefits on behalf of the Covered Person under the state's Medicaid program pursuant to Title XIX of the federal Social Security Act, 42 U.S.C. 1396, et seq.; or
 - 2) payment for the services in question has been made by the human services department to the Medicaid provider; and
 - 3) We are notified that You or Your Dependent receives benefits under the Medicaid program.
3. If You are covered under a Non-ERISA policy issued outside of New Mexico with a Certificate Effective Date of January 1, 2019 or later, these additional requirements apply to you:

Consumer Complaint Notice

If you are resident of New Mexico, your coverage will be administered in accordance with the minimum applicable standards of New Mexico law. If you have concerns regarding your claim, premium, or other matters pertaining to this coverage, you may file a complaint with the New Mexico Office of Superintendent of Insurance (OSI) using the complaint form available on the OSI website and found at: <https://www.osi.state.nm.us/index.php/consumers/consumer-assistance/>

- A. When We determine that benefits are payable, We will pay the benefits in accordance with the **Claims to be Paid** provision immediately after such **Proof of Loss** is received. If a claim is paid more than 45 days from receipt of required **Proof of Loss**, You are entitled to interest on that amount at the rate of 1 1/2 times the prime lending rate, as determined by the superintendent, for New Mexico banks per year during the period the claim is unpaid.
- B. **Legal Actions** cannot be taken against Us sooner than 60 days after Proof of Loss is furnished or more than 3 years after the date Proof of Loss is required to be furnished (ren)according to The Policy.
- C. **Physician** means a person who is:
 - a. a doctor of medicine, osteopathy, psychology or other legally qualified practitioner of healing art recognized by New Mexico law;
 - b. licensed to practice in the jurisdiction where care is being given;
 - c. operating within the scope of his or her license; and
 - d. not the Covered Person or a Family Member.

You have full freedom of choice in the selection of a Hospital for care or of a practitioner of the healing arts or optometrist, psychologist, podiatrist, physician assistant, certified nurse-midwife, registered lay midwife or registered nurse in expanded practice for the treatment of any Injury related to an Accident within the scope and limitations of his or her practice.

- D. You are entitled to cover Your **Dependent Child** up to age 26.
- E. If an unmarried child is age 26 or older and is:
 - a. incapable of self-sustaining employment because of an intellectual disability or physical handicap;
 - b. chiefly dependent on You for financial support;and You have provided proof of his/her disability upon Our request, that child will continue to be a **Dependent Child** until these conditions cease to exist. We may request that proof of such incapacity and dependency is furnished to Us within 31 days of the child's attainment age 26 and subsequently as may be required by Us, but not more frequently than annually after the two year period following the child's attainment age of 26.
- F. **Newborn and Newly Adopted Child Coverage:**

If, while covered under The Policy, You:

 - a. have a newborn child;
 - b. adopt a child;

- c. receive a stepchild; or
- d. become the legal guardian of a child;

the child will become covered under The Policy for 31 days after the date the child becomes eligible. Benefits and amounts will be the minimum amount for those We are providing for Dependent Child(ren) under The Policy at that time.

Coverage of the new child will cease after 31 days from the date the child became eligible unless You:

- a. enroll the new child prior to the expiration of the 31 days; and
- b. pay the additional required premium.

- G. No statement made by You relating to Your insurability will be used to contest the insurance for which the statement was made after the insurance has been in force for two years during Your lifetime. In order to be used, the statement must be in writing and signed by You.

New York:

1. **NOTICE:** The insurance evidenced by this certificate provides ACCIDENT insurance only. It does NOT provide basic hospital, basic medical or major medical insurance as defined by the New York State Department of Financial Services.

IMPORTANT NOTICE — THIS POLICY DOES NOT PROVIDE COVERAGE FOR SICKNESS

North Carolina:

1. If your coverage is issued through a trust, the **Sending Proof of Loss** provision in the **General Provisions** section is amended such that the submission of **Proof of Loss** must be sent within 180 days after the loss.
2. If your coverage is issued through a trust, reference to fraud in **Misstatements** provision in the **General Provisions** section is not applicable.

Oregon:

1. We cannot require that You prove that Your child was born in wedlock, living with You, or claimed as a dependent on Your or Your Spouse's tax return in order for Your child be eligible for Dependent coverage, as shown in the **Definitions** section.
2. The **Spouse** definition if shown in the **Definitions** section will always include domestic partners, civil unions, and any other arrangement allowable by state law.
3. The **Continuation Provisions** section is amended to include the following for Employers with 10 or more employees:
Jury Duty: If You are scheduled to serve or are required to serve as a juror, Your coverage may be continued until the last day of Your Jury Duty, provided You:
 - 1) elected to have Your coverage continued; and
 - 2) provided notice of the election to Your employer in accordance with Your employer's notification policy.

Rhode Island:

1. The **Policy Interpretation** provision if shown in the **General Provisions** section is not applicable.
2. The **Spouse** definition if shown in the **Definitions** section will always include domestic partners, civil unions, and any other arrangement allowable by state law.
3. The following continuation requirement applies to you:
Family Military Leave of Absence: If Your spouse or child enters active full-time military service outside of the continental United States, Hawaii, Puerto Rico or Alaska, and You:
 - 1) have been employed with the same employer for at least two years; and
 - 2) have completed 1,250 hours of service during a 12 month period immediately prior to the date Military Leave of Absence would begin; and
 - 3) have exhausted all the other time made available to You by Your Employer except sick time and short term disability;then Your coverage may be continued for up to 30 days. If the leave ends prior to the agreed upon date, this continuation will cease immediately.

To elect a Family Military Leave of Absence, You must notify Your Employer at least 14 days prior to the date the leave would begin if the leave would consist of five or more consecutive work days. For a leave of less than five days, the Employee should give notice as soon as reasonable possible.

South Carolina:

1. The time period in the **Notice of Claim** provision shown in the **General Provisions** section is changed to 20 days, if not already 20 days.
2. The following physical exam and autopsy requirement applies to you:
Autopsy must be performed during the period of contestability and must take place in the state of South Carolina.
3. Item 2 of the **Legal Actions** provision shown in the **General Provisions** section is replaced by the following:
2) 6 years of the date Proof of Loss is required to be furnished according to the terms of The Policy.

Texas:

1. The **Policy Interpretation** provision if shown in the **General Provisions** section is not applicable.
2. **Notice:**

Have a complaint or need help?

If you have a problem with a claim or your premium, call your insurance company first. If you can't work out the issue, the Texas Department of Insurance may be able to help.

Even if you file a complaint with the Texas Department of Insurance, you should also file a complaint or appeal through your insurance company. If you don't, you may lose your right to appeal.

Hartford Life and Accident Insurance Company

To get information or file a complaint with your insurance company:

Call: Customer Service at 860-547-5000

Toll-free: 1-800-523-2233

Online: <https://www.thehartford.com/contact-the-hartford>

Email: GBD.Customerservice@hartfordlife.com

Mail: The Hartford, Group Benefits Division, P.O. Box 2999, Hartford, CT 06104-2999

The Texas Department of Insurance

To get help with an insurance question or file a complaint with the state:

Call with a question: 1-800-252-3439

File a complaint: www.tdi.texas.gov

Email: ConsumerProtection@tdi.texas.gov

Mail: MC 111-1A, P.O. Box 12030, Austin, TX 78711-2030

¿Tiene una queja o necesita ayuda?

Si tiene un problema con una reclamación o con su prima de seguro, llame primero a su compañía de seguros. Si no puede resolver el problema, es posible que el Departamento de Seguros de Texas (Texas Department of Insurance, por su nombre en inglés) pueda ayudar.

Aun si usted presenta una queja ante el Departamento de Seguros de Texas, también debe presentar una queja a través del proceso de quejas o de apelaciones de su compañía de seguros. Si no lo hace, podría perder su derecho para apelar.

Hartford Life and Accident Insurance Company

Para obtener información o para presentar una queja ante su compañía de seguros:

Llame a: servicio al cliente al 860-547-5000

Teléfono gratuito: 1-800-523-2233

En línea: <https://www.thehartford.com/contact-the-hartford>

Correo electrónico: GBD.Customerservice@hartfordlife.com

Dirección postal: The Hartford, Group Benefits Division, P.O. Box 2999, Hartford, CT 06104-2999

El Departamento de Seguros de Texas

Para obtener ayuda con una pregunta relacionada con los seguros o para presentar una queja ante el estado:

Llame con sus preguntas al: 1-800-252-3439

Presente una queja en: www.tdi.texas.gov

Correo electrónico: ConsumerProtection@tdi.texas.gov

Dirección postal: MC 111-1A, P.O. Box 12030, Austin, TX 78711-2030

Utah:

1. The following benefits are not available:
 - o **Anti-Inflation Benefit**
 - o **Therapeutic Counseling Benefit**
 - o **Accidental Death Benefit with Double Indemnity while On a Common Carrier**
 - o **Accidental Death Motor Vehicle Benefit**
 - o **Accidental Death Benefit while in a Covered Accident**
 - o **Accidental Death and Dismemberment: while Actively at Work**
 - o **Double Indemnity while On A Common Carrier**
2. The maximum age for a student stated in the **Child Education Benefit** is changed to 26 if not already 26.
3. Regarding the definition of **Dependent Child(ren)** if shown in the **Definitions** section::
 - a) items a and b of item 2 do not apply to you
 - b) the second item 2 does not apply to you
 - c) the maximum age for a child is 26 if not already 26.
4. A qualifying **Change in Family Status** will also include from the date of placement for adoption with You.
5. Item 3 of the **Sending Proof of Loss** provision, in the **General Provisions** section does not apply to you.
6. The age references in the **Continuation for Dependent Child(ren) with Disabilities** provision are changed to 26 if not already 26.
7. Waiting periods must be eliminated from all **Accidental Death and Dismemberment** policies, including the **Accidental Hospital Income Benefit**.

Vermont:

1. **Purpose:** Vermont law requires that health insurers offer coverage to parties to a civil union that is equivalent to coverage provided to married persons.
Definitions, Terms, Conditions and Provisions: The definitions, terms, conditions or any other provisions of the policy, contract, certificate and/or riders and are hereby superseded as follows:
 - a) Terms that mean or refer to a marital relationship, or that may be construed to mean or refer to a marital relationship, such as "marriage", "spouse", "husband", "wife", "dependent", "next of kin", "relative", "beneficiary", "survivor", "immediate family" and any other such terms, include the relationship created by a civil union established according to Vermont law.
 - b) Terms that mean or refer to the inception or dissolution of a marriage, such as "date of marriage", "divorce decree", "termination of marriage" and any other such terms include the inception or dissolution of a civil union established according to Vermont law.
 - c) Terms that mean or refer to family relationships arising from a marriage, such as "family", "immediate family", "dependent", "children", "next of kin", "relative", "beneficiary", "survivor" and any other such terms include family relationships created by a civil union established according to Vermont law.
 - d) "Dependent" means a spouse, a party to a civil union established according to Vermont law, and a child or children (natural, stepchild, legally adopted or a minor or disabled child who is dependent on the insured for support and maintenance) who is born to or brought to a marriage or to a civil union established according to Vermont law.
 - e) "Child or covered child" means a child (natural, step-child, legally adopted or a minor or disabled child who is dependent on the insured for support and maintenance) who is born to or brought to a marriage or to a civil union established according to Vermont law.

CAUTION: FEDERAL LAW RIGHTS MAY OR MAY NOT BE AVAILABLE

Vermont law grants parties to a civil union the same benefits, protections and responsibilities that flow from marriage under state law. However, some or all of the benefits, protections and responsibilities related to health insurance that are available to married persons under federal law may not be available to parties to a civil union. For example, federal law, the Employee Income Retirement Security Act of 1974 known as "ERISA", controls the employer/employee relationship with regard to determining eligibility for enrollment in private employer health benefit plans. Because of ERISA, Act 91 does not state requirements pertaining to a private employer's enrollment of a party to a civil union in an ERISA employee welfare benefit plan. However, governmental employers (not federal government) are required to provide health benefits to the dependents of a party to a civil union if the public employer provides health benefits to the dependents of married persons. Federal law also controls group health insurance continuation rights under COBRA for employers with 20 or more employees as well as the Internal Revenue Code treatment of health insurance premiums. As a result, parties to a civil union and their families may or may not have access to certain benefits under the policy, contract, certificate, rider or endorsement that derive from federal law. You are advised to seek expert advice to determine your rights under this contract.

Virginia:

1. **For Your Questions and Complaints:**
State Corporation Commission
Life and Health Division
Bureau of Insurance
P.O. Box 1157
Richmond, VA 23218
1(804) 371-9691 (inside Virginia)
1(877) 310-6560 (outside Virginia)

Washington:

1. The **Accelerated Benefit** is not available.

Wisconsin:

1. The time periods stated in the **Claim Appeal** provision shown in the **General Provisions** section are removed.
2. **For Your Questions and Complaints:**
To request a Complaint Form:
Office of the Commissioner of Insurance
Complaints Department
P.O. Box 7873
Madison, WI 53707-7873
1(800) 236-8517 (outside of Madison)
1(608) 266-0103 (in Madison)



CERTIFICATE OF INSURANCE

HARTFORD LIFE AND ACCIDENT INSURANCE COMPANY Hartford, Connecticut (A stock insurance company)

Policyholder: TRUIST FINANCIAL CORP.

Policy Number: ADD-007284

Policy Effective Date: January 1, 2009

Policy Anniversary Date: January 1, 2024

We have issued The Policy to the Policyholder. Our name, the Policyholder's name and The Policy Number are shown above. The provisions of The Policy, which are important to You, are summarized in this certificate consisting of this form and any additional forms which have been made a part of this certificate. This certificate replaces any other certificate We may have given to You earlier under The Policy. The Policy alone is the only contract under which payment will be made. Any difference between The Policy and this certificate will be settled according to the provisions of The Policy on file with Us at Our home office. The Policy may be inspected at the office of the Policyholder.

Signed for the Company

Kevin Barnett, Secretary

Jonathan Bennett, President

A note on capitalization in this Certificate:

Capitalization of a term, not normally capitalized according to the rules of standard punctuation, indicates a word or phrase that is a defined term in The Policy or refers to a specific provision contained herein.

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SCHEDULE OF INSURANCE

AMENDMENT TO GROUP POLICY ADD-007284 PROCESSED ON AUGUST 20, 2024. ANY CHANGES BETWEEN THIS POLICY AND THE PREVIOUSLY ISSUED POLICY ARE EFFECTIVE AUGUST 1, 2024.

Cost of Coverage:

Contributory Coverage: Supplemental Accidental Death and Dismemberment Insurance
Supplemental Dependents' Accidental Death and Dismemberment Insurance

Eligible Class(es) For Coverage: All Full-time and Part-time Regular Active Teammates who are citizens or legal residents of the United States, its territories and protectorates, excluding temporary, leased or seasonal teammates.

Class 1: All Full-time and Part-time Regular Active Teammates

Regular Employment: at least 20 hours weekly.

Class 2: All Teammates on special contract assignments that confirm their eligibility for Truist health and welfare benefits during the assignment

Regular Employment: regularly scheduled to work at least 1 hour weekly

Annual Enrollment Period: as determined by Your Employer on a yearly basis.

Eligibility Waiting Period for Coverage:

The first day of the month following the date You were hired

The time periods referenced above are continuous. The Eligibility Waiting Period for Coverage will be reduced by the period of time You were a Full-time or Part-time Active Teammate with the Employer under the Prior Policy.

Policy Age Limit: You: None
Spouse: 70

Accidental Death and Dismemberment Benefit (AD&D)

Supplemental AD&D Principal Sum

Principal Sum

The Principal Sum applicable to You is the amount for which:

- a) You are eligible to request as determined below;
- b) You have given us a Written Request; and
- c) the required premium is paid.

Principal Sum Amount: 1, 2, 3, 4, 5, 6, 7, 8, 9, or 10 times Earnings, subject to a Maximum Amount of \$1,000,000

Principal Sum for each of Your Eligible Dependents

The Principal Sum that applies to each person covered under The Policy as Your Dependent, on the date of accident, is determined by multiplying Your Principal Sum by the percentage determined below.

	Spouse	Each Dependent Child
Spouse only	60%	0%
Spouse and Dependent Child(ren)	50%	15%

Dependent Child(ren) only	0%	20%
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Principal Sum for any one Child cannot exceed the lesser of the amount calculated above or \$50,000.

Additional Benefits:

Seat Belt Coverage:

Seat Belt Benefit Amount: 10% of Principal Sum to a maximum amount of \$25,000

Felonious Assault Benefit:

Maximum Amount: \$25,000

Felonious Assault Benefit Percentage: 10%

Child Education Benefit:

Maximum Amount: \$5,000

Percentage of Principal Sum: 5%

Minimum Amount: \$1,000

Day Care Benefit:

Maximum Amount: \$5,000

Day Care Benefit Percentage: 5%

Minimum Amount: \$1,000

Rehabilitation Benefit:

Maximum Amount: \$5,000

Rehabilitation Benefit Percentage: 5%

Spouse Education Benefit:

Maximum Amount: \$5,000

Percentage of Principal Sum: 5%

Minimum Amount: \$1,000

Adaptive Home and Vehicle Benefit:

Maximum Amount: \$3,000

Adaptive Home and Vehicle Benefit Percentage: 3%

Therapeutic Counseling Benefit:

Maximum Amount: \$3,000

Therapeutic Counseling Benefit Percentage: 3%

Continuation of Medical Coverage (COBRA) Benefit:

Maximum Benefit Amount: \$3,000

Minimum Benefit Amount: \$1,000

Percentage for the Continuation of Medical Coverage Benefit: 3%

Extended Dependents Coverage Benefit

Common Disaster Benefit:

Common Disaster Limit: \$1,000,000

Survivor Income Benefit:

Percentage of Principal Sum: 1%

Payment Period: 6 month(s)

Dependent Child Dismemberment Benefit

Permanent Total Disability Benefit:

Disability Commencement Period: 365 day(s)

Qualification Period: 12 month(s)
Benefit Amount: See Principal Sum Amount
Age Limit: 70

Conversion Right

Conversion Limit: \$100,000

ELIGIBILITY AND ENROLLMENT

Eligible Persons: *Who is eligible for coverage?*

All persons in the class or classes shown in the Schedule of Insurance will be considered Eligible Persons.
GBD-1300 D01

Eligibility for Coverage: *When will I become eligible?*

You will become eligible for coverage on the latest of:

- 1) the Policy Effective Date;
- 2) the date You become a member of an Eligible Class; or
- 3) the date You complete the Eligibility Waiting Period for coverage shown in the Schedule of Insurance, if applicable.

GBD-1300 D02

Eligibility for Dependent Coverage: *When will I become eligible for Dependent Coverage?*

You will become eligible for Dependent coverage on the later of:

- 1) the date You become eligible for teammate coverage; or
- 2) the date You acquire Your first Dependent.

GBD-1300 D03

Enrollment: *How do I enroll for coverage?*

You have the option to enroll by voice recording or electronically. Your Employer will provide instructions.

If You do not enroll for Your coverage and/or Your Dependent's coverage within 31 days after becoming eligible under The Policy, or if You were eligible to enroll under the Prior Policy and did not do so, and later choose to enroll, You may enroll for Your coverage and/or Your Dependent's coverage only:

- 1) during an Annual Enrollment Period designated by the Policyholder; or
- 2) within 31 days of the date You have a Change in Family Status.

GBD-1300 D04

Change in Family Status: *What constitutes a Change in Family Status?*

A Change in Family Status occurs when:

- 1) You get married;
- 2) You and Your spouse divorce;
- 3) Your child is born or You adopt or become the legal guardian of a child;
- 4) Your spouse dies;
- 5) Your child is no longer financially dependent on You or dies;
- 6) Your spouse's loss or commencement of employment; or
- 7) You or Your spouse have a change in classification from part-time to full-time or from full-time to part-time.

GBD-1300 D05

PERIOD OF COVERAGE

Effective Date: *When does my coverage start?*

Coverage will start on the latest to occur of:

- 1) the date You become eligible, if You enroll on or before that date;
- 2) the first day of January on or next following the last day of the Annual Enrollment Period, if You enroll during an Annual Enrollment Period; or
- 3) the date You enroll if You do so within 31 days of the date You are eligible.

All Effective Dates of coverage are subject to the Deferred Effective Date provision.
GBD-1300 E01

Deferred Effective Date: *When will my effective date for coverage or a change in my coverage be deferred?*

If, on the date You are to become covered:

- 1) under The Policy;
- 2) for increased benefits; or
- 3) for a new benefit;

You are not Actively at Work due to a physical or mental condition, such coverage will not start until the date You are Actively at Work.

GBD-1300 E03

Continuity from a Prior Policy: *Is there Continuity of Coverage from a Prior Policy?*

Your initial coverage under The Policy will begin, and will not be deferred if on the day before the Effective Date, You were insured under the Prior Policy, but on the Effective Date, You were not Actively at Work, but would otherwise meet the Eligibility requirements of The Policy. However, Your Amount of Insurance will be the amount of accidental death and dismemberment principal sum:

- 1) You had under the Prior Policy; or
- 2) shown in the Schedule of Insurance;

reduced by any coverage amount:

- 1) that is in force, paid or payable under the Prior Policy; or
- 2) that would have been so payable under the Prior Policy had timely election been made.

Such amount of insurance under this provision is subject to any reductions in The Policy and will not increase.

Coverage provided through this provision ends on the first to occur of:

- 1) the last day of a period of 12 consecutive months after the Effective Date;
- 2) the date Your insurance terminates for any reason shown under the Termination provision;
- 3) the last day You would have been covered under the Prior Policy, had the Prior Policy not terminated; or
- 4) the date You are Actively at Work.

However, if the coverage provided through this provision ends because You are Actively at Work, You may be covered as an Active Teammate under The Policy.

GBD-1300 E05

Dependent Effective Date: *When does Dependent coverage start?*

Contributory Coverage will start on the latest to occur of:

- 1) the date You become eligible for Dependent coverage, if You have enrolled on or before that date; or
- 2) the first day of January on or next following the last day of the Annual Enrollment Period, if You enroll during an Annual Enrollment Period; or
- 1) the date You enroll, if You do so within 31 days from the date You are eligible for Dependent coverage.

In no event will Dependent coverage become effective before You become insured.

GBD-1300 E07

Dependent Deferred Effective Date: *When will the effective date for Dependent coverage or a change in coverage be deferred?*

If on the date Your Dependent is to become covered:

- 1) under The Policy;
- 2) for increased benefits; or
- 3) for a new benefit;

he or she is:

- 1) confined in a hospital; or
- 2) Confined Elsewhere;

such coverage will not start until he or she:

- 1) is discharged from the hospital; or
- 2) is no longer Confined Elsewhere;

and has engaged in all the normal and customary activities of a person of like age and gender, in good health, for at least 15 consecutive days.

This Deferred Effective Date provision will not apply to disabled children who qualify under the definition of Dependent Children.

Confined Elsewhere means Your Dependent is unable to perform, unaided, the normal functions of daily living, or leave home or other place of residence without assistance.
GBD-1300 E09

Dependent Continuity from a Prior Policy: *Is there Continuity of Coverage from a Prior Policy for my Dependents?*

If on the day before the Effective Date, You were covered with respect to Your Dependents under the Prior Policy, the Deferred Effective Date provision will not apply to initial coverage under The Policy for such Dependents. However, the Dependent Amount of Insurance will be the amount of accidental death and dismemberment insurance:

- 1) they had under the Prior Policy; or
- 2) shown in the Schedule of Insurance;

reduced by any coverage amount:

- 1) that is in force, paid or payable under the Prior Policy; or
- 2) that would have been so payable under the Prior Policy had timely election been made.

GBD-1300 E11

Change in Coverage: *When may I change my coverage or Coverage for my Dependents?*

After Your initial enrollment You may increase or decrease coverage for You or Your Dependents or add a new Dependent to Your existing Dependent coverage:

- 1) during any Annual Enrollment Period designated by the Policyholder; or
- 2) within 31 days of the date of a Change in Family Status.

GBD-1300 E12

Effective Date for Changes in Coverage: *When will changes in coverage become effective?*

Any decrease in coverage will take effect on the date of the change. Any increase in coverage will take effect on the date of the change.

GBD-1300 E13

Termination: *When will my coverage end?*

Your coverage will end on the earliest of the following:

- 1) the date The Policy terminates;
- 2) the date You are no longer in a class eligible for coverage, or the Policy no longer covers Your class;
- 3) the date the required premium is due but not paid;
- 4) the date Your Employer terminates Your employment;
- 5) the date You are no longer Actively at Work;

unless continued in accordance with one of the Continuation Provisions.

GBD-1300 E15

Dependent Termination: *When does coverage for my Dependent end?*

Coverage for Your Dependent will end on the earliest to occur of:

- 1) the date Your coverage ends;
- 2) the date the required premium is due but not paid;
- 3) the date You are no longer eligible for Dependent coverage;
- 4) the date We or the Employer terminate Dependent coverage;
- 5) the date the Dependent no longer meets the definition of Dependent; or
- 6) the date Your Spouse reaches age 70.

unless continued in accordance with the continuation provisions.

GBD-1300 E18

Continuation Provisions: *Can my coverage and coverage for my Dependents be continued beyond the date it would otherwise terminate?*

Coverage can be continued by Your Employer beyond a date shown in the Termination provision, if Your Employer provides a plan of continuation which applies to all teammates the same way. Coverage may not be continued under more than one Continuation Provision.

The amount of continued coverage applicable to You or Your Dependents will be the amount of coverage in effect on the date immediately before coverage would otherwise have ended. Continued coverage:

- 1) is subject to any reductions in The Policy;
- 2) is subject to payment of premium;

- 3) may be continued up to the maximum time shown in the provisions; and
- 4) terminates if The Policy terminates.

In no event will the amount of insurance increase while coverage is continued in accordance with the following provisions.

In all other respects, the terms of Your coverage and coverage for Your Dependents remain unchanged.

Leave of Absence: If You are on a documented leave of absence, other than Family and Medical Leave or Military Leave of Absence, Your coverage (including Dependent Accidental Death and Dismemberment coverage) may be continued until the last day of the month following the month in which the leave of absence commenced. If the leave terminates prior to the agreed upon date, this continuation will cease immediately.

Military Leave of Absence: If You or Your Dependent enter active military service and are granted a military leave of absence in writing, Your coverage (including Dependent Accidental Death and Dismemberment coverage) may be continued for up to 12 week(s). If the leave ends prior to the agreed upon date, this continuation will cease immediately.

Lay Off: If You are temporarily laid off by the Employer due to lack of work, Your coverage (including Dependent Accidental Death and Dismemberment coverage) may be continued until the last day of the month following the month in which the layoff commenced. If the lay-off becomes permanent, this continuation will cease immediately.

Sickness or Injury: If You are not Actively at Work due to sickness or injury, all of Your coverages (including Dependent Accidental Death and Dismemberment coverage) may be continued:

- 1) for a period of twelve consecutive months from the date You were last Actively at Work; or
- 2) if such absence results in a leave of absence in accordance with state and/or federal family and medical leave laws, then the combined continuation period will not exceed twelve consecutive months.

Family and Medical Leave: If You are granted a leave of absence, in writing, in accordance with state and/or federal family and medical leave laws, all of Your coverages (including Dependent Accidental Death and Dismemberment coverage) may be continued for up to 12 weeks, or 26 weeks if You qualify for Family Military Leave, or longer if required by state law, following the date Your insurance would have terminated. If the leave of absence ends prior to the agreed upon date, this continuation will cease immediately.

Severance: If Your employment terminates and continuation of accidental death and dismemberment is available to You and Your Dependents in a severance plan sponsored by Your Employer, all of Your coverage (including Dependent Accidental Death and Dismemberment coverage) may be continued. Your coverage will continue until the earliest of:

- 1) the date The Policy terminates;
- 2) the date You become covered under another accidental death [and dismemberment policy];
- 3) the date specified in Your Severance plan; or
- 4) 2 months from the date Your employment terminated.

Coverage for Your Dependent will continue until the earliest of:

- 1) the date Your Dependents no longer meet the definition of Dependents;
- 2) the date We or Your Employer terminate Dependent coverage; or
- 3) the date Your coverage terminates.

GBD-1300 E22

Spouse Continuation: *Can coverage for my Spouse be continued in the event of my death?*

If You die while Your Spouse is covered under The Policy, Your surviving Spouse may continue:

- 1) his or her coverage; and
- 2) coverage of Your Dependent Child(ren) who were covered by The Policy on the date of Your death.

We must receive Your Spouse's written request and the required premium to continue the coverage within 31 days of the Premium Due Date next following the date of Your death.

Solely for the purpose of continuing the coverage, Your Spouse will be considered the insured person. However, Your Spouse's or any of the Dependent Child(ren)'s coverage will not continue beyond:

- 1) a date the coverage would otherwise have ended under the Dependent Termination provision; or
- 2) the Premium Due Date next following the date Your Spouse remarries.

GBD-1300 E23

Dependent Continuation: *Can coverage for my Dependents be continued if I die?*

If You die while insured under The Policy, the Accidental Death and Dismemberment Insurance coverage for Your Dependents in force at the time of Your death may be continued, until the earliest of:

- 1) the date the coverage would otherwise have ended under the Dependent Termination provision;
- 2) the date Your Spouse remarries, dies, or obtains coverage under another group plan;
- 3) the date Your Spouse attains age 70; or
- 4) 5 years from Your date of death.

Coverage continued under this provision will be Contributory Coverage and may not be increased.
GBD-1300 E24

Continuation for Dependent Child(ren) with Disabilities: *Will coverage for Dependent Children with Disabilities be continued?*

If Your Dependent Child(ren) reach the age at which they would otherwise cease to be a Dependent as defined, and they are:

- 1) age 26 or older; and
- 2) disabled; and
- 3) primarily dependent upon You for financial support;

then Dependent Child(ren) coverage will not terminate solely due to age. However:

- 1) You must submit proof satisfactory to Us of such Dependent Child(ren)'s disability within 31 days of the date he or she reaches such age; and
- 2) such Dependent Child(ren) must have become disabled before attaining age 26.

Coverage under The Policy will continue as long as:

- 1) You remain insured;
- 2) the child continues to meet the required conditions; and
- 3) any required premium is paid when due.

However, no increase in the Amount of Dependent Accidental Death and Dismemberment Insurance for such Dependent Children will be available.

We have the right to require proof, satisfactory to Us, within 31 days of the child's attainment of the limiting age that the child continues to meet these conditions. We will not require proof more often than once a year after that.

GBD-1300 E25 (NC)

Conversion Right: *If my coverage under The Policy ends, do I have a right to conversion?*

If You or Your Dependents cease to be covered under The Policy because You cease to be eligible for coverage and:

- 1) The Policy has not terminated; and
- 2) You have paid any required premium;

You have a Conversion Right as provided below.

The Conversion Right allows You to request coverage under a conversion policy from the Insurer, without giving medical evidence of insurability, to cover Yourself and Your Dependents who are covered under The Policy on the date Your coverage ceases. Dependents who continue to be covered under The Policy in the same or a different class cannot be covered under Your converted policy.

Insurer, as used for this Conversion Right, means Us or another insurance company which has agreed with Us to issue converted policies according to this conversion right.

You must:

- 1) give the Insurer a written request for the converted policy; and
- 2) pay the Insurer the initial premium;

within 31 days after You cease to be covered under The Policy.

The Conversion Right will provide a converted policy that:

- 1) will have the provisions, limitations and exclusions on the form the Insurer is issuing for this purpose at conversion;
- 2) will provide coverage on a twenty four hour a day basis;
- 3) will provide benefits for Accidental Death and Dismemberment alone;
- 4) will take effect on the date You cease to be covered under The Policy;
- 5) may exclude any condition excluded by The Policy;
- 6) will not pay for any loss covered by The Policy;
- 7) will provide a Principal Sum for You which will be:

- a) the amount of Your Principal Sum under The Policy on the date of conversion, rounded to the nearest \$1,000, subject to a minimum of \$25,000.00 and a maximum of \$100,000, if You are under age 70;
- b) \$25,000.00, if You are age 70 or older but less than age 75; or
- c) \$12,500.00, if You are age 75 or older;
- 8) will have premiums based on the Insurer's rates in effect for new applicants of Your class and age at conversion.

The Principal Sum amounts for Your Dependents who become covered under the converted policy will be the amounts We are offering for this purpose at conversion.

GBD-1300 E37

Reinstatement after Military Service: *Can my coverage be reinstated after return from active military service?*

If:

- 1) Your coverage terminates because You enter active military service; and
- 2) You are rehired within 12 months of the date Your coverage terminated;

then coverage for You and Your previously covered Spouse/Dependents may be reinstated, provided You request such reinstatement within 31 days of the date You return to work.

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

GBD-1300 E38

BENEFITS

Accidental Death and Dismemberment Benefit: *When is the Accidental Death and Dismemberment Benefit payable?*

If You or Your Dependents sustain an Injury that results in any of the following Losses within 365 days of the date of accident, We will pay the injured person's amount of Principal Sum, or a portion of such Principal Sum, as shown opposite the Loss after We receive Proof of Loss, in accordance with the Proof of Loss provision.

This Benefit will be paid according to the General Provisions of The Policy.

We will not pay more than the Principal Sum to any one person, for all Losses due to the same accident. Your amount of Principal Sum is shown in the Schedule of Insurance. The amount of Your Dependent's Principal Sum is shown as a percentage of Your Principal Sum in the Schedule of Insurance.

PA-9223 F07

For Loss of:	Benefit:
Life.....	Principal Sum
Both Hands or Both Feet or Sight of Both Eyes.....	Principal Sum
One Hand and One Foot.....	Principal Sum
Speech and Hearing in Both Ears.....	Principal Sum
Either Hand or Foot and Sight of One Eye.....	Principal Sum
Movement of Both Upper and Lower Limbs (Quadriplegia).....	Principal Sum
Movement of Both Lower Limbs (Paraplegia).....	Three-Quarters of Principal Sum
Movement of Three Limbs (Triplegia).....	Three-Quarters of Principal Sum
Movement of the Upper and Lower Limbs of One Side of the Body (Hemiplegia).....	One-Half of Principal Sum
Either Hand or Foot.....	One-Half of Principal Sum
Sight of One Eye.....	One-Half of Principal Sum
Speech or Hearing in Both Ears.....	One-Half of Principal Sum
Movement of One Limb (Uniplegia).....	One-Quarter of Principal Sum
Thumb and Index Finger of Either Hand.....	One-Quarter of Principal Sum
Use of Both Hands.....	The Principal Sum
Use of One Leg.....	Three-Quarters The Principal Sum
Use of One Arm.....	Three-Quarters The Principal Sum
Use of One Hand.....	One-Half The Principal Sum

PA-9223 F12

Loss means with regard to:

- 1) hands and feet, actual severance through or above wrist or ankle joints;
- 2) sight, speech and hearing, entire and irrecoverable loss thereof;
- 3) thumb and index finger, actual severance through or above the metacarpophalangeal joints; or
- 4) movement, complete and irreversible paralysis of such limbs.

Loss of Use means total and irrecoverable loss of use of leg or arm or hand(s) which commenced within 365 days of the date of accident and continued without interruption for a period of not less than 12 consecutive months, which prevents the Insured Person, during his or her further lifetime, from engaging in any and every occupation or employment for wage or profit for which he or she is reasonably fitted by training, education or experience.

PA-9223 F13

Exposure and Disappearance: *What if Loss is due to exposure or disappearance?*

Exposure to the elements will be presumed to be Injury if:

- 1) it results from the forced landing, stranding, sinking or wrecking of a conveyance in which You or Your Dependents were an occupant at the time of the accident; and
- 2) The Policy would have covered an Injury resulting from the accident.

We will presume that You or Your Dependents suffered Loss of life if:

- 1) the person's body has not been found within one year after the disappearance of a conveyance in which he or she was an occupant at the time of its disappearance;
- 2) the disappearance of the conveyance was due to its accidental forced landing, stranding, sinking or wrecking; and
- 3) The Policy would have covered an Injury resulting from the accident.

PA-9223 F15

Seat Belt Benefit: *When is the Seat Belt Benefit payable?*

If You or Your Dependents sustain an Injury that results in a Loss payable under the Accidental Death and Dismemberment Benefit, We will pay an additional Seat Belt Benefit if the Injury occurred while the injured person was:

- 1) a passenger riding in; or
- 2) the licensed operator of;

a properly registered Motor Vehicle and was wearing a Seat Belt at the time of the Accident as verified on the police accident report.

This Benefit will be paid:

- 1) after We receive Proof of Loss, in accordance with the Proof of Loss provision; and
- 2) according to the General Provisions of The Policy.

The Seat Belt Benefit is the lesser of:

- 1) an amount resulting from multiplying the injured person's amount of Principal Sum by the Seat Belt Benefit Percentage; or
- 2) the Maximum Amount for this Benefit.

If it cannot be determined that the injured person was wearing a Seat Belt at the time of Accident, a Minimum Benefit will be payable under the Seat Belt Benefit.

Accident, for the purpose of this Benefit only, means the unintentional collision of a Motor Vehicle during which the injured person was wearing a Seat Belt.

Seat Belt means:

- 1) an unaltered belt, lap restraint, or lap and shoulder restraint installed by the manufacturer of the Motor Vehicle, or proper replacement parts installed as required by the Motor Vehicle's manufacturer's specifications; or
- 2) a child restraint device that meets the standards of the National Safety Council and is properly secured and used in accordance with applicable state law and installed according to the recommendations of its manufacturer for children of like age and weight.

The specific amounts for this Benefit are shown in the Schedule of Insurance.

PA-9223 F16

Felonious Assault Benefit: *When is the Felonious Assault Benefit payable?*

If You or Your Dependents sustain an Injury that results in Loss payable under the Accidental Death and Dismemberment Benefit, We will pay an additional Felonious Assault Benefit, if Injury is the result of a Felonious Assault.

This Benefit will be paid:

- 1) after We receive Proof of Loss, in accordance with the Proof of Loss provision; and
- 2) according to the General Provisions of The Policy.

The Felonious Assault Benefit will pay the lesser of:

- 1) the amount resulting from multiplying the injured person's amount of Principal Sum by the Felonious Assault Percentage; or
- 2) the Maximum Amount for this Benefit.

Felonious Assault means a violent or criminal act directed at You or Your Dependents during the course of:

- 1) a robbery, kidnapping or criminal assault; or
- 2) an attempt at any of the above;

which constitutes a felony under the law.

The Felonious Assault Benefit will not pay for a Loss that results from a Felonious Assault committed by:

- 1) a member of the injured person's family;
- 2) a member of the household in which the injured person lives; or
- 3) the injured person's fellow employee.

The specific amounts for this Benefit are shown in the Schedule of Insurance.

PA-9223 F19

Child Education Benefit: *When is the Child Education Benefit payable?*

If You or Your Spouse sustains an Injury that results in Loss of life payable under the Accidental Death and Dismemberment Benefit, We will pay an additional Child Education Benefit to Your Dependent Child(ren).

This Benefit will be paid:

- 1) after We receive proof that your Dependent Child(ren) qualify as a Student, as defined in this Benefit; and
- 2) according to the General Provisions of The Policy.

If You die, the Child Education Benefit provides an annual amount equal to the lesser of:

- 1) the amount resulting from multiplying Your Principal Sum by the Child Education Percentage; or
- 2) the Maximum Amount for this Benefit.

If Your Spouse dies, the Child Education Benefit provides an annual amount equal to the lesser of:

- 1) the amount resulting from multiplying Your Spouse's amount of Principal Sum by the Child Education Percentage;
or
- 2) the Maximum Amount for this Benefit.

The Child Education Benefit is payable to each of Your Dependent Child(ren):

- 1) on the date; and
- 2) for whom;

We have received proof satisfactory to Us that he or she is a Student.

If he or she is a minor, We will pay the benefit to the Student's legal guardian.

We will pay the Child Education Benefit to a qualifying Student until the first to occur of:

- 1) Our payment of the fourth Child Education Benefit to or on behalf of that person; or
- 2) the end of the 12th consecutive month during which We have not received proof satisfactory to Us that he or she is a Student.

We will not pay more than one Child Education Benefit to any one Student during any one school year.

We will pay the Minimum Amount for this Benefit in accordance with the Claims to be Paid provision of The Policy if:

- 1) a Principal Sum is payable because of Your death or Your Spouse's death; and
- 2) no person qualifies as a Student.

Student means Your Dependent Child(ren) who is covered on the date of Your or Your Spouse's death and:

- 1) is a full-time (at least 12 course credit hours per semester) post-high school student at an accredited institution of learning on the date of Your or Your Spouse's death; or
- 2) became a full-time (at least 12 course credit hours per semester) post-high school student at an accredited institution of learning within 365 days after Your or Your Spouse's death and was a student in the 12th grade on the date of Your or Your Spouse's death.

If the institution establishes full-time status in any other manner, We reserve the right to determine whether the student qualifies as a Student.

The specific amounts for this Benefit are shown in the Schedule of Insurance.
PA-9223 F20

Day Care Benefit: *When is the Day Care Benefit payable?*

If You or Your Spouse sustains an Injury that results in Loss of life payable under the Accidental Death and Dismemberment Benefit, We will pay an additional Day Care Benefit for each of your Dependent Children who are covered if such Dependent Child is under age 11 at the time of Your or Your Spouse's death.

This Benefit will be paid:

- 1) after We receive proof of enrollment in a Day Care Program as described in this Benefit; and
- 2) according to the General Provisions of The Policy.

We will make one Day Care Benefit payment each year, for a maximum of 4 Day Care Benefit payments, for each Dependent Child. The Benefit will be paid to the person who has primary responsibility for the Dependent Child's Day Care expenses.

Proof of enrollment satisfactory to Us for each Dependent Child in a Day Care Program includes, but will not be limited to, the following:

- 1) a copy of the Dependent Child's approved enrollment application in a Day Care Program;
- 2) cancelled check(s) evidencing payment to a Day Care facility or Day Care provider;
- 3) a letter from the Day Care facility or Day Care provider stating that the Dependent Child:
 - a) is attending a Day Care Program; or
 - b) has been enrolled in a Day Care Program and will be attending within 365 days of the date of the death.

Proof of enrollment must be sent to Us prior to the last day of the 12th month following the date of death.

If you die, the Day Care Benefit pays an amount equal to the lesser of:

- 1) the amount resulting from multiplying Your Principal sum by the Day Care Benefit Percentage; or
- 2) the Maximum Amount for this Benefit.

If Your Spouse dies, the Day Care Benefit pays an amount equal to the lesser of:

- 1) the amount resulting from multiplying Your Spouse's amount of Principal sum by the Day Care Benefit Percentage; or
- 2) the Maximum Amount for this Benefit.

We will pay the Minimum Amount for this Benefit in accordance with the Claims to be Paid provision for payment of benefits for Loss of life if:

- 1) a Principal Sum is payable because of the deceased person's death; and
- 2) no person qualifies as a Child eligible for the Day Care Benefit.

Day Care or Day Care Program means a program of child care which:

- 1) is operated in a private home, school or other facility;
- 2) provides, and makes a charge for, the care of children; and
- 3) is licensed as a day care center or is operated by a licensed day care provider, if such licensing is required by the state or jurisdiction in which it is located; or
- 4) licensing is not required, provides childcare on a daily basis for 12 months a year.

The specific amounts for this Benefit are shown in the Schedule of Insurance.
PA-9223 F21

Rehabilitation Benefit: *When is the Rehabilitation Benefit payable?*

If You or Your Dependents sustain an Injury that results in a Loss other than Loss of life, payable under the Accidental Death and Dismemberment Benefit, We will pay an additional Rehabilitation Benefit for Rehabilitative Program Expenses Incurred within one (1) year of the date of accident.

This Benefit will be paid:

- 1) after We receive proof of Expenses Incurred for a Rehabilitative Program, in accordance with the Proof of Loss provision; and
- 2) according to the General Provisions of The Policy.

The Rehabilitation Benefit provides an amount equal to the least of:

- 1) the actual Expense Incurred for a Rehabilitative Program;
- 2) the amount resulting from multiplying the injured person's amount of Principal Sum by the Rehabilitation Benefit Percentage; or
- 3) the Maximum Amount for this Benefit.

Rehabilitative Program means any training which:

- 1) is required due to the injured person's Injury; and
- 2) prepares the injured person for an occupation for which he or she was not previously trained.

Expense Incurred means the actual cost of:

- 1) training; and
- 2) materials needed for the training.

The specific amounts for this Benefit are shown in the Schedule of Insurance.

PA-9223 F22

Spouse Education Benefit: *When is the Spouse Education Benefit payable?*

If You sustain an Injury that results in a Loss of life, payable under the Accidental Death and Dismemberment Benefit, We will pay an additional Spouse Education Benefit to Your surviving Spouse.

Your Spouse must be covered under The Policy in order to receive this Benefit.

This Benefit will be paid:

- 1) after We receive proof satisfactory to Us that the Spouse has enrolled in an Occupational Training program; and
- 2) according to the General Provisions of The Policy.

The Spouse Education Benefit is the least of:

- 1) the Expense Incurred for Occupational Training;
- 2) the amount resulting from multiplying Your Principal Sum by the Spouse Education Benefit Percentage; or
- 3) the Maximum Amount for this Benefit.

If a Principal Sum is payable because of Your death and there is no surviving Spouse, We will pay the Minimum Amount for this Benefit in accordance with the Claims to be Paid provision.

Your surviving Spouse must enroll in Occupational Training:

- 1) for the purpose of obtaining an independent source of income; and
- 2) within one (1) year of Your death.

Occupational Training means any:

- 1) education;
- 2) professional; or
- 3) trade training;

program which prepares the Spouse for an occupation for which he or she was not previously qualified.

Expense Incurred means:

- 1) the actual tuition charged, exclusive of room and board; and
- 2) the actual cost of the materials needed;

for the Occupational Training.

The expense must be incurred within two (2) years of the date of Your death.

The specific amounts for this Benefit are shown in the Schedule of Insurance.
PA-9223 F23

Adaptive Home and Vehicle Benefit: *When is the Adaptive Home and Vehicle Benefit payable?*

If You or Your Dependents sustain an Injury that results in a Loss, other than a Loss of life, payable under the Accidental Death and Dismemberment Benefit, We will pay an additional Adaptive Home and Vehicle Benefit.

This Benefit will be paid:

- 1) after We receive Proof of Loss, in accordance with the Proof of Loss provision; and
- 2) according to the General Provisions of The Policy.

The Adaptive Home and Vehicle Benefit pays a benefit for the one-time cost of alterations to the injured person's:

- 1) principal residence; and/or
- 2) private automobile;

to make the residence accessible and/or the private automobile drivable or rideable for him or her. The costs must be incurred within two years from the date of accident.

We will pay the Adaptive Home and Vehicle Benefit if:

- 1) such home alterations are:
 - a) made by a person or persons with experience in such alterations; and
 - b) recommended by a recognized organization associated with the Injury; and
- 2) such vehicle modifications are:
 - a) carried out by a person or persons with experience in such matters; and
 - b) approved by the Motor Vehicle Department.

The Adaptive Home and Vehicle Benefit will provide an amount equal to the least of:

- 1) the actual cost of the alterations;
- 2) the amount resulting from multiplying the injured person's amount of Principal Sum by the Adaptive Home and Vehicle Benefit Percentage; or
- 3) the Maximum Amount for this Benefit.

The specific amounts for this Benefit are shown in the Schedule of Insurance.
PA-9223 F24

Therapeutic Counseling Benefit: *When is the Therapeutic Counseling Benefit payable?*

If You or Your Dependents sustain an Injury that results in a Loss, other than Loss of life, that is payable under the Accidental Death and Dismemberment Benefit, We will pay an additional Therapeutic Counseling Benefit if the injured person requires Therapeutic Counseling due to the Loss.

This Benefit will be paid:

- 1) after We receive Proof of Loss, in accordance with the Proof of Loss provision; and
- 2) according to the General Provisions of The Policy.

Therapeutic Counseling must:

- 1) begin within 90 days of the date of the Loss; and
- 2) be incurred no later than one year from the date of the Loss.

The Therapeutic Counseling Benefit is an amount equal to the least of:

- 1) the Reasonable Expenses incurred for Therapeutic Counseling;
- 2) the amount resulting from multiplying the injured person's amount of Principal Sum by the Therapeutic Counseling Percentage; or
- 3) the Maximum Amount for this Benefit.

Therapeutic Counseling means treatment or counseling provided by a licensed therapist or counselor registered or certified to provide psychological treatment or counseling.

Reasonable Expenses means fees and prices which do not exceed those generally charged for similar Therapeutic Counseling in the local area where such Therapeutic Counseling was received. For purposes of this benefit, We reserve the right to determine Reasonable Expenses. A Reasonable Expense is considered to be incurred on the date the Therapeutic Counseling is rendered.

Continuation of Medical Coverage (COBRA) Benefit: *When is the Continuation of Medical Coverage (COBRA) Benefit payable?*

If You sustain an Injury that results in a Loss of life payable under the Accidental Death and Dismemberment Benefit, and Your Dependents:

- 1) are covered under The Policy; and
- 2) elect to continue medical coverage in accordance with the Consolidated Omnibus Reconciliation Act of 1988 (COBRA);

We will pay a Continuation of Medical Coverage Benefit.

This Benefit will be paid:

- 1) after We receive Proof of Loss, in accordance with the Proof of Loss provision; and
- 2) according to the General Provisions of The Policy.

We will pay the COBRA Benefit in three annual installment amounts each equal to the lesser of:

- 1) the amount resulting from multiplying Your Principal Sum by the Percentage for the Continuation of Medical Coverage Benefit; or
- 2) the Maximum Amount for this Benefit.

The COBRA Benefit is payable to Your Dependents' insurance carrier on the date We receive the bill for such continuation of coverage.

If the Principal Sum is payable because of Your death; and

- 1) no person qualifies as a Dependent; or
- 2) Your Dependents do not elect to continue coverage pursuant to COBRA;

We will pay the Minimum Amount for this Benefit in accordance with the Claims to be Paid provision of The Policy.

The specific amounts for this Benefit are shown in the Schedule of Insurance.

PA-9223 F33

Extended Dependents Coverage Benefit: *When is the Extended Dependents Coverage Benefit payable?*

If You die while Your Dependents are covered under The Policy, We will waive the payment of premiums, and continue coverage for Your Dependents.

This Benefit will be paid:

- 1) after We receive Proof of Loss, in accordance with the Proof of Loss provision; and
- 2) according to the General Provisions of The Policy.

We will waive the premium and continue coverage for each of Your Dependents until the first to occur of:

- 1) the date Your Spouse remarries;
- 2) the date he or she ceases to qualify as Your Dependent;
- 3) the date which is one year from the date of Your death; or
- 4) the date The Policy terminates.

PA-9223 F34

Common Disaster Benefit: *When is the Common Disaster Benefit payable?*

If You and Your Spouse die as the result of Injury:

- 1) received in the same accident; or
- 2) in separate accidents which occur within 24 hours of each other;

and a Principal Sum is payable under the Accidental Death and Dismemberment Benefit for each death, the Principal Sum applicable to Your Spouse will be increased to equal the lesser of:

- 1) Your Principal Sum; or
- 2) an amount which, when added to Your Principal Sum, equals the Common Disaster Limit.

This Benefit will be paid:

- 1) after We receive Proof of Loss, in accordance with the Proof of Loss provision; and
- 2) according to the General Provisions of The Policy.

The specific amounts for this Benefit are shown in the Schedule of Insurance.

Survivor Income Benefit: *When is the Survivor Income Benefit payable?*

If You or Your Spouse sustain an Injury that results in Loss of life payable under the Accidental Death and Dismemberment Benefit, We will pay an additional Survivor Benefit if Your Dependents are covered.

This Benefit will be paid:

- 1) after We receive Proof of Loss, in accordance with the Proof of Loss provision; and
- 2) according to the General Provisions of The Policy.

The Survivor Income Benefit provides a monthly Benefit equal to a Percentage of the deceased person's Principal Sum for the Payment Period.

The Survivor Income Benefit will be paid:

- 1) to the beneficiary You designated; or
- 2) if no beneficiary has been designated:
 - a) to Your surviving Spouse;
 - b) if no surviving Spouse, in equal shares to Your surviving Dependent Children;
 - c) if no surviving Dependents, to Your estate.

If a minor child is entitled to this Benefit, We may, at Our option, make Benefit payments according to the Claims to be Paid provision of The Policy. We will begin payments on the first day of the month next following the date the death claim is paid.

The specific amounts for this Benefit are shown in the Schedule of Insurance.

PA-9223 F38

Dependent Child Dismemberment Benefit: *When is the Dependent Child Dismemberment Benefit payable?*

If Your Dependent Child sustains a Loss, other than Loss of Life under the Accidental Death and Dismemberment Benefit, We will double the Principal Sum amount payable for the Loss.

This Benefit will be paid:

- 1) after We receive Proof of Loss, in accordance with the Proof of Loss provision; and
- 2) according to the General Provisions of The Policy.

We will not pay more than an amount equal to double the Principal Sum under this Benefit and the Accidental Death and Dismemberment Benefit combined for all Losses which are due to the same Injury.

PA-9223 F40

Permanent Total Disability Benefit: *When is the Permanent Total Disability Benefit payable?*

If You or Your Spouse are Disabled and the injured person's Disability:

- 1) resulted from Injury received before attainment of the Age Limit;
- 2) began within the Disability Commencement Period after the accident;
- 3) continued without interruption for at least the Qualification Period; and
- 4) is reasonably expected to continue without interruption until death;

We will pay the Benefit Amount, less any amount paid or payable under the Accidental Death and Dismemberment Benefit.

This Benefit will be paid:

- 1) after We receive Proof of Loss for the injured person while he or she is alive, in accordance with the Proof of Loss provision; and
- 2) according to the General Provisions of The Policy.

Disabled or Total Disability, for the purpose of this Benefit, means Your or Your Spouse's:

- 1) inability to perform the material and substantial duties of any occupation for which You, he or she is suited by education, training and experience; or
- 2) with respect to a Spouse who is unemployed, his or her inability to engage in the normal and customary activities of a person of like age and gender in good health.

Your unemployed Spouse must be:

- 1) regularly attended by Physician; and

- 2) continuously confined within his or her house or Hospital, provided such house or Hospital confinement will not preclude transportation of Your Spouse to or from a Hospital or Physician's office for necessary treatment at the direction of his or her Physician.

The specific amounts for this Benefit are shown in the Schedule of Insurance.
PA-9223 F43 (NC)

EXCLUSIONS

Exclusions: *What losses are not covered?*

The Policy does not cover any loss caused or contributed to by:

- 1) intentionally self-inflicted Injury;
- 2) suicide or attempted suicide, whether sane or insane;
- 3) war or act of war, whether declared or not;
- 4) Injury sustained while on full-time active duty as a member of the armed forces (land, water, air) of any country or international authority;

(We will refund the pro rata portion of any premium paid for You or Your Dependents while You or Your Dependents are in the armed forces on full-time active duty, for a period of two months or more. Written notice must be given to Us within 12 months of the date You or Your Dependents enter the armed forces);

- 5) Injury sustained while On any aircraft except a Civil or Public Aircraft, or Military Transport Aircraft;
- 6) Injury sustained while On any aircraft:
 - a) as a pilot, crewmember or student pilot;
 - b) as a flight instructor or examiner;
 - c) if it is owned, operated or leased by or on behalf of the Policyholder, or any Employer or organization whose eligible persons are covered under The Policy;
 - d) being used for tests, experimental purposes, stunt flying, racing or endurance tests;
- 7) Injury sustained while taking drugs, including but not limited to sedatives, narcotics, barbiturates, amphetamines, or hallucinogens unless as prescribed by or administered by a Physician;
- 8) Injury sustained while riding or driving in a scheduled race or testing any Motor Vehicle on tracks, speedways or proving grounds;
- 9) Injury sustained while committing or attempting to commit a felony; or
- 10) Injury sustained while driving while Intoxicated.

Intoxicated means:

- 1) the blood alcohol content;
- 2) the results of other means of testing blood alcohol level; or
- 3) the results of other means of testing other substances;

that meet or exceed the legal presumption of intoxication, or under the influence, under the law of the state where the accident occurred.

PA-9222 G01

GENERAL PROVISIONS

Notice of Claim: *When should I notify the Company of a claim?*

You, or the person who has the right to claim benefits, must give Us, written notice of a claim within 30 days after:

- 1) the date of death; or
- 2) the date of loss.

If notice cannot be given within that time, it must be given as soon as reasonably possible after that. Such notice must include the claimant's name, address and the Policy Number.

GBD-1300 H01

Claim Forms: *Are special forms required to file a claim?*

We will send forms to the claimant to provide Proof of Loss, within 15 days of receiving a Notice of Claim. If We do not send the forms within 15 days, the claimant may submit any other written proof which fully describes the nature and extent of the claim.

Proof of Loss: *What is Proof of Loss?*

Proof of Loss may include, but is not limited to, the following:

- 1) a completed claim form;
- 2) a certified copy of the death certificate (if applicable);
- 3) Your Enrollment form;
- 4) Your Beneficiary Designation (if applicable);
- 5) any and all medical information, including x-ray films and photocopies of medical records, including histories, physical, mental or diagnostic examinations and treatment notes;
- 6) the names and addresses of all:
 - a) Physicians or other qualified medical professionals You have consulted;
 - b) hospitals or other medical facilities in which You have been treated; and
 - c) pharmacies which have filled Your prescriptions within the past three years;
- 7) Your signed authorization for Us to obtain and release medical, employment and financial information (if applicable); or
- 8) Any additional information required by Us to adjudicate the claim.

All proof submitted must be satisfactory to Us.

GBD-1300 H03

Sending Proof of Loss: *When must Proof of Loss be given?*

Written Proof of Loss must be sent within 180 day(s) after the loss. All Proof of Loss should be sent to Us. However, all claims should be submitted to Us within 90 day(s) of the date coverage ends.

If proof is not given by the time it is due, it will not affect the claim if:

- 1) it was not possible to give proof within the required time; and
- 2) proof is given as soon as possible; but
- 3) not later than 1 year after it is due unless You, or the person who has the right to claim benefits, are not legally competent.

GBD-1300 H04 (NC)

Physical Examination and Autopsy: *Can We have a claimant examined or request an autopsy?*

While a claim is pending We have the right at Our expense:

- 1) to have the person who has a loss examined by a Physician when and as often as We reasonably require; and
- 2) to have an autopsy performed in case of death where it is not forbidden by law.

GBD-1300 H05

Claim Payment: *When are benefit payments issued?*

When We determine that benefits are payable, We will pay the benefits in accordance with the Claims to be Paid provision, but not more than 30 day(s) after such Proof of Loss is received.

GBD-1300 H06

Claims to be Paid: *To whom will benefits for my claim be paid?*

Benefits for Loss of Life will be paid in accordance with the Beneficiary Designation. If no beneficiary is named, payment will be made according to the beneficiary designation under the group life policy issued to the Policyholder and in effect at the time of death.

If no beneficiary is named, or if no named beneficiary survives You, We may, at Our option, pay:

- 1) the executors or administrators of Your estate;
- 2) all to Your surviving spouse;
- 3) if Your spouse does not survive You, in equal shares to Your surviving children;
- 4) if no child survives You, in equal shares to Your surviving parents; or
- 5) if no parent survives You, in equal shares to Your surviving siblings.

In addition, We may, at Our option, pay a portion of Your Accidental Death Benefit up to \$500 to any person equitably entitled to payment because of expenses from Your burial. Payment to any person, as shown above, will release Us from liability for the amount paid.

If any beneficiary is a minor, We may pay his or her share, until a legal guardian of the minor's estate is appointed, to a person who at Our option and in Our opinion is providing financial support and maintenance for the minor. We will pay:

- 1) \$200 at Your death; and
- 2) monthly installments of not more than \$200.

Payment to any person as shown above will release Us from all further liability for the amount paid.

We will pay the Accidental Death and Dismemberment Insurance Benefit at Your Dependents' death to You, if living. Otherwise, it will be paid, at Our option, to Your surviving Spouse or the executors or administrators of Your estate.

We will make any payments, other than for loss of life, to You. We may make any such payments owed at Your death to Your estate. If any payment is owed to:

- 1) Your estate;
- 2) a person who is a minor; or
- 3) a person who is not legally competent,

then We may pay up to \$1,000 to a person who is related to You and who, at Our sole discretion, is entitled to it. Any such payment shall fulfill Our responsibility for the amount paid.

GBD-1300 H07

Beneficiary Designation: *How do I designate or change my beneficiary?*

You may designate or change a beneficiary by doing so in writing on a form satisfactory to Us and filing the form with the Employer. Only satisfactory forms sent to the Employer prior to Your death will be accepted.

Beneficiary designations will become effective as of the date You signed and dated the form, even if You have since died. We will not be liable for any amounts paid before receiving notice of a beneficiary change from the Employer.

GBD-1300 H08

Claim Denial: *What notification will my Beneficiary or I receive if a claim is denied?*

If a claim for benefits is wholly or partly denied, You or Your beneficiary will be furnished with written notification of the decision.

This written notification will:

- 1) give the specific reason(s) for the denial;
- 2) make specific reference to the provisions on which the denial is based;
- 3) provide a description of any additional information necessary to perfect a claim and an explanation of why it is necessary; and
- 4) provide an explanation of the review procedure.

GBD-1300 H09

Claim Appeal: *What recourse do my Beneficiary or I have if a claim is denied?*

On any claim, the claimant or his or her representative may appeal to Us for a full and fair review. To do so, he or she:

- 1) must request a review upon written application within:
 - a) 180 days of receipt of claim denial if the claim requires Us to make a determination of disability; or
 - b) 60 days of receipt of claim denial if the claim does not require Us to make a determination of disability; and
- 2) may request copies of all documents, records, and other information relevant to the claim; and
- 3) may submit written comments, documents, records and other information relating to the claim.

We will respond in writing with Our final decision on the claim.

GBD-1300 H10

Policy Interpretation: *Who interprets the terms and conditions of The Policy?*

We have full discretion and authority to determine eligibility for benefits and to construe and interpret all terms and provisions of The Policy. This provision applies where the interpretation of The Policy is governed by the Employee Retirement Income Security Act of 1974, as amended (ERISA).

GBD-1300 H11

Assignment: *Are there any rights of assignment?*

Except for the dismemberment benefits under the Accidental Death and Dismemberment Benefit, You have the right to absolutely assign Your rights and interest under The Policy including, but not limited, to the following:

- 1) the right to make any contributions required to keep the insurance in force;
- 2) the right to convert; and
- 3) the right to name and change a beneficiary.

We will recognize any absolute assignment made by You under The Policy, provided:

- 1) it is duly executed; and
- 2) a copy is acknowledged and on file with Us.

We and the Policyholder assume no responsibility:

- 1) for the validity or effect of any assignment; or
- 2) to provide any assignee with notices which We may be obligated to provide to You.

You do not have the right to collaterally assign Your rights and interest under The Policy.

GBD-1300 H12

Legal Actions: *When can legal action be taken against Us?*

Legal action cannot be taken against Us:

- 1) sooner than 60 days after the date Proof of Loss is furnished; or
- 2) more than 3 years after the date Proof of Loss is required to be furnished according to the terms of The Policy.

GBD-1300 H13

Workers' Compensation: *How does The Policy affect Workers' Compensation coverage?*

The Policy does not replace Workers' Compensation or affect any requirement for Workers' Compensation coverage.

GBD-1300 H14

Insurance Fraud: *How does the Company deal with fraud?*

Insurance Fraud occurs when You, Your Dependents and/or Your Employer provide Us with false information or file a claim for benefits that contains any false, incomplete or misleading information with the intent to injure, defraud or deceive Us. It is a crime if You, Your Dependents and/or Your Employer commit Insurance Fraud. We will use all means available to Us to detect, investigate, deter and prosecute those who commit Insurance Fraud. We will pursue all available legal remedies if You, Your Dependents and/or Your Employer perpetrate Insurance Fraud.

GBD-1300 H15

Misstatements: *What happens if facts are misstated?*

In the absence of Insurance Fraud, if material facts about You or Your Dependents were not stated accurately:

- 1) the premium may be adjusted; and
- 2) the true facts will be used to determine if, and for what amount, coverage should have been in force.

No statement made by You relating to Your insurability will be used to contest the insurance for which the statement was made after the insurance has been in force for two years during Your lifetime. In order to be used, the statement must be in writing and signed by You.

GBD-1300 H16 (NC)

DEFINITIONS

Active Teammate means a teammate who works for the Employer on a regular basis in the usual course of the Employer's business. This must be at least the number of hours shown in the Schedule of Insurance.

PA-9221 C01

Actively at Work means at work with Your Employer on a day that is one of Your Employer's scheduled workdays. On that day, You must be performing for wage or profit all of the regular duties of Your job:

- 1) in the usual way; and
- 2) for Your usual number of hours.

We will also consider You to be Actively At Work on any regularly scheduled vacation day or holiday, only if You were Actively At Work on the preceding scheduled work day.

Actively at Work does not include everyday travel to and from work.

PA-9221 C02

Airworthiness Certificate means:

- 1) the "Standard" Airworthiness Certificate issued by the United States Federal Aviation Administration (FAA); or
- 2) a foreign equivalent issued by the governmental authority with jurisdiction over civil aviation in the country of its registry.

PA-9221 C04

Civil or Public Aircraft means a civil or public aircraft which:

- 1) has a current and valid Airworthiness Certificate;
- 2) is piloted by a person who has a valid and current certificate of competency of a rating which authorizes him or her to pilot the aircraft; and
- 3) is not operated by the militia, or armed forces of any state, national government or international authority.

PA-9221 C07

Common Carrier means a conveyance operated by a concern, other than the Policyholder, organized and licensed for the transportation of passengers for hire and operated by that concern.

Common Carrier will not mean any such conveyance which is hired or used for a sport, gamesmanship, contest, sightseeing, observatory and/or recreational activity, regardless of whether such conveyance is licensed.

PA-9221 C09

Contributory Coverage means coverage for which You are required to contribute toward the cost. Contributory Coverage is shown in the Schedule of Insurance.

PA-9221 C10

Dependent Child(ren) means:

Your children, stepchildren, legally adopted children, children placed for adoption, foster children, or any other children related to You by blood or marriage or domestic partnership provided such children are:

- 1) from live birth but not yet 26; or
- 2) age 26 or older and disabled. Such children must have become disabled before attaining age 26. You must submit proof, satisfactory to Us, of such children's disability.

PA-9221 C13 (Rev.) (NC)

Dependents means Your Spouse and Your Dependent Child(ren). A dependent must be a citizen or legal resident of the United States, its territories and protectorates.

PA-9221 C14

Earnings means the annual earnings calculated by the Employer.

PA-9221 C17

Employer means the Policyholder.

PA-9221 C18

FAA means:

- 1) the Federal Aviation Administration of the United States; or
- 2) the equivalent aviation authority for the country of the aircraft's registry, if the governmental authority is recognized by the United States.

PA-9221 C19

Injury means bodily injury resulting:

- 1) directly from an accident; and
- 2) independently of all other causes;

which occurs while You or Your Dependents are covered under The Policy.

Loss resulting from:

- 1) sickness or disease; or
- 2) medical or surgical treatment of a sickness or disease;

is not considered as resulting from Injury.

PA-9221 C22 (NC)

Military Transport Aircraft means a transport aircraft operated by:

- 1) the United States Air Mobility Command (AMC); or
- 2) a national military air transport service of a governmental authority recognized by the United States.

PA-9221 C24

Motor Vehicle means a self-propelled, four (4) or more wheeled:

- 1) private passenger: car, station wagon, van or sport utility vehicle;
- 2) motor home or camper; or
- 3) pick-up truck;

not being used as a Common Carrier.

A Motor Vehicle does not include farm equipment, snowmobiles, all-terrain vehicles, lawnmowers or any other type of equipment vehicles.

PA-9221 C25

On means, when used with reference to any conveyance (land, water or air), in or on, boarding or alighting from the conveyance.

PA-9221 C28

Physician means a person who is:

- 1) a doctor of medicine, osteopathy, psychology or other legally qualified practitioner of a healing art that We recognize or are required by law to recognize;
- 2) licensed to practice in the jurisdiction where care is being given;
- 3) practicing within the scope of that license; and
- 4) not Related to You by blood or marriage.

PA-9221 C31

Prior Policy means the group accidental death and dismemberment insurance Policy carried by the Policyholder on the day before the Policy Effective Date and will only include the coverage which is transferred to Us.

PA-9221 C33

Related means Your Spouse or other adult living with You, sibling, parent, step-parent, grandparent, aunt, uncle, niece, nephew, son, daughter, grandchild, or step-child or similar relationship in law.

PA-9221 C34

Spouse means Your spouse who:

- 1) is under age 70; and
- 2) is not legally separated or divorced from You.

Spouse will include Your domestic partner or party to a civil union, provided You:

- 1) have executed a domestic partner affidavit satisfactory to Us, establishing that You and Your partner are domestic partners or parties to a civil union for purposes of The Policy; or
- 2) have registered as domestic partners or parties to a civil union with a government agency or office where such registration is available and provide proof of such registration unless requiring proof is prohibited by law.

You will continue to be considered domestic partners or parties to a civil union provided You continue to meet the requirements described in the domestic partner affidavit or required by law.

PA-9221 C37 (Rev.)

The Policy means the policy which We issued to the Policyholder under the Policy Number shown on the face page.

PA-9221 C38

We, Us, or Our means the insurance company named on the face page of The Policy.

PA-9221 C41

You or Your means the person to whom this certificate is issued.

PA-9221 C42

**ERISA INFORMATION
THE FOLLOWING NOTICE
CONTAINS IMPORTANT INFORMATION**

The Employee Retirement Income Security Act ("ERISA") is a federal law that sets the standards for many types of employee benefit plans. One of the requirements under ERISA is that the Plan Sponsor provides participants with a Summary Plan Description ("SPD") which is a non-technical summary of plan provisions. The Truist Financial Corporation Employee Benefit Plan ("Plan") provides eligible employees and their dependents with health, dental, vision, disability, life insurance and accidental death and dismemberment insurance benefits. Each benefit available under the Plan is summarized in a separate booklet. These booklets, taken together, comprise the SPD for the Plan.

This booklet summarizes the Truist Basic Term Life, Dependent Life, Supplemental Term Life and the Standalone Accidental Death and Dismemberment insurance and is referred to in this booklet as the Plan. The Disability insurance program is designed to prevent a lapse in pay if you're out of work due to non-work related illness or disability. Life and Accidental Death and Dismemberment (AD&D) insurance helps provide financial security to you and your loved ones in the case of unforeseen events.

The material contained in each booklet is taken from the actual legal plan documents that governs the principles and provisions under which a plan operates. Therefore, if any conflict exists between the SPD and the actual plan provisions, the terms of the legal plan document will govern.

We encourage Plan participants to read the SPD carefully. If you have any questions regarding the information in the SPD, contact the Plan Administrator whose name and address are listed under "ERISA INFORMATION" for the benefit program.

A listing of all the benefits available under the Plan and the SPD booklets are available on the Truist Human Resources Portal. You may also obtain a copy of the Plan document by calling Truist HR Central, 800-716-2455, Option 1. These documents together make up the legal plan document for Truist Employee Benefit Plan.

1. Plan Name

Group Basic Term Life, Supplemental Dependent Life, Supplemental Term Life Plan, Supplemental Accidental Death & Dismemberment for teammates of TRUIST FINANCIAL CORPORATION EMPLOYEE BENEFIT PLAN.

2. Plan Number

LIFE - 508
ADD - 508

3. Employer/Plan Sponsor

Employee Benefits Committee
Truist Financial Corporation
214 N. Tryon Street, 45th Floor
Charlotte NC 28202

4. Employer Identification Number

56-0939887

5. Type of Plan

Welfare Benefit Plan providing Group Basic Term Life, Supplemental Dependent Life, Supplemental Term Life.

6. **Plan Administrator**

Employee Benefits Committee
Truist Financial Corporation
214 N. Tryon Street, 45th Floor
Charlotte NC 28202

7. **Agent for Service of Legal Process**

For the Plan
Employee Benefits Committee
Truist Financial Corporation
214 N. Tryon Street, 45th Floor
Charlotte NC 28202

For the Policy:

Hartford Life and Accident Insurance Company
One Hartford Plaza
Hartford, Connecticut 06155

In addition to the above, Service of Legal Process may be made on a plan trustee or the plan administrator.

8. **Sources of Contributions (Life)** Basic and supplemental coverage are being offered under a single ERISA plan. The Employer may pay some or all of the premium for the basic coverage. Coverages described in the certificate/policy as noncontributory or as being paid by the Employer, if any, are those paid for directly by the Employer such that you may have no direct out of pocket expense for such coverage. However, teammates who elect supplemental coverage will be required to contribute specified amounts to the plan. Any amounts paid by teammates may be used to pay any benefit or expense under the plan and may be used to reduce what the Employer pays for basic coverage.
-

9. **Type of Administration** The plan is administered by the Plan Administrator with benefits provided in accordance with the provisions of the applicable group plan.
-

10. The Plan and its records are kept on a Policy Year basis.
-

11. **Labor Organizations**

None

12. **Names and Addresses of Trustees**

None

13. **Plan Amendment Procedure**

The Plan Administrator reserves full authority, at its sole discretion, to terminate, suspend, withdraw, reduce, amend or modify the Plan, in whole or in part, at any time, without prior notice.

The Employer also reserves the right to adjust your share of the cost to continue coverage by the same procedures.

STATEMENT OF ERISA RIGHTS

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

1. Receive Information About Your Plan and Benefits

- a) 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 Benefits Security Administration.
- b) 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.
- c) 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.

2. 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.

3. 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 the Plan requires you to complete administrative appeals prior to filing in court, your right to file suit in state or Federal court may be affected if you do not complete the required appeals. 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.

4. Assistance with Your Questions

If you have any questions about your Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration (formerly known as the Pension and Welfare Benefits Administration), U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

CLAIM PROCEDURES

The Plan has designated and named the Insurance Company as the claims fiduciary for benefits provided under the Policy. The Plan has granted the Insurance Company full discretion and authority to determine eligibility for benefits and to construe and interpret all terms and provisions of the Policy, to the extent permitted by applicable state law.

Claim Procedures for Claims Requiring a Determination of Disability

Claims and appeals for disability benefits will be adjudicated in a manner designed to ensure the independence and impartiality of the persons involved in making the decision. Accordingly, decisions regarding hiring, compensation, termination, promotion or other similar matters with respect to any individual (such as a claims adjudicator or medical or vocational expert) shall not be made based upon the likelihood that the individual will support the denial of benefits.

If the Insurance Company fails to strictly adhere to all the requirements of ERISA with respect to a claim, you are deemed to have exhausted the administrative remedies available under the Plan, with certain exceptions. Accordingly, you are entitled to bring a civil action to pursue any available remedies under section 502(a) of ERISA on the basis that the Insurance Company has failed to provide a reasonable claims procedure that would yield a decision on the merits of the claim. If you choose to bring a civil action to pursue remedies under section 502(a) of ERISA under such circumstances, your claim or appeal is deemed denied on review without the exercise of discretion by an appropriate fiduciary. However, the administrative remedies available under the Plan will not be deemed exhausted based on *de minimis* violations that do not cause, and are not likely to cause, prejudice or harm to you so long as the Insurance Company demonstrates that the violation was for good cause or due to matters beyond the control of the Insurance Company and that the violation occurred in the context of an ongoing, good faith exchange of information between the Insurance Company and you. This exception is not available if the violation is part of a pattern or practice of violations by the Insurance Company. Before filing a civil action, you may request a written explanation of the violation from the Insurance Company, and the Insurance Company must provide such explanation within 10 days, including a specific description of its bases, if any, for asserting that the violation should not cause the administrative remedies available under the Plan to be deemed exhausted. If a court rejects your request for immediate review on the basis that the Insurance Company met the standards for the exception, your claim shall be considered as re-filed on appeal upon the Insurance Company's receipt of the decision of the court. Within a reasonable time after the receipt of the decision, the Insurance Company shall provide you with notice of the resubmission.

Claims for Benefits

If you or your authorized representative would like to file a claim for benefits for yourself or your insured dependents, you or your authorized representative should obtain a claim form(s) from your Employer or Plan Administrator. The applicable section of such form(s) must be completed by (1) you, (2) the Employer or Plan Administrator and (3) the attending physician or hospital. Following completion, the claim form(s) must be forwarded to the Insurance Company's claim representative. The Insurance Company will evaluate your claim and determine if benefits are payable.

The Insurance Company will make a decision no more than 45 days after receipt of your properly filed claim. The time for decision may be extended for two additional 30 day periods provided that, prior to any extension period, the Insurance Company notifies you in writing that an extension is necessary due to matters beyond the control of the Insurance Company, identifies those matters and gives the date by which it expects to render its decision. If your claim is extended due to your failure to submit information necessary to decide your claim, the time for decision may be tolled from the date on which the notification of the extension is sent to you until the date the Insurance Company receives your response to our request. If the Insurance Company approves your claim, the decision will contain information sufficient to reasonably inform you of that decision.

Any adverse benefit determination will be in writing and include: 1) the specific reason or reasons for the decision; 2) specific references to the Policy provisions on which the decision is based; 3) a description of any additional material or information necessary for you to perfect the claim and an explanation of why such material or information is necessary; 4) a description of the Insurance Company's review procedures and time limits applicable to such procedures; 5) a statement that you have the right to bring a civil action under section 502(a) of ERISA after you appeal the decision and after you receive a written denial on appeal; 6) a discussion of the decision, including an explanation of the basis for disagreeing with or not following: (a) the views presented by you to the Insurance Company of health care professionals treating you and vocational professionals who evaluated you, (b) the views of medical or vocational experts whose advice was obtained on behalf of the Insurance Company in connection with the adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination, and (c) a disability determination regarding you presented by you to the Insurance Company made by the Social Security Administration; 7) if the adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to your medical circumstances, or a statement that such explanation will be provided free of charge upon request; 8) either the specific internal rules, guidelines, protocols, standards or other similar criteria of the Insurance Company relied upon in making the adverse determination or, alternatively, a statement that such rules, guidelines, protocols, standards or other similar criteria of the Insurance Company do not exist; 9) a statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim for benefits; and

10) a statement prominently displayed in any applicable non-English language clearly indicating how to access the language services provided by the Insurance Company.

Appealing Denials of Claims for Benefits

On any wholly or partially denied claim, you or your representative must appeal once to the Insurance Company for a full and fair review. You must complete this claim appeal process before you file an action in court, with the exception of an action under the deemed exhausted process described above. Your appeal request must be in writing and be received by the Insurance Company no later than the expiration of 180 days from the date you received your claim denial. As part of your appeal:

1. you may request, free of charge, copies of all documents, records, and other information relevant to your claim; and
2. you may submit written comments, documents, records and other information relating to your claim.

The Insurance Company's review on appeal shall take into account all comments, documents, records and other information submitted by you relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination.

Before the Insurance Company can issue an adverse benefit determination on review, the Insurance Company shall provide you, free of charge, with any new or additional evidence considered, relied upon, or generated by the Insurance Company (or at the direction of the Insurance Company) in connection with the claim; such evidence must be provided as soon as possible and sufficiently in advance of the date on which the notice of adverse benefit determination on review is required to be provided to give you a reasonable opportunity to respond prior to that date.

Before the Insurance Company can issue an adverse benefit determination on review based on a new or additional rationale, the Insurance Company shall provide you, free of charge, with the rationale; the rationale must be provided as soon as possible and sufficiently in advance of the date on which the notice of adverse benefit determination on review is required to be provided to give you a reasonable opportunity to respond prior to that date.

The Insurance Company will make a final decision no more than 45 days after it receives your timely appeal. The time for final decision may be extended for one additional 45 day period provided that, prior to the extension, the Insurance Company notifies you in writing that an extension is necessary due to special circumstances, identifies those circumstances and gives the date by which it expects to render its decision. If your claim is extended due to your failure to submit information necessary to decide your claim on appeal, the time for decision shall be tolled from the date on which the notification of the extension is sent to you until the date the Insurance Company receives your response to the request. The Insurance Company may also toll the time for a decision to allow you a reasonable opportunity to respond to new or additional evidence or a new or additional rationale. Tolling will begin on the date that the Insurance Company provides you with new or additional evidence or a new or additional rationale, and end when the Insurance Company receives the response or on the date by which the Insurance Company has requested a response, whichever comes first.

The individual reviewing your appeal shall give no deference to the initial benefit decision and shall be an individual who is neither the individual who made the initial benefit decision, nor the subordinate of such individual. The review process provides for the identification of the medical or vocational experts whose advice was obtained in connection with an initial adverse decision, without regard to whether that advice was relied upon in making that decision. When deciding an appeal that is based in whole or part on 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 and who is neither an individual consulted in connection with the initial benefit decision, nor a subordinate of such individual. If the Insurance Company grants your claim appeal, the decision will contain information sufficient to reasonably inform you of that decision.

However, any final adverse benefit determination on review will be in writing and include: 1) the specific reason or reasons for the decision; 2) specific references to the Policy provisions on which the decision is based; 3) a statement that you are entitled to receive, upon request and free of charge, copies of all documents, records, and other information relevant to your claim; 4) a statement (a) that you have the right to bring a civil action under section 502(a) of ERISA, and (b) describing any applicable contractual limitations period that applies to your right to bring such an action, including the calendar date on which the contractual limitations period expires for the claim; 5) a discussion of the decision, including an explanation of the basis for disagreeing with or not following: (a) the views presented by you to the Insurance Company of health care professionals treating you and vocational professionals who evaluated you, (b) the views of medical or vocational experts whose advice was obtained on behalf of the Insurance Company in connection with the adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination, and (c) a

disability determination regarding you presented by you to the Insurance Company made by the Social Security Administration; 6) if the adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to your medical circumstances, or a statement that such explanation will be provided free of charge upon request; 7) either the specific internal rules, guidelines, protocols, standards or other similar criteria of the Insurance Company relied upon in making the adverse determination or, alternatively, a statement that such rules, guidelines, protocols, standards or other similar criteria of the Plan do not exist; 8) a statement prominently displayed in any applicable non-English language clearly indicating how to access the language services provided by the Insurance Company; and 9) any other notice(s), statement(s) or information required by applicable law.

Claim Procedures for Claims Not Requiring a Determination of Disability

Claims and appeals for benefits will be adjudicated in a manner designed to ensure the independence and impartiality of the persons involved in making the decision. Accordingly, decisions regarding hiring, compensation, termination, promotion or other similar matters with respect to any individual (such as a claims adjudicator or medical expert) shall not be made based upon the likelihood that the individual will support the denial of benefits.

Claims for Benefits

If you or your authorized representative would like to file a claim for benefits for yourself or your insured dependents, you or your authorized representative should obtain a claim form(s) from your Employer or Plan Administrator. The applicable section of such form(s) must be completed by (1) you, (2) the Employer or Plan Administrator and (3) the attending physician or hospital. Following completion, the claim form(s) must be forwarded to the Insurance Company's claim representative. The Insurance Company will evaluate your claim and determine if benefits are payable.

The Insurance Company will make a decision no more than 90 days after receipt of your properly filed claim. However, if the Insurance Company determines that special circumstances require an extension, the time for its decision will be extended for an additional 90 days, provided that, prior to the beginning of the extension period, the Insurance Company notifies you in writing of the special circumstances and gives the date by which it expects to render its decision. If extended, a decision shall be made no more than 180 days after your claim was received. If the Insurance Company approves your claim, the decision will contain information sufficient to reasonably inform you of that decision.

However, any adverse benefit determination will be in writing and include: 1) specific reasons for the decision; 2) specific references to Policy provisions on which the decision is based; 3) a description of any additional material or information necessary for you to perfect the claim and an explanation of why such material or information is necessary; 4) a description of the review procedures and time limits applicable to such, and 5) a statement that you have the right to bring a civil action under section 502(a) of ERISA after you appeal our decision and after you receive a written denial on appeal.

Appealing Denials of Claims for Benefits

On any wholly or partially denied claim, you or your representative must appeal once to the Insurance Company for a full and fair review. You must complete this claim appeal process before you file an action in court. Your appeal request must be in writing and be received by the Insurance Company no later than the expiration of 60 days from the date you received your claim denial. As part of your appeal:

1. you may request, free of charge, copies of all documents, records, and other information relevant to your claim; and
2. you may submit written comments, documents, records and other information relating to your claim.

The Insurance Company's review on appeal shall take into account all comments, documents, records and other information submitted by you relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination.

The Insurance Company will make a final decision no more than 60 days after it receives your timely appeal. However, if the Insurance Company determines that special circumstances require an extension, the time for its decision will be extended for an additional 60 days, provided that, prior to the beginning of the extension period, the Insurance Company notifies you in writing of the special circumstances and gives the date by which it expects to render its decision. If extended, a decision shall be made no more than 120 days after your appeal was received. If the Insurance Company grants your claim appeal, the decision will contain information sufficient to reasonably inform you of that decision.

However, any final adverse benefit determination on review will be in writing and include: 1) specific reasons for the decision and specific references to the Policy provisions on which the decision is based, 2) a statement that you are 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, 3) a statement of your right to bring a civil action under section 502(a) of ERISA, and 4) any other notice(s), statement(s) or information required by applicable law.

**The Plan Described in this Booklet
is Insured by the**

**Hartford Life and Accident Insurance Company
Simsbury, Connecticut
Member of The Hartford Insurance Group**