Truist Financial Corporation

Your Accident Plan

Policy No. 803177 012

Underwritten by Unum Insurance Company

10/14/2022

Unum Insurance Company
2211 Congress Street
Portland, ME 04122
(877) 225-2712
services.unum.com

Group Accident Insurance Certificate of Coverage

We welcome you as a customer and are committed to providing quality service. This is your Accident Certificate of Coverage. Accident coverage can ease the potential financial impact of unforeseen accidents by providing benefits. This certificate describes your Accident benefits in detail.

Policyholder: Truist Financial Corporation

Policy Number: 803177 012

Policy Effective Date: January 1, 2023

Policy Anniversary: January 1

Governing Jurisdiction: North Carolina

This certificate is issued to you under the Policy which is a legal contract between us and the Policyholder. If the terms and provisions of this certificate are different from the Policy, the Policy will govern. A copy of the Policy may be made available to you upon request. The Policy is delivered in and is governed by the laws of the governing jurisdiction and to the extent applicable, the Employee Retirement Income Security Act of 1974 (ERISA) and any amendments.

Please read your certificate carefully and keep it in a safe place.

All references to provisions, sections, and defined terms found within this certificate have been capitalized. If you have any questions about the terms and provisions of this certificate, please contact your Employer or us at (877) 225-2712 Monday through Friday 8 a.m. to 8 p.m. Eastern Standard Time.

This Certificate of Coverage provides limited benefits under the non-participating Policy. The limited benefits provided under this Certificate of Coverage are a supplement to major medical coverage and are not a substitute for major medical coverage or other minimal essential coverage as required by federal law.

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

IMPORTANT CANCELLATION INFORMATION. PLEASE READ THE PROVISION ENTITLED, "CANCELLATION OR MODIFICATION TO THE POLICY AND THIS CERTIFICATE OF COVERAGE".

This certificate contains certain proof of loss requirements, limitations, exclusions, and other provisions that may reduce benefits or prevent an Insured from receiving benefits under this certificate.

Your certificate includes notices as required by your state of residence that may impact your benefits. If you have any questions or concerns regarding your state regulations, you may contact the North Carolina Department of Insurance at (855) 408-1212.

Consumer Complaint Notice

If you are a 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 a claim, premium, or other matters relating 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/ConsumerAssistance/index.aspx.

Table of Contents

Accident Insurance provides financial protection for an Insured by paying benefits if an Insured is involved in a Covered Accident that results in a Covered Loss payable under this certificate.

This section includes highlights of an Insured's coverage. Please refer to the **Accident Details** for further information on the benefits available.

Eligible Group(s)

All Benefit Eligible Employees in Active Employment in the United States scheduled to work a minimum of 20 hours per week.

Paying for Coverage

For you
Contributory Coverage
You must make premium contributions for your coverage.

For your Spouse
Contributory Coverage
You must make premium contributions for your Spouse's coverage.

For your Children
Contributory Coverage
You must make premium contributions for your Children's coverage.

Schedule of Benefits

The following Schedule of Benefits is available to you during an Enrollment Period. You will have the opportunity to apply for coverage for you, your Spouse, and Children.

The benefits an Insured may receive for a Payable Claim are listed in the Schedule of Benefits, subject to all other terms and provisions of this certificate. Amounts are the same for all Insureds, unless noted otherwise. Multiple benefits may be payable for a single Covered Accident.

Injury Benefits

Burns	
2nd Degree Burns	
At least 5%, but less than 20% of skin surface	$500
20% or greater of skin surface	$1,000
3rd Degree Burns	
Less than 5% of skin surface	$2,000
At least 5%, but less than 20% of skin surface	$5,000
20% or greater of skin surface	$10,000
Concussion	$200
Connective Tissue Damage	
One Connective Tissue	$90
Two or more Connective Tissues	$150
Dislocations	
Ankle bone or bones of the foot (other than toes)	$1,650
Collarbone (acromioclavicular and separation)	$325
Collarbone (sternoclavicular)	$825
Elbow joint	$500
Finger or Toe (Digit)	$150
Hand (other than Fingers)	$500
Hip joint	$3,375
Knee joint (other than patella)	$1,650
Kneecap (patella)	$500
Lower Jaw	$500
Shoulder	$500
Wrist joint	$500
Incomplete Dislocation *Payable as a % of the applicable Dislocations benefit*	25%

Eye Injury	$200
Fractures	
Ankle (lower tibia or fibula)	$450
Bones of the Face or Nose (other than Lower Jaw, Mandible or Upper Jaw, Maxilla)	$675
Collarbone (clavicle, sternum) or Shoulder Blade (scapula)	$450
Finger or Toe (Digit)	$225
Foot or Heel (other than Toes)	$450
Forearm (olecranon, radius, or ulna), Hand, or Wrist (other than Fingers)	$450
Hip or Thigh (femur)	$3,375
Kneecap (patella)	$450
Leg (mid to upper tibia or fibula)	$1,350
Lower Jaw, Mandible (other than alveolar process)	$450
Pelvis	$1,350
Rib	$450
Skull (except bones of Face or Nose), Depressed	$4,500
Skull (except bones of Face or Nose), Non-depressed	$2,250
Tailbone (coccyx), Sacrum	$450
Upper Arm between Elbow and Shoulder (humerus)	$675
Upper Jaw, Maxilla (other than alveolar process)	$675
Vertebrae, body of (other than Vertebral Processes)	$1,350
Vertebral Processes	$450
Chip Fracture *Payable as a % of the applicable Fractures benefit*	25%
Internal Injuries	$200
Knee Cartilage (Meniscus) Injury	$150
Lacerations	
No Repair	$50
Repair	
Less than 2 inches	$150
At least 2 inches but less than 6 inches	$300
6 inches or greater	$600
Loss of a Digit	
One Digit (other than a Thumb or Big Toe)	$750
One Digit (a Thumb or Big Toe)	$1,125
Two or more Digits	$1,500
Ruptured or Herniated Disc	
One Disc	$150
Two or more Discs	$250

Treatment and Other Benefits

Ambulance	
Air	$1,000
Ground	$300
Durable Medical Equipment	
Tier 1	$50
Tier 2	$100
Tier 3	$200
Emergency Dental Repair	
Dental Crown	$350
Dental Extraction	$115
Filling or Chip Repair	$90
Emergency Department	$150
Injections to Prevent or Limit Infection	$50
Lodging	$150

Medical Imaging	
Tier 1: X-rays or Ultrasound	$100
Tier 2: Bone Scan, CAT, CT, EEG, MR, MRA, or MRI	$100
Pain Management Injections	$100
Prosthetic Device or Artificial Limb	
One Device or Limb	$750
Two or more Devices or Limbs	$1,500
Skin Grafts	
Due to Burns	
Payable as a % of the applicable Burn benefit	50%
Not due to Burns	
Less than 20% of skin surface	$250
20% or greater of skin surface	$500
Transfusions	$400
Transportation	$100
Treatment in a Physician's Office or Urgent Care Facility	$100

Surgery Benefits

Anesthesia	
Epidural or Regional Anesthesia	$100
General Anesthesia	$250
Connective Tissue Surgery	
Exploratory without Repair	$100
Repair for One Connective Tissue	$800
Repair for Two or more Connective Tissues	$1,200
Dislocations - Surgical Repair *Payable as a % of the applicable Injury benefit*	100%
Eye Surgery	$300
Fractures - Surgical Repair *Payable as a % of the applicable Injury benefit*	100%
General Surgery	
Abdominal, Thoracic, or Cranial	$1,500
Exploratory	$150
Hernia Surgery	$150
Knee Cartilage (Meniscus) Surgery	
Exploratory without Repair	$150
Knee Cartilage (Meniscus) with Repair	$750
Outpatient Surgical Facility	$100
Ruptured or Herniated Disc Surgery	
Exploratory without Repair	$125
Repair for One Disc	$675
Repair for Two or more Discs	$1,000

Hospital Benefits

Admission	$1,500
Admission - Hospital ICU	$1,000
Daily Stay	$200
Daily Stay - Hospital ICU	$200

Recovery Care Benefits

At-Home Care	$100
Physician Follow-Up Visits	$100
Rehabilitation or Subacute Rehabilitation Unit	$100
Therapy Services	$25

Accidental Death and Dismemberment

Benefits

Accidental Death	
Employee	$75,000
Spouse	$37,500
Children	$18,750
Accidental Death - Common Carrier	
Employee	$75,000
Spouse	$37,500
Children	$18,750
Accidental Dismemberment	
Both Feet	$75,000
Both Hands	$75,000
One Foot	$37,500
One Hand	$37,500
Thumb and Index Finger of the same Hand	$18,750
Coma	$15,000
Loss of Use	
Hearing	$37,500
Sight of one Eye	$37,500
Sight of both Eyes	$75,000
Speech	$37,500
Paralysis	
Uniplegia	$18,750
Hemiplegia	$37,500
Paraplegia	$37,500
Triplegia	$56,250
Quadriplegia	$75,000

The information in this section provides details about the benefits that may be payable to you, any applicable Exclusions, and Other Features included in your coverage.

Benefits will only be payable for Covered Accidents that occur on or after the Insured's Coverage Effective Date. Benefits will not be paid for any Injury, treatment or care due to causes other than Covered Accidents.

Coverage Type This certificate provides coverage for accidents that happen at any time, including while an Insured is working.

Injury Benefits

Burns

Benefit Description

We will pay the corresponding amount shown in the Schedule of Benefits if an Insured sustains a 2nd or 3rd degree Burn in a Covered Accident.

Burns are damage to the skin or deeper tissues caused by sun, hot liquids, fire, electricity, or chemicals. Burns are characterized by severe skin damage that causes the affected skin cells to die.

A Physician must diagnose the Burn within 90 days of the Covered Accident.

Benefit Duration

This benefit is payable once per Insured per Covered Accident.

If an Insured sustains more than one type of Burn in a single Covered Accident, we will pay for the Burn with the highest benefit amount.

Concussion

Benefit Description

We will pay the amount shown in the Schedule of Benefits if an Insured sustains a Concussion in a Covered Accident.

A Concussion is a mild traumatic brain injury that alters the way the brain functions. Effects are usually temporary but can include headaches and problems with concentration, memory, balance, and coordination.

A Physician must diagnose the Concussion within 14 days of the Covered Accident.

Benefit Duration

This benefit is payable once per Insured per Covered Accident.

Connective Tissue Damage

Benefit Description

We will pay the corresponding amount shown in the Schedule of Benefits if an Insured sustains one or more completely torn, ruptured, or severed Connective Tissues in a Covered Accident.

A Physician must diagnose the Connective Tissue Damage within 90 days of the Covered Accident.

For purposes of this benefit, the following are considered Connective Tissues:
- tendons;
- ligaments;
- rotator cuffs; and
- muscles.

For purposes of this benefit, the following do not meet the Benefit Description of Connective Tissue Damage:
- sprains; and
- pulled muscles.

Benefit Duration

This benefit is payable once per Insured per Covered Accident.

Dislocations

Benefit Description

We will pay the corresponding amount shown in the Schedule of Benefits if an Insured sustains a dislocated joint in a Covered Accident.

If an Insured has an Incomplete Dislocation, we will pay the percentage amount shown in the Schedule of Benefits for the joint involved.

A Dislocation is an Injury to a joint where the ends of the bones are forced from their normal positions. An Incomplete Dislocation is a Dislocation in which the joint is not completely separated.

A Physician must set the dislocated joint within 90 days of the Covered Accident.

Benefit Duration

This benefit is payable once per Insured per joint per Covered Accident.

If an Insured sustains multiple dislocated joints in a single Covered Accident, we will pay for each joint, but will pay no more than two times the amount for the joint involved with the highest benefit amount.

If the dislocation requires a Surgical Procedure, an Insured may also be eligible for the Dislocations - Surgical Repair benefit.

We will pay additional Dislocations benefits for a dislocation of the same joint if the dislocation is sustained in a different or unrelated Covered Accident and is more than 180 days after the prior Covered Accident.

Eye Injury

Benefit Description

We will pay the amount shown in the Schedule of Benefits if an Insured sustains an Eye Injury in a Covered Accident.

The Eye Injury must require the removal of a foreign object with or without anesthesia.

A Physician must remove the object within 90 days of the Covered Accident.

Benefit Duration

This benefit is payable once per Insured per Covered Accident.

Fractures

Benefit Description

We will pay the corresponding amount shown in the Schedule of Benefits if an Insured sustains a fractured bone in a Covered Accident.

If an Insured has a Chip Fracture, we will pay the percentage amount shown in the Schedule of Benefits for the bone involved.

A fracture is a break of a bone. A Chip Fracture is a Fracture in which a piece of the bone is broken off near a joint at a place where a ligament is usually attached.

A Physician must confirm the bone fracture within 90 days of the Covered Accident by X-ray or other medical imaging study.

For purposes of this benefit, a bone injury diagnosed as a stress fracture does not meet the Benefit Description of Fractures.

Benefit Duration

This benefit is payable once per Insured per bone per Covered Accident.

If an Insured sustains multiple Fractures of the same bone in a single Covered Accident, we will only pay one Fractures benefit for that bone.

If an Insured sustains Fractures of multiple bones in a single Covered Accident, we will pay for each bone, but will pay no more than two times the amount for the bone involved

with the highest benefit amount.

If the fracture requires a Surgical Procedure, an Insured may also be eligible for the Fractures - Surgical Repair benefit.

We will pay additional Fractures benefits for a fracture of the same bone if the fracture is sustained in a different or unrelated Covered Accident and is more than 180 days after the prior Covered Accident.

Internal Injuries

Benefit Description

We will pay the amount shown in the Schedule of Benefits if an Insured sustains an Internal Injury in a Covered Accident.

A Physician must diagnose the Internal Injury within 90 days of the Covered Accident.

For purposes of this benefit, Internal Injuries include:
- a collapsed or punctured lung;
- a ruptured or torn spleen, kidney, or liver; or
- a ruptured eardrum.

For purposes of this benefit, the following do not meet the Benefit Description of Internal Injuries:
- bruised organs or muscles;
- internal bleeding;
- swollen glands or organs;
- injuries to teeth, bones, joints or other connective tissues; and
- injuries for which another Injury Benefit is payable.

Benefit Duration

This benefit is payable once per Insured per Covered Accident.

Knee Cartilage (Meniscus) Injury

Benefit Description

We will pay the amount shown in the Schedule of Benefits if an Insured sustains a partially torn or fully torn Knee Cartilage in a Covered Accident.

Knee Cartilage is the area of tissue which acts like a shock absorber in the joint called the meniscus. The meniscus may be partially torn or fully torn by a forceful knee movement while weight bearing on the same leg.

A Physician must confirm the Knee Cartilage (Meniscus) Injury within 90 days of the Covered Accident by an MRI, other medical imaging study, or Surgical Procedure.

Benefit Duration

This benefit is payable once per Insured per Covered Accident.

Lacerations

Benefit Description

We will pay the corresponding amount shown in the Schedule of Benefits if an Insured sustains a Laceration in a Covered Accident.

A Laceration is an open wound or cut on the outside of the body.

A Physician must treat the Laceration within three days of the Covered Accident.

For purposes of this benefit, the following are considered repair techniques used by a Physician:
- stitches;
- staples; and
- tissue adhesive.

Benefit Duration

This benefit is payable once per Insured per Covered Accident.

If an Insured sustains multiple Lacerations in a single Covered Accident, the amount payable will be based on the total length of all Lacerations sustained requiring repair.

Loss of a Digit

Benefit Description

We will pay the corresponding amount shown in the Schedule of Benefits if an Insured sustains permanent and total loss of one or more fingers, thumbs, or toes in a Covered Accident.

A Physician must treat the Loss of a Digit within 90 days of the Covered Accident.

For purposes of this benefit, the following losses meet the Benefit Description of Loss of a Digit:
- for fingers and thumbs, the digit must be cut off below the joint closest to the fingertip; and
- for toes, the digit must be cut off at the joint where it is attached to the foot.

Benefit Duration

This benefit is payable once per Insured per Covered Accident.

Ruptured or Herniated Disc

Benefit Description

We will pay the corresponding amount shown in the Schedule of Benefits if an Insured sustains a Ruptured or Herniated Disc in a Covered Accident.

A Ruptured or Herniated Disc, also known as a slipped disc, occurs when one of the intervertebral discs in the spine develops a crack in its outer wall, allowing the inner core to leak out in to the spinal canal, causing pain or numbness.

A Physician must diagnose the Ruptured or Herniated Disc within 90 days of the Covered Accident.

Benefit Duration

This benefit is payable once per Insured per Covered Accident.

Treatment and Other Benefits

Ambulance

Benefit Description

We will pay the corresponding amount shown in the Schedule of Benefits if a licensed professional ambulance company transports an Insured by air or ground to or from a Hospital or between medical facilities where treatment is received due to Injuries sustained in a Covered Accident.

If an Insured is treated by Ambulance staff, but is not transported for a Covered Accident, we will pay the corresponding amount shown for Ambulance - Ground.

The Ambulance transportation must be within 180 days of the Covered Accident.

Benefit Duration

This benefit is payable once per Insured per Covered Accident for each mode of Ambulance transportation.

Durable Medical Equipment

Benefit Description

We will pay the corresponding amount shown in the Schedule of Benefits if an Insured is prescribed Durable Medical Equipment by a Physician, Occupational Therapist, Physical Therapist, or Speech Therapist as an aid in treatment, recovery, or mobility due to Injuries sustained in a Covered Accident.

The Durable Medical Equipment must be prescribed to the Insured within 90 days of the Covered Accident.

Durable Medical Equipment

Tier 1	- Arm Sling	- Neck Brace

	- Cane - Medical Ring Cushion	- Wrist or Ankle Splint
Tier 2	- Bedside Commode - Cold Therapy System (Cryotherapy) - Crutches	- Leg Brace - Shower Chair - Walker or Walking Boot that extends above the ankle
Tier 3	- Back Brace - Body Jacket - Continuous Passive Movement (CPM) - Electric Scooter	- Halo - Hospital Bed - Knee Scooter - Stair Lift Chair - Wheelchair

We will use a current relative value scale to determine the appropriate Tier amount for any medical equipment not listed above.

For purposes of this benefit, the Durable Medical Equipment must:
- be designed for and able to withstand repeated use by more than one person;
- customarily serve a medical purpose; and
- be generally not useful in the absence of an Injury or Sickness.

Benefit Duration
This benefit is payable once per Insured per Covered Accident.

If an Insured is prescribed multiple pieces of Durable Medical Equipment as a result of a single Covered Accident, we will pay for each piece of Durable Medical Equipment, but will pay no more than three times the amount for the piece of Durable Medical Equipment with the highest Tier amount per Calendar year.

Emergency Dental Repair

Benefit Description
We will pay the corresponding amount shown in the Schedule of Benefits if an Insured has an Emergency Dental Repair for a partially broken or broken tooth sustained in a Covered Accident.

The partially broken or broken tooth must require repair by a Dental Crown, or Dental Extraction, or Filling or Chip Repair.

The Emergency Dental Repair must be within 180 days of the Covered Accident.

Benefit Duration
This benefit is payable once per Insured per Covered Accident.

If an Insured has multiple Emergency Dental Repairs as a result of a single Covered Accident, we will pay for each Emergency Dental Repair, but will pay no more than three times the amount for the Emergency Dental Repair with the highest benefit amount.

Emergency Department

Benefit Description
We will pay the amount shown in the Schedule of Benefits if an Insured requires examination or treatment by a Physician in the Emergency Department due to Injuries sustained in a Covered Accident.

Emergency Department treatment must be within three days of the Covered Accident.

Benefit Duration
This benefit is payable once per Insured per Covered Accident.

We will pay additional Emergency Department benefits if:
- an Insured is treated in the Emergency Department due to Injuries sustained in a different or unrelated Covered Accident; or
- the Insured is treated in the Emergency Department more than 90 days after the date of the previous Emergency Department treatment.

Injections to Prevent or Limit Infection

Benefit Description

We will pay the amount shown in the Schedule of Benefits if an Insured receives an injection after exposure to bacteria, viruses, or venom in a Covered Accident.

A Physician must administer the injection within 180 days of the Covered Accident.

For purposes of this benefit, the following are considered Injections to Prevent or Limit Infection:
- tetanus boosters;
- rabies shots;
- antivenom; and
- immune globulin.

For the purposes of this benefit, the following do not meet the Benefit Description of Injections to Prevent or Limit Infection:
- immunizations;
- tetanus boosters as part of routine medical care; and
- EpiPen injections intended to limit an allergic reaction.

Benefit Duration

This benefit is payable once per Insured per Covered Accident.

Lodging

Benefit Description

We will pay the amount shown in the Schedule of Benefits for each day of a hotel stay for a companion accompanying an Insured to a Surgical Procedure or during a period of Confinement due to Injuries sustained in a Covered Accident.

The Lodging must be within 180 days of the Covered Accident.

The Surgical Procedure or Confinement must be at a Hospital or other medical facility more than 50 miles from the companion's residence.

Benefit Duration

This benefit is payable up to a maximum of 30 days per Covered Accident.

Medical Imaging

Benefit Description

We will pay the corresponding amount shown in the Schedule of Benefits if an Insured undergoes a Medical Imaging test ordered by a Physician due to Injuries sustained in a Covered Accident.

The Medical Imaging must be within 180 days of the Covered Accident.

For purposes of this benefit, X-rays are considered a single test, regardless of the number of images produced.

Medical Imaging Tests

Tier 1	- X-rays - Ultrasound	
Tier 2	- Bone Scan - Computed Axial Tomography (CAT) - Computed Tomography Scan (CT) - Electroencephalogram (EEG)	- Magnetic Resonance (MR) - Magnetic Resonance Angiogram (MRA) - Magnetic Resonance Imaging (MRI)

Benefit Duration

This benefit is payable once per Insured per Tier of Medical Imaging Tests per Covered Accident.

Pain Management

Benefit Description

We will pay the amount shown in the Schedule of Benefits if an Insured receives an

Injections

injection for the purposes of blocking pain in a particular region of the body due to Injuries sustained in a Covered Accident.

A Physician must administer the injection within 180 days of the Covered Accident.

For purposes of this benefit, the following are considered Pain Management Injections:
- cortisone shots;
- steroid shots; and
- epidural steroids.

For the purposes of this benefit, the following do not meet the Benefit Description of Pain Management Injections:
- oral prescriptions for pain relief;
- over the counter pain medications;
- topical pain management;
- general, regional, or local anesthesia; and
- pain management injections for chronic pain or causes other than a Covered Accident.

Benefit Duration
This benefit is payable once per Insured per Covered Accident.

Prosthetic Device or Artificial Limb

Benefit Description
We will pay the corresponding amount shown in the Schedule of Benefits if an Insured receives a Prosthetic Device or Artificial Limb for a permanently missing hand, arm, foot, leg, or eye due to Injuries sustained in a Covered Accident.

The Prosthetic Device or Artificial Limb can be a newly required device or a replacement of an existing device, which was irreparably damaged in the Covered Accident.

The Prosthetic Device or Artificial Limb must be received within 365 days of the Covered Accident.

For purposes of this benefit, the following do not meet the Benefit Description of Prosthetic Device or Artificial Limb:
- hearing aids;
- dental aids (including false teeth);
- eyeglasses;
- cosmetic prostheses such as wigs; and
- artificial hips, knees, or other joint replacements.

Benefit Duration
This benefit is payable once per Insured per Covered Accident.

Skin Grafts

Benefit Description
We will pay the corresponding amount shown in the Schedule of Benefits if an Insured receives a Skin Graft due to Injuries sustained in a Covered Accident.

A Skin Graft is the transplantation of a piece of skin to replace a lost portion of skin due to burns or other accidental traumatic loss of skin.

The Insured must receive the Skin Graft within 180 days of the Covered Accident.

Benefit Duration
This benefit is payable once per Insured per type of Skin Graft per Covered Accident.

Transfusions

Benefit Description
We will pay the amount shown in the Schedule of Benefits if an Insured receives a Transfusion due to Injuries sustained in a Covered Accident.

A Transfusion is the receipt of blood, plasma, or platelets intravenously.

The Transfusion must be within 180 days of the Covered Accident.

Benefit Duration
This benefit is payable once per Insured per Covered Accident.

Transportation

Benefit Description
We will pay the amount shown in the Schedule of Benefits for any mode of Transportation, including a personal car, for an Insured and one companion if the Insured requires diagnosis, treatment, or a Surgical Procedure due to Injuries sustained in a Covered Accident.

The Transportation must be within 180 days of the Covered Accident.

The diagnosis, treatment, or Surgical Procedure must be at a Hospital or other medical facility more than 50 miles from the Insured's residence.

For purposes of this benefit, any mode of Ambulance transportation does not meet the Benefit Description of Transportation.

Benefit Duration
This benefit is payable up to a maximum of six one-way trips per Insured per Covered Accident. A trip must either start or end at the Insured's residence.

Treatment in a Physician's Office or Urgent Care Facility

Benefit Description
We will pay the amount shown in the Schedule of Benefits if an Insured receives initial examination or treatment by a Physician due to Injuries sustained in a Covered Accident.

The Treatment in a Physician's Office or Urgent Care Facility must be within 14 days of the Covered Accident.

For purposes of this benefit, the following do not meet the Benefit Description of Treatment in a Physician's Office or Urgent Care Facility:
- routine physical or annual wellness exam;
- Occupational Therapy;
- Speech Therapy;
- Physical Therapy; and
- Chiropractic Therapy.

Benefit Duration
This benefit is payable once per Insured per Covered Accident.

Surgery Benefits

Anesthesia

Benefit Description
We will pay the corresponding amount shown in the Schedule of Benefits if general, epidural, or regional Anesthesia is administered to an Insured during a Surgical Procedure due to Injuries sustained in a Covered Accident.

General Anesthesia is the induction of a balanced state of unconsciousness, accompanied by the absence of pain sensation and the paralysis of skeletal muscle over the entire body. Epidural or regional Anesthesia is a form of regional anesthesia involving the injection of drugs through a catheter into the epidural space.

A Physician must administer the Anesthesia within 365 days of the Covered Accident.

For purposes of this benefit, the following do not meet the Benefit Description of Anesthesia:
- epidural anesthesia administered for Childbirth;
- peripheral nerve blocks; and
- local anesthesia.

Benefit Duration
This benefit is payable once per Insured per Covered Accident.

Connective Tissue Surgery

Benefit Description
We will pay the corresponding amount shown in the Schedule of Benefits if an Insured undergoes a Surgical Procedure to treat one or more torn, ruptured, or severed Connective Tissues sustained in a Covered Accident.

A Physician must perform the Surgical Procedure within 365 days of the Covered Accident.

For purposes of this benefit, the following are considered Connective Tissues:
- tendons;
- ligaments;
- rotator cuffs; and
- muscles.

Benefit Duration
This benefit is payable once per Insured per Covered Accident.

Dislocations - Surgical Repair

Benefit Description
We will pay the corresponding amount shown in the Schedule of Benefits for a Surgical Procedure to repair a dislocated joint sustained in a Covered Accident.

A Physician must perform the Surgical Procedure within 365 days of the Covered Accident.

Benefit Duration
This benefit is payable once per Insured per joint per Covered Accident.

If an Insured sustains multiple dislocated joints in a single Covered Accident and they are repaired with a Surgical Procedure, we will pay the Dislocations - Surgical Repair benefit for each joint, but will pay no more than two times the amount for the joint involved with the highest benefit amount.

We will pay additional Dislocations - Surgical Repair benefits for a Surgical Procedure of the same joint if the dislocation is sustained in a different or unrelated Covered Accident and is more than 180 days after the prior Covered Accident.

Eye Surgery

Benefit Description
We will pay the amount shown in the Schedule of Benefits if an Insured undergoes a Surgical Procedure with anesthesia due to an Eye Injury sustained in a Covered Accident.

A Physician must perform the Surgical Procedure within 365 days of the Covered Accident.

Benefit Duration
This benefit is payable once per Insured per Covered Accident.

Fractures - Surgical Repair

Benefit Description
We will pay the corresponding amount shown in the Schedule of Benefits for a Surgical Procedure to repair a fractured bone sustained in a Covered Accident.

A Physician must perform the Surgical Procedure within 365 days of the Covered Accident.

Benefit Duration
This benefit is payable once per Insured per bone per Covered Accident.

If an Insured sustains multiple Fractures of the same bone in a single Covered Accident and they are repaired with a Surgical Procedure, we will only pay one Fractures -

Surgical Repair benefits for that bone.

If an Insured sustains Fractures of multiple bones in a single Covered Accident and they are repaired with a Surgical Procedure, we will pay the Fractures - Surgical Repair benefit for each bone, but will pay no more than two times the amount for the bone involved with the highest benefit amount.

We will pay additional Fractures - Surgical Repair benefits for a Surgical Procedure of the same bone if the fracture is sustained in a different or unrelated Covered Accident and is more than 180 days after the prior Covered Accident.

General Surgery

Benefit Description

We will pay the corresponding amount shown in the Schedule of Benefits if an Insured undergoes a Surgical Procedure due to Injuries sustained in a Covered Accident.

If an exploratory abdominal, thoracic, or cranial Surgical Procedure is performed, we will pay the corresponding amount for General Surgery - Exploratory.

A Physician must perform the Surgical Procedure within 365 days of the Covered Accident.

For purposes of this benefit, the following are considered a General Surgery:
- abdominal surgery;
- thoracic surgery; and
- cranial surgery.

Benefits for General Surgery will not be paid for a Covered Accident for which any other Surgery benefits are paid.

Benefit Duration

This benefit is payable once per Insured per Covered Accident.

Hernia Surgery

Benefit Description

We will pay the amount shown in the Schedule of Benefits if an Insured undergoes a Surgical Procedure to repair a Hernia sustained in a Covered Accident.

A hernia occurs when an organ is displaced and protrudes through the wall of the cavity containing it.

A Physician must perform the Surgical Procedure within 365 days of the Covered Accident.

Benefit Duration

This benefit is payable once per Insured per Covered Accident.

Knee Cartilage (Meniscus) Surgery

Benefit Description

We will pay the corresponding amount shown in the Schedule of Benefits if an Insured undergoes a Surgical Procedure to treat a Knee Cartilage (Meniscus) Injury sustained in a Covered Accident.

A Physician must perform the Surgical Procedure within 365 days of the Covered Accident.

Benefit Duration

This benefit is payable once per Insured per Covered Accident.

Outpatient Surgical Facility

Benefit Description

We will pay the amount shown in the Schedule of Benefits if an Insured undergoes a Surgical Procedure on an Outpatient Basis in a Hospital, Ambulatory Surgical Center, or other medical facility due to Injuries sustained in a Covered Accident.

A Physician must perform the Surgical Procedure within 365 days of the Covered

Accident.

For purposes of this benefit, the following do not meet the Benefit Description of Outpatient Surgical Facility:
- Surgical Procedures performed in the Emergency Department; and
- Surgical Procedures performed while Confined in a Hospital or other medical facility.

Benefit Duration
This benefit is payable once per Insured per Covered Accident.

Ruptured or Herniated Disc Surgery

Benefit Description
We will pay the corresponding amount shown in the Schedule of Benefits if an Insured undergoes a Surgical Procedure to treat a Ruptured or Herniated Disc sustained in a Covered Accident.

A Physician must perform the Surgical Procedure within 365 days of the Covered Accident.

Benefit Duration
This benefit is payable once per Insured per Covered Accident.

Hospital Benefits

Admission

Benefit Description
We will pay the amount shown in the Schedule of Benefits if an Insured is admitted and Confined to a Hospital due to Injuries sustained in a Covered Accident.

The Admission and Confinement must be within 180 days of the Covered Accident.

This benefit will be paid in addition to any Admission - Hospital ICU, Daily Stay, and Daily Stay - Hospital ICU benefits.

For purposes of this benefit, the following Hospital services are not eligible:
- treatment in the Emergency Department;
- treatment on an Outpatient Basis; and
- any Confinement of less than 20 hours.

Benefit Duration
This benefit is payable up to a maximum of one day per Insured per Covered Accident.

Admission - Hospital ICU

Benefit Description
We will pay the amount shown in the Schedule of Benefits if an Insured is admitted and Confined to a Hospital ICU due to Injuries sustained in a Covered Accident.

The Admission and Confinement must be within 180 days of the Covered Accident.

This benefit will be paid in addition to any Admission, Daily Stay, and Daily Stay - Hospital ICU benefits.

Benefit Duration
This benefit is payable up to a maximum of one day per Insured per Covered Accident.

Daily Stay

Benefit Description
We will pay the amount shown in the Schedule of Benefits for each day an Insured is Confined in a Hospital due to Injuries sustained in a Covered Accident.

The Confinement must begin within 180 days of the Covered Accident.

This benefit will be paid in addition to any Admission, Admission - Hospital ICU, and Daily Stay - Hospital ICU benefits.

For purposes of this benefit, the following Hospital services are not eligible:

- treatment in the Emergency Department;
- treatment on an Outpatient Basis; and
- any Confinement of less than 20 hours.

Benefit Duration
This benefit is payable up to a maximum of 365 days per Insured per Covered Accident.

Daily Stay - Hospital ICU

Benefit Description
We will pay the amount shown in the Schedule of Benefits for each day an Insured is Confined in a Hospital ICU due to Injuries sustained in a Covered Accident.

The Confinement must begin within 180 days of the Covered Accident.

This benefit will be paid in addition to any Admission, Admission - Hospital ICU, and Daily Stay benefits.

Benefit Duration
This benefit is payable up to a maximum of 15 days per Insured per Covered Accident.

Recovery Care Benefits

At-Home Care

Benefit Description
We will pay the amount shown in the Schedule of Benefits for each day an Insured receives At-Home Care from a Nurse at the direction of a Physician.

At-Home Care must be prescribed to begin immediately after a Surgical Procedure or period of Confinement due to Injuries sustained in a Covered Accident.

For purposes of this benefit, the following services do not meet the Benefit Description of At-Home Care:
- hospice care; and
- any care provided by you, your Spouse, Children, parents, siblings, a business or professional partner, or any person who has a financial affiliation or business interest with you.

Benefits for At-Home Care will not be paid for any day that benefits are paid for Admission, Admission - Hospital ICU, Daily Stay, Daily Stay - Hospital ICU or Rehabilitation or Subacute Rehabilitation Unit.

Benefit Duration
This benefit is payable up to a maximum of five days per Insured per Covered Accident.

Physician Follow-Up Visits

Benefit Description
We will pay the amount shown in the Schedule of Benefits if an Insured receives:
- initial examination or treatment by a Physician due to Injuries sustained in a Covered Accident more than 14 days after the Covered Accident; or
- follow-up care by a Physician prescribed to occur after the initial examination or treatment due to Injuries sustained in a Covered Accident.

The Physician Follow-up Visit must be within 365 days from the Covered Accident.

For purposes of this benefit, care received in a Physician's office, Hospital, or through Telemedicine meet the Benefit Description of Physician Follow-up Visits.

For purposes of this benefit, routine physical or wellness exams do not meet the Benefit Description of Physician Follow-up Visits.

Benefit Duration
This benefit is payable up to a maximum of two visits per Insured per Covered Accident.

Rehabilitation or Subacute

Benefit Description
We will pay the amount shown in the Schedule of Benefits for each day an Insured is

Rehabilitation Unit

Confined in a Rehabilitation or Subacute Rehabilitation Unit.

The Insured must be transferred to the Rehabilitation or Subacute Rehabilitation Unit for inpatient care immediately after a period of Confinement in a Hospital due to Injuries sustained in a Covered Accident.

Benefits for Rehabilitation or Subacute Rehabilitation Unit will not be paid for any day that benefits are paid for Admission, Admission - Hospital ICU, Daily Stay, Daily Stay-Hospital ICU or At-Home Care.

Benefit Duration
This benefit is payable up to a maximum of 15 days per Insured per Covered Accident.

Therapy Services

Benefit Description
We will pay the amount shown in the Schedule of Benefits for each day an Insured receives Therapy Services due to Injuries sustained in a Covered Accident.

A Physician must prescribe the Therapy Services to the Insured on an Outpatient Basis with a Physician, Occupational Therapist, Physical Therapist, or Speech Therapist.

Therapy Services must be received within 365 days of the Covered Accident.

For purposes of this benefit, the following are considered Therapy Services:
- Occupational Therapy;
- Physical Therapy;
- Speech Therapy; and
- Chiropractic Therapy.

For purposes of this benefit, therapy received in a Rehabilitation or Subacute Rehabilitation Unit is considered inpatient and does not meet the Benefit Description of Therapy Services.

Benefit Duration
This benefit is payable up to a maximum of 15 days per Insured per Covered Accident.

If more than one type of Therapy Service is received on the same day, we will pay only one day of Therapy Services.

Accidental Death and Dismemberment Benefits

Accidental Death

Benefit Description
We will pay the corresponding amount shown in the Schedule of Benefits if an Insured dies due to Injuries sustained in a Covered Accident.

The Accidental Death must be within 365 days of the Covered Accident.

Benefit Duration
This benefit is payable once per Insured.

Accidental Death - Common Carrier

Benefit Description
We will pay the corresponding amount shown in the Schedule of Benefits if an Insured dies while traveling as a fare-paying passenger on a Common Carrier due to Injuries sustained in a Covered Accident.

A Common Carrier is commercial transportation including airplanes, trains, buses, trolleys, subways, ferries and boats that operate on a regularly scheduled basis between predetermined points or cities. Taxis and privately chartered vehicles are not common carriers.

The Accidental Death must be within 365 days of the Covered Accident.

Benefit Duration

This benefit is payable once per Insured.

Accidental Dismemberment

Benefit Description

We will pay the corresponding amount shown in the Schedule of Benefits if an Insured sustains a Dismemberment in a Covered Accident.

The Accidental Dismemberment must be within 365 days of the Covered Accident.

For purposes of this benefit, the following losses meet the Benefit Description of Accidental Dismemberment:

- for the loss of a foot, all of the foot is cut off at or above the ankle joint;
- for the loss of a hand, all four fingers are cut off at or below the knuckles joining each to the hand; and
- for the loss of a thumb and index finger, all of the thumb and index finger are cut off at or below the joint closest to the wrist.

Benefit Duration

This benefit is payable once per Insured per Covered Accident.

If an Insured sustains multiple Dismemberments in a single Covered Accident, we will pay for each Dismemberment, but will pay no more than the Employee's Accidental Death benefit amount.

Coma

Benefit Description

We will pay the amount shown in the Schedule of Benefits if an Insured is in a Coma for a period of seven or more consecutive days due to Injuries sustained in a Covered Accident.

A Coma is a continuous state of profound unconsciousness requiring intubation for respiratory assistance characterized by the absence of:

- eye opening;
- verbal response; and
- motor response.

A Physician must confirm the Coma within 365 days of the Covered Accident.

For purposes of this benefit, the following do not meet the Benefit Description of Coma:

- Coma due to stroke; and
- any medically induced Coma.

Benefit Duration

This benefit is payable once per Insured per Covered Accident.

Loss of Use

Benefit Description

We will pay the corresponding amount shown in the Schedule of Benefits if an Insured loses the ability to hear, see, or speak due to Injuries sustained in a Covered Accident.

A Physician must confirm the Loss of Use within 365 days of the Covered Accident.

For the purposes of this benefit, the following losses meet the Benefit Description of Loss of Use:

- for the loss of hearing, total deafness in both ears;
- for the loss of sight in one eye, the eye must be totally blind and no sight can be restored in that eye;
- for the loss of sight in both eyes, the:
  - sight in the better eye reduced to a best corrected visual acuity of 20/200 or less (Snellen or E-Chart Acuity);
  - visual field remaining is less than 20° in the better eye; and
  - the Insured was not previously legally blind; and
- for the loss of speech, the ability to speak is a total and irrecoverable loss.

For purposes of this benefit, any loss that can be corrected to any functional degree by

any procedure, aid, or device does not meet the Benefit Description of Loss of Use.

Benefit Duration
This benefit is payable once per Insured per Covered Accident.

If an Insured sustains multiple losses in a single Covered Accident, we will pay for each Loss of Use, but will pay no more than the Employee's Accidental Death benefit amount.

Paralysis

Benefit Description
We will pay the corresponding amount shown in the Schedule of Benefits if an Insured sustains Paralysis of one or more limbs in a Covered Accident.

A Physician must confirm the Paralysis within 365 days of the Covered Accident.

For the purposes of this benefit, the following types of Paralysis meet the Benefit Description of Paralysis:

- for Uniplegia, the total and irreversible paralysis of any one limb;
- for Hemiplegia, the total and irreversible paralysis of both limbs on either side of the body, for example the right arm and right leg, or the left arm and left leg;
- for Paraplegia, the total and irreversible paralysis of any two limbs;
- for Triplegia, the total and irreversible paralysis of any three limbs; and
- for Quadriplegia, the total and irreversible paralysis of all four limbs.

Benefit Duration
This benefit is payable once per Insured per Covered Accident.

Exclusions

We will not pay benefits for a claim that is caused by, contributed to by, or resulting from any of the following:

- committing or attempting to commit a felony;
- being engaged in an illegal occupation or activity;
- injuring oneself intentionally or attempting or committing suicide, whether sane or not;
- active participation in a riot or insurrection. This does not include civil commotion or disorder, Injury as an innocent bystander, or Injury for self-defense;
- participating in war or any act of war, whether declared or undeclared. This does not include any acts of terrorism;
- combat or training for combat while serving in the armed forces of any nation or authority, including the National Guard, or similar government organizations;
- a Covered Loss that occurs while an Insured is legally incarcerated in a penal or correctional institution;
- elective procedures, cosmetic surgery, or reconstructive surgery unless it is a result of organ donation, trauma, infection, or other diseases;
- any Sickness, bodily infirmity, or other abnormal physical condition or Mental or Nervous Disorders, including diagnosis, treatment, or surgery for it;
- infection. This exclusion does not apply when the infection is due directly to a cut or wound sustained in a Covered Accident;
- experimental or investigational procedures;
- operating any motorized vehicle while intoxicated;
- operating, learning to operate, serving as a crew member of any aircraft or hot air balloon, including those which are not motor-driven, unless flying as a fare paying passenger;
- jumping, parachuting, or falling from any aircraft or hot air balloon, including those which are not motor-driven;
- travel or flight in any aircraft or hot air balloon, including those which are not motor-driven, if it is being used for testing or experimental purposes, used by or for any military authority, or used for travel beyond the earth's atmosphere;
- practicing for or participating in any semi-professional or professional competitive athletic contests for which any type of compensation or remuneration is received;
- riding or driving an air, land or water vehicle in a race, speed or endurance contest; and
- engaging in hang-gliding, bungee jumping, sail gliding, parasailing, parakiting, or BASE jumping.

The Accidental Death and Dismemberment Benefits are also subject to the following Exclusions. We will not pay benefits for a claim that is caused by, contributed to by, or resulting from any of the following:

- being intoxicated; and
- voluntary use of or treatment for voluntary use of any prescription or non-prescription drug, alcohol, poison, fume, or other chemical substance unless taken as prescribed or directed by the Insured's Physician. For purposes of this exclusion, poison does not include food poisoning.

Additionally, no benefits will be paid for a Covered Loss that occurs prior to the Coverage Effective Date.

Continuity of Coverage

We will provide coverage for an Insured if the Insured was covered by a similar prior policy on the day before the Policy Effective Date of this certificate.

Coverage is subject to payment of premium and all other terms of this certificate. If you are on a temporary Layoff or Leave of Absence on the Policy Effective Date of this certificate, we will consider your temporary Layoff or Leave of Absence to have started on that date and coverage will continue for the period provided for temporary Layoff or Leave of Absence under Continuation of your Coverage During Extended Absences in this certificate.

If you have not returned to Active Employment before any Insured's Covered Loss, any benefits payable will be limited to what would have been paid by the prior carrier.

Newborn, Newly Adopted, or Newly Fostered Children Coverage Feature

Your newborn, newly adopted, or newly fostered Children will automatically be covered for 31 days from their Coverage Eligibility Date if you are insured.

If you wish to continue Child coverage, you must notify us on or before the end of the 31 day period and pay any additional premium.

If you already have coverage for your Children, then all eligible Children will be covered and you do not need to notify us or pay any additional premium for the newly eligible Child.

Waiting Period

The continuous period of time you must be in an Eligible Group before you are eligible for coverage:

If you are in an Eligible Group on or before January 1, 2023: None
If you enter an Eligible Group after January 1, 2023: None

Rehire
If your employment ends and you are rehired within 12 months, any prior period of work in an Eligible Group with your Employer, will apply toward the Waiting Period.

Coverage Eligibility Date

For you
If you are in an Eligible Group, you are eligible for coverage on the later of:
- the Policy Effective Date; or
- the day after any applicable Waiting Period has been satisfied.

For your Spouse
If you elect coverage for yourself, your Spouse is eligible for coverage on the later of:
- the date you are eligible for coverage; or
- the date you first acquire a Spouse.

For your Children
If you elect coverage for yourself, your Children are eligible for coverage on the later of:
- the date you are eligible for coverage; or
- the date you first acquire the Child.

Enrolling for Coverage

Initial Enrollment
Contributory Coverage
You may apply for any coverage available for you, your Spouse, and Children within 31 days of an Insured's Coverage Eligibility Date.

The enrollment period is waived when a parent is required to enroll a child due to an administrative or court order.

Late Enrollment
Contributory Coverage
If you did not apply for coverage during an Insured's Initial Enrollment or you voluntarily cancelled coverage for an Insured and are re-applying, you may apply for coverage during any scheduled Enrollment Period.

Applying for Changes in Coverage

Contributory Coverage
You may cancel coverage for an Insured at any time during the Policy Year, during any scheduled Enrollment Period, or within 31 days of a Qualifying Life Event.

Coverage Effective Date

Initial Enrollment
Contributory Coverage
Coverage for an Insured will begin on the first day of the month following the later of:
- the Insured's Coverage Eligibility Date if you apply on or before that date; or
- the date you apply for the Insured's coverage, if coverage is applied for within 31 days of the Insured's Coverage Eligibility Date.

Late Enrollment
Contributory Coverage
Coverage for an Insured will begin on the later of:
- the first day of the next Policy Year; or
- the first day of the month following the date you apply for the Insured's coverage.

Coverage Effective Date for Changes in Coverage

Contributory Coverage
Changes in coverage for an Insured will begin on the latest of:
- the first day of the next Policy Year;
- the first day of the month following the date of a Qualifying Life Event; or
- the first day of the month following the date you apply for the change in coverage due to a Qualifying Life Event, if it's within 31 days of the Qualifying Life Event.

Any cancellation in coverage for an Insured will take effect on the first day of the month following the date the cancellation in coverage is made.

Any change or cancellation in coverage will not affect a Payable Claim that occurs prior to the change or cancellation.

Coverage Effective Date if you are not in Active Employment

You must be in Active Employment in order for coverage to become effective for any Insured in accordance with the Coverage Effective Date provision.

If you are not in Active Employment due to an Injury, Sickness, temporary Layoff, or Leave of Absence on the date coverage would become effective, the Insured's Coverage Effective Date will be the date you return to Active Employment.

Coverage Effective Date for Initial Enrollment, Late Enrollment, and Changes in Coverage is subject to this provision.

A delay of Coverage Effective Date for a change in coverage will not affect coverage that is currently in force.

Continuation of your Coverage During Extended Absences

Leave of Absence, other than a Family and Medical Leave of Absence
You will be covered in accordance with your Employer's Leave of Absence policy, provided premium is paid.

Family and Medical Leave of Absence
We will continue coverage in accordance with your Employer's Human Resource policy on family and medical leaves of absence if premium payments continue and your Employer approved your leave in Writing. You will be covered up to the end of the latest of:
- the leave period required by the Federal Family and Medical Leave Act of 1993, and any amendments;
- the leave period required by applicable state law; or
- the leave period provided to you for an Injury or Sickness, provided premium is paid and your Employer has approved your leave in Writing.

If your Employer's Human Resource policy doesn't provide for continuation of your coverage during a family and medical leave of absence, coverage will be reinstated when you return to Active Employment.

We will not apply a new Waiting Period.

Injury or Sickness
You will be covered for up to 3 months from the date your absence due to an Injury or Sickness begins, provided premium is paid.

Temporary Layoff
You will be covered in accordance with your Employer's temporary Layoff policy, provided premium is paid.

End of Coverage

For you
If you choose to cancel your coverage under this certificate, your coverage will end on the first of the month following the date you provide notification to your Employer.

Otherwise, your coverage under this certificate ends on the earliest of:
- the date the Policy is cancelled by us or your Employer;
- the date you are no longer in an Eligible Group;
- the date your Eligible Group is no longer covered;
- the date of your death;
- the last day of the period any required premium contributions are made; or
- the last day you are in Active Employment.

However, as long as premium is paid as required, coverage will continue:
- in accordance with the Continuation of your Coverage During Absences provision; or
- if you elect to continue coverage for you under Portability of Accident Insurance.

We will provide coverage for a Payable Claim that occurs while you are covered under this certificate.

For your Spouse
If, while your coverage is in force, you choose to cancel your Spouse's coverage under this certificate, your Spouse's coverage will end on the first of the month following the date you provide notification to your Employer.

Otherwise, your Spouse's coverage will end on the earliest of:
- the date your coverage under this certificate ends;
- the date your Spouse is no longer eligible for coverage;
- the date your Spouse no longer meets the definition of a Spouse;
- the date of your Spouse's death; or
- the date of divorce or annulment.

If your Spouse's coverage ends as a result of your death, divorce or annulment, your

Spouse may elect to continue Spouse and Children coverage, as long as premium is paid as required under Portability of Accident Insurance.

We will provide coverage for a Payable Claim that occurs while your Spouse is covered under this certificate.

For your Children

If, while your coverage is in force, you choose to cancel your Children's coverage under this certificate, your Children's coverage will end on the first of the month following the date you provide notification to your Employer.

Otherwise, your Children's coverage will end on the earliest of:

- the date your coverage under this certificate ends;
- the date your Children are no longer eligible for coverage; or
- the date your Children no longer meet the definition of Children.

We will provide coverage for a Payable Claim that occurs while your Children are covered under this certificate.

Filing a Claim

We encourage early notification of a claim for benefits under this certificate so that a claim decision can be made in a timely manner. If there are any questions on how to file a claim, please contact us or your Employer.

Step 1 - Notice of Claim

Notice of a claim may be provided in Writing, online at: **services.unum.com**, or by contacting us directly at 1-800-858-6843. Notice of a claim should be provided within 30 days from the date of the Covered Loss, or as soon as reasonably possible.

Step 2 - Claim Forms

After receiving notice of a claim, we will send a claim form to you or your authorized representative within 15 days from the date we receive the notice of a claim. Claim forms may also be available from your Employer or from us online at: **services.unum.com**.

When you or your authorized representative receive the claim form, you or your authorized representative must fill out your own section of the claim form and provide the Insured's Physician with the applicable section of the claim form. The Insured's Physician should complete their section of the form and send it directly to us.

If you or your authorized representative do not receive a claim form from us within 15 days after we receive notice of a claim, a Written statement from you or your authorized representative as to the nature and extent of the Covered Loss will be deemed Proof of Loss, if sent to us within the time limit stated in the Proof of Loss section below.

Completed claim forms may be sent to us by mail or fax:

Mailing Address: The Benefits Center
P.O. Box 100158
Columbia, South Carolina 29202-3158
Fax: 1-800-447-2498

Step 3 - Proof of Loss

Proof of Loss must be sent to us no later than 180 days after the date of Covered Loss. If it is not reasonably possible to provide Proof of Loss within this time period, it will not affect a Payable Claim if it is provided as soon as reasonably possible, and in no event later than one year from the time Proof of Loss is otherwise required, unless the Insured lacks the legal capacity to do so.

Proof of Loss, provided at your or your authorized representative's expense, must establish the nature and extent of the Covered Loss and should include but not be limited to the following:

- the cause of death or Covered Loss;
- the extent of the Covered Loss;
- the date of Covered Loss;
- the name and address of any Hospital or institution where treatment was received, including all attending Physicians; and
- in case of death, a certified copy of the death certificate or other lawful evidence providing equivalent information.

Claim Procedures

After the Insured has satisfied the requirements under Filing a Claim, we will process and evaluate the information to determine if a claim is payable. We will notify the Insured of a claim decision and issue payment for a Payable Claim in accordance with the Payment of Benefits provision.

If we determine additional time is needed to review a claim, we may extend the time period for Payment of Benefits by 30 days. We will notify the Insured of the circumstances requiring a review extension and when we anticipate making a claim decision.

If a claim for benefits under this certificate is wholly or partially denied, we will provide notice of our decision in Writing. The notice will contain the following information:

- the specific reason(s) for the determination with reference to those provisions on

which the decision is based;
- a description of any additional material or information necessary to complete the claim and why that material or information is necessary;
- procedures and time limits for appealing our decision, and the Insured's right to obtain information about those procedures;
- a statement describing the right to bring a lawsuit under Section 502(a) of ERISA following a claim determination; and
- a statement disclosing any internal rule, guidelines, protocol, or similar criteria used in making the decision (or a statement that such information will be provided free of charge upon request).

Payment of Benefits

Benefits for which we are liable will be paid within 30 days from the date we receive satisfactory Proof of Loss. All benefits will be paid to you, unless we receive Written authorization to pay them elsewhere. This is an assignment of benefits.

In the event of your death, any unpaid benefits will be paid to your beneficiary in accordance with the Beneficiary Designation and Change provision.

In the event of your Spouse's death, should your Spouse have survived you and continued coverage, any unpaid benefits for your Spouse, will be paid to your surviving Spouse's beneficiary in accordance with the Beneficiary Designation and Change provision.

Beneficiary Designation and Change

When a person becomes insured under this certificate, the Insured is responsible for designating a beneficiary in Writing for any benefits due in the event of the Insured's death. It is important to list the full name of each beneficiary and that all beneficiary designations are kept current and provided to us or the Employer. A beneficiary designation form may be available from the Employer or from us online at: **services.unum.com**.

You are the Beneficiary for any Insured under this certificate while you are still living unless there is a valid change in beneficiary designation by an Insured. If an Insured wishes to change their beneficiary designation, they may do so by sending us or the Employer a completed, dated, and signed beneficiary designation change form. Changes in beneficiary designations will take effect on the date notice of the beneficiary designation is signed by the Insured.

Unless you make an irrevocable designation of beneficiary, the right to change a beneficiary is reserved to you and the consent of the beneficiary or beneficiaries shall not be requisite to assignment of the Policy and this certificate or to change of beneficiary or beneficiaries, or to any changes in the Policy or this certificate. A change of beneficiary will not have a bearing on any payment we make before we receive it.

Payment of Benefits will be administered based upon the currently available beneficiary designation on file with us or the Employer. If we have taken any action or made any payment before receiving notice of a beneficiary designation, that beneficiary designation will not go into effect for those actions taken or payments made.

If more than one beneficiary is named and the order or share of payments is not designated, the beneficiaries will share equally. The share of a beneficiary who dies before an Insured, the share of a beneficiary who is legally unable to receive benefits, or the share of benefits that are unallocated will pass to any surviving beneficiaries in proportion to their current allocations. The aggregated shares of benefits in excess of 100% will be deducted from surviving beneficiaries in proportion to their current allocations.

If a beneficiary is not named, or if all named beneficiaries do not survive the Insured, or the named beneficiary is legally unable to receive benefits, any benefits due will be paid to the Insured's estate.

In the event of your death, should your Spouse survive you and elect to continue coverage under Portability of Accident Insurance, your surviving Spouse should name a

beneficiary according to the requirements specified within this provision.

Payments to a Minor or Incompetent Insured or Insured's Beneficiary

If an Insured or an Insured's beneficiary is a minor or is incompetent, we can pay up to $2,000 to the person or institution that appears to have assumed the custody and main support of the Insured, the minor, or the Insured's beneficiary unless or until that Insured, the minor, or the Insured's beneficiary's appointed legal representative makes a formal claim. If we pay benefits to such person or institution, we will not have to pay those benefits again.

Physical Examinations and Autopsy

Right to Exam

We have the right to request the Insured to be examined by one or more Physicians, other medical practitioners, or vocational experts of our choice as often as it is reasonably necessary during the pendency of an Insured's claim.

Any exam that we require will be paid at our expense.

Autopsy

We will have the right, at our expense, to request an Autopsy where it is allowed by law.

Legal Actions

The time limit on Legal Actions for a Covered Loss is subject to applicable law in the state where the Policy was issued.

If you or your authorized representative disagree with our decision, you or your authorized representative can start Legal Action regarding your claim 60 days after Proof of Loss has been given to us and up to three years from the latest of when:

- original Proof of Loss was first required to have been given to us;
- your claim was denied; or
- your benefits were terminated,

unless otherwise provided under federal law.

Authorization for Release of Information

We may request Written authorization from an Insured. This authorization may be required in order for us to obtain the necessary medical and non-medical information needed for Proof of Loss. This information may include any appropriate financial records such as income tax returns. Failure to provide us with Written authorization may result in the denial of a claim if the Insured does not send proof to us and we are not able to obtain the proof that is required to make a claim decision.

Overpayment of Claims

We have the right to recover any overpayments due to:

- fraud;
- Misstatement of Information; or
- any error we make in processing a claim.

We must be reimbursed in full. If it is not possible for you to reimburse us in a lump sum payment, we will develop a reasonable method of repayment. This may include reducing or withholding future payments.

We will not recover more money than the amount we paid you.

Unpaid Premium

Any Unpaid Premium due for an Insured's coverage at the time of payment for a claim may be deducted from the Insured's claim payment.

Appeal Procedures

Any request to file an appeal of a wholly or partially denied claim must be sent to us in Writing within 180 days from the date of Written notice of our claim decision. You have the right to:

- upon request and free of charge, reasonable access to and copies of, all relevant documents as defined by applicable U.S. Department of Labor regulations; and
- submit Written comments, documents, records, and other information relating to the claim to us.

Once we receive an Insured's appeal request, it will be assigned to an appeals specialist. The appeals specialist is a person different from the person who made the initial determination and such person will not be the original decision maker's subordinate. In

the case of a claim denied on the grounds of a medical judgment, we will consult with a health professional with appropriate training and experience. The health care professional who is consulted on appeal will not be the individual who was consulted during the initial determination or a subordinate. If the advice of a medical or vocational expert was obtained in connection with the denial of an Insured's claim, we will provide the Insured with the names of each such expert, regardless of whether the advice was relied upon.

We will make a full and fair review of the claim and all new information submitted, whether or not presented or available at the initial determination. No deference will be afforded to the initial determination. We will notify the Insured of the appeal decision within 45 days from receipt of the Written request for review. If we determine additional time is needed to review the appeal request, we may extend this time period by an additional 45 days. We will notify the Insured if an extension is needed.

If any review extension is necessary due to the Insured's failure to provide the information necessary to make a decision, we will notify the Insured of the review extension and specifically describe what information is required. This information must be sent to us within the time specified from the date of our request. The 45 day review extension will begin on the date we receive the requested information.

If the Insured fails to provide us with the requested information within the specified time period, we will make a decision based on the information available to us at that time.

If an appeal is wholly or partially denied, we will provide notice in Writing. Notice of a denied appeal will contain the following information:

- the specific reason(s) for the denial with reference to those provisions on which the denial is based;
- a statement disclosing any internal rule, guidelines, protocol, or similar criteria used in making the decision (or a statement that such information will be provided free of charge upon request);
- a statement describing the right to bring a lawsuit under Section 502(a) of ERISA if you disagree with the appeal decision;
- a statement that entitles the Insured, at their request, reasonable access to or copies of all documents, records, or other information relevant to the appeal decision free of charge; and
- the statement that "You or your Plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your State insurance regulatory agency."

Unless there are special circumstances, this administrative appeal process must be completed before an Insured begins any Legal Action regarding a claim.

When Days Begin and End

For the purpose of all dates under this Certificate of Coverage, all days begin at 12:01 a.m. and end at 12:00 midnight.

Certificate of Coverage Contents

Coverage for an Insured is provided under this Certificate of Coverage which is a part of the Policy issued to the Policyholder. The Policy consists of:

- all Policy provisions, and any riders, amendments and endorsements, and other attachments to the Policy;
- this Certificate of Coverage, and any riders, amendments and endorsements, and other attachments to this Certificate of Coverage;
- the Policyholder's application for group insurance; and
- Employee's signed applications, if applicable.

Your Certificate of Coverage

We will provide the Employer with a Certificate of Coverage for distribution to each Insured Employee. Your certificate describes:

- the coverage to which an Insured may be entitled;
- to whom we will make a payment; and
- the limitations, exclusions, and requirements that apply to an Insured's coverage.

If any of the terms and provisions of this certificate are different than in the Policy, the Policy will govern.

Cancellation or Modification to the Policy and this Certificate of Coverage

The Policy and this Certificate of Coverage may be cancelled or modified by the Employer at any time without the Insured's consent. We will not modify rates before the later of the date the Policy or this Certificate of Coverage has been in force for 12 months or the end of any Rate Guarantee Period as stated in the Rate Schedule. Any modification to rates thereafter will not be more frequently than every six months. Any cancellation or modification to the Policy or certificate requested by the Employer will take effect on the date agreed upon by us and the Employer.

All Policy and certificate modifications will take effect according to the Coverage Effective Date for Changes in Coverage provision.

Time Limit on Certain Defenses

Representation in Applications

Any statements made by you will be considered a representation and not a warranty. We will not use such statements to avoid insurance, reduce benefits, or deny a claim unless it is included in an application signed by you, and a copy of the signed application has been provided to you or your beneficiary.

Contestability

We can take legal or other action using statements made in signed applications for coverage only when a Covered Loss occurs during the first two years after an Insured's Coverage Effective Date.

Misstatement of Information

If you or your Employer provides us information about an Insured that is incorrect during the first two years after an Insured's Coverage Effective Date, we will:

- use the facts to decide whether the Insured has coverage under this certificate and the Policy and in what amounts; and
- if necessary, make the applicable premium adjustments.

Assignment

An Assignment transfers all or part of your legal title and rights under the Policy and this certificate to someone else, known as an "assignee." We will recognize your assignee(s) as owners of the rights you transferred under the Policy and this certificate if:

- the Written form has been signed by you and the assignee and the form is acceptable to us; and
- a signed or certified copy of the Written Assignment has been filed with us.

An Assignment will take effect on the date notice of the Assignment is signed by you. If we have taken any action or made any payment before we receive notice of the Assignment, that Assignment will not go into effect for those actions taken or payments made. An Assignment does not change an Insured's coverage or beneficiary designation.

We are not responsible for the validity of any Assignment. We advise you to verify your Assignment is legal in your state and that it accomplishes the goals you intend.

Fraud

We want to make sure you and your Employer do not incur additional insurance costs as a result of the undermining effects of insurance fraud. We promise to focus on all means necessary to support fraud detection, investigation, and prosecution.

You are guilty of a Class H felony if you knowingly and with intent to injure, defraud or deceive us. This includes providing any Written or oral statements that contain any false or misleading information concerning a fact or matter material to a claim.

These actions will result in denial of a claim, and are subject to prosecution and punishment to the full extent under state and federal law. We will pursue all appropriate legal remedies in the event of insurance fraud.

Agency

For purposes of the Policy, your Employer acts on their own behalf or as your agent. Under no circumstances will your Employer be deemed our agent.

Workers' Compensation or State Disability Insurance

This certificate does not replace or affect the requirements for coverage by any workers' compensation or state disability insurance.

Communicating With you or your Employer

We may provide notices, information, and other communications to you or your Employer in Written form.

To protect our customers, we will abide by all applicable privacy laws and regulations.

Additional Services

This certificate may include enrollment, risk management, financial protection, and other support services related to your Employer's benefit program.

Active Employment

You are working for your Employer for earnings that are paid regularly and you are performing the Material and Substantial Duties of your Regular Occupation. You must be regularly scheduled to work at least the minimum number of hours as determined by your Employer.

Your work site must be:
- your Employer's usual place of business in the United States;
- an alternative work site in the United States at the direction of your Employer; or
- a location in the United States to which your job requires you to travel.

Normal vacation, holidays, or temporary business closures are considered Active Employment provided you are in Active Employment on the last scheduled work day preceding such time off.

For purposes of this certificate, temporary business closures that meet the Glossary definition of Active Employment include, but are not limited to:
- inclement weather;
- power outage; and
- public health agency orders.

Temporary and seasonal workers are excluded from coverage.

Ambulatory Surgical Center

A facility, separate from a Hospital, equipped for Physicians to perform Surgical Procedures on an Outpatient Basis and must:
- provide anesthesia administered by a licensed anesthesiologist or licensed nurse anesthetist; and
- have agreements with local Hospitals to immediately accept patients who develop complications.

Calendar Year

The period beginning on the Insured's Coverage Effective Date and ending on December 31 of the same year. For each following year, it is the period beginning on January 1 and ending on December 31.

Certificate of Coverage

The document issued to the Employee, also referred to as the "certificate," describing an Insured's benefits and rights under the Policy, including any riders, amendments and endorsements, and other attachments to this certificate and the Policy.

Childbirth

Birth of a child by routine vaginal delivery or non-emergency Cesarean section.

Childbirth or Complications of Pregnancy will be treated as any other Sickness.

Children

Any child from live birth to age 26 who is:
- your own natural offspring;
- your Spouse's child;
- your lawfully adopted child as of the earliest of the date:
  - the child is placed in your home or in a medical facility;
  - a petition is filed for you to adopt the child; or
  - an adoption agreement, signed by you that includes your binding obligation to assume financial responsibility for the child;
- a foster child placed with you by an authorized placement agency or by judgment, decree, or other order of any court of competent jurisdiction; or
- any other child residing with you through legal mandate that is dependent on you.

Coverage for your Child may be continued past age 26 if your Child is incapable of self-sustaining employment due to permanent intellectual or physical incapacity prior to reaching age 26 and is dependent upon you for support and maintenance.

You must submit proof of the Child's incapacity and dependency to us within 120 days of the Child's 26th birthday or we will accept proof within 120 days of the Child's Coverage Eligibility Date that the Child was continuously covered under this or another similar group policy since age 26. Ongoing proof of incapacity and dependency must be provided when requested by us, but not more frequently than once a year.

Your Children may not be Insured as both a Child and an Employee.

Your Children may not be Insured by more than one Employee.

Chiropractic Therapy

Spinal manipulation services conducted by a licensed chiropractor to correct a structural imbalance.

For purposes of this certificate, the following services do not meet the Glossary definition of Chiropractic Therapy:
- massage therapy;
- treatment of chronic conditions; and
- other Injuries not related to structural imbalance.

Complications of Pregnancy

Abnormal conditions or concurrent diseases that significantly affect the pregnancy's usual medical management. A complication may exist during the pregnancy, during the birth, or after the birth. A non-elective cesarean section is considered a complication of pregnancy.

Childbirth or Complications of Pregnancy will be treated as any other Sickness.

Confined or **Confinement**

Assignment to a bed as a resident inpatient in a medical or treatment facility, including an Observation Unit, for a minimum of 20 continuous hours on the advice of a Physician.

Contributory Coverage

Any amount of coverage for which you pay all or part of the premium. The maximum amount that you may be required to contribute to the cost of your coverage shall not exceed the premium charged for the amounts of your coverage.

Covered Accident

An unintended or unforeseen bodily Injury sustained by an Insured and which:
- occurs on or after the Coverage Effective Date;
- occurs while coverage is in force; and
- is not excluded by name or specific description in this certificate.

Covered Loss

An accidental death, dismemberment, loss, or other Injury for which benefits are payable under this certificate.

Emergency Department

A specified area within a Hospital, or standalone facility that is affiliated with a Hospital, designated for the emergency care of accidental Injuries or Sicknesses. This area must:
- be staffed and equipped to handle trauma;
- be supervised and have treatment provided by Physicians; and
- provide care seven days per week, 24 hours per day.

Employee

A person, also referred to as "you," who is in Active Employment in the United States with the Employer.

Employer

The Policyholder, including all United States divisions, subsidiaries, and affiliated companies of the named Policyholder for whose Employees premium is being paid.

Enrollment Period

A period of time determined by your Employer and us during which you are eligible to enroll for or change your coverage. This period of time may be limited.

Hospital

A licensed state tax-supported institution supervised by Physicians and operated pursuant to law on a full-time basis. The Hospital must:
- provide overnight care to people with Injuries or Sicknesses;
- have full-time Nurses on duty or on call who are supervised by a registered Nurse; and
- have X-ray equipment, a laboratory, and a surgical operating room at its locations or available to use on a pre-arranged basis.

For purposes of this certificate, the following hospital units meet the Glossary definition of Hospital:
- Hospital Subacute ICU;
- Progressive Care Unit;
- Intermediate Care Unit; and

- Step-Down Unit.

For purposes of this certificate, the following do not meet the Glossary definition of Hospital:
- a nursing home, a rest home, home for the aged, or an assisted living facility;
- a hospice care facility;
- a Rehabilitation or Subacute Rehabilitation Unit;
- a psychiatric unit or facility for the treatment of Mental or Nervous Disorders; and
- a facility for the treatment of Substance Abuse.

Hospital ICU

A specifically designated area of the Hospital that is restricted to patients who are critically ill or injured and who require intensive, comprehensive observation and care. The Hospital ICU must:
- be separate and apart from the surgical recovery room and from rooms, beds, and wards customarily used for patient Confinement;
- be permanently equipped with special lifesaving equipment for the care of the critically ill or injured;
- be under close observation by a specially trained nursing staff assigned exclusively to the ICU on a 24 hour basis; and
- have a Physician assigned to the ICU on a full-time basis.

For purposes of this certificate, the following Hospital units meet the Glossary definition of Hospital ICU:
- Intensive Care Unit (ICU);
- Coronary Care Unit;
- Neonatal ICU;
- Pulmonary Care Unit;
- Burn Unit; and
- Transplant Unit.

Injury

Any damage or harm to the body that is the direct result of an accident and not related to any other cause.

Insured

Any person who has coverage under this certificate.

Layoff

Temporary absence from Active Employment for a period of time that has been agreed to in advance by your Employer.

Normal vacation time, holidays, or temporary business closures are not considered a temporary Layoff.

Leave of Absence

Temporary absence from Active Employment for a period of time under a leave granted in Writing by your Employer that is in accordance with your Employer's formal leave policies.

Normal vacation time, holidays, or temporary business closures are not considered a Leave of Absence.

Material and Substantial Duties

Duties that:
- are routinely required for the performance of your Regular Occupation; and
- cannot be reasonably omitted or modified.

Mental or Nervous Disorders

A psychiatric or psychological condition classified in the most recent *Diagnostic and Statistical Manual of Mental Health Disorders* (DSM) published by the American Psychiatric Association (APA), as of the date of Covered Loss. If the DSM is discontinued or replaced, these disorders will be those classified in the diagnostic manual then used by the APA as of the date of Covered Loss. If the APA no longer publishes a diagnostic manual or the APA ceases to exist, we will use a comparable diagnostic manual.

Nurse

A healthcare professional trained to care for people with Injuries or Sicknesses. A Nurse may include a graduate Registered Nurse (R.N.), Licensed Practical Nurse (L.P.N.), or Licensed Vocational Nurse (L.V.N.).

We will not recognize you, your Spouse, Children, parents, siblings, a business or professional partner, or any person who has a financial affiliation or business interest with you, as a Nurse for a claim that you send to us.

Occupational Therapist

A healthcare professional licensed by the state to practice Occupational Therapy, who:
- performs services which are allowed by their license;
- performs services for which benefits are provided by this certificate; and
- possesses the designation "Occupational Therapist Registered" (OTR).

We will not recognize you, your Spouse, Children, parents, siblings, a business or professional partner, or any person who has a financial affiliation or business interest with you, as an Occupational Therapist for a claim that you send to us.

Occupational Therapy

The treatment of a physically disabled person by means of constructive activities designed and adapted to promote the restoration of the person's ability to satisfactorily accomplish the ordinary tasks of daily living and those tasks required by the person's particular occupational role.

For purposes of this certificate, the following do not meet the Glossary definition of Occupational Therapy:
- diversional therapy;
- recreational therapy; and
- any vocational therapies (e.g. hobbies, arts, and crafts).

Outpatient Basis

Medical care and treatment received without being admitted to a Hospital or other facility.

Payable Claim

A claim for which we are liable for under the terms of this certificate.

Physical Therapist

A healthcare professional licensed by the state to practice Physical or Chiropractic Therapy, who:
- performs services which are allowed by their license;
- performs services for which benefits are provided by this certificate; and
- practices according to the Code of Ethics of the American Physical Therapy Association.

We will not recognize you, your Spouse, Children, parents, siblings, a business or professional partner, or any person who has a financial affiliation or business interest with you, as a Physical Therapist for a claim that you send to us.

Physical Therapy

Treatment by physical means, hydrotherapy, heat or similar modalities, physical agents, bio-mechanical, and neuro-physiological principles and devices. Such therapy is given to relieve pain, restore function, and to prevent disability following Injury or loss of a body part.

Physician

A person performing tasks that are within the limits of his or her medical license and is also:
- a legally qualified medical practitioner according to the laws and regulations of the governing jurisdiction;
- licensed to practice medicine, prescribe and administer drugs, or to perform surgery; or
- a person with a doctoral degree in Psychology (Ph.D. or Psy.D.) whose primary practice is treating patients.

We will not recognize you, your Spouse, Children, parents, siblings, a business or professional partner, or any person who has a financial affiliation or business interest with you, as a Physician for a claim that you send to us.

Plan

Your Employer's Accident Welfare Benefit Plan under ERISA which includes this certificate, your Employer's Group Accident Insurance Policy, and other benefit plan documents consistent with this Plan.

Policy

The Group Accident Insurance Policy issued to the Policyholder, including this Certificate of Coverage and any riders, amendments and endorsements, and other attachments to this certificate and the Policy.

Policyholder

The entity to which the Policy is issued.

Qualifying Life Event

For coverage determination purposes, a Qualifying Life Event means an event including, but not limited to:

- birth, adoption, or addition of a Child;
- a change in legal marital status;
- a change in employment status; or
- death of an Insured.

Qualifying Life Event coverage changes made in accordance with the Start of Coverage provisions must be consistent with the Qualifying Life Event.

For further information regarding Qualifying Life Events, please refer to your Employer's Human Resource policy.

Regular Occupation

The occupation you are routinely performing. We will look at your occupation as it is normally performed in the national economy, instead of how the work tasks are performed for a specific employer at a specific location.

Rehabilitation Unit

An appropriately licensed facility that provides rehabilitation care services on an inpatient basis. The care services provided by the Rehabilitation Unit must:

- consist of the combined use of medical, social, educational, and vocational services to enable patients disabled by accidental Injury or Sickness to achieve the highest possible functional ability; and
- be provided by or under the supervision of an organized staff of Physicians.

The Rehabilitation Unit may be part of a Hospital or a standalone facility.

For purposes of this certificate, the following do not meet the Glossary definition of Rehabilitation Unit:

- a nursing home, a rest home, home for the aged, or an assisted living facility;
- a hospice care facility;
- a Subacute Rehabilitation Unit;
- a psychiatric unit or facility for the treatment of Mental or Nervous Disorders; and
- a facility for the treatment of Substance Abuse.

Sickness

An illness or disease.

Speech Therapist

A healthcare professional licensed by the state to practice Speech Therapy, who:

- performs services which are allowed by their license;
- performs services for which benefits are provided by this certificate; and
- practices according to the Code of Ethics of the American Speech-Language-Hearing Association.

We will not recognize you, your Spouse, Children, parents, siblings, a business or professional partner, or any person who has a financial affiliation or business interest with you, as a Speech Therapist for a claim that you send to us.

Speech Therapy

Treatment and assistance for disorders related to speech, language, cognitive-communication, voice, swallowing, and fluency.

Spouse

The person who is your partner through lawful marriage, civil union, domestic partnership (established by a declaration acceptable to us), or your legally separated Spouse.

Your Spouse may not be Insured as both a Spouse and an Employee.

Subacute Rehabilitation

A licensed facility or distinct part of a facility supervised at all times by a Physician or Nurse. The facility must provide care to people with Injuries or Sicknesses on an inpatient

Unit

basis. The Subacute Rehabilitation Unit must have a Physician available at all times and have a transfer agreement in effect with one or more participating Hospitals.

For purposes of this certificate, the following do not meet the Glossary definition of Subacute Rehabilitation Unit:
- a nursing home, a rest home, home for the aged, or an assisted living facility;
- a hospice care facility;
- a Rehabilitation Unit;
- a psychiatric unit or facility for the treatment of Mental or Nervous Disorders; and
- a facility for the treatment of Substance Abuse.

Substance Abuse

Abuse of or addiction to drugs or alcohol.

Surgical Procedure

The cutting into the skin or other organ to accomplish any of the following goals:
- further explore the condition for the purpose of diagnosis;
- take a biopsy of a suspicious lump;
- remove diseased tissues or organs;
- remove an obstruction;
- reposition structures to their normal position;
- redirect channels;
- transplant tissue or whole organs;
- implant mechanical or electronic devices;
- repair an area that has been injured or affected by trauma, overuse, or Sickness; or
- restore proper function.

For purposes of this certificate, the following do not meet the Glossary definition of Surgical Procedure:
- venipuncture (drawing blood);
- lumbar puncture;
- epidural steroid injections;
- removal of skin tags; and
- foreign body removal from the eye.

Telemedicine

A medical inquiry with a Physician via the use of telecommunication and information technologies (including, but not limited to, audio or video communications) for the Insured's evaluation, diagnosis, or treatment as would be practiced in person. This does not include requests for prescription refills or medical records.

Unum Insurance Company

Referred to as "Unum" and "we," "us," or "our."

Urgent Care Facility

A health care facility that is organizationally separate from a Hospital with the primary purpose of offering and providing urgent and immediate, short-term medical care, without an appointment.

Writing or **Written**

A record on or transmitted by paper, electronic, or telephonic means consistent with applicable law.

UNDER NORTH CAROLINA GENERAL STATUTE SECTION 58-50-40, NO PERSON, EMPLOYER, PRINCIPAL, AGENT, TRUSTEE, OR THIRD PARTY ADMINISTRATOR, WHO IS RESPONSIBLE FOR THE PAYMENT OF GROUP HEALTH OR LIFE INSURANCE OR GROUP HEALTH PLAN PREMIUMS, SHALL:

(1) CAUSE THE CANCELLATION OR NONRENEWAL OF GROUP HEALTH OR LIFE INSURANCE, HOSPITAL, MEDICAL, OR DENTAL SERVICE CORPORATION PLAN, MULTIPLE EMPLOYER WELFARE ARRANGEMENT, OR GROUP HEALTH PLAN COVERAGES AND THE CONSEQUENTIAL LOSS OF THE COVERAGES OF THE PERSONS INSURED, BY WILLFULLY FAILING TO PAY THOSE PREMIUMS IN ACCORDANCE WITH THE TERMS OF THE INSURANCE OR PLAN CONTRACT; AND

(2) WILLFULLY FAIL TO DELIVER, AT LEAST 45 DAYS BEFORE THE TERMINATION OF THOSE COVERAGES, TO ALL PERSONS COVERED BY THE GROUP POLICY A WRITTEN NOTICE OF THE PERSON'S INTENTION TO STOP PAYMENT OF PREMIUMS. THIS WRITTEN NOTICE MUST ALSO CONTAIN A NOTICE TO ALL PERSONS COVERED BY THE GROUP POLICY OF THEIR RIGHTS TO HEALTH INSURANCE CONVERSION POLICIES UNDER ARTICLE 53 OF CHAPTER 58 OF THE GENERAL STATUTES AND THEIR RIGHTS TO PURCHASE INDIVIDUAL POLICIES UNDER THE FEDERAL HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT AND UNDER ARTICLE 68 OF CHAPTER 58 OF THE GENERAL STATUTES.

VIOLATION OF THIS LAW IS A FELONY. ANY PERSON VIOLATING THIS LAW IS ALSO SUBJECT TO A COURT ORDER REQUIRING THE PERSON TO COMPENSATE PERSONS INSURED FOR EXPENSES OR LOSSES INCURRED AS A RESULT OF THE TERMINATION OF THE INSURANCE.

Unum Insurance Company
2211 Congress Street, Portland, ME 04122
(877) 225-2712
services.unum.com

Be Well Benefit

We encourage our Insureds to maintain a healthy lifestyle. For those who take precautionary measures by receiving routine health screenings, we offer a Be Well Benefit. This is an annual cash benefit that may be claimed after completing an eligible Be Well Screening, and may be used to help with monetary expenditures such as transportation, missed work, or other incidentals.

For the purpose of determining your coverage and eligibility for the Be Well Benefit, all terms and provisions of your Certificate of Coverage apply unless modified below.

Policyholder: Truist Financial Corporation

Policy Number: 803177 012

Policy Effective Date: January 1, 2023

Be Well Benefit Effective Date: January 1, 2023

Eligible Group(s)

All Benefit Eligible Employees in Active Employment in the United States scheduled to work a minimum of 20 hours per week.

Paying for Coverage

The Be Well Benefit is automatically included in the cost of your Accident Insurance coverage.

Be Well Benefit

For you	For your Spouse	For your Children
$50	$50	$50

Be Well Benefit Payment Conditions

Each Insured is eligible to receive a maximum of one Be Well Benefit per Calendar year.

The Be Well Benefit will become payable provided the following conditions are met:
- the date of the Be Well Screening is after the Be Well Benefit Effective Date; and
- an Insured's coverage is in force.

Be Well Screenings

Cholesterol and Diabetes	Eligible screenings include, but may not be limited to: blood test for triglycerides, fasting plasma glucose (FPG), fasting blood glucose test, hemoglobin A1C(HbA1c), Serum cholesterol test to determine total, HDL and LDL cholesterol levels, two hour post-load plasma glucose.
Cancer	Eligible screenings include, but may not be limited to: colonoscopy, virtual colonoscopy, CEA (blood test for colon cancer), low-dose computerized tomography (CT) (imaging study for lung cancer), double-contrast barium enema, fecal immunochemical testing, fecal DNA testing, PSA (blood test for prostate cancer), bone marrow testing, serum protein electrophoresis (blood test for myeloma), dermatological screenings for skin cancer, flexible sigmoidoscopy, hemoccult stool analysis, pap smear, thin prep pap test, cytology

	(PAP) smear, CA 15-3 (blood test for breast cancer), CA-125 (blood test for ovarian cancer), BRCA1 or BRCA2 testing.
Cardiovascular Function	Eligible screenings include, but may not be limited to: echocardiogram, electrocardiogram, stress test on a bicycle or treadmill, myocardial perfusion imaging.
Imaging Studies	Eligible screenings include, but may not be limited to: chest x-ray, carotid ultrasound (Doppler), mammography, breast ultrasound, breast MRI, breast thermography, transvaginal ultrasound, bone density scans, aortic ultrasound.
Annual Examinations by a Physician	Eligible examinations include sports physicals, annual exams for adults, and well-child visits.
Immunizations	Eligible immunizations include, but may not be limited to: HPV, Hepatitis B, chicken pox, MMR, meningitis, tetanus, pneumonia, influenza.

Unum Insurance Company
2211 Congress Street, Portland, ME 04122
(877) 225-2712
services.unum.com

Portability of Accident Insurance

Portability allows you, your Spouse, and Children to continue coverage when coverage under the Employer's group Policy would otherwise end due to an Eligible Portability Event. The certificate issued to you when you first became insured under your Employer's group policy will reflect the terms and condition of the coverage that can be continued.

Portability of Accident Insurance is made a part of the Accident Insurance Policy and is subject to all of the provisions, limitations and exclusions of the Policy and certificate, unless changed by this document. Additionally, defined terms found within Portability of Accident Insurance have been capitalized and have the same meaning as the terms in the Glossary section of the Certificate of Coverage.

Any future changes made in the Employer's group Policy will not apply to coverage an Insured has ported, unless required by law.

If you have any questions about portable coverage, please contact your Employer or us.

Policyholder: Truist Financial Corporation

Policy Number: 803177 012

Policy Effective Date: January 1, 2023

Portability Effective Date: January 1, 2023

Portability Provisions

Eligible Portability Events

You are eligible to port coverage on the date of the following Eligible Portability Events:
- your employment with your Employer ends; or
- you are no longer in an Eligible Group.

However, you will not be considered eligible to port coverage at the time of an Eligible Portability Event if the Employer's Policy is cancelled by us.

Portable Coverage Available

The amount of coverage in force for each Insured on the date of your Eligible Portability Event is available to port subject to the following:

For you
The maximum amount of coverage available to port is your in force coverage at the time of your Eligible Portability Event.

For your Spouse
The maximum amount of coverage available to port is your Spouse's in force coverage at the time of your Eligible Portability Event.

For your Children
The maximum amount of coverage available to port is your Children's in force coverage at the time of your Eligible Portability Event.

If you wish to make a change to an Insured's in force coverage at time of port, please refer to Changes to Ported Coverage for guidelines in changing coverage.

Coverage for any Insured cannot be increased above the amount currently in force at the time you apply for portable coverage.

Applying for Portable Coverage

If you choose to apply for portable coverage for yourself, you may also port coverage for your Spouse and/or Children.

You must apply for portable coverage and pay the first premium within 31 days from the date of an Eligible Portability Event.

Applications for Portability are available from your Employer.

Ported Coverage Effective Date

Once premiums and all forms have been received, ported coverage is effective on the day after coverage would have otherwise ended under your Employer's Policy.

Changes to Ported Coverage

You may decrease coverage for an Insured at any time.

Ported coverage cannot be increased at any time for any Insured.

Decreases in coverage will take effect on the first of the month following the date we process the change.

Any decrease in coverage will not affect a Payable Claim that occurs prior to the decrease.

End of Ported Coverage

If you choose to cancel your ported coverage, coverage for all Insureds will end on the first of the month following the date you provide notification to us.

For you

Otherwise, your ported coverage will end on the earliest of:

- the date you fail to pay the required premium within 31 days of a premium due date;
- the date you are rehired by your Employer or return to an Eligible Group and are covered under the Employer's group Policy;
- the date coverage provided under Portability is cancelled by us for any reason upon 45 days notice; or
- the date you die.

For your Spouse

Your Spouse's ported coverage will end on the earliest of:

- the date your ported coverage ends;
- the date your Spouse is no longer eligible for coverage;
- the date your Spouse no longer meets the definition of a Spouse;
- the date of your Spouse's death; or
- the date of divorce or annulment.

If your Spouse's coverage ends as a result of your death, divorce or annulment, your Spouse has the option to port coverage in accordance with Portability for your Spouse and Children in the Event of your Death, Divorce or Annulment.

For your Children

Your Children's ported coverage will end on the earliest of:

- the date your ported coverage ends;
- the date your Children are no longer eligible for coverage; or
- the date your Children no longer meet the definition of Children.

Once ported coverage ends, it cannot be reinstated.

In the event your Employer's group Policy is terminated, Insureds who have continued their coverage under Portability of Accident Insurance prior to the Employer's group Policy termination date will not be affected.

Paying for

You must make all premium contributions for ported coverage. We will bill you directly for

Ported Coverage any premium due.

Rates for Ported Coverage Premium will be based on the rates for Portability in effect on the date you apply to port coverage.

Portability rates may be changed by us at any time, however, not more frequently than every 6 months. We will provide Written notice at least 45 days before any change is to take effect.

Portability for your Spouse and Children in the Event of your Death, Divorce or Annulment

Eligible Portability Events for your Spouse Your Spouse is eligible to port Spouse and Children coverage on the date of the following Eligible Portability Events for your Spouse:
- your death; or
- divorce or annulment.

Portable Coverage Available The amount of coverage in force for each Insured, on the date of the Eligible Portability Event for your Spouse, is available to port subject to the following:

For your Spouse
The maximum amount of coverage available to port is your Spouse's in force coverage at the time of the Eligible Portability Event for your Spouse.

For your Children
The maximum amount of coverage available to port is your Children's in force coverage at the time of the Eligible Portability Event for your Spouse.

If your Spouse wishes to make a change to an Insured's in force coverage at time of port, please refer to Changes to Ported Coverage for guidelines in changing coverage.

Coverage for any Insured cannot be increased above the amount currently in force at the time your Spouse applies for portable coverage.

Applying for Portable Coverage If your Spouse chooses to apply for portable Spouse coverage, your Spouse may also apply for portable Children coverage.

Your Spouse must apply for portable coverage and pay the first premium within 31 days from the date of the Eligible Portability Event for your Spouse.

Applications for Portability are available from us.

Ported Coverage Effective Date Once premiums and all forms have been received, ported coverage is effective on the day after coverage would have otherwise ended under the Employer's Policy.

Changes to Ported Coverage Your Spouse may decrease their Spouse and Children coverage at any time.

Ported coverage cannot be increased at any time for any Insured.

Decreases in coverage will take effect on the first of the month following the date we process the change.

Any decrease in coverage will not affect a Payable Claim that occurs prior to the decrease.

End of Ported Coverage If your Spouse chooses to cancel ported coverage, your Spouse and Children's coverage will end on the first of the month following the date your Spouse provides notification to us.

For your Spouse
Otherwise, your Spouse's ported coverage will end on the earliest of:
- the date your Spouse fails to pay the required premium within 31 days of a premium due date;

- the date your Spouse is no longer eligible for coverage;
- the date coverage provided under Portability is cancelled by us for any reason upon 45 days notice; or
- the date of your Spouse's death.

For your Children

Your Children's ported coverage will end on the earliest of:

- the date your Spouse's ported coverage ends;
- the date your Children are no longer eligible for coverage; or
- the date your Children no longer meet the definition of Children.

Once ported coverage ends, it cannot be reinstated.

In the event the Employer's group Policy is terminated, Insureds who have continued their coverage under Portability of Accident Insurance prior to the Employer's group Policy termination date will not be affected.

Paying for Ported Coverage

Your Spouse must make all premium contributions for Spouse and Children ported coverage. We will bill your Spouse directly for any premium due.

Rates for Ported Coverage

Premium will be based on the rates for Portability in effect on the date your Spouse applies to port Spouse and Children coverage.

Portability rates may be changed by us at any time, however, not more frequently than every 6 months. We will provide Written notice at least 45 days before any change is to take effect.

GROUP ACCIDENT

THE FOLLOWING NOTICES AND CHANGES TO YOUR COVERAGE ARE REQUIRED BY CERTAIN STATES. PLEASE READ CAREFULLY.

State variations apply and are subject to change. Consult your Employer or plan administrator for the most current state provisions that may apply to you.

Full effect will be given to your state's civil union, domestic partner and same sex marriage laws to the extent they apply to you under a group insurance policy issued in another state.

If you have a complaint about your insurance you may contact us at 1-800-321-3889, or the department of insurance in your state of residence. Links to the websites of each state department of insurance can be found at www.naic.org.

Si usted tiene una queja acerca de su seguro puede comunicarse con nosotros a traves del numero 1-800-321-3889, o al departamento de seguros de su estado de residencia. Puede encontrar enlaces a los sitios web de los departamentos de seguros de cada estado en www.naic.org.

The states of **Florida and Maryland** require us to advise residents of these states that if your Certificate was issued in a jurisdiction other than the state in which you reside, it may not provide all of the benefits required by the laws of your residence state.

If you are a resident of one of the states noted below, and the provisions referenced below appear in your certificate in a form less favorable to you as an Insured, they are amended as follows:

For residents of Arkansas

The **Exclusions** provision in the **Accident Details** section of the certificate is amended by providing that any exclusion for claims caused by, contributed to by, or resulting from active participation in a riot, insurrection, or terrorist activity. This exclusion is amended by removing "or terrorist activity".

The **Newborn Coverage Feature** provision in the **Accident Details** section of the certificate is amended as follows:

> **Newborn Coverage Feature**
> Your newborn or newly adopted Children will automatically be covered for 60 days from their Coverage Eligibility Date if you are insured.
>
> If you wish to continue Child coverage, you must notify us and pay any additional premium.
>
> If you already have coverage for your Children, then all eligible Children will be covered and you do not need to notify us or pay any additional premium for the newly eligible Child.

The **Initial Enrollment** language in the **Enrolling for Coverage** provision in the **Start of Coverage** section of the certificate is amended for Children so that you can apply for their coverage within 90 days.

The **Initial Enrollment** language in the **Coverage Effective Date** provision in the **Start of Coverage** section of the certificate is amended for Children so that if coverage for a newly acquired Child is applied for within 90 days of the Child's Coverage Eligibility Date, coverage will begin on the Child's Coverage Eligibility Date, provided premiums are paid.

The **Children** definition in the **Glossary** section of the certificate is amended for a Child who is incapable of self-sustaining employment due to permanent intellectual or physical incapacity as follows:

> Coverage for your Child may be continued past age 26 if your Child is incapable of self-sustaining employment due to permanent intellectual or physical incapacity prior to reaching age 26 and is dependent upon you for support and maintenance. You must submit proof of the Child's incapacity and dependency to us in order to continue coverage that would have otherwise ended due to age. Ongoing proof of incapacity and dependency must be provided, at our expense, when requested by us.

For residents of Colorado

The **Exclusions** provision in the **Accident Details** section of the certificate is amended by providing that any exclusion for claims caused by, contributed to by, or resulting from injuring oneself intentionally or attempting or committing suicide, whether sane or not is applied only if you were sane when the event occurred.

For residents of Idaho

The **Exclusions** provision in the **Accident Details** section of the certificate is amended as follows:

We will not pay benefits for a claim that is caused by, contributed to by, or resulting from any of the following:

- participation in a felony;
- injuring oneself intentionally or attempting or committing suicide, whether sane or not;
- active participation in a riot or insurrection. This does not include civil commotion or disorder, Injury as an innocent bystander, or Injury for self-defense;
- participating in war or any act of war, whether declared or undeclared;
- elective procedures, cosmetic surgery, or reconstructive surgery unless it is a result of congenital disease or anomaly of a covered dependent child;
- Mental or Nervous Disorders;
- experimental or investigational procedures;
- operating any motorized vehicle while intoxicated;
- operating, learning to operate, serving as a crew member as a professional of any aircraft or hot air balloon as a professional, including those which are not motor-driven, unless flying as a fare paying passenger;
- jumping, parachuting, or falling from any aircraft or hot air balloon, including those which are not motor-driven;
- travel or flight as a professional in any aircraft or hot air balloon, including those which are not motor-driven, if it is being used for testing or experimental purposes, used by or for any military authority, or used for travel beyond the earth's atmosphere;
- practicing for or participating in any professional competitive athletic contests for which any type of compensation or remuneration is received;
- riding or driving an air, land or water vehicle in a professional race, speed or endurance contest; and
- engaging in hang-gliding, bungee jumping, sail gliding, parasailing, parakiting, or BASE jumping as a professional.

The Accidental Death and Dismemberment Benefits are also subject to the following Exclusions. We will not pay benefits for a claim that is caused by, contributed to by, or resulting from any of the following:

- voluntary use of or treatment for voluntary use of any prescription or non-prescription drug, alcohol, poison, fume, or other chemical substance unless taken as prescribed or directed by the Insured's Physician.

Additionally, no benefits will be paid for a Covered Loss that occurs prior to the Coverage Effective Date.

The **Newborn Coverage Feature** provision in the **Accident Details** section of the certificate is amended as follows:

Newborn Coverage Feature
Your newborn or newly adopted Children will automatically be covered for 60 days from the moment of live birth if you are insured.

Coverage will only continue if you notify us and enroll your Child for coverage on or before the end of the 60 day period. The appropriate premium (if any) must be received by us within 31 days of the date the monthly premium invoice is received by the Policyholder and a notice of premium (if any) is provided to the Employee.

If you already have coverage for your Children, then all eligible Children will be covered and you do not need to notify us or pay any additional premium for the newly eligible Child.

The **Claim Procedures** provision in the **Claim Provisions** section of the certificate is amended so that notification of a claim decision and payment issued for a Payable Claim happens immediately.

A **Congenital Anomalies** definition has been added to the **Glossary** section of the certificate as follows:

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

For residents of Indiana

The **Payment of Benefits** provision in the **Claim Provisions** section of the certificate is amended so that benefits for which we are liable will be paid immediately or within 30 days after receipt of satisfactory Written Proof of Loss.

The **Children** definition in the **Glossary** section of the certificate is amended as follows:

Any child from moment of birth to age 26 who is:
- your own natural offspring;
- your stepchild;
- your lawfully adopted child as of the earliest of the date:
  - the child is placed in your home or in a medical facility;
  - a petition is filed for you to adopt the child; or
  - an adoption agreement, signed by you that includes your binding obligation to assume financial responsibility for the child;
- a foster child placed with you by an authorized placement agency or by judgment, decree, or other order of any court of competent jurisdiction;
- any child subject to your legal guardianship; or
- any other child residing with you through legal mandate that is dependent on you for financial support.

Coverage for your Child may be continued past age 26 if your Child is incapable of self-sustaining employment due to permanent intellectual or physical incapacity prior to reaching age 26 and is dependent upon you for support and maintenance.

You must submit proof of the Child's incapacity and dependency to us within 120 days of the Child's 26th birthday or we will accept proof within 120 days of the Child's Coverage Eligibility Date that the Child was continuously covered under this or another similar group policy since age 26. Ongoing proof of incapacity and dependency must be provided when requested by us, but not more frequently than once a year.

Your Children may not be Insured as both a Child and an Employee.

Your Children may not be Insured by more than one Employee.

For residents of Louisiana

The **Exclusions** provision in the **Accident Details** section of the certificate is amended by providing that any exclusion for claims caused by, contributed to by, or resulting from a Covered Loss that occurs while an Insured is legally incarcerated in a penal or correctional institution is amended so that if the Insured has not been adjudicated or convicted of a criminal offense, this exclusion would not apply.

The **Claim Procedures** provision in the **Claim Provisions** section of the certificate is amended so that notification of a claim decision and payment issued for a Payable Claim is within 30 days.

The **Payment of Benefits** provision in the **Claim Provisions** section of the certificate is amended as follows:

Payment of Benefits
Benefits for which we are liable will be paid after we complete the Claims Procedures. All benefits will be paid to you, unless we receive Written authorization to pay them elsewhere. This is an assignment of

benefits. We may be subject to a penalty, payable to you, of double the amount of benefits due to the Insured under the terms of this certificate during the period of delay should we issue any benefit payment after 30 days from the date we receive satisfactory proof. This penalty may also include attorney's fees to be determined by the court.

In the event of your death, any unpaid benefits will be paid to your beneficiary in accordance with the Beneficiary Designation and Change provision.

In the event of your Spouse's death, should your Spouse have survived you and continued coverage, any unpaid benefits for your Spouse, will be paid to your surviving Spouse's beneficiary in accordance with the Beneficiary Designation and Change provision.

The **Children** definition in the **Glossary** section of the certificate for "any other child residing with you through legal mandate that is dependent on you for financial support" is amended as follows:

- any other child, including grandchild, residing with you through legal mandate;

The **Children** definition in the **Glossary** section of the certificate is amended to include any other Child if placed following an execution of an act of voluntary surrender on the date on which the act of voluntary surrender becomes irrevocable.

For residents of Minnesota

The state of **Minnesota** requires us to notify you that the provisions in the Policy, including those in the Certificate of Coverage, conform to the minimum requirements of Minnesota law. The minimum requirements of Minnesota law will apply to your claim.

The **Exclusions** provision in the **Accident Details** section of the certificate is amended so that any exclusion for claims caused by, contributed to by, or resulting from injuring oneself intentionally or attempting or committing suicide, whether sane or not, is amended by removing the phrase, "or attempting or committing suicide".

The **Exclusions** provision in the **Accident Details** section of the certificate is amended so that any exclusion for claims caused by, contributed to by, or resulting from:

- a Covered Loss that occurs while an Insured is legally incarcerated in a penal or correctional institution;

is removed.

The **Newborn Coverage Feature** provision in the **Accident Details** section of the certificate is amended as follows:

Newborn Coverage Feature
Your newborn or newly adopted Children will automatically be covered from their Coverage Eligibility Date if you are insured.

If you do not have coverage for your Child at the time of birth or adoption, you must pay any required additional premium. If we do not receive premium for your newly eligible Child, we may reduce any benefits payable by the amount of the past due premiums applicable to the additional Child.

If you already have coverage for your Children, then all eligible Children will be covered and you do not need to pay any additional premium for the newly eligible Child.

For residents of Montana

The state of **Montana** requires us to notify you that the provisions in the Policy, including those in the Certificate of Coverage, conform to the minimum requirements of Montana law. The minimum requirements of Montana law will apply to your claim.

The **Exclusions** provision in the **Accident Details** section of the certificate is amended for Accidental Death and Dismemberment Benefits as follows:

The Accidental Death and Dismemberment Benefits are also subject to the following Exclusions. We will not pay benefits for a claim that is caused by, contributed to by, or resulting from any of the following:

- an Insured being voluntarily intoxicated; and
- an Insured's voluntary use of or treatment for voluntary use of any prescription or non-prescription drug, alcohol, poison, fume, or other chemical substance unless taken as prescribed or directed by the Insured's Physician.

The **Newborn Coverage Feature** provision in the **Accident Details** section of the certificate is amended as follows:

Newborn Coverage Feature
An Insured's newborn or newly adopted Children will automatically be covered for 31 days from their Coverage Eligibility Date if you are insured.

If you wish to continue Child coverage, you must notify us on or before the end of the 31 day period and pay any additional premium.

If you already have coverage for your Children, then all eligible Children will be covered and you do not need to notify us or pay any additional premium for the newly eligible Child.

The **Overpayment of Claims** provision in the **Claim Provisions** section of the certificate is amended by limiting the right to recover overpayments to 12 months from the date of payment. This provision reads as follows:

We have the right to recover any overpayments for up to 12 months due to:

- Fraud;
- Misstatement of Information; or
- any error we make in processing a claim.

The 12 months we have to recover overpayments will begin:

- for Fraud, on the date the Department of Insurance (DOI) determines insufficient evidence of Fraud exists. If we suspect a claim is overpaid as the result of Fraud, we will report the activity and evidence to the DOI;
- for reasons other than Fraud, including error, omissions, misstatement, misrepresentation, or concealment of information, on the date we have actual knowledge of the invalid claim, overpayment, or other incorrect payment. We will not request reimbursement of an unpaid claim not the result of Fraud more than 24 months from the date of payment, regardless of the date we obtain actual knowledge of the invalid claim, overpayment, or other incorrect information.

We must be reimbursed in full. If it is not possible for you to reimburse us in a lump sum payment, we will develop a reasonable method of repayment. This may include reducing or withholding future payments upon Written authorization from you.

We will not recover more money than the amount we paid you.

The **Representation in Applications** provision in the **General Provisions** section of the certificate is amended as follows:

In the absence of Fraud, any statements made by you will be considered a representation and not a warranty. We will not use such statements to avoid insurance, reduce benefits, or deny a claim unless it is included in an application signed by you, and a copy of the signed application has been provided to you or your beneficiary.

The **Childbirth** definition in the **Glossary** section of the certificate is amended as follows:

Birth of a child by vaginal delivery or Cesarean section.

Childbirth will be treated as any other Covered Sickness.

For purposes of the definition of **Children** in the **Glossary** section of the certificate, Children are defined as any Children born to age 26.

For residents of New Hampshire

The **Contestability** provision in the **Policy Provisions** section of the Policy is amended to remove reference to Fraud. The last sentence has been replaced to read as follows:

> However, in the event of nonpayment of premium by the Insured or the Policyholder, we can take action at any time under the provision titled Cancellation or Modification of this Policy by Us and as permitted by applicable law.

The **Burns** benefit in the **Accident Highlights** section of the certificate is amended to add a new skin surface benefit to read "Less than 5% of skin surface."

The **Injury Benefits** in the **Accident Highlights** section of the certificate is amended to add Dislocation - Open Reduction and Fracture - Open Reduction benefits.

The **Loss of a Digit** benefit in the **Accident Highlights** section of the certificate is amended to reflect a specific dollar amount in the Schedule of Benefits as follows: the greater of the amount elected by the employer or $1,000 for one digit or $2,000 for two or more digits.

The **Accidental Death and Accidental Death - Common Carrier** benefits in the **Accident Highlights** section of the certificate are amended to reflect a specific dollar amount for Spouses and Children in the Schedule of Benefits as follows: the greater of the amount elected by the employer or $10,000.

The **Dislocations** benefit in the **Accident Details** section of the certificate is amended so that if an Insured has a Dislocation requiring open reduction, we will pay the percentage amount shown in the Schedule of Benefits for the joint involved.

The Fractures benefit in the **Accident Details** section of the certificate is amended so that if an Insured has a Fracture requiring open reduction, we will pay the percentage amount shown in the Schedule of Benefits for the bone involved.

The **Loss of a Digit** benefit in the **Accident Details** section of the certificate is amended to remove the paragraph describing the physical limitations for the Benefit Description.

The **Emergency Dental Repair** benefit in the **Accident Details** section of the certificate is amended to remove the limitation on types of required repair.

The **Injections to Prevent or Limit Infection** benefit in the **Accident Details** section of the certificate is mended to remove the criteria that does not meet the Benefit Description.

The **Pain Management Injections** benefit in the **Accident Details** section of the certificate is amended to remove the criteria that does not meet the Benefit Description.

The **Exclusions** provision in the **Accident Details** section of the certificate is amended a follows:

> We will not pay benefits for a claim that is caused by, contributed to by, or resulting from any of the following:
> - participation in a felony;
> - injuring oneself intentionally or attempting or committing suicide, whether sane or not;
> - active participation in a riot or insurrection. This does not include civil commotion or disorder, Injury as an innocent bystander, or Injury for self-defense;
> - participating in war or any act of war, whether declared or undeclared;
> - combat or training for combat while serving in the armed forces of any nation or authority, including the National Guard, or similar government organizations;
> - elective procedures, cosmetic surgery, or reconstructive surgery unless it is a result of organ donation, trauma, infection, or other disease;
> - any Sickness or Mental or Nervous Disorders as defined in this certificate;
> - commission of a felony while operating any motorized vehicle while intoxicated;

- operating, learning to operate, serving as a crew member as a professional of any aircraft or hot air balloon as a professional, including those which are not motor-driven, unless flying as a fare paying passenger;
- practicing for or participating in any professional competitive athletic contests for which any type of compensation or remuneration is received.

The Accidental Death and Dismemberment Benefits are also subject to the following Exclusion. We will not pay benefits for a claim that is caused by, contributed to by, or resulting from voluntary use of or treatment for voluntary use of any prescription or non-prescription drug, alcohol, poison, fume, or other chemical substance unless taken as prescribed or directed by the Insured's Physician.

Additionally, no benefits will be paid for a Covered Loss that occurs prior to the Coverage Effective Date.

The **Claim Procedures** provision in the **Claims Provisions** section of the certificate is amended so that notification of a claim decision and payment issued for a Payable Claim is within 30 days.

The **Appeal Procedures** provision in the **Claim Provisions** section of the certificate is amended to reflect that the appeals specialist is a person different from the person who made the initial determination and such person will not be the original decision maker's subordinate or the supervisor of the person making the initial determination.

The **Assignment** provision in the **General Provisions** section of the certificate is amended to reflect that in no event may an Insured's assignee be a healthcare provider.

The **Contestability** provision in the **General Provisions** section of the certificate is amended to remove reference to Fraud. Language has been replaced to read as follows:

However, in the event of nonpayment of an Insured's premium, we can take action at any time under the provision titled Cancellation or Modification to the Policy and this Certificate of Coverage and as permitted by applicable law.

The **Injury** definition in the **Glossary** section of the certificate is amended to read "Any damage or harm to the body.

The **Nurse** definition in the **Glossary** section of the certificate is amended to define a Nurse to include an Advanced Practice Registered Nurse, graduate Registered Nurse (R.N.), Licensed Practical Nurse (L.P.N.), or Licensed Vocational Nurse (L.V.N.).

For residents of Ohio

The **Newborn Coverage Feature** provision in the **Accident Details** section of the certificate is amended as follows:

Newborn Coverage Feature
Your newborn, newly adopted, or Children placed for adoption will automatically be covered for 31 days from their Coverage Eligibility Date if you are insured.

If you wish to continue Child coverage, you must notify us on or before the end of the 31 day period and pay any additional premium.

If you already have coverage for your Children, then all eligible Children will be covered and you do not need to notify us or pay any additional premium for the newly eligible Child.

The **Payment of Benefits** provision in the **Claim Provisions** section of the certificate is amended so that benefits for which we are liable will be paid immediately or within 30 days after receipt of satisfactory Written Proof of Loss.

The **Children** definition in the **Glossary** section of the certificate for "your lawfully adopted child as of the earliest of the date" is amended as follows:

- your lawfully adopted child as of the earliest of the date;

- the child is placed in your home or in a medical facility;
- you have initiated adoption proceedings;
- a petition is filed for you to adopt the child; or
- an adoption agreement, signed by you that includes your binding obligation to assume financial responsibility for the child.

For residents of South Dakota

The **Exclusions** provision in the **Accident Details** section of the certificate for "operating any motorized vehicle while intoxicated" is replaced with the following:

- commission of a felony while operating any motorized vehicle while intoxicated.

The **Exclusions** provision in the **Accident Details** section of the certificate for Accidental Death and Dismemberment Benefits is amended so that any exclusions for claims caused by, contributed to by, or resulting from any of the following:

- being intoxicated; and
- voluntary use of or treatment for voluntary use of any prescription or non-prescription drug, alcohol, poison, fume, or other chemical substance unless taken as prescribed or directed by the Insured's Physician.

are removed.

For purposes of the definition of **Children** in the **Glossary** section of the certificate, Children are defined as any Children born to age 26.

The **Physician** definition in the **Glossary** section of the certificate is amended as follows:

A person performing tasks that are within the limits of their medical license and is also:
- a legally qualified medical practitioner according to the laws and regulations of the governing jurisdiction;
- licensed to practice medicine, prescribe and administer drugs, or to perform surgery; or
- a person with a doctoral degree in Psychology (Ph.D. or Psy.D.) whose primary practice is treating patients.

We will not recognize you, your Spouse, Children, parents, siblings, a business or professional partner, or any person who has a financial affiliation or business interest with you, as a Physician for a claim that you send to us. This exclusion does not apply in those areas in which the above mentioned person is the only Physician in the area and acting within the scope of their normal employment.

For residents of Texas

The **Recovery Care Benefits** in the **Accident Highlights** section of the certificate has been amended to add Acquired Brain Injury, Telehealth Service, and Telemedicine Medical Service.

An **Acquired Brain Injury** benefit has been added to the **Recovery Care Benefits** category in the **Accident Details** section of the certificate as follows:

Acquired Brain Injury
Benefit Description
We will pay the amount shown in the Schedule of Benefits if an Insured requires services, therapies, or treatment as a result of an Acquired Brain Injury sustained in a Covered Accident.

For purposes of this benefit, the following are considered services, therapies, and treatment for an Acquired Brain Injury:
- Cognitive Communication Therapy;
- Cognitive Rehabilitation Therapy;
- Community Reintegration Services;
- Neurobehavioral;

- Neurocognitive Therapy and Rehabilitation;
- Neurofeedback Therapy;
- Neurophysiological;
- Neuropsychological;
- Post-acute Transition Services;
- Psychophysiological Testing or Treatment; and
- Remediation.

A Physician must prescribe the services, therapies, or treatment, and they must be performed at a Physician's office or at a Hospital on an inpatient or Outpatient Basis.

Benefit Duration
This benefit is payable up to a maximum of six services, therapies, or treatment per Insured per Covered Accident.

A **Telehealth** benefit has been added to the **Recovery Care Benefits** category in the Accident Details section of the certificate as follows:

Telehealth Service
Benefit Description
We will pay the amount shown in the Schedule of Benefits if an Insured receives the Telehealth Service as a result of a Covered Accident.

The Telehealth Service must be provided within 60 days of the Covered Accident.

For purposes of this benefit, routine examinations or preventive testing do not meet the Benefit Description of Telehealth Service.

Benefit Duration
This benefit is payable once per Insured per Covered Accident.

A **Telemedicine Medical Service** benefit has been added to the **Recovery Care Benefits** category in the Accident Details section of the certificate as follows:

Telemedicine Medical Service
Benefit Description
We will pay the amount shown in the Schedule of Benefits if an Insured receives the Telemedicine Medical Service as a result of a Covered Accident.

The Telemedicine Medical Service must be provided within 60 days of the Covered Accident.

For purposes of this benefit, routine examinations or preventive testing do not meet the Benefit Description of Telemedicine Medical Service.

Benefit Duration
This benefit is payable once per Insured per Covered Accident.

The **Fraud** provision in the **General Provisions** section of the certificate is amended as follows:

We want to make sure you and your Employer do not incur additional insurance costs as the result of the undermining effects of insurance fraud. We promise to focus on all means necessary to support fraud detection, investigation, and prosecution.

Anyone who knowingly, and with intent to injure, defraud, or deceive us may be guilty of Fraud as determined by a court of law. This includes filing a claim or providing information that contains any false, incomplete, or misleading information.

These actions will result in denial of a claim, and are subject to prosecution and punishment to the full extent under state and federal law. We will pursue all appropriate legal remedies in the event of insurance fraud.

The **Payment of Benefits** provision in the **Claim Provisions** section of the certificate is amended as follows:

Payment of Benefits
Benefits for which we are liable will be paid after we complete the Claims Procedures. All benefits will be paid to you, unless we receive Written authorization to pay them elsewhere. This is an assignment of benefits. Benefits for Children who are receiving financial and medical benefits through the Texas Department of Human Services will be paid to the Texas Department of Human Services whenever:

- the Texas Department of Human Services is paying benefits pursuant to Chapters 31 and 32 of the Human Resources Code, i.e., financial and medical assistance service programs administered pursuant to the Human Resources Code;
- the parent who is covered by this certificate has possession or access to the Child pursuant to a court order, or is not entitled to access or possession of the Child and is required by the court to pay child support; and
- we are notified at the time of claim that the Child is receiving financial and medical assistance.

In addition, benefits for Children may also be paid to a possessory or managing conservator of the Child if the appointment for that Child was issued by a court in this or another state.

In the event of your death, any unpaid benefits will be paid to your beneficiary in accordance with the Beneficiary Designation and Change provision or, if required, to the Texas Department of Human Services.

In the event of your Spouse's death, should your Spouse have survived you and continued coverage, any unpaid benefits for your Spouse, will be paid to your surviving Spouse's beneficiary in accordance with the Beneficiary Designation and Change provision.

The **Glossary** section of the certificate has been amended to include the following definitions:

Cognitive Communication Therapy
Services designed to address modalities of comprehension and expression, including understanding, reading, writing, and verbal expression of information.

Cognitive Rehabilitation Therapy
Services designed to address therapeutic cognitive activities, based on an assessment and understanding of the individual's brain-behavioral deficits.

Community Reintegration Services
Services that facilitate the continuum of care as an affected individual transitions into the community.

Neurobehavioral Testing
An evaluation of the history of neurological and psychiatric difficulty, current symptoms, current mental status, and premorbid history, including the identification of problematic behavior and the relationship between behavior and the variables that control behavior. This may include interviews of the individual, family, or others.

Neurobehavioral Treatment
Interventions that focus on behavior and the variables that control behavior.

Neurocognitive Rehabilitation
Services designed to assist cognitively impaired individuals to compensate for deficits in cognitive functioning by rebuilding cognitive skills and/or developing compensatory strategies and techniques.

Neurocognitive Therapy
Services designed to address neurological deficits in informational processing and to facilitate the development of higher level cognitive abilities.

Neurofeedback Therapy
Services that utilize operant conditioning learning procedure based on electroencephalography (EEG) parameters, and which are designed to result in improved mental performance and behavior, and stabilized mood.

Neurophysiological Testing
An evaluation of the functions of the nervous system.

Neurophysiological Treatment
Interventions that focus on the functions of the nervous system.

Neuropsychological Testing
The administering of a comprehensive battery of tests to evaluate neurocognitive, behavioral, and emotional strengths and weaknesses and their relationship to normal and abnormal central nervous system functioning.

Neuropsychological Treatment
Interventions designed to improve or minimize deficits in behavioral and cognitive processes.

Post-acute Transition Services
Services that facilitate the continuum of care beyond the initial neurological consult through rehabilitation and community reintegration.

Psychophysiological Testing
An evaluation of the interrelationships between the nervous system and other bodily organs and behavior.

Psychophysiological Treatment
Interventions designed to alleviate or decrease abnormal physiological responses of the nervous system due to behavioral or emotional factors.

Remediation
The process(es) of restoring and improving a specific function.

Telehealth Services
A health service, other than a Telemedicine Medical Service, delivered by a licensed or certified health professional acting within the scope of the health professional's license or certification who does not perform a Telemedicine Medical Service that requires the use of advanced telecommunications technology, other than by telephone or facsimile, including:
- compressed digital interactive video, audio, or data transmission;
- clinical data transmission using computer imaging by way of still-image capture and store and forward; and
- other technology that facilitates access to health care services or medical specialty expertise.

Telemedicine Medical Service
A health care service initiated by a Physician or provided by a health professional acting under Physician delegation and supervision, for purposes of patient assessment by a health professional, diagnosis or consultation by a Physician, treatment, or the transfer of medical data, that requires the use of advanced telecommunications technology, other than by telephone or facsimile, including:
- compressed digital interactive video, audio, or data transmission;
- clinical data transmission using computer imaging by way of still-image capture and store and forward; and
- other technology that facilitates access to health care services or medical specialty expertise.

For residents of Utah

The **Burns** benefit in the **Accident Details** section of the certificate has been amended to allow a Physician to diagnose the Burn within 90 days of the Covered Accident or as soon as reasonably possible.

The **Concussion** benefit in the **Accident Details** section of the certificate has been amended to allow a Physician to diagnose the Concussion within 14 days of the Covered Accident or as soon as reasonably possible.

The **Connective Tissue Damage** benefit in the **Accident Details** section of the certificate has been amended to allow a Physician to diagnose the Connective Tissue Damage within 90 days of the Covered Accident or as soon as reasonably possible.

The **Dislocations** benefit in the **Accident Details** section of the certificate has been amended to allow a Physician to set the dislocated joint within 90 days of the Covered Accident or as soon as reasonably possible.

The **Eye Injury** benefit in the **Accident Details** section of the certificate has been amended to allow a Physician to remove the object within 90 days of the Covered Accident or as soon as reasonably possible.

The **Fractures** benefit in the **Accident Details** section of the certificate has been amended to allow a Physician to confirm the bone fracture within 90 days of the Covered Accident by X-ray or other medical imaging study or as soon as reasonably possible.

The **Internal Injuries** benefit in the **Accident Details** section of the certificate has been amended to allow a Physician to diagnose the Internal Injury within 90 days of the Covered Accident or as soon as reasonably possible and to remove "internal bleeding" from the description criteria of Internal Injuries.

The **Knee Cartilage (Meniscus) Injury** benefit in the **Accident Details** section of the certificate has been amended to allow a Physician to confirm the Knee Cartilage (Meniscus) Injury within 90 days or as soon as reasonably possible of the Covered Accident by an MRI, other medical imaging study, or Surgical Procedure.

The **Lacerations** benefit in the **Accident Details** section of the certificate has been amended to allow a Physician to treat the Laceration within three days of the Covered Accident or as soon as reasonably possible.

The **Loss of a Digit** benefit in the **Accident Details** section of the certificate has been amended to allow a Physician to treat the Loss of a Digit within 90 days of the Covered Accident or as soon as reasonably possible.

The **Ruptured or Herniated Disc** benefit in the **Accident Details** section of the certificate has been amended to allow a Physician to diagnose the Ruptured or Herniated Disc within 90 days of the Covered Accident or as soon as reasonably possible.

The **Ambulance** benefit in the **Accident Details** section of the certificate has been amended to allow the Ambulance transportation within 180 days of the Covered Accident or as soon as reasonably possible.

The **Emergency Department** benefit in the **Accident Details** section of the certificate has been amended to allow the Emergency Department treatment within three days of the Covered Accident or as soon as reasonably possible.

The **Injections to Prevent or Limit Infection** benefit in the **Accident Details** section of the certificate has been amended to allow a Physician to administer the injection within 180 days of the Covered Accident or as soon as reasonably possible.

The **Medical Imaging** benefit in the **Accident Details** section of the certificate has been amended to allow Medical Imaging to happen within 180 days of the Covered Accident or as soon as reasonably possible.

The **Pain Management Injections** benefit in the **Accident Details** section of the certificate has been amended to allow a Physician to administer the injection within 180 days of the Covered Accident or as soon as reasonably possible.

The **Skin Grafts** benefit in the **Accident Details** section of the certificate has been amended to allow the Insured to receive the Skin Graft within 180 days of the Covered Accident or as soon as reasonably possible.

The **Transfusions** benefit in the **Accident Details** section of the certificate has been amended to allow the Insured to receive the Transfusion within 180 days of the Covered Accident or as soon as reasonably possible.

The **Transportation** benefit in the **Accident Details** section of the certificate has been amended to allow the Transportation within 180 days of the Covered Accident or as soon as reasonably possible.

The **Treatment in a Physician's Office or Urgent Care Facility** benefit in the **Accident Details** section of the certificate has been amended to allow for treatment within 14 days of the Covered Accident or as soon as reasonably possible.

The **Admission** benefit in the **Accident Details** section of the certificate has been amended to allow the Admission and Confinement within 180 days of the Covered Accident or as soon as reasonably possible.

The **Admission - Hospital ICU** benefit in the **Accident Details** section of the certificate has been amended to allow the Admission and Confinement within 180 days of the Covered Accident or as soon as reasonably possible.

The **Daily Stay** benefit in the **Accident Details** section of the certificate has been amended to allow the Confinement within 180 days of the Covered Accident or as soon as reasonably possible.

The **Daily Stay - Hospital ICU** benefit in the **Accident Details** section of the certificate has been amended to allow the Confinement within 180 days of the Covered Accident or as soon as reasonably possible.

The **Coma** benefit in the **Accident Details** section of the certificate has been amended to define a Coma as a continuous state of profound unconsciousness characterized by the absence of eye opening, verbal response, and motor response.

The **Exclusions** provision in the **Accident Details** section of the certificate is amended by providing that any exclusion for claims caused by or resulting from commission of or attempt to commit a felony; engaging in an illegal occupation or activity; or participation in a riot, insurrection, or terrorist activity is applied only if you were a voluntary participant.

The **Exclusions** provision in the **Accident Details** section of the certificate is amended so that any exclusion for claims caused by or resulting from "operating any motorized vehicle while intoxicated" reads as follows:

- operating any motorized vehicle while intoxicated in violation of a law. For purposes of this exclusion, "intoxicated" means the Insured's blood alcohol level met or exceeded the level that creates a legal presumption of intoxication under the laws of the jurisdiction in which the incident occurred.

The **Exclusions** provision in the **Accident Details** section of the certificate is amended so that any Accidental Death and Dismemberment Benefit claims caused by or resulting from "being intoxicated" reads as follows:

- being intoxicated at the time of the incident while operating a vehicle or other device involved in the incident in violation of a law. For purposes of this exclusion, "intoxicated" means the Insured's blood alcohol level met or exceeded the level that creates a legal presumption of intoxication under the laws of the jurisdiction in which the incident occurred; and

The **Children** definition in the **Glossary** section of the certificate is amended as follows:

Any child from the moment of birth to age 26 who is:
- your own natural offspring;
- your Spouse's child;
- your lawfully adopted child as of the earliest of the date:
  - the child is placed in your home or in a medical facility. If placement for adoption occurs within 30 days of the child's birth, coverage begins from the moment of birth. If placement for adoption occurs 30 days or more after the child's birth, coverage begins from the date of placement;
  - you have initiated adoption proceedings;
  - a petition is filed for you to adopt the child; or
  - an adoption agreement, signed by you that includes your binding obligation to assume financial responsibility for the child;
- a foster child placed with you by an authorized placement agency or by judgment, decree, or other order of any court of competent jurisdiction; or
- any other child for whom you are required by court or administrative order to provide coverage for.

Coverage for your Child may be continued past age 26 if your Child is incapable of self-sustaining employment due to permanent intellectual or physical incapacity prior to reaching age 26 and is dependent upon you for support and maintenance.

You must submit proof of the Child's incapacity and dependency to us within 120 days of the Child's 26th birthday or we will accept proof within 120 days of the Child's Coverage Eligibility Date that the Child was continuously covered under this or another similar group policy since age 26. Ongoing proof of incapacity and dependency must be provided when requested by us, but not more frequently than once a year.

Your Children may not be Insured as both a Child and an Employee.

Your Children may not be Insured by more than one Employee.

The **Hospital** definition in the **Glossary** section of the certificate has been amended as follows:

An institution licensed as a hospital and operating within the scope of its license and provides medically necessary hospital confinement or treatment for sick or injured people.

For purposes of this certificate, the following hospital units meet the Glossary definition of Hospital:
- Hospital Subacute ICU;
- Progressive Care Unit;
- Intermediate Care Unit; and
- Step-Down Unit.

For purposes of this certificate, the following do not meet the Glossary definition of Hospital:
- a nursing home, a rest home, home for the aged, or an assisted living facility;
- a hospice care facility;
- a Rehabilitation or Subacute Rehabilitation Unit;
- a psychiatric unit or facility for the treatment of Mental or Nervous Disorders; and
- a facility for the treatment of Substance Abuse.

The **Nurse** definition in the **Glossary** section of the certificate has been amended to be defined as a healthcare professional trained, duly licensed, and operating within the scope of their license, to care for people with Injuries or Sicknesses.

The **Occupational Therapist** definition in the **Glossary** section of the certificate has been amended to be defined as a healthcare professional licensed by the state to practice Occupational Therapy, who performs services which are allowed by their license.

The **Physician** definition in the **Glossary** section of the certificate has been amended to be defined as a person performing tasks that are within the limits of their medical license.

The **Speech Therapist** definition in the **Glossary** section of the certificate has been amended to be defined as a healthcare professional licensed by the state to practice Speech Therapy, who performs services which are allowed by their license.

For residents of Vermont

The state of **Vermont** requires us to notify you that the provisions in the Policy, including those in the Certificate of Coverage, conform to the minimum requirements of Vermont law. The minimum requirements of Vermont law will apply to your claim.

The minimum hours requirement of the **Eligible Groups** provision in the **Accident Highlights** section of the certificate is amended to cover eligible employees working at least 17.5 hours per week.

The **Emergency Dental Repair** benefit in the **Accident Details** section of the certificate has been amended to allow an Emergency Dental Repair to be made within 365 days of the Covered Accident.

The **Injections to Prevent or Limit Infection** benefit in the **Accident Details** section of the certificate has been amended to allow a Physician to administer the injection within 365 days of the Covered Accident.

The **Medical Imaging** benefit in the **Accident Details** section of the certificate has been amended to allow Medical Imaging to happen within 365 days of the Covered Accident.

The **Pain Management Injections** benefit in the **Accident Details** section of the certificate has been amended to allow a Physician to administer the injection within 365 days of the Covered Accident.

The **Skin Grafts** benefit in the **Accident Details** section of the certificate has been amended to allow the Insured to receive the Skin Graft within 365 days of the Covered Accident.

The **Transfusions** benefit in the **Accident Details** section of the certificate has been amended to allow the Insured to receive the Transfusion within 365 days of the Covered Accident.

The **Treatment in a Physician's Office or Urgent Care Facility** benefit in the **Accident Details** section of the certificate has been amended to allow for treatment within 365 days of the Covered Accident.

The **Rehabilitation or Subacute Rehabilitation Unit** benefit in the **Accident Details** section of the certificate has been amended to allow for a benefit payable up to a maximum of 30 days per Insured per Covered Accident.

The **Exclusions** provision in the **Accident Details** section of the certificate is amended by providing that any exclusion for claims caused by, contributed to by, or resulting from injuring oneself intentionally or attempting or committing suicide, whether sane or not is applied only if you were sane when the event occurred.

The **Exclusions** provision in the **Accident Details** section of the certificate is amended by providing that any exclusion for claims caused by, contributed to by, or resulting from any Sickness, bodily infirmity, or other abnormal physical condition, including diagnosis, treatment, or surgery for it is amended to exclude Mental or Nervous Disorders.

The **Exclusions** provision in the **Accident Details** section of the certificate is amended so that any Accidental Death and Dismemberment Benefit claims caused by, contributed to by, or resulting from:

- being intoxicated; and
- voluntary use of or treatment for voluntary use of any prescription or non-prescription drug, alcohol, poison, fume, or other chemical substance unless taken as prescribed or directed by the Insured's Physician.

are removed.

The **Autopsy** provision in the **Claim Provisions** section of the certificate is amended so that when we request an Autopsy where it is allowed by law, and not prohibited by the Insured's religion, it will be at our expense.

The **Fraud** provision in the **General Provisions** section of the certificate is amended as follows:

> We want to make sure you and your Employer do not incur additional insurance costs as the result of the undermining effects of insurance fraud. We promise to focus on all means necessary to support fraud detection, investigation, and prosecution.
>
> Anyone who knowingly, and with intent to injure, defraud, or deceive us may be guilty of Fraud as determined by a court of law. This includes filing a claim or providing information that contains any false, incomplete, or misleading information.
>
> These actions will result in denial of a claim, and are subject to prosecution and punishment to the full extent under state and federal law. We will pursue all appropriate legal remedies in the event of insurance fraud.

For purposes of the definition of **Children** in the **Glossary** section of the certificate, Children are defined as any Children born to age 26.

The **Covered Accident** definition in the **Glossary** section of the certificate is amended as follows:

> A bodily Injury sustained by an Insured, which is the direct cause of the loss, independent of disease or bodily infirmity and which:
> - occurs on or after the Coverage Effective Date;
> - occurs while coverage is in force; and
> - is not excluded by name or specific description in this certificate.

The **Hospital** definition in the **Glossary** section of the certificate has been amended to remove the following criteria from what does not meet the Glossary definition of Hospital:

- a psychiatric unit or facility for the treatment of Mental or Nervous Disorders; and
- a facility for the treatment of Substance Abuse.

The **Mental or Nervous Disorders** definition in the **Glossary** section of the certificate is removed in its entirety.

The **Rehabilitation Unit** definition in the **Glossary** section of the certificate has been amended to remove the following criteria from what does not meet the Glossary definition of Rehabilitation Unit:

- a psychiatric unit or facility for the treatment of Mental or Nervous Disorders; and
- a facility for the treatment of Substance Abuse.

The **Subacute Rehabilitation Unit** definition in the Glossary section of the certificate has been amended to remove the following criteria from what does not meet the Glossary definition of Subacute Rehabilitation Unit:

- a psychiatric unit or facility for the treatment of Mental or Nervous Disorders; and
- a facility for the treatment of Substance Abuse.

The **Substance Abuse** definition in the **Glossary** section of the certificate is removed in its entirety.

ERISA

Additional Summary Plan Description Information

If the Policy provides benefits under a Plan which is subject to the Employee Retirement Income Security Act of 1974 (ERISA), the following provisions apply. These provisions, together with your Certificate of Coverage, constitute the summary plan description. The summary plan description and the Policy constitute the Plan. Benefit determinations are controlled exclusively by the Policy, your Certificate of Coverage and the information contained in this document.

Name of Plan:
Truist Financial Corporation Plan

Name and Address of Employer:
Truist Financial Corporation
214 North Tryon Street
Charlotte, North Carolina
28202

Plan Identification Number:
a. Employer IRS Identification #: 56-0939887
b. Plan #: 508

Type of Welfare Plan:
Accident

Type of Administration:
The Plan is administered by the Plan Administrator. Benefits are administered by the insurer and provided in accordance with the insurance policy issued to the Plan.

ERISA Plan Year Ends:
December 31

Plan Administrator, Name, Address, and Telephone Number:
Truist Financial Corporation
214 North Tryon Street
Charlotte, North Carolina
28202
(800) 716-2455

Truist Financial Corporation is the Plan Administrator and named fiduciary of the Plan, with authority to delegate its duties. The Plan Administrator may designate Trustees of the Plan, in which case the Administrator will advise you separately of the name, title and address of each Trustee.

Agent for Service of Legal Process on the Plan:
Truist Financial Corporation
214 North Tryon Street
Charlotte, North Carolina
28202

Service of legal process may also be made upon the Plan Administrator, or a Trustee of the Plan, if any.

Funding and Contributions:
The Plan is funded by insurance issued by Unum Insurance Company, 2211 Congress Street, Portland, Maine 04122, under 803177 012. Contributions to the Plan are made as stated under Paying for Coverage in the Certificate of Coverage.

Employer's Right to Amend the Plan
The Employer reserves the right, in its sole and absolute discretion, to amend, modify, or terminate, in whole or in part, any or all of the provisions of the Plan (including any related documents and underlying

policies), at any time and for any reason or no reason. Any amendment, modification, or termination must be in Writing and endorsed on or attached to the Plan.

Employer's Right to Request Policy Change

The Employer can request a Policy change. A change to the Policy will be made valid once approved by one of our officers. The change must be in Writing and endorsed on or attached to the Policy.

Cancellation of the Policy by the Employer

The Employer may cancel the Policy by providing us Written notice. In any event of cancellation, coverage will continue through the end of the day the cancellation takes effect.

A cancellation of the Policy will not affect a Payable Claim.

Cancellation or Modification of the Policy by Us

In addition, we may cancel or modify the Policy if the Policy terms are not met, the Employer fails to satisfy its obligations, premium is not paid, a change in the Employer or in the law impacts the benefits payable or the risks insured or, depending on the Policy, at our election after any rate guarantee period.

In any event, we will provide Written notice to the Employer prior to any cancellation or modification date. The Employer may cancel the Policy if it chooses not to accept the Policy modifications made by us.

A cancellation of the Policy will not affect a Payable Claim.

Your Rights Under ERISA

As a participant in the Plan you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all Plan participants shall be entitled to:

Receive Information About Your Plan and Benefits

Examine, without charge, at the Plan Administrator's office and at other specified locations, all documents governing the Plan, including insurance contracts, 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.

Obtain, upon Written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The Plan Administrator may make a reasonable charge for the copies.

Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for Plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other Plan participants and beneficiaries. No one, including your Employer or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a benefit or exercising your rights under ERISA.

Enforce Your Rights

If your claim for a 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 up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator.

If you have a claim for benefits that is denied or ignored, in whole or in part, you may file suit in a state or federal court. If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated

against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, if, for example, it finds your claim is frivolous.

Assistance with Your Questions

If you have any questions about your Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security 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.

Privacy Notice

This Privacy Notice applies to Unum Group's United States insurance operations and is being provided on behalf of its affiliates listed below ("Unum" "we"), as required by the Gramm-Leach Bliley Act and state insurance laws. This Notice describes how we collect, share, and protect nonpublic personal information (NPI).

COLLECTING INFORMATION
We collect NPI about our customers to provide them with insurance products and services, perform underwriting, provide stop loss coverage, and administer claims. The types of NPI we collect for these purposes may include telephone number, address, Social Security number, date of birth, occupation, income, and medical history, including treatment. We may receive NPI from your applications and forms, medical providers, other insurers, employers, insurance support organizations and service providers.

SHARING INFORMATION
We share the types of NPI described above primarily with people who perform insurance, business and professional services for us, such as helping us perform underwriting, provide stop loss coverage, pay claims, detect fraud, and to provide reinsurance or auditing. We may share NPI with medical providers for insurance and treatment purposes and with insurance support organizations. The organizations may retain the NPI and disclose it to others for whom it performs services. In certain cases, we may share NPI with group policyholders for reporting and auditing purposes, with parties for a proposed or final sale of insurance business or for study purposes. We may also share NPI when otherwise required or permitted by law, such as sharing with governmental or other legal authorities. When legally necessary, we ask your permission before sharing NPI about you. Our practices apply to our former, current and future customers.

We do not share your health NPI to market any product or service. We also do not share any NPI to market non-financial products and services.

The law allows us to share NPI as described above (except health information) with affiliates to market financial products and services. The law does not allow you to restrict these disclosures. We may also share with companies that help us market our insurance products and services, such as vendors that provide mailing services to us. We may share with other financial institutions to jointly market financial products and services. When required by law, we ask your permission before we share NPI for marketing purposes.

When other companies help us conduct business, we expect them to follow applicable privacy laws. We do not authorize them to use or share NPI except when necessary to conduct the work they are performing for us or to meet regulatory or other governmental requirements.

Unum companies, including insurers and insurance service providers, may share NPI about you with each other. The NPI might not be directly related to our transaction or experience with you. It may include financial or other personal information such as employment history. Consistent with the Fair Credit Reporting Act, we ask your permission before sharing NPI that is not directly related to our transaction or experience with you.

SAFEGUARDING INFORMATION
We have physical, electronic and procedural safeguards that protect the confidentiality and security of NPI. We give access only to employees who need to know the NPI to provide insurance products or services to you.

ACCESS TO INFORMATION
You may request access to certain NPI we collect to provide you with insurance products and services. You must make your request in writing, providing your full name, address, telephone number and policy number, to the address below. We will reply within 30 business days of receipt. If you request, we will send copies of the NPI to you or make available to you at our office. If the NPI includes health information, we may provide the health information to you through a health care provider you designate. We will also send you information related to disclosures. We may charge a reasonable fee to cover our copying costs.

This section applies to NPI we collect to provide you with coverage. It does not apply to NPI we collect in anticipation of a claim or civil or criminal proceeding.

CORRECTION OF INFORMATION
If you believe the NPI we have about you is incorrect, please write to us and include your full name, address, telephone number and policy number if we have issued a policy, and the reason you believe the NPI is inaccurate. We will reply within 30 business days of receipt. If we agree with you, we will correct the NPI and

notify you and insurance support organizations that may have received NPI from us in the preceding 7 years. We will also, if you ask, notify any person who may have received the incorrect NPI from us in the past 2 years.

If we disagree with you, we will tell you we are not going to make the correction and the reason(s) for our refusal. We will also tell you that you may submit a statement to us. Your statement should include the NPI you believe is correct and the reason(s) why you disagree with our decision not to correct the NPI in our files. We will file your statement with the disputed NPI to be accessible. We will include your statement any time the disputed NPI is reviewed or disclosed. We will also give the statement to insurance support organizations that gave us NPI and to any person designated by you, if we disclosed the disputed NPI to that person in the past two years.

COVERAGE DECISIONS
If we decide not to issue coverage to you, we will provide you with the specific reason(s) for our decision. We will also tell you how to access and correct certain NPI. You may submit a written request for the reason(s) for our decision within 90 business days of our decision. We will reply within 21 business days of receipt with the specific reasons, if not initially furnished, and specific items of information that supported our decision.

CONTACTING US
For additional information about Unum's commitment to privacy and to view a copy of our HIPAA Privacy Notice, please visit: unum.com/privacy or coloniallife.com. You may also write to: Privacy Officer, Unum, 2211 Congress Street, B267, Portland, Maine 04122 or at Privacy@unum.com.

We reserve the right to modify this notice. We will provide you with a new notice if we make material changes to our privacy practices.

Unum is providing this notice to you on behalf of the following insuring companies: Unum Life Insurance Company of America, Unum Insurance Company, First Unum Life Insurance Company, Provident Life and Accident Insurance Company, Provident Life and Casualty Insurance Company, Colonial Life & Accident Insurance Company, The Paul Revere Life Insurance Company and Starmount Life Insurance Company.

unum.com MK-1883 (06-2020)

NOTICE CONCERNING COVERAGE LIMITATIONS AND EXCLUSIONS UNDER THE NORTH CAROLINA LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION ACT

Residents of this state who purchase life insurance, annuities or health insurance should know that the insurance companies and Health Maintenance Organizations (HMOs) licensed in this state to write these types of insurance are members of the North Carolina Life and Health Insurance Guaranty Association. The purpose of this association is to assure that policyholders will be protected, within limits, in the unlikely event that a member insurer or HMO becomes financially unable to meet its obligations. If this should happen, the guaranty association will assess its other member companies for the money to pay the claims of the insured person who live in this state and, in some cases, to keep coverage in force. The valuable extra protection provided by these insurers through the guaranty association is not unlimited, however. And, as noted below, this protection is not a substitute for consumers' care in selecting companies that are well-managed and financially stable.

The North Carolina Life and Health Insurance Guaranty Association may not provide coverage for this policy. If coverage is provided, it may be subject to substantial limitations or exclusions, and require continued residency in North Carolina. You should not rely on coverage by the North Carolina Life and Health Insurance Guaranty Association in selecting an insurance company or in selecting an insurance policy.

Coverage is NOT provided for a policy or any portion of it that is not guaranteed by the insurer or for which you have assumed the risk, such as a variable contract sold by prospectus.

Insurance companies or their agents are required by law to give or send you this notice. However, insurance companies and their agents are prohibited by law from using the existence of the guaranty association to induce the purchase any kind of insurance policy.

North Carolina Life and Health Insurance Guaranty Association
4441 SIX FORKS RD STE 106-153
RALEIGH NC 27609-5729

North Carolina Department of Insurance, Consumer Services Division
1201 Mail Service Center
Raleigh, North Carolina 27699-1201

The state law that provides for this safety-net coverage is called the North Carolina Life and Health Insurance Guaranty Association Act. Below is a brief summary of this law's coverages, exclusions and limits. This summary does not cover all provisions of the law; nor does it in any way change anyone's rights or obligations under the act or the rights or obligations of the guaranty association.

COVERAGE

Generally, individuals will be protected by the life and health guaranty association if they live in this state and hold a life or health insurance contract, or an annuity, or if they are insured under a group insurance contract, issued by a member insurer or HMO. The beneficiaries, payees or assignees of the insured persons are protected as well, even if they live in another state.

EXCLUSIONS FROM COVERAGE

However, persons holding such policies are **not** protected by this association if:

- They are eligible for protection under the laws of another state (this may occur when the insolvent insurer was incorporated in another state whose guaranty association protects insureds who live outside that state);
- The insurer was not authorized to do business in this state;
- Their policy was issued by a fraternal benefit society, a mandatory state pooling plan, a mutual assessment company or similar plan in which the policyholder is subject to future assessments, or by an insurance exchange.

- They acquired rights to receive payment through a structured settlement factoring transaction.

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

- Any policy or portion of a policy which is not guaranteed by the insurer or for which the individual has assumed the risk, such as a variable contract sold by prospectus;
- Any policy of reinsurance (unless an assumption certificate was issued);
- Interest rate yields that exceed the average rate specified in the law;
- Dividends;
- Experience or other credits given in connection with the administration of a policy by a group contract holder;
- Employers' plans to the extent they are self-funded (that is, not insured by an insurance company, even if an insurance company administers them);
- Unallocated annuity contracts (which give rights to group contract holders, not individuals), unless they fund a government lottery or a benefit plan of an employer, association or union, except that unallocated annuities issued to employee benefit plans protected by the Federal Pension Benefit Guaranty Corporation are not covered;
- A policy or contract commonly known as Medicare Part C, Medicare Part D, Medicaid or any regulations issued pursuant thereto.

LIMITS ON AMOUNT OF COVERAGE

The act also limits the amount the association is obligated to pay out as follows:

(1) The guaranty association cannot pay out more than the insurance company would owe under the policy or contract.
(2) Except as provided in (3), (4) and (5) below, the guaranty association will pay a maximum of $300,000 per individual, per insolvency, no matter how many policies or types of policies issued by the insolvent company.
(3) The guaranty association will pay a maximum of $500,000 with respect to a health benefit plan.
(4) The guaranty association will pay a maximum of $1,000,000 with respect to the payee of a structured settlement annuity.
(5) The guaranty association will pay a maximum of $5,000,000 to any one unallocated annuity contract holder.