T-Mobile USA, Inc. Employee Benefit Plan
Book 2

Summary Plan Description for Short-Term Disability Plans

Insurance Certificates for Long Term Disability

Insurance Certificates for Basic Life, Basic AD&D and Voluntary Life and AD&D Plans

Insurance Certificate for Group Business Travel Accident Insurance and Global Travel Coverage

Insurance Certificates for Legal Plan and Supplemental Health Plans

Effective January 1, 2026

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Welcome

WHAT'S INSIDE

This document serves as a Summary Plan Description (SPD) for the benefits that are governed by ERISA and as a summary for all other benefits described below. The SPD contains important information regarding your benefits under the T-Mobile USA, Inc. Employee Benefit Plan (the "Plan") and other benefits offered by T-Mobile partners to T-Mobile Employees. This Plan provides benefits to eligible T-Mobile USA, Inc. Employees. The following benefit summaries are only summaries of these benefits—not complete descriptions in every detail.

This Summary Plan Description and summaries, along with the certificates or policies of insurance and the policies and procedures utilized with respect to any adverse benefit determination, shall constitute the ERISA Plan Document ("Plan Document"). For the sake of convenience, this document will be referred to as the SPD even though it also, together with other documents, serves as the Plan Document for the ERISA benefits offered under the Plan and a summary for other benefits.

Every effort has been made to ensure the accuracy of each benefit summary. Should a conflict arise, the legal terms of the appropriate Plan Document, and not the benefit summaries, will control.

INTRODUCTION TO OUR BENEFIT PLANS

The benefits described in this handbook are a valuable part of your total compensation package. They are designed to promote your health and well-being, along with that of your family. They help make necessary health care services more affordable. If you have dependents that need care while you work, there's a benefit plan that can save you money on the cost of that care.

Benefits Offered:

The Plan offers the following benefits, some of which are governed by the Employee Retirement Income Security Act of 1974 ("ERISA"):

- Disability Income Plans, which protect a portion of your income if you become too ill or injured to work;
- Life and Accidental Death & Dismemberment (AD&D) Insurance; and
- Business Travel Accident Insurance.
- Voluntary Benefits

THE COMPANY'S RIGHTS AND RESPONSIBILITIES

T-Mobile USA, Inc. (sometimes referred to in this SPD as simply the "Company") reserves the right to change, suspend or discontinue the Plan, including any or all of its component programs, in whole or in part, at any time and for any reason. The Company does not promise the continuation of any benefits, nor does it promise any specific level of benefits at, during or after employment. The Plan and its component programs and the other benefits described in this document may be changed, suspended or discontinued in whole or in part any time by the Company.

The Plan Administrator has the sole discretionary authority and responsibility to interpret and construe the provisions of the Plan and to determine all factual and legal questions under the Plan, except to the extent that the Plan Administrator has delegated such authority and responsibility to other entities. For non-ERISA benefits, the T-Mobile partners that offer the benefits are responsible for interpreting their documents.

Any benefits, rights or obligations of participant and beneficiaries under the Plan following termination of coverage are described in detail in the "Termination" and "Continuation of Coverage" sections of this document.

The Summary Plan Description does not create a contract of employment.

Short-Term Disability / Maternity Benefits Summary

This benefits guide contains important information regarding your Short-Term Disability benefits, including maternity benefits (the "Program"). These benefits provide eligible Employees with short-term income protection in the event of a Disability due to a covered Injury, Sickness, Mental Illness, Substance Abuse, or Pregnancy. These benefits are provided through the T-Mobile USA, Inc. Employee Benefits Plan (the "Plan"). This document, along with the policies and procedures utilized with respect to any adverse benefit determination, shall constitute the Plan Document and the Summary Plan Description for the Program as required by ERISA. The benefits described herein are those in effect as of January 1, 2026.

ELIGIBILITY

Eligible Employees:

All Full-time Active Employees and Part-time Active Employees, excluding interns, temporary, leased, or seasonal Employees.

- Full-time Employment: at least 30 hours weekly.
- Part-time Employment: less than 30 hours weekly.

Eligibility Waiting Period for Coverage:

The first day of the month following completion of 180 days of employment. Exception: if the 180th day of employment falls on the first day of a month you are eligible on that day.

The time period referenced above is continuous and does not include periods of employment prior to your most recent hire date.

EXAMPLES:

You meet your 180 days of employment on August 2nd. Your coverage will become effective on September 1st if you were Actively at Work on your last scheduled day before September 1st. If not, your effective date for coverage will be deferred.

You meet your 180 days of employment on August 1st. Your coverage will become effective on August 1st if you were Actively at Work on your last scheduled day before August 1st. If not, your effective date for coverage will be deferred.

Exception: Employees that were employed by United States Cellular Corporation or its subsidiaries and affiliates (USCC), and who became T-Mobile Employees upon the closing of the transaction whereby T-Mobile's acquired substantially all of USCC's wireless operations on 8/1/25 will have their USCC hire date determine eligibility for the waiting period for coverage.

PERIOD OF COVERAGE

Effective Date:

When does my coverage start?

Your coverage will start on the date you become eligible.

Deferred Effective Date:

When will my effective date for coverage or a change in my coverage be deferred?

If you are absent from work due to:

- Accidental bodily Injury;

- Sickness;
- Mental Illness;
- Substance Abuse; or
- Pregnancy;

on the day prior to the date your coverage would otherwise have become effective, your insurance will not become effective until you are Actively at Work one full day.

Exception: If after being Actively at Work you are absent again for the related or same cause within 60 calendar days, your coverage will not become effective. See Recurrent Disability.

EXAMPLES:

Due to same cause: You go out on a continuous absence on August 5th, but you are not eligible for STD until September 1st, therefore you are denied STD benefits. If you return to work after September 1st but do not remain at work for 60 consecutive days or more and go back out on absence due to the same or related condition then your STD will remain denied because you were not eligible for STD when you went out on a continuous absence.

Due to new condition that is unrelated: You go out on a continuous absence on August 5th, but you are not eligible for STD until September 1st, therefore you are denied STD benefits. If you return to work after September 1st and go back out of work due to a new disabling condition, you would be eligible for STD.

Termination:

When will my coverage end?

Your coverage will end on the earliest of the following:

- The date the Program terminates;
- The date you are no longer an Eligible Employee; or
- The date you cease to be an Active Employee in an eligible class for any reason; unless continued in accordance with one of the Continuation Provisions.

Continuation Provisions:

Can my coverage be continued beyond the date it would otherwise terminate?

Coverage can be continued beyond a date shown in the Termination provision, if T-Mobile USA, Inc (TMUS) provides a plan of continuation which applies to all Employees the same way. Continued coverage:

- Is subject to any reductions in the Program; and
- Terminates if:
  - The Program terminates; or
  - Coverage for your class terminates.

In any event, your benefit level, or the amount of earnings upon which your benefits may be based, will be that in effect on the day before your coverage was continued. The Continuation Provisions shown below may not be applied consecutively. The maximum amount of time covered under the continuation provision from the start of your continuous leave would be 12 months. Coverage may be continued in accordance with the above restrictions and as described below:

- **Military Leave of Absence:** If you enter active military service and are granted a military leave of absence in writing, your coverage may be continued for up to 12 months. If your military leave ends prior to the agreed upon date, this continuation will cease immediately.
- **Family Medical Leave:** If you are granted a leave of absence in writing, under the Family and Medical Leave Act of 1993, or other applicable state or local law, your coverage may be continued for up to 12 weeks, or 26 weeks if you qualify for Family Military Leave, or longer if required by other applicable law, following the date your leave commenced. If this leave terminates prior to the agreed upon date, this continuation will cease immediately.

- **Leave of Absence:** If you are on an approved leave of absence, other than Family and Medical Leave or Military Leave of Absence, your coverage may be continued for up to 12 months following the month in which the leave of absence commenced. If the leave terminates prior to the agreed upon date, this continuation will cease immediately.

Coverage While Disabled:

Does my coverage continue while I am Disabled and no longer an Active Employee?

If you are Disabled and you cease to be an Active Employee, your coverage will be continued:

- While you remain Disabled; and
- Until the end of the period for which you are entitled to receive Short-Term Disability Benefits.

After Short-Term Disability benefit payments have ceased, your coverage will be reinstated, provided:

- You return to work for one full day as an Active Employee in an eligible class; and
- The Program remains in force.

BENEFITS

Date Benefits Commence:

- For Disability caused by Injury or Sickness—the 8th consecutive full calendar day of absence after the date of Disability; or
- For Disability caused by Delivery—the date of Delivery (see Maternity Leave Benefit).

Weekly Benefit:

Week 1: is an Elimination Period, no Benefit is paid.

Week 2 – 26: 85% of your Pre-disability Earnings, reduced by Deductible Income.

See *Maternity Leave Benefit* for enhanced Weekly Benefit available if you are absent from work due to Delivery (*Benefits* section).

Pre-Disability Earnings:

Pre-disability Earnings are comprised of up to two components. Both are based on your pay as of the last day you actively worked before you became Disabled.

Annual Total Base Pay:

- This is your Total Base Pay listed in Workday.

Annual Target Sales Incentive Pay:

- This component only applies to incentive-eligible Employees with a career band designated as SL, Customer and Frontline Experience Roles in T-Mobile for Business, and Customer Experience Center Employees with a monthly incentive plan (i.e., not an annual corporate bonus plan).
- This is your target annual incentive listed in Workday. If you are part-time, your annual incentive listed in Workday will be prorated based on your FTE percent in Workday.

Pre-disability Earnings does not include anything other than the amounts listed above. So, it doesn't include corporate bonus, tips, tokens, overtime/double-time pay, shift differential pay, stock options, prizes, gifts, stock bonuses, any other fringe benefits, TMUS's contributions on your behalf to any deferred compensation arrangement or pension plan, or any other compensation.

Weekly Rate of Pay:

Your Weekly Rate of Pay means your Pre-disability Earnings divided by 52.

Maximum Duration of Benefits:

The maximum duration of Disability benefits is 26 weeks reduced by your Elimination Period if caused by Injury, Sickness, Mental Illness, Substance Abuse, or Pregnancy (prior to Delivery).

Example—You have surgery on August 1 and are expected to be disabled for 26 weeks. Week 1, August 1 – 7 is unpaid, weeks 2 – 26 are eligible for pay (if Disabled).

See Maternity Leave Benefit in the Benefits section for enhanced Weekly Benefit available if you are absent from work due to Delivery.

Disability Benefit:

When am I eligible to receive Disability benefits under the Program? If, while eligible for this Benefit, you:

- Become Totally Disabled;
- Remain Totally Disabled; and
- Submit Proof of Loss to the Claims Administrator.

What are my Disability benefits under the Program?

If you satisfy the eligibility requirements, the Program will pay the Weekly Benefit.

The amount of any Weekly Benefit payable will be reduced by:

- Any state statutory paid leave. Employees in states with paid leave plans should apply for benefits through the appropriate state agency, as the T-Mobile Disability and other paid leave plans offset those potential payments. T-Mobile's plans pay the difference between what you are eligible to receive from your state paid leave plan and what you are eligible to receive under the T-Mobile Disability plans.

Partial Week Payment:

How is a benefit calculated for a period of less than a week?

If a Weekly Benefit is payable for less than a week, the Program will pay 1/5 of the Weekly Benefit for each day you were Disabled.

Recurrent Disability:

What happens to my benefits if I return to work as an Active Employee or remain off work after my Disability and then become Disabled again?

When your return to work as an Active Employee is followed by a Disability or when you remain off work for a reason **not** related to your Disability such as for Bonding, Care of Family Member or other paid or unpaid leave, a period of approved PTO or unpaid time off and then remain off work related to a Disability for at least 8 consecutive full calendar days in a row; and such Disability is:

- Due to the same cause (Injury, Sickness, Mental Illness Substance Abuse, or Pregnancy); or
- Due to a related cause; and
- Within 60 consecutive calendar days of the return to work.

If you were eligible, and approved for benefits, the Period of Disability prior to your return to work and the recurrent Disability will be considered one Period of Disability, provided the Program remains in force.

If you return to work as an Active Employee or remain off work for the reasons noted above for 60 consecutive days or more, any recurrence of a Disability will be treated as a new Disability.

EXAMPLES:

- You are out from July 1 to July 28 and are approved for STD. (July 1 – 7) is your Elimination Period, no benefit paid. The 3 weeks from July 9 to July 28 are paid at 85%. You return to work on July 29 and then from August 20 to January 20 you go back out due to the same condition. If the new period of continuous absence is approved for STD, you would

not need to complete another Elimination Period and the 22 additional weeks of absence would count as week's 5 – 26 of your STD Benefit.

If in the above example, you go back out due to a new condition that is unrelated, this would be considered a new claim and you would be eligible for 26 weeks of STD benefits reduced by a (1) week Elimination Period.

- You are out from July 1 to July 28 and are approved for STD. (July 1 – 7) is your Elimination Period, no benefit paid. The 3 weeks from July 8 to July 28 are paid at 85%. You transition to a continuous leave of absence to care for an ill family member from July 29 to August 20 and then remain on a continuous leave for the same condition as the July 1 STD claim. If the new period of continuous absence is approved for STD, you would not need to complete another Elimination Period and the 22 additional weeks of absence would count as weeks 5 – 26 of your STD Benefit.

If in the preceding example, you remain out due to a new condition that is unrelated, this would be considered a new claim and you would be eligible for 26 weeks of STD benefits reduced by a (1) week Elimination Period.

Period of Disability:

A continuous length of time during which you are Disabled under the Program.

Multiple Causes:

How long will benefits be paid if a period of Disability is extended by another cause?

If a period of Disability is extended by a new cause while Weekly Benefits are payable, Weekly Benefits will continue while you remain Disabled, subject to the following:

- Weekly Benefits will not continue beyond the end of the original Maximum Duration of Benefits; and
- Any Exclusions will apply to the new cause of Disability.

Termination of Payment:

When will my benefit payments end?

Benefit payments will stop on the earliest of:

- The date you are no longer Disabled;
- The date you are no longer under the Regular Care of a Physician;
- The date you refuse the Claims Administrator's request that you submit to an examination by a Physician or other qualified medical professional;
- The date of your death;
- The date you refuse to receive recommended treatment that is generally acknowledged by Physicians to cure, correct, or limit the disabling condition;
- The date you engage in leisure travel. Travel required for medical treatment is acceptable, such as traveling to a specialty clinic for a medical appointment or procedure;
- The date you engage in activities or conduct which is inconsistent with the medical condition;
- The date that you engage in any outside employment which is inconsistent with the medical condition or other leave reason (except required military duties), except where applicable law permits otherwise;
- The first date benefits were payable based on your submission of fraudulent paperwork;
- The last day benefits are payable according to the Maximum Duration of Benefits;
- The date your Current Weekly Earnings exceed 80% of your Pre-disability Earnings; or
- The date no further benefits are payable under any provision in the Program that limits benefit duration.

Disabled and Working Benefits:

How are benefits paid when I am Disabled and Working?

If, while covered under this benefit, you are Disabled and Working, the Claims Administrator will use the following calculation to determine your Weekly Benefit:

Weekly Benefit = (A – B) x C

Where:

A = Your Weekly Pre-disability Earnings.

B = Your Current Weekly Earnings.

C = The Weekly Benefit percentage payable if you were Totally Disabled.

Maternity Leave Benefit:

How are benefits paid if I am absent from work due to Delivery?

Starting with the date of your Delivery, for a period of up to eight (8) weeks, your Weekly Benefit will be 100% of your Weekly Rate of Pay. The seven (7) day Elimination Period will be waived starting on the date of your Delivery. If you remain Disabled after the eight-week Maternity Leave Benefit, your Weekly Benefit as defined by the Program will resume. The Maternity Leave Benefit does not increase the overall Maximum Duration of Benefits Payable under the Program unless you are Disabled prior to Delivery. In that case, the Maternity Leave Benefit will be paid for the full eight weeks even if the total claim duration of Benefits exceeds 26 weeks.

When should the Claims Administrator be notified of a Maternity Leave claim?

You, your supervisor, or your Physician must give the Claims Administrator notice of a claim by calling the special claims telephone number provided to Employees. Such notice must be given no later than the seventh calendar day of an absence due to the same or a related Disability.

When must Maternity Leave claim information be given?

Written claim information must be sent to the Claims Administrator within 15 calendar day(s) after the start of the period for which the Claims Administrator is liable for payment. If claim information is not given by the time it is due, it will not affect the claim if:

- It was not possible to provide claim information within the required time; and
- Claim information is given as soon as possible.

What is required to properly file a Maternity Leave claim?

An Eligible Employee will be required to furnish appropriate medical documentation for the Delivery of a child. The medical documentation will be completed and signed by the individual's health care provider.

EXCLUSIONS AND LIMITATIONS

Exclusions:

What Disabilities are not covered?

The Program does not cover and will not pay a benefit for any Disability:

- Unless you are under the Regular Care of a Physician;
- That is caused or contributed to by war or act of war (declared or not);
- Caused by your commission of or attempt to commit a felony;

- Caused or contributed to by your being engaged in an illegal occupation;
- Caused or contributed to by an intentionally self-inflicted Injury;
- For which Workers' Compensation benefits are paid, or may be paid, if duly claimed;
- Sustained as a result of doing any work for pay or profit for another Employer;
- That is for elective cosmetic procedures; or
- That are related to falsified information submitted regarding your Disability.

GENERAL PROVISIONS

Claims Administrator:

What is the role of the Claims Administrator?

The Claims Administrator:

- Determines benefits payable according to the terms and conditions of the Program.

However, TMUS has the responsibility for deciding final appeals of claims which were initially denied by the Claims Administrator, and for making final determinations regarding eligibility for coverage.

Notice of Claim:

When should the Claims Administrator be notified of a claim?

You, your supervisor, or your Physician must give the Claims Administrator notice of a claim by calling the special claims telephone number provided to Employees. Such notice must be given no later than the seventh calendar day of an absence due to the same or a related Disability.

Claim Forms:

Are special forms required to file a claim?

The Claims Administrator will send forms to you to file a claim, within 15 days of receiving a notice of claim. If the Claims Administrator does not send the forms within 15 days, you may submit any other proof which fully describes the nature and extent of your claim.

Filing a Claim:

What is required to properly file a claim?

Filing a claim may include but is not limited to the following:

- Documentation of:
  - The date your Disability began;
  - The cause of your Disability;
  - The prognosis of your Disability;
  - Your Pre-disability Earnings, Current Weekly Earnings, or any income, including but not limited to copies of your filed and signed federal and state tax returns; and
  - Evidence that you are under the Regular Care of a Physician.
- Any and all medical information, including x-ray films and photocopies of medical records, including histories, physical, mental, or diagnostic examinations and treatment notes;
- The names and addresses of all:

  - Physicians or other qualified medical professionals you have consulted;
  - Hospitals or other medical facilities in which you have been treated; and
  - Pharmacies which have filled your prescriptions within the past three years.
- Your signed authorization for the Claims Administrator to obtain and release:
  - Medical, employment and financial information; and
  - Any other information the Claims Administrator may reasonably require.
- Your signed statement identifying all Deductible Income; and
- Proof that you and your dependents have applied for all Deductible Income that is available.

All information submitted must be satisfactory to the Claims Administrator.

Additional Information:

What additional information is the Claims Administrator entitled to?

To assist the Claims Administrator in determining if you are Disabled, or to determine if you meet any other term or condition of the Program, the Claims Administrator has the right to require you to:

- Meet and interview with the Claims Administrator; and
- Be examined by a Physician, vocational expert, functional expert, or other medical or vocational professional of the Claims Administrator's choice.

Any such interview, meeting or examination will be:

- At the Claims Administrator's expense; and
- As reasonably required by the Claims Administrator.

The additional information must be satisfactory to the Claims Administrator. Unless the Claims Administrator determines you have a valid reason for refusal, the Claims Administrator may deny, suspend, or terminate your benefits if you refuse to be examined or meet to be interviewed by the Claims Administrator.

Sending Claim Information:

When must claim information be given?

Written claim information must be sent to the Claims Administrator within 15 day(s) after the start of the period for which the Claims Administrator is liable for payment. If claim information is not given by the time it is due, it will not affect the claim if:

- It was not possible to provide claim information within the required time; and
- Claim information is given as soon as possible.

The Claims Administrator may request claim information and documentation throughout your Disability. In such cases, the Claims Administrator must receive the requested information and documentation within 15 calendar days of the request.

Claim Payment:

When are benefit payments issued?

When the Claims Administrator determines that you:

- Are Disabled; and
- Eligible to receive benefits.

The Claims Administrator will submit the amount of benefit to be paid on a weekly basis to T-Mobile for processing on a weekly pay schedule. You will receive the funds in the same manner that you receive your regular pay. If any payment is due after a claim is terminated, it will be paid as soon as claim information satisfactory to the Claims Administrator is received.

When does an overpayment occur?

An overpayment occurs:

- When we determine that the total amount that has been paid in benefits is more than the amount that was due to you under the policy; or
- When payment is made that should have been made under another group policy or statutory plan.

This includes, but is not limited to, overpayments resulting from:

- Retroactive awards received from sources listed in the other income benefits definition;
- Failure to report, or late notifications to us of any other income benefit(s) or earned income;
- Misstatement (i.e., incorrect date of Disability);
- Fraud; or
- Any errors we make.

What Happens If the Claim Administrator Overpays Your Claim?

The Claim Administrator has the right to recover any overpayments. You must reimburse the overpayment in full. The Claim Administrator will determine the method by which the repayment is to be made. The Claim Administrator will not recover more money than the amount we paid you.

CLAIMS PROCEDURES

TMUS has the full discretion and authority to determine eligibility for benefits and to construe and interpret all terms and provisions of the Plan.

Claim and Appeal Procedures for Claims Requiring a Determination of Disability.

Claims for Benefits:

The claim decision will be made no more than 45 days after receipt of your properly filed claim. The time for decision may be extended for two additional 30-day periods provided that, prior to any extension period, you are notified in writing that an extension is necessary due to matters beyond the control of the Plan, that the notice identifies those matters, and gives the date by which a decision is expected to be made. If your claim is extended due to your failure to submit information necessary to decide your claim, the time for decision may be tolled from the date on which the notification of the extension is sent to you until the date we receive your response to our request. If the Claim Administrator approves your claim, the decision will contain information sufficient to reasonably inform you of that decision.

Any adverse benefit determination will be in writing and will include:

- The specific reason(s) for the denial;
- References to the specific Plan provisions on which the denial is based;
- A description of any additional material or information necessary for you to have your denial reversed and an explanation of why this material or information is needed;
- A description of the Plan's procedures for having your claim reviewed and the time limits applicable to those procedures;
- A statement of your right to bring a civil action in federal court under Section 502(a) of ERISA following a denial on appeal;
- A discussion of the decision, including an explanation of the basis for disagreeing with or not following the views of health care professionals treating you and vocational professionals who evaluated you, the views of medical or vocational experts whose advice was obtained on behalf of the Plan in making the determination (without regard to whether the advice was relied upon in making the benefit determination) and/or any Social Security Disability determination you presented to the Plan;

- If the denial is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to your medical circumstances, or a statement that such explanation will be provided free of charge upon request;
- Either the specific internal rules, guidelines, protocols, standards, or other similar criteria of the Plan relied upon in making the determination, or a statement that such rules, guidelines, protocols, standards, or other similar criteria of the Plan do not exist; and
- A statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim for benefits.

Appealing Denial of Claims for Benefits:

First Level Appeal

On any wholly or partially denied claim, you or your representative may file a first level appeal with the Claims Administrator for a full and fair review. Your appeal request must be in writing and be received by the Claims Administrator no later than the expiration of 180 days from the date you received your claim denial.

As part of your first level appeal:

- You may request, free of charge, copies of all documents, records, and other information relevant to your claim; and
- You may submit written comments, documents, records, and other information relating to your claim.

The Claims Administrator's review of your first level appeal request shall take into account all comments, documents, records, and other information submitted by you relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination.

A first level appeal decision will be made no more than 45 days after the Claims Administrator receives your timely appeal. The time for decision may be extended for one additional 45-day period provided that, prior to the extension, you are notified in writing that an extension is necessary due to special circumstances, and such notice identifies those circumstances and gives the date by which the Claims Administrator expects to render its decision. If your claim is extended due to your failure to submit information necessary to decide your claim on appeal, the time for decision shall be tolled from the date on which the notification of the extension is sent to you until the date the Claims Administrator receives your response to the request.

The individual reviewing your first level appeal shall give no deference to the initial benefit decision and shall be an individual who is neither the individual who made the initial benefit decision, nor the subordinate of such individual. The review process provides for the identification of the medical or vocational experts whose advice was obtained in connection with an initial adverse decision, without regard to whether that advice was relied upon in making that decision. When deciding a first level appeal that is based in whole or part on medical judgment, the Claims Administrator will consult with a medical professional having the appropriate training and experience in the field of medicine involved in the medical judgment and who is neither an individual consulted in connection with the initial benefit decision, nor a subordinate of such individual.

The Claims Administrator will provide you, free of charge, with any new or additional evidence considered, relied upon or generated by the Plan or other person making the benefit determination (or at the direction of the Plan or such other person) in connection with your first level appeal as soon as possible and sufficiently in advance of the date on which it provides you with notice of its determination on your first level appeal, so that you will have a reasonable opportunity to respond prior to that date. In addition, if the denial of your first level appeal is based on a new or additional rationale, the Claims Administrator will provide you, free of charge, with the new or additional rationale as soon as possible and sufficiently in advance of the date on which it provides you with notice of its determination on your first level appeal, so that you will have a reasonable opportunity to respond prior to that date.

If the Claims Administrator grants your first level appeal, the decision will contain information sufficient to reasonably inform you of that decision.

However, any adverse benefit determination on review will be in writing will include:

- The specific reason(s) for the denial;
- References to the specific Plan provisions on which the denial is based;

- A statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim;
- A statement describing any voluntary appeal procedures offered by the Plan and your right to obtain information about those procedures;
- A statement describing your right to bring a civil action under Section 502(a) of ERISA following denial of the appeal and any applicable contractual limitations period that applies to your right to bring a civil action for benefits, including the calendar date on which the contractual limitations period expires;
- A discussion of the decision, including an explanation of the basis for disagreeing with or not following the views of health care professionals treating you and vocational professionals who evaluated you, the views of medical or vocational experts whose advice was obtained on behalf of the Plan in making the determination (without regard to whether the advice was relied upon in making the benefit determination) and/or any Social Security Disability determination you presented to the Plan;
- If the adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to your medical circumstances, or a statement that such explanation will be provided free of charge upon request; and
- Either the specific internal rules, guidelines, protocols, standards, or other similar criteria relied upon in making the determination, or a statement that such rules, guidelines, protocols, standards, or other similar criteria of the Plan do not exist.

Also, upon request, the Claims Administrator will provide you with a statement identifying those medical or vocational experts whose advice was obtained in connection with the appeal.

Second Level Appeal

If you are not satisfied with the determination of the Claims Administrator on your first level appeal, you can submit a second level appeal to the Claims Administrator. All second level appeals should be submitted in writing to the Claims Administrator within 180 days after you receive the notice of determination on your first level appeal.

Like first level appeals, the review of a second level appeal will afford no deference to prior determinations and will be conducted by someone other than the individuals who made the prior determinations or subordinates of such individuals. Also, if the first level appeal was denied based on a medical judgment, the Claims Administrator may consult with a health professional with appropriate training and experience in the pertinent field of medicine, and who is not a professional consulted during the prior determinations, or a subordinate of such professional. The Claims Administrator will also identify medical or vocational experts whose advice was obtained on behalf of the Plan in connection with the adverse benefit determination being appealed, even if the advice was not relied upon in making the benefit determination.

The Claims Administrator will provide you, free of charge, with any new or additional evidence considered, relied upon or generated by the Plan or other person making the benefit determination (or at the direction of the Plan or such other person) in connection with your second level appeal as soon as possible and sufficiently in advance of the date on which it provides you with notice of its determination on your second level appeal, so that you will have a reasonable opportunity to respond prior to that date. In addition, if the denial of your second level appeal is based on a new or additional rationale, the Claims Administrator will provide you, free of charge, with the new or additional rationale as soon as possible and sufficiently in advance of the date on which it provides you with notice of its determination on your second level appeal, so that you will have a reasonable opportunity to respond prior to that date.

The Claims Administrator, in consultation with the Plan Administrator, will review and decide your second level appeal. The Claims Administrator will provide you written or electronic notification of the determination on your second level appeal not later than 45 days after the Claims Administrator receives your timely request for a second level appeal. The time for decision may be extended for one additional 45-day period provided that, prior to the extension, you are notified in writing that an extension is necessary due to special circumstances and such notice identifies those circumstances and gives the date by which the Claims Administrator expects to render its decision. If your claim is extended due to your failure to submit information necessary to decide your second level appeal, the time for decision shall be tolled from the date on which the notification of the extension is sent to you until the date the Claims Administrator receives your response to the request.

Denial notifications of second level appeals will include the information listed above for first level appeal denials.

You are required to utilize both the first and second levels of appeal as provided under the Plan in order to be considered to have exhausted your claim and appeal rights under the Plan, which is required before filing a lawsuit to dispute your claim, as further described in the last paragraph of this "Claims Procedures" section.

Claim and Appeal Procedures for Claims Not Requiring a Determination of Disability

Claims for Benefits

The claim decision will be made no more than 90 days after receipt of your properly filed claim. However, if there are special circumstances that require an extension, the time for claim decision will be extended for an additional 90 days, provided that, prior to the beginning of the extension period, you are notified in writing of the special circumstances and are given the date by which a decision is expected to be made. If extended, a decision shall be made no more than 180 days after your claim was received. If the Claim Administrator approves your claim, the decision will contain information sufficient to reasonably inform you of that decision.

However, any adverse benefit determination will be in writing and include: 1) specific reasons for the decision; 2) specific references to Plan provisions on which the decision is based; 3) a description of any additional material or information necessary for you to perfect the claim and an explanation of why such material or information is necessary; 4) a description of the review procedures and time limits applicable to such, and 5) a statement that you have the right to bring a civil action under section 502(a) of ERISA after you appeal the decision and after you receive a written denial on appeal.

Appealing Denials of Claims for Benefits

On any wholly or partially denied claim, you or your representative may appeal to the Claims Administrator for a full and fair review. Your appeal request must be in writing and be received by the Claims Administrator no later than the expiration of 60 days from the date you received your claim denial.

As part of your appeal:

- You may request, free of charge, copies of all documents, records, and other information relevant to your claim; and
- You may submit written comments, documents, records, and other information relating to your claim.

The review on appeal shall take into account all comments, documents, records, and other information submitted by you relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination.

A final decision will be made no more than 60 days after it receives your timely appeal. However, if special circumstances require an extension, the time for its decision will be extended for an additional 60 days, provided that, prior to the beginning of the extension period, you are notified in writing of the special circumstances and given the date by which the Claims Administrator expects to render its decision. If extended, a decision shall be made no more than 120 days after your appeal was received. If the Claims Administrator grants your claim appeal, the decision will contain information sufficient to reasonably inform you of that decision.

However, any final adverse benefit determination on review will be in writing and include: 1) specific reasons for the decision and specific references to the Plan provisions on which the decision is based, 2) a statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant to the claim, 3) a statement of your right to bring a civil action under section 502(a) of ERISA, and 4) any other notice(s), statement(s) or information required by applicable law.

No person may bring a legal action for benefits unless and until he or she has timely made a benefits claim and appealed a denied claim within the time limits and procedures described in this section. Further, no action may be brought against the Plan or T-Mobile or any of their delegates, employees, officers, or Board members more than one year after the earlier of the decision became final, the claimant has exhausted their claim and appeal rights under the Plan, or the date proof of claim was due.

DEFINITIONS

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

- In the usual way; and
- For your usual number of hours.

You will be considered Actively at Work on a day that is not a scheduled work day only if you were Actively at Work on the preceding scheduled work day.

Active Employee means an employee who works for T-Mobile on a regular basis in the usual course of T-Mobile's business either Full-time or Part-time, excluding interns, temporary, leased, or seasonal Employees.

Claims Administrator means Broadspire Services, Inc.

Current Weekly Earnings means Weekly earnings you receive from TMUS while you are Disabled and eligible for the Disabled and Working Benefit.

Current Weekly Earnings also includes the pay you could have received for another job or a modified job if:

- Such job was offered to you by TMUS and you refused the offer; and
- The requirements of the position were consistent with:
  - Your education, training, and experience; and
  - Your capabilities as medically substantiated by your Physician.

Deductible Income:

- Any amount you receive or are eligible to receive if you filed for under a state disability income benefit law or similar law;
- Any amount you receive or are eligible to receive because of your Disability under another group coverage;
- Any Disability or retirement benefits you receive under TMUS's retirement plan;
- Any amount you receive or are eligible to receive under any unemployment compensation law or similar act or law;
- Any amount you receive or are eligible to receive from or on behalf of a third party because of your Disability, whether by judgment, settlement, or other method. If you notify us before filing suit or settling your claim against such third party, the amount used as Deductible Income will be reduced by a pro rata share of your costs of recovery, including reasonable attorney fees; and
- Any amount you receive by compromise, settlement, or other method as a result of a claim for any of the above, whether disputed or undisputed.

Deductible Income does not include:

- Any cost-of-living increase in any Deductible Income other than Work Earnings, if the increase becomes effective while you are Disabled and while you are eligible for the Deductible Income;
- Reimbursement for hospital, medical, or surgical expense;
- Reasonable attorneys' fees incurred in connection with a claim for Deductible Income;
- Benefits from any individual disability insurance policy;
- Group credit or mortgage disability insurance benefits;
- Accelerated death benefits paid under a life coverage plan or life insurance policy;
- Benefits from the following:
  - Profit sharing plan;
  - Thrift or savings plan;

  - Deferred compensation plan;
  - Plan under IRC Section 401(k), 408(k), 408(p), or 457;
  - Individual Retirement Account (IRA);
  - Tax Sheltered Annuity (TSA) under IRC Section 403(b);
  - Stock ownership plan; and
  - Keogh (HR-10) plan.
- The following amounts under TMUS's retirement plan:
  - A lump sum distribution of your entire interest in the plan;
  - Any amount which is attributable to your contributions to the plan; and
  - Any amount you could have received upon termination of employment without being disabled or retired.
- Benefits from the following:
  - Military pension and disability income plans;
  - Franchise disability income plans; and
  - A retirement plan from another Employer.

Delivery means live birth of child by Vaginal or C-section delivery. This would not include a miscarriage or a stillborn delivery as these are not considered the live birth of a child.

Disabled and Working means that you are prevented by:

- Injury;
- Sickness;
- Mental Illness;
- Substance Abuse; or
- Pregnancy;

from working your regular scheduled hours based on the FTE percent noted in Workday and released by your healthcare provider to work on a fixed reduced schedule due to your Disability, and as a result, your Current Weekly Earnings are more than 20% but are less than or equal to 80% of your Pre- disability Earnings.

Disability or Disabled means Total Disability

Elimination Period means a 7-consecutive full calendar day period at the beginning of any one period of Disability which must elapse before benefits are payable.

Employer means T-Mobile USA, Inc. (TMUS)

Essential Duty means a duty that:

- Is substantial, not incidental;
- Is fundamental or inherent to the occupation; and
- Cannot be reasonably omitted or changed.

Your ability to work the number of hours in your regularly scheduled workweek is an Essential Duty.

During the COVID-19 pandemic, when you are required to work on-site, being COVID-19 free and wearing a mask (in locations where this is required) are considered "Essential Duties."

Injury means bodily Injury resulting:

- Directly from accident; and
- Independently of all other causes.

which occurs while you are covered under the Program. However, an Injury will be considered a Sickness if your Disability begins more than 30 days after the date of the accident.

Mental Illness means a mental disorder as listed in the current version of the Diagnostic and Statistical Manual of Mental Disorders, published by the American Psychiatric Association. A Mental Illness may be caused by biological factors or result in physical symptoms or manifestations.

For the purpose of the Program, Mental Illness does not include the following mental disorders outlined in the current version of the Diagnostic and Statistical Manual of Mental Disorders:

- Mental Retardation;
- Pervasive Developmental Disorders;
- Motor Skills Disorder;
- Substance-Related Disorders;
- Delirium, Dementia, Amnesic and Other Cognitive Disorders; or
- Narcolepsy and Sleep Disorders related to a General Medical Condition.

Occupation means your Occupation as it is recognized in the general workplace. Your Occupation does not mean the specific job you are performing for T-Mobile or at a specific location.

Physician means a person who is:

- A Doctor of Medicine, osteopathy, psychology, or other legally qualified practitioner of a healing art that the Claims Administrator recognize or are required by law to recognize;
- Licensed to practice in the jurisdiction where care is being given;
- Practicing within the scope of that license; and
- Not Related to you by blood or marriage.

Pre-disability Earnings are comprised of up to two components. Both are based on your pay as of the last day you actively worked before you became Disabled.

Annual Total Base Pay:

- This is your Total Base Pay listed in Workday.

Annual Target Sales Incentive Pay:

- This component only applies to incentive-eligible Employees with a career band designated as SL, Customer and Frontline Experience Roles in T-Mobile for Business, and Customer Experience Center Employees with a monthly incentive plan (i.e., not an annual corporate bonus plan).
- This is your target annual incentive listed in Workday. If you are part-time, your annual incentive listed in Workday will be prorated based on your FTE percent in Workday.

Pre-disability Earnings does not include anything other than the amounts listed above. So, it doesn't include corporate bonus, tips, tokens, overtime/double-time pay, shift differential pay, stock options, prizes, gifts, stock bonuses, any other fringe benefits, TMUS's contributions on your behalf to any deferred compensation arrangement or pension plan, or any other compensation.

Program means Short-Term Disability benefits, including maternity benefits.

Regular Care of a Physician means that you are being treated by a Physician:

- Whose medical training and clinical experience are suitable to treat your disabling condition; and
- Whose treatment is:
  - Consistent with the diagnosis of the disabling condition;
  - According to guidelines established by medical, research, and rehabilitative organizations; and

- Administered as often as needed; to achieve the maximum medical improvement.

Related means your spouse or other adult living with you, sibling, parent, stepparent, grandparent, aunt, uncle, niece, nephew, son, daughter, or grandchild.

Sickness means a Disability which is:

- Caused or contributed to by:
  - Any condition, illness, disease, or disorder of the body;
  - Any infection, except a pus-forming infection of an accidental cut or wound or bacterial infection resulting from an accidental ingestion of a contaminated substance;
  - Hernia of any type unless it is the immediate result of an accidental Injury covered by the Program; or
  - Pregnancy.
- Caused or contributed to by any medical or surgical treatment for a condition shown in items above.

Substance Abuse means the pattern of pathological use of alcohol or other psychoactive drugs and substances characterized by:

- Impairments in social and/or occupational functioning;
- Debilitating physical condition;
- Inability to abstain from or reduce consumption of the substance; or
- The need for daily substance use to maintain adequate functioning. Substance includes alcohol and drugs but excludes tobacco and caffeine.

Total Disability or Totally Disabled means:

- You are considered disabled if you are limited from performing one or more of the Essential Duties (Main Responsibilities) of your Occupation solely due to your Sickness, Injury, Mental Illness, Substance Abuse, or Pregnancy that causes you to be absent from work for at least 8 consecutive full calendar days in a row.

Weekly Rate of Pay means your Pre-disability Earnings divided by 52.

PROGRAM ADMINISTRATIVE FACTS

Plan Name:

The Short-Term Disability and Maternity Leave Program provided under the T-MOBILE USA, INC. EMPLOYEE BENEFIT PLAN.

Plan Number

506

Employer/Plan Sponsor

T-MOBILE USA, INC.
12920 SE 38th Street
Bellevue, WA 98006-7305

Employer Identification Number

91-1983600

Type of Plan

Welfare Benefit Plan providing Group Short-Term Disability and Maternity Leave benefits.

Plan Administrator

T-MOBILE USA, INC.
12920 SE 38th Street
Bellevue, WA 98006-7305

Agent for Service of Legal Process

For the Plan:

T-MOBILE USA, INC.
12920 SE 38th Street
Bellevue, WA 98006-7305

For the Claims Administrator:

Broadspire Services, Inc.
PO BOX 14773
Lexington KY 40512

1-877-222-8705

Sources of Contributions:

The cost of the Program benefits are paid entirely by TMUS.

Type of Administration:

The Plan is administered by the Plan Administrator with benefits provided in accordance with the provisions of the applicable Plan Document.

The Plan and its records are kept on a Plan year basis.

Plan Amendment Procedure:

The Plan Administrator reserves full authority, at its sole discretion, to terminate, suspend, withdraw, reduce, amend, or modify the Plan, in whole or in part, at any time, without prior notice.

TMUS also reserves the right to adjust your share of the cost to continue coverage by the same procedures.

Summary Plan Description Group Short-Term Disability

Name of Plan:

T-Mobile USA, Inc. Employee Benefit Plan

Name and Address of Employer who is the Plan Sponsor:

T-Mobile USA, Inc.
12920 SE 38th Street
Bellevue, Washington 98006

The Plan Sponsor retains all fiduciary responsibilities with respect to the Plan except to the extent the Plan Sponsor has delegated to other entities one or more fiduciary responsibility with respect to the Plan.

Agent for Legal Process:

The Plan Sponsor named above.

Employer Tax ID#:

91-1983600

Plan Number (PN):

506

Type of Plan:

Welfare Benefit Plan providing Group Short-Term Disability.

Short-Term Disability Claims Administrator:

Broadspire Services, Inc.
PO BOX 14773
Lexington KY 40512

1-877-222-8705

Type of Administration:

The Plan is administered on behalf of the Plan Administrator by Broadspire Services, Inc. The benefits are paid from funds provided by TMUS on behalf of the Plan in accordance with a contract with Broadspire Services, Inc. Broadspire Services, Inc. is the Claims Administrator.

Source of Contribution under the Plan:

There are no contributions to the Plan. All Benefits under the Plan are paid from the general assets of the Plan Sponsor. Any required Employee contributions are used to partially reimburse the Plan Sponsor for Benefits under the Plan.

Statement of Employee Retirement Income Security Act of 1974 (ERISA) Rights

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

Receive Information about Your Plan and Benefits

- Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and union halls, all documents governing the Plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.
- Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated Summary Plan Description. The administrator may make a reasonable charge for the copies.
- Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.
- Obtain a copy of the Plan's Qualified Medical Child Support Order (QMCSO) procedures from the Plan Administrator, free of charge.

Continue Group Health Plan Coverage

Continue health care coverage for yourself, Spouse, or dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this Summary Plan Description and the documents governing the Plan on the rules governing your COBRA continuation coverage rights.

Prudent Actions by Plan Fiduciaries

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

Enforce Your Rights

If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of Plan Documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits that is denied or ignored, in whole or in part, and if you have exhausted the internal claims procedures available to you under the Plan (discussed in the claims and appeals sections above), you may file suit in a state or Federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in Federal court. If it should happen that plan fiduciaries misuse the plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions

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

Group Disability Income Insurance

HARTFORD LIFE AND ACCIDENT INSURANCE COMPANY
One Hartford Plaza
Hartford, Connecticut 06155
(A stock insurance company)

The Hartford® is The Hartford Financial Services Group, Inc. and its subsidiaries.

CERTIFICATE OF INSURANCE

Policyholder: T-MOBILE USA, INC.
Policy Number: GLT-402610
Policy Effective Date: June 1, 2013
Policy Anniversary Date: January 1, 2026

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

Signed for the Company

Kevin Barnett, ***Secretary*** **Michael J. Fish,** ***Head of Group Benefits***

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

Form GBD-1200 (10/08) (Rev-1) (WA)(402610) 2.77

Schedule Of Insurance

The Policy of long term Disability insurance provides You with long term income protection if You become Disabled from a covered injury, sickness or pregnancy. **Please refer to Your group enrollment form to see the Option that applies to You.**

The benefits described herein are those in effect as of June 17, 2025.

Cost of Coverage:
Options 1: You do not contribute toward the cost of coverage.

Options 2 and 3: You must contribute toward the cost of coverage.

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

Disclosure of Services:
In addition to the insurance coverage, We may offer noninsurance benefits and services to Active Employees.

Disclosure of Payment to the Policyholder:
We have agreed to make payment to the Policyholder for reimbursement of cost(s) associated with:
1) audit;
2) marketing communication services; and
3) other administrative expenses.

Eligible Class(es) For Coverage: All Full-time and Part-time Active Employees who are citizens or legal residents of the United States, its territories and protectorates; excluding Puerto Rico, U.S. Virgin Islands, temporary, leased or seasonal employees as follows:

Class 1: All Full-time Active Employees
Class 2: All Part-time Active Employees

Full-time Employment: at least 30 scheduled hours weekly
Part-time Employment: at least 20 scheduled hours weekly

Eligibility Waiting Period for Coverage:
The first day of the month coinciding with or next following 180 day(s) of employment

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

Elimination Period: 180 day(s)

Maximum Monthly Benefit: $20,000

Minimum Monthly Benefit: $100

Benefit Percentage:
Option 1: 50%
Option 2: 60%
Option 3: 66.67%

Maximum Duration of Benefits

Maximum Duration of Benefits Table

Age When Disabled	Benefits Payable
Prior to Age 63	To Normal Retirement Age or 42 months, if greater
Age 63	To Normal Retirement Age or 36 months, if greater
Age 64	30 months
Age 65	24 months
Age 66	21 months
Age 67	18 months
Age 68	15 months
Age 69 and over	12 months

Normal Retirement Age means the Social Security Normal Retirement Age as stated in the 1983 revision of the United States Social Security Act. It is determined by Your date of birth as follows:

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

Additional Benefit:

Family Care Credit Benefit
see benefit

Survivor Income Benefit
see benefit

Workplace Modification Benefit
see benefit

Ability Plus Benefit
see benefit

Eligibility And Enrollment

Eligible Persons: *Who is eligible for coverage?*
All persons in the class or classes shown in the Schedule of Insurance will be considered Eligible Persons.

Eligibility for Coverage: *When will I become eligible?*
You will become eligible for coverage on the later of:
1) the Policy Effective Date; or
2) the date on which You complete the Eligibility Waiting Period for Coverage shown in the Schedule of Insurance, if applicable.

With respect to Option 1 & 2:
Enrollment: *How do I enroll for coverage?*
All eligible Active Employees will be enrolled automatically by the Employer.

With respect to Option 2 & 3:

Enrollment: How do I enroll for coverage?
You must enroll. To enroll for coverage You must:
1) complete and sign a group insurance enrollment form which is satisfactory to Us; and
2) deliver it to Your Employer.

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

If You do not enroll within 31 days after becoming eligible under The Policy, or if You were eligible to enroll under the Prior Policy and did not do so, and later choose to enroll You may enroll at any time.

If you do not enroll within 31 days after becoming eligible under The Policy or the Prior Policy, or if You were eligible to enroll through under the Prior Policy and did not to do, and later choose to enroll You must give us Evidence of Insurability satisfactory to Us.

Evidence of Insurability: *What is Evidence of Insurability and what happens if Evidence of Insurability is not satisfactory to Us?*
Evidence of Insurability must be satisfactory to Us and may include, but will not be limited to:
1) a completed and signed application approved by Us;
2) a medical examination, if requested;
3) attending Physicians' statements; and
4) any additional information We may require.

All Evidence of Insurability will be furnished at Our expense. We will then determine if You are insurable under The Policy.

If Your Evidence of Insurability is not satisfactory to Us:
1) Your Monthly Benefit will equal the amount for which You were eligible without providing Evidence of Insurability, provided You enrolled within 31 days of the date You were first eligible to enroll; and
2) You will not be covered under The Policy if You enrolled more than 31 days after the date You were first eligible to enroll.

Change in Family Status: *What constitutes a Change in Family Status?*
A Change in Family Status occurs when:
1) You get married or You execute a domestic partner affidavit;
2) You and Your spouse divorce or You terminate a domestic partnership;
3) Your child is born or You adopt or become the legal guardian of a child;
4) Your spouse or domestic partner dies;
5) Your child is no longer financially dependent on You or dies;
6) Your spouse or domestic partner is no longer employed, which results in a loss of group insurance; or
7) You have a change in classification from part-time to full-time or from full-time to part-time.

Period Of Coverage

Effective Date: *When does my coverage start?*
Your coverage will start on the date You become eligible.

Deferred Effective Date: *When will my effective date for coverage or a change in my coverage be deferred?*
If You are absent from work due to:

1) accidental bodily injury;
2) sickness;
3) Mental Illness;
4) Substance Abuse; or
5) pregnancy;

on the date Your insurance, or increase in coverage, would otherwise have become effective, Your insurance, or increase in coverage will not become effective until You are Actively at Work one full day.

Changes in Coverage: *Can I change my benefit options?*

You may change Your benefit option at any time. You may decrease coverage, or increase coverage to a higher option. An increase in coverage will be subject to Your submission of an application that meets Our approval.

Any such increase in coverage is subject to the following provisions:

1) Deferred Effective Date; and
2) Pre-existing Conditions Limitation.

When will a requested change in benefit option take effect?
If You enroll for a change in benefit option within 31 days following a Change in Family Status, the change will take effect on the date You enroll for the change.

Any such increase is subject to the following provisions:

1) Deferred Effective Date; and
2) Pre-existing Condition Limitation.

Do coverage amounts change if there is a change in my class or my rate of pay?
Your coverage may increase or decrease on the date there is a change in Your class or Pre-disability Earnings. However, no increase in coverage will be effective unless on that date You:

1) are an Active Employee; and
2) are not absent from work due to being Disabled. If You were so absent from work, the effective date of such increase will be deferred until You are Actively at Work for one full day.

No change in Your Pre-disability Earnings will become effective until the date We receive notice of the change.

What happens if the Employer changes The Policy?
Any increase or decrease in coverage because of a change in The Policy will become effective on the date of the change, subject to the following provisions:

1) the Deferred Effective Date provisions; and
2) Pre-existing Conditions Limitation.

Continuity From A Prior Policy: *Is there continuity of coverage from a Prior Policy?*
If You were:

1) insured under the Prior Policy; and
2) not eligible to receive benefits under the Prior Policy;

on the day before the Policy Effective Date, the Deferred Effective Date provision will not apply.

Is my coverage under The Policy subject to the Pre-existing Condition Limitation?
If You become insured under The Policy on the Policy Effective Date and were covered under the Prior Policy on the day before the Policy Effective Date, the Pre-existing Conditions Limitation will end on the earliest of:

1) the Policy Effective Date, if Your coverage for the Disability was not limited by a pre-existing condition restriction under the Prior Policy; or
2) the date the restriction would have ceased to apply had the Prior Policy remained in force, if Your coverage was limited by a pre-existing condition limitation under the Prior Policy.

The amount of the Monthly Benefit payable for a Pre-existing Condition in accordance with the above paragraph will be the lesser of:

1) the Monthly Benefit which was paid by the Prior Policy; or
2) the Monthly Benefit provided by The Policy.

The Pre-existing Conditions Limitation will apply after the Policy Effective Date to the amount of a benefit increase which results from a change from the Prior Policy to The Policy, a change in benefit options, a change of class or a change in The Policy.

Do I have to satisfy an Elimination Period under The Policy if I was Disabled under the Prior Policy?
If You received monthly benefits for disability under the Prior Policy, and You returned to work as a Full-time or Part-time Active Employee before the Policy Effective Date, then, if within 6 months of Your return to work:

1) You have a recurrence of the same disability while covered under The Policy; and
2) there are no benefits available for the recurrence under the Prior Policy;

the Elimination Period, which would otherwise apply, will be waived if the recurrence would have been covered without any further elimination period under the Prior Policy.

Termination: *When will my coverage end?*

Your coverage will end on the earliest of the following:

1) the date The Policy terminates;
2) the date The Policy no longer insures Your class;
3) the date premium payment is due but not paid;
4) the last day of the period for which You make any required premium contribution;
5) the date Your Employer terminates Your employment; or
6) the date You cease to be a Full-time or Part-time Active Employee in an eligible class for any reason;

unless continued in accordance with any of the Continuation Provisions.

Continuation Provisions: *Can my coverage be continued beyond the date it would otherwise terminate?*
Coverage can be continued by Your Employer beyond a date shown in the Termination provision, if Your Employer provides a plan of continuation which applies to all employees the same way. Continued coverage:

1) is subject to any reductions in The Policy;
2) is subject to payment of premium; and
3) terminates if:
   a) The Policy terminates; or
   b) coverage for Your class terminates.

In any event, Your benefit level, or the amount of earnings upon which Your benefits may be based, will be that in effect on the day before Your coverage was continued. Coverage may be continued in accordance with the above restrictions and as described below:

Leave of Absence: If You are on a documented leave of absence, other than Military Leave of Absence, Your coverage may be continued for 12 month(s) from start date the leave of absence commenced. If the leave terminates prior to the agreed upon date, this continuation will cease immediately.

Medical Leave of Absence: If You are on a documented medical leave of absence, Your coverage may be continued for up to 12 month(s) from the start date the leave of absence commenced. If the leave terminates prior to the agreed upon date, this continuation will cease immediately.

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

Coverage while Disabled: *Does my insurance continue while I am Disabled and no longer an Active Employee?*
If You are Disabled and You cease to be an Active Employee, Your insurance will be continued:
1) during the Elimination Period while You remain Disabled by the same Disability; and
2) after the Elimination Period for as long as You are entitled to benefits under The Policy.

Waiver of Premium: *Am I required to pay premiums while I am Disabled?*
No premium will be due for You:
1) after the Elimination Period; and
2) for as long as benefits are payable.

Extension of Benefits for Disability: *Do my benefits continue if The Policy terminates?*
If You are entitled to benefits while Disabled and The Policy terminates, benefits:
1) will continue as long as You remain Disabled by the same Disability; but
2) will not be provided beyond the date We would have ceased to pay benefits had the insurance remained in force.

Termination of The Policy for any reason will have no effect on Our liability under this provision.

Benefits

Disability Benefit: *What are my Disability Benefits under The Policy?*
We will pay You a Monthly Benefit if You:
1) become Disabled while insured under The Policy;
2) are Disabled throughout the Elimination Period;
3) remain Disabled beyond the Elimination Period; and
4) submit Proof of Loss to Us.

Benefits accrue as of the first day after the Elimination Period and are paid monthly. However, benefits will not exceed the Maximum Duration of Benefits.

Mental Illness Limitation: *Are benefits limited for Mental Illness?*
If You are Disabled because of:
1) Mental Illness that results from any cause; or
2) any condition that may result from Mental Illness;

then, subject to all other provisions of The Policy, We will limit the Maximum Duration of Benefits. Benefits will be payable:
1) for as long as You are confined in a hospital or other place licensed to provide medical care for the disabling condition; or
2) if not confined, or after You are discharged and still disabled, for a total of 24 months for all such disabilities during Your lifetime.

Specified Condition Limitation: *Are benefits limited for any specified conditions?*
If You are Disabled because of any of the following conditions or symptom complexes:
1) chronic fatigue conditions such as:
   a) chronic fatigue syndrome;
   b) chronic fatigue immunodeficiency syndrome;
2) post viral syndrome;
3) limbic encephalopathy;
4) Epstein-Barr virus infection;
5) herpes virus type 6 infection;
6) myalgic encephalomyelitis;

7) any allergy or sensitivity to chemicals or the environment such as:
   a) environmental allergies;
   b) sick building syndrome;
   c) multiple chemical sensitivity syndrome or chronic toxic encephalopathy;
8) chronic pain conditions such as:
   a) fibromyalgia;
   b) reflex sympathetic dystrophy or myofascial pain;
   c) carpal tunnel or repetitive motion syndrome;
   d) temporomandibular joint disorder; or
   e) craniomandibular joint disorder.

Specified Condition Limitation does not include neoplastic diseases, neurologic diseases, endocrine diseases, hematologic diseases, asthma, allergy-induced reactive lung disease, tumors, malignancies, or vascular malformations, demyelinating diseases, or lupus.

We will limit the Maximum Duration of Benefits, subject to all other provisions of The Policy.

Benefits will be payable until the earlier of:
1) the date benefit payments terminate under the Termination of Payment provision; or
2) the date You have received Disability benefit payments from Us for one or more of the diseases specified above for a total of 24 month(s) in Your lifetime.

The period of time referenced above will include the time that one or more of the specified diseases are the working diagnosis of the condition which is a cause of Your Disability.

Recurrent Disability: *What happens if I Recover but become Disabled again?*
Periods of Recovery during the Elimination Period will not interrupt the Elimination Period, if the number of days You return to work as an Active Employee are equal to 60 days or less.

Any day within such period of Recovery, will not count toward the Elimination Period.

After the Elimination Period, if You return to work as an Active Employee and then become Disabled and such Disability is:
1) due to the same cause; or
2) due to a related cause; and
3) within 6 months of the return to work;

the Period of Disability prior to Your return to work and the recurrent Disability will be considered one Period of Disability, provided The Policy remains in force.

If You return to work as an Active Employee for 60 days or more, any recurrence of a Disability will be treated as a new Disability. The new Disability is subject to a new Elimination Period and a new Maximum Duration of Benefits.

Period of Disability means a continuous length of time during which You are Disabled under The Policy.

Recover or Recovery means that You are no longer Disabled and have returned to work with the Employer and premiums are being paid for You.

Calculation of Monthly Benefit: Return to Work Incentive: *How are my Disability benefits calculated?*
If You remain Disabled after the Elimination Period, but work while You are Disabled, We will determine Your Monthly Benefit for a period of up to 12 consecutive months as follows:
1) multiply Your Pre-disability Earnings by the Benefit Percentage;
2) compare the result with the Maximum Benefit; and
3) from the lesser amount, deduct Other Income Benefits.

The result is Your Monthly Benefit. Current Monthly Earnings will not be used to reduce Your Monthly Benefit. However, if the sum of Your Monthly Benefit and Your Current Monthly Earnings exceeds 100% of Your Pre-

disability Earnings, We will reduce Your Monthly Benefit by the amount of excess.

The 12 consecutive month period will start on the last to occur of:
1) the day You first start work; or
2) the end of the Elimination Period.

If You are Disabled and not receiving benefits under the Return to Work Incentive, We will calculate Your Monthly Benefit as follows:
1) multiply Your Monthly Income Loss by the Benefit Percentage;
2) compare the result with the Maximum Benefit; and
3) from the lesser amount, deduct Other Income Benefits. The result is Your Monthly Benefit.

Calculation of Monthly Benefit: *What happens if the sum of my Monthly Benefit, Current Monthly Earnings, and Other Income Benefits exceeds 100% of my Pre-disability Earnings?*
If the sum of Your Monthly Benefit, Current Monthly Earnings, and Other Income Benefits exceeds 100% of Your Pre-disability Earnings, We will reduce Your Monthly Benefit by the amount of the excess. However, Your Monthly Benefit will not be less than the Minimum Monthly Benefit.

If an overpayment occurs, We may recover all or any portion of the overpayment, in accordance with the Overpayment Recovery provision.

Minimum Monthly Benefit: *Is there a Minimum Monthly Benefit?*
Your Monthly Benefit will not be less than the Minimum Monthly Benefit shown in the Schedule of Insurance.

Partial Month Payment: *How is the benefit calculated for a period of less than a month?*
If a Monthly Benefit is payable for a period of less than a month, We will pay 1/30 of the Monthly Benefit for each day You were Disabled.

Termination of Payment: *When will my benefit payments end?*
Benefit payments will stop on the earliest of:
1) the date You are no longer Disabled;
2) the date You fail to furnish Proof of Loss;
3) the date You are no longer under the Regular Care of a Physician;
4) the date You refuse Our request that You submit to an examination by a Physician or other qualified medical professional;
5) the date of Your death;
6) the date You refuse to receive recommended treatment that is generally acknowledged by Physicians to cure, correct or limit the disabling condition;
7) the last day benefits are payable according to the Maximum Duration of Benefits Table;
8) the date Your Current Monthly Earnings:
    a) are equal to or greater than 80% of Your Indexed Pre-disability Earnings if You are receiving benefits for being Disabled from Your Occupation; or
    b) exceed 60% of Your Indexed Pre-disability Earnings if You are receiving benefits for being Disabled from Any Occupation;
9) the date no further benefits are payable under any provision in The Policy that limits benefit duration; or
10) the date You refuse to participate in a Rehabilitation program, or refuse to cooperate with or try:
    a) modifications made to the work site or job process to accommodate Your identified medical limitations to enable You to perform the Essential Duties of Your Occupation;
    b) adaptive equipment or devices designed to accommodate Your identified medical limitations to enable You to perform the Essential Duties of Your Occupation;
    c) modifications made to the work site or job process to accommodate Your identified medical limitations to enable You to perform the Essential Duties of Any Occupation, if You were receiving benefits for being disabled from Any Occupation; or
    d) adaptive equipment or devices designed to accommodate Your identified medical limitations to enable You to perform the Essential Duties of Any Occupation, if You were receiving benefits for being disabled from Any Occupation;

provided a qualified Physician or other qualified medical professional agrees that such modifications, Rehabilitation program or adaptive equipment accommodate Your medical limitation.

Family Care Credit Benefit: *What if I must incur expenses for Family Care Services in order to participate in a Rehabilitation program?*
If You are working as part of a program of Rehabilitation, We will, for the purpose of calculating Your benefit, deduct the cost of Family Care from earnings received from work as a part of a program of Rehabilitation, subject to the following limitations:

1) Family Care means the care or supervision of:
   a) Your children under age 13; or
   b) a member of Your household who is mentally or physically handicapped and dependent upon You for support and maintenance;
2) the maximum monthly deduction allowed for each qualifying child or family member is:
   a) $350 during the first 12 months of Rehabilitation; and
   b) $175 thereafter;
   but in no event may the deduction exceed the amount of Your monthly earnings;
3) Family Care Credits may not exceed a total of $2,500 during a calendar year;
4) the deduction will be reduced proportionally for periods of less than a month;
5) the charges for Family Care must be documented by a receipt from the caregiver;
6) the credit will cease on the first to occur of the following:
   a) You are no longer in a Rehabilitation program; or
   b) Family Care Credits for 24 months have been deducted during Your Disability; and
7) no Family Care provided by someone Related to the family member receiving the care will be eligible as a deduction under this provision.

Your Current Monthly Earnings after the deduction of Your Family Care Credit will be used to determine Your Monthly Income Loss. In no event will You be eligible to receive a Monthly Benefit under The Policy if Your Current Monthly Earnings before the deduction of the Family Care Credit exceed 80% of Your Indexed Pre-disability Earnings.

Survivor Income Benefit: *Will my survivors receive a benefit if I die while receiving Disability Benefits?*
If You were receiving a Monthly Benefit at the time of Your death, We will pay a Survivor Income Benefit, when We receive proof satisfactory to Us:

1) of Your death; and
2) that the person claiming the benefit is entitled to it.

We must receive the satisfactory proof for Survivor Income Benefits within 1 year of the date of Your death.

The Survivor Income Benefit will only be paid:

1) to Your Surviving Spouse; or
2) if no Surviving Spouse, in equal shares to Your Surviving Children.

If there is no Surviving Spouse or Surviving Children, then no benefit will be paid.

However, We will first apply the Survivor Income Benefit to any overpayment which may exist on Your claim.

If a minor child is entitled to benefits, We may, at Our option, make benefit payments to the person caring for and supporting the child until a legal guardian is appointed.

The Survivor Income Benefit is calculated as 3 times the lesser of:

1) Your Monthly Income Loss multiplied by the Benefit Percentage in effect on the date of Your death; or
2) The Maximum Monthly Benefit.

Surviving Spouse means Your spouse who was not legally separated or divorced from You when You died. "Spouse" will include Your domestic partner provided You:

1) have executed a domestic partner affidavit satisfactory to Us, establishing that You and Your partner are domestic partners for purposes of The Policy; or
2) have registered as domestic partners with a government agency or office where such registration is

available and provide proof of such registration unless requiring proof is prohibited by law.
You will continue to be considered domestic partners provided You continue to meet the requirements described in the domestic partner affidavit or required by law.

Surviving Children means Your unmarried children, step children, legally adopted children who, on the date You die, are primarily dependent on You for support and maintenance and who are under age 25.

The term Surviving Children will also include any other children related to You by blood or marriage or domestic partnership and who:
1) lived with You in a regular parent-child relationship; and
2) were eligible to be claimed as dependents on Your federal income tax return for the last tax year prior to Your death.

Workplace Modification Benefit: *Will the Rehabilitation program provide for modifications to my workplace to accommodate my return to work?*
We will reimburse Your Employer for the expense of reasonable Workplace Modifications to accommodate Your Disability and enable You to return to work as an Active Employee. You qualify for this benefit if:
1) Your Disability is covered by The Policy;
2) the Employer agrees to make modifications to the workplace in order to reasonably accommodate Your return to work and the performance of the Essential Duties of Your job; and
3) We approve, in writing, any proposed Workplace Modifications.

Benefits paid for such Workplace Modification shall not exceed $25,000. We have the right, at Our expense, to

have You examined or evaluated by:
1) a Physician or other health care professional; or
2) a vocational expert or rehabilitation specialist;
of Our choice so that We may evaluate the appropriateness of any proposed modification.

We will reimburse the Employer's costs for approved Workplace Modifications after:
1) the proposed modifications made on Your behalf are complete;
2) We have been provided written proof of the expenses incurred to provide such modification; and
3) You have returned to work as an Active Employee.

Workplace Modification means change in Your work environment, or in the way a job is performed, to allow You to perform, while Disabled, the Essential Duties of Your job. Payment of this benefit will not reduce or deny any benefit You are eligible to receive under the terms of The Policy.

With respect to Class 1:
Ability Plus Benefit: *What is the Ability Plus Benefit?*
We will pay You the Ability Plus Benefit if:
1) a Monthly Benefit is payable;
2) You become Cognitively Impaired or unable to perform two or more Activities of Daily Living (ADLs) for which You cannot be reasonably accommodated by adaptive equipment:
   a) during or after the Elimination Period, and
   b) for at least 30 consecutive days; and
3) the Disability and such impairment or inability begins while You are covered under this benefit.

The Ability Plus Benefit will be 20% of Your Monthly Income Loss, but not greater than the lesser of:
1) $5000; or
2) the Maximum Monthly Benefit.

We will pay the benefit to You monthly. For periods of less than one month, We will pay 1/30th of the Ability Plus Benefit for each day of covered loss. The Ability Plus Benefit is payable in addition to the Monthly Benefit payable under the Disability Benefit.

The Ability Plus Benefit will not:

1) be reduced by Other Income Benefits;
2) increase or reduce other benefits under The Policy; or
3) be subject to the Cost of Living Adjustment.

You are not restricted in any way as to Your use of this Ability Plus Benefit.

We will stop paying You the Ability Plus Benefit on the date:
1) Your Monthly Benefit terminates;
2) You are not Cognitively Impaired and You are able to perform five or more ADLs; or
3) You reach the maximum payment period shown in this benefit.

Cognitively Impaired means You suffer severe deterioration, or loss of:
1) memory;
2) orientation; or
3) the ability to understand or reason;

so that You are unable to perform common tasks such as, but not limited to, medication management, money management and using the telephone. The impairment in intellectual capacity must be measurable by standardized tests.

Activities of Daily Living (ADLs) means the following functions performed with or without equipment or adaptive devices:
1) bathing Yourself by being able to either:
   a) wash Yourself in a tub or shower devices; or
   b) give Yourself a sponge bath;
2) dressing Yourself by putting on and taking off needed garments and any braces or artificial limbs necessary for You to wear;
3) using the toilet by being able to get to and from, and on and off the toilet, and performing the associated hygienic tasks; or
4) transferring from bed to chair or wheelchair; or
5) bladder and bowel control by being able to either:
   a) voluntarily control bowel and bladder function; or
   b) maintain a reasonable level of personal hygiene, if You are not so able; and
6) feeding Yourself, once the food has been prepared and made available to You.

With respect to Class 2:
Ability Plus Benefit: *What is the Ability Plus Benefit?*
We will pay You the Ability Plus Benefit if:
1) a Monthly Benefit is payable;
2) You become Cognitively Impaired or unable to perform two or more Activities of Daily Living (ADLs) for which You cannot be reasonably accommodated by adaptive equipment:
   a) during or after the Elimination Period, and
   b) for at least 30 consecutive days; and
3) the Disability and such impairment or inability begins while You are covered under this benefit.

The Ability Plus Benefit will be 30% of Your Pre-disability Earnings, but not greater than the lesser of:
1) $5,000; or
2) the Maximum Monthly Benefit.

We will pay the benefit to You monthly. For periods of less than one month, We will pay 1/30th of the Ability Plus Benefit for each day of covered loss. The Ability Plus Benefit is payable in addition to the Monthly Benefit payable under the Disability Benefit.

The Ability Plus Benefit will not:
1) be reduced by Other Income Benefits; or
2) increase or reduce other benefits under The Policy.

You are not restricted in any way as to Your use of this Ability Plus Benefit.

We will stop paying You the Ability Plus Benefit on the date:
1) Your Monthly Benefit terminates; or
2) You are not Cognitively Impaired and You are able to perform five or more ADLs.

Cognitively Impaired means You suffer severe deterioration, or loss of:
1) memory;
2) orientation; or
3) the ability to understand or reason;

so that You are unable to perform common tasks such as, but not limited to, medication management, money management and using the telephone. The impairment in intellectual capacity must be measurable by standardized tests.

Activities of Daily Living (ADLs) means the following functions performed with or without equipment or adaptive devices:
1) bathing Yourself by being able to either:
   a) wash Yourself in a tub or shower devices; or
   b) give Yourself a sponge bath;
2) dressing Yourself by putting on and taking off needed garments and any braces or artificial limbs necessary for You to wear;
3) using the toilet by being able to get to and from, and on and off the toilet, and performing the associated hygienic tasks; or
4) transferring from bed to chair or wheelchair; or
5) bladder and bowel control by being able to either:
   a) voluntarily control bowel and bladder function; or
   b) maintain a reasonable level of personal hygiene, if You are not so able; and
6) feeding Yourself, once the food has been prepared and made available to You.

Exclusions And Limitations

Exclusions: *What Disabilities are not covered?*
The Policy does not cover, and We will not pay a benefit for, any Disability:
1) unless You are under the Regular Care of a Physician;
2) that is caused or contributed to by war or act of war, whether declared or not;
3) caused by Your commission of or attempt to commit a felony;
4) caused or contributed to by Your being engaged in an illegal occupation; or
5) caused or contributed to by an intentionally self-inflicted injury.

If You are receiving or are eligible for benefits for a Disability under a prior disability plan that:
1) was sponsored by Your Employer; and
2) was terminated before the Effective Date of The Policy; no benefits will be payable for the Disability under The Policy.

With respect to Class 1:
Pre-existing Condition Limitation: *Are benefits limited for Pre-existing Condition?*
We will not pay any benefit, or any increase in benefits, under The Policy for any Disability that results from, or is caused or contributed to by, a Pre-existing Condition, unless, at the time You become Disabled:
1) You have not received Medical Care for the condition for 3 consecutive month(s) while insured under The Policy; or
2) You have been continuously insured under The Policy for 12 consecutive month(s).

Pre-existing Condition means:
1) any accidental bodily injury, sickness, Mental Illness, pregnancy, episode of Substance Abuse, or Other Limited Conditions; or

2) any manifestations, symptoms, findings, or aggravations related to or resulting from such accidental bodily injury, sickness, Mental Illness, pregnancy, Substance Abuse, or Other Limited Conditions;

for which You received Medical Care during the 3 consecutive month(s) period that ends the day before:

1) Your effective date of coverage; or
2) the effective date of a Change in Coverage.

Medical Care is received when a Physician or other health care provider:

1) is consulted or gives medical advice; or
2) recommends, prescribes, or provides Treatment.

Treatment includes but is not limited to:

1) medical examinations, tests, attendance or observation; and
2) use of drugs, medicines, medical services, supplies or equipment.

With respect to Class 2:

Pre-existing Condition Limitation: *Are benefits limited for Pre-existing Conditions?*

We will not pay any benefit, or any increase in benefits, under The Policy for any Disability that results from, or is caused or contributed to by, a Pre-existing Condition, unless, at the time You become Disabled:

1) You have not received Medical Care for the condition for 6 consecutive month(s) while insured under The Policy; or
2) You have been continuously insured under The Policy for 24 consecutive month(s).

Pre-existing Condition means:

1) any accidental bodily injury, sickness, Mental Illness, pregnancy, episode of Substance Abuse, or Other Limited Conditions; or
2) any manifestations, symptoms, findings, or aggravations related to or resulting from such accidental bodily injury, sickness, Mental Illness, pregnancy, Substance Abuse, or Other Limited Conditions;

for which You received Medical Care during the 6 consecutive month(s) period that ends the day before:

1) Your effective date of coverage; or
2) the effective date of a Change in Coverage.

Medical Care is received when a Physician or other health care provider:

1) is consulted or gives medical advice; or
2) recommends, prescribes, or provides Treatment.

Treatment includes but is not limited to:

1) medical examinations, tests, attendance or observation; and
2) use of drugs, medicines, medical services, supplies or equipment.

General Provisions

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

You must give Us written notice of a claim within 30 days after Disability or loss occurs. Failure to give notice within such time shall not invalidate or reduce any claim if it shall be shown not to have been reasonably possible to give such notice and that notice was given as soon as was reasonably possible. Such notice must include Your name, Your address and the Policy Number.

If You are Disabled and become eligible for the Ability Plus Benefit, You must file a separate Notice of Claim within 30 days of becoming eligible.

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

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

of Your claim.

Proof of Loss: *What is Proof of Loss?*
Proof of Loss may include but is not limited to the following:

1) documentation of:
   a) the date Your Disability began;
   b) the cause of Your Disability;
   c) the prognosis of Your Disability;
      d) Your Pre-disability Earnings, Current Monthly Earnings or any income, including but not limited to copies of Your filed and signed federal and state tax returns; and
   e) evidence that You are under the Regular Care of a Physician;
   2) any and all medical information, including x-ray films and photocopies of medical records, including histories, physical, mental or diagnostic examinations and treatment notes;
3) the names and addresses of all:
   a) Physicians or other qualified medical professionals You have consulted;
   b) hospitals or other medical facilities in which You have been treated; and
   c) pharmacies which have filled Your prescriptions within the past three years;
4) Your signed authorization for Us to obtain and release:
   d) medical, employment and financial information; and
   e) any other information We may reasonably require;
5) disclosure of all information and documentation required by Us relating to Other Income Benefits;
6) proof that You and Your dependents have applied for all Other Income Benefits which are available; and
   7) disclosure of all information and documentation required by Us in order to exercise Our Subrogation or Reimbursement rights.

You will not be required to claim any retirement benefits which You may only get on a reduced basis. All proof submitted must be satisfactory to Us.

Additional Proof of Loss: *What Additional Proof of Loss is the Company entitled to?*
To assist Us in determining if You are Disabled, or to determine if You meet any other term or condition of The Policy, We have the right to require You to:

1) meet and interview with Our representative; and
2) be examined by a Physician, vocational expert, functional expert, or other medical or vocational professional of Our choice.

Any such interview, meeting or examination will be:

1) at Our expense; and
2) as reasonably required by Us.

Your Additional Proof of Loss must be satisfactory to Us. Unless We determine You have a valid reason for refusal, We may deny, suspend or terminate Your benefits if You refuse to be examined or meet to be interviewed by Our representative.

Sending Proof of Loss: *When must Proof of Loss be given?*
Written Proof of Loss must be sent to Us within 90 days following the completion of the Elimination Period. If proof is not given by the time it is due, it will not affect the claim if:

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

We may request Proof of Loss throughout Your Disability, as reasonably required. In such cases, We must receive the proof within 30 day(s) of the request.

Claim Payment: *When are benefit payments issued?*
When We determine that You;

1) are Disabled; and
2) eligible to receive benefits;

We will pay accrued benefits at the end of each month that You are Disabled. We may, at Our option, make an advance benefit payment based on Our estimated duration of Your Disability. If any payment is due after a claim is terminated, it will be paid as soon as Proof of Loss satisfactory to Us is received.

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

Claims to be Paid: *To whom will benefits for my claim be paid?*
All payments are payable to You. Any payments owed at Your death may be paid to Your estate. If any payment is owed to:

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

then We may pay up to $1,000 to a person who is Related to You and who, at Our sole discretion, is entitled to it. Any such payment shall fulfill Our responsibility for the amount paid.

Claim Denial: *What notification will I receive if my claim is denied?*
If a claim for benefits is wholly or partly denied, You will be furnished with written notification of the decision. This written notification will:

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

Claim Appeal: *What recourse do I have if my claim is denied?*
On any claim, You or Your representative may appeal to Us for a full and fair review. To do so You:

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

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

Social Security: *When must I apply for Social Security Benefits?*
You must apply for Social Security disability benefits when the length of Your Disability meets the minimum duration required to apply for such benefits. You must apply within 45 days from the date of Our request. If the Social Security Administration denies Your eligibility for benefits, You will be required:

1) to follow the process established by the Social Security Administration to reconsider the denial; and
2) if denied again, to request a hearing before an Administrative Law Judge of the Office of Hearing and Appeals.

Benefit Estimates: *How does the Company estimate Disability benefits under the United States Social Security Act?* We reserve the right to reduce Your Monthly Benefit by estimating the Social Security disability benefits You or Your spouse and children may be eligible to receive.

When We determine that You or Your dependent may be eligible for benefits, We may estimate the amount of these benefits. We may reduce Your Monthly Benefit by the estimated amount.

Your Monthly Benefit will not be reduced by estimated Social Security disability benefits if:

1) You apply for Social Security disability benefits and pursue all required appeals in accordance with the Social Security provision; and
2) You have signed a form authorizing the Social Security Administration to release information about awards directly to Us; and
3) You have signed and returned Our reimbursement agreement, which confirms that You agree to repay all overpayments.

If We have reduced Your Monthly Benefit by an estimated amount and:

1) You or Your dependent are later awarded Social Security disability benefits, We will adjust Your Monthly Benefit when We receive proof of the amount awarded, and determine if it was higher or lower than Our estimate; or
2) Your application for Social Security disability benefits has been denied, We will adjust Your Monthly Benefit when You provide Us proof of final denial from which You cannot appeal from an Administrative Law Judge of the Office of Hearing and Appeals.

If Your Social Security benefits were lower than We estimated, and We owe You a refund, We will make such refund in a lump sum. If Your Social Security benefits were higher than We estimated, and if Your Monthly Benefit has been overpaid, You must make a lump sum refund to Us equal to all overpayments, in accordance with the Overpayment Recovery provision.

Overpayment: *When does an overpayment occur?*
An overpayment occurs:
1) when We determine that the total amount We have paid in benefits is more than the amount that was due to You under The Policy; or
2) when payment is made by Us that should have been made under another group policy.

This includes, but is not limited to, overpayments resulting from:
1) retroactive awards received from sources listed in the Other Income Benefits definition;
2) failure to report, or late notification to Us of any Other Income Benefit(s) or earned income;
3) misstatement;
4) fraud; or
5) any error We may make.

Overpayment Recovery: *How does the Company exercise the right to recover overpayments?*
We have the right to recover from You any amount that We determine to be an overpayment. You have the obligation to refund to Us any such amount. Our rights and Your obligations in this regard may also be set forth in the reimbursement agreement You will be required to sign when You become eligible for benefits under The Policy.

If benefits are overpaid on any claim, You must reimburse Us within 30 days. If reimbursement is not made in a

timely manner, We have the right to:
1) recover such overpayments from:
   a) You;
   b) any other organization;
   c) any other insurance company;
   d) any other person to or for whom payment was made; and
   e) Your estate;
2) reduce or offset against any future benefits payable to You or Your survivors, including the Minimum Monthly Benefit, until full reimbursement is made. Payments may continue when the overpayment has been recovered;
3) refer Your unpaid balance to a collection agency; and
4) pursue and enforce all legal and equitable rights in court.

Subrogation: *What are Our subrogation rights?*
If You:
1) suffer a Disability caused, in full or in part, by the act or omission of any person or legal entity;
2) become entitled to and are paid benefits under The Policy in compensation for lost wages; and
3) do not initiate legal action for the recovery of such benefits from a Third Party in a reasonable period of time or notify Us that You do not intend to do so;

then We will be subrogated to any rights You may have against a Third Party and may, at Our option, bring legal action against or otherwise pursue a Third Party to recover any payments made by Us in connection with the Disability.

Third Party as used in this provision, means:
1) any person or legal entity whose act or omission, in full or in part, causes You to suffer a Disability for

which benefits are paid or payable under The Policy; or
2) any insurer, including Your own, that provides benefits to You as a result of the act or omission which causes You to suffer a Disability for which benefits are paid or payable under The Policy.

Reimbursement: *What are Our reimbursement rights?*
We have the right to be reimbursed for any benefit payments made or required to be made under The Policy for a Disability for which You recover any funds from a Third Party.

If You recover any funds from a Third Party as:
1) a legal judgment;
2) an arbitration award; or
3) a settlement or otherwise;

You or Your attorney shall hold in constructive trust the lesser of:
1) the entire amount of the benefit payment(s) made or required to be made by Us; or
2) the total amount of the recovered funds;

less Our pro rata share of any reasonable attorneys' fees and court costs associated with the recovered funds.
We have the right of first reimbursement regardless of:
1) whether You are made whole;
2) how the recovered funds are characterized; or
3) whether the particular funds recovered are still in Your possession.

By accepting benefit payment(s) under The Policy, You:
1) agree to cooperate fully with Our reimbursement rights, including disclosure of all information and documentation required by Us in order to exercise Our reimbursement rights; and
2) will not do anything to prejudice Our reimbursement rights.

You or Your attorney's failure to cooperate fully with Our reimbursement rights may result in denial or termination of Your benefits under The Policy.

Third Party as used in this provision, means:
1) any person or legal entity whose act or omission, in full or in part, causes You to suffer a Disability for which benefits are paid or payable under The Policy; or
2) any insurer, including Your own, that provides benefits to You as a result of the act or omission which causes You to suffer a Disability for which benefits are paid or payable under The Policy.

Legal Actions: *When can legal action be taken against Us?*
Legal action cannot be taken against Us:
1) sooner than 60 days after the date Proof of Loss is given; or
2) more than 3 years after the date Proof of Loss is required to be given according to the terms of The Policy.

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

Misstatements: *What happens if facts are misstated?*
If material facts about You were not stated accurately:
1) Your premium may be adjusted; and
2) the true facts will be used to determine if, and for what amount, coverage should have been in force.

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

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

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

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

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

Physical Examinations and Autopsy: *Will I be examined during the course of my claim?*
While a claim is pending We have the right at Our expense:

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

Definitions

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

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

We will consider You Actively at Work on a day that is not a scheduled work day only if You were Actively at Work on the preceding scheduled work day.

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

Any Occupation means any occupation for which You are qualified by education, training or experience, and that has an earnings potential greater than the lesser of:

1) 60% of Your Indexed Pre-disability Earnings; or
2) the Maximum Monthly Benefit.

Current Monthly Earnings means monthly earnings You receive from:

1) Your Employer; and

2) other employment; while You are Disabled.

However, if the other employment is a job You held in addition to Your job with Your Employer, then during any period that You are entitled to benefits for being Disabled from Your Occupation, only the portion of Your earnings that exceeds Your average earnings from the other employer over the 6 month period just before You became Disabled will count as Current Monthly Earnings.

Current Monthly Earnings also includes the pay You could have received for another job or a modified job if:
1) such job was offered to You by Your Employer, or another employer, and You refused the offer; and
2) the requirements of the position were consistent with:
   a) Your education, training and experience; and
   b) Your capabilities as medically substantiated by Your Physician.

Disability or Disabled means You are prevented from performing one or more of the Essential Duties of:
1) Your Occupation during the Elimination Period;
2) Your Occupation, for the 24 months following the Elimination Period, and as a result Your Current Monthly Earnings are less than 80% of Your Indexed Pre-disability Earnings; and
3) after that, Any Occupation.

If at the end of the Elimination Period, You are prevented from performing one or more of the Essential Duties of Your Occupation, but Your Current Monthly Earnings are equal to or greater than 80% of Your Pre-disability Earnings, Your Elimination Period will be extended for a total period of 12 months from the original date of Disability, or until such time as Your Current Monthly Earnings are less than 80% of Your Pre-disability Earnings, whichever occurs first. For the purposes of extending Your Elimination Period, Your Current Monthly Earnings will not include the pay You could have received for another job or a modified job if such job was offered to You by Your Employer, or another employer, and You refused the offer.

Your Disability must result from:
1) accidental bodily injury;
2) sickness;
3) Mental Illness;
4) Substance Abuse; or
5) pregnancy.

Your failure to pass a physical examination required to maintain a license to perform the duties of Your Occupation, alone, does not mean that You are Disabled.

Elimination Period means the longer of the number of consecutive days at the beginning of any one period of Disability which must elapse before benefits are payable or the expiration of any Employer sponsored short term disability benefits or salary continuation program, excluding benefits required by state law.

Employer means the Policyholder.

Essential Duty means a duty that:
1) is substantial, not incidental;
2) is fundamental or inherent to the occupation; and
3) cannot be reasonably omitted or changed.

Your ability to work the number of hours in Your regularly scheduled workweek is an Essential Duty.

Indexed Pre-disability Earnings means Your Pre-disability Earnings adjusted annually by adding the lesser of:
1) 10%; or
2) the percentage change in the Consumer Price Index (CPI-W).

The percentage change in the CPI-W means the difference between the current year's CPI-W as of July 31, and the prior year's CPI-W as of July 31, divided by the prior year's CPI-W. The adjustment is made January 1st each year after You have been Disabled for 12 consecutive month(s), provided You are receiving benefits at the time the adjustment is made.

The term Consumer Price Index (CPI-W) means the index for Urban Wage Earners and Clerical Workers published by the United States Department of Labor. It measures on a periodic (usually monthly) basis the change in the cost of typical urban wage earners' and clerical workers' purchase of certain goods and services. If the index is discontinued or changed, We may use another nationally published index that is comparable to the CPI-W.

Mental Illness means a mental disorder as listed in the current version of the Diagnostic and Statistical Manual of Mental Disorders, published by the American Psychiatric Association. A Mental Illness may be caused by biological factors or result in physical symptoms or manifestations.

For the purpose of The Policy, Mental Illness does not include the following mental disorders outlined in the Diagnostic and Statistical Manual of Mental Disorders:

1) Mental Retardation;
2) Pervasive Developmental Disorders;
3) Motor Skills Disorder;
4) Substance-Related Disorders;
5) Delirium, Dementia, and Amnesic and Other Cognitive Disorders; or
6) Narcolepsy and Sleep Disorders related to a General Medical Condition.

Monthly Benefit means a monthly sum payable to You while You are Disabled, subject to the terms of The Policy.

Monthly Income Loss means Your Pre-disability Earnings minus Your Current Monthly Earnings.

Other Income Benefits means the amount of any benefit for loss of income, provided to You or Your family, as a result of the period of Disability for which You are claiming benefits under The Policy. This includes any such benefits for which You or Your family are eligible or that are paid to You or Your family, or to a third party on Your behalf, pursuant to any:

1) temporary, permanent disability, or impairment benefits under a Workers' Compensation Law, the Jones Act, occupational disease law, similar law or substitutes or exchanges for such benefits;
2) governmental law or program that provides disability or unemployment benefits as a result of Your job with Your Employer;
3) plan or arrangement of coverage, whether insured or not, which is received from Your Employer as a result of employment by or association with Your Employer or which is the result of membership in or association with any group, association, union or other organization;
4) mandatory "no-fault" automobile insurance plan;
5) disability benefits under:
    a) the United States Social Security Act or alternative plan offered by a state or municipal government;
    b) the Railroad Retirement Act;
    c) the Canada Pension Plan, the Canada Old Age Security Act, the Quebec Pension Plan or any provincial pension or disability plan; or
    d) similar plan or act;

    that You, Your spouse and/or children, are eligible to receive because of Your Disability; or
6) disability benefit from the Department of Veterans Affairs, or any other foreign or domestic governmental agency:
    a) that begins after You become Disabled; or
    b) that You were receiving before becoming Disabled, but only as to the amount of any increase in the benefit attributed to Your Disability.

Other Income Benefits also means the amount of any payments that are made to You or to Your family, or to a third party on Your behalf, pursuant to any:

1) disability benefit under Your Employer's Retirement Plan;
2) temporary, permanent disability or impairment benefits under a Workers' Compensation Law, the Jones Act, occupational disease law, similar law or substitutes or exchanges for such benefits;
3) portion of a judgement or settlement of a claim or lawsuit that represents or compensates for Your loss of earnings, less Our pro rata share of any associated reasonable attorneys' fees and court costs;

4) retirement benefit from a Retirement Plan that is wholly or partially funded by employer contributions, unless:
   a) You were receiving it prior to becoming Disabled; or
   b) You immediately transfer the payment to another plan qualified by the United States Internal Revenue Service for the funding of a future retirement;

   (Other Income Benefits will not include the portion, if any, of such retirement benefit that was funded by Your after-tax contributions.); or
5) retirement benefits under:
   a) the United States Social Security Act or alternative plan offered by a state or municipal government;
   b) the Railroad Retirement Act;
   c) the Canada Pension Plan, the Canada Old Age Security Act, the Quebec Pension Plan or any provincial pension or disability plan; or
   d) similar plan or act;

   that You, Your spouse and/or children receive because of Your retirement, unless You were receiving them prior to becoming Disabled.

If You are paid Other Income Benefits in a lump sum or settlement, You must provide proof satisfactory to Us of:
1) the amount attributed to loss of income; and
2) the period of time covered by the lump sum or settlement.

We will pro-rate the lump sum or settlement over this period of time. If You cannot or do not provide this information, We will assume the entire sum to be for loss of income, and the time period to be 24 month(s). We may make a retroactive allocation of any retroactive Other Income Benefit. A retroactive allocation may result in an overpayment of Your claim.

The amount of any increase in Other Income Benefits will not be included as Other Income Benefits if such increase:
1) takes effect after the date benefits become payable under The Policy; and
2) is a general increase which applies to all persons who are entitled to such benefits.

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

Pre-disability Earnings means Your regular annual rate of pay in effect on the last day You were Actively at Work before You became Disabled, including:
1) contributions You make through a salary reduction agreement with the Employer to:
   a) an Internal Revenue Code (IRC) Section 401(k), 403(b), 408(k), 408(p) or 457 deferred compensation arrangement;
   b) an executive non-qualified deferred compensation arrangement; or
   c) a salary reduction arrangement under an IRC Section 125 plan; plus
2) annual target incentives expected to be paid by Your Employer in effect on the last day You were Actively at Work before You became Disabled;

divided by 12.

Pre-disability Earnings does not include bonuses, commissions, tips and tokens, overtime pay or any other fringe benefits or extra compensation.

Annual target incentives:
1) apply to incentive-eligible employees with a career band designated as SL, customer and frontline experience roles in T-Mobile for Business, and Customer Experience Center employees with a monthly incentive plan (i.e. not an annual corporate bonus plan); and
2) are listed in the Employer's HR system. If You are part-time, Your annual incentive listed in the HR system will be prorated based on Your Full-time Employment percent.

Prior Policy means the long term disability insurance carried by the Employer on the day before the Policy Effective Date.

Regular Care of a Physician means that You are being treated by a Physician:

1) whose medical training and clinical experience are suitable to treat Your disabling condition; and
2) whose treatment is:
   a) consistent with the diagnosis of the disabling condition;
   b) according to guidelines established by medical, research, and rehabilitative organizations; and
   c) administered as often as needed;

   to achieve the maximum medical improvement.

Rehabilitation means a process of Our working together with You in order for Us to plan, adapt, and put into use options and services to meet Your return to work needs. A Rehabilitation program may include, when We consider it to be appropriate, any necessary and feasible:

1) vocational testing;
2) vocational training;
3) alternative treatment plans such as:
   a) support groups;
   b) physical therapy;
   c) occupational therapy; or
   d) speech therapy;
4) work-place modification to the extent not otherwise provided;
5) job placement;
6) transitional work; and
7) similar services.

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

Retirement Plan means a defined benefit or defined contribution plan that provides benefits for Your retirement and which is not funded wholly by Your contributions. It does not include:

1) a profit sharing plan;
2) thrift, savings or stock ownership plans;
3) a non-qualified deferred compensation plan; or
4) an individual retirement account (IRA), a tax sheltered annuity (TSA), Keogh Plan, 401(k) plan, 403(b) plan or 457 deferred compensation arrangement.

Substance Abuse means the pattern of pathological use of alcohol or other psychoactive drugs and substances characterized by:

1) impairments in social and/or occupational functioning;
2) debilitating physical condition;
3) inability to abstain from or reduce consumption of the substance; or
4) the need for daily substance use to maintain adequate functioning.

Substance includes alcohol and drugs but excludes tobacco and caffeine.

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

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

Your Occupation means Your Occupation as it is recognized in the general workplace. Your Occupation does not mean the specific job You are performing for a specific employer or at a specific location.

You or Your means the person to whom this certificate is issued.

Maryland

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

State Notices

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

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

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

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

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

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

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

Alaska:

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

Arizona:

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

Arkansas:

1. **NOTICE:** You have the right to file a complaint with the Arkansas Insurance Department (AID). You may call AID to request a complaint form at (800) 852-5494 or (501) 371-2640 or write the Department at:
   Arkansas Insurance Department
   1 Commerce Way, Suite 102
   Little Rock, AR 72202
2. The **Policy Interpretation** provision, if shown in the **General Provisions** section of the Certificate, is not applicable.

California:

1. **NOTICE:** READ YOUR CERTIFICATE CAREFULLY
   You have a 30 day right from Your original Certificate Effective Date to examine Your certificate. If You are not satisfied, You may return it to Us within 30 days of Your original Certificate Effective Date. In that event, We will consider it void from its Effective Date and any premiums paid will be refunded. Any claims paid under The Policy during the initial 30 day period will be deducted from the refund.

   PLEASE BE ADVISED THAT YOU RETAIN ALL RIGHTS WITH RESPECT TO YOUR POLICY/CERTIFICATE AGAINST YOUR ORIGINAL INSURER IN THE EVENT THE ASSUMING INSURER IS UNABLE TO FULFILL ITS OBLIGATIONS. IN SUCH EVENT YOUR ORIGINAL INSURER REMAINS LIABLE TO YOU NOTWITHSTANDING THE TERMS OF ITS ASSUMPTION AGREEMENT.
2. The **Policy Interpretation** provision, if shown in the General Provisions section of the Certificate, does not apply to you. The following requirement applies to you:

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

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

3. **For Your Questions and Complaints:**
   State of California Insurance Department
   Consumer Communications Bureau
   300 South Spring Street, South Tower
   Los Angeles, CA 90013
   Toll Free: 1(800) 927-HELP
   TDD Number: 1(800) 482-4833

Web Address: www.insurance.ca.gov

Colorado:

1. The **Surviving Children** definition within the **Survivor Income Benefit** will always include children related to You by civil union.
2. The **Surviving Spouse** definition within the **Survivor Income Benefit** will always include civil unions.
3. Entering a civil union, terminating a civil union, the death of a party to a civil union or a party to a civil union losing employment, which results in a loss of group insurance, will all constitute as a **Change in Family Status**.
4. The **Complications of Pregnancy** provision, if shown in the **Definitions** section of the Certificate, is revised as follows:

   Complications of Pregnancy means a condition whose diagnosis is distinct from pregnancy but adversely affected or caused by pregnancy, such as:
   1) acute nephritis or nephrosis;
   2) cardiac decompensation;
   3) missed abortion; and
   4) similar medical and surgical conditions of comparable severity.

   Complications of Pregnancy will also include:
   1) pre-eclampsia;
   2) placenta previa;
   3) physician prescribed bed rest for intra-uterine growth retardation, funneling, incompetent cervix;
   4) termination of ectopic pregnancy;
   5) spontaneous termination of pregnancy, occurring during a period of gestation in which a viable birth is not possible;
   6) non-elective Cesarean section; and
   7) similar medical and surgical conditions of comparable severity.

   However, the term Complications of Pregnancy will not include:
   1) elective Cesarean section;
   2) false labor, occasional spotting, or morning sickness;
   3) hyperemesis gravidarum; or
   4) similar conditions associated with the management of a difficult pregnancy not consisting of a nosologically distinct Complication of Pregnancy.
5. The **Claim Appeal** provision will always include the following:

   In addition, if a claim for benefits is wholly or partially denied and all administrative remedies have been exhausted, You are entitled to pursue such claim anew, from the beginning, in a court with jurisdiction and entitled to a trial by jury.
6. The **Policy Interpretation** provision, if shown in the **General Provisions** section of the Certificate, is not applicable.

Florida:

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

Georgia:

1. **NOTICE:** The laws of the state of Georgia prohibit insurers from unfairly discriminating against any person based upon his or her status as a victim of family abuse.

Idaho:

1. **For Your Questions and Complaints:**
   Idaho Department of Insurance
   Consumer Affairs

700 W State Street, 3rd Floor
PO Box 83720
Boise, ID 83720-0043
Toll Free: 1-800-721-3272
Web Address: www.DOI.Idaho.gov

2. **Notice to Buyer: This is a disability income protection policy.**
   3. The **Elimination Period** provision, shown in the **Schedule of Insurance** section of the Certificate, cannot exceed:
   1) 90 days for plan designs with a **Maximum Duration of Benefits Payable** of 1 year or less;
   2) 180 days for plan designs with a **Maximum Duration of Benefits Payable** of more than 1 year but less than 2 years; or
   3) 365 days for plan designs with a **Maximum Duration of Benefits Payable** of 2 years or more.
   4. The **Maximum Duration of Benefits Payable** provision, shown in the **Schedule of Insurance** section of the Certificate, cannot be less than 6 months.

Illinois:

1. The **Policy Interpretation** provision, if shown in the **General Provisions** section of the Certificate, is not applicable.
2. **For Your Questions and Complaints:** Illinois Department of Insurance Consumer Services Station Springfield, Illinois 62767
   Consumer Assistance: 1(866) 445-5364
   Officer of Consumer Health Insurance: 1(877) 527-9431
3. In accordance with Illinois law, insurers are required to provide the following **NOTICE** to applicants of insurance policies issued in Illinois.

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

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

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

Indiana:

1. **For Your Questions and Complaints:**
Public Information/Market Conduct
Indiana Department of Insurance
311 W. Washington St. Suite 300
Indianapolis, IN 46204-2787
1(317) 232-2395

Kansas:

1. The following requirement applies to you:

Policy Interpretation: *Who interprets Policy terms and conditions?*

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

Louisiana:

1. The following requirement is applicable to you:

   Reinstatement after Military Service: *Can coverage be reinstated after return from active military service?*
   If Your or Your Dependents' coverage ends because You or Your Dependents enter active military service, coverage may be reinstated, provided You request such reinstatement upon Your or Your Dependents' release from active military service.

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

Maine:

1. **NOTICE:** The benefits under the policy are subject to reduction due to other sources of income.

   This means that your benefits will be reduced by the amount of any other benefits for loss of time provided to you or for which you are eligible as a result of the same period of disability for which you claim benefits under the policy.

   Other sources of income are plans or arrangements of coverage that provide disability-related benefits such as Worker's Compensation or other similar governmental programs or laws, or disability-related benefits received from your employer or as the result of your employment, membership or association with any group, union, association or other organization. Other sources of income include disability-related benefits under the United States Social Security Act or an alternate governmental plan, the Railroad Retirement Act, and other similar plans or acts. Other sources of income may also include certain disability-related or retirement benefits that you receive because of your retirement unless you were receiving them prior to becoming disabled.

   What comprises other sources of income under the policy is determined by the nature of the policyholder. Therefore, we strongly urge you to **Read Your Certificate Carefully.** A full description of the plans and types of plans considered to be other sources of income under the policy will be found in the definition of "Other Income Benefits" located in the Definitions section of your certificate.
2. **NOTICE:** The laws of the State of Maine require notification of the right to designate a third party to receive notice of cancellation, to change such a designation and, to have the Policy reinstated if the insured suffers from cognitive impairment or functional incapacity and the ground for cancellation was the insured's nonpayment of premium or other lapse or default on the part of the insured.

   Within 10 days after a request by an insured, a Third Party Notice Request Form shall be mailed or personally delivered to the insured.
3. The following **requirement is applicable to you**:

   Reinstatement: *Can my coverage be reinstated after it ends?*
   We will reinstate The Policy upon receipt of all current and late premiums if:
   1) You, any person authorized to act on Your behalf, or any of Your dependents may request reinstatement of The Policy within 90 days following cancellation of The Policy for nonpayment of premium provided You suffered from cognitive impairment or functional incapacity at the time the contract cancelled; and

2) all current and late premium payments are received within 15 days of Our request.

We may request a medical demonstration, at Your expense, that You suffered from cognitive impairment or functional incapacity at the time of cancellation of The Policy.

Massachusetts:

1. The **Surviving Children** definition in the **Survivor Income Benefit** will also include a child in the process of adoption.
2. The following continuation requirement is applicable to you

   In accordance with Massachusetts state law, if Your insurance terminates because Your employment terminates or You cease to be a member of an eligible class, Your insurance will automatically be continued until the end of a 31 day period from the date Your insurance terminates or the date You become eligible for similar benefits under another group plan, whichever occurs first. You must pay the required premium for continued coverage.

   Additionally, if Your insurance terminates because Your employment is terminated as a result of a plant closing or covered partial closing, Your insurance may be continued. You must elect in writing to continue insurance and pay the required premium for continued coverage. Coverage will cease on the earliest to occur of the following dates:
   1) 90 days from the date You were no longer eligible for coverage as an Active Employee;
   2) the date You become eligible for similar benefits under another group plan;
   3) the last day of the period for which required premium is made;
   4) the date the group insurance policy terminates; or
   5) the date Your Employer ceases to be a Participant Employer, if applicable.

Michigan:

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

Minnesota:

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

Missouri:

1. The **Exclusions** provision shall only exclude for intentionally self-inflicted Injury, suicide or attempted suicide, which occur while You are sane.

Montana:

1. **NOTICE:** Conformity with Montana statutes: The provisions of the certificate conform to the minimum requirements of Montana law and control over any conflicting statutes of any state in which the insured resides on or after the effective date of the certificate.
2. Pregnancy will be covered, the same as any other sickness, anything in The Policy to the contrary notwithstanding.
3. The definition of **Physician** in the **Definitions** section will include the following freedom of choice language: You have full freedom of choice in the selection of any health care provider for treatment within the scope and limitations of his or her practice, including a licensed physician, physician assistant, dentist, osteopath, chiropractor, optometrist, podiatrist, psychologist, licensed social worker, licensed professional counselor, licensed marriage and family therapist, acupuncturist, naturopathic physician, physical therapist or advanced practice registered nurse.

New Hampshire:

1. If Your claim is denied, You may appeal to Us within 180 days of receipt of the claim denial, subject to the other terms of the **Claim Appeal** provision.
2. The time period stated for legal action to start in the **Legal Actions** provision shown in the **General Provisions**
   section can not be less than 3 years after the time **Proof of Loss** is required to be given.

3. The time period for receipt of **Medical Care**, as described in the **Pre-existing Condition** definition of the **Exclusions and Limitations** section, is 3 consecutive months. No benefit or increase in benefits for a **Pre-existing Condition** will be payable until You have been treatment free or continuously insured for 9 consecutive months, or less respectively, if shown in the Certificate.
4. Termination of coverage will not affect benefits otherwise payable for a claim incurred while the Policy is in force.
5. **Notice:** This is an ancillary health certificate. This certificate provides limited benefits. Benefits provided are supplemental and are not intended to cover all medical expenses.
6. **Notice: READ YOUR CERTIFICATE CAREFULLY -** You have a 30 day right to examine Your certificate. If You are not satisfied, You may return it to Us within 30 days from the later of Your original Certificate Effective Date or the date The Policy was received by the Policyholder. In that event, We will consider it void from its Effective Date and any premiums paid will be refunded. Any claims paid under The Policy during the initial 30 day period will be deducted from the refund.
7. **Notice:** The Policy does not provide comprehensive health insurance coverage. It is not intended to satisfy the individual mandate of the Affordable Care Act (ACA) or provide the minimum essential coverage required by the ACA (often referred to as "Major Medical Coverage"). It does not provide coverage for hospital, medical, surgical, or major medical expenses.

New Jersey:

1. The **Surviving Children** definition within the **Survivor Income Benefit** will always include children related to You by civil union.
2. The **Surviving Spouse** definition within the **Survivor Income Benefit** will always include civil unions and domestic partners, provided You continue to meet the requirements described in the domestic partner affidavit, civil union license or civil union certificate or as required by law. Same sex relationships entered into under the laws of another State or Country, which closely approximate a civil union or a domestic partnership under New Jersey law, will be recognized as civil unions or domestic partners under New Jersey law.

New Mexico:

1. The **Surviving Children** definition within the **Survivor Income Benefit,** if included in Your Certificate, will include children up to age 26.

New York:

1. The **Other Income Benefits** definition will not include a portion of a settlement or judgment of a lawsuit that

   represents or compensates for Your loss of earnings.
2. The **Conversion Right** provision, if shown in the **Period of Coverage** section of the Certificate, is not applicable.
3. The **Subrogation** provision, if shown in the **General Provisions** section of the Certificate, is not applicable.
4. The **Reimbursement** provision, if shown in the **General Provisions** section of the Certificate, is not applicable.
5. If the definition of **Surviving Spouse** within the **Survivor Income Benefit** requires the completion of a domestic partner affidavit, the following requirement applies to you:

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

   The domestic partner affidavit further requires that You and Your domestic partner provide proof of

financial interdependence in the form of at least two of the following:

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

North Carolina:

1. The **Subrogation** provision, if shown in the **General Provisions** section of the Certificate, is not applicable.
2. The **Other Income Benefits** definition will not include a mandatory "no-fault" automobile insurance plan.
3. You are not required to be under the **Regular Care of a Physician** if qualified medical professionals have determined that further medical care and treatment would be of no benefit to You.
4. The **Exclusions** provision shall only exclude for Workers' Compensation if the final adjudication of the Worker's Compensation claim determined that benefits are paid, or may be paid, if duly claimed.
5. Within the **Misstatements** provision reference to fraudulent misstatements will not apply to You.
6. The **Sending Proof of Loss** provision is amended to state that written **Proof of Loss** must be sent to Us within

   180 days following the completion of the **Elimination Period**.
7. The **Claims to be Paid** provision is amended to state that We may pay up to $3,000 to a person who is Related to You and who, at Our sole discretion, is entitled to it. Any such payment shall fulfill Our responsibility for the amount paid.
8. **Notice of Claim** may also be given to Our representative, if applicable.
9. **NOTICE:** UNDER NORTH CAROLINA GENERAL STATUTE SECTION 58-50-40, NO PERSON, EMPLOYER, FINANCIAL AGENT, TRUSTEE, OR THIRD PARTY ADMINISTRATOR, WHO IS RESPONSIBLE FOR THE PAYMENT OF GROUP LIFE INSURANCE, GROUP HEALTH OR GROUP HEALTH PLAN PREMIUMS, SHALL:
   1. CAUSE THE CANCELLATION OR NONRENEWAL OF GROUP LIFE INSURANCE, GROUP HEALTH INSURANCE, HOSPITAL, MEDICAL, OR DENTAL SERVICE CORPORATION PLAN, MULTIPLE EMPLOYER WELFARE ARRANGEMENT, OR GROUP HEALTH PLAN COVERAGES AND THE CONSEQUENTIAL LOSS OF THE COVERAGES OF THE PERSON INSURED, BY WILLFULLY FAILING TO PAY THOSE PREMIUMS IN ACCORDANCE WITH THE TERMS OF THE INSURANCE OR PLAN CONTRACT; AND
   2. WILLFULLY FAIL TO DELIVER, AT LEAST 45 DAYS BEFORE THE TERMINATION OF THOSE COVERAGES, TO ALL PERSONS COVERED BY THE GROUP POLICY WRITTEN NOTICE OF

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

IMPORTANT TERMINATION INFORMATION

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

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

PRE-EXISTING LIMITATION
READ CAREFULLY
NO BENEFITS WILL BE PAYABLE UNDER THIS PLAN FOR PRE-EXISTING CONDITIONS WHICH ARE NOT COVERED UNDER THE PRIOR PLAN. PLEASE READ THE LIMITATIONS IN THE CERTIFICATE.

READ YOUR CERTIFICATE CAREFULLY.

Oregon:

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

   Jury Duty: If You are scheduled to serve or are required to serve as a juror, Your coverage may be continued until the last day of Your Jury Duty, provided You:
   1) elected to have Your coverage continued; and
   2) provided notice of the election to Your Employer in accordance with Your Employer's notification policy.

Rhode Island:

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

South Carolina:

1. The **Physical Examinations and Autopsy** provision will state that such autopsy must be performed during the period of contestability and must take place in the state of South Carolina.
2. If You become insured under The Policy on the Policy Effective Date and were insured under the Prior Policy within 30 days of being covered under The Policy, the **Pre-existing Condition Limitation** will end on the earliest of:
   1) the Policy Effective date, if Your coverage for the Disability was not limited by a pre-existing condition restriction under the Prior Policy; or
   2) the date the restriction would have ceased to apply had the Prior Policy remained in force, if Your coverage was limited by a pre-existing condition limitation under the Prior Policy.

   This is subject to the other terms and conditions of the **Continuity From a Prior Policy** provision.

South Dakota:

1. The definition of **Physician** can include You or a person Related to You by blood or marriage in the event that the Physician is the only one in the area and is acting within the scope of their normal employment.
2. The **Other Income Benefits** definition will not include the amount of any benefit for loss of income, provided to Your family, Your Spouse or Your Spouse's family.

Texas:

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

Have a complaint or need help?

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

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

Hartford Life and Accident Insurance Company
To get information or file a complaint with your insurance company:

Call: Customer Service at 860-547-5000 Toll-free: 1-800-523-2233

Online: https://www.thehartford.com/contact-the-hartford Email: gbdcustomerservice@thehartford.com
Mail: The Hartford, Group Benefits Division, P.O. Box 2999, Hartford, CT 06104-2999

The Texas Department of Insurance
To get help with an insurance question or file a complaint with the state:

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

File a complaint: www.tdi.texas.gov
Email: ConsumerProtection@tdi.texas.gov
Mail: MC 111-1A, P.O. Box 12030, Austin, TX 78711-2030

¿Tiene una queja o necesita ayuda?

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

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

Hartford Life and Accident Insurance Company
Para obtener información o para presentar una queja ante su compañía de seguros:

Llame a: servicio al cliente al 860-547-5000 Teléfono gratuito: 1-800-523-2233

En línea: https://www.thehartford.com/contact-the-hartford Correo electrónico: gbdcustomerservice@thehartford.com
Dirección postal: The Hartford, Group Benefits Division, P.O. Box 2999, Hartford, CT 06104-2999

El Departamento de Seguros de Texas
Para obtener ayuda con una pregunta relacionada con los seguros o para presentar una queja ante el

estado:

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

Presente una queja en: www.tdi.texas.gov
Correo electrónico: ConsumerProtection@tdi.texas.gov
Dirección postal: MC 111-1A, P.O. Box 12030, Austin, TX 78711-2030

Utah:

1. If the **Sending Proof of Loss** provision provides a timeframe in which proof must be submitted before it affects Your claim, this time limitation shall not apply to You.

Vermont:

1. The following requirement applies:

Purpose: Vermont law requires that health insurers offer coverage to parties to a civil union that is equivalent to coverage provided to married persons.

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

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

CAUTION: FEDERAL LAW RIGHTS MAY OR MAY NOT BE AVAILABLE

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

2. Vermont Mental Health and Substance Abuse Exclusion and Limitation Parity:
   If You become Disabled as a legal resident of Vermont and The Policy covers 25 or more legal residents of Vermont, the following applies:
   1) Disability due to Mental Illness or Substance Abuse may not be excluded from coverage; and
   2) the Maximum Duration of Benefits for Disability due to Mental Illness or Substance Abuse may not be limited. The Maximum Duration of Benefits shown in the Schedule of Insurance shall apply to You.

Virginia:

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

Washington:

1. The following continuation applies to you:

   General Work Stoppage (including a strike or lockout): If Your employment terminates due to a cessation of active work as the result of a general work stoppage (including a strike or lockout), Your coverage shall be continued during the work stoppage for a period not exceeding 6 months. If the work stoppage ends, this continuation will cease immediately.

Wisconsin:

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

ERISA Information

The Following Notice
Contains Important Information

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

The benefits described in your booklet-certificate (Booklet) are provided under a group insurance policy (Policy) issued by the Hartford Life and Accident Insurance Company (Insurance Company) and are subject to the Policy's terms and conditions. The Policy and Booklet are incorporated into, and form a part of, the Plan. The Plan has designated and named the Insurance Company as the claims fiduciary for benefits provided under the Policy. The Plan has granted the Insurance Company full discretion and authority to determine eligibility for benefits and to construe and interpret all terms and provisions of the Policy, to the extent permitted by applicable state law.

A copy of the Plan is available for your review during normal working hours in the office of the Plan Administrator.

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1. **Plan Name**

   T-MOBILE USA, INC. EMPLOYEE BENEFIT PLAN.

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2. **Plan Number**

   LTD - 506

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3. **Employer/Plan Sponsor**

   T-MOBILE USA, INC.
   12920 SE 38th Street
   Bellevue, WA 98006-7305

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4. **Employer Identification Number**

   91-1983600

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5. **Type of Plan**

   Welfare Benefit Plan providing Group Long Term Disability.

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6. **Plan Administrator**

   T-MOBILE USA, INC.
   12920 SE 38th Street
   Bellevue, WA 98006-7305

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7. **Agent for Service of Legal Process**

For the Plan

T-MOBILE USA, INC.
12920 SE 38th Street
Bellevue, WA 98006-7305

For the Policy:

Hartford Life and Accident Insurance Company
One Hartford Plaza
Hartford, Connecticut 06155

In addition to the above, Service of Legal Process may be made on a plan trustee or the plan administrator.

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8. **Sources of Contributions (Long Term Disability)** The Employer pays the premium for the insurance, but may allocate part of the cost to the employee, or the employee may pay the entire premium. The Employer determines the portion of the cost to be paid by the employee. The insurance company/provider determines the cost according to the rate structure reflected in the Policy of Incorporation.

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9. **Type of Administration** The plan is administered by the Plan Administrator with benefits provided in accordance with the provisions of the applicable group plan.

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10. The Plan and its records are kept on a Policy Year basis.

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11. **Labor Organizations**

    None

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12. **Names and Addresses of Trustees**

    None

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13. **Plan Amendment Procedure**

    The Plan Administrator reserves full authority, at its sole discretion, to terminate, suspend, withdraw, reduce, amend or modify the Plan, in whole or in part, at any time, without prior notice.

    The Employer also reserves the right to adjust your share of the cost to continue coverage by the same procedures.

Statement Of ERISA Rights

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

1. Receive Information About Your Plan and Benefits

a) Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and union halls, all documents governing the Plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.
b) Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary Plan description. The administrator may make a reasonable charge for the copies.
c) Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

2. Prudent Actions by Plan Fiduciaries

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

3. Enforce Your Rights

If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules. Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of Plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court. If the Plan requires you to complete administrative appeals prior to filing in court, your right to file suit in state or Federal court may be affected if you do not complete the required appeals. If it should happen that Plan fiduciaries misuse the Plan’s money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

4. Assistance with Your Questions

If you have any questions about your Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration (formerly known as the Pension and Welfare Benefits Administration), U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

CLAIM PROCEDURES

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

Claim Procedures for Claims Requiring a Determination of Disability

Claims and appeals for disability benefits will be adjudicated in a manner designed to ensure the independence and impartiality of the persons involved in making the decision. Accordingly, decisions regarding hiring, compensation, termination, promotion or other similar matters with respect to any individual (such as a claims adjudicator or medical or vocational expert) shall not be made based upon the likelihood that the individual will support the denial of benefits.

If the Insurance Company fails to strictly adhere to all the requirements of ERISA with respect to a claim, you are deemed to have exhausted the administrative remedies available under the Plan, with certain exceptions. Accordingly, you are entitled to bring a civil action to pursue any available remedies under section 502(a) of ERISA on the basis that the Insurance Company has failed to provide a reasonable claims procedure that would yield a decision on the merits of the claim. If you choose to bring a civil action to pursue remedies under section 502(a) of ERISA under such circumstances, your claim or appeal is deemed denied on review without the exercise of discretion by an appropriate fiduciary. However, the administrative remedies available under the Plan will not be deemed exhausted based on *de minimis* violations that do not cause, and are not likely to cause, prejudice or harm to you so long as the Insurance Company demonstrates that the violation was for good cause or due to matters beyond the control of the Insurance Company and that the violation occurred in the context of an ongoing, good faith exchange of information between the Insurance Company and you. This exception is not available if the violation is part of a pattern or practice of violations by the Insurance Company. Before filing a civil action, you may request a written explanation of the violation from the Insurance Company, and the Insurance Company must provide such explanation within 10 days, including a specific description of its bases, if any, for asserting that the violation should not cause the administrative remedies available under the Plan to be deemed exhausted. If a court rejects your request for immediate review on the basis that the Insurance Company met the standards for the exception, your claim shall be considered as re-filed on appeal upon the Insurance Company's receipt of the decision of the court. Within a reasonable time after the receipt of the decision, the Insurance Company shall provide you with notice of the resubmission.

Claims for Benefits

If you or your authorized representative would like to file a claim for benefits for yourself or your insured dependents, you or your authorized representative should obtain a claim form(s) from your Employer or Plan Administrator. The applicable section of such form(s) must be completed by (1) you, (2) the Employer or Plan Administrator and (3) the attending physician or hospital. Following completion, the claim form(s) must be forwarded to the Insurance Company's claim representative. The Insurance Company will evaluate your claim and determine if benefits are payable.

The Insurance Company will make a decision no more than 45 days after receipt of your properly filed claim. The time for decision may be extended for two additional 30 day periods provided that, prior to any extension period, the Insurance Company notifies you in writing that an extension is necessary due to matters beyond the control of the Insurance Company, identifies those matters and gives the date by which it expects to render its decision. If your claim is extended due to your failure to submit information necessary to decide your claim, the time for decision may be tolled from the date on which the notification of the extension is sent to you until the date the Insurance Company receives your response to our request. If the Insurance Company approves your claim, the decision will contain information sufficient to reasonably inform you of that decision.

Any adverse benefit determination will be in writing and include: 1) the specific reason or reasons for the decision; 2) specific references to the Policy provisions on which the decision is based; 3) a description of any additional material or information necessary for you to perfect the claim and an explanation of why such material or information is necessary; 4) a description of the Insurance Company's review procedures and time limits

applicable to such procedures; 5) a statement that you have the right to bring a civil action under section 502(a) of ERISA after you appeal the decision and after you receive a written denial on appeal; 6) a discussion of the decision, including an explanation of the basis for disagreeing with or not following: (a) the views presented by you to the Insurance Company of health care professionals treating you and vocational professionals who evaluated you, (b) the views of medical or vocational experts whose advice was obtained on behalf of the Insurance Company in connection with the adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination, and (c*)* a disability determination regarding you presented by you to the Insurance Company made by the Social Security Administration; 7) if the adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to your medical circumstances, or a statement that such explanation will be provided free of charge upon request; 8) either the specific internal rules, guidelines, protocols, standards or other similar criteria of the Insurance Company relied upon in making the adverse determination or, alternatively, a statement that such rules, guidelines, protocols, standards or other similar criteria of the Insurance Company do not exist; 9) a statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim for benefits; and 10) a statement prominently displayed in any applicable non-English language clearly indicating how to access the language services provided by the Insurance Company.

Appealing Denials of Claims for Benefits

On any wholly or partially denied claim, you or your representative must appeal once to the Insurance Company for a full and fair review. You must complete this claim appeal process before you file an action in court, with the exception of an action under the deemed exhausted process described above. Your appeal request must be in writing and be received by the Insurance Company no later than the expiration of 180 days from the date you received your claim denial. As part of your appeal:

1. you may request, free of charge, copies of all documents, records, and other information relevant to your claim; and
2. you may submit written comments, documents, records and other information relating to your claim.

The Insurance Company's review on appeal shall take into account all comments, documents, records and other information submitted by you relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination.

Before the Insurance Company can issue an adverse benefit determination on review, the Insurance Company shall provide you, free of charge, with any new or additional evidence considered, relied upon, or generated by the Insurance Company (or at the direction of the Insurance Company) in connection with the claim; such evidence must be provided as soon as possible and sufficiently in advance of the date on which the notice of adverse benefit determination on review is required to be provided to give you a reasonable opportunity to respond prior to that date.

Before the Insurance Company can issue an adverse benefit determination on review based on a new or additional rationale, the Insurance Company shall provide you, free of charge, with the rationale; the rationale must be provided as soon as possible and sufficiently in advance of the date on which the notice of adverse benefit determination on review is required to be provided to give you a reasonable opportunity to respond prior to that date.

The Insurance Company will make a final decision no more than 45 days after it receives your timely appeal. The time for final decision may be extended for one additional 45 day period provided that, prior to the extension, the Insurance Company notifies you in writing that an extension is necessary due to special circumstances, identifies those circumstances and gives the date by which it expects to render its decision. If your claim is extended due to your failure to submit information necessary to decide your claim on appeal, the time for decision shall be tolled from the date on which the notification of the extension is sent to you until the date the Insurance Company receives your response to the request. The Insurance Company may also toll the time for a decision to allow you a reasonable opportunity to respond to new or additional evidence or a new or additional rationale. Tolling will begin on the date that the Insurance Company provides you with new or additional evidence or a new or

additional rationale, and end when the Insurance Company receives the response or on the date by which the Insurance Company has requested a response, whichever comes first.

The individual reviewing your appeal shall give no deference to the initial benefit decision and shall be an individual who is neither the individual who made the initial benefit decision, nor the subordinate of such individual. The review process provides for the identification of the medical or vocational experts whose advice was obtained in connection with an initial adverse decision, without regard to whether that advice was relied upon in making that decision. When deciding an appeal that is based in whole or part on medical judgment, the Insurance Company will consult with a medical professional having the appropriate training and experience in the field of medicine involved in the medical judgment and who is neither an individual consulted in connection with the initial benefit decision, nor a subordinate of such individual. If the Insurance Company grants your claim appeal, the decision will contain information sufficient to reasonably inform you of that decision.

However, any final adverse benefit determination on review will be in writing and include: 1) the specific reason or reasons for the decision; 2) specific references to the Policy provisions on which the decision is based; 3) a statement that you are entitled to receive, upon request and free of charge, copies of all documents, records, and other information relevant to your claim; 4) a statement (a) that you have the right to bring a civil action under section 502(a) of ERISA, and (b) describing any applicable contractual limitations period that applies to your right to bring such an action, including the calendar date on which the contractual limitations period expires for the claim; 5) a discussion of the decision, including an explanation of the basis for disagreeing with or not following: (a) the views presented by you to the Insurance Company of health care professionals treating you and vocational professionals who evaluated you, (b) the views of medical or vocational experts whose advice was obtained on behalf of the Insurance Company in connection with the adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination, and (c*)* a disability determination regarding you presented by you to the Insurance Company made by the Social Security Administration; 6) if the adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to your medical circumstances, or a statement that such explanation will be provided free of charge upon request; 7) either the specific internal rules, guidelines, protocols, standards or other similar criteria of the Insurance Company relied upon in making the adverse determination or, alternatively, a statement that such rules, guidelines, protocols, standards or other similar criteria of the Plan do not exist; 8) a statement prominently displayed in any applicable non-English language clearly indicating how to access the language services provided by the Insurance Company; and 9) any other notice(s), statement(s) or information required by applicable law.

Claim Procedures for Claims Not Requiring a Determination of Disability

Claims and appeals for benefits will be adjudicated in a manner designed to ensure the independence and impartiality of the persons involved in making the decision. Accordingly, decisions regarding hiring, compensation, termination, promotion or other similar matters with respect to any individual (such as a claims adjudicator or medical expert) shall not be made based upon the likelihood that the individual will support the denial of benefits.

Claims for Benefits

If you or your authorized representative would like to file a claim for benefits for yourself or your insured dependents, you or your authorized representative should obtain a claim form(s) from your Employer or Plan Administrator. The applicable section of such form(s) must be completed by (1) you, (2) the Employer or Plan Administrator and (3) the attending physician or hospital. Following completion, the claim form(s) must be forwarded to the Insurance Company's claim representative. The Insurance Company will evaluate your claim and determine if benefits are payable.

The Insurance Company will make a decision no more than 90 days after receipt of your properly filed claim. However, if the Insurance Company determines that special circumstances require an extension, the time for its decision will be extended for an additional 90 days, provided that, prior to the beginning of the extension period, the Insurance Company notifies you in writing of the special circumstances and gives the date by which it expects to render its decision. If extended, a decision shall be made no more than 180 days after your claim was

received. If the Insurance Company approves your claim, the decision will contain information sufficient to reasonably inform you of that decision.

However, any adverse benefit determination will be in writing and include: 1) specific reasons for the decision; 2) specific references to Policy provisions on which the decision is based; 3) a description of any additional material or information necessary for you to perfect the claim and an explanation of why such material or information is necessary; 4) a description of the review procedures and time limits applicable to such, and 5) a statement that you have the right to bring a civil action under section 502(a) of ERISA after you appeal our decision and after you receive a written denial on appeal.

Appealing Denials of Claims for Benefits

On any wholly or partially denied claim, you or your representative must appeal once to the Insurance Company for a full and fair review. You must complete this claim appeal process before you file an action in court. Your appeal request must be in writing and be received by the Insurance Company no later than the expiration of 60 days from the date you received your claim denial. As part of your appeal:

1. you may request, free of charge, copies of all documents, records, and other information relevant to your claim; and
2. you may submit written comments, documents, records and other information relating to your claim.

The Insurance Company's review on appeal shall take into account all comments, documents, records and other information submitted by you relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination.

The Insurance Company will make a final decision no more than 60 days after it receives your timely appeal. However, if the Insurance Company determines that special circumstances require an extension, the time for its decision will be extended for an additional 60 days, provided that, prior to the beginning of the extension period, the Insurance Company notifies you in writing of the special circumstances and gives the date by which it expects to render its decision. If extended, a decision shall be made no more than 120 days after your appeal was received. If the Insurance Company grants your claim appeal, the decision will contain information sufficient to reasonably inform you of that decision.

However, any final adverse benefit determination on review will be in writing and include: 1) specific reasons for the decision and specific references to the Policy provisions on which the decision is based, 2) a statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant to the claim, 3) a statement of your right to bring a civil action under section 502(a) of ERISA, and 4) any other notice(s), statement(s) or information required by applicable law.

The Plan Described in this Booklet is Insured by the Hartford Life and Accident Insurance Company Hartford, Connecticut Member of The Hartford Insurance Group

Group Term Life Insurance Certificate with Accelerated Benefit

HARTFORD LIFE AND ACCIDENT INSURANCE COMPANY
One Hartford Plaza
Hartford, Connecticut 06155
(A stock insurance company)

CERTIFICATE OF INSURANCE

Policyholder: T-MOBILE USA, INC.
Policy Number: GL-402610
Policy Effective Date: June 1, 2013
Policy Anniversary Date: January 1, 2026

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

ACCELERATED BENEFITS UNDER THIS CERTIFICATE DO NOT, AND ARE NOT INTENDED TO, QUALIFY AS LONG-TERM CARE UNDER WASHINGTON STATE LAW. WASHINGTON STATE LAW PREVENTS ACCELERATED LIFE BENEFITS FROM BEING MARKETED OR SOLD AS LONG-TERM CARE

IF YOU OR YOUR DEPENDENT RECEIVE PAYMENT OF ACCELERATED BENEFITS UNDER THIS CERTIFICATE, YOU OR YOUR DEPENDENT MAY LOSE THE RIGHT TO RECEIVE CERTAIN PUBLIC FUNDS SUCH AS MEDICARE, MEDICAID, SOCIAL SECURITY, SUPPLEMENTAL SECURITY, SUPPLEMENTAL SECURITY INCOME AND POSSIBLY OTHERS.

ANY BENEFITS RECEIVED UNDER THE ACCELERATED BENEFIT PROVISION MAY BE TAXABLE. YOU OR YOUR DEPENDENT SHOULD CONSULT A PERSONAL TAX ADVISOR FOR FURTHER INFORMATION.

Signed for the Company

Kevin Barnett, ***Secretary***

Michael J. Fish, ***Head of Group Benefits***

A note on capitalization in this Certificate:

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

Form GBD-1100 (10/08) (WA)(402610) 1.107

Schedule Of Insurance

The benefits described herein are those in effect as of January 1, 2026.

Cost of Coverage:
Non-Contributory Coverage: Basic Life Insurance

Contributory Coverage: Supplemental Life Insurance
Supplemental Dependent Life Insurance

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

Disclosure of Services:
In addition to the insurance coverage, We may offer noninsurance benefits and services to Active Employees.

Disclosure of Payment to the Policyholder:
We have agreed to make payment to the Policyholder for reimbursement of cost(s) associated with:
1) audit;
2) marketing communication services; and
3) other administrative expenses.

Eligible Class(es) For Coverage: All Full-time and Part-time Active Employees who are citizens or legal residents of the United States, its territories and protectorates; excluding temporary, leased or seasonal employees as follows:

Class 1: All Full-time Active Employees
Class 2: All Part-time Active Employees

Full-time Employment: at least 30 scheduled hours weekly
Part-time Employment: at least 20 scheduled hours weekly

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

With respect to Basic Life Insurance:
Eligibility Waiting Period for Coverage:
None

With respect to Supplemental Life Insurance and Supplemental Dependent Life Insurance:
Eligibility Waiting Period for Coverage:
The first day of the month following 30 day(s) of employment.

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

Life Insurance Benefit

Amount of Life Insurance:

Basic Amount of Life Insurance

Maximum Amount

1.5 times Your annual Earnings, subject to a maximum of $1,000,000 rounded to the next

higher $1,000 if not already a multiple of $1,000.

Supplemental Amount of Life Insurance

Guaranteed Issue Amount	Maximum Amount
3 times Your annual Earnings, subject to a maximum of $750,000 rounded to the next higher $1,000 if not already a multiple of $1,000.	1, 2, 3, 4, 5, 6, 7, or 8 times Your annual Earnings, subject to a maximum of $2,000,000 rounded to the next higher $1,000 if not already a multiple of $1,000.

Dependent Life Insurance Benefit

Supplemental Amount of Dependent Life Insurance

	Guaranteed Issue Amount	Maximum Amount
Option 1: Spouse		$10,000
Option 2: Spouse		$50,000
Option 3: Spouse	$50,000	$100,000
Option 4: Spouse	$50,000	$150,000
Option 5: Spouse	$50,000	$200,000
Option 6: Spouse	$50,000	$250,000
Option 7: Spouse		$25,000
Option 8: Spouse	$50,000	$75,000

	Maximum Amount
Dependent Children: live birth but under age 26 year(s)	$10,000 Option 1
Dependent Children: live birth but under age 26 year(s)	$20,000 Option 2

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

Reduction in Amount of Life Insurance

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

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

Reduction in Coverage Due to Age

We will reduce the Life Insurance Benefit for You by 35% on the Policy Anniversary Date following the date You attain age 70 and by 50% on the Policy Anniversary Date following the date You attain age 75. The reduction will

apply to the Amount of Life Insurance in force immediately prior to the first reduction made. The reduced amount of coverage will be rounded to the next higher multiple of $1,000, if not already a multiple of $1,000. An appropriate adjustment in premium will be made.

Reductions also apply if:
1) You become covered under The Policy; or
2) Your coverage increases;

on or after the date You attain age 70.

Eligibility And Enrollment

Eligible Persons: *Who is eligible for coverage?*
All persons in the class or classes shown in the Schedule of Insurance will be considered Eligible Persons.

Eligibility for Coverage: *When will I become eligible?*
You will become eligible for coverage on the latest of:
1) the Policy Effective Date;
2) the date You become a member of an Eligible Class; or
3) the date You complete the Eligibility Waiting Period for Coverage shown in the Schedule of Insurance, if applicable.

Eligibility for Dependent Coverage: *When will I become eligible for Dependent Coverage?*
You will become eligible for Dependent coverage on the later of:
1) the date You become eligible for employee coverage; or
2) the date You acquire Your first Dependent.

No person may be insured as a Dependent and an Active Employee under The Policy.

Enrollment: *How do I enroll for coverage?*
For Non-Contributory Coverage, Your Employer will automatically enroll You for coverage. However, You will be required to complete a beneficiary designation form.

To enroll for Contributory Coverage, You must:
1) complete and sign a group insurance enrollment form which is satisfactory to Us, for Your and Your Dependent's coverage; and
2) deliver it to Your Employer.

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

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

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

Evidence of Insurability Requirements: *When will I first be required to provide Evidence of Insurability?*
We require Evidence of Insurability for initial coverage, if You:
1) enroll more than 31 days after the date You are first eligible to enroll, including electing initial coverage after a Change in Family Status;
2) enroll for an Amount of Life Insurance greater than the Supplemental Guaranteed Issue Amount, regardless of when You enroll for coverage; or
3) were eligible for any coverage under the Prior Policy, but did not enroll and later choose to enroll for that coverage under The Policy.

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

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

However, no Evidence of Insurability will be required if the Amount of Life Insurance for Your Dependent Child(ren) is $20,000 or less.

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

Change in Family Status: *What constitutes a Change in Family Status?*
A Change in Family Status occurs when:
1) You get married or You execute a domestic partner affidavit;
2) You and Your spouse divorce or You terminate a domestic partnership;
3) Your child is born or You adopt or become the legal guardian of a child;
4) Your spouse or domestic partner dies;
5) Your child is no longer financially dependent on You or dies;
6) Your spouse or domestic partner is no longer employed, which results in a loss of group insurance, or a change in Your spouse's employment with the consequence that such spouse becomes eligible for other group insurance coverage;
7) You have a change in classification from part-time to full-time or from full-time to part-time;
8) Your spouse takes an unpaid leave of absence from the employer; or
9) Your dependent is no longer eligible.

Period Of Coverage

Effective Date: *When does my coverage start?*
Non-Contributory Coverage will start on the date You become eligible.

Contributory Coverage, for which Evidence of Insurability is not required, will start on the latest to occur of:
1) the date You become eligible, if You enroll on or before that date; or
2) the date You enroll, if You do so within 31 days from the date You are eligible.

Any coverage for which Evidence of Insurability is required, will become effective on the later of:
1) the date You become eligible; or
2) the date We approve Your Evidence of Insurability.

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

Deferred Effective Date: *When will my effective date for coverage or a change in my coverage be deferred?*
If, on the date You are to become covered:
1) under The Policy;
2) for increased benefits; or
3) for a new benefit;

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

Continuity from a Prior Policy: *Is there continuity of coverage from a Prior Policy?*
Your initial coverage under The Policy will begin, and will not be deferred if, on the day before the Policy Effective Date, You were insured under the Prior Policy, but on the Policy Effective Date, You were not Actively at Work, and would otherwise meet the Eligibility requirements of The Policy. However, Your Amount of Insurance will be the lesser of the amount of life insurance:

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

reduced by any coverage amount:

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

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

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

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

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

Dependent Effective Date: *When does Dependent coverage start?*
Coverage, for which Evidence of Insurability is not required, will start on the latest to occur of:

1) the date You become eligible for Dependent coverage, if You have enrolled on or before that date; or
2) the date You enroll, if You do so within 31 days from the date You are eligible for Dependent coverage.

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

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

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

Dependent Deferred Effective Date: *When will the effective date for Dependent coverage or a change in coverage be deferred?*
If, on the date Your Dependent, other than a newborn, is to become covered:

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

and he or she is:

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

such coverage will not start until he or she:

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

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

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

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

Dependent Continuity from a Prior Policy: *Is there continuity of coverage from a Prior Policy for my Dependents?*
If on the day before the Policy Effective Date, You were covered with respect to Your Dependents under the Prior

Policy, the Deferred Effective Date provision will not apply to initial coverage under The Policy for such Dependents. However, the Dependent Amount of Insurance will be the lesser of the amount of life insurance:

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

reduced by any coverage amount:

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

Change in Coverage: *When may I change my coverage or coverage for my Dependents?*
After Your initial enrollment You may increase or decrease coverage for You or Your Dependents, or add a new Dependent to Your existing Dependent coverage at any time.

Effective Date for Changes in Coverage: *When will changes in coverage become effective?*
Any decrease in coverage will take effect on the date of the change.

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

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

With respect to Supplemental Life Insurance enrollments during an Annual Enrollment Period:
Increase in Amount of Life Insurance: *If I request an increase in the Amount of Life Insurance for myself, must I provide Evidence of Insurability?*
If You are:

1) already enrolled for an Amount of Supplemental Life Insurance under The Policy, then You must submit Evidence of Insurability for an increase of more than one level; or
2) not already enrolled for an Amount of Supplemental Life Insurance under The Policy, then You must provide Evidence of Insurability for an increase of more than one level;

including an initial amount.

In any event, if the Amount of Life Insurance You request is greater than $750,000, You must provide Evidence of Insurability.

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

With respect to Supplemental Life Insurance enrollments due to a Change in Family Status:
Increase in Amount of Life Insurance: *If I request an increase in the Amount of Life Insurance for myself, must I provide Evidence of Insurability?*
If You are:

1) already enrolled for an Amount of Supplemental Life Insurance under The Policy, then You must submit Evidence of Insurability for any increase that would result in an amount that is greater than the Guaranteed Issue Amount; or
2) not already enrolled for an Amount of Supplemental Life Insurance under The Policy, then You must provide Evidence of Insurability for any amount;

including an initial amount.

In any event, if the Amount of Life Insurance You request is greater than the Guaranteed Issue Amount, You must provide Evidence of Insurability.

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

With respect to Supplemental Dependent Life Insurance enrollment during an Annual Enrollment Period:

Increase in Amount of Life Insurance: *If I request an increase in the Amount of Life Insurance for my Dependents, must we provide Evidence of Insurability?*
If Your Dependents are:

1) already enrolled for an Amount of Supplemental Life Insurance under The Policy, then Your Dependents must submit Evidence of Insurability for an increase over $50,000; or
2) not already enrolled for an Amount of Supplemental Life Insurance under The Policy, then Your Dependents must provide Evidence of Insurability for any amount.

In any event, if the Amount of Life Insurance You request is greater than the Guaranteed Issue Amount, Your Dependents, as applicable, must provide Evidence of Insurability.

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

With respect to Supplemental Dependent Spouse Life Insurance enrollment following a Change in Family Status:
Increase in Amount of Life Insurance: *If I request an increase in the Amount of Life Insurance for my Dependents must we provide Evidence of Insurability?*
If Your Dependents are:

1) already enrolled for an Amount of Supplemental Life Insurance under The Policy, then Your Dependents must submit Evidence of Insurability for an increase over $50,000; or
2) not already enrolled for an Amount of Supplemental Life Insurance under The Policy, then Your Dependents must provide Evidence of Insurability for any amount.

In any event, if the Amount of Life Insurance You request is greater than the Guaranteed Issue Amount, Your Dependents, as applicable, must provide Evidence of Insurability.

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

With respect to Supplemental Life Insurance enrollments not during an Annual Enrollment Period or due to a Change in Family Status:
Increase in Amount of Life Insurance: *If I request an increase in the Amount of Life Insurance for myself or my dependents, must I provide Evidence of Insurability?*
If You or Your Dependents are:

1) already enrolled for an Amount of Supplemental Life Insurance under The Policy, then You must submit Evidence of Insurability for any amount; or
2) not already enrolled for an Amount of Supplemental Life Insurance under The Policy, then You must provide Evidence of Insurability for any amount;
   including an initial amount.

In any event, if the Amount of Life Insurance You request is greater than the Guaranteed Issue Amount, You or Your Dependents, as applicable, must provide Evidence of Insurability.

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

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

Termination: *When will my coverage end?*
Your coverage will end on the earliest of the following:

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

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

Dependent Termination: *When does coverage for my Dependent end?*
Coverage for Your Dependent will end on the earliest to occur of:
1) the date Your coverage ends;
2) the date the required premium is due but not paid;
3) the date You are no longer eligible for Dependent coverage;
4) the date We or the Employer terminate Dependent coverage; or
5) the date the Spouse no longer meets the definition of Spouse or the end of the month following the date the Dependent Child(ren) no longer meets the definition of Dependent Child(ren);

unless continued in accordance with the Continuation Provisions.

Continuation Provisions: *Can my coverage and coverage for my Dependents be continued beyond the date it would otherwise terminate?*
Coverage can be continued by Your Employer beyond a date shown in the Termination provision, if Your Employer provides a plan of continuation which applies to all employees the same way.

The amount of continued coverage applicable to You or Your Dependents will be the amount of coverage in effect on the date immediately before coverage would otherwise have ended. Continued coverage:
1) is subject to any reductions in The Policy;
2) is subject to payment of premium;
3) may be continued up to the maximum time shown in the provisions; and
4) terminates if The Policy terminates.

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

The maximum amount of time covered under the continuation provision from the start of your continuous leave would be 60 months.

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

Leave of Absence: If You are on an approved leave of absence, other than Military Leave of Absence, Your coverage (including Dependent Life coverage) may be continued for up to 60 months from the start date the leave of absence commenced. If the leave terminates prior to the agreed upon date, this continuation will cease immediately.

Military Leave of Absence: If You enter active full-time military service and are granted a military leave of absence in writing, Your coverage (including Dependent Life coverage) may be continued for up to 63 months from the start date leave of absence commenced. If the leave ends prior to the agreed upon date, this continuation will cease immediately.

Layoff: if You are temporarily laid off by the Employer due to lack of work, all of Your coverage (including Dependent Life coverage) may be continued for up to 6 months following the date the layoff commenced. If the layoff becomes permanent, this continuation will cease immediately.

Status Change: If You are:
1) employed by the Policyholder; and
2) no longer in an Eligible Class due to a reduction in the number of scheduled hours You work;

Your coverage (including Dependent Life coverage) may be continued for up to 6 months after the date Your scheduled hours were reduced.

Labor Dispute: If You are not Actively at Work as the result of a labor dispute, all of Your coverages (including Dependent Life coverage) may be continued during such dispute for a period not exceeding 6 months from the start date the leave of absence commenced. If the labor dispute ends, this continuation will cease immediately.

Severance: If Your employment terminates and continuation of life insurance is available to You and Your

Dependents in a severance plan sponsored by the Employer, all of Your coverage (including Dependent Life coverage) may be continued. Your coverage will continue until the earliest of:

1) the date The Policy terminates;
2) the date You become covered under another group life insurance policy;
3) the end of the month coincident with or next following the date specified in Your severance plan; or
4) for up to 18 month(s) from the date Your employment terminated.

Coverage for Your Dependents will continue until the earliest of:

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

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

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

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

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

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

Coverage under The Policy will continue as long as:

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

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

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

Benefits

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

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

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

Accelerated Benefit: *What is the benefit?*

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

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

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

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

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

The Amount of Life Insurance payable upon the Terminally Ill person's death will be reduced by any Accelerated Benefit Amount paid under this benefit. In addition, Your remaining Amount of Life Insurance will be subject to any reductions in The Policy and will not increase once an Accelerated Benefit has been paid. Any premium required

will be based on the amount of Your Life Insurance remaining after the Accelerated Benefit is paid under this benefit.

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

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

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

In the event:
1) You are required by law to accelerate benefits to meet the claims of creditors; or
2) if a government agency requires You to apply for benefits to qualify for a government benefit or entitlement; You will still be required to satisfy all the terms and conditions herein in order to receive an Accelerated Benefit.

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

Terminal Illness or Terminally Ill means that an individual has a medical condition which a Physician has certified is reasonably expected to result in death within 24 months or less after the date of certification.

Proof of Terminal Illness and Examinations: *Must proof of Terminal Illness be submitted?*
We reserve the right to require satisfactory Proof of Terminal Illness on an ongoing basis. Any diagnosis submitted must be provided by a Physician.

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

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

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

If coverage under The Policy ends because:
1) The Policy is terminated; or,
2) coverage for an Eligible Class is terminated;

then You or Your Dependent must have been insured under The Policy for 5 years or more, in order to be eligible to convert coverage. The amount which may be converted under these circumstances is limited to the lesser of:
1) $10,000; or

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

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

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

Conversion: *How do I convert my coverage or my Dependents' coverage?*
To convert Your coverage or coverage for Your Dependents, You must:
1) complete a Notice of Conversion Right form; and
2) have Your Employer sign the form.

The Insurer must receive this within:
1) 31 days after Life Insurance terminates; or
2) 15 days from the date Your Employer signs the form;

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

After the Insurer verifies eligibility for coverage, the Insurer will send You a Conversion Policy proposal. You must:
1) complete and return the request form in the proposal; and
2) pay the required premium for coverage;

within the time period specified in the proposal.

Any individual policy issued to You or Your Dependents under the Conversion Right:
1) will be effective as of the 32nd day after the date coverage ends; and
2) will be in lieu of coverage for this amount under The Policy.

Conversion Policy Provisions: *What are the Conversion Policy provisions?*
The Conversion Policy will:
1) be issued on any one of the Life Insurance policy forms the Insurer is issuing for this purpose at the time of conversion; and
2) base premiums on the Insurer's rates in effect for new applicants of Your class and age at the time of conversion.

The Conversion Policy will not provide:
1) the same terms and conditions of coverage as The Policy;
2) any benefit other than the Life Insurance Benefit; and
3) term insurance.

However, Conversion is not available for any Amount of Life Insurance which was, or is being, continued:
1) under a certificate of insurance issued in accordance with the Portability provision; or
2) in accordance with the Continuation Provisions;

until such coverage ends.

Death within the Conversion Period: *What if I or my Dependents die before coverage is converted?*
We will pay the deceased person’s Amount of Life Insurance You would have had the right to apply for under this provision if:
1) coverage under The Policy terminates; and
2) You or Your Dependent die within 31 days of the date coverage terminates; and
3) We receive Proof of Loss.

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

Portability Benefits: *What is Portability?*

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

Qualifying Events: *What are Qualifying Events?*
Qualifying Events for You are:

1) Your employment terminates for any reason prior to age 75; or
2) Your membership in an Eligible Class under The Policy ends;

provided the Qualifying Event occurs prior age 75.

Qualifying Events for Your Dependents are:

1) Your employment terminates, for any reason prior to age 75;
2) Your death;
3) Your membership in a class eligible for Dependent coverage ends; or
4) He or she no longer meets the definition of Dependent, however, a Dependent Child(ren) who reaches the limiting age under The Policy is not eligible for Portability;

provided the Qualifying Event occurs prior to age 75.

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

Electing Portability: *How do I elect Portability?*
You may elect Portability for Your coverage after Your Basic and Supplemental Life Insurance coverage ends due to a Qualifying Event. You may also elect Portability for Your Dependent coverage if Your Dependent coverage ends due to a Qualifying Event. The Policy must still be in force in order for Portability to be available.

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

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

This must be received within:

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

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

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

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

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

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

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

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

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

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

Effect of Portability on Other Provisions: *How does Portability affect other Provisions?*
Portability is not available for any Amount of Life Insurance which was, or is being, continued in accordance with the:

1) Conversion Right; or
2) Continuation provisions;

under The Policy. However, if:

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

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

General Provisions

Notice of Claim: *When should I notify the Company of a claim?*
You, or the person who has the right to claim benefits, must give Us, written notice of a claim within 30 days after the date of death.

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

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

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

1) a completed claim form;
2) a certified copy of the death certificate (if applicable);
3) Your Enrollment form;
4) Your Beneficiary Designation (if applicable);
5) documentation of:
    a) the date Your disability began;
    b) the cause of Your disability; and
    c) the prognosis of Your disability;
    6) any and all medical information, including x-ray films and photocopies of medical records, including histories, physical, mental or diagnostic examinations and treatment notes;
7) the names and addresses of all:
    a) Physicians or other qualified medical professionals You have consulted;
    b) hospitals or other medical facilities in which You have been treated; and
    c) pharmacies which have filled Your prescriptions within the past three years;
    8) Your signed authorization for Us to obtain and release medical, employment and financial information (if applicable); or
9) any additional information required by Us to adjudicate the claim. All proof submitted must be satisfactory to Us.

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

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

1) it was not reasonably possible to give proof within the required time; and
2) proof is given as soon as reasonably possible; but

3) not later than 1 year after it is due unless You, or the person who has the right to claim benefits, are not legally competent.

Physical Examination and Autopsy: *Can We have a claimant examined or request an autopsy?*
While a claim is pending We have the right at Our expense:
1) to have the person who has a loss examined by a Physician, with the exception of death benefits, when and as often as We reasonably require; and
2) to reasonably request to have an autopsy performed in case of death where it is not forbidden by law.

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

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

Claims to be Paid: *To whom will benefits for my claim be paid?*
Life Insurance Benefits will be paid in accordance with the life insurance Beneficiary Designation provided it does not contradict the Claim Payment provision.

If no beneficiary is named, or if no named beneficiary survives You, We may, at Our option, pay:
1) all to Your surviving spouse;
2) if Your spouse does not survive You, in equal shares to Your surviving children;
3) if no child survives You, in equal shares to Your surviving parents; or
4) the executors or administrators of Your estate.

In addition, We may, at Our option, pay a portion of Your Life Insurance Benefit up to $500 to any person equitably entitled to payment by reason of having incurred expenses on Your behalf or because of expenses from Your burial. Payment to any person, as shown above, will release Us from liability for the amount paid.

If any beneficiary is a minor, We may pay his or her share, until a legal guardian of the minor's estate is appointed, to a person who at Our option and in Our opinion is providing financial support and maintenance for the minor. We will pay:
1) $200 at Your death; and
2) monthly installments of not more than $200.
Payment to any person as shown above will release Us from all further liability for the amount paid.

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

If benefits are payable and meet Our guidelines, then You, or your Beneficiary, may elect to receive benefits in a lump sum payment or may elect to receive benefits through a draft book account. The draft book account will be owned by:
1) You, if living; or
2) Your beneficiary, in the event of Your death.

However, an account will not be established for:
1) a benefit payable to Your estate; or
2) an amount that is less than $10,000.

We will make any payments, other than for loss of life, to You. We may make any such payments owed at Your death to Your estate. If any payment is owed to:
1) Your estate;
2) a person who is a minor; or
3) a person who is not legally competent,
then We may pay up to $1,000 to a person who is related to You and who, at Our sole discretion, is entitled to it. Any such payment shall fulfill Our responsibility for the amount paid.

Beneficiary Designation: *How do I designate or change my beneficiary?*
You may designate or change a beneficiary by doing so in writing on a form satisfactory to Us and filing the form with the Employer. Only satisfactory forms sent to the Employer prior to Your death will be accepted.

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

In no event may a beneficiary be changed by a power of attorney.

Claim Denial: *What notification will my beneficiary or I receive if a claim is denied?*
If a claim for benefits is wholly or partly denied, You or Your beneficiary will be furnished with written notification of the decision. This written notification will:

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

Claim Appeal: *What recourse do my beneficiary or I have if a claim is denied?*
On any claim, the claimant or his or her representative may appeal to Us for a full and fair review. To do so, he or she:

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

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

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

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

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

Incontestability: *When can the Life Insurance Benefit of The Policy be contested?*
Except for non-payment of premiums, Your or Your Dependent's Life Insurance Benefit cannot be contested after two years from its effective date.

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

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

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

Assignment: *Are there any rights of assignment?*
You have the right to absolutely assign all of Your rights and interest under The Policy including, but not limited to the following:
1) the right to make any contributions required to keep the insurance in force;
2) the right to convert; and
3) the right to name and change a beneficiary.

We will recognize any absolute assignment made by You under The Policy, provided:
1) it is duly executed; and
2) a copy is acknowledged and on file with Us.

We and the Policyholder assume no responsibility:
1) for the validity or effect of any assignment; or
2) to provide any assignee with notices which We may be obligated to provide to You.

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

Legal Actions: *When can legal action be taken against Us?*
Legal action cannot be taken against Us:
1) sooner than 60 days after the date written Proof of Loss is furnished; or
2) more than 6 years after the date Proof of Loss is required to be furnished according to the terms of The Policy.

Workers' Compensation: *How does The Policy affect Workers' Compensation coverage?*
The Policy does not replace Workers' Compensation or affect any requirement for Workers' Compensation coverage.

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

Misstatements: *What happens if facts are misstated?*
If material facts about You or Your Dependents were not stated accurately:
1) the premium may be adjusted; and
2) the true facts will be used to determine if, and for what amount, coverage should have been in force.

Definitions

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

Actively at Work means at work with Your Employer on a day that is one of Your Employer's scheduled workdays. On that day, You must be performing for wage or profit all of the regular duties of Your job:
1) in the usual way; and
2) for Your usual number of hours.

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

Contributory Coverage means coverage for which You are required to contribute toward the cost. Contributory Coverage is shown in the Schedule of Insurance.

Dependent Child(ren) means:
Your children, stepchildren, legally adopted children, or any other children related to You by blood or marriage or domestic partnership provided such children are:
1) from live birth but not yet 26 years; or
2) age 26 or older and disabled. Such children must have become disabled before attaining age 26. You must submit proof, satisfactory to Us, of such children's disability.

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

Earnings means Your regular annual rate of pay in effect on the last day You were Actively at Work, including:
1) contributions You make through a salary reduction agreement with the Employer to:
   a) an Internal Revenue Code (IRC) Section 401(k), 403(b), 408(k), 408(p) or 457 deferred compensation arrangement;
   b) an executive non-qualified deferred compensation arrangement; or
   c) a salary reduction arrangement under an IRC Section 125 plan; plus
2) annual target incentives expected to be paid by Your Employer in effect on the last day You were Actively at Work.

Earnings does not include bonuses, commissions, tips and tokens, overtime pay or any other fringe benefits or extra compensation.

However, if You are an hourly paid Active Employee, Earnings means the product of:
1) 2080 hours per year or the number of hours you are scheduled to work per year, not to exceed 2080, multiplied by:
2) Your hourly wage in effect on the date immediately prior to the last day You were Actively at Work; plus
3) annual target incentives expected to be paid by Your Employer in effect on the last day You were Actively at Work.

Annual target incentives:
1) apply to incentive-eligible employees with a career band designated as SL, customer and frontline

experience roles in T-Mobile for Business, and Customer Experience Center employees with a monthly incentive plan (i.e. not an annual corporate bonus plan); and
2) are listed in the Employer's HR system. If You are part-time, Your annual incentive listed in the HR system will be prorated based on Your Full-time Employment percent.

Employer means the Policyholder.

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

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

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

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

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

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

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

Spouse means Your spouse who:
1) is not legally separated or divorced from You; and
2) is not in active full-time military service.

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

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

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

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

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

HARTFORD LIFE AND ACCIDENT INSURANCE COMPANY

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

The Hartford Financial Services Group, Inc. (NYSE: HIG) operates through its subsidiaries under the brand name, The Hartford®. For additional information, see www.thehartford.com.

Noninsurance Services

Noninsurance Services are added support services offered by The Hartford and/or third party vendors that complement insurance provided by The Hartford. These services may assist in making the most of the financial protection the insurance provides.

Eligibility: These services may be available at no additional cost and are in addition to the insurance coverage. Participation in these services is voluntary and does not require separate enrollment. Some services may require a loss to participate. Please contact the Policyholder for more information on the available Noninsurance Services with The Hartford.

The following services may be available:

Will Preparation: These services provide access to an online tool which includes an educational portal, to assist in creating legally binding and customized wills, living wills and/or trusts. Assistance from licensed attorneys may also be provided.

Estate Planning: These services provide support prior to, or following a loss. Services include access to funeral planning tools, and support resources to provide emotional, legal or financial guidance. Additional services may include estate guidance proceedings and durable power of attorney, if needed.

Financial Planning: These services provide referrals to financial estate advisors. If a medical emergency happens while traveling, these services may provide help to reduce travel expenses.

Probate and Estate Settlement: These services provide support and guidance on the administrative tasks associated with probate and estate settlement. Referrals to professional service providers are available.

Funeral Planning and Bereavement: These services provide guidance with important decisions before and after a loss. A care team is available to:

- help with funeral plan wishes;
- assist with funeral planning; and
- provide local funeral home price comparisons.

After a loss, these services offer grief support, as well as family advocacy and professional negotiation of funeral prices and other after loss services with local providers. This may expedite claims payments. A secure digital vault is also available to store and share important documents. Funeral planning tools and resources do not constitute an insurance funded prearrangement contract as described in the Revised Code of Washington (RCW)18.39.255.

Termination of Noninsurance Services: Services end when the underlying Policy terminates, or when the insured is no longer covered under The Policy. If death occurs prior to The Policy termination date, some services will be made available after the termination of coverage.

Noninsurance Services Vendors: The third party vendor is liable to the Eligible Person for these services as arranged for by The Hartford. The Hartford is not responsible for the content, performance, accuracy or quality of the vendor services. The Hartford may change vendors or may terminate any Noninsurance Service. Eligible Persons will be given 60 days' notice of termination, unless it is due to circumstances beyond The Hartford's control, such as the vendor terminating its services. You can obtain vendor contact information by visiting www.thehartford.com.

Signed for Hartford Life and Accident Insurance Company

Kevin Barnett, *Secretary*

Michael J. Fish, *Head of Group Benefits*

Maryland

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

State Notices

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

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

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

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

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

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

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

Alaska:

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

Arizona:

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

Arkansas:

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

California:

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

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

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

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

Colorado:

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

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

Florida:

1. **Legal Actions** cannot be taken against Us more than 5 years after the date Proof of Loss is required to be furnished according to the terms of The Policy.
2. **NOTICE: The benefits of the policy providing you coverage may be governed primarily by the laws of a state other than Florida.**

Georgia:

1. **NOTICE:** The laws of the state of Georgia prohibit insurers from unfairly discriminating against any person based upon his or her status as a victim of family abuse.

Idaho:

1. **For Your Questions and Complaints:**
   Idaho Department of Insurance
   Consumer Affairs
   700 W State Street, 3rd Floor
   PO Box 83720
   Boise, ID 83720-0043
   Toll Free: 1-800-721-3272
   Web Address: www.DOI.Idaho.gov

Illinois:

1. You may file a consumer complaint online at the Illinois Department of Insurance's website or by mail. The Department maintains a Consumer Division in Chicago at 115 S. Lasalle Street, 13th Floor, Chicago, Illinois 60603; and in Springfield at 320 West Washington Street, Springfield, Illinois 62767.

   This notice is to advise you that should any complaints arise regarding this insurance, you may contact the following:
   Illinois Department of Insurance
   320 W. Washington Street
   Springfield, Illinois 62767-0001

   Illinois Department of Insurance
   115 S. LaSalle Street
   13th Floor
   Chicago, Illinois 60603

   Consumer Complaints: DOI.Complaints@illinois.gov; toll-free: 1(866) 445-5364
   Officer of Consumer Health Insurance: DOI.Complaints@illinois.gov; toll-free: 1(877) 527-9431

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

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

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

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

Indiana:

1. **For Your Questions and Complaints:**
   Public Information/Market Conduct
   Indiana Department of Insurance
   311 W. Washington St. Suite 300
   Indianapolis, IN 46204-2787
   1(317) 232-2395

Louisiana:

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

   Reinstatement after Military Service: *Can coverage be reinstated after return from active military service?*
   If Your or Your Dependents' coverage ends because You or Your Dependents enter active military service, coverage may be reinstated, provided You request such reinstatement upon Your or Your Dependents' release from active military service.

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

Maine:

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

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

Massachusetts:

1. The definition of **Terminal Illness or Terminally Ill** shown in the **Accelerated Benefit** cannot exceed 24 months.
2. **NOTICE: As of January 1, 2009, the Massachusetts Health Care Reform Law requires that**

Massachusetts residents, eighteen (18) years of age and older, must have health coverage that meets the Minimum Creditable Coverage standards set by the Commonwealth Health Insurance Connector, unless waived from the health insurance requirement based on affordability or individual hardship. For more information call the Connector at 1-877-MA-ENROLL or visit the Connector website (www.mahealthconnector.org).

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

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

Michigan:

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

Minnesota:

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

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

   whichever is later.

   The amount of premium charged may not exceed 102% of the premium paid for other similarly situated employees who are Actively at Work. The Employer will inform You of:
   1) Your right to continue coverage;
   2) the amount of premium; and
   3) how, where and by when payment must be made.

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

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

   Upon the termination of continued coverage, You may:
   1) exercise Your Conversion Right; or
   2) continue coverage under a group Portability policy; and
   3) qualify for Retiree coverage.

   Minnesota law requires that if Your coverage ends because the Employer fails to notify You of Your right to continue coverage or fails to pay the premium after timely receipt, the Employer will be liable for benefit payments to the extent We would have been liable had You still been covered.
3. If the following paragraph appears in the **Accelerated Benefit** provision, it does not apply to you:

In the event:

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

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

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

Missouri:

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

Montana:

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

requirements of Montana law and control over any conflicting statutes of any state in which the insured resides on or after the effective date of the certificate.

New Hampshire:

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

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

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

Your former Spouse may continue his or her coverage.

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

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

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

New Mexico:

1. **For Your Questions and Complaints:**
   Office of Superintendent of Insurance
   Consumer Assistance Bureau
   P.O. Box 1689

Santa Fe, NM 87504-1689
1(855) 427-5674

New York:

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

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

North Carolina:

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

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

IMPORTANT TERMINATION INFORMATION

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

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

North Dakota:

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

Ohio:

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

Oregon:

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

   Jury Duty: If You are scheduled to serve or are required to serve as a juror, Your coverage may be continued until the last day of Your Jury Duty, provided You:
   1) elected to have Your coverage continued; and
   2) provided notice of the election to Your Employer in accordance with Your Employer's notification policy.

Rhode Island:

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

South Carolina:

1. The dollar amount stated in the third paragraph of the **Claims to be Paid** provision is changed to $2,000, if greater than $2,000.
2. If the **Continuity from a Prior Policy for Disability Extension** provision is included in the Certificate and You qualify for continued coverage, Your Amount of Insurance will be the greater of the amount of life insurance and accidental death and dismemberment principal sum that You had under the Prior Policy or the amount shown in the Schedule of Insurance. This Amount of Insurance will be reduced by any coverage amount that is in force, paid or payable under the Prior Policy or that would have been payable under the Prior Policy had timely election been made.
3. If The Policy Terminates or Your Employer ceases to be a Participating Employer and You have been approved for the **Waiver of Premium**, Your coverage under the terms of this provision will not be affected. Your Dependent coverage will continue for a period of 12 months from the date of Policy termination and will be subject to the terms and conditions of The Policy.
4. If The Policy Terminates or Your Employer ceases to be a Participating Employer and You have been approved for the **Disability Extension**, Your and Your Dependent's coverage will be continued for a

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

South Dakota:

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

Texas:

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

Have a complaint or need help?

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

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

Hartford Life and Accident Insurance Company
To get information or file a complaint with your insurance company:

Call: Customer Service at 860-547-5000 Toll-free: 1-800-523-2233

Online: https://www.thehartford.com/contact-the-hartford Email: GBD.Customerservice@hartfordlife.com
Mail: The Hartford, Group Benefits Division, P.O. Box 2999, Hartford, CT 06104-2999

The Texas Department of Insurance
To get help with an insurance question or file a complaint with the state:

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

File a complaint: www.tdi.texas.gov

Email: ConsumerProtection@tdi.texas.gov
Mail: MC 111-1A, P.O. Box 12030, Austin, TX 78711-2030

¿Tiene una queja o necesita ayuda?

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

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

Hartford Life and Accident Insurance Company
Para obtener información o para presentar una queja ante su compañía de seguros:

Llame a: servicio al cliente al 860-547-5000 Teléfono gratuito: 1-800-523-2233

En línea: https://www.thehartford.com/contact-the-hartford Correo electrónico: GBD.Customerservice@hartfordlife.com
Dirección postal: The Hartford, Group Benefits Division, P.O. Box 2999, Hartford, CT 06104-2999

El Departamento de Seguros de Texas
Para obtener ayuda con una pregunta relacionada con los seguros o para presentar una queja ante el estado:

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

Presente una queja en: www.tdi.texas.gov
Correo electrónico: ConsumerProtection@tdi.texas.gov
Dirección postal: MC 111-1A, P.O. Box 12030, Austin, TX 78711-2030

Utah:

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

Vermont:

1. The following requirement applies:

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

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

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

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

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

Virginia:

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

Washington:

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

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

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

Wisconsin:

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

ERISA Information

The Following Notice
Contains Important Information

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

The benefits described in your booklet-certificate (Booklet) are provided under a group insurance policy (Policy) issued by the Hartford Life and Accident Insurance Company (Insurance Company) and are subject to the Policy's terms and conditions. The Policy and Booklet are incorporated into, and form a part of, the Plan. The Plan has designated and named the Insurance Company as the claims fiduciary for benefits provided under the Policy. The Plan has granted the Insurance Company full discretion and authority to determine eligibility for benefits and to construe and interpret all terms and provisions of the Policy, to the extent permitted by applicable state law.

A copy of the Plan is available for your review during normal working hours in the office of the Plan Administrator.

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1. **Plan Name**

   T-MOBILE USA, INC. EMPLOYEE BENEFIT PLAN.

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2. **Plan Number**

   LIFE - 506

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3. **Employer/Plan Sponsor**
   T-MOBILE USA, INC.
   12920 SE 38th Street
   Bellevue, WA 98006-7305

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4. **Employer Identification Number**

   91-1983600

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5. **Type of Plan**

   Welfare Benefit Plan providing Group Basic Term Life, Supplemental Dependent Life, Supplemental Term Life.

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6. **Plan Administrator**
   T-MOBILE USA, INC.
   12920 SE 38th Street
   Bellevue, WA 98006-7305

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7. **Agent for Service of Legal Process**

For the Plan
T-MOBILE USA, INC.
12920 SE 38th Street
Bellevue, WA 98006-7305

For the Policy:

Hartford Life and Accident Insurance Company
One Hartford Plaza
Hartford, Connecticut 06155

In addition to the above, Service of Legal Process may be made on a plan trustee or the plan administrator.

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8. **Sources of Contributions (Life)** Basic and supplemental coverage are being offered under a single ERISA plan. The Employer may pay some or all of the premium for the basic coverage. Coverages described in the certificate/policy as noncontributory or as being paid by the Employer, if any, are those paid for directly by the Employer such that you may have no direct out of pocket expense for such coverage. However, employees who elect supplemental coverage will be required to contribute specified amounts to the plan. Any amounts paid by employees may be used to pay any benefit or expense under the plan and may be used to reduce what the Employer pays for basic coverage.

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9. **Type of Administration** The plan is administered by the Plan Administrator with benefits provided in accordance with the provisions of the applicable group plan.

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10. The Plan and its records are kept on a Policy Year basis.

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11. **Labor Organizations**

    None

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12. **Names and Addresses of Trustees**

    None

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13. **Plan Amendment Procedure**

    The Plan Administrator reserves full authority, at its sole discretion, to terminate, suspend, withdraw, reduce, amend or modify the Plan, in whole or in part, at any time, without prior notice.

    The Employer also reserves the right to adjust your share of the cost to continue coverage by the same procedures.

Statement Of ERISA Rights

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

1. Receive Information About Your Plan and Benefits

a) Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and union halls, all documents governing the Plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.
b) Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary Plan description. The administrator may make a reasonable charge for the copies.
c) Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

2. Prudent Actions by Plan Fiduciaries

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

3. Enforce Your Rights

If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules. Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of Plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court. If the Plan requires you to complete administrative appeals prior to filing in court, your right to file suit in state or Federal court may be affected if you do not complete the required appeals. If it should happen that Plan fiduciaries misuse the Plan’s money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

4. Assistance with Your Questions

If you have any questions about your Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration (formerly known as the Pension and Welfare Benefits Administration), U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

CLAIM PROCEDURES

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

Claim Procedures for Claims Requiring a Determination of Disability

Claims and appeals for disability benefits will be adjudicated in a manner designed to ensure the independence and impartiality of the persons involved in making the decision. Accordingly, decisions regarding hiring, compensation, termination, promotion or other similar matters with respect to any individual (such as a claims adjudicator or medical or vocational expert) shall not be made based upon the likelihood that the individual will support the denial of benefits.

If the Insurance Company fails to strictly adhere to all the requirements of ERISA with respect to a claim, you are deemed to have exhausted the administrative remedies available under the Plan, with certain exceptions. Accordingly, you are entitled to bring a civil action to pursue any available remedies under section 502(a) of ERISA on the basis that the Insurance Company has failed to provide a reasonable claims procedure that would yield a decision on the merits of the claim. If you choose to bring a civil action to pursue remedies under section 502(a) of ERISA under such circumstances, your claim or appeal is deemed denied on review without the exercise of discretion by an appropriate fiduciary. However, the administrative remedies available under the Plan will not be deemed exhausted based on *de minimis* violations that do not cause, and are not likely to cause, prejudice or harm to you so long as the Insurance Company demonstrates that the violation was for good cause or due to matters beyond the control of the Insurance Company and that the violation occurred in the context of an ongoing, good faith exchange of information between the Insurance Company and you. This exception is not available if the violation is part of a pattern or practice of violations by the Insurance Company. Before filing a civil action, you may request a written explanation of the violation from the Insurance Company, and the Insurance Company must provide such explanation within 10 days, including a specific description of its bases, if any, for asserting that the violation should not cause the administrative remedies available under the Plan to be deemed exhausted. If a court rejects your request for immediate review on the basis that the Insurance Company met the standards for the exception, your claim shall be considered as re-filed on appeal upon the Insurance Company's receipt of the decision of the court. Within a reasonable time after the receipt of the decision, the Insurance Company shall provide you with notice of the resubmission.

Claims for Benefits

If you or your authorized representative would like to file a claim for benefits for yourself or your insured dependents, you or your authorized representative should obtain a claim form(s) from your Employer or Plan Administrator. The applicable section of such form(s) must be completed by (1) you, (2) the Employer or Plan Administrator and (3) the attending physician or hospital. Following completion, the claim form(s) must be forwarded to the Insurance Company's claim representative. The Insurance Company will evaluate your claim and determine if benefits are payable.

The Insurance Company will make a decision no more than 45 days after receipt of your properly filed claim. The time for decision may be extended for two additional 30 day periods provided that, prior to any extension period, the Insurance Company notifies you in writing that an extension is necessary due to matters beyond the control of the Insurance Company, identifies those matters and gives the date by which it expects to render its decision. If your claim is extended due to your failure to submit information necessary to decide your claim, the time for decision may be tolled from the date on which the notification of the extension is sent to you until the date the Insurance Company receives your response to our request. If the Insurance Company approves your claim, the decision will contain information sufficient to reasonably inform you of that decision.

Any adverse benefit determination will be in writing and include: 1) the specific reason or reasons for the decision; 2) specific references to the Policy provisions on which the decision is based; 3) a description of any additional material or information necessary for you to perfect the claim and an explanation of why such material or

information is necessary; 4) a description of the Insurance Company's review procedures and time limits applicable to such procedures; 5) a statement that you have the right to bring a civil action under section 502(a) of ERISA after you appeal the decision and after you receive a written denial on appeal; 6) a discussion of the decision, including an explanation of the basis for disagreeing with or not following: (a) the views presented by you to the Insurance Company of health care professionals treating you and vocational professionals who evaluated you, (b) the views of medical or vocational experts whose advice was obtained on behalf of the Insurance Company in connection with the adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination, and (c*)* a disability determination regarding you presented by you to the Insurance Company made by the Social Security Administration; 7) if the adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to your medical circumstances, or a statement that such explanation will be provided free of charge upon request; 8) either the specific internal rules, guidelines, protocols, standards or other similar criteria of the Insurance Company relied upon in making the adverse determination or, alternatively, a statement that such rules, guidelines, protocols, standards or other similar criteria of the Insurance Company do not exist; 9) a statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim for benefits; and a statement prominently displayed in any applicable non-English language clearly indicating how to access the language services provided by the Insurance Company.

Appealing Denials of Claims for Benefits

On any wholly or partially denied claim, you or your representative must appeal once to the Insurance Company for a full and fair review. You must complete this claim appeal process before you file an action in court, with the exception of an action under the deemed exhausted process described above. Your appeal request must be in writing and be received by the Insurance Company no later than the expiration of 180 days from the date you received your claim denial. As part of your appeal:

1. you may request, free of charge, copies of all documents, records, and other information relevant to your claim; and
2. you may submit written comments, documents, records and other information relating to your claim.

The Insurance Company's review on appeal shall take into account all comments, documents, records and other information submitted by you relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination.

Before the Insurance Company can issue an adverse benefit determination on review, the Insurance Company shall provide you, free of charge, with any new or additional evidence considered, relied upon, or generated by the Insurance Company (or at the direction of the Insurance Company) in connection with the claim; such evidence must be provided as soon as possible and sufficiently in advance of the date on which the notice of adverse benefit determination on review is required to be provided to give you a reasonable opportunity to respond prior to that date.

Before the Insurance Company can issue an adverse benefit determination on review based on a new or additional rationale, the Insurance Company shall provide you, free of charge, with the rationale; the rationale must be provided as soon as possible and sufficiently in advance of the date on which the notice of adverse benefit determination on review is required to be provided to give you a reasonable opportunity to respond prior to that date.

The Insurance Company will make a final decision no more than 45 days after it receives your timely appeal. The time for final decision may be extended for one additional 45 day period provided that, prior to the extension, the Insurance Company notifies you in writing that an extension is necessary due to special circumstances, identifies those circumstances and gives the date by which it expects to render its decision. If your claim is extended due to your failure to submit information necessary to decide your claim on appeal, the time for decision shall be tolled from the date on which the notification of the extension is sent to you until the date the Insurance Company receives your response to the request. The Insurance Company may also toll the time for a decision to allow you a reasonable opportunity to respond to new or additional evidence or a new or additional rationale. Tolling will

begin on the date that the Insurance Company provides you with new or additional evidence or a new or additional rationale, and end when the Insurance Company receives the response or on the date by which the Insurance Company has requested a response, whichever comes first.

The individual reviewing your appeal shall give no deference to the initial benefit decision and shall be an individual who is neither the individual who made the initial benefit decision, nor the subordinate of such individual. The review process provides for the identification of the medical or vocational experts whose advice was obtained in connection with an initial adverse decision, without regard to whether that advice was relied upon in making that decision. When deciding an appeal that is based in whole or part on medical judgment, the Insurance Company will consult with a medical professional having the appropriate training and experience in the field of medicine involved in the medical judgment and who is neither an individual consulted in connection with the initial benefit decision, nor a subordinate of such individual. If the Insurance Company grants your claim appeal, the decision will contain information sufficient to reasonably inform you of that decision.

However, any final adverse benefit determination on review will be in writing and include: 1) the specific reason or reasons for the decision; 2) specific references to the Policy provisions on which the decision is based; 3) a statement that you are entitled to receive, upon request and free of charge, copies of all documents, records, and other information relevant to your claim; 4) a statement (a) that you have the right to bring a civil action under section 502(a) of ERISA, and (b) describing any applicable contractual limitations period that applies to your right to bring such an action, including the calendar date on which the contractual limitations period expires for the claim; 5) a discussion of the decision, including an explanation of the basis for disagreeing with or not following: (a) the views presented by you to the Insurance Company of health care professionals treating you and vocational professionals who evaluated you, (b) the views of medical or vocational experts whose advice was obtained on behalf of the Insurance Company in connection with the adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination, and (c*)* a disability determination regarding you presented by you to the Insurance Company made by the Social Security Administration; 6) if the adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to your medical circumstances, or a statement that such explanation will be provided free of charge upon request; 7) either the specific internal rules, guidelines, protocols, standards or other similar criteria of the Insurance Company relied upon in making the adverse determination or, alternatively, a statement that such rules, guidelines, protocols, standards or other similar criteria of the Plan do not exist; 8) a statement prominently displayed in any applicable non-English language clearly indicating how to access the language services provided by the Insurance Company; and 9) any other notice(s), statement(s) or information required by applicable law.

Claim Procedures for Claims Not Requiring a Determination of Disability

Claims and appeals for benefits will be adjudicated in a manner designed to ensure the independence and impartiality of the persons involved in making the decision. Accordingly, decisions regarding hiring, compensation, termination, promotion or other similar matters with respect to any individual (such as a claims adjudicator or medical expert) shall not be made based upon the likelihood that the individual will support the denial of benefits.

Claims for Benefits

If you or your authorized representative would like to file a claim for benefits for yourself or your insured dependents, you or your authorized representative should obtain a claim form(s) from your Employer or Plan Administrator. The applicable section of such form(s) must be completed by (1) you, (2) the Employer or Plan Administrator and (3) the attending physician or hospital. Following completion, the claim form(s) must be forwarded to the Insurance Company's claim representative. The Insurance Company will evaluate your claim and determine if benefits are payable.

The Insurance Company will make a decision no more than 90 days after receipt of your properly filed claim. However, if the Insurance Company determines that special circumstances require an extension, the time for its decision will be extended for an additional 90 days, provided that, prior to the beginning of the extension period, the Insurance Company notifies you in writing of the special circumstances and gives the date by which it expects

to render its decision. If extended, a decision shall be made no more than 180 days after your claim was received. If the Insurance Company approves your claim, the decision will contain information sufficient to reasonably inform you of that decision.

However, any adverse benefit determination will be in writing and include: 1) specific reasons for the decision; 2) specific references to Policy provisions on which the decision is based; 3) a description of any additional material or information necessary for you to perfect the claim and an explanation of why such material or information is necessary; 4) a description of the review procedures and time limits applicable to such, and 5) a statement that you have the right to bring a civil action under section 502(a) of ERISA after you appeal our decision and after you receive a written denial on appeal.

Appealing Denials of Claims for Benefits

On any wholly or partially denied claim, you or your representative must appeal once to the Insurance Company for a full and fair review. You must complete this claim appeal process before you file an action in court. Your appeal request must be in writing and be received by the Insurance Company no later than the expiration of 60 days from the date you received your claim denial. As part of your appeal:

1. you may request, free of charge, copies of all documents, records, and other information relevant to your claim; and
2. you may submit written comments, documents, records and other information relating to your claim.

The Insurance Company's review on appeal shall take into account all comments, documents, records and other information submitted by you relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination.

The Insurance Company will make a final decision no more than 60 days after it receives your timely appeal. However, if the Insurance Company determines that special circumstances require an extension, the time for its decision will be extended for an additional 60 days, provided that, prior to the beginning of the extension period, the Insurance Company notifies you in writing of the special circumstances and gives the date by which it expects to render its decision. If extended, a decision shall be made no more than 120 days after your appeal was received. If the Insurance Company grants your claim appeal, the decision will contain information sufficient to reasonably inform you of that decision.

However, any final adverse benefit determination on review will be in writing and include: 1) specific reasons for the decision and specific references to the Policy provisions on which the decision is based, 2) a statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant to the claim, 3) a statement of your right to bring a civil action under section 502(a) of ERISA, and 4) any other notice(s), statement(s) or information required by applicable law.

The Plan Described in this Booklet is Insured by the
Hartford Life and Accident Insurance Company Hartford, Connecticut
Member of The Hartford Insurance Group

Accidental Death And Dismemberment Insurance

Certificate of Insurance
HARTFORD LIFE AND ACCIDENT INSURANCE COMPANY
Hartford, Connecticut

Policyholder: T-Mobile USA, Inc.
Policy Number: ADD-S07649
Policy Effective Date: June 1, 2013
Certificate Effective Date: February 1, 2025

We have issued a policy to the Policyholder. Our name, the Policyholder name and the Policy Number are shown above. The provisions of the policy which are important to you are summarized in this Certificate; consisting of this Certificate and any additional forms which have been made a part of this Certificate. This Certificate replaces all certificates which may have been given to you earlier for the policy. The policy alone is the only contract under which payment will be made. Any difference between the policy and this Certificate will be settled according to the provisions of the policy.

Kevin Barnett, *Secretary*

Jonathan Bennett, *President*

Form PA-5427 A2 (-S07649)
Printed in U.S.A.

Schedule

Cost of Coverage:
Non-Contributory Coverage: Basic Accidental Death and Dismemberment Insurance

Contributory Coverage: Supplemental Accidental Death and Dismemberment Insurance

Eligible Persons:

Class 1: All Full-time and Part-time Active Employees of the Policyholder.

Eligibility Waiting Period for Coverage:
Basic – None
Supplemental – First of the month following 30 days

Full-time Employee means a person who:
a) is regularly employed by the Policyholder in the usual course of their business; and
b) works at least 30 hours per work week.

Part-time Employee means a person who:
a) is regularly employed by the Policyholder in the usual course of their business; and
b) works at least 20 hours per work week.

Basic Principal Sum

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

Supplemental Principal Sum

1, 2, 3, 4, 5, 6, 7 or 8 times Your annual Earnings, subject to a maximum of $2,000,000 rounded to the next higher $1,000 if not already a multiple of $1,000.

Earnings means Your regular annual rate of pay, including Commissions, but not bonuses, tips and tokens, overtime pay or any other fringe benefits or extra compensation, in effect on the date immediately prior to the last day You were Actively at Work.

However, if You are an hourly paid Active Employee, Earnings means the product of:
1) 2080 hours per year or the number of hours you are scheduled to work per year, not to exceed 2080, multiplied by:
2) Your hourly wage in effect on the date immediately prior to the last day You were Actively at Work; and
3) Commissions.

Commissions means the total of monetary commissions You received from the Employer over:
1) the twelve month period immediately prior to the date You were last Actively at Work; or
2) the total period of time You worked for the Employer, if less than the above period.

Eligible Dependents: Eligible Person's Spouse and Child(ren)

Supplemental Principal Sum For Each Insured Person's Eligible Dependents:

The Principal Sum applicable to each person covered under this policy as an Insured Person's Dependent is calculated by

applying the percent, determined below, to the Insured Person's Principal Sum.

Percent Applicable to:

Insured Person with Covered:*	Spouse	Each Child
Spouse, but no covered Child	60%	0%
Spouse & Child(ren)	50%	25%
Child(ren), but no covered Spouse	0%	25%

*As determined on the date of accident.

The Principal Sum cannot exceed the lesser of the amount calculated above or as follows:
Spouse Only - $900,000
Child Only: - $100,000
Spouse & Child: - $750,000/$100,000

Policy Age Limit: None

Seat Belt and Air Bag Coverage
Seat Belt Benefit Amount: 10%
Maximum Amount: $25,000
Air Bag Benefit Amount:
100% Maximum Amount: $5,000

Spouse Education Benefit
Maximum Amount: $25,000
Percentage of Principal Sum: 20%
Minimum Amount: $500

Child Education Benefit
Maximum Amount: $25,000
Percentage of Principal Sum: 10%
Minimum Amount: $2,500

Conversion Privilege Benefit (Insured Person Only)
Conversion Limit: $250,000

Extended Felonious Assault Benefit
Percentage of Principal Sum: 50%
Maximum Amount: $25,000

Repatriation Benefit (Insured Person Only)
Percentage of Principal Sum: 10%
Maximum Amount: $5,000

Rehab Benefit
Percentage of Principal Sum: 10%
Maximum Amount: $10,000

Common Carrier Benefit
Common Carrier Limit: $500,000

Day Care Benefit (Insured Person Only)
Maximum Amount: $12,500
Percentage of Principal Sum: 20%
Minimum Amount: $500

Continuation of Medical Coverage Benefit
Maximum Amount: $5,000
Percentage of Principal Sum: 5%
Minimum Amount: $1,000

Coma Benefit (Insured Person only)
Waiting Period: 30 days

Traumatic Brain Injury
Waiting Period: 30 days
Percentage: 100%

Emergency Evacuation
Maximum Amount: $250,000

Medical/Dental
Percentage of principal Sum: 5%
Maximum Amount: $5,000

Dependent Child Dismemberment
Maximum Amount: $100,000

Definitions

Active Full-time Employee means an employee who works for the Employer on a regular basis in the usual course of the Employer's business. You must work at least the number of hours in the Employer's normal work week. This must be at least 30 hours per week for full-time and 20 hours per week for part-time. You will be considered actively at work with Your Employer on a day which is one of the Employer's scheduled work days if You are performing, in the usual way, all of the regular duties of Your job on a regular basis that day. You will also be considered actively at work on a paid vacation day or a day which is not one of the Employer's scheduled work days only if You were actively at work on the preceding scheduled work day.

Employer means the Policyholder named in the Schedule of Insurance.

We, **us** or **our** means the insurance company named on the face page.

You, your or **Insured Person** means an Eligible Person while he or she is covered under the policy.

Actively-at-Work means a person who is performing all the regular duties of his or her occupation on a Full-time basis at his or her regular place of employment or while on a Business Trip.

Actively-at-Work does not include everyday travel to and from work.

Business Trip means a bonafide trip while on assignment at the direction of the Policyholder for the purpose of furthering the business of the Policyholder:

a) which begins when a person leaves his or her residence or place of regular employment, whichever last occurs, for the purpose of beginning the trip;
b) which ends when he or she returns to his or her residence or place of regular employment, whichever first occurs.

Injury means bodily injury resulting directly from accident and independently of all other causes which occurs while you are covered under the Policy.
Loss resulting from:

a) sickness or disease, except a pus-forming infection which occurs through an accidental wound; or
b) medical or surgical treatment of a sickness or disease; is not considered as resulting from Injury.

On, when used with reference to any conveyance (land, water or air), means in or on, boarding or alighting from the conveyance.

Civil or **Public Aircraft** means an aircraft which:

a) has a current and valid Airworthiness Certificate;
b) is piloted by a person who has a valid and current certificate of competency of a rating which authorizes him or her to pilot the aircraft; and
c) is not operated by the militia or armed forces of any state, national government or international authority.

Airworthiness Certificate means:

a) the "Standard" Airworthiness Certificate issued by the United States Federal Aviation Administration; or
b) a foreign equivalent issued by the governmental authority with jurisdiction over civil aviation in the country of its registry.

Military Transport Aircraft means a transport aircraft operated by:

a) the United States Air Mobility Command (AMC); or
b) a national military air transport service of any country.

Common Carrier means a conveyance operated by a concern, other than the Policyholder, organized and licensed for the transportation of passengers for hire and operated by an employee of that concern.

Scheduled Aircraft means a Civil Aircraft operated by a scheduled airline which

a) is licensed by the FAA for the transportation of passengers for hire; and

b) publishes its flight schedules and fares for regular passenger service.

Written Request means any form provided by us for the particular request.

Insured Persons Period Of Coverage

Effective Date: Each Eligible Person becomes an Insured Person for Basic Benefits on the later of:
a) the Policy Effective Date; or
b) the first day of the month on or next following the date he or she becomes eligible.

Each Eligible Person is eligible for Voluntary Benefits and who gives us a Written Request for those Benefits becomes covered for those Benefits on the later of:
a) the Policy Effective Date; or
b) the first day of the month on or next following the date we receive the request.

Termination: Coverage of each person as an Insured Person terminates on the earlier of:
a) the date this policy is terminated; or
b) the Premium Due Date on or next following the date he or she:
   1) ceases to be an Eligible Person; or
   2) attains the Policy Age Limit, if any, shown in the Schedule.

An Insured Person's coverage for Voluntary Benefits terminates on the earlier of:
a) the date he or she requests that his or her Voluntary Benefits as an Insured Person be terminated;
b) the Premium Due Date on or next following the date he or she ceases to be eligible for Voluntary Benefits; or
c) the Premium Due Date on which he or she fails to pay any required premium for Voluntary Benefits.

Request For Change In Coverage: If an Insured Person gives us a Written Request for a change in his or her coverage, and if he or she:
a) is not eligible for the coverage requested, the change will not become effective;
b) is eligible for the coverage requested, the change will become effective on the first of the month on or next following the date we receive the request.

Dependents Period Of Coverage

Eligibility: Eligible Dependents are defined in the Schedule. In any event, an Insured Person is not an Eligible Dependent.

Spouse means the Eligible Person's spouse unless:
a) the Eligible Person and spouse are legally separated or divorced; or
b) the spouse has attained the Policy Age Limit, if any, shown in the Schedule.

The term "spouse" used in this policy will include, with respect to California residents only, an individual who is in a registered domestic partnership with the Eligible Person in accordance with California law. Reference to an Eligible Person's marriage or divorce shall include his or her registered domestic partnership or dissolution of his or her registered domestic partnership.

Child or Children means the Eligible Person's unmarried child, stepchild, legally adopted child, foster child, or child of a registered domestic partner:
a) who is less than age 26 and primarily dependent on the Insured Person for support and maintenance; or
b) who is but less than age 26 who:
1) regularly attends an institution of learning; and
2) is primarily dependent on the Insured Person for support and maintenance.

Effective Date: Each Eligible Dependent will become covered under the policy on the later of:
a) the date the Eligible Person becomes an Insured Person; or

b) the date the person qualifies as an Eligible Dependent.

Termination: Coverage of each Eligible Dependent terminates on the Premium Due Date on or next following the earliest of:
a) the date the Eligible Person ceases to be an Insured Person; or
b) the date he or she ceases to qualify as an Eligible Dependent.

Incapacitated Child
Coverage of a child who, on the date he or she reaches age 26, is:
a) covered under the policy;
b) mentally or physically incapable of earning his or her own living; and
c) unmarried and primarily dependent on the Insured Person for support and maintenance;
will not terminate solely due to age. But the Insured Person must give us written notice of the incapacity within 31 days of the termination date.

Coverage will continue as long as:
a) the incapacity continues; and
b) the required premium is paid.

We may, from time to time, require proof of continued incapacity and dependency. After the first two years, we cannot require proof more than once each year.

Exceptions To Termination

Under what conditions can Your insurance be continued under the continuation provisions?
If the Insured Person is absent from work as an Active Employee, his or her insurance may be continued up to the maximum period of time stated. In each instance, such continuation shall be at the Employer's option, but must be according to a plan which applies to all employees in the same way. Continued coverage:
1. is subject to any reductions in the Policy;
2. is subject to payment of premium by the Employer; and
3. terminates when the Policy terminates.

If You are absent from work as an Active Employee due to a labor dispute, all of Your coverage may be continued for up to 6 months from the start date the labor dispute commenced, or the first to occur of:
1. The date the Group Insurance Policy terminates;
2. the date premium is due for You but not paid by the Employer; or
3. the last day of the pay period for which You made any required premium contribution, if You fail to make any further required contribution.

If You are on an approved leave of absence, other than military leave, all of Your coverage may be continued for up to 60 months from the start date the leave of absence commenced, or the first to occur of:
1. The date the Group Insurance Policy terminates;
2. the date premium is due for You but not paid by the Employer; or
3. the last day of the pay period for which You made any required premium contribution, if You fail to make any further required contribution

If You enter active military service and are granted a military leave of absence in writing, all of Your coverage may be continued for up to 63 months from the start date the leave of absence commenced, or the first to occur of:
1. The date the Group Insurance Policy terminates;
2. the date premium is due for You but not paid by the Employer; or
3. the last day of the pay period for which You made any required premium contribution, if You fail to make any further required contribution.

If Your employment terminates and continuation of accidental death and dismemberment is available to You and Your Dependents in a severance plan sponsored by the Employer, all of Your coverage may be continued. Your coverage will continue until the earliest of:
1. The date the Group Insurance Policy terminates;

2. the You become covered under another accidental death and dismemberment policy;
3. the end of the month coincident with or next following the date specified in Your severance plan; or
4. for up to 18 months from the date Your employment terminated.

If the Insured Person is laid off due to lack of work, all of his or her coverage may be continued for up to 6 months following the month in which the layoff commenced.

If the Insured Person is:
1. employed by the Employer; and
2. no longer in an eligible class due to a reduction in the number of scheduled hours worked;

All of Your coverage may be continued for up to 6 months from the date You were last Actively-at-Work, or the first to occur of:
1. The date the Group Insurance Policy terminates;
2. the date premium is due for You but not paid by the Employer; or
3. the last day of the pay period for which You made any required premium contribution, if You fail to make any further required contribution.

Coverage for Your Dependents will continue until the earliest of:
1. the date Your Dependents no longer meet the definition of Dependents;
2. the date We or Your Employer terminate Dependent coverage; or
3. the date Your coverage terminates.

In all other respects, the terms of Your insurance remains unchanged.

Exclusions

The policy does not cover any loss resulting from:
1. intentionally self-inflicted Injury, suicide or attempted suicide, whether sane or insane;
2. war or act of war, whether declared or undeclared;
3. Injury sustained while full-time in the armed forces of any country or international authority;
4. Injury sustained while riding On any aircraft except a Civil or Public Aircraft, or Military Transport Aircraft;
5. Injury sustained while riding On any aircraft:
   a) as a pilot, crewmember or student pilot;
   b) as a flight instructor or examiner; or
   c) if it is owned, operated or leased by or on behalf of the Policyholder, or any employer or organization whose eligible persons are covered under the policy;
6. Injury sustained while voluntarily taking drugs which federal law prohibits dispensing without a prescription, including sedatives, narcotics, barbiturates, amphetamines, or hallucinogens, unless the drug is taken as prescribed or administered by a licensed physician;
7. Injury sustained while committing or attempting to commit a felony;
8. Injury sustained as a result of being legally intoxicated from the use of alcohol.

Coverage is limited to $50,000 for Employees who are pilots flying an aircraft that is not Corporate Owned or Leased

Accidental Death And Dismemberment Benefit

If an Insured Person's injury results in any of the following losses within 365 days after the date of accident, we will pay the sum shown opposite the loss. We will not pay more than the Principal Sum for all losses due to the same accident. The amount of the Principal Sum is determined in the Schedule.

For Loss of:
Life..... The Principal Sum
Both Hands or Both Feet or Sight of Both Eyes.....The Principal Sum

One Hand and One Foot	The Principal Sum
Speech and Hearing	The Principal Sum
Either Hand or Foot and Sight of One Eye	The Principal Sum
Movement of Both Upper and Lower Limbs (Quadriplegia)	One hundred and fifty The Principal Sum
Movement of Both Lower Limbs (Paraplegia)	Three-Quarters The Principal Sum
Movement of Three Limbs (Triplegia)	Three-Quarters The Principal Sum
Movement of Both Upper and Lower Limbs of One Side of Body (Hemiplegia)	Sixty-Six and Two Thirds The Principal Sum
Either Hand or Foot	One-Half The Principal Sum
Sight of One Eye	One-Half The Principal Sum
Speech or Hearing	One-Half The Principal Sum
Movement of One Limb (Uniplegia)	One-Half The Principal Sum
Thumb and Index Finger of Either Hand	One-Quarter The Principal Sum

Loss means with regard to:

a) hands and feet, actual severance through or above wrist or ankle joints;
b) sight, speech or hearing, entire and irrecoverable loss thereof;
c) thumb and index finger, actual severance through or above the metacarpophalangeal joints;
d) movement of limbs, complete and irreversible paralysis of such limbs.

If loss is sustained by an Insured Person while riding as a passenger on any Common Carrier, the amount of Principal Sum payable under the Accidental Death and Dismemberment Benefit will be doubled. However, in no event will the Principal Sum stated in the Schedule be increased by more than the Common Carrier Limit.

Common Carrier means a Conveyance operated by a concern, other than the Policyholder, organized and licensed for the transportation of passengers for hire and operated by an employee of that concern.

Exposure

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

a) it results from the forced landing, stranding, sinking or wrecking of a conveyance in which the Insured Person was an occupant at the time of the accident; and
b) this policy would have covered injury resulting from the accident.

Disappearance

An Insured Person will be presumed to have suffered loss of life if:

a) his or her body has not been found within one year after the disappearance of a conveyance in which he or she was an occupant at the time of its disappearance;
b) the disappearance of the conveyance was due to its accidental forced landing, stranding, sinking or wrecking; and
c) this policy would have covered injury resulting from the accident.

Seat Belt & Air Bag Benefit

If Your Injury results in a covered Loss under the Accidental Death and Dismemberment Benefit while:

a) a passenger riding in; or
b) the licensed operator of;

an Automobile, and at the time of the accident You were properly wearing a Seat Belt as verified on the police report, then the amount of the Principal Sum will be increased by a Percentage of the Principal Sum, up to a Maximum Amount.

If the above Seat Belt Benefit is payable, we will pay an additional Percentage of the Principal Sum, up to a Maximum Amount, as an Air Bag Benefit if:

a) You were positioned in a seat that was equipped with a factory-installed Air Bag;

b) You were properly strapped in the Seat Belt when the Air Bag inflated; and
c) the police report establishes that the Air Bag inflated properly upon impact.

Air Bag means an inflatable, supplemental passive restraint system installed by the manufacturer of the Automobile, or proper replacement parts as required by the Automobile manufacturer's specifications that inflates upon collision to protect an individual from Injury and death. An Air Bag is not considered a Seat Belt.

Automobile means a duly registered, four-wheeled, private passenger: car, pick-up truck, van, self-propelled motor home or sport utility vehicle which is not being used as a Common Carrier.

Common Carrier means a conveyance operated by a concern, other than the Policyholder, organized and licensed for the transportation of passengers for hire and operated by an employee of that concern.

Seat Belt means an unaltered belt, lap restraint, or lap and shoulder restraint installed by the manufacturer of the Automobile, or proper replacement parts as required by the Automobile manufacturer's specifications.

Exclusions: This Seat Belt and Air Bag Benefit does not cover any loss if You were:
a) using any controlled substance, as defined in Title II of the Connecticut Comprehensive Drug Abuse Prevention and Control Act of 1970, unless prescribed by a physician; and
b) operating the Automobile.

The Percentage of the Principal Sum, Minimum Amount and Maximum Amount for the Seat Belt and Air Bag Benefit are shown in the Schedule.

Education Benefit

If:
a) the Insured Person's Spouse and Eligible Child(ren) are covered under the policy; and
b) a Principal Sum is payable under the Accidental Death and Dismemberment Benefit because of the Insured Person's or Covered Spouse's death; we will pay an Education Benefit to each Student as provided below.

A Student is a person for whom we receive proof that he or she:
a) is covered as the Insured Person's Eligible Dependent on the date of the Insured Person's or Covered Spouse's death; and
b) is a full-time post-high school student in a school for higher learning on the date of the Insured Person's or Covered Spouse's death; or
c) became a full-time post-high school student in a school for higher learning within 365 days after the Insured Person's or Covered Person's death and was a student in the 12th grade on the date of the Insured Person's or Covered Person's death.

He or she is not considered to be a Student after the first to occur of:
a) our payment of the fourth Education Benefit to or on behalf of that person; or
b) the end of the 12th consecutive month during which we have not received proof that he or she is a Student.

If the Insured Person dies, the Education Benefit is an amount equal to the lesser of:
a) the Maximum Amount; or
b) the amount determined by applying the Percent to the amount of the Insured Person's Principal Sum.

If the Covered Spouse dies, the Education Benefit is an amount equal to the lesser of:
a) the Maximum Amount; or
b) the amount determined by applying the Percent to the amount of the Covered Spouse's Principal Sum.

We will pay the Education Benefit to any one Student during any one school year. The Education Benefit is payable to each person:
a) on the date; and

b) for whom;

we have received proof that he or she is a Student.

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

If:

a) a Principal Sum is payable because of the Insured Person's and/or Covered Spouse's death; and
b) no Eligible Dependent qualifies as a Student;

we will pay the Minimum Amount in accordance with the Payment of Claims provision.

The amount of Principal Sum is determined in the Schedule.

The Maximum Amount, Percent and Minimum Amount are shown in the Schedule.

Form 7582 M2

Spouse Education Benefit

If the Insured Person's Injury results in loss of life and a Principal Sum is payable under the Accidental Death and Dismemberment Benefit, we will pay an Education Benefit to his or her surviving Spouse as provided below.

The surviving Spouse, to qualify for the Education Benefit, must enroll in an Occupational Training program:

a) for the purpose of obtaining an independent source of income;
b) within three (3) years of the date of the Insured Person's death.

The Education Benefit is an amount equal to the lesser of:

a) the Expense Incurred for Occupational Training;
b) a Percentage of your Principal Sum; or
c) the Maximum Amount.

The expense must be incurred within 48 months of the date of your death.

We will pay the Education Benefit due immediately after we receive proof that the Spouse has enrolled in an Occupational Training program.

Occupational Training means any:

a) education;
b) professional; or
c) trade training;

program which prepares the Spouse for an occupation for which he or she otherwise would not have been qualified.

Expense Incurred means:

a) the actual tuition charged, exclusive of room and board; and
b) the actual cost of the materials needed;

for the Occupational Training program.

If a Principal Sum is payable because of the Insured Person's death and there is no Surviving Covered Spouse, we will pay the Minimum Amount in accordance with the Payment of Claims provision.

Your amount of the Principal Sum is determined in the Schedule.

The Maximum Amount, Percentage of Principal Sum and Minimum Amount are shown in the Schedule.

Rehabilitation Benefit

If an Insured Person's Injury results in any loss, other than loss of life, payable under the policy, within 365 days after the date of accident, we will pay a benefit equal to the lesser of:

a) the Expense Incurred for Rehabilitative Training;
b) a Percentage of the Insured Person's Principal Sum; or
c) the Maximum Amount;

for Rehabilitative Training.

The expense must be incurred within two (2) years of the date of accident. The amount of Principal Sum is determined in the Schedule.

The Percentage of Principal Sum and Maximum Amount are shown in the Schedule.

Rehabilitative Training means any training which:

a) is required due to the Insured Person's Injury; and
b) prepares the Insured Person for an occupation in which he or she would not have engaged except for the Injury.

Expense Incurred means the actual cost:

a) of the training; and
b) of the materials needed for the training.

Form 7582 M4 REHABILITATION BENEFIT

Conversion Privilege (Insured Person Only)

If you cease to be covered under the policy because you cease to be eligible for coverage and:

a) the policy has not terminated; and
b) you have not failed to pay any required premium;

you have a conversion privilege as provided below.

The conversion right allows you to request coverage under a conversion policy from the Insurer, without giving medical evidence of insurability, to cover yourself but not your dependents.

Insurer, as used on this page, means us or another insurance company which has agreed with us to issue converted policies according to this conversion privilege.

You must:

a) give the Insurer a Written Request for the converted policy; and
b) pay the Insurer the initial premium;

within 31 days after you cease to be covered under the policy.

The converted policy:

a) will have the provisions, limitations and exclusions on the form the Insurer is issuing for this purpose at conversion;
b) will provide coverage on a twenty-four hour-a-day basis;
c) will provide benefits for accidental death and dismemberment alone;
d) will take effect on the date you cease to be covered under the policy;
e) may exclude any condition excluded by the policy;
f) will not pay for any loss covered by the policy;
g) will provide a Principal Sum for yourself which will be the amount of your Principal Sum under the policy on the date of conversion, rounded to the nearest $1,000, subject a maximum amount of $250,000;
h) will have premiums based on the Insurer's rates in effect for new applicants of your class and age at conversion.

The policy, as used on this page, means the group policy under which you are covered.

Extended Felonious Assault Benefit

If, as the result of a Felonious Assault, You suffer a covered Loss under the Accidental Death and Dismemberment Benefit within 365 days after the date of Injury, we will pay an additional benefit equal to a Percentage of Your Principal Sum, not to exceed the Maximum Amount.

The Percentage of Principal Sum and Maximum Amount are shown in the Schedule.

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

a) a robbery, hold-up, kidnapping or criminal assault; or
b) an attempt at any of the above;

which constitutes a felony under the law.

Repatriation Benefit

If an Insured Person's injury results in loss of life payable under the policy within 365 days after the date of accident, we will pay the lesser or:

a) the expense incurred for:
    1) preparation of the deceased's body for burial or cremation; and
    2) transportation of the deceased's body to the place of burial or cremation;
b) the Percentage of the Covered Person's Principal Sum; or
c) the Maximum Amount;

provided that the Insured Person's death occurred more than 200 miles from the primary place of residence or outside the territorial limits of the state or country of permanent residence.

The amount of the Principal Sum is determined in the Schedule.

The Percentage of Principal Sum and Maximum Amount are shown in the Schedule.

Day Care Benefit

We will pay a Day Care Benefit for each Child if:

a) a Principal Sum is payable under the Accidental Death and Dismemberment Benefit because of the Insured Person's death and
b) proof of enrollment in a Day Care Program is provided as described below.

Payment will be made to the person who has legal physical custody of the Child(ren) and who has primary responsibility for the Child(ren)'s Expenses. Payment will be made in accordance with the Claims provision of the Policy.

Proof of enrollment for each child in a Day Care Program may be in the form of, but will not be limited to, the following:

a) a copy of the child's approved enrollment application in a Day Care Program; or
b) cancelled check(s) evidencing payment to a Day Care facility or Day Care Provider; or
c) a letter from the Day Care facility or Day Care provider stating that the child:
    1) is attending a Day Care Program; or
    2) has been enrolled in a Day Care Program and will be attending within 36 months of the date of the Insured Person's death.

Proof of enrollment must be sent to us prior to the last day of the 12th month on or next following the date of the Insured Person's death.

One Day Care Benefit payment will be made each year, for a maximum of 4 Day Care Benefit payments, for each Child. The

Day Care Benefit is the lesser amount of:

a) the Maximum Amount; or
b) an amount determined by applying the Day Care Percent to the amount of the deceased Person's Principal Sum.

We will pay the Minimum Amount stated in the Schedule in accordance with the Claims Provision for payment of benefits for loss of life if:

a) a Principal Sum is payable because of the Insured Person's death; and
b) no person qualifies as a Child for a Day Care Benefit.

Child means the Insured Person's unmarried child, stepchild, legally adopted child, child in the process of adoption or foster child who is less than age 13, and primarily dependent on the Insured Person for support and maintenance.

Day Care Program means a program of child care which:

a) is operated in a private home, school or other facility; and
b) provides, and makes a charge for, the care of children; and
c) is licensed as a Day Care center or is operated by a licensed Day Care provider, if such licensing is required by the state of jurisdiction in which it is located; or
d) if licensing is not required, provides child care on a daily basis for 12 months a year.

The Maximum Amount, Minimum Amount, Percent and Principal Sum are shown in the Schedule.

Continuation Of Medical Coverage Benefit

If:

a) an Insured Person’s Eligible Dependents are covered under this policy; and
b) a Principal Sum is payable under the Accidental Death and Dismemberment Benefit because of the Insured Person’s death;

we will pay a Continuation of Medical Coverage Benefit provided the Insured Person’s Covered Dependents elect to continue Medical Coverage in accordance with the Consolidated Omnibus Reconciliation Act of 1998 (COBRA).

The Continuation of Medical Coverage Benefit will be paid in three annual installment amounts each equal to the lesser of:

a) a percentage of the Insured Person’s Principal Sum; or
b) the Maximum Amount.

The Continuation of Medical Coverage Benefit is payable to the Insured Person’s Covered Dependent’s Insurance Carrier on the date we have received the bill for such continuation of coverage.

If:

a) a Principal Sum is payable because of the Insured Person’s death; and
b) no person qualifies as a Covered Dependent; or
c) the Insured Person’s Covered Dependents to not elect to continue coverage pursuant to COBRA;

we will pay the Minimum Amount in accordance with the claim provision for payment of benefits for loss of life.

The Maximum Amount, Percent, and Minimum Amount are shown in the Schedule. The Principal Sum is determined in the Schedule.

Coma Benefit (Insured Person Only)

If, as the result of an Injury, you:
a) become Comatose within 30 days from the accident; and
b) remain continuously Comatose for at least the number of days shown as the Waiting Period;
we will pay 2% of the Comatose Maximum Benefit Amount for each month after the Waiting Period that you remain in a Coma.

Payment will cease on the earliest to occur of:
1) the end of the month in which you die;
2) the end of the month in which you recover from the Coma; or
3) when the total payment equals the Comatose Maximum Benefit Amount.

The Comatose Maximum Benefit Amount equals the Principal Sum less all other payments under the Accidental Death and Dismemberment Benefit for the Injury.

Coma means complete and continuous:
a) unconsciousness; and
b) inability to respond to external or internal stimuli.

The amount of the Principal Sum is determined in the Enrollment Form on file with the Policyholder The Waiting Period is shown in the Schedule.

We will not pay more than the Principal Sum under this benefit, and the Accidental Death and Dismemberment Benefit for all losses including Coma, which are due to the same accident.

Traumatic Brain Injury Benefit

If the Insured Person's Injury results in a Traumatic Brain Injury within 90 days after the date of the accident and such Traumatic Brain Injury:
a) requires that the Insured Person be hospitalized for at least 7 days during the first 60 days following the accident; and
b) continues for 12 consecutive months,
we will pay the Principal Sum.

The Principal Sum is shown in the Schedule.

Traumatic Brain Injury means physical damage to the brain which, at the end of 12 consecutive months, a Physician has certified is:
a) permanent, complete and irreversible; and
b) prevents the Insured Person from performing all the substantial and material functions and activities of a person of like age and sex.

Physician means a legally qualified physician or surgeon other than a physician or surgeon who is related to the Insured Person by blood or marriage.

Dependent Child Dismemberment Benefit

Dependent Child Dismemberment Benefit: When is the Dependent Child Dismemberment Benefit payable?
If Your Dependent Child sustains a Loss, other than Loss of Life under the Accidental Death and Dismemberment Benefit, we will double the Principal Sum amount payable for the Loss.

This Benefit will be paid:

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

We will not pay more than an amount equal to double the Principal Sum under this Benefit and the Accidental Death and Dismemberment Benefit combined for all Losses which are due to the same Injury.

Claims

Notice of Claim: The person who has the right to claim benefits (the claimant or beneficiary) must give us written notice of a claim within 30 days after a covered loss begins. If notice cannot be given within that time, it must be given as soon as reasonably possible.

The notice should include your name and the policy number. Send it to our office in Hartford, Connecticut, or give it to our agent.

Claim Forms: When we receive the notice of claim, we will send forms to the claimant for giving us proof of loss. The forms will be sent within 15 days after we receive the notice of claim.

If the forms are not received, the claimant will satisfy the proof of loss requirement if a written notice of the occurrence, character and nature of the loss is sent to us.

Proof of Loss: Proof of loss must be sent to us in writing within 90 days after:

a) the end of a period of our liability for periodic payment claims; or
b) the date of the loss for all other claims.

If the claimant is not able to send it within that time, it may be sent as soon as reasonably possible without affecting the claim. The additional time allowed cannot exceed one year unless the claimant is legally incapacitated.

Time of Claim Payment: We will pay any daily, weekly or monthly benefit due:

a) on a monthly basis, after we receive the proof of loss, while the loss and our liability continue; or
b) immediately after we receive the proof of loss following the end of our liability.

We will pay any other benefit due immediately after we receive the proof of loss.

Payment of Claims: We will pay any benefit due for loss of the Insured Person's life:

a) according to the beneficiary designation in effect at the time of the Insured Person's death; or
b) if no beneficiary is designated, according to the beneficiary designation under the Group Life Insurance Policy issued to the Policyholder and in effect at the time of death; or
c) to the survivors, in equal shares, in the first of the following classes to have a survivor at the Insured Person's death:
    1) spouse,
    2) children,
    3) parents,
    4) brothers and sisters.

If there is no survivor in these classes, payment will be made to the Insured Person's estate.

All other benefits due and not assigned will be paid to the Insured Person, if living. Otherwise, the benefits will be paid according to the preceding paragraph.

Benefits will be paid into a checking account which will be owned by:

a) you; or
b) the beneficiary or beneficiaries named in writing by you.

The checking account owner may elect a lump sum payment by writing a check for the full amount in the checking account.

However, a checking account will not be established for a benefit payable to your estate or for a Principal Sum that is less than $10,000.

If a benefit due is payable to:
a) your estate; or
b) you or a beneficiary who is either a minor or not competent to give a valid release for the payment; we may pay up to $1,000 of the benefit due to some other person.

The other person will be someone related to you or the beneficiary by blood or marriage who we believe is entitled to the payment. We will be relieved of further responsibility to the extent of any payment made in good faith.

Appealing Denial of Claims: If a claim for benefits is wholly or partially denied, notice of the decision shall be furnished to you. The written decision will:
a) give the specific reason or reasons for denial;
b) make specific reference to the policy provision on which the denial is based;
c) provide a description of any additional information necessary to prepare the claim and an explanation of why it is necessary; and
d) provide an explanation of the review procedure.

On any denied claim, you or your representative may appeal to us for a full and fair review. The claimant may:
a) request a review upon written application within 60 days of the receipt of claim denial;
b) review pertinent documents;
c) submit issues and comments in writing.

We will make a decision no more than 60 days after the receipt of the request for review, except in special circumstances (such as the need to hold a hearing), but in no case more than 120 days after we receive the request for review. The written decision will include specific reasons on which the decision is based.

Physical Examinations and Autopsy: While a claim is pending we have the right at our expense:
a) to have the person who has a loss examined by a physician when and as often as we feel is necessary; and
b) to make an autopsy in case of death where it is not forbidden by law.

Legal Actions: You cannot take legal action against us:
a) before 60 days following the date proof of loss is sent to us;
b) after 3 years following the date proof of loss is due.

Naming a Beneficiary: You may name a beneficiary or change a revocably named beneficiary by giving your Written Request to the Policyholder. Your request takes effect on the date you execute it, regardless of whether you are living when the Policyholder receives it. We will be relieved of further responsibility to the extent of any payment we made in good faith before the Policyholder received your request.

Assignment: We will recognize any assignment you make under the policy, provided:
a) it is duly executed; and
b) a copy is on file with us.

We and the Policyholder assume no responsibility for the validity or effect of an assignment.

Policy Transition Provisions

We will cover each Prior Insured Person:
a) upon payment of the required premium;
b) under the provisions and conditions of The Policy.

The coverage under The Policy will be:
a) effective on the Policy Effective Date stated on the face page; and

b) in the amount closest to the amount(s) of coverage he or she had under the Prior Policy.

Prior Policy means Policy No. 647541-B issued by Standard Insurance Company or ADD-S07126.

The Policy means Policy No. ADD-S07649 issued by Hartford Life and Accident Insurance Company.

Prior Insured Person means the Insured Person who was covered under the Prior Policy on the day before The Policy's Effective Date.

It is agreed and understood that this provision will not break the continuity of insurance on any Insured Person if:
a) he or she was insured under the Prior Policy as it was constituted prior to effective date of The Policy; and
b) he or she is immediately thereafter insured under The Policy, as stated in this provision.

A designation of beneficiary in effect on June 1, 2013 for the Prior Policy is considered to be a designation of beneficiary under The Policy which shall take effect on the effective date of The Policy. However, any designation of beneficiary made on or before the effective date of the policy in connection with the insurance provided by The Policy, in lieu of the designation of beneficiary made under the Prior Policy, takes effect on the effective date of The Policy.

Form PA-8684 (HLA)
Printed in U.S.A.

Statutory Notices

For Residents of Arkansas: **IMPORTANT NOTICE:** ARKANSAS INSURED'S ACCESS TO INSURER INFORMATION: This notice is to comply with Arkansas House Bill 1221. We are required by law to notify you of the complete addresses and phone numbers of the Arkansas Insurance Department, the insurance company's servicing office, and the agent. Below is this information: Arkansas Insurance Department, Consumer Services Division, 400 University Tower Building, Little Rock, Arkansas 72204, Telephone: 1-800-852-5494. Servicing Office: Hartford Life Insurance Company, Special Risk Life and Health Department, P.O. Box 2250, Alpharetta, GA 30023 Telephone: (770) 753-0085. If you have any questions, contact your Hartford agent.Form PA-7597-1

For Residents of California:
IF YOU HAVE A COMPLAINT, AND CONTACTS BETWEEN YOU AND THE INSURER OR AN AGENT OR OTHER REPRESENTATIVE OF THE INSURER HAVE FAILED TO PRODUCE A SATISFACTORY SOLUTION TO THE PROBLEM, THEN YOU MAY CONTACT: STATE OF CALIFORNIA INSURANCE DEPARTMENT, CONSUMER COMMUNICATIONS BUREAU, 300 SOUTH SPRING STREET, SOUTH TOWER, LOS ANGELES, CA, 90013, 1-800-927-HELP. THE HARTFORD'S ADDRESS AND TOLL-FREE NUMBER IS: THE HARTFORD, GROUP BENEFITS DIVISON, POLICYHOLDER SERVICES, PO BOX 2999, HARTFORD, CT, 06104-2999, TELEPHONE: 1-800-572-9047
Form PA-8292-1

For Residents of Florida: NOTICE: The benefits of the policy providing your coverage are governed by the laws of a state other than Florida.

For Residents of Indiana: IMPORTANT NOTICE: We are here to serve you. As our policyholder, your satisfaction is very important to us. Should you have a valid claim, we fully expect to provide a fair settlement in a timely fashion. If for any reason you wish to contact: The Hartford, please write to us at: The Hartford, Hartford Plaza, COGS-1-34, Hartford, CT, 06115, Attn: James E. Parker. The Indiana Department of Insurance please write to: Public Information/Market Conduct, Indiana Department of Insurance, 311 W. Washington St., Suite 300, Indianapolis, IN 46204-2787 Consumer Hotline: 1-800-622-4461 In the Indianapolis Area: 1-317-232-2395. Form PA-8104-2

For Residents of North Carolina: THIS CERTIFICATE OF INSURANCE PROVIDES COVERAGE UNDER A GROUP MASTER POLICY ISSUED OUT-OF-STATE. THIS CERTIFICATE PROVIDES ALL OF THE BENEFITS MANDATED BY THE NORTH CAROLINA INSURANCE CODE, BUT YOU MAY NOT RECEIVE ALL OF THE PROTECTIONS

PROVIDED BY A POLICY ISSUED IN NORTH CAROLINA AND GOVERNED BY ALL OF THE LAWS OF NORTH CAROLINA. Form PA-8362

For Residents of Texas: IMPORTANT NOTICE - You may call The Hartford's toll-free telephone number for information or to make a complaint at: 1-800-428-5711. You may also write to The Hartford at: P.O. Box 2999, Hartford, CT 06104-2999. You may contact the Texas Department of Insurance to obtain information on companies, coverages, rights or complaints at: 1-800-252-3439. You may write the Texas Department of Insurance at: P.O. Box 149104, Austin, TX 78714-9104 FAX # (512) 475-1771. Web: http://www.tdi.state.tx.us E-mail: ConsumerProtection@tdi.state.tx.us PREMIUM OR CLAIM DISPUTES: Should you have a dispute concerning your premium or about a claim you should contact the agent or The Hartford first. If the dispute is not resolved, you may contact the Texas Department of Insurance. This notice is for information only and does not become a part or condition of this document.

AVISO IMPORTANTE: Para obtener informacion o para someter una queja: Usted puede llamar al numero de telefono gratis de The Hartford para informacion o para someter una queja al: 1-800-428-5711. Usted tambien puede escribir a The Hartford: P.O. Box 2999, Hartford, CT 06104-2999. Puede comunicarse con el Departamento de Seguros de Texas para obtener informacion acerca de companias, coberturas, derechos o quejas al: 1-800-252-3439. Puede escribir al Departamento de Seguros de Texas: P.O. Box 149104, Austin, TX 78714-9104. FAX # (512) 475-1771. Web: http://www.tdi.state.tx.us E-mail: ConsumerProtection@tdi.state.tx.us DISPUTAS SOBRE PRIMAS O RECLAMOS: Si tiene una disputa concerniente a su prima o a un reclamo, debe comunicarse con el agente o The Hartford primero. Si no se resuelve la disputa, puede entonces comunicarse con el departamento (TDI). Este aviso es solo para proposito de informacion y no se convierte en parte o condicion este documento. Form PA-8422

For Residents of Wisconsin: If you are a resident of the State of Wisconsin, the following notice applies: KEEP THIS NOTICE WITH YOUR INSURANCE PAPERS. PROBLEMS WITH YOUR INSURANCE? - If you are having problems with your insurance company or agent, do not hesitate to contact the insurance company or agent to resolve your problem. Hartford Life Insurance Companies, Group Benefits Division Policyholder Services, P.O. Box 2999, Hartford, CT 06104-2999. Telephone: 800-572-9047. You can also contact the OFFICE OF THE COMMISSIONER OF INSURANCE, a state agency which enforces Wisconsin's insurance laws, and file a complaint. You can contact the OFFICE OF THE COMMISSIONER OF INSURANCE by writing to: Office of the Commissioner of Insurance Complaints Department, P.O. Box 7873, Madison, WI 53707-7873 1-800-236-8517 1-608-266-0103 or you can call 1-800-236-8517 outside of Madison, or 266-0103 in Madison, and request a complaint form. Form PA-8560-4

Business Travel Accident and Global Health

Hartford Fire Insurance Company

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

The Hartford® is The Hartford Financial Services Group, Inc. and its subsidiaries.

SCHEDULE

Policy Number:	10-GTA-101903	
Policyholder Name:	T-Mobile	
Policyholder Address:	6500 Sprint Parkway Overland Park, KS 66251	
Policy Issue State:	Kansas	
Previous Policy No:	10-ETB-114056 10-GTA-101001	
Policy Period:	Policy Effective Date:	1/1/2022
	Policy Anniversary Date:	1/1/2022 1/1/2023 1/1/2024
	Policy Termination Date:	1/1/2025

Newly Acquired Corporations, Partnerships, or Sole Proprietorships

The premium for this Policy applies only to the Policyholder as constituted on the Policy Effective Date (or any renewal date of this Policy). However, any corporation, partnership, or sole proprietorship and acquired by the Policyholder after the Policy Effective Date (or any renewal date) will be considered a part of the Policyholder, or a Covered Affiliate or Subsidiary, as of the date of the acquisition, but only if the following conditions are both met by the Policyholder within a reasonable time after the acquisition date:

1) Policyholder must report to Us, in writing, the name of the newly acquired entity and all underwriting information We deem necessary to determine any additional premium required; and
2) It must agree to, and must pay, any required additional premium (or an appropriate portion thereof as agreed upon with Us).

If both conditions are not met within a reasonable time after the acquisition date, the newly acquired entity will not be considered a part of the Policyholder, or a Covered Affiliate or Subsidiary, and the employees from the newly acquired entity will not be considered as employees of the Policyholder or a Covered Affiliate or Subsidiary for Policy purposes, until the date both conditions are met.

PREMIUM

Policy Premium:	$297,048.
Premium Mode:	3-year annual installments due on the Effective Date and each Anniversary Date thereafter 1st annual installment of $99,016: January 1, 2022 – January 1, 2023

2nd annual installment of $99,016: January 1, 2023 – January 1, 2024
3rd annual installment of $99,016: January 1, 2024 – January 1, 2025

War Risk Premium: $5,000.00 per annual installment, already included in the installment premium above

DESCRIPTION OF ELIGIBLE CLASS(ES)

Class	Description Of Class(es)	Applicable Hazard Riders	Applicable Benefit Riders
1	All Executives of the Policyholder (Senior VP and above).	H-1, H-4, H-8(A), H-11, H-40	B-4, B-7, B-11, B-13, B-19, B-21, B-26, B-32, B-33, B-38, B-39, B-49, B-50, B-51, B-52, B-55, B-60
2	All Active US and International full-time non-bargaining and part-time employees of the Policyholder who work 20 or more hours per week.	H-3, H-4, H-8(B), H-10, H-15, H-40	B-4, B-7, B-11, B-13, B-19, B-21, B-26, B-32, B-33, B-38, B-39, B-49, B-50, B-51, B-52, B-55, B-60
3	All active US and international members of the Board of Directors of the Policyholder.	H-3, H-4, H-8(B), H-10, H-15, H-40	B-4, B-7, B-11, B-13, B-19, B-21, B-26, B-32, B-33, B-38, B-39, B-49, B-50, B-51, B-52, B-55, B-60
4	All eligible Spouses*, who are traveling with the Employee at the direction and expense of the Policyholder, who are not in any other Class.	H-7, H-21, H-40	B-4, B-7, B-11, B-13, B-19, B-21, B-26, B-32, B-33, B-38, B-39, B-49, B-50, B-51, B-52, B-55, B-60
5	All eligible Dependent Children, who are traveling with the Employee at the direction and expense of the Policyholder, who are not in any other Class.	H-7, H-21, H-40	B-4, B-7, B-11, B-13, B-26, B-32, B-38, B-39, B-49, B-50, B-51, B-52, B-55, B-60

***Spouse** means any individual who, under applicable state law is recognized as a Spouse.

Spouse also includes any individual who is a partner to a civil union, a registered domestic partnership, or other relationship allowed by state law.

Spouse will include Your affidavit domestic partner provided You have executed a domestic partner affidavit satisfactory to Us, establishing that You and Your partner are domestic partners for purposes of the Policy. You will continue to be considered affidavit domestic partners provided You continue to meet the requirements described in the domestic partner affidavit.

Spouse does not include any person who is insured as an Active Employee.

BENEFITS AND AMOUNTS

Class 1	**PRINCIPAL SUM**
Accidental Death & Dismemberment	$3,000,000
Class 2	
Accidental Death & Dismemberment	Five (5) times Annual Salary to a maximum of $3,000,000
Class 3	
Accidental Death & Dismemberment	$500,000
Class 4	
Accidental Death & Dismemberment	$50,000
Class 5	

Accidental Death & Dismemberment	$25,000

Annual Salary means the Insured Person's base annual income and commission, but not including bonuses, overtime pay, and special compensation.

AGGREGATE LIMIT

$20,000,000 Per Covered Accident

HAZARD RIDER(S)

This Policy covers Injury resulting from the following hazard(s):

Identifier	Form Number	Description
H-1	Form BTA PA-10048	24-Hour Accident Protection Business and Pleasure Hazard Rider
H-3	Form BTA PA-10053	24-Hour Accident Protection While on Business Hazard Rider
H-4	Form BTA PA-10054	24-Hour Accident Protection While on a Policyholder Aircraft for Passenger, Pilot and Crew Hazard Rider
H-7	Form BTA PA-10050	24-Hour Family Relocation Trip Hazard Rider
H-8(A)	Form BTA PA-10055	24-Hour Hijacking or Sky-jacking Business and Pleasure Hazard Rider
H-8(B)	Form BTA PA-10055	24-Hour Hijacking or Sky-jacking Business Hazard Rider
H-10	Form BTA PA-10057	24-Hour Violent Act On a Trip—Business Only—Hazard Rider
H-11	Form BTA PA-10058	24-Hour Violent Act Hazard Rider
H-15	Form BTA PA-10062	Commutation Hazard Rider
H-21	Form BTA PA-10068	Family Travel Rider
H-40	Form BTA PA-10087	War Risk Hazard Rider

BENEFIT RIDER(S)

Identifier	Form Number	Description
B-4	Form BTA PA-10115	Adaptive Home & Vehicle Benefit Rider
B-7	Form BTA PA-10093	Bereavement Counseling Benefit Rider
B-11	Form BTA PA-10097	Carjacking Benefit Rider
B-13	Form BTA PA-10099	Coma Benefit Rider
B-19	Form BTA PA-10105	Day Care Benefit Rider
B-21	Form BTA PA-10107	Education Expense Rider
B-26	Form BTA PA-10112	Funeral Expense Rider
B-32	Form BTA PA-10119	Medical Emergency Evacuation Benefit Rider
B-33	Form BTA PA-10149	Mortgage Continuation Benefit Rider
B-38	Form BTA PA-10123 (KS)	Out of Country Medical Benefit Rider
B-39	Form BTA PA-10124	Paralysis Benefit Rider
B-49	Form BTA PA-10133	Rehabilitation Expense Benefit Rider
B-50	Form BTA PA-10134	Repatriation of Remains Benefit Rider

B-51	Form BTA PA-10135	Seat Belt and Airbag Benefit Rider
B-52	Form BTA PA-10136	Security Evacuation Benefit Rider
B-55	Form BTA PA-10139	Therapeutic Counseling Benefit Rider
B-60	Form BTA PA-10144	Worksite Modification Benefit Rider

BLANKET TRAVEL ACCIDENT POLICY (INCLUDING AMENDATORY RIDERS)

Hartford Fire Insurance Company

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

The Hartford® is The Hartford Financial Services Group, Inc. and its subsidiaries.

Policyholder: T-Mobile

Policy Number: 10-GTA-101903

We will pay benefits according to the conditions of this Policy.

This is a legal contract between the Policyholder and Us. We agree to provide the rights and benefits of this Policy according to its conditions and provisions.

This Policy begins on the Policy Effective Date shown in the Schedule and continues in effect until the Policy Termination Date as long as premiums are paid when due, unless otherwise terminated as further provided in this Policy. If this Policy is terminated, insurance ends on the date to which premiums have been paid. After the Policy Termination Date, this Policy may be renewed for additional periods of time by mutual written consent between Us and the Policyholder at the premium rates set by Us for the renewal period.

PLEASE READ THE POLICY CAREFULLY.

This Policy is delivered in and governed by the laws of the Policy Issue State, and to the extent applicable, by the Employee Retirement Income Security Act of 1974 (as amended). This Policy may be inspected at the office of the Policyholder.

THIS POLICY IS NOT A MEDICARE SUPPLEMENT POLICY.

THIS IS A LIMITED BENEFIT POLICY.

IT PROVIDES BENEFITS FOR SPECIFIC LOSSES FROM ACCIDENT ONLY. IT IS NOT INTENDED TO COVER ALL MEDICAL COSTS.

Signed for Hartford Fire Insurance Company at Hartford, Connecticut

Lisa Levin, *Secretary*

Douglas Elliot, *President*

Non-Participating

Definitions

Accident, Accidental means a sudden, abrupt, and unexpected event.

Aircraft means a vehicle which:

1) has a valid Airworthiness Certificate issued by the FAA;
2) is being flown by a pilot with a valid license to operate the Aircraft.

Airworthiness Certificate means a valid and current "Standard Airworthiness Certificate" issued by the FAA.

Alcohol and Substance Abuse means the overindulgence in or dependence on a stimulant, depressant or other chemical substance, leading to effects that are detrimental to the individual's physical or mental health or the welfare of others.

Ambulatory Surgical Center (ASC) or **Ambulatory Medical Center** means a licensed healthcare facility where surgical procedures or medical Treatment that does not require an overnight Hospital stay are performed by a Physician. The facility must:

1) be under the direct supervision of a Physician;
2) provide Treatment by Physicians and/or Medical Professionals; and
3) have written agreements in place with one or more Hospitals to immediately accept patients who develop complications.

An ASC is also known as an outpatient surgery center or a same day surgery center.

Automobile means a self-propelled private passenger motor vehicle with four or more wheels that is of a type both designed and required to be licensed for use on the highways of any state or country. Automobile includes, but is not limited to:

1) a sedan
2) station wagon
3) sport utility vehicle, and
4) a motor vehicle of the pickup, panel, van, camper, or motor home type

Automobile does not include a mobile home or any motor vehicle that is used in mass or public transit.

Benefit Plan means a policy or other benefit or service arrangement for medical or dental care, or providing accident or health coverage, under any of the following:

1) individual, group or blanket coverage, whether on an insured or self- funded basis;
2) Hospital or medical service organizations;
3) health maintenance organizations;
4) labor-management plans;
5) employee benefit organization plans;
6) association plans; or
7) any other "employee welfare benefit plan" as defined in the Employee Retirement Income Security Act of 1974, as amended.

Business of the Policyholder means while on assignment by or at the direction of the Policyholder for the purpose of furthering the business of the Policyholder, but does not include any period of time:

1) while the Insured Person is working at his or her regular place of employment;
2) during the course of everyday travel to and from work; or
3) during an authorized leave of absence or vacation.

If an Insured Person's assignment to a location exceeds 365 days, such assignment will be deemed to change the Insured Person's residence and regular place of employment to the new location.

Civil Aircraft means a civilian or public Aircraft which:

1) has an Airworthiness Certificate;

is piloted by a person who has:

a) a current pilot certificate which the appropriate Aircraft category rating for that Aircraft; and

b) a current medical certificate which is appropriate for the operation of that Aircraft; and

is not operated by the militia, or armed forces of any state, national government or international authority.

A Civil Aircraft does not include a Policyholder Aircraft.

Coinsurance means the percentage of the Usual and Customary Charges incurred for Covered Medical Services payable by Us.

Coma, Comatose means a profound state of unconsciousness from which the Insured Person cannot be aroused to consciousness by external or internal stimulation, as determined by a Physician.

Common Carrier means any air, land or water motorized Conveyance operated under a license for the transportation of fare-paying Passengers, including ridesharing programs. Common Carrier does not include courtesy transportation for which a charge is not made or cruise ships at sea more than 24 consecutive hours or any Conveyance, regardless of whether the Conveyance is licensed that is hired or used for a sport, gamesmanship, contest, or recreational activity. These Conveyances can include, but are not limited to, race cars, bobsleds, hunting vehicles, sightseeing vehicles, helicopters, fishing boats, parasails, paragliders, and boat cruises operating beyond 12 hours.

Complications of Pregnancy means any condition, whether or not a pregnancy is terminated, that requires Hospital Confinement and whose diagnosis is distinct from pregnancy but is adversely affected or caused by pregnancy. Examples include acute nephritis; cardiac decompensation; disease of the endocrine, hemopoietic, nervous or vascular systems; ectopic pregnancy that is terminated; hyperemesis gravidarum; missed abortion; nephrosis; non-elective caesarean section; spontaneous termination of pregnancy that occurs during a period of gestation when a viable birth is not possible; or any similar condition(s) of comparable severity.

This definition does not include: elective caesarean section unrelated to a diagnosed complication of pregnancy; false labor; morning sickness; multiple gestation pregnancy; occasional spotting; physician prescribed rest during pregnancy; pre-eclampsia; any similar condition(s) associated with a difficult pregnancy but not considered a classifiable, distinct complication of pregnancy; or any other condition associated with pregnancy but has not been diagnosed by a Physician as a complication of pregnancy as defined.

Confined, Confinement means the assignment to a bed in a medical facility for a period of at least 24 consecutive hours.

Conveyance means any motorized craft, vehicle, or mode of transportation licensed or registered by a governmental authority with competent jurisdiction. Conveyances include, but are not limited to, air ambulances, land ambulances and private motor vehicles.

Covered Accident means an Accident that occurs directly and independently of all other causes while coverage is in effect for an Insured Person resulting in a Covered Loss under the Policy for which benefits are payable.

The Insured Person must be participating in a Covered Hazard, as identified in the Schedule, when the Accident occurs.

Covered Hazard means those hazards set out in the Covered Hazards section of the Schedule, in which Insured Persons are provided insurance under the Policy.

Covered Loss means an accidental death, dismemberment, or other Injury covered under the Policy.

Covered Trip means Policyholder sponsored travel by air, land, or sea with a destination that is more than 100 miles from the Insured Person's primary residence. It includes the period time from the start of travel away from the Insured Person's place of primary residence or workplace, until the end of travel when the Insured Person returns to his primary residence or workplace, provided the duration of the travel does not last more than 365 days.

Deductible means the amount of Usual and Customary Charges for Covered Medical Services that must be incurred by the Insured Person before benefits become payable. The amount of the Deductible is shown in the Rider Schedule. Benefits are not payable for charges applied to the Deductible.

Dependent Child(ren) means:

1) an Insured Person's or Spouse's natural child, legally adopted child or stepchild;
2) a child placed into the Insure Person's or Spouse's custody for adoption (regardless of whether the adoption has become final);
3) a child for whom the Insured Person or Spouse is ordered by a court or administrative order to provide coverage regardless of whether he/she is the custodial or non-custodial parent; or
4) an Insured Person's or Spouse's foster child or any other child for whom the Insured Person or Spouse has been appointed legal guardian; or
5) any other child who lives with the Insured Person in a regular parent/child relationship and is dependent on the Insured Person for support and maintenance;

who is/are:

1) unmarried; and
2) under 18 years of age; or
3) a student age 18 or older but under age 26.

If an unmarried child is age 18 or older and is:

1) incapable of self-sustaining employment because of a mental or physical disability;
2) chiefly dependent on the Insured Person or Spouse for financial support and maintenance; and
3) proof has been provided of his/her disability upon Our request, that child will continue to be a dependent child until these conditions cease to exist.

Diagnostic Exams mean any of the following major/advanced tests: angiogram, arteriogram, bone scintigraphy, CT, EEG, EKG, EMG, MRI, PET, SPECT, or thallium stress test. This definition does not include any lab test or x-ray.

Durable Medical Equipment means equipment of a type that is designed primarily for use, and used primarily, by people who are sick (for example, a wheelchair or a hospital bed). It does not include items commonly used by people who are not sick, even if the items can be used in the Treatment of Emergency Sickness or can be used for rehabilitation or improvement of health (for example, a stationary bicycle or a spa).

Eligible Class means any group of people listed in the Description of Eligible Class(es) shown in the Schedule.

Emergency Room (ER) means a specified area within a Hospital that is designated for emergency healthcare. This area must:

1) be staffed and equipped to handle trauma;
2) be under the direct supervision of a Physician;
3) provide Treatment by Physicians and/or Medical Professionals; and
4) provide care 24 hours per day, 7 days per week.

This definition does not include an Urgent Care Facility.

Emergency Sickness means an illness or disease diagnosed by a Physician which causes a severe or acute symptom that, if not provided with immediate Treatment, would reasonably be expected to result in serious deterioration of the person's health, or place his/her life in jeopardy. Emergency Sickness also includes pregnancy and Complications of Pregnancy.

Experimental or Investigative Treatment means a device or prescription medication which is recommended by a Physician, but is not considered by the medical community as a whole to be safe and effective for the condition for which the Treatment, device or prescription medication is being used, including any Treatment, procedure, facility, equipment, drugs, drug usage, devices, or supplies not recognized as accepted medical practice, and any of those items requiring federal or other government agency approval not received at the time the services are rendered.

FAA means:

1) the Federal Aviation Administration of the United States; or

2) the similar aviation authority for the country of the Aircraft's registry, if the country is recognized by the United States.

Geographic Area means the city, providence or region in which the service, procedure, devices, drugs, Treatment or supplies are provided or a greater area, if necessary, to obtain a representation cross-section of charges for a like treatment, service, procedure, device, drug, or supply. Inside the United States, this would be based on the first three digits of the zip code.

Home Country means a country from which the Insured Person holds a passport. If the Insured Person holds passports from more than one country, his or her Home Country will be the country that the Insured Person has declared to Us in writing as his or her Home Country.

Home Health Care means healthcare services provided by a Home Health Care Agency in the residence of an Insured Person, including, but not limited to, counseling services, home health aide services, Hospice Care, skilled nursing care, medical social services and Therapy Services. Services must be rendered under a plan of care that is established and reviewed regularly by a Physician.

Home Health Care Agency means an appropriately licensed home health care agency which:

1) is primarily engaged in providing home health services;
2) provides services under the supervision of a Physician or Medical Professional;
3) has a planned program of policies and procedures developed with and periodically reviewed by one or more Physicians; and
4) maintains clinical records on all patients.

Hospice Care means specialized care, medical services and emotional support for an Insured Person who is in the last stages of an advanced illness, focusing on comfort and quality of life rather than cure.

Hospice Facility means an appropriately licensed healthcare facility, or a distinct unit within a Hospital or other institution, which:

1) provides Hospice Care and related services 24 hours per day, 7 days per week;
2) is under the direct supervision of a Physician and has a Physician or Medical Professional available at all times; and
3) is not mainly a place for care of the aged/elderly, care of persons with Substance Abuse issues/disorders, care of persons with Mental and Nervous Disorders, or a hotel or similar establishment.

Confinement in a Hospice Facility must follow certification by a Physician or hospice medical director that an Insured Person is terminally ill with less than 6 months to live if the Covered Loss runs its normal course. This definition does not include a nursing home, Rehabilitation Facility, Skilled Nursing Facility or swing bed hospitals that are authorized to provide and be paid for extended care services.

Hospital means an institution which:

1) operates pursuant to law;
2) primarily and continuously provides Medical Care and Treatment of sick and injured persons on an inpatient basis;
3) operates facilities for medical and surgical diagnosis and treatment by or under the supervision of a staff of legally qualified physicians; and
4) provides 24 hour a day nursing service by or under the supervision of registered graduate nurses (R.N.).

Hospital does not mean any institution or part thereof, which is used primarily as:

1) a nursing home, convalescent home or Skilled Nursing Facility;
2) an alcohol or drug treatment facility; or
3) a place for rest, custodial care or for the aged.

Host Country means the country, other than an Excluded Country, in which the Insured Person is traveling while covered under the Policy.

Immediate Family Member means a person who is related to the Insured Person in any of the following ways: Spouse, brother-in-law, sister-in-law, daughter-in-law, mother-in-law, father-in-law, parent (includes step-parent), grand-parent (includes step grand-parent), brother or sister (includes stepbrother or stepsister and half-brother or half-sister), or child (includes a child legally adopted or a child placed for adoption but not yet adopted), or stepchild.

Injury means bodily injury sustained by an Insured Person caused from a Covered Accident that:

1) occurs while this Policy is in force as to the Insured Person whose Injury is the basis of claim; and

occurs under the circumstances described in a Covered Hazard applicable to that Insured Person.

See the Schedule for applicability of all Covered Hazards and benefits. All Injuries sustained by one Insured Person in any one Covered Accident, including all related conditions and recurrent symptoms of the Injuries are considered a single Injury.

Inpatient means an Insured Person who is Confined and charged by a medical facility for room and board or is being held in a Hospital for a period of 24 consecutive hours or more. The requirement that an Insured Person be charged by the medical facility does not apply to Confinement in a Veteran's Administration Hospital or other Federal Government Hospital.

Insured Person means a person:

1) who is a member of an Eligible Class described in the Schedule;

for whom premium has been paid; and

while covered under this Policy.

Intensive Care Unit (ICU) means a specifically designated area of a Hospital that provides the highest level of Medical Care and:

1) is restricted to patients who are critically ill or injured and who require intensive comprehensive observation and care;

is separate and apart from the surgical recovery room and from rooms, beds and wards customarily used for patient Confinement;

is permanently equipped with special lifesaving equipment and medical apparatus for the care of the critically ill or injured;

is under constant and continuous observation by a specially trained nursing staff assigned exclusively to the unit on a 24-hour basis; and

has a Physician assigned to the unit on a full-time basis.

An Intensive Care Unit may include Hospital units with the following (or similar) names: burn unit; critical care unit; neonatal intensive care unit; cardiac care unit; or transplant unit.

An Intensive Care Unit is not any of the following step-down units: intermediate care unit; modified/moderate care unit; Observation Unit; progressive care unit; or sub-acute intensive care unit.

This definition does not include a private monitored room.

Kidnap, Kidnapped, or Kidnapping means the wrongful abduction and holding under duress or by fraudulent means of an Insured Person by any person or group making a ransom demand or series of ransom demands for the release of such Insured Person.

Leased Aircraft means any Aircraft not owned by the Policyholder but:

1) furnished for the use of and at the discretion of the Policyholder;

under the Policyholder's care, custody, or control for a stated period of time other than for a specific purpose or trip;

subject to a formal written lease agreement defining:

a) all terms, conditions, and obligations of both parties during the term of the lease; and

b) provisions for the safe return of the Aircraft to the owner, fair wear and tear expected;

with or without a pilot or crew furnished by the owner in attendance; and

with or without maintenance furnished by the owner.

Medical Care means necessary:

1) medical or surgical Treatment, services and supplies;
2) Hospital, nursing and ambulance services.

Each item of Medical Care must be:

1) prescribed by a Physician;
2) for the sole purpose of treating the Injury.

Medical Emergency Evacuation means, if warranted by the severity of the Insured Person's Injury or Emergency Sickness:

1) the Insured Person's immediate Transportation from the place where he or she suffers an Injury or Emergency Sickness to the nearest Hospital or other medical facility where appropriate medical treatment can be obtained;
2) the Insured Person's Transportation to his or her current place of primary residence to obtain further medical treatment in a Hospital or other medical facility or to recover after suffering an Injury or Emergency Sickness and being treated at a local Hospital or other medical facility; or
3) both 1) and 2) above.

A Medical Emergency Evacuation also includes medical treatment, medical services and medical supplies necessarily received in connection with such Transportation.

Medically Necessary or **Medical Necessity** means a determination by the Insured Person's Physician that Treatment, service or supply provided to treat an Injury or Sickness is:

1) appropriate and consistent with the diagnosis and does not exceed in scope, duration, or intensity the level of care needed to provide safe, adequate, and appropriate treatment of the Injury or Sickness;
2) is commonly accepted as proper care or Treatment of the Injury or Sickness in accordance with the medical practices of the United States and federal guidelines;
3) can reasonably be expected to result in or contribute to the improvement of the Injury or Sickness; and
4) is provided in the most conservative manner or in the least intensive setting without adversely affecting the condition of the Injury or the quality of the Medical Care provided.

The fact that a Physician may prescribe, order, recommend, or approve a treatment, service or supply does not, of itself, make the treatment, service, or supply medically necessary for the purpose of determining eligibility for coverage under the Rider.

The Medical Professional must be acting within the scope of his/her license. A Medical Professional does not include an Insured Person or any Immediate Family Member.

Medical Professional means a person who is appropriately licensed to provide Medical Care and Treatment, including a nurse practitioner (NP/APRN), physician's assistant (PA) or registered nurse (RN). The medical professional must be acting within the scope of his/her license. A medical professional does not include an Insured Person or any Immediate Family Member.

Member of the Household means a person who maintains residence at the same address as the Insured Person at the time of the Injury.

Mental and Nervous Disorders means any condition, disease or disorder listed as a mental or nervous disorder in the most recent edition of the International Classification of Diseases (ICD) and the Diagnostic and Statistical Manual of Mental Disorders (DSM), where improvement can be reasonably expected with therapy.

This definition does not include conditions, diseases or disorders related to Substance Abuse.

Military Transport Aircraft means a transport Aircraft operated by:

1) the United States Air Mobility Command (AMC); or
2) a national military air transport service of any country.

Natural Disaster means an event, including, but not limited to, wind storm, rain, snow, sleet, hail, lightning, dust or sand storm, earthquake, tornado, flood, volcanic eruption, wildfire, or other similar event that:

1) is due to natural causes; and

2) results in severe damage such that the area in which loss occurs is declared a disaster area by a competent governmental authority having jurisdiction.

On the Premises of the Policyholder means on real estate owned, leased, controlled or under the management of the Policyholder and used by the Policyholder to conduct business.

Outpatient means an Insured Person who receives Treatment or services at a Hospital, Ambulatory Surgery Center (ASC), lab, medical clinic, Physician or Medical Professional's office/clinic, radiologic center or other licensed medical facility and is neither Confined nor charged for room and board.

Paralysis means the complete loss of muscle function in a part of the body as a result of neurological damage, as determined by a Physician.

Passenger(s) means a person not performing as a pilot, operator, or crew member of a Conveyance.

Physician means a provider or practitioner who:

1) is properly licensed or certified to provide care or Treatment under the laws of the state where he or she practices;

provides services that are within the scope of his or her license or certificate; and

is not the Insured Person, a Member of the Household of the Insured Person or an Immediate Family Member.

Policy means this insurance policy, certificate, the Schedule and all attached riders, amendments, endorsements or other papers.

Policy Period means the period between the Policy Effective Date and Policy Termination Date. These dates are shown on the Schedule.

Policyholder Aircraft means an Aircraft which is owned by the Policyholder, a Leased Aircraft or an Aircraft operated by or on behalf of the Policyholder.

Pre-existing Condition means a health condition for which an Insured Person has sought or received medical advice or Treatment from a Physician or Medical Professional at any time during the 12 months immediately preceding the Policy Effective Date of coverage under the Policy.

Rehabilitation Care Facility means an appropriately licensed healthcare facility, or a distinct unit within a Hospital or other institution, which:

1) provides Rehabilitation Care Services;

is under the direct supervision of a Physician;

has a planned program of policies and procedures developed with and periodically reviewed by one or more Physicians; and

is not mainly a place for rest, Custodial Care, care of the aged/elderly, care of persons with Substance Abuse issues/disorders, care of persons with Mental and Nervous Disorders, or a hotel or similar establishment.

Confinement in a rehabilitation care facility must be at the direction of a Physician. This definition does not include a Hospice Facility, nursing home, Skilled Nursing Facility or swing bed hospitals that are authorized to provide and be paid for extended care services.

Relocation Trip means a trip which:

1) begins when the Insured Person or his or her Spouse or Dependent Child(ren) leave his or her former place of residence for the purpose of relocating to a new residence; and

ends when he or she arrives at his or her new place of residence;

provided such trip is due to the Insured Person's relocation which is at the request and expense of the Policyholder.

A Relocation Trip will not include any period of time in excess of 7 days of the Relocation Trip during which the Insured Person or his or her Spouse or Dependent Child(ren) take a vacation or Sojourn and/or Personal Deviation which substantially differs from the Relocation Trip.

Schedule means the benefits, benefit amounts, terms, limitations, and provisions of coverage selected by the Policyholder which is attached to and made a part of this Policy.

Scheduled Aircraft means a Civil Aircraft operated by a scheduled airline, which:

1) is licensed by the FAA for the transportation of Passengers for hire; and
2) publishes its flight schedules and fares for regular passenger service.

Sickness means an illness, disease or condition that impairs an Insured Person's normal functioning of mind or body and which is not the direct result of an Injury or Accident. Sickness also includes Complications of Pregnancy.

Skilled Nursing Facility means an appropriately licensed healthcare facility, or a distinct unit within a Hospital or other institution, which:

1) provides skilled nursing care and related services 24 hours per day, 7 days per week;
2) is under the direct supervision of a Physician and has a Physician or Medical Professional available at all times;
3) has a planned program of policies and procedures developed with and periodically reviewed by one or more Physicians; and
4) is not mainly a place for rest, Custodial Care, care of the aged/elderly, care of persons with Substance Abuse issues/disorders, care of persons with Mental and Nervous Disorders, or a hotel or similar establishment.

Confinement in a Skilled Nursing Facility must be at the direction of a Physician. This definition does not include a Hospice Facility, nursing home, Rehabilitation Care Facility or swing bed hospitals that are authorized to provide and be paid for extended care services.

Sojourn and/or Personal Deviation means non-business travel or activities undertaken while on the Business of the Policyholder, or during a Business Trip, but unrelated to furthering the Business of the Policyholder.

Spouse means any individual who is recognized as the spouse of the Insured Person, under applicable state law.

Spouse will also include a domestic partner or civil union partner as determined by any controlling legal authority or, in the absence of such authority, by agreement between Us and the Policyholder.

Surgical Replantation means the surgical reattachment of an arm, leg, hand, foot, finger, or toe that has been severed from an Insured Person's body.

Therapy Services means acupuncture, respiratory therapy, occupational therapy, physical therapy or speech therapy.

Transportation means moving an individual by the most efficient and available land, water or air Conveyance.

Treatment means medical advice, diagnosis, care or services (including diagnostic measures) received by a person, or the use of drugs or medicines by a person.

Trip means a trip taken by an Insured Person which begins when the Insured Person leaves his or her residence or place of regular employment for the purpose of going on the trip (whichever occurs last) and is deemed to end when the Insured returns from the trip to his or her residence or place of regular employment (whichever occurs first). However, the trip is deemed to exclude any period of time during which the Insured Person is on an authorized leave of absence or vacation or travel to and from the Insured Person's place of regular employment. This definition does not include the Insured Person's trip to a location that extends for more than 365 days. Such a trip will be deemed to change the Insured Person's residence or place of regular employment to the new location.

Usual and Customary Charge(s) means the average amount charged by most providers for Treatment, service or supplies in the Geographic Area where the Treatment, service or supply is provided.

Violent Act means any willful or unlawful use of force in connection with the commission of or the attempt to commit a crime (including, but not limited to, robbery, hold-up, extortion, theft, Kidnapping, hostage-taking, assault, battery, sniping, murder, manslaughter, riot, or insurrection) that:

1) results in Injury to the Insured Person; and
2) is a felony or a misdemeanor in the jurisdiction in which it occurs.

We, **Us** or **Our** means the Hartford Fire Insurance Company.

POLICY EFFECTIVE AND TERMINATION DATES

Policy Effective Date. This Policy begins on the Policy Effective Date shown in the Schedule at 12:01 AM Standard Time at the address of the Policyholder where this Policy is delivered.

Policy Termination Date. We may terminate this Policy by giving 31 days advance notice in writing to the Policyholder. Either We or the Policyholder may terminate this Policy on any premium due date by giving 31 days advance notice in writing to the other party.

This Policy may, at any time, be terminated by mutual written consent of the Policyholder and Us. This Policy terminates automatically on the earlier of:

1) the Policy Termination Date shown in the Schedule; or
2) the end of the Grace Period if premiums are not paid when due.

Termination takes effect at 12:01 AM Standard Time at the Policyholder's address on the date of termination

INSURED PERSON'S EFFECTIVE AND TERMINATION DATES

Insured Person's Effective Date. An Insured Person's coverage under this Policy begins on the latest of:

1) the Policy Effective Date;
2) the date for which the first premium for the Insured Person's coverage is paid; or
3) the date the person becomes a member of an Eligible Class as described in the Schedule.

A change in an Insured Person's coverage under this Policy due to a change in his or her Eligible Class, or Covered Hazard becomes effective on the later of:

1) when the change in his or her Eligible Class, or Covered Hazard occurs; or

if the change requires a change in premium, the date the changed premium is paid.

However, a change in coverage applies only with respect to a Covered Loss that occurs once the change becomes effective.

Insured Person's Termination Date. An Insured Person's coverage under this Policy ends on the earliest of:

1) the date this Policy is terminated (unless the Policyholder and Us agree, in writing, to permit coverage to continue to the end of the period for which premiums have been paid in lieu of a return of unearned premiums);

the end of the Grace Period if premiums are not paid when due; or

the date the Insured Person ceases to be a member of any Eligible Class described in the Schedule.

Termination of coverage will not affect a claim for a Covered Loss that occurs either before or after such termination if that loss results from a Covered Accident that occurred while the Insured Person's coverage was in force under this Policy.

PREMIUM

Premiums

Premiums are payable to Us as shown in the Schedule. We may change the required premiums due on any Policy anniversary date after the first Policy anniversary date, as measured annually from the Policy Effective Date, by giving the Policyholder at least 31 days advance written notice.

We may change the required premiums as a condition of any renewal of this Policy. We may also change the required premiums at any time when any change affecting rates is made in this Policy. Any such change in this Policy will not take effect until any required additional premium is received by Us, except as otherwise agreed to in writing by the Policyholder and Us.

We may change the premium rates if:

1) there is a change in the Policy;
2) there is any change to state or federal law or inaction by state or federal law makers which affects Our liability under the Policy on a temporary or permanent basis;
3) Social Security Disability benefits are reduced or eliminated on a temporary or permanent basis due to the actual or threatened insolvency of the Social Security Disability Insurance Trust Fund;
4) there is a 10% increase or decrease in the number of insured;
5) the Policyholder adds or deletes a subsidiary, affiliated business entity or Policyholder Aircraft; or
6) there has been a material misstatement in the reported experience during the pre-sale process.

Renewal

This Policy may be renewed, subject to Our consent, by payment of premiums as they become due. The renewal premiums will be based on Our rates in effect at the time of renewal.

Grace Period

A grace period of 31 days will be provided for the payment of any premium due after the Initial Premium. This Policy will not be terminated for nonpayment of premium during the Grace Period if the Policyholder pays all premiums due by the last day of the Grace Period. This Policy will terminate on the last day of the period for which all premiums have been paid if the Policyholder fails to pay all premiums due by the last day of the Grace Period.

If We expressly agree to accept late payment of a premium without terminating the Policy, the Policyholder will be liable to Us for any unpaid premiums for the time this Policy is in force.

No grace period will be provided if We receive notice to terminate this Policy prior to a premium due date.

ACCIDENTAL DEATH AND DISMEMBERMENT (AD&D) BENEFIT(S)

If the Insured Person's Injury results in any of the losses listed in the table below within 365 days after the date of the Covered Accident, We will pay the sum shown opposite the loss. We will not pay more than the Accidental Death or Accidental Dismemberment Principal Sum shown for each Insured Person for all losses due to the s a m e Covered Accident subject to the Age Reduction Schedule. The Accidental Death or Accidental Dismemberment Principal Sum amount is shown in the Schedule.

For Loss of:	Benefit:
Life	100% of the Accidental Death Principal Sum
Both Hands or Both Feet or Sight of Both Eyes	100% of the Accidental Dismemberment Principal Sum
One Hand and One Foot	100% of the Accidental Dismemberment Principal Sum
One Hand and Sight of One Eye	100% of the Accidental Dismemberment Principal Sum
One Foot and Sight of One Eye	100% of the Accidental Dismemberment Principal Sum
Speech and Hearing in Both Ears	100% of the Accidental Dismemberment Principal Sum
Speech and Hearing in One Ear	75% of the Accidental Dismemberment Principal Sum
One Arm or One Leg	75% of the Accidental Dismemberment Principal Sum
One Hand or One Foot	50% of the Accidental Dismemberment Principal Sum
Sight of One Eye	50% of the Accidental Dismemberment Principal Sum
Speech or Hearing in Both Ears	50% of the Accidental Dismemberment Principal Sum
Thumb and Index Finger on the Same Hand	25% of the Accidental Dismemberment Principal Sum
Hearing in One Ear	25% of the Accidental Dismemberment Principal Sum
One Thumb	10% of the Accidental Dismemberment Principal Sum

For purposes of this benefit:

1) **Loss of Arm** means Severance of an arm above the elbow joint, including the Severance of the entire arm.
2) **Loss of Both Feet, Loss of One Foot** means Severance of a foot or both feet above the ankle joint, including the Severance of an entire leg or any part of a leg that includes an entire foot.
3) **Loss of Both Hands, Loss of One Hand** means Severance of at least four whole fingers at or proximal to the metacarpophalangeal joints (the joints that connect the fingers and the hand) from one or both hands, including the Severance of an entire arm or any part of an arm that includes an entire hand.
4) **Loss of Fingers or Thumb** means Severance of more than one finger or the thumb at least at or proximal to the first interphalangeal joint of each finger.
5) **Loss of Hearing** means total and permanent loss of hearing in one or both ears which cannot be corrected by any means.
6) **Loss of Leg** means Severance of a leg above the knee joint, including the Severance of the entire leg.
7) **Loss of Sight of Both Eyes, Loss of Sight of One Eye** means total and permanent loss of sight or blindness which cannot be corrected by any means, or Severance of one or both eyes.
8) **Loss of Speech** means total and permanent loss of audible voice communication which cannot be corrected by any means.
9) **Severance** means the complete separation and dismemberment of the part from the body.

Surgical Replantation Benefit

If a limb or appendage is Surgically Replanted, the amount payable will be 50% of the amount which would have been paid for a Loss of such limb or appendage. If the Surgical Replantation fails to provide the person with at least 75% use of the limb or appendage, the Benefit Amount for the Loss will be paid, less any amount paid for the Surgical Replantation.

The amount payable depends on the type of Loss as shown above. All benefits are subject to the Accidental Dismemberment Principal Sum amount shown in the Schedule. We will not pay more than the Accidental Dismemberment Principal Sum shown for each Insured Person for all losses due to the same Covered Accident subject to the Age Reduction Schedule.

Exposure and Disappearance

We will presume an Insured Person has died due to Injuries if, while insurance is in effect, the Insured Person dies as a result of exposure to the elements as a result of an Injury.

We will presume the Insured Person has died if, while insurance is in effect and after the forced landing, stranding, sinking, or wrecking of a vehicle:

1) the Insured Person disappears; and
2) the Insured Person's body is not found within 1 year(s) of disappearance; and
3) a valid death certificate is issued by a court of competent jurisdiction.

LIMITATIONS AND EXCLUSIONS

Economic Sanction

We will not provide coverage or pay benefits under this Policy to the extent, and only to the extent, that We are prohibited from providing coverage or making payment by any type of travel restriction, trade restriction, economic sanction, or embargo imposed by the United States government.

Limitation on Multiple Benefits

If an Insured Person suffers one or more Covered Losses from the same Covered Accident for which amounts are payable under all of the benefits provided by this Policy, the maximum amount payable under all of the benefits combined will not exceed the largest amount payable for one of those Covered Losses.

Limitation on Multiple Covered Hazards or Classes

If an Insured Person's Injury is caused by a Covered Accident that occurs while the Insured Person is covered under more than one Covered Hazard or Class, and if the same benefit applies to that Insured Person with respect to more than one such Covered Hazard or Class, then the Accidental Death or Accidental Dismemberment Principal Sum for that Insured Person for that Covered Accident will be determined as though the Covered Accident occurred while the Insured Person was covered under only one such Covered Hazard and Class. We will pay the benefits for the Covered Hazard and Class with the largest Principal Sum for that Insured Person.

Aggregate Limit

The Accidental Death or Accidental Dismemberment Principal Sum otherwise payable shall be reduced if more than one Insured Person suffers a loss as a result of the same Covered Accident, and if amounts are payable for those losses under all of the benefits provided by the Policy.

The Accidental Death or Accidental Dismemberment Principal Sum payable for all such losses for all Insured Persons under all those benefits combined will not exceed the amount shown as the Aggregate Limit in the Schedule or shown on the Hazard Rider Schedule. If the combined Accidental Death or Accidental Dismemberment Principal Sum otherwise payable for all Insured Persons must be reduced to comply with this provision, the reduction will be taken by applying the same percentage of reduction to the individual Accidental Death or Accidental Dismemberment Principal Sum otherwise payable for each Insured Person for all such losses under all those benefits combined.

Exclusions

Unless otherwise specified in the Policy, including any attached Riders, the Policy does not cover loss resulting from or for:

1) Suicide or attempted suicide, whether sane or insane, or intentionally self-inflicted Injury;

War or act of war, whether declared or undeclared;

Injury sustained while on active-duty service in the military, naval or air force of any country or international organization. Upon Our receipt of proof of service, We will refund any premium paid for this time. Reserve or National Guard Service is not excluded, unless it extends beyond 31 days;

Injury sustained while on any Aircraft except a Civil Aircraft, or Military Transport Aircraft, unless specifically covered by a Hazard Rider;

Except when specifically covered by a Hazard Rider, Injury sustained while on any Aircraft:

a) as a pilot, crewmember or student pilot;

b) as a flight instructor or examiner;

c) if it is owned, operated or leased by or on behalf of the Policyholder, or any employer or organization covering any Eligible Class under the Policy; or

d) being used for tests, experimental purposes, stunt flying, racing or endurance tests;

Injury sustained while the Insured Person is under the influence of any narcotics, drug or controlled substance, unless administered by or taken according to the instruction of a licensed Physician;

Injury sustained as a result of the Insured Person's voluntary intoxication through the use of poison, gas or fumes, whether by ingestion, injection, inhalation or absorption;

Injury sustained by an Insured Person during or as a result of his or her commission of a felony or while incarcerated for a felony, except that this exclusion will not be applicable upon acquittal or dismissal of the felony charges;

Injury sustained while the Insured Person is under the influence of intoxicants (as defined by the law of the jurisdiction in which the Injury occurred) while operating any vehicle or means of Transportation or Conveyance;

Injury sustained while the Insured Person is visually, manually or cognitively distracted or engaged in behavior which diverts attention and focus away from the roadway through use of a handheld mobile telephone or portable electronic device while operating any vehicle or means of Transportation or Conveyance or any form of distracted driving as defined by the law of the jurisdiction in which the Injury occurred;

Injury sustained by an Insured Person during or as a result of his or her participation in activities not sponsored or supervised by the Policyholder or any Extreme Sport or Extra-Hazardous Activities;

Sickness, disease, or bacterial or viral infection, or medical or surgical treatment thereof unless and only to the extent covered by Rider, except for any bacterial infection resulting from an accidental external cut or wound or accidental ingestion of contaminated food;

Mental and Nervous Disorders;

Services for which no charge is normally made.

CLAIMS PROVISIONS

Notice of Claim

The person who has the right to claim benefits (the claimant, beneficiary or his or her representative) must give Us written Notice of a Claim within 30 days after a Covered Loss begins or as soon as reasonably possible.

Notice of claim may be submitted as instructed on the applicable form or mailed to Our home office in Hartford, CT. Notice given by or on behalf of an Insured Person to Us, or to Our authorized agent, with information sufficient to identify the Insured Person, shall be notice to Us. Failure to give notice within this time frame will not invalidate nor reduce any claim. The notice should include the Insured Person's name and the Policy Number.

Claim Forms

When We receive the notice of claim, We will send forms to the claimant for giving Us Proof of Loss. The forms will be sent within 10 days after We receive the notice of claim. If the forms are not received, the claimant will satisfy the Proof of Loss requirement if a written notice of the occurrence, character and extent of the loss is sent to Us.

Proof of Loss

Written Proof of Loss must be furnished to Us within 90 days after the date of the loss. If the claim is for loss of time due to disability, subsequent written proofs of the continuance of such disability must be furnished at such intervals as We may reasonably require. Failure to furnish proof within the time required neither invalidates nor reduces any claim if it was not reasonably possible to give proof within such time, provided such proof is furnished as soon as reasonably possible.

All Proof of Loss submitted must be satisfactory to Us and must include information which is required by Us to adjudicate the claim. In addition, the claimant must provide Us any Proof of Loss documentation specifically required in any relevant Rider. We reserve the right to request additional information reasonably related to the claim.

Time of Payment of Claims

We will pay any benefit due, other than benefits for which the Policy provides periodic payment, immediately after We receive Proof of Loss. Subject to due written Proof of Loss, all accrued benefits for which the Policy provides periodic payment will be paid not later than at the expiration of each period of 30 days during the continuance of the period for which benefits are due, and any balance remaining unpaid at the termination of the period will be paid immediately upon receipt of the proof.

Payment of Claims

We will pay any benefit due for loss of life:

1) according to the written beneficiary designation on file with the Policyholder; otherwise, if no beneficiary is named or no named beneficiary survives the Insured Person, We will pay

to the survivors in equal shares, in the first of the following classes to have a survivor at the Insured Person's death:

a) Spouse;

b) children;

c) parents;

d) brothers and sisters.

If there is no survivor in these classes or if there are legal impediments to determining who the survivors or beneficiaries are, payment will be made to the Insured Person's estate.

All other benefits due and not assigned will be paid to the Insured Person, if living. Otherwise, the benefits will be paid according to the preceding language.

If a benefit due is payable to:

1) the Insured Person's estate; or
2) the Insured Person or a beneficiary who is either a minor or not competent to give a valid release for the payment,

We may pay up to $1,000 of the benefit due to some other person whom We believe is entitled to the payment, and who is related to the Insured Person or the beneficiary by blood or marriage. We will be relieved of further responsibility to the extent of any payment made in good faith. We may pay benefits directly to any Hospital or person rendering covered services unless the Insured Person requests otherwise in writing. The Insured Person must make the request no later than the time he or she files Proof of Loss.

Upon receipt of due written Proof of Loss, benefit payments for charges incurred by the Insured Person for covered medical services will be made directly to the provider at Our option. If any such charges have been paid by the Insured Person, the benefit payment for those charges will be made to the Insured Person upon written proof of payment.

Modified Payment of Claims

When We receive notice for losses suffered by an Insured Person whose residence is outside the United States, We may pay any benefits that may become payable under the Policy to the Policyholder, who:

1) will hold such payment in trust for the sole use and benefit of the Insured Person or his or her beneficiary or other person to whom such benefits are payable (the Payee), as described in the Payment of Claims provision within this section;
2) will transmit such payment to such Payee in accordance with the Payment of Claims and Time of Payment of Claims provisions of this section;
3) agrees that any such payment made by Us to the Policyholder constitutes a full discharge of Our liability with respect to the claim for which payment is made;
4) will alone assume full responsibility for the proper application or distribution of such payment; and
5) will indemnify, defend and hold Us harmless for any claims, demands, judgments, losses, costs, expenses, liabilities and damages whatsoever, including interest, penalties and legal fees, arising from or relating in any way to such payment or to the amount, application or distribution thereof; and
6) will, with respect to any application or disbursement of such payment in foreign currency, use the foreign exchange rate in effect at the Policyholder's payor bank on the date the benefits become payable to convert United States of America dollar-denominated currency into foreign currency.

Appealing Denial of Claims

If a claim for benefits is wholly or partially denied, notice of the decision shall be furnished to the Insured Person. This written decision will:

1) give the specific reason or reasons for denial;
2) make specific reference to Policy provisions on which the denial is based;
3) provide a description of any additional information necessary to prepare the claim and an explanation of why it is necessary; and
4) provide an explanation of the review procedure.

On any denied claim, an Insured Person or his representative may appeal to Us for a full and fair review. The claimant may:

1) request a review upon written request within 60 days of receipt of claim denial;
2) review pertinent documents; and
3) submit issues and comments in writing.

We will make a decision no more than 60 days after receipt of the request for review, except in special circumstances (such as the need to hold a hearing), but in no case more than 120 days after We receive the request for review. The written decision will include specific reasons for the decision on which the decision is based.

Physical Examinations and Autopsy

We, at Our own expense, shall have the right and opportunity to have:

1) a claimant for whom a claim is made examined by a Physician or Medical Professional of Our choice during the pendency of a claim as often as reasonably required; and
2) an autopsy conducted for a claimant for whom a claim is made in case of death, where not prohibited by law.

Legal Actions

No legal action may start:

1) until 60 days after Proof of Loss has been given; or

more than 5 years after the time Proof of Loss is required to be given, unless otherwise required by law.

Assignment

This insurance may not be assigned. The Insured Person may not assign any of his or her rights, privileges, or benefits under this Policy. Benefit payments may be assigned as allowed in the Payment of Claims provision.

Workers' Compensation Coverage

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

GENERAL PROVISIONS

Entire Contract

The entire contract between the Policyholder and Us consists of this Policy and any other papers made a part of this Policy at issue.

Incontestability

In the absence of fraud, the validity of this Policy shall not be contested, except for nonpayment of premium, after it has been in force for two years from the Policy Effective Date.

Statements

In the absence of fraud, all statements made by the Policyholder and persons insured under this Policy will be deemed representations and not warranties. No statement will be used in any contest unless it is in writing, s i g n e d by the person making it and a copy of it is given to the person who made it, or, in the event of the death or incapacity of the Insured Person, to the Insured Person's beneficiary or personal representative.

Changes

No agent has authority to change or waive any part of this Policy. To be valid, any change or waiver must be in writing, approved by one of Our officers and made part of this Policy.

Noncompliance with Policy Requirements

Any express waiver by Us of any requirements of this Policy will not constitute a continuing waiver of such requirements. Any failure by Us to insist upon compliance with any Policy provision will not operate as a waiver or amendment of that provision.

Data Furnished by Policyholder

The Policyholder must maintain adequate records acceptable to Us and provide any information required by Us relating to this insurance, its premium, and any benefits claimed or paid hereunder.

Right to Audit

We will have the right to inspect and audit, at any reasonable time, all records and procedures of the Policyholder that may have a bearing on this insurance, its premium, and any benefits claimed or paid hereunder.

Certificates

If required by the laws of the state where this Policy is delivered, We will give certificates to the Policyholder for delivery to Insured Persons. The certificates will state the features of this Policy which are important to Insured Persons.

Conformity with State and Federal Law

Any provision of the Policy that is contrary to the law of the jurisdiction in which it is delivered or with any other applicable law is amended to meet the minimum requirements of the law.

Right to Receive and Release Needed Information

We have the right to decide in Our sole judgment what facts We need to administer this Policy. We may get needed facts from, or give them to, any other organization or person. We need not tell, or get the consent of, any person to do this. Each person claiming benefits under this Policy must give Us any facts We need to determine coverage under this Policy or determine the correct payment of a claim.

Facility of Payment and Right to Recovery

If a payment made under another plan includes an amount that should have been paid under this Policy, We may pay that amount to the organization making that payment. That amount will then be treated as though it were a benefit paid under this Policy, and We will not have to pay that amount again. If the amount of the payments made by Us is more than it should have paid under this Policy, We may recover the excess from any person(s) to or for whom We have overpaid, including insurance companies or other organizations. If benefits are overpaid, We may recover the amount overpaid by requesting a lump sum payment of the overpaid amount or reducing future benefits payable under this Policy.

New Entrants

This Policy will allow from time to time, that new eligible Insured Persons of the Policyholder be added to the Eligible Class(es) of Insured Persons originally insured under this Policy.

Misstatement of Age

If premiums for the Insured are based on age and the Insured Person has misstated his or her age, there will be a fair adjustment of premiums based on his or her true age. If the benefits for which the Insured Person is insured are based on age and the Insured Person has misstated his or her age, there will be an adjustment of said benefit based on his or her true age. We require satisfactory proof of age before paying any claim.

Clerical Error

Clerical error, whether by the Policyholder or Us, will not void the insurance of any Insured Person if that insurance would otherwise have been in effect nor extend the insurance of any Insured if that insurance would otherwise have ended or been reduced as provided in this Policy.

Policy Interpretation

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

Disclosure of Services

In addition to the insurance coverage, We may offer noninsurance benefits and services under this Policy.

Hartford Fire Insurance Company

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

The Hartford® is The Hartford Financial Services Group, Inc. and its subsidiaries.

Policyholder: T-Mobile

Policy Number: 10-GTA-101903

H-1 — 24-Hour Accident Protection Business and Pleasure Hazard Rider

This Hazard Rider is attached to and made part of the Policy as of the Policy Effective Date shown in the Policy Schedule. It applies only with respect to Covered Losses for which benefits are payable on or after that date. It is subject to all of the provisions, limitations, and exclusions of the Policy except as they are specifically modified by this Hazard Rider.

This Hazard Rider applies only with respect to an Insured Person in an Eligible Class(es) to which this Hazard applies as stated in the Schedule.

24-HOUR ACCIDENT PROTECTION BUSINESS AND PLEASURE HAZARD

We will pay the Policy benefits for the Hazard described in this Rider when an Insured Person suffers an Injury anywhere in the world resulting from a Covered Loss any time while insured by the Policy and while the Insured Person is:

1) a Passenger on, boarding, or alighting from a Civil Aircraft or Military Transport Aircraft;

being struck or run down by an Aircraft;

operating or a Passenger on, boarding, alighting from, or being struck or run down by any Conveyance being used as a means of Transportation.

EXCLUSIONS

This Hazard does not cover Injury resulting from an Accident that occurs while the Insured Person is operating or a Passenger on, boarding, or alighting from or by being struck or run down by any Aircraft engaged in an Extra-Hazardous Aviation Activity.

In all other respects, the Policy remains the same

Signed for Hartford Fire Insurance Company at Hartford, Connecticut

Lisa Levin, *Secretary*

Douglas Elliot, *President*

Hartford Fire Insurance Company

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

The Hartford® is The Hartford Financial Services Group, Inc. and its subsidiaries.

Policyholder: T-Mobile

Policy Number: 10-GTA-101903

H-3 — 24-Hour Accident Protection While on Business Hazard Rider

This Hazard Rider is attached to and made part of the Policy as of the Policy Effective Date shown in the Policy Schedule. It applies only with respect to Covered Losses for which benefits are payable on or after that date. It is subject to all of the provisions, limitations, and exclusions of the Policy except as they are specifically modified by this Hazard Rider.

This Hazard Rider applies only with respect to an Insured Person in an Eligible Class(es) to which this Hazard applies as stated in the Schedule.

24-HOUR ACCIDENT PROTECTION WHILE ON BUSINESS HAZARD

We will pay the Policy benefits for the Hazard described in this Rider when an Insured Person suffers an Injury resulting from a Covered Loss during a Trip and while on the Business of the Policyholder, not lasting for more than 365 days, including an Injury while:

1) operating or a Passenger on, boarding, alighting from, or being struck or run down by any Conveyance being used as a means of land or water Transportation, except:

   a) any such Conveyance the Insured Person has been hired to operate or for which the Insured Person has been hired as a crew member and while the Insured Person is performing as an operator or crew member on any such Conveyance; or

   b) any such Conveyance the Insured Person is operating, or for which the Insured Person is performing as a crew member, (including while on, boarding, alighting from, or being struck or run down by) for the Transportation of Passengers or property for hire, profit or gain; or

a Passenger on, boarding, or alighting from a Civil Aircraft or Military Transport Aircraft; or

being struck or run down by an Aircraft.

The benefits under this Rider also apply where the Sojourn or Personal Deviation involves one or more stops en route to the destination, and extensions time spent at the destination, that do not last longer than a total of 4 days.

EXCLUSIONS

This Hazard does not cover Injury resulting from an Accident that occurs while the Insured Person is operating or a Passenger on, boarding, or alighting from or by being struck or run down by any Aircraft engaged in an Extra-Hazardous Aviation Activity.

In all other respects, the Policy remains the same.

Signed for Hartford Fire Insurance Company

Lisa Levin, *Secretary*

Douglas Elliot, *President*

Hartford Fire Insurance Company

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

The Hartford® is The Hartford Financial Services Group, Inc. and its subsidiaries.

Policyholder: T-Mobile

Policy Number: 10-GTA-101903

H-4 — 24-Hour Accident Protection While on a Policyholder Aircraft for Passenger and Pilot and Crew Hazard Rider

This Hazard Rider is attached to and made part of the Policy as of the Policy Effective Date shown in the Policy Schedule. It applies only with respect to Covered Losses for which benefits are payable on or after that date. It is subject to all of the provisions, limitations, and exclusions of the Policy except as they are specifically modified by this Hazard Rider.

This Hazard Rider applies only with respect to an Insured Person in an Eligible Class(es) to which this Hazard applies as stated in the Schedule.

24-HOUR ACCIDENT PROTECTION WHILE ON A POLICYHOLDER AIRCRAFT FOR PASSENGER AND PILOT AND CREW HAZARD

We will pay Policy benefits for the Hazard described in this Rider, if an Insured Person suffers an Injury as a result of a Covered Loss anywhere in the world during a Trip on the Business of the Policyholder:

1) if the Insured Person is operating or a Passenger on, boarding, alighting from, or being struck or run down by the Policyholder Aircraft, specified below, while such Insured Person

   a) is a Passenger; or

   b) is acting or training as a pilot, specified below, or crew member by or on behalf of the Policyholder, but only if such Insured Person is certified and licensed by a governmental authority with competent jurisdiction to operate or serve as a pilot or crew on such Policyholder Aircraft; or

due to any Passengers who temporarily perform pilot or crew functions in a life-threatening emergency.

For purposes of this Rider, only the following Insured Person(s) are authorized as pilot(s):

Pilots on file with the Policyholder

The above-named pilot(s) must have a current and valid medical certificate and pilot certificate with a proper rating to fly such Aircraft.

The Policyholder Aircraft(s) covered by this Rider are:

Aircraft as specified by Policyholder

Newly Acquired Aircraft Coverage: The Policyholder Aircraft Passenger and Pilot and Crew Hazard shall apply to any Newly Acquired Aircraft from the date such Aircraft is delivered to the Policyholder, provided the Policyholder:

1) notifies Us within 30 days; and

2) pays any required premium for such coverage.

Substitute and Replacement Aircraft Coverage: The Policyholder Aircraft Passenger and Pilot and Crew Hazard shall apply to any Substitute Aircraft or Replacement Aircraft from the time such Aircraft is used as a temporary substitute by the Policyholder, provided the Policyholder Aircraft covered under the Policy is withdrawn from use due to its breakdown, repair, servicing, loss, or destruction.

LIMITATIONS AND EXCLUSIONS

This Hazard does not cover Injury resulting from an Accident that occurs while the Insured Person is operating or a Passenger on, boarding, or alighting from or by being struck or run down by any Aircraft engaged in an Extra-Hazardous Aviation Activity.

The following exclusions in the Policy do not apply to this Rider to the extent the Rider specifically covers them:

1) Injury sustained while on any Aircraft except a Civil Aircraft, or Military Transport Aircraft;
2) Injury sustained while on any Aircraft;
   a) as a pilot, crew member or student pilot;
   b) as a flight instructor or examiner;
   c) if it is owned, operated or leased by or on behalf of the Policyholder, or any employer or organization covering any Eligible Class under the Policy.

DEFINITIONS

Except as defined below, the definitions in the Policy apply to this Rider.

Newly Acquired Aircraft means an Aircraft that is owned, leased for a period of more than 30 consecutive days, or operated by or on behalf of the Policyholder, which is acquired either in addition to or in place of any Policyholder Aircraft covered under the Policy prior to such acquisition.

Replacement Aircraft means any Aircraft which is:

1) of similar or lesser size, weight and performance as the Policyholder Aircraft covered under the Policy;
2) is not owned by the Policyholder;
3) is operated by a properly licensed pilot certified and licensed by a governmental authority with competent jurisdiction to operate; and
4) is used as a temporary substitute for the Policyholder Aircraft covered under the Policy.

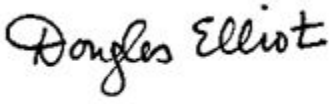
Substitute Aircraft means any Aircraft which:

1) is of the same class as the Policyholder Aircraft covered under the Policy;
2) is not owned by the Policyholder;
3) is operated by a properly licensed pilot certified and licensed by a governmental authority with competent jurisdiction to operate;
4) is not more than 3 seats and also not more than 25% larger in passenger and crew member seat capacity than the aircraft withdrawn from normal use; and
5) is used as a temporary substitute for the Policyholder Aircraft covered under the Policy.

In all other respects, the Policy remains the same.

Signed for Hartford Fire Insurance Company

Lisa Levin, *Secretary*



Douglas Elliot, *President*

Hartford Fire Insurance Company

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

The Hartford® is The Hartford Financial Services Group, Inc. and its subsidiaries.

Policyholder: T-Mobile

Policy Number: 10-GTA-101903

H-7 — 24-Hour Family Relocation Trip Hazard Rider

This Hazard Rider is attached to and made part of the Policy as of the Policy Effective Date shown in the Policy Schedule. It applies only with respect to Covered Losses for which benefits are payable on or after that date. It is subject to all of the provisions, limitations, and exclusions of the Policy except as they are specifically modified by this Hazard Rider.

This Hazard Rider applies only with respect to an Insured Person in an Eligible Class(es) to which this Hazard applies as stated in the Schedule.

24-HOUR FAMILY RELOCATION TRIP HAZARD

We will pay the Policy benefits for the Hazard described in this Rider when an Insured Person's Spouse or Dependent Child(ren) suffer(s) an Injury as a result of a Covered Loss which occurs anywhere in the world during a Relocation Trip.

A Relocation Trip will not include any period of time in excess of 14 days during which the Insured Person takes a vacation, or a Sojourn or Personal Deviation from the Relocation Trip.

In all other respects, the Policy remains the same.

Signed for Hartford Fire Insurance Company

Lisa Levin, *Secretary*

Douglas Elliot, *President*

Hartford Fire Insurance Company

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

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Policyholder: T-Mobile

Policy Number: 10-GTA-101903

H-8(A) — 24-Hour Hijacking or Sky-jacking Business and Pleasure Hazard Rider

This Hazard Rider is attached to and made part of the Policy as of the Policy Effective Date shown in the Policy Schedule. It applies only with respect to Covered Losses for which benefits are payable on or after that date. It is subject to all of the provisions, limitations, and exclusions of the Policy except as they are specifically modified by this Hazard Rider.

This Hazard Rider applies only with respect to an Insured Person in an Eligible Class(es) to which this Hazard applies as stated in the Schedule.

24-HOUR HIJACKING OR SKY-JACKING BUSINESS AND PLEASURE HAZARD

We will pay the Policy benefits for the Hazard described in this Rider when an Insured Person suffers an Injury resulting from a Covered Loss which occurs during a Hijacking or Sky-jacking anywhere in the world. Coverage under this Rider shall continue while the Insured Person is subject to the control of the hijacker(s) and during travel directly to his or her residence or original destination.

DEFINITIONS

Hijacking means unlawful seizure or wrongful exercise of control of an Aircraft or other Conveyance, or the crew thereof, in which the Insured Person is traveling as a Passenger.

Sky-jacking means unlawful seizure or wrongful exercise of control of an Aircraft or other Conveyance, or the crew thereof, in which the Insured Person is traveling as a Passenger. It will also include any attempt at Sky-jacking and consequent exposure to the Insured Person.

EXCLUSIONS

This Hazard does not cover Injury resulting from an Accident that occurs while the Insured Person is operating or a Passenger on, boarding, or alighting from or by being struck or run down by any Aircraft engaged in an Extra-Hazardous Aviation Activity.

In all other respects, the Policy remains the same.

Signed for Hartford Fire Insurance Company

Lisa Levin, *Secretary*

Douglas Elliot, *President*

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Policyholder: T-Mobile

Policy Number: 10-GTA-101903

H-8(B) — 24-Hour Hijacking or Sky-jacking Business Hazard Rider

This Hazard Rider is attached to and made part of the Policy as of the Policy Effective Date shown in the Policy Schedule. It applies only with respect to Covered Losses for which benefits are payable on or after that date. It is subject to all of the provisions, limitations, and exclusions of the Policy except as they are specifically modified by this Hazard Rider.

This Hazard Rider applies only with respect to an Insured Person in an Eligible Class(es) to which this Hazard applies as stated in the Schedule.

24-HOUR HIJACKING OR SKY-JACKING BUSINESS HAZARD

We will pay the Policy benefits for the Hazard described in this Rider when an Insured Person suffers an Injury resulting from a Covered Loss which occurs during a Hijacking or Sky-jacking anywhere in the world while the Insured Person is on the Business of the Policyholder. Coverage under this Rider shall continue while the Insured Person is subject to the control of the hijacker(s) and during travel directly to his or her residence or original destination.

DEFINITIONS

Hijacking means unlawful seizure or wrongful exercise of control of an Aircraft or other Conveyance, or the crew thereof, in which the Insured Person is traveling as a Passenger.

Sky-jacking means unlawful seizure or wrongful exercise of control of an Aircraft or other Conveyance, or the crew thereof, in which the Insured Person is traveling as a Passenger. It will also include any attempt at Sky-jacking and consequent exposure to the Insured Person.

EXCLUSIONS

This Hazard does not cover Injury resulting from an Accident that occurs while the Insured Person is operating or a Passenger on, boarding, or alighting from or by being struck or run down by any Aircraft engaged in an Extra-Hazardous Aviation Activity

In all other respects, the Policy remains the same.

Signed for Hartford Fire Insurance Company

Lisa Levin, *Secretary*

Douglas Elliot, *President*

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Policyholder: T-Mobile

Policy Number: 10-GTA-101903

H-10 — 24-Hour Violent Act On a Trip—Business Only—Hazard Rider

This Hazard Rider is attached to and made part of the Policy as of the Policy Effective Date shown in the Policy Schedule. It applies only with respect to Violent Acts that occur on or after that date. It is subject to all of the provisions, limitations, and exclusions of the Policy except as they are specifically modified by this Hazard Rider.

This Hazard Rider applies only with respect to an Insured Person in an Eligible Class(es) to which this Hazard applies as stated in the Schedule.

24-HOUR VIOLENT ACT ON A TRIP—BUSINESS ONLY—HAZARD

We will pay the Policy benefits for the Hazard described in this Rider, if an Insured Person suffers an Injury as a result of a Violent Act that occurs during a Trip on the Business of the Policyholder, while the Insured Person is covered under the Policy.

This Hazard will not apply to a Covered Loss that results from a Violent Act committed by:

1) the Insured Person;

the Insured Person's Immediate Family Member;

an employee of the Policyholder;

a former employee of the Policyholder whose employment with the Policyholder ended less than 6 months before the date of the Violent Act;

a Member of the Household in which the Insured Person resides; or

any Insured Person currently eligible for coverage under the Policy.

With respect to Sojourn and Personal Deviation, this Rider only applies where the Sojourn or Personal Deviation:

1) does not depart more than 500 miles from the direct route or destination(s) with respect to the circumstances described herein; and

if it involves one or more stops en route to the destination and/or an extensions time spent at the destination, does not last longer than a total of 14 days or 25% of the time that would otherwise have been spent

whichever is less.

EXCLUSIONS

Any aviation exclusion is waived with respect to an Insured Person to whom this Hazard applies, but only with respect to an Injury sustained by the Insured Person under the circumstances described in this Rider. However, unless otherwise provided by this Policy, that exclusion is not waived if the Insured Person is operating or a Passenger on, boarding, or alighting from or by being struck or run down by any Aircraft, if the Accident causing such Injury occurs while the Insured Person is:

1) riding as a Passenger in any Aircraft not intended and/or licensed for the transportation of Passengers; or
2) performing, learning to perform or instructing others to perform as a pilot or crew member of any Aircraft; or
3) riding as a Passenger in a Policyholder Aircraft or in an Aircraft owned, leased or operated by the Insured Person's employer.

All other exclusions in the Policy apply.

ADDITIONAL PROOF OF LOSS

In addition to the Proof of Loss requirements in the Policy, a police report detailing the Violent Act must be provided.

In all other respects, the Policy remains the same.

Signed for Hartford Fire Insurance Company

Lisa Levin, *Secretary*

Douglas Elliot, *President*

Hartford Fire Insurance Company

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Policyholder: T-Mobile

Policy Number: 10-GTA-101903

H-11 — 24-Hour Violent Act Hazard Rider

This Hazard Rider is attached to and made part of the Policy as of the Policy Effective Date shown in the Policy Schedule. It applies only with respect to Violent Acts that occur on or after that date. It is subject to all of the provisions, limitations, and exclusions of the Policy except as they are specifically modified by this Hazard Rider.

This Hazard Rider applies only with respect to an Insured Person in an Eligible Class(es) to which this Hazard applies as stated in the Schedule.

24-HOUR VIOLENT ACT HAZARD

We will pay the Policy benefits for the Hazard described in this Rider, if an Insured Person suffers an Injury as a result of a Violent Act that occurs anywhere in the world while the Insured Person is covered under the Policy.

This Hazard will not apply to a Covered Loss that results from a Violent Act committed by:

1) the Insured Person;
2) the Insured Person's Immediate Family Member;
3) an employee of the Policyholder;
4) a former employee of the Policyholder whose employment with the Policyholder ended less than 6 months before the date of the Violent Act;
5) a Member of the Household in which the Insured Person resides; or
6) any Insured Person currently eligible for coverage under the Policy.

EXCLUSIONS

Any aviation exclusion is waived with respect to an Insured Person to whom this Hazard applies, but only with respect to an Injury sustained by the Insured Person under the circumstances described in this Rider. However, unless otherwise provided by this Policy, that exclusion is not waived if the Insured Person is operating or a Passenger on, boarding, or alighting from or by being struck or run down by any Aircraft, if the Accident causing such Injury occurs while the Insured Person is:

1) riding as a Passenger in any Aircraft not intended and/or licensed for the transportation of Passengers; or
2) performing, learning to perform or instructing others to perform as a pilot or crew member of any Aircraft; or
3) riding as a Passenger in a Policyholder Aircraft or in an Aircraft owned, leased or operated by the Insured Person's employer.

All other exclusions in the Policy apply.

ADDITIONAL PROOF OF LOSS

In addition to the Proof of Loss requirements in the Policy, a police report detailing the Violent Act must be provided.

In all other respects, the Policy remains the same.

Signed for Hartford Fire Insurance Company

Lisa Levin, *Secretary*

Douglas Elliot, *President*

Hartford Fire Insurance Company

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Policyholder: T-Mobile

Policy Number: 10-GTA-101903

H-15 — Commutation Hazard Rider

This Hazard Rider is attached to and made part of the Policy as of the Policy Effective Date shown in the Policy Schedule. It applies only with respect to Covered Accidents that occur on or after that date. It is subject to all of the provisions, limitations, and exclusions of the Policy except as they are specifically modified by this Hazard Rider.

This Hazard Rider applies only with respect to an Insured Person in an Eligible Class(es) to which this Hazard applies as stated in the Schedule.

EXTRAORDINARY COMMUTATION HAZARD

We will pay the Policy benefits for the Hazard described in this Rider, for an Injury which occurs while the Insured Person is commuting directly between his or her residence and place of regular employment:

1) by Automobile or other Conveyance not normally used by the Insured Person for commuting; and
2) during a strike, power failure, major breakdown, or similar event which results in the discontinuance or interruption of one or more public transportation systems regularly used by the Insured Person;

on a regularly scheduled workday.

In all other respects, the Policy remains the same.

Signed for Hartford Fire Insurance Company

Lisa Levin, *Secretary*

Douglas Elliot, *President*

Hartford Fire Insurance Company

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Policyholder: T-Mobile

Policy Number: 10-GTA-101903

H-21 — Family Travel Hazard Rider

This Hazard Rider is attached to and made part of the Policy as of the Policy Effective Date shown in the Policy Schedule. It applies only with respect to Covered Losses for which benefits are payable on or after that date. It is subject to all of the provisions, limitations, and exclusions of the Policy except as they are specifically modified by this Hazard Rider.

This Hazard Rider applies only with respect to an Insured Person in an Eligible Class(es) to which this Hazard applies as stated in the Schedule.

FAMILY TRAVEL HAZARD

We will pay the Policy benefits for the Hazard described in this Rider when the Spouse or Dependent Child(ren) of the Insured Person suffer(s) an Injury resulting from a Covered Loss:

1) while accompanying the Insured Person or on his or her way to join the Insured Person on a Trip while on the Business of the Policyholder, including a Sojourn or Personal Deviation taken during the course of such Trip; and

when such Trip is authorized by and/or paid for in whole or in part by the Policyholder.

Benefits payable under this Hazard are subject to the Exclusions listed in the Policy.

In all other respects, the Policy remains the same.

Signed for Hartford Fire Insurance Company

Lisa Levin, *Secretary*

Douglas Elliot, *President*

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Hartford, CT 06155
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Policyholder: T-Mobile

Policy Number: 10-GTA-101903

H-40 — War Risk Hazard Rider

This Hazard Rider is attached to and made part of the Policy as of the Policy Effective Date shown in the Policy Schedule. It applies only with respect to Covered Losses that occur on or after that date. It is subject to all of the provisions, limitations, and exclusions of the Policy except as they are specifically modified by this Hazard Rider.

This Hazard Rider applies only with respect to an Insured Person in an Eligible Class(es) to which this Hazard applies as stated in the Schedule.

WAR RISK HAZARD

We hereby waive the exclusion "war or act of war, whether declared or undeclared," in the Exclusions section of the Policy, provided an Insured Person suffers a Covered Loss due to or contributed by declared or undeclared War occurring worldwide, except:

1) in the United States of America or the Insured Person's country of permanent residence; or
2) if the Insured Person is traveling within the geographical limits, territorial waters, or the airspace above a Designated War Risk Territory.

Coverage may be extended for Covered Losses due to or contributed by declared or undeclared War that occurs in the Designated War Risk Territory if the Policyholder reports actual exposure within these countries to Us as indicated below in the Reporting Requirements. Additional premium may apply.

This War risk coverage is subject to an Aggregate Limit per Covered Loss as shown in the Rider Schedule below.

Reporting Requirements

The Policyholder agrees to report in advance in writing, exposure of Insured Persons in the Designated War Risk Territory(ies). The report must include the name of each Insured Person exposed, his or her specific itinerary and designation(s) in the Designated War Risk Territory(ies), and the effective and termination dates of his or her exposure and Principal Sum amount. Additional premium may apply.

Changes in War Risk Territories

We may, with 10 days written notice to the Policyholder, make changes to the list of countries designated as Designated War Risk Territory(ies), that in Our opinion, are required to accurately reflect existing war risk conditions. We may also, at any Policy anniversary date, as measured annually from the Policy Effective Date, and with at least 10 days written notice to the Policyholder, request information regarding any/all travel by an Insured Person to countries other than the Insured Person's country of origin or country of citizenship.

Termination Date

War risk coverage ends on the earliest of:

1) the date the Policy terminates;
2) the date We receive written notice from the Policyholder of the Policyholder's intent to terminate War risk coverage (or on the date specified in the written notice, if later); or
3) the date specified in Our written notice to the Policyholder of Our intent to terminate War risk coverage (or 10 days after the date the written notice is received by the Policyholder, if later).

If War risk coverage terminates prior to the end of a period for which premium has already been paid, any unearned premium will be returned on a pro-rata basis, but the return of the unearned premium is not a condition of cancellation. Our failure to exercise any of Our rights under this coverage will not be deemed a waiver of these rights.

Termination of War risk coverage will not affect a claim for a Covered Loss that occurred while War risk coverage was in effect.

DEFINITIONS

Except as defined below, the definitions in the Policy apply to this Rider.

Designated War Risk Territory(ies) means Afghanistan, Iraq, Israel (West Bank/Gaza Strip), Libya, Somalia, Sudan, Syria, and Yemen or any country subject to the administration and enforcement of U. S. economic embargoes and trade sanctions by the Office of Foreign Assets Control (OFAC).

War means armed conflict, hostilities or warlike operations (whether war be declared or not) by order of any government or public authority including but not limited to invasion, acts of any enemy foreign to the nationality of the Insured Person or the country in (or over) which the act occurs, civil war, riot, rebellion, insurrection, revolution, overthrow of the legally constituted government, civil commotion assuming the proportions of (or amounting to) an uprising, military or usurped power, or explosion of war weapons.

In all other respects, the Policy remains the same.

Signed for Hartford Fire Insurance Company

Lisa Levin, *Secretary*

Douglas Elliot, *President*

Hartford Fire Insurance Company

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

The Hartford® is The Hartford Financial Services Group, Inc. and its subsidiaries.

Policyholder: T-Mobile

Policy Number: 10-GTA-101903

B-4 — Adaptive Home & Vehicle Benefit Rider

This Rider is attached to and made part of the Policy as of the Policy Effective Date shown in the Policy Schedule. It applies only with respect to Covered Accidents that occur on or after that date. It is subject to all of the provisions, limitations, and exclusions of the Policy except as they are specifically modified by this Rider. Please refer to the Policy Schedule for the applicability of this Rider with respect to each Description of Eligible Class(es) and each Covered Hazard.

ADAPTIVE HOME & VEHICLE MODIFICATION BENEFIT

If an Insured Person suffers an Injury, other than loss of life, that results in a loss payable under the Accidental Dismemberment, or Paralysis Benefit, We will pay an additional benefit that is the lesser of:

1) the Benefit Amount as indicated in the Rider Schedule; or
2) the actual cost

for Home Alteration and Vehicle Modification Expenses that are incurred within 24 months of the date of the Covered Accident that caused the Injury if an Insured Person:

1) did not require, prior to the date of the Covered Accident that caused the Injury, the use of a wheelchair or other adaptive device to be ambulatory; and
2) as a direct result of such Injury, the use of a wheelchair or other adaptive device to be ambulatory is now compulsory.

This benefit will be payable only if:

1) such Home Alterations are:
   a) made by a person(s) with experience in such alterations; and
   b) recommended by a recognized organization providing support and assistance to wheelchair or other adaptive device users; and
2) such Vehicle Modifications are:
   a) carried out by a person(s) with experience in Vehicle Modifications; and
   b) approved by the motor vehicle department of the state.

RIDER SCHEDULE

Adaptive Home & Vehicle Modification Benefit

Class:	Benefit Amount:
Classes 1, 2, 3, 4, 5	$50,000

DEFINITIONS

Except as defined below, the definitions in the Policy apply to this Rider.

Home Alteration means changes to the residence of the Insured Person that are necessary to make the residence accessible and habitable to the Insured Person.

Home Alteration and Vehicle Modification Expenses as used in this Rider mean one-time expenses that:

1) are charged for:

   a) alterations to the Insured Person's residence that are necessary to make the residence accessible and habitable for a wheelchair-confined person or adaptive device user; or

   b) modifications to an Automobile owned or leased by the Insured Person or modifications to an Automobile newly purchased for the Insured Person that are necessary to make the Automobile accessible to and/or driveable by the Insured Person;

do not include charges that would not have been made if no coverage existed; and

do not exceed the usual level of charges for similar alterations and modifications in the locality where the expense is incurred.

Expenses incurred due to the alterations to the Automobile and residence of the Insured Person must:

1) be made on behalf of the Insured Person; and

be in compliance with any applicable laws or requirements for approval by the appropriate government authorities.

Vehicle Modifications means changes, including but not limited to installation of equipment to an Automobile that are necessary to make such Automobile accessible to or drivable by an Insured Person.

In all other respects, the Policy remains the same.

Signed for Hartford Fire Insurance Company

Lisa Levin, *Secretary*

Douglas Elliot, *President*

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Policyholder: T-Mobile

Policy Number: 10-GTA-101903

B-7 — Bereavement Counseling Benefit Rider

This Rider is attached to and made part of the Policy as of the Policy Effective Date shown in the Policy Schedule. It applies only with respect to Covered Accidents that occur on or after that date. It is subject to all of the provisions, limitations, and exclusions of the Policy except as they are specifically modified by this Rider. Please refer to the Policy Schedule for the applicability of this Rider with respect to each Description of Eligible Class(es) and each Covered Hazard.

BEREAVEMENT COUNSELING BENEFIT

If the Insured Person suffers an accidental death or an accidental dismemberment or Paralysis for which an Accidental Death, or Accidental Dismemberment or Paralysis Benefit is payable under the Policy or if he or she goes into a Coma for which a Coma Benefit is payable, We will pay the Bereavement Counseling Benefit if an Insured Person or his or her Spouse and/or Dependent Child(ren) receives Bereavement Counseling.

We will pay the Bereavement Counseling Benefit Amount for each Bereavement Counseling session he or she attends, up to the Maximum Number of Sessions as found in the Rider Schedule.

Bereavement Counseling sessions must first begin within 365 days after the date of the Covered Accident. Benefits for any Bereavement Counseling session must be incurred within 2 year(s) after the date of the Insured Person's Covered Accident.

RIDER SCHEDULE

Bereavement Counseling Benefit

Class:	Benefit Amount:	Maximum Number of Sessions:
Classes 1, 2, 3, 4, 5	$250 per session	20

ADDITIONAL PROOF OF LOSS

In addition to the Proof of Loss requirements in the Policy, evidence of expenses incurred for services provided for Bereavement Counseling is required in order to receive benefits under this Rider.

DEFINITIONS

Except as defined below, the definitions in the Policy apply to this Rider.

Bereavement Counseling means treatment or counseling for the grief reaction resulting from an Insured Person's Covered Accident. Counseling must be provided by a licensed therapist, counselor, or psychiatrist who is registered or certified to provide psychological treatment or counseling.

In all other respects, the Policy remains the same.

Signed for Hartford Fire Insurance Company

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Policyholder: T-Mobile

Policy Number: 10-GTA-101903

B-11 — Carjacking Benefit Rider

This Rider is attached to and made part of the Policy as of the Policy Effective Date shown in the Policy Schedule. It applies only with respect to a Carjacking that occurs on or after that date. It is subject to all of the provisions, limitations, and exclusions of the Policy except as they are specifically modified by this Rider. Please refer to the Policy Schedule for the applicability of this Rider with respect to each Description of Eligible Class(es) and each Covered Hazard.

CARJACKING BENEFIT

We will pay an additional benefit amount under this Rider when the Insured Person suffers a Covered Loss for which benefits are payable under the Accidental Death Benefit, Accidental Dismemberment Benefit, Paralysis Benefit or Coma Benefit that results from a Carjacking of an Automobile that the Insured Person was operating or riding in as a Passenger (including getting in or out of such Automobile).

The amount payable under this Rider is the lesser of the Benefit Amounts shown in the Rider Schedule. Only one benefit is payable, the largest, under this Rider for all losses as a result of the same Carjacking.

Verification of the Carjacking must be a part of an official report of the Carjacking or be certified, in writing, by the investigating officer(s).

RIDER SCHEDULE

Carjacking Benefit

Class:	Benefit Amount:
Classes 1, 2, 3, 4, 5	$50,000

DEFINITIONS

Except as defined below, the definitions in the Policy apply to this Rider.

Carjacking means taking unlawful possession of an Automobile by means of force or threats against the person(s) then rightfully occupying such Automobile.

In all other respects, the Policy remains the same.

Signed for Hartford Fire Insurance Company

Lisa Levin, *Secretary*

Douglas Elliot, *President*

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Policyholder: T-Mobile

Policy Number: 10-GTA-101903

B-13 — Coma Benefit Rider

This Rider is attached to and made part of the Policy as of the Policy Effective Date shown in the Policy Schedule. It applies only with respect to Covered Accidents that occur on or after that date. It is subject to all of the provisions, limitations, and exclusions of the Policy except as they are specifically modified by this Rider. Please refer to the Policy Schedule for the applicability of this Rider with respect to each Description of Eligible Class(es) and each Covered Hazard.

COMA BENEFIT

If an Injury renders the Insured Person Comatose within 365 days of the date of the Covered Accident, and if the Coma continues for a period of 30 consecutive days, We will pay a monthly benefit equal to the Monthly Benefit Amount shown in the Rider Schedule. No benefit is provided for the first 30 days of the Coma.

The benefit is payable monthly as long as the Insured Person remains Comatose due to the Injury, but ceases on the earliest of:

1) the end of the month in which the Insured Person dies;
2) the end of the month in which the Insured Person recovers from the Coma;
3) the end of the month in which the Monthly Benefit Period ends; or
4) the total payments equal the Maximum Benefit Amount.

We will pay benefits calculated at a rate of 1/30th of the monthly benefit for each day for which We are liable when the Insured Person is Comatose for less than a full month.

If an Insured Person is in a Coma for which the Monthly Benefit Amount is payable and dies within 365 days after the Covered Accident, We will pay a lump sum equal to the Insured Person's Maximum Benefit Amount, less any benefit amount for Coma already paid.

We reserve the right, at the end of the first 30 consecutive days of Coma and as often as We may reasonably require thereafter, to determine, on the basis of all the facts and circumstances, that the Insured Person is Comatose, including, but not limited to, requiring an independent medical examination provided at Our expense.

RIDER SCHEDULE

Coma Benefit

Class:	Maximum Benefit Amount:	Monthly Benefit Amount:	Monthly Benefit Period:
Class 1	$3,000,000	1% of the Maximum Benefit Amount per month for the Monthly Benefit Period.	100 months
Class 2	Five (5) times Annual Salary to a maximum of $3,000,000	1% of the Maximum Benefit Amount per month for the Monthly Benefit Period.	100 months
Class 3	$500,000	1% of the Maximum Benefit Amount per month for the Monthly Benefit Period.	100 months
Class 4	$50,000	1% of the Maximum Benefit Amount per month for the Monthly Benefit Period.	100 months
Class 5	$25,000	1% of the Maximum Benefit Amount per month for the Monthly Benefit Period.	100 months

DEFINITIONS

Except as defined below, the definitions in the Policy apply to this Rider.

Monthly Benefit Period means the number of months as shown in the Rider Schedule during which the Insured Person remains in a Coma and for which the monthly Coma benefit is payable.

In all other respects, the Policy remains the same.

Signed for Hartford Fire Insurance Company

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Policyholder: T-Mobile

Policy Number: 10-GTA-101903

B-19 — Day Care Benefit Rider

This Rider is attached to and made part of the Policy as of the Policy Effective Date shown in the Policy Schedule. It applies only with respect to Covered Accidents that occur on or after that date. It is subject to all of the provisions, limitations, and exclusions of the Policy except as they are specifically modified by this Rider. Please refer to the Policy Schedule for the applicability of this Rider with respect to each Description of Eligible Class(es) and each Covered Hazard.

DAY CARE BENEFIT

If the Accidental Death Benefit is payable under the Policy and the Insured Person has or is survived by one or more Children, We will pay a benefit on behalf of any Child of the Insured Person who:

1) is enrolled in a Day Care Program on the date of the Covered Accident causing the Insured Person's death and on the date of the Insured Person's death; or

enrolls in a Day Care Program within 365 days after the Insured Person's death. The benefit is payable annually for each year of the Child's enrollment in a Day Care Program, for a maximum of 4 Day Care Benefit payments for each Child.

The total amount of the benefit each year is equal to the least of:

1) the actual cost of care for that Child charged by that Day Care Program for that year;

the Percentage of the Accidental Death Principal Sum shown on the Rider Schedule; or

the Maximum Benefit Amount shown in the Rider Schedule.

The benefit will be paid to the person who has primary responsibility for the Child's Day Care Program expenses. The benefit is not payable for any period of enrollment in a Day Care Program before the date of the Accident that caused the Insured Person's death. The benefit is not payable for any period of enrollment after the earlier of:

1) the date the Child reaches 13 years of age; or

the date 4 year(s) after the later of the date of the Insured Person's death or the date the Child first enrolls in a Day Care Program.

RIDER SCHEDULE

Day Care Benefit

Class:	Percentage of Accidental Death Principal Sum:	Maximum Benefit Amount:
Class 1, 2, 3, 4	10% of Accidental Death Principal Sum	$25,000

ADDITIONAL PROOF OF LOSS

In addition to the Proof of Loss requirements in the Policy, We will require proof of enrollment for each Child in a Day Care Program. Proof may be in the form of, but not be limited to, the following:

1) a copy of the Child's approved enrollment application in a Day Care Program; or
2) canceled check(s) or similar evidence of payment to the provider of the Day Care Program; or
3) a letter from the provider of the Day Care Program stating that the Child:
   a) is attending a Day Care Program; or

b) has been enrolled in a Day Care Program and will be attending within 365 days of the date of the Insured Person's death.

Proof of enrollment and payment must be sent to Us prior to the last day of the 12th month following the date of the Insured Person's death and then annually thereafter.

DEFINITIONS

Except as defined below, the definitions in the Policy apply to this Rider.

Child, Children for the purposes of this Rider means the Insured Person's unmarried child, including a natural, step, foster or adopted child, from the moment of placement in the Insured Person's home, under age 13, and primarily dependent upon the Insured Person for support and maintenance.

Day Care Program means a program of childcare which:

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

In all other respects, the Policy remains the same.

Signed for Hartford Fire Insurance Company

Lisa Levin, *Secretary*

Douglas Elliot, *President*

Hartford Fire Insurance Company

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Policyholder: T-Mobile

Policy Number: 10-GTA-101903

B-21 — Education Expense Benefit Rider

This Rider is attached to and made part of the Policy as of the Policy Effective Date shown in the Policy Schedule. It applies only with respect to Covered Accidents that occur on or after that date. It is subject to all of the provisions, limitations, and exclusions of the Policy except as they are specifically modified by this Rider. Please refer to the Policy Schedule for the applicability of this Rider with respect to each Description of Eligible Class(es) and each Covered Hazard.

EDUCATION EXPENSE BENEFIT

If an Insured Person suffers a loss of life for which an Accidental Death Benefit is payable under the Policy, We will pay the following benefit(s):

Dependent Child Education

We will pay a benefit to or on behalf of any child of the Insured Person who meets the definition of Dependent Child on the date of the Covered Accident causing the Insured Person's death and on the date of the Insured Person's death and who, on the date of the Insured Person's death:

1) is a full-time student in any Institution of Higher Learning above grade 12; or

is in grade 12 and subsequently enrolls as a full-time student in an Institution of Higher Learning within 365 days after the date of the Insured Person’s death.

The benefit will be paid for each year of the Dependent Child's continuous enrollment as a full-time student in an Institution of Higher Learning, to a maximum of four (4) consecutive years or the date the Dependent Child reaches age 29, whichever comes first.

The total amount of the benefit each year is equal to the least of:

1) the actual tuition (exclusive of room and board) charged by that institution for enrollment during that year for that Dependent Child;

the Percentage of Accidental Death Principal Sum shown in the Rider Schedule based on the Insured Person’s Accidental Death Principal Sum on the date of the Covered Accident; or

the Maximum Annual Amount shown in the Rider Schedule.

The applicable portion of the yearly benefit for each term of enrollment is payable upon receipt of proof of enrollment and payment for that term.

A Dependent Child who ceases to be enrolled as a full-time student becomes permanently ineligible for the benefit, even if he or she re-enrolls at a later date. The benefit is not payable for any term of enrollment as a full-time student that begins before the date of the Insured Person's death.

Spouse Education

We will pay a benefit to or on behalf of the Spouse of the Insured Person who meets the definition of Spouse on the date of the Covered Accident causing the Insured Person's death and on the date of the Insured Person's death and who, for the purpose of obtaining an independent source of support or to enrich his or her ability to earn a living:

1) is enrolled in any Institution of Higher Learning or professional or trade training program on the date of the Insured Person’s death; or

subsequently enrolls in an Institution of Higher Learning or professional or trade training program within 30 months after the date of the Insured Person's death.

The benefit will be paid for each year of the Spouse's continuous enrollment in an Institution of Higher Learning or professional or trade training program, to a maximum of four (4) consecutive years.

The total amount of the benefit each year is equal to the least of:

1) the actual tuition (exclusive of room and board) charged by that institution for enrollment during that year for the Spouse;

the Percentage of Accidental Death Principal Sum shown in the Rider Schedule based on the Insured Person's Accidental Death Principal Sum on the date of the Covered Accident; or

the Maximum Annual Amount shown in the Rider Schedule.

The applicable portion of the yearly benefit for each term of enrollment is payable upon receipt of proof of enrollment and payment for that term.

A Spouse who ceases to be enrolled as described above becomes permanently ineligible for the benefit, even if he or she re-enrolls at a later date. The benefit is not payable for any term of enrollment that begins before the date of the Insured Person's death.

RIDER SCHEDULE

Dependent Child Education:

Class:	Percentage of Accidental Death Principal Sum:	Maximum Annual Amount:
Class 1, 2, 3, 4	10% of Accidental Death Principal Sum	$10,000

Spouse Education:

Class:	Percentage of Accidental Death Principal Sum:	Maximum Annual Amount:
Class 1, 2, 3, 4	10% of Accidental Death Principal Sum	$10,000

In all other respects, the Policy remains the same.

Signed for Hartford Fire Insurance Company

Lisa Levin, *Secretary*

Douglas Elliot, *President*

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Policyholder: T-Mobile

Policy Number: 10-GTA-101903

B-26 — Funeral Expense Benefit Rider

This Rider is attached to and made part of the Policy as of the Policy Effective Date shown in the Policy Schedule. It applies only with respect to Covered Accidents that occur on or after that date. It is subject to all of the provisions, limitations, and exclusions of the Policy except as they are specifically modified by this Rider. Please refer to the Policy Schedule for the applicability of this Rider with respect to each Description of Eligible Class(es) and each Covered Hazard.

FUNERAL EXPENSE BENEFIT

If an Insured Person suffers a loss of life for which the Accidental Death Benefit is payable under the Policy, We will pay the Funeral Expense Benefit.

The Funeral Expense Benefit is equal to the least of:

1) the actual charges incurred for Funeral Expenses;
2) the Percentage of the Accidental Death Principal Sum shown in the Rider Schedule; or
3) the Maximum Benefit Amount shown in the Rider Schedule.

RIDER SCHEDULE

Funeral Expense Benefit

Class:	Percentage of Accidental Death Principal Sum:	Maximum Benefit Amount:
Class 1, 2, 3, 4, 5	10% of Accidental Death Principal Sum	$10,000

ADDITIONAL PROOF OF LOSS

In addition to the Proof of Loss requirements in the Policy, We will require the following additional proof of loss:

1) a copy of the invoice for Funeral Expenses;
2) canceled check(s) or similar evidence of payment for such Funeral Expenses.

DEFINITIONS

Except as defined below, the definitions in the Policy apply to this Rider.

Funeral Expenses means:

1) transportation of the deceased from the death site to the funeral service site;

a container or casket for the deceased's remains to be placed in;

basic services of the funeral home and staff, including but not limited to embalming, interment, or cremation; and

the costs incurred for the purchase of a cemetery plot, tomb or mausoleum including plaque, tombstone or monument.

In all other respects, the Policy remains the same.

Signed for Hartford Fire Insurance Company

Lisa Levin, *Secretary*

Douglas Elliot, *President*

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Hartford, CT 06155
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Policyholder: T-Mobile

Policy Number: 10-GTA-101903

B-32 — Medical Emergency Evacuation Benefit Rider

This Rider is attached to and made part of the Policy as of the Policy Effective Date shown in the Policy Schedule. It applies only with respect to Covered Accidents and Emergency Sicknesses that occur on or after that date. It is subject to all of the provisions, limitations, and exclusions of the Policy except as they are specifically modified by this Rider. Please refer to the Policy Schedule for the applicability of this Rider with respect to each Description of Eligible Class(es) and each Covered Hazard.

MEDICAL EMERGENCY EVACUATION BENEFIT

We will pay for Covered Medical Emergency Evacuation Expenses reasonably incurred if the Insured Person suffers an Injury or Emergency Sickness that warrants his or her Medical Emergency Evacuation while he or she is outside a 100 mile radius from his or her current place of primary residence, up to the Maximum Benefit Amount shown in the Rider Schedule for all Medical Emergency Evacuations due to all Injuries from the same Covered Accident or all Emergency Sicknesses from the same or related causes.

Benefits will not be payable, unless:

1) the Physician ordering the Medical Emergency Evacuation certifies that the severity of the Insured Person's Injury or Emergency Sickness requires a Medical Emergency Evacuation;

all Transportation arrangements made for the Medical Emergency Evacuation are by the most direct and economical method and route possible;

the charges incurred are Medically Necessary, and do not exceed the usual level of charges for similar Transportation, Treatment, services, or supplies in the locality where the expense is incurred; and

the charges incurred do not include charges that would not have been incurred if no insurance existed.

FAMILY TRAVEL BENEFIT

Following an Insured Person's Medical Emergency Evacuation, We will pay for expenses reasonably incurred:

1) to return to their current place of primary residence, the Insured Person's Spouse and any of the Insured Person's Dependent Children who were accompanying the Insured Person when the Medical Emergency Evacuation became necessary, with an attendant for the Dependent Children if necessary and if the Dependent Children are not accompanied by the Spouse; but not to exceed the cost of a single one-way economy airfare ticket less the value of applied credit from any unused return travel tickets per person;

for lodging and meals for up to 10 days for the Insured Person's Spouse and Dependent Children in the area where the Insured Person is Confined, if:

a) they were accompanying the Insured Person when the Medical Emergency Evacuation became necessary; and

b) the place of Confinement is outside a 100-mile radius from the Insured Person's place of primary residence. We will only pay for such expenses for days in excess of the days that had been planned for the trip prior to the Insured Person's Medical Emergency Evacuation, and only while he or she remains so Confined. We will not pay for such expenses in excess of, for the Spouse and Dependent Children combined, $200 per day for lodging and $100 per day for meals;

to bring one person chosen by the Insured Person to and from the Hospital or other medical facility where the Insured Person is Confined if:

c) the Insured Person is alone; and

d) the place of Confinement is outside a 100-mile radius from the Insured Person's place of primary residence; but not to exceed the cost of one round-trip economy airfare ticket; and

for lodging and meals for up to 10 days for such person in the area of such place of Confinement, but:

e) only while the Insured Person remains so Confined; and

f) not to exceed $200 per day for lodging and $100 per day for meals.

EMERGENCY REUNION BENEFIT

Following a Medical Emergency Evacuation for which a Medical Emergency Evacuation Benefit is payable under this Rider, We will pay for the expenses reasonably incurred

1) to bring one person chosen by the Insured Person to and from the Hospital or other medical facility where the Insured Person is Confined if:

   a) the Insured Person is alone; and

   b) the place of Confinement is outside a 100-mile radius from the Insured Person's place of primary residence; but not to exceed the cost of one round-trip economy airfare ticket; and

2) for lodging and meals for up to 10 days for such person in the area of such place of Confinement, but:

   a) only while the Insured Person remains so Confined; and

   b) not to exceed $200 per day for lodging and $100 per day for meals.

The total of all benefits outlined in this Rider may not exceed the Maximum Benefit Amount shown in the Rider Schedule.

RIDER SCHEDULE

Medical Emergency Evacuation Benefit

Class:	Maximum Benefit Amount:
Class 1, 2, 3, 4, 5	Actual cost of the Medical Emergency Evacuation

LIMITATIONS AND EXCLUSIONS

Our designated travel assistance provider must make all arrangements and must authorize all expenses in advance of any benefits being payable. Benefits will not be payable unless We authorize in writing, or by authorized electronic or telephonic means, all expenses in advance, and services are rendered by Us or Our designated travel assistance provider. We reserve the right to determine the benefit payable, including reductions, if it is not reasonably possible to contact Us in advance. In the event the Insured Person refuses to be evacuated, We will not be liable for any expenses incurred after the date medical evacuation is recommended.

DEFINITIONS

Except as defined below, the definitions in the Policy apply to this Rider.

Covered Medical Emergency Evacuation Expense(s) means an expense that:

1) is charged for a Medically Necessary Emergency Evacuation Service;

2) does not exceed the usual level of charges for similar Transportation, Treatment, services or supplies in the locality where the expense is incurred; and

3) does not include charges that would not have been made if no insurance existed.

Medically Necessary Emergency Evacuation Service means any Transportation, medical Treatment, medical service or medical supply that:

1) is an essential part of a Medical Emergency Evacuation due to the Injury or Emergency Sickness for which it is prescribed or performed;

2) meets generally accepted standards of medical practice; and

3) either is ordered by a Physician and performed under his or her care or supervision or order, or is required by the standard regulations of the Conveyance transporting the Insured Person.

In all other respects, the Policy remains the same.

Signed for Hartford Fire Insurance Company

Lisa Levin, *Secretary*

Douglas Elliot, *President*

Hartford Fire Insurance Company

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

The Hartford® is The Hartford Financial Services Group, Inc. and its subsidiaries.

Policyholder: T-Mobile

Policy Number: 10-GTA-101903

B-33 — Mortgage Continuation Benefit Rider

This Rider is attached to and made part of the Policy as of the Policy Effective Date shown in the Policy Schedule. It applies only with respect to Covered Accidents that occur on or after that date. It is subject to all of the provisions, limitations, and exclusions of the Policy except as they are specifically modified by this Rider. Please refer to the Policy Schedule for the applicability of this Rider with respect to each Description of Eligible Class(es) and each Covered Hazard.

MORTGAGE CONTINUATION BENEFIT

If the Accidental Death Benefit is payable under the Policy and the Insured Person has or is survived by a Spouse, We will pay an additional monthly Mortgage Continuation Benefit equal to the least of:

1) the actual cost of the monthly Mortgage payment;

the remainder of the Mortgage balance; or

the Monthly Benefit Amount shown in the Rider Schedule.

The benefit will be paid to the Spouse or appointed legal guardian of the youngest Dependent Child. The benefit is payable monthly until the earliest of:

1) the date the Insured Person's surviving Spouse dies;

the end of the calendar year when the youngest Dependent Child reaches age 18;

the date the Mortgage is paid in full;

the date the house is sold;

the end of the month in which the Monthly Benefit Period ends; or

the date the total payments equal the Maximum Benefit Amount.

RIDER SCHEDULE

Mortgage Continuation Benefit

Class:	Monthly Benefit Amount:	Monthly Benefit Period:
Class 1, 2, 3, 4	$1,000	12 months

ADDITIONAL PROOF OF LOSS

In addition to the Proof of Loss requirements in the Policy, the Mortgage company contact information, loan number, monthly Mortgage payment amount and loan balance are required in order to receive benefits under this Rider.

DEFINITIONS

Except as defined below, the definitions in the Policy apply to this Rider.

Mortgage means a loan that is secured by a single-family home, townhouse, condominium, or cooperative that is owned and used as a primary residence and includes any property taxes and insurance that may be included in the monthly payment.

In all other respects, the Policy remains the same.

Signed for Hartford Fire Insurance Company

Lisa Levin, *Secretary*

Douglas Elliot, *President*

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Policyholder: T-Mobile

Policy Number: 10-GTA-101903

B-38 — Out of Country Medical Expense Benefit Rider

This Rider is attached to and made part of the Policy as of the Policy Effective Date shown in the Policy Schedule. It applies only with respect to Covered Losses that occur on or after that date. It is subject to all of the provisions, limitations, and exclusions of the Policy except as they are specifically modified by this Rider. Please refer to the Policy Schedule for the applicability of this Rider with respect to each Description of Eligible Class(es) and each Covered Hazard.

OUT OF COUNTRY MEDICAL EXPENSE BENEFIT

If the Insured Person is participating in a Covered Hazard outside of the United States or its territories for a period of less than 365 days, and the Insured Person suffers a Medical Emergency, We will pay the Out of Country Medical Expense Benefit.

The Out of Country Medical Expense Benefit Amount equals the Usual and Customary Charges incurred outside of the Insured Person's Country of Permanent Residence for Covered Medical Services that are Medically Necessary and received due to that Medical Emergency, up to the Maximum Amount per Insured Person. Benefits are payable for charges incurred within the Maximum Benefit Period shown in the Rider Schedule.

FOREIGN TRAVEL IMMUNIZATION BENEFIT

We will pay the Benefit Amount shown in the Rider Schedule, subject to all applicable conditions and exclusions, if the Insured Person is traveling during the course of a Covered Hazard outside of the United States or its territories and certain immunization or vaccination shots are required in order to enter the country. We will indemnify the Insured Person the Benefit Amount for each required immunization and/or vaccination up to the Benefit Maximum shown in the Rider Schedule.

MEDICAL EMERGENCY GUARANTEE CHARGE EXPENSE BENEFIT

If the Insured Person is participating in a Covered Hazard outside of the United States or its territories for a period of less than 365 days, and the Insured Person suffers a Medical Emergency for which the Usual and Customary Charges become payable under the Out of Country Medical Expense Benefit, and such Insured Person incurs a Hospital Admission Guarantee Charge, We will pay the actual expenses incurred for guarantee of the payment to the Hospital or the medical provider up to the Maximum Medical Emergency Guarantee Charge Expense Amount shown in the Rider Schedule.

COVERED MEDICAL SERVICES

Covered Medical Services under this Rider are as follows:

1) **Hospital:** the following services provided when the Insured Person is Confined in a Hospital:

   a) the daily room rate for a semi-private room when an Insured Person is Confined in a Hospital and general nursing care is provided and charged for by the Hospital. In computing the number of days payable under this benefit, the date of admission will be counted but not the date of discharge.

   b) ancillary Hospital services and supplies including operating room, laboratory tests, Diagnostic Exams, anesthesia and medicines (excluding take home drugs) when Confined in a Hospital.

   c) the daily room rate when an Insured Person is Confined in a Hospital in a bed in the Intensive Care Unit and nursing services other than private duty nursing services.

Private Duty Nurse: private duty nursing services by a registered nurse (RN) or licensed practical nurse (LPN) while an Insured Person is Confined in a Hospital. These services must be ordered by a Physician.

Emergency Room: expenses incurred due to Treatment in an Emergency Room. Such expenses include the attending Emergency Room Physician's charges, x-rays, laboratory procedures, medications, use of the Emergency Room, and medical supplies. In the case of Injury, Emergency Room Treatment must begin within 72 hours of a Medical Emergency.

Prosthesis: artificial limbs, eyes, larynx, or other prosthesis for initial acquisition and fitting. We will not pay for repair or replacement of any prosthesis, unless due to a Covered Accident.

Ambulatory Surgical Center or Ambulatory Medical Center: Treatment including operating room, laboratory tests, anesthesia, medical supplies, and medicines (excluding take home drugs) provided in an Ambulatory Surgical Center or Ambulatory Medical Center.

Physician: expenses for Treatment provided by a Physician.

Anesthesia: expenses for pre-operative screening, anesthetics, and administration of anesthesia during a surgical procedure whether on an Inpatient or Outpatient basis.

Durable Medical Equipment Rental: expenses for rental of a wheelchair, orthopedic appliances, orthopedic braces, or other medical equipment that has therapeutic value for an Insured Person. We will not cover computers, motor vehicles, or modifications to a motor vehicle, ramps and installation costs, eyeglasses, and hearing aids. No benefits will be paid for rental charges in excess of the purchase price.

Blood and Blood Products: expenses for blood, blood products, artificial blood products, and transfusions of any blood or blood products.

Ambulance: expenses for transportation from the emergency site to the Hospital.

Radiological Procedures: Outpatient expenses for CAT Scan, MRI, x-ray, CT, PET, ultrasound, and other radiological procedures. Does not include dental x-rays.

Outpatient Laboratory Tests: expenses for laboratory tests provided when the Insured Person is not Confined in a Hospital and provided by a medical facility other than an Emergency Room or Ambulatory Surgical Center.

Prescription Drug: expenses for drugs prescribed by a Physician for the Treatment of Injury or Sickness and administered on an outpatient basis.

Rehabilitation Care Facility: expenses for physical and occupational rehabilitation. Treatment must be provided in a duly licensed Rehabilitation Care Facility and be under the direction of a Physician.

Dental: expenses including dental x-rays for the repair or Treatment of each Injured tooth that is whole, sound, and a natural tooth at the time of the Medical Emergency.

Vision or Hearing Products: eyeglasses, contact lenses, and hearing aids when damage occurs in a Medical Emergency that requires medical Treatment.

Skilled Nursing Facility: expenses for Confinement in a Skilled Nursing Facility if it begins within 5 consecutive days after an Insured Person is Confined in a Hospital as a result of a Medical Emergency. We will pay for Treatment if a Physician visits the Insured Person at least once every 30 days and certifies that the Confinement is Medically Necessary.

Home Health Care: expenses for Home Health Care beginning within 5 consecutive days after discharge from a Hospital, Skilled Nursing Facility, or Rehabilitation Care Facility.

Manipulative Therapy: expenses for chiropractic adjustment, spinal manipulation or neck manipulation performed by a licensed health care practitioner.

Physical and Occupational Therapy: expenses for physical or occupational therapy and an office visit connected with any such service.

RIDER SCHEDULE

Out of Country Medical Expense Benefit

Maximum Amount per Insured Person:	$250,000
Deductible:	$0 per Medical Emergency
Coinsurance:	100% of Usual and Customary Charges
Maximum Benefit Period:	52 weeks from the date of the Medical Emergency

Foreign Travel Immunization Benefit

Foreign Travel Immunization Benefit:	$100 per required immunization and vaccination required
Benefit Maximum:	$1,000

Medical Emergency Guarantee Charge Expense Benefit

Maximum Medical Emergency Guarantee Charge Expense Amount:	$10,000

LIMITATIONS AND EXCLUSIONS

Rider Exclusions

Unless otherwise specified in this Rider, in addition to the exclusions in the Policy, We will not pay Out of Country Medical Benefits for any loss, Treatment, or services resulting from, or contributed to, by:

1) elective or cosmetic surgery, except for reconstructive surgery needed as the result of an Injury;
2) Injury for which expenses are paid or payable under any automobile insurance policy without regard to fault; (This exclusion does not apply in any state where prohibited.);
3) Treatment or service provided by a private duty nurse;
4) Routine physical exams and medical services or wellness visits;
5) aggravation or re-Injury of a Pre-existing Condition;
6) manipulative therapy or chiropractic care;
7) Injury for which expenses are incurred that are in excess of Usual and Customary Charges for Covered Medical Services, or expenses that are not covered;
8) Mental and Nervous Disorders;
9) Experimental or Investigative Treatment or procedures;
10) diagnosis or treatment of acne;
11) human organ or tissue transplants or treatment thereof.

DEFINITIONS

Except as defined below, the definitions in the Policy apply to this Rider.

Covered Medical Services means the services covered by this Rider. Covered Medical Services are shown in the Rider Schedule and described in the Covered Medical Services provision.

Country of Permanent Residence means country or location in which the Insured Person maintains a primary permanent residence.

Hospital Admission Guarantee Charge means any charge or expense made by a Hospital prior to and as a condition of an Insured Person's admission to that Hospital.

Medical Emergency means a condition caused by an Injury or Sickness that meets all of the following criteria:

1) there is present a severe or acute symptom requiring immediate care and the failure to obtain such care could

reasonably result in serious deterioration of the Insured Person's condition or place his or her life in jeopardy;

the severe or acute symptom occurs suddenly and unexpectedly; and

the severe or acute symptom occurs while the Policy is in force as to the person suffering the symptom and under the circumstances described in a Covered Hazard:

a) applicable to that person; and

b) to which this Rider applies.

In all other respects, the Policy remains the same.

Signed for Hartford Fire Insurance Company

Lisa Levin, *Secretary*

Douglas Elliot, *President*

Hartford Fire Insurance Company

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

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Policyholder: T-Mobile

Policy Number: 10-GTA-101903

B-39 — Paralysis Benefit Rider

This Rider is attached to and made part of the Policy as of the Policy Effective Date shown in the Policy Schedule. It applies only with respect to Covered Accidents that occur on or after that date. It is subject to all of the provisions, limitations, and exclusions of the Policy except as they are specifically modified by this Rider. Please refer to the Policy Schedule for the applicability of this Rider with respect to each Description of Eligible Class(es) and each Covered Hazard.

PARALYSIS BENEFIT

We will pay the percentage of the Maximum Benefit Amount shown below if Injury to the Insured Person results in any one of the types of loss(es) specified below within 365 days of the date of the Covered Accident that caused the Injury, provided that the Paralysis is diagnosed by a Physician as reasonably expected to continue for the duration of his or her lifetime.

If an Insured Person dies within 365 days of the Covered Accident, then We will pay a lump sum equal to the Insured Person's Maximum Benefit Amount shown in the Rider Schedule, less any Benefit Amount for Paralysis already paid.

RIDER SCHEDULE

Class:	**Maximum Benefit Amount**
Class 1	$3,000,000
Class 2	Five (5) times Annual Salary to a maximum of $3,000,000
Class 3	$500,000
Class 4	$50,000
Class 5	$25,000
Loss	**Class 1, 2, 3, 4, 5**
Quadriplegia	100% of the Maximum Benefit Amount
Triplegia	75% of the Maximum Benefit Amount
Paraplegia	75% of the Maximum Benefit Amount
Hemiplegia	50% of the Maximum Benefit Amount
Uniplegia	25% of the Maximum Benefit Amount

LIMITATIONS AND EXCLUSIONS

Rider Exclusions

If an Insured Person suffers a loss for which a benefit is payable under more than one of the following provisions: Accidental Death and Dismemberment Benefit; or only one benefit, the one which would pay the largest benefit amount, will be paid.

DEFINITIONS

Except as defined below, the definitions in the Policy apply to this Rider.

Hemiplegia means the complete and irreversible paralysis of the upper and lower Limbs of the same side of the body.

Limb, Limbs means entire arm or entire leg.

Paraplegia means the complete and irreversible paralysis of both lower Limbs.

Quadriplegia means the complete and irreversible paralysis of both upper and both lower Limbs.

Triplegia means the complete and irreversible paralysis of three Limbs.

Uniplegia means the complete and irreversible paralysis of one Limb.

In all other respects, the Policy remains the same.

Signed for Hartford Fire Insurance Company

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Policyholder: T-Mobile

Policy Number: 10-GTA-101903

B-49 — Rehabilitation Expense Benefit Rider

This Rider is attached to and made part of the Policy as of the Policy Effective Date shown in the Policy Schedule. It applies only with respect to Covered Accidents that occur on or after that date. It is subject to all of the provisions, limitations, and exclusions of the Policy except as they are specifically modified by this Rider. Please refer to the Policy Schedule for the applicability of this Rider with respect to each Description of Eligible Class(es) and each Covered Hazard.

REHABILITATION EXPENSE BENEFIT

If the Insured Person is participating in a Covered Hazard and suffers a Covered Accident for which an Accidental Dismemberment or Paralysis benefit is payable under the Policy, We will reimburse the Insured Person for Covered Rehabilitative Expenses that result from the Injury causing the dismemberment or Paralysis up to the Maximum Benefit Amount shown in the Rider Schedule for all Injuries caused by the same Covered Accident. The Covered Rehabilitative Expenses must be incurred within 2 years after the date of the Covered Accident causing the Injury.

RIDER SCHEDULE

Rehabilitation Expense Benefit

Class:	Maximum Benefit Amount:
Classes 1, 2, 3, 4, 5	$50,000

DEFINITIONS

Except as defined below, the definitions in the Policy apply to this Rider.

Covered Rehabilitative Expense(s) means expenses that:

1) are charged for a Medically Necessary Rehabilitative Training Service of the Insured Person performed under the care, supervision or order of a Physician;
2) do not exceed the usual level of charges for similar Treatment, supplies, or services in the locality where the expenses are incurred (for a Hospital room and board charge, does not exceed the most common charge for Hospital semi-private room and board in the Hospital where the expense is incurred); and
3) does not include charges that would not have been made if no insurance existed.

Medically Necessary Rehabilitative Training Service means any medical service, medical supply, medical Treatment or Hospital Confinement (or part of a Hospital Confinement) that:

1) is essential for physical rehabilitative training due to the Injury for which it is prescribed or performed;
2) meets generally accepted standards of medical practice; and
3) is ordered by a Physician.

In all other respects, the Policy remains the same.

Signed for Hartford Fire Insurance Company

Lisa Levin, *Secretary*

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Hartford, CT 06155
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Policyholder: T-Mobile

Policy Number: 10-GTA-101903

B-50 — Repatriation of Remains Benefit Rider

This Rider is attached to and made part of the Policy as of the Policy Effective Date shown in the Policy Schedule. It applies only with respect to Covered Losses that occur on or after that date. It is subject to all of the provisions, limitations, and exclusions of the Policy except as they are specifically modified by this Rider. Please refer to the Policy Schedule for the applicability of this Rider with respect to each Description of Eligible Class(es) and each Covered Hazard.

REPATRIATION OF REMAINS BENEFIT

If an Insured Person suffers an Injury or Emergency Sickness that results in loss of life while covered under the Policy, We will pay for certain expenses incurred as a result of such death including, but not limited to, the following:

1) the expense incurred for the preparation of the deceased's body for burial or cremation;
2) the most economical coffin or receptacle adequate for transporting the remains; and
3) transportation of the deceased's body to the place of burial or cremation;

up to the Maximum Benefit Amount shown in the Rider Schedule below, provided that the death of the Insured Person occurred outside a 100-mile radius from his or her current place of primary residence.

FAMILY TRAVEL BENEFIT

Following an Insured Person's death for which a Repatriation of Remains benefit is payable under this Rider, We will pay for expenses reasonably incurred:

1) to return to their current place of primary residence, the Insured Person's Spouse and any of the Insured Person's Dependent Children who were accompanying the Insured Person when his or her death occurred, with an attendant for the Dependent Children if necessary and if the Dependent Children are not accompanied by the Spouse; but not to exceed the cost of a single one-way economy airfare ticket less the value of applied credit from any unused return travel tickets per person; and

for lodging and meals for up to 10 days for the Insured Person's Spouse and Dependent Children in the area where the Insured Person's death occurred, if they were accompanying the Insured Person at that time. We will only pay for such expenses for days in excess of the days that had been planned for the trip prior to the Insured Person's death, and only prior to the repatriation of his or her remains. We will not pay for such expenses in excess of, for the Spouse and Dependent Children combined, $200 per day for lodging and $100 per day for food.

IDENTIFICATION AND ESCORT EXPENSE BENEFIT

If an Insured Person suffers an Injury or an Emergency Sickness that results in loss of life and the Repatriation of Remains Benefit is payable, We will pay for expenses reasonably incurred if an Immediate Family Member or authorized representative incurs Identification Expenses or Escort Expenses while:

1) en route and during the stay in the city or town where the Insured Person's body is located, including transportation by the most direct route by a licensed Common Carrier to and from such location, but not to exceed the cost of one round-trip economy airfare ticket; and

for lodging and meals for up to 10 days for such person in the area where the Insured Person's death occurred, and not to exceed $200 per day for lodging and $100 per day for meals.

The total of all benefits outlined in this Rider may not exceed the Maximum Benefit Amount shown in the Rider Schedule.

RIDER SCHEDULE

Repatriation of Remains Benefit

Class:	Maximum Benefit Amount:
Class 1, 2, 3, 4, 5	Actual cost of the Repatriation of Remains

LIMITATIONS AND EXCLUSIONS

Our designated travel assistance provider must make all arrangements and must authorize all expenses in advance of any benefits being payable. Benefits will not be payable unless We authorize in writing, or by authorized electronic or telephonic means, all expenses in advance, and services are rendered by Us or Our designated travel assistance provider. We reserve the right to determine the benefit payable, including reductions, if it is not reasonably possible to contact Us in advance. In the event the Insured Person refuses to be evacuated, We will not be liable for any expenses incurred after the date medical evacuation is recommended.

DEFINITIONS

Except as defined below, the definitions in the Policy apply to this Rider.

Escort Expenses mean expenses for an Immediate Family Member or authorized representative to join the Insured Person's body during the repatriation to the Insured Person's place of permanent residence.

Identification Expenses mean expenses incurred by an Immediate Family Member or authorized representative when identifying the remains of the Insured Person.

In all other respects, the Policy remains the same.

Signed for Hartford Fire Insurance Company

Lisa Levin, *Secretary*

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Hartford, CT 06155
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Policyholder: T-Mobile

Policy Number: 10-GTA-101903

B-51 — Seat Belt and Airbag Benefit Rider

This Rider is attached to and made part of the Policy as of the Policy Effective Date shown in the Policy Schedule. It applies only with respect to Covered Accidents that occur on or after that date. It is subject to all of the provisions, limitations, and exclusions of the Policy except as they are specifically modified by this Rider. Please refer to the Policy Schedule for the applicability of this Rider with respect to each Description of Eligible Class(es) and each Covered Hazard.

SEAT BELT BENEFIT

If an Insured Person suffers a loss of life for which the Accidental Death Benefit is payable under the Policy and the Covered Accident causing death occurs while the Insured Person is operating, or riding as a Passenger in, an Automobile and wearing a properly fastened Seat Belt, We will pay the Seat Belt Benefit.

The Seat Belt Benefit is equal to the lesser of:

1) the Percentage of Accidental Death Principal Sum shown in the Rider Schedule; or
2) the Maximum Benefit Amount shown in the Rider Schedule.

AIRBAG BENEFIT

If the Insured Person is wearing a Seat Belt and received a payment as indicated above, We will pay the Airbag Benefit if:

1) the Insured Person was positioned in a seat equipped with a factory installed Airbag;
2) the Insured Person was properly strapped in the Seat Belt when the Airbag inflated; and
3) the police report establishes that the Airbag inflated properly upon impact.

The Airbag Benefit is equal to the lesser of:

1) the Percentage of Accidental Death Principal Sum shown in the Rider Schedule; or
2) the Maximum Benefit Amount shown in the Rider Schedule.

LIMITED BENEFIT

If a police report is not available, or it is unclear whether the Insured Person was wearing a Seat Belt, or positioned in a seat protected by a properly functioning and properly deployed Airbag, We will pay a limited benefit of $1,000.

RIDER SCHEDULE

Seat Belt Benefit

Class:	Percentage of Accidental Death Principal Sum:	Maximum Benefit Amount:
Class 1, 2, 3, 4, 5	25% of Accidental Death Principal Sum	$50,000

Airbag Benefit

Class:	Percentage of Accidental Death Principal Sum:	Maximum Benefit Amount:
Class 1, 2, 3, 4, 5	25% of Accidental Death Principal Sum	$50,000

DEFINITIONS

Except as defined below, the definitions in the Policy apply to this Rider.

Airbag means an inflatable supplemental passive restraint system installed by the manufacturer of the Automobile, or proper replacement parts as required by the Automobile manufacturer's specifications that inflates upon collision to protect an individual from injury and death. An Airbag is not considered a Seat Belt.

Seat Belt means:

1) an unaltered belt, lap restraint, or shoulder restraint installed by the manufacturer of the Automobile, or proper replacement parts as required by the Automobile manufacturer's specifications; or

a child restraint device that meets the standards of the National Safety Council and is properly secured and utilized in accordance with applicable state law and the recommendations of its manufacturer for children of like age and weight.

In all other respects, the Policy remains the same.

Signed for Hartford Fire Insurance Company

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Policyholder: T-Mobile

Policy Number: 10-GTA-101903

B-52 — Security Evacuation Benefit Rider

This Rider is attached to and made part of the Policy as of the Policy Effective Date shown in the Policy Schedule. It applies only with respect to Covered Accidents that occur on or after that date. It is subject to all of the provisions, limitations, and exclusions of the Policy except as they are specifically modified by this Rider. Please refer to the Policy Schedule for the applicability of this Rider with respect to each Description of Eligible Class(es) and each Covered Hazard.

SECURITY EVACUATION BENEFIT

If, as a result of an Occurrence that takes place while the Insured Person is covered under the Policy and participating in a Covered Hazard, and while traveling outside his or her Home Country, an Insured Person requires a Security Evacuation, We will pay benefits for the Transportation of the Insured Person to the Nearest Place of Safety. The determination that an Insured Person requires a Security Evacuation must be made by a Designated Security Consultant and all arrangements must be made by Our designated travel assistance provider.

Benefits will be payable for eligible expenses up to the Maximum Benefit Amount shown in the Rider Schedule. Eligible expenses are for Transportation to the Nearest Place of Safety and Related Costs necessary to ensure the Insured Person's safety and well-being as determined by the Designated Security Consultant. Security Evacuation benefits are payable only once per Occurrence.

Benefits will also be payable for Transportation and Related Costs within 7 days of the Security Evacuation to the following location(s) as chosen by the Insured Person:

1) back to the Host Country if return is safe and permitted;

the Insured Person's Home Country;

where the Insured Person is currently permanently assigned by the Policyholder;

where the Policyholder is located; or

where the entity that sponsored the Insured Person's trip is located.

Benefits will be payable for consulting services by Designated Security Consultant for seeking information on Missing Person or Kidnapping cases if the Insured Person is deemed Kidnapped or a Missing Person by local or international authorities. This benefit is subject to the Maximum Benefit Amount as shown in the Rider Schedule.

Our designated travel assistance provider must make all arrangements and must authorize all expenses in advance of any benefits being payable. Our designated travel assistance provider is not responsible for the availability of Transportation services. If possible, the Insured Person's Common Carrier tickets will be used. Where a Security Evacuation becomes impractical because of hostile or dangerous conditions, a Designated Security Consultant will endeavor to maintain contact with the Insured Person until a Security Evacuation becomes viable.

RIDER SCHEDULE

Security Evacuation Benefit

Class:	Maximum Benefit Amount:
Class 1, 2, 3, 4, 5	Actual cost of the Security Evacuation up to a maximum amount of $100,000

LIMITATIONS AND EXCLUSIONS

Right of Recovery

For the purpose of this Rider, if, after a Security Evacuation is completed, it becomes clear that the Insured Person was an active participant in the events that led to an Occurrence, We have the right to recover all Transportation and Related Costs from the Insured Person.

Excess Provision

Benefits payable for the eligible expenses under this Rider will be limited to that part of the eligible expense, if any, which is in excess of the total benefits payable for the same Security Evacuation under any other valid and collectible insurance or other indemnity. If the other valid and collectible insurance or indemnity provides benefits on an excess coverage basis, benefits will be paid first by the insurer or services plan whose coverage has been in effect for the longer period of time at the date of the Security Evacuation.

For purposes of this Rider, an Insured Person's entitlement to other valid and collectible insurance or indemnity will be determined as if this Rider did not exist and will not depend on whether timely application for benefits from other valid and collectible insurance or indemnity is made by or on behalf of the Insured Person.

Benefits under this Rider will be reduced to the extent that benefits for expenses are covered by any other valid and collectible insurance or indemnity whether or not a claim is made for such benefits.

Changes in Terms and Conditions

The terms and conditions of this Rider, including but not limited to the definition of Excluded Countries, may be changed at any time to reflect conditions that, in Our opinion, constitute a change in the Policyholder's Security Evacuation exposure. We will give the Policyholder written notice of any change in the terms and conditions of this Rider at least 10 days in advance of the effective date of the change.

Exclusions

Unless otherwise specified in this Rider, in addition to the exclusions in the Policy, no benefits are payable under this Rider for charges, fees or expenses:

1) payable under any other provision of, or Rider to, the Policy to which this Rider is attached;

that are recoverable through the Insured Person's employer;

arising from or attributable to an actual fraudulent, dishonest or criminal act committed or attempted by an Insured Person, acting alone or in collusion with others;

arising from or attributable to an alleged:

a) violation of the laws of the Host Country by an Insured Person; or

b) violation of the laws of the Insured Person's Home Country;

unless the Designated Security Consultant determines that such allegations were intentionally false, fraudulent and malicious and made solely to achieve a political, propaganda and/or coercive effect upon or at the expense of the Insured Person;

due to the Insured Person's failure to maintain and possess duly authorized and issued required travel documents and visas;

arising from an Occurrence which took place in an Excluded Country;

for repatriation of remains expenses;

for common or endemic or epidemic diseases or global pandemic disease as defined by the World Health Organization;

for medical services;

for monies payable in the form of a ransom if a Missing Person case evolves into a Kidnapping;

arising from or attributable, in whole or in part, to a debt, insolvency, commercial failure, the repossession of any property by any title holder or lien holder or any other financial cause;

arising from or attributable, in whole or in part to non-compliance by the Insured Person with regard to any obligation specified in a contract or license; or

due to military or political issues if the Insured Person's Security Evacuation request is made more than 7 days after the Appropriate Authority(ies) Advisory was issued.

DEFINITIONS

Except as defined below, the definitions in the Policy apply to this Rider

Advisory means a formal recommendation by the Appropriate Authorities that the Insured Person or citizens of his or her Home Country or citizens of the Host Country leave the Host Country.

Appropriate Authority(ies) means the government authority(ies) in the Insured Person's Home Country or the government authority(ies) of the Host Country.

Designated Security Consultant means an employee of a security firm under contract with Our designated travel assistance provider who is experienced in security and measures necessary to ensure the safety of the Insured Person(s) in his or her care.

Excluded Countries means the following countries from which Security Evacuations are not available under this Rider: Iraq, Afghanistan, Pakistan, Israel (West Bank and Gaza Strip), Iran, Somalia and Chechnya or] any country subject to the administration and enforcement of U. S. economic embargoes and trade sanctions by the Office of Foreign Assets Control (OFAC).

Imminent Physical Danger means the Insured Person is subject to possible physical injury or sickness that could result in grave physical harm or death.

Missing Person means an Insured Person who disappeared for an unknown reason and whose disappearance was reported to the Appropriate Authority(ies).

Nearest Place of Safety means a location determined by the Designated Security Consultant where:

1) the Insured Person can be presumed safe from the Occurrence that precipitated the Insured Person's Security Evacuation; and
2) the Insured Person has access to transportation; and
3) the Insured Person has the availability of temporary lodging, if needed.

Occurrence means any of the following situations in which an Insured Person finds himself or herself while covered by the Policy:

1) expulsion from a Host Country or being declared persona non-grata on the written authority of the recognized government of a Host Country;
2) political or military events involving a Host Country, if the Appropriate Authorities issue an Advisory stating that citizens of the Insured Person's Home Country or citizens of the Host Country should leave the Host Country;
3) Verified Physical Attack or a Verified Threat of Physical Attack from a third party;
4) Natural Disaster within 7 days of an event;
5) the Insured Person had been deemed Kidnapped or a Missing Person by local or international authorities and, when found, his or her safety and/or well-being are in question within 3 days of his or her being found;
6) Our designated travel assistance provider/Designated Security Consultant recommends an evacuation.

Related Cost(s) means food, lodging and, if necessary, physical protection for the Insured Person during Transportation to the Nearest Place of Safety.

Security Evacuation means the extrication of an Insured Person from the Host Country due to an Occurrence which results in the Insured Person being placed in Imminent Physical Danger.

Verified Physical Attack means deliberate physical harm of the Insured Person confirmed by documentation or physical evidence.

Verified Threat of Physical Attack means a threat against the Insured Person's health and safety as confirmed by documentation and/or physical evidence.

In all other respects, the Policy remains the same.

Signed for Hartford Fire Insurance Company

Lisa Levin, *Secretary*

Douglas Elliot, *President*

Hartford Fire Insurance Company

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

The Hartford® is The Hartford Financial Services Group, Inc. and its subsidiaries.

Policyholder: T-Mobile

Policy Number: 10-GTA-101903

B-55 — Therapeutic Counseling Benefit Rider

This Rider is attached to and made part of the Policy as of the Policy Effective Date shown in the Policy Schedule. It applies only with respect to Covered Losses that occur on or after that date. It is subject to all of the provisions, limitations, and exclusions of the Policy except as they are specifically modified by this Rider. Please refer to the Policy Schedule for the applicability of this Rider with respect to each Description of Eligible Class(es) and each Covered Hazard.

THERAPEUTIC COUNSELING BENEFIT

We will pay for expenses incurred by the Insured Person for Therapeutic Counseling sessions up to the Therapeutic Counseling Benefit Amount per session for the Maximum Number of Sessions as shown in the Rider Schedule below, if:

1) an Insured Person incurs a Covered Loss, other than a loss of life, for which a benefit is payable under the Accidental Dismemberment or Paralysis Benefits of the Policy; and

the Insured Person initially requires Therapeutic Counseling within 365 days due to the Covered Loss.

Benefits for any Therapeutic Counseling session must be incurred within 2 year(s) after the date of the Covered Accident causing the Injury.

RIDER SCHEDULE

Therapeutic Counseling Benefit

Class:	Benefit Amount:	Maximum Number of Sessions:
Class 1, 2, 3, 4, 5	$250 per session	20

ADDITIONAL PROOF OF LOSS

In addition to the Proof of Loss requirements in the Policy, evidence of expenses incurred for services provided for Therapeutic Counseling is required in order to receive benefits under this Rider.

DEFINITIONS

Except as defined below, the definitions in the Policy apply to this Rider.

Therapeutic Counseling means treatment or counseling provided by a licensed therapist, counselor, or psychiatrist who is registered or certified to provide psychological treatment or counseling.

In all other respects, the Policy remains the same.

Signed for Hartford Fire Insurance Company

Lisa Levin, *Secretary*

Douglas Elliot, *President*

Hartford Fire Insurance Company

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

The Hartford® is The Hartford Financial Services Group, Inc. and its subsidiaries.

Policyholder: T-Mobile

Policy Number: 10-GTA-101903

B-60 — Worksite Modification Benefit Rider

This Rider is attached to and made part of the Policy as of the Policy Effective Date shown in the Policy Schedule. It applies only with respect to Covered Accidents that occur on or after that date. It is subject to all of the provisions, limitations, and exclusions of the Policy except as they are specifically modified by this Rider. Please refer to the Policy Schedule for the applicability of this Rider with respect to each Description of Eligible Class(es) and each Covered Hazard.

WORKSITE MODIFICATION BENEFIT

If an Insured Person suffers an Injury, other than loss of life, that results in a loss payable under the Accidental Dismemberment, or Paralysis Benefit, We will pay an additional benefit that is the lesser of:

1) the Benefit Amount as indicated in the Rider Schedule; or

the actual cost for the Covered Worksite Modification Expenses that are incurred within 12 months of the date of the Covered Accident that caused the Injury if an Insured Person:

a) did not require, prior to the date of the Accident that caused the Injury, the use of a wheelchair or other adaptive device to be ambulatory; and

b) as a direct result of such Injury, the use of a wheelchair or other adaptive device to be ambulatory is now compulsory.

RIDER SCHEDULE

Worksite Modification Benefit

Class:	Benefit Amount:
Class 1, 2, 3, 4, 5	$25,000

DEFINITIONS

Except as defined below, the definitions in the Policy apply to this Rider.

Covered Worksite Modification Expenses for the purpose of this Rider, means one-time expenses that are charged for alterations to the Insured Person's work station that are necessary to make it accessible for a wheelchair-confined person or adaptive device user, but do not:

1) include charges that would not have been made if no insurance existed; and

2) exceed the usual level of charges for similar alterations and modifications in the locality where the expense is incurred; but only if the alterations to the Insured Person's worksite are:

a) made on behalf of the Insured Person;

b) recommended by a nationally-recognized organization providing support and assistance to wheelchair or other adaptive device users;

c) carried out by individuals experienced in such alterations and modifications; and

d) in compliance with any applicable laws or requirements for approval by the appropriate government authorities.

In all other respects, the Policy remains the same.

Signed for Hartford Fire Insurance Company

Lisa Levin, *Secretary*

Douglas Elliot, *President*

HARTFORD FIRE INSURANCE COMPANY

One Hartford Plaza

Hartford, Connecticut 06155

(A stock insurance company)

The Hartford® is The Hartford Financial Services Group, Inc. and its subsidiaries.

Policyholder: T-Mobile

Policy Number: 10-GTA-101903

POLICY AMENDATORY RIDER

This Rider is attached to and made part of the Policy as of 02/09/2023. It applies only with respect to Covered Accidents that occur on or after that date. It is subject to all of the provisions, limitations, and exclusions of the Policy except as they are specifically modified by this Rider.

Rider # **1**:

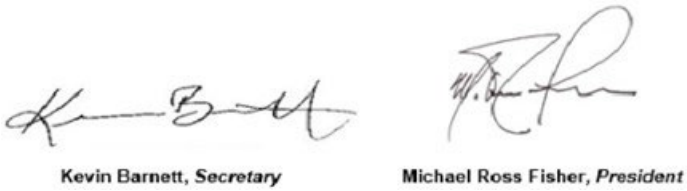
In consideration of the policy premium, it is hereby understood and agreed that the Policyholder Address is amended to read as follows:

6160 Sprint Parkway

Overland Park, KS 66251

In all other respects, the Policy remains the same.

Signed for Hartford Fire Insurance Company



Kevin Barnett, *Secretary*

Michael Ross Fisher, *President*

Form BTA-1200

HARTFORD FIRE INSURANCE COMPANY

One Hartford Plaza

Hartford, Connecticut 06155

(A stock insurance company)

The Hartford® is The Hartford Financial Services Group, Inc. and its subsidiaries.

Policyholder: T-Mobile

Policy Number: 10-GTA-101903

POLICY AMENDATORY RIDER #2

This Rider is attached to and made part of the Policy as of 01/01/2022. It applies only with respect to Covered Accidents that occur on or after that date. It is subject to all of the provisions, limitations, and exclusions of the Policy except as they are specifically modified by this Rider.

It is hereby understood and agreed that the following **definition** as shown on the **Policy Form** has been amended to read as follows:

Relocation Trip means a trip which:

1) begins when the Insured Person or his or her Spouse or Dependent Child(ren) leave his or her former place of residence for the purpose of relocating to a new residence; and
2) ends when he or she arrives at his or her new place of residence;

provided such trip is due to the Insured Person's relocation which is at the request and expense of the Policyholder.

A Relocation Trip will not include any period of time in excess of 14 days of the Relocation Trip during which the Insured Person or his or her Spouse or Dependent Child(ren) take a vacation or Sojourn and/or Personal Deviation which substantially differs from the Relocation Trip.

It is also hereby understood and agreed that the **Sojourn or Personal Deviation** days as shown on the **H-3 – 24 Hour Accident Protection While on Business Hazard Rider, Form BTA PA-10053** been amended to read as follows: 14 Days

In all other respects, the Policy remains the same. Signed for Hartford Fire Insurance Company

Kevin Barnett, *Secretary*

Michael Ross Fisher, *President*

Form BTA-1200

HARTFORD FIRE INSURANCE COMPANY

One Hartford Plaza

Hartford, Connecticut 06155

(A stock insurance company)

The Hartford® is The Hartford Financial Services Group, Inc. and its subsidiaries.

Policyholder: T-Mobile

Policy Number: 10-GTA-101903

POLICY AMENDATORY RIDER

This Rider is attached to and made part of the Policy as of January 1, 2022. It applies only with respect to Covered Accidents that occur on or after that date. It is subject to all of the provisions, limitations, and exclusions of the Policy except as they are specifically modified by this Rider.

Rider #3

In consideration of the policy premium, it is hereby understood and agreed that under the section **OUT OF COUNTRY MEDICAL EXPENSE BENEFIT**, Form PA-10123 (KS), **B-38 Out of Country Medical Expense Benefit Rider** is amended to read as follows:

If the Insured Person is participating in a Covered Hazard outside of his or her Country of Permanent Residence for a period of less than 365 days, and the Insured Person suffers a Medical Emergency, We will pay the Out of Country Medical Expense Benefit.

In all other respects, the Policy remains the same.

Signed for Hartford Fire Insurance Company

Kevin Barnett, *Secretary*

H. Clay Bassett, JR, *P&C Chief Underwriting Officer*

Form BTA-1200

HARTFORD FIRE INSURANCE COMPANY

One Hartford Plaza Hartford, Connecticut 06155

(A stock insurance company)

The Hartford® is The Hartford Financial Services Group, Inc. and its subsidiaries.

Policyholder: T-Mobile

Policy Number: 10-GTA-101903

POLICY AMENDATORY RIDER

This Rider is attached to and made part of the Policy as of 1/1/2025. It applies only with respect to Covered Accidents that occur on or after that date. It is subject to all of the provisions, limitations, and exclusions of the Policy except as they are specifically modified by this Rider.

In consideration of the Policy Premium, the Policy Period shall be renewed effective 1/1/2025 to 1/1/2028.

PREMIUM

Policy Premium:	$282,195.00
Premium Mode:	3 year annual installments due on the Effective Date and each Anniversary Date thereafter

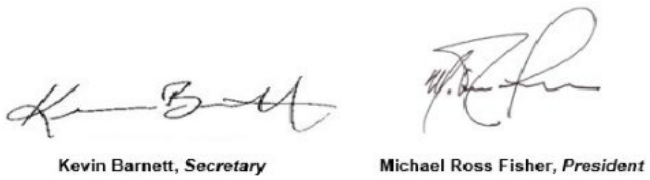
1st annual installment of $94,065.00: January 1st, 2025 - January 1st, 2026 2nd annual installment of $94,065.00: January 1st, 2026 - January 1st, 2027 3rd annual installment of $94,065.00: January 1st, 2027 - January 1st, 2028

It is also hereby understood and agreed that the Designated War Risk Countries on **Form BTA PA-10087, H-40 – War Risk Hazard Rider,** have been amended to read as follows:

Designated War Risk Territory(ies) means United States, Iraq, Afghanistan, Belarus, Pakistan, Israel, West Bank, Gaza Strip, Iran, Lebanon, Libya, Russia, Somalia, Sudan, Syria, Ukraine, Chechnya or Yemen. (*Subject to change)

In all other respects, the Policy remains the same.

Signed for Hartford Fire Insurance Company



Kevin Barnett, *Secretary* Michael Ross Fisher, *President*

Form BTA-1200

Legal Plans

METLIFE LEGAL PLANS®
SUMMARY PLAN DESCRIPTION

Introduction

MetLife Legal Plans® was established to provide personal legal services for eligible employees and their spouses and dependent children. This summary provides general information about the plan, who is eligible to receive benefits under the plan, what those benefits are, how to obtain benefits, and what your rights under ERISA are. If you have any questions that are not answered, please contact the benefits department.

MetLife Legal Plans, Inc. has been selected to provide legal plan benefits. The services will be provided through a panel of carefully selected participating law firms. Lawyers in this network are called Plan Attorneys. These arrangements are described in detail in this summary. The actual provisions of the plan are set out in a written document maintained by your employer. All statements made in this booklet are subject to the provisions and terms of that document, which control in the event of conflict with this summary.

How To Get Legal Services

Website

When you are ready to use the legal plan, you can create an account using the email and password of your choice on the members' website (members.legalplans.com). Once you've created an account, you will have access to a guided experience to see your coverages and find an attorney, as well as access to our digital estate planning solution to create wills, living wills and powers of attorney.

Client Service Center

You may also use MetLife Legal Plans®, by calling MetLife Legal Plans' Client Service Center at **1-800-821-6400** Monday – Friday 8 a.m. to 8 p.m., Eastern Time. Be prepared to give the last four of your SSN and Zip Code. If you are a spouse or an eligible dependent child of an eligible person, you will need the last four of your SSN and Zip Code of the member through whom you are eligible. The Client Service Representative who answers your call will:

- Verify your eligibility for services;
- Make an initial determination of whether and to what extent your case is covered (the Plan Attorney will make the final determination of coverage);
- Give you a Case Number which is similar to a claim number (you will need a new Case Number for each new case you have);
- Give you the telephone number of the Plan Attorney most convenient to you; and
- Answer any questions you have about the Legal Plan.

You then call the Plan Attorney to schedule an appointment at a time convenient to you. Evening and Saturday appointments are available.

If you choose, you may select a non-Plan Attorney. Also, where there are no participating law firms, you will be asked to select your own attorney. In both of these circumstances, MetLife Legal Plans will reimburse you for these non-Plan Attorneys' fees in accordance with a set fee schedule.

For services to be covered, you or your eligible dependents must have obtained a case number and retained

an attorney and the attorney must begin work on the covered legal matter while you are an eligible member of the legal plan.

WHAT SERVICES ARE COVERED

MetLife Legal Plans® entitles you and your eligible dependents to receive certain personal legal services. The available benefits are very comprehensive, but there are limitations and other conditions which must be met. Please take time to read the description of benefits carefully. The covered services are listed in Appendix A. All listed benefits are available to you and your spouse and dependents, unless otherwise noted.

Exclusions

Excluded services are those legal services that are not provided under the plan. No services, not even a consultation, can be provided for:

- Employment-related matters, including company or statutory benefits
- Matters involving your employer, MetLife or its affiliates, or plan attorneys
- Matters in which there is a conflict of interest between the employee and spouse or dependents, in which case services are excluded for the spouse and dependents
- Appeals and class actions
- Farm, business, and investment matters and matters involving property held for investment or rental or issues when the participant is the landlord
- Patent, trademark and copyright matters
- Costs or fines
- Frivolous or unethical matters
- Matters for which an attorney-client relationship exists prior to the participant becoming eligible for plan benefits

Eligibility

To be eligible for legal services under the legal plan, you must have included the plan in your benefits selection. You are eligible to enroll in the plan for yourself and, for some cases, your eligible dependents. Eligible dependents include your lawful spouse and your [unmarried] child (or children) up to the age of [21] [provided he or she depends on you for support].

Enrollment

During your employer's annual enrollment period, you can change or update your benefits selections. You may choose to join or drop out of the plan at that time. If you become an eligible employee after the annual enrollment period, you can elect to participate in the Legal Plan by completing your election form within 30 days of employment. The Plan has a minimum participation period of one year, and you must maintain the coverage for the entire year.

When Coverage Begins

Generally, Plan coverage becomes effective on the date of the following:

The first day of the month in which your employer has agreed to provide the Plan, typically January 1, for the elections you made during the previous enrollment period; or

If you were hired after an enrollment period, the first day of the month after you submitted a properly completed enrollment form.

WHEN COVERAGE ENDS

Your ability to receive legal services under the plan ends if you are no longer an eligible employee or if you choose not to enroll during future annual enrollment periods.

If you cease to be eligible to participate in the plan or your employment with the company ends, the plan will cover the legal fees for those covered services that were opened and pending during the period you were enrolled in the plan. No new matters may be started after you become ineligible.

AMENDMENT OR TERMINATION

While your employer expects to continue to offer participation in the legal services plan, it reserves the right to amend, or terminate the plan at any time. If the plan is terminated, all covered services then in process will be handled to their conclusion under the terms of the plan.

ADMINISTRATION AND FUNDING

The legal services plan is provided for and administered through a contract with MetLife Legal Plans. MetLife Legal Plans makes all determinations regarding attorneys' fees and what constitutes covered services. All contributions collected from employees electing this coverage are paid to MetLife Legal Plans.

COST OF THE PLAN

You pay the cost of the plan through after-tax payroll deductions, based on your enrollment choice.

PLAN CONFIDENTIALITY, ETHICS AND INDEPENDENT JUDGMENT

Your use of the plan and the legal services provided are confidential. The Plan Attorney will maintain strict confidentiality of the traditional lawyer-client relationship. Your employer will know nothing about your legal issue or the services you use under the plan. Plan administrators will have access only to limited statistical information needed for orderly administration of the plan.

No one will interfere with your Plan Attorney's independent exercise of professional judgment when representing you. All attorneys' services provided under the plan are subject to ethical rules established by the courts for lawyers. The attorney will adhere to the rules of the plan and he or she will not receive any further instructions, direction, or interference from anyone else connected with the Plan. The attorney's obligations are exclusively to you. The attorney's relationship is exclusively with you. MetLife

Legal Plans or the law firm providing services under the Plan is responsible for all services provided by the attorneys.

You should understand that the plan has no liability for the conduct of any Plan Attorney. You have the right to file a complaint with the state bar concerning attorney conduct pursuant to the plan. You have the right to retain at your own expense any attorney authorized to practice law in your state.

Plan attorneys will refuse to provide services if a matter is clearly without merit, frivolous, or for the purpose of harassing another person. If you have a complaint about the legal services you have received or the conduct of an attorney, call MetLife Legal Plans at **1-800-821-6400**. We will review your complaint and respond within two business days of your call.

Other Special Rules

In addition to the coverages and exclusions listed, there are certain rules for special situations. Please read this section carefully.

What if other coverage is available to you? If you are entitled to receive legal representation provided by another organization such as an insurance company or a government agency or if you are entitled to legal services under any other legal plan, coverage will not be provided under this Plan. However, if you are eligible for legal aid or public defender services, you will still be eligible for benefits under this plan so long as you meet the eligibility requirements.

What if you are involved in a legal dispute with your dependents? You may need legal help with a problem involving your spouse or your children. In some cases, both you and your child may need an attorney. If it would be improper for one attorney to represent both you and your dependent, only you will be entitled to representation under the plan. In these situations, your dependent will not be covered under the plan.

What if you are involved in a legal dispute with another employee? If you or your dependents are involved in a dispute with another eligible employee or that employee's dependents, MetLife Legal Plans will arrange for legal representation with independent and separate counsel for both parties.

What if the court awards attorneys' fees as part of a settlement? If you are awarded attorneys' fees as a part of a court settlement, the plan must be repaid from this award to the extent that it paid the fee for your attorney.

Denial Of Benefits And Appeal Procedures

Denials of Eligibility
MetLife Legal Plans verifies eligibility using information provided by *{Company Name}*. When you call for services, you will be advised if you are ineligible and MetLife Legal Plans will contact *{Company Name}* for assistance. If you are not satisfied with the final determination of eligibility, you have the right to a formal review and appeal. Send a letter within 60 days explaining why you believe you are eligible to:

T-Mobile
12920 SE 38th Street
Bellvue, WA 98006

Within 30 days, you will be provided with a written explanation.

Denials of Coverage
If you are denied coverage by MetLife Legal Plans or by any Plan Attorney, you may appeal by sending a letter to:

MetLife Legal Plans, Inc.
Director of Administration
1111 Superior Avenue
Suite 800
Cleveland, Ohio 44114-2507

The Director will issue MetLife Legal Plans' final determination within 60 days of receiving your letter. This determination will include the reasons for the denial with reference to the specific plan provisions on which the denial is based, a description of any additional information that might cause MetLife Legal Plans to reconsider the decision, an explanation of the review procedure, and notice of the right to bring a civil action under Section 502(a) of ERISA.

YOUR ERISA RIGHTS

Congress enacted the Employee Retirement Income Security Act of 1974 ("**ERISA**") to safeguard your interests and those of your beneficiaries under your employee benefit plan. As a participant in the plan, you are entitled to certain rights and protections under the ERISA. ERISA provides that all plan participants shall be entitled to:

- Examine without charge at the plan administrator's office and at other specified locations all Plan documents, including collective bargaining agreements and copies of all documents filed by the plan with U.S. Department of Labor, such as detailed annual reports and plan descriptions;
- Obtain copies of all plan documents and other plan information upon written request to the plan administrator. The administrator may make a reasonable charge for the copies;
- Receive a summary of the Plan's annual financial report from the plan administrator, who is required by law to furnish this to you.

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 welfare benefit or exercising your rights under ERISA. If your claim for a welfare benefit is denied in whole or in part, you must receive a written explanation of the reason for the denial. You have the right to have the plan review and reconsider your claim. Under ERISA, there are steps you can take to enforce these rights. If you

request materials from the plan and do not receive them within 30 days, you may file suit in a federal court. If you do, the court may require the plan administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits which is denied or ignored in whole or in part, you may file suit in a state or federal court. If 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 lose, the court may order you to pay these costs and fees, if for example it finds your claim is frivolous. 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, you should contact the nearest area office of the Employee Benefits Security Administration, U.S. Department of Labor listed in your telephone directory, or at 200 Constitution Avenue, NW, Washington, DC. 20210. You can also call the publications hotline of the Employee Benefits Security Administration.

FOR YOUR INFORMATION:

Name of Plan:	MetLife Legal Plans®
Plan Sponsor:	T-Mobile
Type of Plan:	Welfare benefit plan for group legal services
Plan Administrator:	Plan sponsor
Agent for Service of Legal Process:	Plan administrator
Provider of Benefits:	MetLife Legal Plans, Inc. 1111 Superior Avenue Cleveland, OH 44114-2407 (800) 821-6400 www.legalplans.com
Plan Identification Number:	990/3975 (base plan) 990/6842 (Plus Parents plan)
Sponsor's Employer Identification Number:	
Effective Date:	01/01/2024
Plan Year:	January – December

If you have any concerns about this plan, please call MetLife Legal Plans at 1-800-821-6400. A MetLife Legal Plans representative will help you resolve the issue to your satisfaction.

Appendix A

Definitions of Covered Services

ADVICE AND CONSULTATION

Office Consultation

This service enables the Covered Person to talk with a Plan Attorney about any personal legal problems not specifically excluded. The attorney will:

- explain the Covered Person's rights;
- point out his or her options; and,
- if needed, suggest a course of action.

The Plan Attorney will describe any further coverage under the Plan and will represent the Covered Person if requested. If representation is covered as outlined in this Schedule, the Covered Person will not be charged for the Plan Attorney's services. For non-covered matters where this is the only service provided, You may obtain consultations with a Plan Attorney for an unlimited number of matters. If representation is suggested but is not covered, the Plan Attorney will give a written fee estimate. The Covered Person may then choose to:

- retain the Plan Attorney at his or her own expense;
- seek other counsel; or,
- do nothing.

This service is not intended to provide the Covered Person with continuing access to a Plan Attorney in order to seek advice that would allow the Covered Person to undertake his or her own representation. For non-covered matters that are not otherwise excluded, this benefit provides four hours of attorney time and services per year. The Covered Person is responsible to pay fees beyond the 4 hours. No more than a combined maximum total of four hours of attorney time and service are provided for the member, spouse and qualified dependents annually.

Telephone Advice

This service enables the Covered Person to talk with a Plan Attorney about any personal legal problems not specifically excluded. The attorney will:

- explain the Covered Person's rights;
- point out his or her options; and,
- if needed, suggest a course of action.

The Plan Attorney will describe any further coverage under the Plan and will represent the Covered Person if requested. If representation is covered as outlined in this Schedule, the Covered Person will not be charged for the Plan Attorney's services. For non-covered matters where this is the only service provided, You may obtain consultations with a Plan Attorney for an unlimited number of matters. If representation is suggested but is not covered, the Plan Attorney will give a written fee estimate. The Covered Person may then choose to:

- retain the Plan Attorney at his or her own expense;
- seek other counsel; or,
- do nothing.

This service is not intended to provide the Covered Person with continuing access to a Plan Attorney in order to seek advice that would allow the Covered Person to undertake his or her own representation. For non-covered matters that are not otherwise excluded, this benefit provides four hours of attorney time and services per year. The Covered Person is responsible to pay fees beyond the 4 hours. No more than a combined maximum total of four hours of attorney time and service are provided for the member, spouse and qualified dependents annually**.**

CONSUMER PROTECTION

Consumer Protection Matters

This service provides the Covered Person with representation as a plaintiff in consumer protection matters and includes representation at trial. It covers disputes over consumer goods and services where:

- the amount being contested exceeds the small claims court limit; and
- the controversy is evidenced by a written document such a sales slip, contract, note or warranty.

This service does not include disputes over real estate, construction, insurance, or collection activities after a judgment.

Small Claims Assistance

This service provides the Covered Person with:

- counseling on prosecuting a small claims action;
- help in preparing documents;
- advice on evidence, documentation, and witnesses; and
- help in preparing for trial.

This service does not cover the Plan Attorney's attendance or representation at a small claims trial, collection activities after a judgment, or any services relating to post-judgment actions.

Personal Property Protection

This service provides the Covered Person with:

- Counseling on any personal property issue. Examples are consumer credit reports, contracts for purchase of personal property, consumer credit agreements or installment sales agreements;
- Counseling on pursuing or defending a small claims action;
- Reviewing personal legal documents; and
- Preparing promissory notes, affidavits and demand letters.

FINANCIAL MATTERS

Debt Collection Defense
This benefit provides Covered Persons with an attorney's services for negotiation with creditors for a repayment schedule, to limit creditor harassment, and representation in defense of any action for personal debt collection, tax agency debt collection, foreclosure, repossession, or garnishment, up to and including trial if necessary. It includes a motion to vacate a default judgment. It does not include counter-, cross-, or third party claims, bankruptcy, any action arising out of family law matters, including support and post decree issues, or any matter where the creditor is affiliated with the sponsor or employer.

Identity Restoration
This service provides the Participant and their enrolled family members with access to full-service Identity Restoration support provided by Aura's U.S.-based White Glove Fraud Resolution Specialists. Fraud experts will work with Participants to navigate bureaus and financial institutions, make phone calls, and complete forms to quicky quickly restore your identity and secure your assets and information. Aura's experienced agents will take care of the heavy lifting, saving the Participant countless hours of their precious time. Fully Covered

Identity Theft Defense
This service provides the Covered Person with consultations with an attorney regarding potential creditor actions resulting from identity theft and attorney services as needed to contact creditors, credit bureaus, and financial institutions. It also provides defense services for specific creditor actions over disputed accounts. The defense services include limiting creditor harassment and representation in defense of any action that arises out of the identity theft such as foreclosure, repossession, or garnishment, up to and including trial if necessary. The service also provides the Covered Person with online help and information about identity theft and prevention. It does not include counter claims, cross claims, bankruptcy, any action arising out of divorce or post decree matters, or any matter where the creditor is affiliated with the sponsor or employer.

Personal Bankruptcy or Wage Earner Plan
This service covers the Employee and spouse in pre-bankruptcy planning, the preparation and filing of a personal bankruptcy or wage earner petition, and representation at all court hearings and trials. This service is not available if a creditor is affiliated with the employer, even if the Employee or spouse chooses to reaffirm that specific debt.

Tax Audits
This service provides the Covered Person with an attorney to:

- review tax returns;
- review questions from the IRS or other state or local taxing authority concerning the Covered Person's tax return;
- negotiate with the taxing authority;
- advise the Covered Person on necessary documentation; and
- attend an IRS or a state or local taxing authority audit, if necessary.

This service does not include prosecuting a claim for the return of overpaid taxes, costs of hiring an accountant, or the preparation of any tax returns.

DEFENSE OF CIVIL LAWSUITS

Administrative Hearing Representation

This service provides the Covered Person with defense in civil proceedings. It includes proceedings before a municipal, county, state, or federal administrative board, agency, or commission. It includes the hearing before an administrative board or agency over an adverse governmental action. It does not apply where legal representation is available or being provided by virtue of a homeowner or vehicle insurance policy. It does not include:

- family matters;
- post judgment matters; or
- litigation of a job-related incident.

Civil Litigation Defense

This service provides the Covered Person with defense in civil proceedings. It includes proceedings in a trial court of general jurisdiction or before an administrative agency or a local, state, or federal agency. It does not apply where legal representation is available or being provided by virtue of another insurance policy. It does not include:

- family matters;
- post judgment matters; or
- litigation of a job-related incident.

This service does not include bringing counterclaims, cross claims, or third-party claims.

Incompetency Defense

This service provides the Covered Person with defense in any incompetency action. It includes representation at court hearings when there is a proceeding to find the Covered Person incompetent.

DOCUMENT PREPARATION

Affidavits

This service covers preparation of any affidavit in which the Covered Person is the person making the statement.

Deeds

This service covers the preparation of any deed for which the Covered Person is either the grantor or grantee.

Demand Letters

This service provides for:

- the preparation of letters which demand money, property or some other property interest of the Covered Person;
- mailing them to the addressee; and
- forwarding and explaining any response to the Covered Person.

Negotiations and representation in litigation are not included.

Mortgages
This service provides for the preparation of any mortgage for which the Covered Person is the mortgagor. This service does not include documents pertaining to business, commercial, or rental property.

Promissory Notes
This service provides for the preparation of any promissory note for which the Covered Person is the payor or payee.

Document Review
This service provides for the review of any personal legal document of the Covered Person, such as letters, leases, or purchase agreements.

Elder Law Matters

This service provides the Covered Person with:

- Counseling on any personal issues relating to the Covered Person's parents as they effect the Covered Person;
- Reviewing documents of the parents as they effect the Covered Person, including Medicare or Medicaid materials, prescription plans, leases, nursing home agreements, powers of attorney, living wills and wills;
- Preparing deeds involving the parents when the Covered Person is the grantor or the grantee; and
- Preparing promissory notes involving the parents when the Covered Person is either the payor or payee.

FAMILY LAW

Adoption and Legitimization (Contested and Uncontested)
This service provides for all legal services and court work in a state or federal court for an adoption for the Contractholder and spouse. Legitimization of a child for the Contractholder and spouse, including reformation of a birth certificate, is also covered.

Divorce, Dissolution and Annulment (Contested and Uncontested)
This service is available to the Plan Member only, not to a spouse or dependents. This service includes preparing and filing all necessary pleadings, motions and affidavits, drafting settlement or separation agreements, and representation at the hearing or trial, whether the Plan Member is a plaintiff or a defendant. This service does not include disputes that arise after a decree is issued.

Enforcement or Modification of Support Order
This service is available to the Plan Member and spouse, and covers representation after a judgment has been entered to enforce or modify a court's award of support or alimony, whether the Plan Member or spouse is a plaintiff or a defendant. This service does not cover transfer of a divorce decree from one state to another, the division of property, or collection activities after a judgment.

Guardianship or Conservatorship (Contested or Uncontested)
This service covers establishing a guardianship or conservatorship over a person and his or her estate when the Employee or spouse is appointed as guardian or conservator. It includes obtaining a permanent and/or temporary guardianship or conservatorship, gathering any necessary medical evidence, preparing the paperwork, attending the hearing, and preparing the initial accounting. This service does not include representation of the person over whom guardianship or conservatorship is sought, any annual accountings after the initial accounting, or terminating the guardianship or conservatorship once it has been established.

Name Change
This service covers the Covered Person for all necessary pleadings and court hearings for a legal name change.

Prenuptial Agreement
Where allowed by law, this service provides for the negotiation, preparation, review, and execution of an agreement by the Contractholder and his or her fiancé(e)/partner prior to marriage or legal union outlining how property is to be divided in the event of:

- separation;
- divorce; or
- death of either.

Representation is provided only to the Contractholder. The fiancé(e)/partner must have separate counsel or waive representation. It does not include subsequent litigation arising out of a prenuptial agreement.

Protection from Domestic Violence
This service covers the Employee only, not the spouse or dependents, as the victim of domestic violence. It provides the Employee with representation to obtain a protective order, including all required paperwork and attendance at all court appearances. The service does not include representation in suits for damages, defense of any action, or representation for the offender.

Reproductive Assistance Law Coverage – Twenty Hour Maximum
This service covers the Participating Employee and/or spouse for the first twenty hours of legal services and court work related to reproductive assistance matters. Reproductive assistance matters may include, but shall not be limited to, as permitted by law, surrogacy, egg donation, sperm donation, gamete donation, embryo donation and embryo adoption. This service includes reviewing and preparing any necessary agreements or documents, the preparation and filing of any pleadings or other documentation to obtain any necessary orders or decrees, and representation at any hearing or other proceeding related to the matter as may be required by law. This service does not include representation of any party other than the Participating Employee and/or spouse, even if the Participating Employee and/or spouse may be required to pay that party's legal fees or expenses. It is the Participating Employee and/or spouse's responsibility to pay fees beyond the first twenty hours.

IMMIGRATION

Immigration Assistance
This service covers advice and consultation, preparation of affidavits and powers of attorney, review of any immigration documents, and helping the Covered Person prepare for hearings.

INSURANCE MATTERS

Caregiving Support
A caregiver can be someone caring for a child, spouse, or parent, or an extended family member that needs assistance for all types of reasons from simple to complex. To help you manage the care of others or if you'd like support yourself, you and your loved ones have a caregiving benefit that provides unlimited access to a 100% confidential, multi-disciplinary team of highly trained experts and digital tools. Your dedicated care experts work with you and your family to create a holistic care plan and provide the resources and guidance needed to make care-related decisions, delivering better outcomes for all. Here is a small sample of caregiving problems that this benefit supports: -Elder Care -Child and adolescent wellbeing - Cognitive issues and dementia - Aging in place - Homecare and placement - Crisis intervention - Mental health and emotional support - Substance abuse and addiction - New and chronic diagnoses - Financial challenges, such as bill pay - Insurance and Medicare Navigation - legal issues, such as POA & wills.

PERSONAL INJURY

Personal Injury (25% Network Maximum)
Subject to applicable law and court rules, Plan Attorneys will handle personal injury matters where the Covered Person is the plaintiff at a maximum fee of 25% of the gross award. It is the Covered Person's responsibility to pay the attorney's fee and all costs.

REAL ESTATE MATTERS

Boundary or Title Disputes
This service provides representation for the Covered Person in disputes concerning boundary or real property title disputes involving his or her residence. It does not apply where legal representation is available or being provided by virtue of homeowner or title insurance policies.

Eviction and Tenant Problems (Tenant Only)
This service covers the Covered Person as a tenant for matters involving leases, security deposits or disputes with a residential landlord. The service includes eviction defense, up to and including trial. It does not include representation in disputes with other tenants or as a plaintiff in a lawsuit against the landlord, including an action for return of a security deposit.

Security Deposit Assistance (Tenant Only)
This service covers counseling the Covered Person in recovering a security deposit from the Covered Person's residential landlord; reviewing the lease and other relevant documents; and preparing a demand letter to the landlord for the return of the deposit.

It also covers:

- assisting the Covered Person in prosecuting a small claims action;
- helping prepare documents;
- advising on evidence, documentation and witnesses; and
- preparing the Participant for the small claims trial.

This service does not include:

- the Plan Attorney's attendance or representation at the small claims trial;
- collection activities after a judgment; or
- any services relating to post-judgment actions.

Home Equity Loans (Primary Residence)
This service covers the review or preparation of a home equity loan on the Covered Person's primary residence.

Home Equity Loans (Second or Vacation Home)
This service covers the review or preparation of a home equity loan on the Covered Person's second or vacation home.

Refinancing of Home (Primary and Secondary Residence)
This service provides the Covered Person with counsel in the refinancing of or obtaining a home equity loan on the Covered Person's primary or secondary residence. It includes the review or preparation of all relevant documents, including the mortgage, deed, and documents pertaining to title, insurance, recordation and taxation.

It does not include:

- services provided by an attorney representing a lending institution or title company;
- the sale or purchase of a home; or
- the refinancing of or obtaining a home equity loan on:
  1. rental property; or
  2. property held for business or investment.

Sale or Purchase of Home (Primary and Secondary Residence)

This service provides the Covered Person with counsel for the purchase and sale of the Covered Person's primary or secondary residence or of vacant property to be used for building a primary or secondary residence. It includes the review or preparation of all relevant documents, including the construction documents for a new home, purchase agreement, mortgage, deed and documents pertaining to title, insurance, recordation, and taxation. The service also includes attendance of a Plan Attorney at closing in cities where it is the custom to do so. It does not include:

- services provided by an attorney representing a lending institution or title company;
- refinancing a home;
- home equity loans; or

- the sale or purchase of:
  1. rental property; or
  2. property held for business or investment.

Property Tax Assessment
This service provides the Covered Person with coverage for review and advice on a property tax assessment on his or her residence. The service includes:

- filing the paperwork,
- gathering the evidence,
- negotiating a settlement and attending the hearing necessary to seek a reduction of the assessment.

Zoning Applications
This service provides the Covered Person with counsel to help get a zoning change or variance for his or her residence. This service includes:

- reviewing the law;
- reviewing the surveys;
- advising the Covered Person;
- preparing applications for the zoning hearings;
- preparing for the hearing; and
- attending the hearing, if necessary, to change the zoning.

TRAFFIC AND CRIMINAL MATTERS

Habeas Corpus
This service covers the Participant for the preparation of all paperwork needed, and attendance at the hearing to pursue a habeas corpus proceeding to obtain the release of a Participant who is being unlawfully imprisoned.

Misdemeanor Defense
This service covers representation for Participants in defense of any criminal misdemeanor charge except those relating to traffic or driving under influence charges. Representation includes court hearings, negotiation with the prosecutor and trial. It does not include representation of a felony charge that is subsequently reduced to a misdemeanor. This service also does not cover any post-sentencing proceeding, probation violation hearing or appeals by either party.

Juvenile Court Defense
This service provides representation of a Contractholder and Contractholder's Dependent Child in any juvenile court matter, provided there is no conflict of interest between the Contractholder and Child. In that event, or where the court requires separate counsel for the Child, this service provides an attorney for the Contractholder only, including services for parental responsibility.

Traffic Ticket Defense (No DUI)
This service provides the Covered Person with representation in defense of any traffic ticket including

traffic misdemeanor offenses. However, no service is provided where the ticket was the result of any driving under the influence or related charge or vehicular homicide. This service includes representation for:

- court hearings;
- negotiation with the prosecutor; and
- trial.

Restoration of Driving Privileges
This service covers the Covered Person with representation in proceedings to restore the Covered Person's driver's license.

WILLS AND ESTATE PLANNING

Trusts
This service includes the preparation of revocable or irrevocable living trusts for the Covered Person. It does not include tax planning.

Living Wills
This service covers the preparation of a living will for the Covered Person.

Powers of Attorney
This service includes the preparation of any power of attorney when the Covered Person is granting the power.

Probate Proceedings
This service provides representation for the Plan Member or spouse when the Plan Member or spouse is probating an estate and has been appointed executor or administrator. The service includes all of the court proceedings to transfer probate assets from the decedent to the heirs; the correspondence necessary to transfer non-probate assets such as proceeds from insurance policies, joint bank accounts, stock accounts or a house; and any tax filings. This service does not include prosecuting or defending any litigation including a will contest.

Electronic Estate Documents

This service provides the Participant with access to a digital estate planning platform at an online website. The digital estate planning platform includes facilitation of the selection, completion, and execution of common estate planning documents that include:

- simple wills;
- powers of attorney;
- living wills; and
- other related documents.

Wills and Codicils
This service covers the preparation of simple or complex wills or codicils for the Covered Person. The creation of a testamentary trust is covered. The service does not include tax planning.

Plus Parents Covered Services
This service provides your parents and parents-in-law access to legal help for the issues they face, from estate planning to elder care matters and identity theft issues.

Identity Restoration
This service provides the Participant and their enrolled family members with access to full-service Identity Restoration support provided by Aura's U.S.-based White Glove Fraud Resolution Specialists. Fraud experts will work with Participants to navigate bureaus and financial institutions, make phone calls, and complete forms to quicky quickly restore your identity and secure your assets and information. Aura's experienced agents will take care of the heavy lifting, saving the Participant countless hours of their precious time. Fully Covered

Promissory Notes
This service covers the preparation of any promissory note for which the Participant is the payor or payee.

Deeds
This service covers the preparation of any deed for which the Participant is either the grantor or grantee.

Mortgages
This service covers the preparation of any mortgage or deed of trust for which the Participant is the mortgagor. This service does not include documents pertaining to business, commercial or rental property.

Living Wills
This service covers the preparation of a living will for the Participant.

Powers of Attorney
This service covers the preparation of any power of attorney when the Participant is granting the power.

Wills and Codicils
This service covers the preparation of a simple or complex will for the Participant. The creation of any testamentary trust is covered. The benefit includes the preparation of codicils and will amendments. It does not include tax planning.

Affidavits
This service covers preparation of any affidavit in which the Participant is the person making the statement.

Demand Letters
This service covers the preparation of letters that demand money, property or some other property interest of the Participant, except an interest that is an excluded service. It also covers mailing them to the addressee and forwarding and explaining any response to the Participant. Negotiations and representation in litigation are not included.

Document Review
This service covers the review of any personal legal document of the Participant, such as letters, leases or purchase agreements.

Exclusions

Excluded services are those legal services that are not provided under the plan. No services, not even a consultation, can be provided for the following matters:

- Employment-related matters, including company or statutory benefits
- Matters involving the company, MetLife and affiliates, and Plan Attorneys
- Matters in which there is a conflict of interest between the employee and spouse or dependents in which case services are excluded for the spouse and dependents
- Appeals and class actions
- Farm matters, business or investment matters, matters involving property held for investment or rental, or issues when the Participant is the landlord
- Patent, trademark, and copyright matters
- Costs or fines
- Frivolous or unethical matters
- Matters for which an attorney-client relationship exists prior to the Participant becoming eligible for plan benefits

IF YOU HAVE ANY QUESTIONS, PLEASE VISIT OUR WEBSITE AT WWW.LEGALPLANS.COM

Critical Illness Plan

CONTINENTAL AMERICAN INSURANCE COMPANY

Columbia, South Carolina
800.433.3036

Group Critical Illness Insurance Policy

This limited Plan provides supplemental benefits only. It does not constitute comprehensive health insurance coverage and does not satisfy the requirement of minimum essential coverage under the Affordable Care Act.

This Plan provides benefits for the Critical Illnesses listed in the Policy Schedule.

Please read it carefully.
This policy is not a Medicare supplement policy.

THIS IS NOT A POLICY OF WORKERS' COMPENSATION INSURANCE. THE EMPLOYER DOES NOT BECOME A SUBSCRIBER TO THE WORKERS' COMPENSATION SYSTEM BY PURCHASING THIS POLICY, AND IF THE EMPLOYER IS A NON-SUBSCRIBER, THE EMPLOYER LOSES THOSE BENEFITS WHICH WOULD OTHERWISE ACCRUE UNDER THE WORKERS' COMPENSATION LAWS. THE EMPLOYER MUST COMPLY WITH THE WORKERS' COMPENSATION LAW AS IT PERTAINS TO NON-SUBSCRIBERS AND THE REQUIRED NOTIFICATIONS THAT MUST BE FILED AND POSTED.

The Policyholder as shown on the Policy Schedule applied for coverage under this Group Critical Illness Insurance Policy (the "Plan"). This Plan is issued by Continental American Insurance Company (the "Company," "CAIC," "we," "us," or "our"). Based on the Master Application and the timely payment of premiums, the Company agrees to pay the benefits provided on the following pages. (Please note that male pronouns—such as "he," "him," and "his"—are used for both males and females, unless the context clearly shows otherwise.)

You will notice that certain words and phrases (including some medical terms and the names of Plan documents) in this document are capitalized. The capitalized words refer to terms with very specific definitions as they apply to this insurance Plan.

This Plan is a legal contract between the Company and the Policyholder. All material printed by the Company on the following pages is part of the Plan. This Plan is delivered in and governed by the laws of the jurisdiction shown on the Policy Schedule.

In witness whereof, the Company executes this Plan at its home office in Columbia, South Carolina, on the Effective Date.

Signed for the Company at its Home Office,

Virgil R. Miller, President

J. Matthew Loudermilk, Secretary

Group Critical Illness Insurance
Non-Participating

Continental American Insurance Company (CAIC), a proud member of the Aflac family of insurers, is a wholly-owned subsidiary of Aflac Incorporated and underwrites group coverage.

Section I: Eligibility, Effective Date, and Termination

Eligibility

An Employee is eligible to be covered under this Plan if he is Actively at Work for his employer and included in the class that is eligible for coverage, as shown on the Master Application.

Dependents of an Employee are eligible for coverage under this Plan. A ***Dependent*** is:

- The Spouse of an Employee, **or**
- The Dependent Child of an Employee or an Employee's Spouse (details included in the **Definitions** section).

Grandchildren are eligible for coverage under this Plan. A ***Grandchild*** is the child, under age 26, of you or your Spouse's natural or legally-adopted son or daughter, who is legally dependent upon you for support.

Insured means an Employee or eligible Dependent, if any, who is covered under the Plan in the following categories:

- **Employee Coverage –** We insure the Employee and any Dependent Children.
- **Employee and Spouse Coverage –** We insure the Employee, Spouse, and any Dependent Children.

We will not insure anyone specifically excluded from coverage by Endorsement to the Certificate or by application, even if that person would otherwise be eligible for coverage.

Details for adding Insureds to Plan coverage are outlined in the Effective Date section.

Effective Date

The Plan's Effective Date is shown on the schedule page. This Plan becomes effective on the Policy Effective Date at 12:01 a.m., as determined by the Policyholder's address.

"An eligible Employee must be enrolled in this Plan and the required premiums paid for coverage to become effective. He must be enrolled within 31 days of the date he first becomes eligible for coverage."

We may require evidence of insurability satisfactory to us if the amount of coverage applied for exceeds the guaranteed-issue amount, if any, or if we do not receive the Application within 31 days after the Employee was first eligible for coverage. Evidence of insurability may also be required based on an agreement between the Policyholder and us.

An Employee's Effective Date is the date his insurance takes effect. After we receive and approve the Application, that date is either:

- The date shown on the Certificate Schedule if the Employee is Actively at Work on that date, **or**
- The date the Employee returns to an Actively-at-Work status if he was not Actively at Work on the date shown on the Certificate Schedule.

The Effective Date for a Spouse or Dependent Child is:

- The date shown on the Certificate Schedule if that Spouse or Dependent Child is not confined to a hospital and is eligible for coverage on that date, **or**
- The date the Spouse or Dependent Child is no longer confined to a hospital (if that Spouse or Dependent Child was confined to a hospital on the Certificate Schedule date) and is eligible for coverage on that date.

A Spouse may be added to the Plan after the Employee's Effective Date. To be added, the Employee must

complete an Application to add his Spouse to the Plan. The Company will assign the Effective Date for a Spouse's coverage after approving the application. For Spouse coverage to become effective, the Spouse must be included in the premium payment.

Newborn children will be covered from the moment of birth, adopted children from the date the petition is filed for adoption, and step-children from the date of the Employee's marriage.

A day begins at 12:01 a.m. standard time at the Employee's, Spouse's, or Dependent Child's place of residence.

Plan Termination

The Company has the right to cancel the Plan on any premium due date for the following reasons:

- The premium is not paid before the end of the Grace Period,
- The number of participating Employees is less than the number mutually agreed upon by the Company and the Policyholder in the signed Master Application,
- The Policyholder does not provide timely information or meet any obligations required by this Plan and applicable law, **or**
- The Company cancels the Plan any time after the end of the first policy year. To do this, the Company must give the Policyholder 31 days' written notice.

The Policyholder has the right to cancel the Plan on any premium due date.

- To do this, the Policyholder must give the Company at least 31 days' written notice.
- The Plan will end on the date in the written notice or the date the Company receives the notice, whichever is later.

All outstanding premiums are due upon Plan termination. If the Company accepts premium payments after the Plan terminates, this will not reinstate the Plan; we will refund any excess premium.

The Policyholder has the sole responsibility of notifying Certificateholders in writing of the Plan's termination as soon as reasonably possible. If the Plan terminates, it—and all Certificates and Riders issued under the Plan—will terminate on the specified termination date. The termination occurs as of 12:01 a.m. at the Policyholder's address.

Termination of an Employee's Insurance

An Employee's insurance will terminate on whichever occurs first:

- The date the Company terminates the Plan.
- The 31st day after the premium due date, if the premium has not been paid.
- The date he no longer belongs to an eligible class.

Insurance for a covered Spouse or Dependent Child will terminate on the earliest of any of the bullet points listed above, or:

- The premium due date following the date the covered Spouse or Dependent Child no longer qualifies as a Dependent.
- The premium due date following the date we receive the Employee's written request to terminate coverage for his Spouse or all Dependent Children.

If an Insured's coverage terminates, we will provide benefits for valid claims that arose while his coverage was active.

Continuation Privilege

When an Employee is no longer a member of an eligible class and his coverage would otherwise end, he may elect to continue his coverage under this Plan. The Employee may continue the coverage he had on the date his

Certificate would otherwise terminate, including any in-force Spouse or Dependent Child coverage.

To keep his coverage in force, the Employee must:

- Notify the Company in writing within 31 days after the date his coverage would otherwise terminate, **and**
- Pay the required premium to the Company no later than 31 days after the date his coverage would otherwise terminate and on each premium due date thereafter.

Ported coverage will end on the earliest of the following dates:

- 31 days after the date the Employee fails to pay any required premium; **or**
- The date the Group Plan is terminated.

If an Employee qualifies for this Continuation Privilege, then the Company will apply the same Benefits, Plan Provisions, and Premium Rate as shown in his previously issued Certificate.

Section II: Premium Provisions

Premium Payments

Premiums for this Plan should be paid to the Company at its Home Office in Columbia, South Carolina. The first premiums are due on this Plan's Effective Date. After that, premiums are due on the first day of each month that the Plan remains in effect.

Payment of any premium will not keep the Plan in force beyond the due date of the next premium, except as set forth in the Grace Period provision.

Premium Changes

The Plan's first Anniversary Date appears on the Policy Schedule. Subsequent anniversaries will be the same date each following year.

Unless we have agreed in writing not to increase premiums, the premium may change:

- On the Policy Anniversary Date based on renewal underwriting.
- Whenever the terms or conditions of the Plan are modified. The new premium rates will apply only to premiums due on or after the rate change takes effect.

We will provide the Policyholder a 60-day advance written notice of any change to a premium.

Premiums on the Policy Anniversary Date are determined by the Attained Age of each Employee. The Attained Age rates are shown in the Schedule of Premiums.

Grace Period

This Plan has a 31-day Grace Period. If a premium is not paid on or before its due date, the premium may be paid during the next 31 days. During the Grace Period, the Plan will stay in force, unless the Policyholder has given the Company written notice of its intention to discontinue the Plan. If the Plan is discontinued, the Plan's termination date will be the latest date for which premium has been paid.

Section III: Definitions

When the terms below are used in this Plan, the following definitions apply:

Accident means an event that results in accidental bodily injury to an Insured, independent of disease or bodily infirmity. A ***Covered Accident*** is an Accident that occurs while coverage is in force.

Actively at Work (Active Work) refers to an Employee's ability to perform his regular employment duties for a full normal workday. The Employee may perform these activities either at his employer's regular place of business or at a location where he is required to travel to perform the regular duties of his employment.

Acute Coronary Syndrome is an obstruction of the coronary arteries that occurs as a result of Myocardial Infarction with or without ST elevation. This is determined by an electrocardiogram (ECG). Acute Coronary Syndrome includes unstable angina but does not include stable angina.

Arteriosclerosis means a disease of the arteries characterized by plaque deposits on the arteries' inner walls, resulting in their abnormal thickening and loss of elasticity.

Arteriovenous Malformation means a congenital disease of the blood vessels in the brain, brain stem, or spinal cord that is characterized by a complex, tangled web of abnormal arteries and veins and may be connected by one or more fistulas.

Atherosclerosis means a disease in which plaque builds up inside a person's arteries.

Attained Age means the Employee's age on his Certificate Effective Date and on each Policy Anniversary Date thereafter.

Bone Marrow Transplant (Stem Cell Transplant) means a procedure to replace damaged or destroyed bone marrow with healthy bone marrow stem cells. For a benefit to be payable, a Bone Marrow Transplant (Stem Cell Transplant) must be caused by at least one of the following diseases:

- Aplastic anemia
- Congenital neutropenia
- Severe immunodeficiency syndromes
- Sickle cell anemia
- Thalassemia
- Fanconi anemia
- Leukemia
- Lymphoma
- Multiple myeloma

The Bone Marrow Transplant (Stem Cell Transplant) benefit is not payable if the Transplant results from a covered Critical Illness for which a benefit has been paid under this Plan.

Brain Aneurysm is a weak area in the wall of a blood vessel of the brain that causes the blood vessel to bulge, balloon out, or rupture.

Cancer (internal or invasive) is a disease that meets either of the following definitions:

- A malignant tumor characterized by:
    - The uncontrolled growth and spread of malignant cells, **and**
    - The invasion of distant tissue.
- A disease meeting the diagnostic criteria of malignancy, as established by the American Board of Pathology. A Pathologist must have examined and provided a report on the histocytologic architecture or pattern of the tumor, tissue, or specimen.

Cancer (internal or invasive) also includes:

- Melanoma that is Clark's Level III or higher ***or*** Breslow depth equal to or greater than 0.77mm,

- Myelodysplastic syndrome – RCMD (refractory cytopenia with multilineage dysplasia),
- Myelodysplastic syndrome – RAEB (refractory anemia with excess blasts),
- Myelodysplastic syndrome – RAEB-T (refractory anemia with excess blasts in transformation), **or**
- Myelodysplastic syndrome – CMML (chronic myelomonocytic leukemia).

The following are **not** considered internal or invasive Cancers:

- Pre-malignant tumors or polyps
- Carcinomas in Situ
- Any superficial, non-invasive Skin Cancers including basal cell and squamous cell carcinoma of the skin
- Melanoma in Situ
- Melanoma that is Diagnosed as
    - Clark's Level I or II,
    - Breslow depth less than 0.77mm, **or**
    - Stage 1A melanomas under TNM Staging

Carcinoma in Situ is Non-Invasive Cancer that is in the natural or normal place, confined to the site of origin without having invaded neighboring tissue.

Melanoma in Situ means melanoma cells that occur only on the outer layer of the skin (the epidermis), where there is no invasion of the deeper layer (the dermis).

Non-Invasive Cancer is a Cancer that is in the natural or normal place, confined to the site of origin without having invaded neighboring tissue.

For the purposes of this Plan, a Non-Invasive Cancer is:

- Internal Carcinoma in Situ
- Myelodysplastic Syndrome – RA (refractory anemia)
- Myelodysplastic Syndrome – RARS (refractory anemia with ring sideroblasts) Skin Cancer, as defined in this Plan, is not payable under the Non-Invasive Cancer benefit.

Skin Cancer is a Cancer that forms in the tissues of the skin.

The following are considered Skin Cancers:

- Basal cell carcinoma
- Squamous cell carcinoma of the skin
- Melanoma in Situ
- Melanoma that is Diagnosed as:
    - Clark's Level I or II,
    - Breslow depth less than 0.77mm, **or**
    - Stage 1A melanomas under TNM Staging

These conditions are not payable under the Cancer (internal or invasive) benefit.

Cancer, Non-Invasive Cancer, or Skin Cancer must be Diagnosed in one of two ways:

1. ***Pathological Diagnosis*** is a Diagnosis based on a microscopic study of fixed tissue or preparations from the hemic (blood) system. This Diagnosis must be made by a certified Pathologist and conform to the American Board of Pathology standards.
2. ***Clinical Diagnosis*** is based only on the study of symptoms. The Company will accept a Clinical Diagnosis only if**:**

- A Doctor cannot make a Pathological Diagnosis because it is medically inappropriate or life-threatening,
- Medical evidence exists to support the Diagnosis, **and**
- A Doctor is treating the Insured for Cancer or Carcinoma in Situ.

Cardiomyopathy means a disease with measurable deterioration of the function of the myocardium, and is typically characterized by breathlessness and swelling of the legs.

Chronic Kidney Disease means a disease characterized by the gradual loss in renal function over time due to diabetes mellitus, Hypertension, glomerulonephritis, polycystic kidney disease, autoimmune disease, or genetic disease.

Claimant means a person who is authorized to make a claim under the Certificate.

Coma means a state of continuous, profound unconsciousness, lasting at least seven consecutive days, and characterized by the absence of:

- Spontaneous eye movements,
- Response to painful stimuli, **and**
- Vocalization.

Coma does not include a medically-induced coma.

To be payable as an Accident benefit, the Coma must be caused solely by or be solely attributed to a Covered Accident.

To be considered a Critical Illness, the Coma must be caused solely by or be solely attributed to one of the following diseases:

- **Brain Aneurysm**, which is an excessive, localized enlargement of an artery in the brain caused by a weakening of the artery wall, usually due to a defect in the vessel at birth or resulting from high blood pressure.
- **Diabetes**, which is a metabolic disease characterized by the inadequate secretion or utilization of insulin, by excessive urine production, by excessive amounts of sugar in the blood and urine, and by thirst, hunger, and loss of weight.
- **Encephalitis**, which is a disease characterized by inflammation of the brain, usually caused by a direct viral infection or a hypersensitive reaction to a virus or foreign protein.
- **Epilepsy**, which is a neurological disease characterized by sudden, recurring attacks of motor, sensory, or psychic malfunction with or without loss of consciousness or convulsive seizures.
- **Hyperglycemia**, which is a disease where an excessive amount of glucose circulates in the blood plasma.
- **Hypoglycemia,** which is a disease where blood glucose concentrations fall below the necessary level to support the body's need for energy and stability throughout its cells.
- **Meningitis**, which is a disease caused by viral or bacterial infection and characterized by inflammation of the meninges.

Complete Remission is defined as having no Symptoms and no Signs that can be identified to indicate the presence of Cancer.

Coronary Artery Bypass Surgery means open heart surgery to correct the narrowing or blockage of one or more coronary arteries with bypass grafts and where such narrowing or blockage is attributed to Coronary Artery Disease or Acute Coronary Syndrome. This excludes any non-surgical procedure, such as, but not limited to, balloon angioplasty, laser relief, or stents.

Coronary Artery Disease occurs when the coronary arteries become damaged due to acute coronary occlusion, coronary atherosclerosis, aneurysm and/or dissection of the coronary arteries, or coronary atherosclerosis due to lipid rich plaque.

Critical Illness is a disease or a sickness as defined in the Plan that first manifests while your coverage is in force.

Any loss due to Critical Illness must begin while your coverage is in force. Critical Illness includes only the following, provided such Critical Illness meets all applicable definitions contained in the Plan and, where indicated, is caused by an underlying condition:

- Bone Marrow Transplant (Stem Cell Transplant)
- Cancer
- Coma
- Coronary Artery Bypass Surgery
- Heart Attack (Myocardial Infarction)
- Kidney Failure (End-Stage Renal Failure)
- Loss of Sight, Speech, or Hearing
- Major Organ Transplant
- Non-Invasive Cancer
- Paralysis
- Stroke
- Sudden Cardiac Arrest

Date of Diagnosis is defined as follows:

- ***Bone Marrow Transplant (Stem Cell Transplant):*** The date the surgery occurs.
- ***Cancer:*** The day tissue specimens, blood samples, or titer(s) are taken (Diagnosis of Cancer and/or Carcinoma in Situ is based on such specimens).
- ***Coma*****:** The first day of the period for which a Doctor confirms a Coma that is due to one of the underlying diseases and that has lasted for at least seven consecutive days.
- ***Coronary Artery Bypass Surgery:*** The date the surgery occurs.
- ***Heart Attack (Myocardial Infarction):*** The date the infarction (death) of a portion of the heart muscle occurs. This is based on the criteria listed under the Heart Attack (Myocardial Infarction) definition.
- ***Kidney Failure (End-Stage Renal Failure):*** The date a Doctor recommends that an Insured begin renal dialysis.
- ***Loss of Sight, Speech, or Hearing:*** The date the loss due to one of the underlying diseases is objectively determined by a Doctor to be total and irreversible.
- ***Major Organ Transplant*****:** The date the surgery occurs.
- ***Non-Invasive Cancer:*** The day tissue specimens, blood samples, or titer(s) are taken (Diagnosis of Cancer and/or Carcinoma in Situ is based on such specimens).
- ***Paralysis*****:** The date a Doctor Diagnoses an Insured with Paralysis due to one of the underlying diseases as specified in this Plan, where such Diagnosis is based on clinical and/or laboratory findings as supported by the Insured's medical records.
- ***Skin Cancer:*** The date the skin biopsy samples are taken for microscopic examination.
- ***Stroke*****:** The date the Stroke occurs (based on documented neurological deficits and neuroimaging studies).
- ***Sudden Cardiac Arrest:*** The date the pumping action of the heart fails (based on the Sudden Cardiac Arrest definition).

Dependent means an Employee's Spouse or Dependent Child. ***Spouse*** is an Employee's legal wife or husband who is listed on the Employee's Application. ***Dependent Children*** are an Employee's or an Employee's Spouse's natural children, step-children, Grandchildren, adopted children, or Children Placed for Adoption, who are

younger than age 26.

Children Placed for Adoption are Children for whom you have entered a decree of adoption or for whom you have initiated adoption proceedings. A decree of adoption must be entered within one year from the date proceedings were initiated, unless extended by order of the court. You must continue to have custody pursuant to the decree of the court.

A child is considered to be the child of an Insured if the Insured is a party to a suit in which the Insured seeks to adopt the child.

There is an exception to the age-26 limit listed above. This limit will not apply to any Dependent Child who is incapable of self-sustaining employment due to mental or physical handicap and is dependent on a parent for support and maintenance. The Employee or the Employee's Spouse must furnish proof of this incapacity and dependency to the Company within 31 days following the Dependent Child's 26th birthday.

Diagnosis (***Diagnosed***) refers to the definitive and certain identification of an illness or disease that:

- Is made by a Doctor and
- Is based on clinical or laboratory investigations, as supported by the Insured's medical records.

The illness must meet the requirements outlined in this Plan for the particular Critical Illness being Diagnosed.

Diagnosis must be made and Treatment must be received in the United States or its territories.

Doctor is a person who is:

- Legally qualified to practice medicine,
- Licensed as a Doctor by the state where Treatment is received, **and**
- Licensed to treat the type of condition for which a claim is made.

A Doctor does not include the Insured or any of the Insured's Family Members.

For the purposes of this definition, ***Family Member*** includes the Employee's Spouse as well as the following members of the Employee's immediate family:

- Son
- Daughter
- Mother
- Father
- Sister
- Brother

This includes step-Family Members and Family-Members-in-law.

Employee is a person who meets eligibility requirements under **Section I – Eligibility**, **Effective Date, and Termination** and who is covered under this Plan. The Employee is the primary Insured under this Plan.

Heart Attack (Myocardial Infarction) is the death of a portion of the heart muscle (myocardium) caused by a blockage of one or more coronary arteries due to Coronary Artery Disease or Acute Coronary Syndrome.

Heart Attack (Myocardial Infarction) does not include:

- Any other disease or injury involving the cardiovascular system.
- Cardiac Arrest not caused by a Heart Attack (Myocardial Infarction).

Diagnosis of a Heart Attack (Myocardial Infarction) must include the following:

- New and serial electrocardiographic (ECG) findings consistent with Heart Attack (Myocardial Infarction), and

- Elevation of cardiac enzymes above generally accepted laboratory levels of normal. (In the case of creatine physphokinase (CPK) a CPK-MB measurement must be used.)

Confirmatory imaging studies, such as thallium scans, MUGA scans, or stress echocardiograms may also be used.

Hypertension means a disease that is characterized by elevated blood pressure in the arteries with a systolic reading of at least 140 mmHg and a diastolic reading of at least 90 mmHg.

Kidney Failure (End-Stage Renal Failure) means end-stage renal failure caused by End-Stage Renal Disease, which results in the chronic, irreversible failure of both kidneys to function.

Kidney Failure (End-Stage Renal Failure) is covered only under the following conditions:

- A Doctor advises that regular renal dialysis, hemo-dialysis, or peritoneal dialysis (at least weekly) is necessary to treat the Kidney Failure (End-Stage Renal Failure); **or**
- The Kidney Failure (End-Stage Renal Failure) results in kidney transplantation.

Loss of Sight, Speech, or Hearing

Loss of Sight means the total and irreversible loss of all sight in both eyes.

To be payable as an Accident benefit, Loss of Sight must be caused solely by or be solely attributed to a Covered Accident.

To be considered a Critical Illness, Loss of Sight must be caused solely by or be solely attributed to one of the following diseases:

- **Retinal Disease**, which is a disease that affects the retina of the eye;
- **Optic Nerve Disease**, which is a disease that affects the optic nerve of the eye; **or**
- **Hypoxia**, which is a disease characterized by a deficiency in the amount of oxygen reaching the tissues of the eyes.

Loss of Speech means the total and permanent loss of the ability to speak.

To be payable as an Accident benefit, Loss of Speech must be caused solely by or be solely attributed to a Covered Accident.

To be considered a Critical Illness, Loss of Speech must be caused solely by or be solely attributable to one of the following diseases:

- **Alzheimer's Disease**, which is a progressive mental deterioration due to generalized degeneration of the brain; **or**
- **Arteriovenous Malformation**, which is a congenital disease of blood vessels in the brain, brain stem, **or** spinal cord that is characterized by a complex, tangled web of abnormal arteries and veins connected by one or more fistulas.

Loss of Hearing means the total and irreversible loss of hearing in both ears. Loss of Hearing does not include hearing loss that can be corrected by the use of a hearing aid or device.

To be payable as an Accident benefit, Loss of Hearing must be caused solely by or be solely attributed to a Covered Accident.

To be considered a Critical Illness, Loss of Hearing must be caused solely by or be solely attributed to one of the following diseases:

- **Alport Syndrome**, which is an inherited disease of the kidney caused by a genetic mutation and can be characterized by hearing loss;
- **Autoimmune Inner Ear Disease**, which is an inflammatory condition of the inner ear occurring when the body's immune system attacks cells in the inner ear that are mistaken for bacteria or a virus;
- **Chicken Pox**, which is an acute contagious disease that is caused by the varicella-zoster virus and is characterized by skin eruptions, slight fever, and malaise;
- **Diabetes**, which is a metabolic disease characterized by the inadequate secretion or utilization of insulin, by excessive urine production, by excessive amounts of sugar in the blood and urine, and by thirst, hunger, and loss of weight;
- **Goldenhar Syndrome**, which is rare congenital disease that causes abnormalities in the face and head and can cause hearing loss;
- **Meniere's Disease**, which is a disorder of the inner ear that causes spontaneous episodes of vertigo, hearing loss, ear ringing, and a feeling of fullness or pressure in the ear;
- **Meningitis**, which is a disease characterized by inflammation of the meninges caused by viral or bacterial infection; **or**
- **Mumps**, which is an infectious disease caused by paramyxovirus, and characterized by inflammatory swelling of the parotid and/or other salivary glands.

Maintenance Drug Therapy is a course of systemic medication given to a patient after a Cancer goes into Complete Remission because of primary Treatment. Maintenance Drug Therapy includes ongoing hormonal therapy, immunotherapy, or chemo-prevention therapy. Maintenance Drug Therapy is meant to decrease the risk of Cancer recurrence; it is not meant to treat a Cancer that is still present.

Major Organ Transplant means undergoing surgery as a recipient of a covered transplant of a human heart, lung, liver, kidney, or pancreas. A transplant must be caused by one or more of the following diseases:

- Bronchiectasis, which is a lung disease state defined by localized, irreversible dilation of the bronchial tree caused by destruction of the muscle and elastic tissue.
- Cardiomyopathy, which is a heart disease characterized by the measurable deterioration of the function of the heart muscle, where the heart muscle becomes enlarged, thick, or rigid.
- Cirrhosis, which is a liver disease characterized by replacement of liver tissue by fibrosis, scar tissue, and regenerative nodules, leading to loss of liver function.
- Chronic obstructive pulmonary disease, which is a lung disease characterized by persistently poor airflow as a result of breakdown of lung tissue and dysfunction of the small airways.
- Congenital Heart Disease, which is heart disease characterized by abnormalities in cardiovascular structures that occur before birth.
- Coronary Artery Disease
- Cystic fibrosis, which is a hereditary disease of the exocrine glands affecting the pancreas, respiratory system, and sweat glands. It is characterized by the production of abnormally viscous mucus by the affected glands.
- Hepatitis, which is a disease caused by the hepatitis A, B, or C virus and is characterized by the inflammation of the liver.
- Interstitial lung disease, which is a lung disease that affects the interstitium of the lungs.
- Lymphangioleiomyomatosis, which is a lung disease characterized by an indolent, progressive growth of smooth muscles cells throughout the lungs, pulmonary blood vessels, lymphatics, and pleurae.
- Polycystic liver disease, which is characterized by multiple variable-sized cysts lined by cuboidal epithelium.
- Pulmonary fibrosis, which is a lung disease where the lung tissue becomes thickened, stiff, and scarred due to chronic inflammation.
- Pulmonary hypertension, which is a disease characterized by increased pressure in the pulmonary artery

and results in the thickening of the pulmonary arteries and the narrowing of these blood vessels, which causes the right side of the heart to become enlarged.
- Sarcoidosis, which is a disease characterized by the growth of granulomatous lesions that appear in the body.
- Valvular heart disease, which is a disease of the heart valves.

A Major Organ Transplant benefit is not payable if the Major Organ Transplant results from a covered Critical Illness for which a benefit has been paid.

Malignant Hypertension is blood pressure that is so high that it actually causes damage to organs, particularly in the nervous system, the cardiovascular system, and/or the kidneys. One type of such damage is called papilledema, a condition in which the optic nerve leading to the eye becomes dangerously swollen, threatening vision.

Paralysis *or* ***Paralyzed*** means the permanent, total, and irreversible loss of muscle function to the whole of at least two limbs.

To be payable as an Accident benefit, the Paralysis must be caused solely by or be solely attributed to a Covered Accident.

To be considered a Critical Illness, Paralysis must be caused solely by or be solely attributed to one or more of the following diseases:
- **Amyotrophic Lateral Sclerosis**, which is a progressive degeneration of the motor neurons of the central nervous system, leading to wasting of the muscles and paralysis;
- **Cerebral Palsy**, which is a disorder of movement, muscle tone, or posture that is caused by injury or abnormal development in the immature brain. Cerebral Palsy can be characterized by stiffness and movement difficulties, or by involuntary and uncontrolled movements;
- **Parkinson's disease**, which is a progressive disease of the nervous system marked by tremor, muscular rigidity, and slow, imprecise movement; **or**
- **Poliomyelitis**, which is an acute infectious disease caused by the poliovirus and characterized by fever, motor paralysis, and atrophy of skeletal muscles. This often results in permanent disability and deformity, and is marked by inflammation of nerve cells in the anterior gray matter in each lateral half of the spinal cord.

The Diagnosis of Paralysis must be supported by neurological evidence.

Pathologist is a Doctor who is licensed:
To practice medicine, **and**
- By the American Board of Pathology to practice pathologic anatomy.
- A Pathologist also includes an Osteopathic Pathologist who is certified by the Osteopathic Board of Pathology.

Severe Burn or ***Severely Burned*** means a burn resulting from fire, heat, caustics, electricity, or radiation. The burn must meet all of the following criteria:
- Be a full-thickness or third-degree burn, as determined by a Doctor. A ***Full-Thickness Burn*** or
- ***Third-Degree Burn*** is the destruction of the skin through the entire thickness or depth of the dermis (or possibly into underlying tissues). This results in loss of fluid and sometimes shock.
- Cause cosmetic disfigurement to the body's surface area of at least 35 square inches.
- Be caused solely by or be solely attributed to a Covered Accident.

Signs and/or Symptoms are the evidence of disease or physical disturbance observed by a Doctor or other medical professional. The Doctor (or other medical professional) must observe these Signs while acting within the scope of his license.

Stroke means apoplexy due to rupture or acute occlusion of a cerebral artery. The apoplexy must cause complete or partial loss of function involving the motion or sensation of a part of the body and must last more than 24 hours. Stroke must be either:

- ***Ischemic***: Due to advanced Arteriosclerosis or Arteriosclerosis of the arteries of the neck or brain, or vascular embolism, **or**
- ***Hemorrhagic***: Due to uncontrolled Hypertension, Malignant Hypertension, Brain Aneurysm, or Arteriovenous Malformation.

The Stroke must be positively Diagnosed by a Doctor based upon documented neurological deficits and confirmatory neuroimaging studies.

Stroke does not include:

- Transient Ischemic Attacks (TIAs)
- Head injury
- Chronic cerebrovascular insufficiency
- Reversible ischemic neurological deficits unless brain tissue damage is confirmed by neurological imaging

Stroke will be covered only if the Insured submits evidence of the neurological damage by providing:

- Computed Axial Tomography (CAT scan) images, **or**
- Magnetic Resonance Imaging (MRI).

Sudden Cardiac Arrest is the sudden, unexpected loss of heart function in which the heart, abruptly and without warning, stops working as a result of an internal electrical system heart malfunction due to Coronary Artery Disease, Cardiomyopathy, or Hypertension.

Sudden Cardiac Arrest is not a Heart Attack (Myocardial Infarction). A Sudden Cardiac Arrest benefit is not payable if the Sudden Cardiac Arrest is caused by or contributed to by a Heart Attack (Myocardial Infarction).

Treatment or ***Medical Treatment*** is the consultation, care, or services provided by a Doctor. This includes receiving any diagnostic measures and taking prescribed drugs and medicines.

Treatment-Free From Cancer refers to the period of time without the consultation, care, or services provided by a Doctor. This includes receiving diagnostic measures and taking prescribed drugs and medicines. Treatment does not include Maintenance Drug Therapy or routine follow-up visits to verify whether Cancer or Carcinoma in Situ has returned.

Section IV: Benefit Provisions

The benefit amounts payable under this section are shown in the Policy Schedule. The Company will pay benefits for a Critical Illness in the order the events occur.

Critical Illness Benefit

Initial Diagnosis

We will pay the Critical Illness benefit when an Insured is Diagnosed with one of the Critical Illnesses shown in the Certificate Schedule, and when such Diagnosis is caused by or solely attributed to an underlying disease as

identified herein. We will pay this benefit if:

- The Date of Diagnosis is while his coverage is in force, **and**
- The Certificate does not exclude the illness or condition by name or by specific description.

If an Initial Diagnosis claim is for a Diagnosis of Cancer, the Insured:

- Must be Treatment-Free From Cancer for at least 12 months before the Diagnosis Date; **and**
- Must be in Complete Remission prior to the date of a subsequent Diagnosis as evidenced by the absence of all clinical, radiological, biological, and biochemical proof of the presence of the Cancer.

Benefits will be based on the Face Amount in effect on the Critical Illness Date of Diagnosis.

Additional Diagnosis

Once benefits have been paid for a Critical Illness, the Company will pay benefits for each different Critical Illness when:

- The new Critical Illness is not caused or contributed to by a Critical Illness for which benefits have been paid.

If an Additional Diagnosis claim is for a Diagnosis of Cancer, the Insured:

- Must be Treatment-Free From Cancer for at least 12 months before the Diagnosis Date; **and**
- Must be in Complete Remission prior to the date of a subsequent Diagnosis as evidenced by the absence of all clinical, radiological, biological, and biochemical proof of the presence of the Cancer.

Reoccurrence

Once benefits have been paid for a Critical Illness, benefits are payable for that same Critical Illness when:

- The Date of Diagnosis for the Reoccurrence of that Critical Illness is separated from the prior occurrence of that Critical Illness by at least 6 consecutive months, **and**
- The Critical Illness is not caused or contributed to by a Critical Illness for which benefits have been paid.

If a Reoccurrence claim is for a Diagnosis of Cancer, the Insured:

- Must be Treatment-Free From Cancer for at least 12 months before the Diagnosis Date; **and**
- Must be in Complete Remission prior to the date of a subsequent Diagnosis as evidenced by the absence of all clinical, radiological, biological, and biochemical proof of the presence of the Cancer.

Partial Benefits

Partial Benefits are payable if the Date of Diagnosis is while the Insured's coverage is in force, and the Certificate does not exclude the illness or condition by name or by specific description.

Non-Invasive Cancer

We will pay the amount shown in the Policy Schedule for the Diagnosis of a Non-Invasive Cancer. This benefit is payable in addition to all other applicable benefits.

Coronary Artery Bypass Surgery

We will pay the amount shown in the Policy Schedule for Coronary Artery Bypass Surgery. This benefit is payable in addition to all other applicable benefits.

Additional Benefits

Additional Benefits are payable if the Date of Diagnosis is while the Insured's coverage is in force, and the Certificate does not exclude the illness or condition by name or by specific description.

Skin Cancer Benefit

We will pay the amount shown in the Policy Schedule for the Diagnosis of Skin Cancer. This benefit is payable once per calendar year.

Health Screening Benefit

We will pay the amount shown in the Policy Schedule for Health Screening Tests performed while an Insured's coverage is in force. This benefit is payable once per calendar year, per Insured. Benefits are not payable for Covered Dependent Children.

This benefit is only payable for Health Screening Tests performed as the result of preventive care, including tests and diagnostic procedures ordered in connection with routine examinations.

Health Screening Tests include, but are not limited to, the following:

- Blood test for triglycerides
- Bone marrow testing
- Breast ultrasound
- CA 15-3 (blood test for breast cancer)
- CA 125 (blood test for ovarian cancer)
- CEA (blood test for colon cancer)
- Chest X-ray
- Colonoscopy
- DNA stool analysis
- Fasting blood glucose test
- Flexible sigmoidoscopy
- Hemocult stool analysis
- Mammography
- Pap smear
- PSA (blood test for prostate cancer)
- Serum cholesterol test to determine level of HDL and LDL
- Serum protein electrophoresis (blood test for myeloma)
- Spiral CT screening for lung cancer
- Stress test on a bicycle or treadmill
- Thermography

Accident Benefit

We will pay the amount shown in the Benefit Schedule if an Insured sustains a Covered Accident and suffers any of the following, which is solely due to, caused by, and attributed to, the Covered Accident:

- Coma
- Loss of Sight, Speech, or Hearing
- Severe Burn
- Paralysis.

Waiver of Premium Benefit

If an Employee becomes Totally Disabled as defined in this Plan due to a covered Critical Illness, we will waive premiums for the Employee and any currently covered Dependents (this includes any Riders that are in force).

Total Disability or ***Totally Disabled*** means the Employee is:

- Not working at any job for pay or benefits,
- Under the care of a Doctor for the Treatment of a covered Critical Illness, and
- ***Unable to Work***, which means either:
    - During the first 365 days of Total Disability, the Employee is unable to work at the occupation he was performing when his Total Disability began; **or**
    - After the first 365 days of Total Disability, the Employee is unable to work at any gainful occupation for which he is suited by education, training, or experience.

After 90 days of Total Disability, all Plan premiums will be waived if:

- The Employee's Total Disability began before the age of 65;
- The Employee's Total Disability has continued without interruption for at least 90 days, during which time the Employee and/or the Policyholder have paid premiums; **and**
- The Employee provides proof of Total Disability as required by us. Satisfactory Proof of Loss for Total

Disability must be provided at least once every 12 months.

Pending our approval of a claim for the Waiver of Premium Benefit, premiums should be paid as they are due. Premiums that were paid for the first 90 days of Total Disability will be refunded after the claim for this benefit is approved.

Waiver of Premium will continue until the earliest of the following:

- The premium due date following the Employee's 65th birthday,
- The date the Company has waived premiums for a total of 24 months of Total Disability,
- The date the Employee refuses to provide proof of continuing Total Disability,
- The date the Employee's Total Disability ends, **or**
- The date coverage ends according to the Termination provisions in **Section I – Eligibility, Effective Date, and Termination.**

If the Employee is still eligible for coverage when he returns to Active Work, coverage for any Insured may be continued if premium payments are resumed.

Section V: Limitations and Exclusions

Cancer Diagnosis Limitation

Benefits are payable for Cancer and/or Non-Invasive Cancer as long as the Insured:

- Is Treatment-Free From Cancer for at least 12 months before the Diagnosis Date; **and**
- Is in Complete Remission prior to the date of a subsequent Diagnosis, as evidenced by the absence of all clinical, radiological, biological, and biochemical proof of the presence of the Cancer.

Exclusions

We will not pay for loss due to any of the following:

- **Self-Inflicted Injuries –** injuring or attempting to injure oneself intentionally or taking action that causes oneself to become injured
- **Suicide –** committing or attempting to commit suicide, while sane or insane
- **Illegal Acts –** participating or attempting to participate in an illegal activity, or working at an illegal job
- **Participation in Aggressive Conflict** of any kind, including:
  - War (declared or undeclared) or military conflicts
  - Insurrection or riot
  - Civil commotion or civil state of belligerence
- **Illegal substance abuse, which includes the following:**
  - Abuse of legally-obtained prescription medication
  - Illegal use of non-prescription drugs

Section VI: Claim Provisions

Notice of Claim

Written notice of claim must be given to us:

- Not later than the 20th day after the Date of Diagnosis, **or**
- As soon as reasonably possible.

When we receive written Notice of Claim, we will send a claim form. If the Claimant does not receive the claim

form within 15 days after the notice is sent, written Proof of Loss can be sent to us without waiting for the form. Notice must include the Employee's name and the Certificate number. Notice can be mailed to the Company at:

P.O. Box 427, Columbia, South Carolina, 29202

Proof of Loss

Proof of Loss refers to documentation that supports a claim. (This information is often found in standardized medical documents, such as hospital bills and operative reports. It includes a statement by the treating Doctor.) Proof of Loss establishes the nature and extent of the loss, the Company's obligation to pay the claim, and the Claimant's right to receive payment.

The Claimant must provide Proof of Loss to the Company at:

P.O. Box 427, Columbia, South Carolina, 29202

Proof of Loss must be given to us within 90 days of the Date of Diagnosis. Failure to give Proof of Loss within such time shall not invalidate or reduce any claim if such Proof of Loss is given as soon as reasonably possible. The Company will not accept Proof of Loss any later than one year and three months after the Date of Diagnosis, except in the absence of the Employee's legal mental capacity.

The Claimant will be responsible for the cost of obtaining a completed claim form. We may request additional Proof of Loss, such as records from hospitals or Doctors. We will be responsible for the cost of obtaining these records.

We may require authorizations to obtain medical and psychiatric information as well as non-medical information, including personal financial information.

When we receive the claim and due Proof of Loss, we will review the Proof of Loss. If we approve the claim, we will pay the benefits subject to the terms of the Certificate.

Physical Examination and Autopsy

The Company may have an Insured examined as often as reasonably necessary while a claim is pending. In the case of death, the Company may also require an autopsy, unless prohibited by law. The Company will cover all costs for exams or autopsy.

Prompt Payment of Benefits

For benefits other than for loss of time, the Company will, once we receive the required Proof of Loss, pay, deny, or settle each submitted claim not later than the 60th day after the date proof of loss is received. Subject to written Proof of Loss, all accrued benefits payable under the policy for loss of time will be paid at least monthly during the period for which the insurer is liable. Any balance remaining unpaid at the end of that time will be paid as soon as possible after the proof of loss is received.

Payment of Claims

We will pay all benefits to the Employee unless otherwise assigned. For any benefits that remain unpaid at the time of death, we will pay those benefits in the following order:

1. To the beneficiary designated by the Insured or the beneficiary's assignee;
2. To the Insured's surviving Spouse;
3. To the Insured's estate.

Unpaid Premium

When a claim is paid, we may deduct any premium due and unpaid from the claim payment.

Changing of Beneficiary

A change in beneficiary must be submitted in writing to our Home Office and signed by the Employee. Unless otherwise specified by the Employee, a change in beneficiary will take effect on the date the notice of change is signed. We will not be liable for any action taken before notice is received and recorded at the Home Office.

Claim Review

If a claim is denied, the Employee will be given written notice of:

- The reason for the denial,
- The Plan provision that supports the denial, **and**
- His right to ask for a review of the claim.

Appeals Procedure

Before filing any lawsuit—and no later than 60 days after notice of denial of a claim—the Employee, the Claimant, or an authorized representative of either must appeal any denial of benefits under the Plan by sending a written request for review of the denial to our Home Office.

Legal Action

The Employee cannot take legal action against us for benefits under this Plan:

- Within 60 days after he has sent us written Proof of Loss, **or**
- More than three years from the time written proof is required to be given.

Section VII: General Provisions

Entire Contract Changes

The *Entire Contract of Insurance* is made up of:

- This Policy
- The Master Application
- Certificates
- Endorsements
- Benefit agreements **and**
- Riders (if any).

In the absence of fraud, a statement made by the Policyholder or an Insured is considered a representation and not a warranty. A statement made by the Policyholder or an Insured may not be used in any contest under the Plan, unless a copy of the written instrument containing the statement is or has been provided to:

- The person making the statement; **or**
- If the statement was made by the Insured and the Insured has died or become incapacitated, the Insured's beneficiary or personal representative.

Changes to this Plan:

- Will not be valid unless approved in writing by an executive officer of the Company.
- Must be noted on or attached to the Contract.
- May not be made by any agent (nor can an agent waive any Plan provisions).

Misstatement of Age

If an age has been misstated on the Application, the benefits will be those that the paid premium would have purchased at the correct age.

Successor Insured

If an Employee dies while covered under his Certificate and his Spouse is also insured under this Plan at this time of his death, then his surviving Spouse may elect to become the primary Insured at the current Spouse Face Amount. This would include continuation of any Dependent Child coverage that is in force at that time.

To become the primary Insured and keep coverage in force, the surviving Spouse must:

- Notify the Company in writing within 31 days after the date of the Employee's death; **and**
- Pay the required premium to the Company no later than 31 days after the date of the Employee's death, and on each premium due date thereafter.

If the Certificate does not cover a surviving Spouse, the Certificate will terminate on the next premium due date following the Employee's death.

Time Limit on Certain Defenses

After two years from the Employee's Effective Date of coverage, the Company may not void coverage or deny a claim for any loss because of misstatements made on the Employee's Application. This does not apply to fraudulent misstatements.

Clerical Error

Clerical error by the Policyholder will not end coverage or continue terminated coverage. In the event of a clerical error, the Company will make a premium adjustment.

Individual Certificates

The Company will give the Policyholder a Certificate for each Employee. The Certificate will set forth:

- The coverage,
- To whom benefits will be paid, **and**
- The rights and privileges under the Plan.

Required Information

The Policyholder will be responsible for furnishing all information and proofs that the Company may reasonably require with regard to the Plan.

Conformity with State Statutes

This Plan was issued on its Effective Date in the state noted on the Master Application. Any Plan provision that conflicts with that state's statutes is amended to conform to the minimum requirements of those statutes.

Section VIII: Incorporation Of Rider Provisions

The attached listed Certificate Riders are made a part of this Plan.

Rider Name	Form Number
Continuation of Coverage Endorsement	C00704TX
Optional Benefits Rider	C21301TX
Childhood Conditions Rider	C21302
Progressive Diseases Rider	C21303TX

Specified Disease Rider	C21306TX
Cancer Survivor Benefit Rider	C21313

Policy Schedule

Policyholder:	T Mobile USA
Jurisdiction:	Texas
Policy Number:	0003254505
Policy Effective Date:	January 1, 2025
Policy Anniversary Date:	January 1, 2026
Face	
Amount:	See Certificates
Spouse Amount:	See Certificates
Covered Dependent Children:	100% of applicable Face Amount
Partial Benefits Percentage:	25% of applicable Face Amount
Additional Benefits:	
Health Screening Benefit Amount:	$75 per Insured per calendar year
Skin Cancer:	$250
Skin Cancer for Covered Dependent Children:	50% of Skin Cancer Benefit Amount
Accident Benefits:	100% of applicable Face Amount
Waiver of Premium:	Yes

This Plan is delivered in and governed by the laws of the jurisdiction shown above.

This Plan is age-banded. That means Employees' rates may increase on the Policy Anniversary Date. Premiums at the Policy Anniversary Date are determined by the Employee's Attained Age rate, as shown in the Policy Schedule of Premiums.

Benefit Schedule

Critical Illness Benefits

The applicable benefit amount (Face Amount) is payable for the following Critical Illnesses, provided such Critical Illness meets all applicable definitions contained in the Plan and is caused by an underlying disease as set forth herein:

- Bone Marrow Transplant (Stem Cell Transplant)
- Cancer
- Heart Attack (Myocardial Infarction)
- Kidney Failure (End-Stage Renal Failure)
- Major Organ Transplant
- Stroke
- Sudden Cardiac Arrest

Partial Benefits

Non-Invasive Cancer
Coronary Artery Bypass Surgery

Additional Benefits

Health Screening Benefit Skin Cancer
Waiver of Premium
Accident Benefits
Coma
Loss of Sight, Speech, or Hearing
Severe Burn
Paralysis

Classifications and Schedule of Premiums

Rates Table For:
T MOBILE USA (TX)
Group Critical Illness 21000 GP-48675
PLAN-323464

Deduction Frequency : Weekly (52pp / yr)

Employee - Uni-Tobacco

	$5,000	**$10,000**	**$15,000**	**$20,000**	**$25,000**	**$30,000**	**$35,000**	**$40,000**
18-24	$0.44	$0.57	$0.71	$0.84	$0.98	$1.12	$1.25	$1.39
25-29	$0.45	$0.60	$0.75	$0.90	$1.05	$1.20	$1.35	$1.50
30-34	$0.54	$0.78	$1.02	$1.26	$1.50	$1.74	$1.98	$2.22
35-39	$0.71	$1.13	$1.54	$1.95	$2.37	$2.78	$3.19	$3.60
40-44	$1.02	$1.74	$2.47	$3.19	$3.91	$4.63	$5.36	$6.08
45-49	$1.57	$2.85	$4.12	$5.40	$6.67	$7.94	$9.22	$10.49
50-54	$2.36	$4.42	$6.48	$8.53	$10.59	$12.65	$14.71	$16.77
55-59	$3.52	$6.75	$9.97	$13.20	$16.42	$19.64	$22.87	$26.09
60-64	$5.22	$10.14	$15.06	$19.98	$24.90	$29.82	$34.74	$39.66

65-69	$7.79	$15.29	$22.78	$30.27	$37.77	$45.26	$52.75	$60.24
70+	$11.14	$21.98	$32.82	$43.66	$54.50	$65.34	$76.17	$87.01

Spouse - Uni-Tobacco

	$5,000	**$10,000**	**$15,000**	**$20,000**	**$25,000**	**$30,000**	**$35,000**	**$40,000**
18-24	$0.44	$0.57	$0.71	$0.84	$0.98	$1.12	$1.25	$1.39
25-29	$0.45	$0.60	$0.75	$0.90	$1.05	$1.20	$1.35	$1.50
30-34	$0.54	$0.78	$1.02	$1.26	$1.50	$1.74	$1.98	$2.22
35-39	$0.71	$1.13	$1.54	$1.95	$2.37	$2.78	$3.19	$3.60
40-44	$1.02	$1.74	$2.47	$3.19	$3.91	$4.63	$5.36	$6.08
45-49	$1.57	$2.85	$4.12	$5.40	$6.67	$7.94	$9.22	$10.49
50-54	$2.36	$4.42	$6.48	$8.53	$10.59	$12.65	$14.71	$16.77
55-59	$3.52	$6.75	$9.97	$13.20	$16.42	$19.64	$22.87	$26.09
60-64	$5.22	$10.14	$15.06	$19.98	$24.90	$29.82	$34.74	$39.66
65-69	$7.79	$15.29	$22.78	$30.27	$37.77	$45.26	$52.75	$60.24
70+	$11.14	$21.98	$32.82	$43.66	$54.50	$65.34	$76.17	$87.01

CONTINENTAL AMERICAN INSURANCE COMPANY

Columbia, South Carolina
800.433.3036

Amendment
to Policy and Certificate of Insurance for Group Critical Illness

This Amendment alters the Policy and the Certificate to which it is attached. Unless specifically addressed by this Amendment, all other Policy and Certificate provisions, definitions, and other terms apply.

Effective Date

This Amendment becomes effective on the Effective Date of the form to which it is attached.

The Plan Termination provision is deleted and replaced with the following:

Plan Termination

The Company has the right to cancel the Plan on any premium due date for the following reasons:

- The premium is not paid before the end of the Grace Period,
- The number of participating Employees is less than the number mutually agreed upon by the Company and the Policyholder in the signed Master Application,
- The Policyholder does not provide timely information or meet any obligations required by this Plan and applicable law, or
- The Company cancels the Plan any time after the end of the first policy year. To do this, the Company must give the Policyholder 31 days' written notice.

The Policyholder has the right to cancel the Plan on any premium due date.

- To do this, the Policyholder must give the Company at least 31 days' written notice.
- The Plan will end on the date in the written notice or the date the Company receives the notice, whichever is later.

All outstanding premiums are due upon Plan termination. If the Company receives premium payments after the Plan terminates, this will not reinstate the Plan.

The Policyholder has the sole responsibility of notifying Certificateholders in writing of the Plan's termination as soon as reasonably possible. If the Plan terminates, it—and all Certificates and Riders issued under the Plan—will terminate on the specified termination date. The termination occurs as of 12:01 a.m. at the Policyholder's address.

The Continuation Privilege provision is deleted and replaced with the following:

Continuation Privilege

When you are no longer a member of an eligible class and your coverage would otherwise end, you may elect to continue your coverage under this Plan. You may continue the coverage you had on the date your Certificate would otherwise terminate, including any in-force Spouse or Dependent Child coverage, without any additional underwriting requirements.

To keep your coverage in force, you must:

- Notify the Company in writing within 31 days after the date your coverage would otherwise terminate. You may notify us by sending written notice to P.O. Box 84078, Columbus, Georgia 31993-9102 or by calling the Customer Service number at 800.433.3036, and
- Pay the required premium directly to the Company no later than 31 days after the date your coverage would otherwise terminate and on each premium due date thereafter.

Continued coverage will end on the earliest of the following dates:

- 31 days after the premium due date (the last day of the Grace Period), if the premium has not been paid, or
- The date the Group Plan is terminated.

If you qualify for this Continuation Privilege, then the Company will apply the same Benefits, Premium Rate, and Plan Provisions as shown in your previously-issued Certificate. Notification of any changes in the Plan will be provided directly by the Company.

The Additional Diagnosis provision is deleted and replaced with the following:

Additional Diagnosis

Once benefits have been paid for a Critical Illness, the Company will pay benefits for each different Critical Illness when the new Critical Illness is not caused or contributed to by a Critical Illness for which benefits have been paid.

If an Additional Diagnosis claim is for a Diagnosis of Cancer, the Insured:

- Must be Treatment-Free From Cancer for at least 12 months before the Diagnosis Date; and
- Must be in Complete Remission prior to the date of a subsequent Diagnosis as evidenced by the absence of all clinical, radiological, biological, and biochemical proof of the presence of the Cancer.

The Reoccurrence provision is deleted and replaced with the following:

Reoccurrence

Once benefits have been paid for a Critical Illness, benefits are payable for that same Critical Illness when the Date of Diagnosis for the Reoccurrence of that Critical Illness is separated from the prior occurrence of that Critical Illness by at least six consecutive months.

If a Reoccurrence claim is for a Diagnosis of Cancer, the Insured:

- Must be Treatment-Free From Cancer for at least 12 months before the Diagnosis Date; and
- Must be in Complete Remission prior to the date of a subsequent Diagnosis as evidenced by the absence of all clinical, radiological, biological, and biochemical proof of the presence of the Cancer.

The Health Screening Benefit is deleted and replaced with the following:

Health Screening Benefit

We will pay the amount shown in the Policy Schedule for Health Screening Tests performed while an Insured's coverage is in force. This benefit is payable once per calendar year, per Insured. Benefits are not payable for Covered Dependent Children.

This benefit is only payable for Health Screening Tests performed as the result of preventive care, including tests

and diagnostic procedures ordered in connection with routine examinations.

Health Screening Tests include, but are not limited to, the following:

- Blood test for triglycerides.
- Bone marrow testing.
- Breast ultrasound.
- CA 15-3 (blood test for breast cancer).
- CA 125 (blood test for ovarian cancer).
- CEA (blood test for colon cancer).
- Chest X-ray.
- Colonoscopy.
- DNA stool analysis.
- Fasting blood glucose test.
- Flexible sigmoidoscopy.
- Hemoccult stool analysis.
- Mammography.
- Pap smear.
- PSA (blood test for prostate cancer).
- Serum cholesterol test to determine level of HDL and LDL.
- Serum protein electrophoresis (blood test for myeloma).
- Spiral CT screening for lung cancer.
- Stress test on a bicycle or treadmill.
- Thermography.
- HIV test performed via nucleic acid test (NAT).
- HPV test performed via Pap smear.

The Proof of Loss provision is deleted and replaced with the following:

Proof of Loss

Proof of Loss refers to documentation that supports a claim. (This information is often found in standardized medical documents, such as hospital bills and operative reports. It includes a statement by the treating Doctor.) Proof of Loss establishes the nature and extent of the loss, the Company's obligation to pay the claim, and the Claimant's right to receive payment.

The Claimant must provide Proof of Loss to the Company at:

P.O. Box 427, Columbia, South Carolina, 29202.

Proof of Loss must be given to us within 90 days of the Date of Diagnosis. Failure to give Proof of Loss within such time shall not invalidate or reduce any claim if such Proof of Loss is given as soon as reasonably possible. The Company will not accept Proof of Loss any later than one year and three months after the Date of Diagnosis, except in the absence of the Claimant's legal mental capacity.

The Claimant will be responsible for the cost of obtaining a completed claim form. We may request additional Proof of Loss, such as records from hospitals or Doctors. The Claimant will be responsible for the cost of obtaining these records.

We may require authorizations to obtain medical and psychiatric information as well as non-medical information, including personal financial information.

When we receive the claim and due Proof of Loss, we will review the Proof of Loss. If we approve the claim, we will pay the benefits subject to the terms of the Certificate.

The Individual Certificates provision is deleted and replaced with the following:

The Company will make available to the Policyholder a Certificate for Employees. The Certificate will set forth:

- The coverage,
- To whom benefits will be paid, and
- The rights and privileges under the Plan.

General Provisions

This Amendment is part of the Policy and Certificate and will terminate when that Policy or Certificate terminates, or when premiums are no longer paid for this Amendment.

This Amendment is subject to all of the terms of the Group Critical Illness Policy and Certificate to which it is attached unless any such items are inconsistent with the terms of this Amendment.

Signed for the Company at its Home Office,

Virgil R. Miller, President

J. Matthew Loudermilk, Secretary

CONTINENTAL AMERICAN INSURANCE COMPANY

Columbia, South Carolina
800.433.3036

Please call the toll-free number above with any questions about this coverage.

Amendment to Policy and Certificate of Insurance for Group Critical Illness

This Amendment is subject to all of the provisions of the Policy and Certificate to which it is attached. Additions or changes have been made to the Policy and Certificate and are indicated below.

EFFECTIVE DATE
If issued at the same time as the Certificate, this Amendment becomes effective at the same time as the Certificate. If issued after the Certificate, this Amendment will have a later Effective Date.

The definition of Dependent is deleted and replaced with the following:
Dependent means your Spouse or your Dependent Child. ***Spouse*** is your legal wife or husband, including a legally-recognized same-sex Spouse, or a person of either gender who is in a legally recognized and registered domestic partnership, civil union, reciprocal beneficiary relationship, or similar relationship with you, who is listed on your Application. ***Dependent Children*** are your or your Spouse's natural children, step-children, foster children, children subject to legal guardianship, adopted children, or Children Placed for Adoption, who are younger than age 26. However, we will continue coverage for Dependent Children insured under the Plan after the age of 26 if they are incapable of self-sustaining employment due to mental or physical disability, and are chiefly dependent on a parent for support and maintenance. You or your Spouse must furnish proof of this incapacity and dependency to the Company within 31 days following the Dependent Child's 26th birthday.

The insurance on any Dependent Child will terminate on the last day of the month in which the Dependent Child turns age 26; it is your responsibility to notify us in writing when coverage on a Dependent Child terminates. Termination will be without prejudice to any claim originating prior to the date of termination. Our acceptance of any applicable premium after such date will be considered as premium for only the remaining persons who qualify as Insureds under this Plan. When coverage on all Dependent Children terminates, you must notify the Company, in writing, and elect whether to continue this Plan on an Employee or Employee and Spouse Coverage basis. After such notice, we will arrange for the payment of the appropriate premium due, including returning any unearned premium, if applicable.

Children Placed for Adoption are Children for whom you have entered a decree of adoption, have initiated adoption proceedings, or are a party to a suit in which you seek to adopt the child. A decree of adoption must be entered within one year from the date proceedings were initiated, unless extended by order of the court. You must continue to have custody pursuant to the decree of the court.

The definition of Major Organ Transplant is deleted and replaced with the following:
Major Organ Transplant means undergoing surgery as a recipient of a covered transplant of a human heart, lung, liver, kidney, or pancreas. A transplant must be caused by one or more of the following diseases:

- Bronchiectasis, which is a lung disease state defined by localized, irreversible dilation of the bronchial tree caused by destruction of the muscle and elastic tissue.
- Cardiomyopathy, which is a heart disease characterized by the measurable deterioration of the function of the heart muscle, where the heart muscle becomes enlarged, thick, or rigid.

- Cirrhosis, which is a liver disease characterized by replacement of liver tissue by fibrosis, scar tissue, and regenerative nodules, leading to loss of liver function.
- Chronic obstructive pulmonary disease, which is a lung disease characterized by persistently poor airflow as a result of breakdown of lung tissue and dysfunction of the small airways.
- Congenital Heart Disease, which is heart disease characterized by abnormalities in cardiovascular structures that occur before birth.
- Coronary Artery Disease
- Cystic fibrosis, which is a hereditary disease of the exocrine glands affecting the pancreas, respiratory system, and sweat glands. It is characterized by the production of abnormally viscous mucus by the affected glands.
- Hepatitis, which is a disease caused by the hepatitis A, B, or C virus and is characterized by the inflammation of the liver.
- Interstitial lung disease, which is a lung disease that affects the interstitium of the lungs.
- Lymphangioleiomyomatosis, which is a lung disease characterized by an indolent, progressive growth of smooth muscles cells throughout the lungs, pulmonary blood vessels, lymphatics, and pleurae.
- Polycystic liver disease, which is characterized by multiple variable-sized cysts lined by cuboidal epithelium.
- Pulmonary fibrosis, which is a lung disease where the lung tissue becomes thickened, stiff, and scarred due to chronic inflammation.
- Pulmonary hypertension, which is a disease characterized by increased pressure in the pulmonary artery and results in the thickening of the pulmonary arteries and the narrowing of these blood vessels, which causes the right side of the heart to become enlarged.
- Sarcoidosis, which is a disease characterized by the growth of granulomatous lesions that appear in the body.
- Valvular heart disease, which is a disease of the heart valves.

If, while the certificate in force, the Insured is placed on a transplant list for a Major Organ Transplant due to one of the above-identified diseases, we will pay 25% of the Critical Illness benefit. The remainder of the Critical Illness benefit will become payable on the date the surgery occurs. A Major Organ Transplant benefit is not payable if the Major Organ Transplant results from a covered Critical Illness for which a benefit has been paid.

CONTRACT

This Amendment is part of the Policy and Certificate and will terminate when the Policy or Certificate terminates.

Signed for the Company at its Home Office,

Virgil R. Miller, President

J. Matthew Loudermilk, Secretary

CONTINENTAL AMERICAN INSURANCE COMPANY

Columbia, South Carolina
800.433.3036

Please call the toll-free number above with any questions about this coverage.

Continuation of Coverage Endorsement

This Endorsement is part of the Policy and Certificate to which it is attached. This Endorsement is subject to all the definitions, terms, and other provisions of the Policy and Certificate to which it is attached, unless those terms are inconsistent with this Endorsement.

EFFECTIVE DATE
If issued at the same time as the Certificate, this Endorsement becomes effective when the Certificate becomes effective. If issued after the Certificate, this Endorsement will have a later Effective Date.

The following provisions are added after the Continuation Privilege provision in your Certificate:
CONTINUATION OF COVERAGE
If the Group Policy is terminated by the Policyholder and is not replaced with another group policy you may apply to continue the coverage you had on the Group Policy termination date. This includes any in-force Spouse or Dependent Child coverage. The Group Policy will be continued as if the Group Policy is in force for those who have applied to continue their coverage under this provision. The members will continue to have coverage, with their Certificates remaining in force.

The Company will apply the same benefits and plan provisions as shown in your Certificate on the date you are eligible to continue coverage under this provision. Your continued coverage is subject to all of the provisions, exclusions and limitations of the Group Policy.

To keep your Certificate in force, you must:

- Apply to the Company in writing under this Continuation of Coverage provision within 31 days after the date your Certificate would terminate, **and**
- Pay the required premium no later than 31 days after the date the Certificate would terminate and on each premium due date thereafter to the Company at our Customer Service Center in Columbus, Georgia.

PREMIUMS
Initial premium rates will be based on the rates in effect at the time you apply to continue your coverage. Premium rates can be changed by the Company at any time upon 60 days written notice to you. Any such change will be applied to all Certificates in your class and will not be based on your or your Spouse and Dependent Children's health or other individual factors.

You may decrease, but not increase, the amount of your coverage, and the amount of your Spouse's coverage, if any.

TERMINATION
Your continued coverage, including any in-force Spouse or Dependent Child coverage, will end:

- 31 days after the date you fail to pay any required premium.
- When coverage is terminated by the Company. We will provide you a 31-day advance written notice of

any termination.

- On the date you die (unless your Spouse elects to become the Primary Insured under the Successor Insured provision, if applicable).

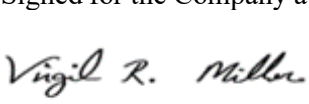
Once continued coverage is cancelled it cannot be reinstated. If your coverage terminates, we will provide benefits for valid claims that arose while your coverage was active.

CONTRACT

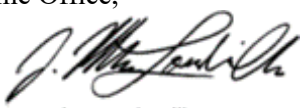
This Endorsement is part of the Certificate. It will terminate when:

- The Certificate terminates.

Signed for the Company at its Home Office,



Virgil R. Miller, President



J. Matthew Loudermilk, Secretary

CONTINENTAL AMERICAN INSURANCE COMPANY

Columbia, South Carolina
800.433.3036

Optional Benefits Rider
To Certificate of Insurance for Group Critical Illness

This Rider is part of the Certificate to which it is attached. We have issued this Rider because:

- You paid the additional premium for this Rider, and
- We have accepted your Application.

This Rider is subject to all the definitions, exclusions, limitations, terms, and other provisions of the Certificate to which it is attached, unless those terms are inconsistent with this Rider.

The benefits are available to those Insureds designated in the Certificate Schedule. Diagnosis must occur while this Rider is in force.

Effective Date

If issued at the same time as the Certificate, this Rider becomes effective when the Certificate becomes effective. If issued after the Certificate, this Rider will have a later Effective Date.

Definitions

When the terms below are used in this Rider, the following definitions will apply (other applicable terms and definitions are included in the **Definitions** section of your Certificate):

Activities of Daily Living (ADLs) are activities used in measuring levels of personal functioning capacity. These activities are normally performed without assistance, allowing personal independence in everyday living. For the purposes of this Plan, ADLs include the following:

- **Bathing** – the ability to wash oneself in a tub, shower, or by sponge bath. This includes the ability to get into and out of the tub or shower with or without the assistance of equipment;
- **Dressing** – the ability to put on, take off, and secure all necessary and appropriate items of clothing and any necessary braces or artificial limbs;
- **Toileting** – the ability to get to and from the toilet, get on and off the toilet, and perform associated personal hygiene with or without the assistance of equipment;
- **Transferring** – the ability to move in and out of a bed, chair, or wheelchair with or without the assistance of equipment;
- **Mobility** – the ability to walk or wheel on a level surface from one room to another with or without the assistance of equipment;
- **Eating** – the ability to get nourishment into the body by any means once it has been prepared and made available with or without the assistance of equipment; **and**
- **Continence** – the ability to voluntarily maintain control of bowel and/or bladder function. In the event of incontinence, the ability to maintain a reasonable level of personal hygiene.

Date of Diagnosis is defined as follows:

- **Advanced Alzheimer's Disease:** The date a Doctor Diagnoses the Insured as incapacitated due to Alzheimer's disease.

- **Advanced Parkinson's Disease:** The date a Doctor Diagnoses the Insured as incapacitated due to Parkinson's disease.
- **Benign Brain Tumor:** The date a Doctor determines a Benign Brain Tumor is present based on examination of tissue (biopsy or surgical excision) or specific neuroradiological examination.

Advanced Alzheimer's Disease means Alzheimer's Disease that causes the Insured to be incapacitated. Alzheimer's Disease is a progressive degenerative disease of the brain that is Diagnosed by a psychiatrist or neurologist as Alzheimer's Disease. To be incapacitated due to Alzheimer's Disease, the Insured must:

- Exhibit the loss of intellectual capacity involving impairment of memory and judgment, resulting in a significant reduction in mental and social functioning; **and**
- Require substantial physical assistance from another adult to perform at least three ADLs.

Advanced Parkinson's Disease means Parkinson's Disease that causes the Insured to be incapacitated. Parkinson's Disease is a brain disorder that is Diagnosed by a psychiatrist or neurologist as Parkinson's Disease. To be incapacitated due to Parkinson's Disease, the Insured must:

- Exhibit at least two of the following clinical manifestations:
  - Muscle rigidity
  - Tremor
  - Bradykinesis (abnormal slowness of movement, sluggishness of physical and mental responses); **and**
- Require substantial physical assistance from another adult to perform at least three ADLs.

Benign Brain Tumor is a mass or growth of abnormal, noncancerous cells in the brain. The tumor is composed of similar cells that do not follow normal cell division and growth patterns and develop into a mass of cells that microscopically do not have the characteristic appearance of a Cancer. Benign Brain Tumor must be caused by Multiple Endocrine Neoplasia, Neurofibromatosis, or Von Hippel-Lindau Syndrome.

Multiple Endocrine Neoplasia is a genetic disease in which one or more of the endocrine glands are overactive or form a tumor.

Neurofibromatosis is a genetic disease in which the nerve tissue grows tumors that may be benign and may cause serious damage by compressing nerves and other tissue.

Von Hippel-Lindau Syndrome is a genetic disease that predisposes a person to have benign or malignant tumors.

Benefit Provisions

We will pay the benefit shown if an Insured is Diagnosed with one of the conditions listed in the Rider Schedule if the Date of Diagnosis is while this Rider is in force.

Payment of benefits contained in this Rider is subject to the Critical Illness Benefit provisions in your Certificate.
The benefits contained in this Rider are considered to be Critical Illnesses as defined in your Certificate.

General Provisions

Time Limit on Certain Defenses

After two years from the Insured's Effective Date of coverage, the Company may not void coverage or deny a claim for any loss because of misstatements made on the Application. This does not apply to fraudulent misstatements.

Contract

This Rider is part of the Critical Illness Certificate. It will terminate when:

- That Certificate terminates, **or**
- Premiums are no longer paid for this Rider.

This Rider is subject to all of the terms of the Certificate to which it is attached unless any such terms are inconsistent with the terms of this Rider.

Signed for the Company at its Home Office,

Virgil R. Miller, President

J. Matthew Loudermilk, Secretary

OPTIONAL BENEFITS RIDER SCHEDULE

Benefits

Advanced Alzheimer's Disease	100% of applicable Face Amount
Advanced Parkinson's Disease	100% of applicable Face Amount
Benign Brain Tumor	100% of applicable Face Amount

CONTINENTAL AMERICAN INSURANCE COMPANY

Columbia, South Carolina

800.433.3036

Childhood Conditions Rider
To Certificate of Insurance for Group Critical Illness

This Rider is part of the Certificate to which it is attached. We have issued this Rider because:

- You paid the additional premium for this Rider, and
- We have accepted your Application.

This Rider is subject to all the definitions, exclusions, limitations, terms, and other provisions of the Certificate to which it is attached, unless those terms are inconsistent with this Rider.

The benefits are available to covered Dependent Children as defined in your Certificate. Diagnosis must occur while this Rider is in force.

Effective Date

If issued at the same time as the Certificate, this Rider becomes effective when the Certificate becomes effective. If issued after the Certificate, this Rider will have a later Effective Date.

Definitions

When the terms below are used in this Rider, the following definitions apply (other applicable terms and definitions are included in the **Definitions** section of your Certificate):

Date of Diagnosis is defined as follows:

- ***Cystic Fibrosis :*** The date a Doctor Diagnoses a Dependent Child as having Cystic Fibrosis and where such Diagnosis is supported by medical records.
- ***Cerebral Palsy:*** The date a Doctor Diagnoses a Dependent Child as having Cerebral Palsy and where such Diagnosis is supported by medical records.
- ***Cleft Lip or Cleft Palate:*** The date a Doctor Diagnoses a Dependent Child as having Cleft Lip or Cleft Palate and where such Diagnosis is supported by medical records.
- ***Down Syndrome:*** The date a Doctor Diagnoses a Dependent Child as having Down Syndrome and where such Diagnosis is supported by medical records.
- ***Phenylalanine Hydroxylase Deficiency Disease (PKU):*** The date a Doctor Diagnoses a Dependent Child as having PKU and where such Diagnosis is supported by medical records.
- ***Spina Bifida:*** The date a Doctor Diagnoses a Dependent Child as having Spina Bifida and where such Diagnosis is supported by medical records.
- ***Type I Diabetes:*** The date a Doctor Diagnoses a Dependent Child as having Type I Diabetes and where such Diagnosis is supported by medical records.

Cystic Fibrosis is a hereditary chronic disease of the exocrine glands. This disease is characterized by the production of viscid mucus that obstructs the pancreatic ducts and bronchi, leading to infection and fibrosis.

Cerebral Palsy is a disorder of movement, muscle tone, or posture that is caused by injury or abnormal development in the immature brain. Cerebral Palsy can be characterized by stiffness and movement difficulties, involuntary and uncontrolled movements, or disturbed sensation.

- ***Spastic Cerebral Palsy*** is characterized by stiffness and movement difficulties.
- ***Athetoid Cerebral Palsy*** is characterized by involuntary and uncontrolled movements.
- ***Ataxic Cerebral Palsy*** is characterized by a disturbed sense of balance and depth perception.

Cleft Lip occurs when there is an opening (one or two vertical fissures) in the lip. A ***Cleft Palate*** occurs when the two sides of a palate do not join, resulting in an opening in the roof of the mouth or soft tissue in the back of the mouth. Sometimes, an opening in the bones of the upper jaw or upper gum accompanies a Cleft Palate.

A Cleft Lip or Palate can occur on one or both sides of the face. If a Dependent Child has both a Cleft Lip and Cleft Palate or has one on each side of the face, we will pay this benefit only once.

Down Syndrome is a chromosomal condition characterized by the presence of an extra copy of genetic material on the 21st chromosome, either in whole or part.

Phenylalanine Hydroxylase Deficiency Disease (PKU) is an autosomal recessive metabolic genetic disorder characterized by homozygous or compound heterozygous mutations in the gene for the hepatic enzyme phenylalanine hydroxylase (PAH), rendering it nonfunctional. A Doctor must Diagnose this disease based on a PKU test.

Spina Bifida refers to any birth defect involving incomplete closure of the spinal canal or spine. This includes:

- ***Spina Bifida Cystica*****,** which is a condition where a cyst protrudes through the defect in the vertebral arch.
- ***Spina Bifida Occulta*****,** which is a condition where the bones of the spine do not close, but the spinal cord and meninges remain in place. Skin usually covers the defect.
- ***Meningoceles*****,** which is a condition where the tissue covering the spinal cord sticks out of the spinal defect, but the spinal cord remains in place.
- ***Myelomeningocele*****,** which is a condition where the un-fused portion of the spinal column allows the spinal cord to protrude through an opening. The meningeal membranes that cover the spinal cord form a sac enclosing the spinal elements.

Type I Diabetes means a form of diabetes mellitus causing total insulin deficiency of a Dependent Child along with continuous dependence on exogenous insulin in order to maintain life. A Doctor must Diagnose Type I Diabetes based on one of the following diagnostic tests:

- Glycated hemoglobin (A1C) test
- Random blood sugar test
- Fasting blood sugar test

Benefit Provisions

We will pay the benefit shown if a Dependent Child is Diagnosed with one of the conditions listed in the Rider Schedule if the Date of Diagnosis is while this Rider is in force.

Payment of benefits contained in this Rider is subject to the Critical Illness Benefit provisions in your Certificate. The benefits contained in this Rider are considered to be Critical Illnesses as defined in your Certificate.

General Provisions

Time Limit on Certain Defenses

After two years from the Insured's Effective Date of coverage, the Company may not void coverage or deny a claim for any loss because of misstatements made on the Application. This does not apply to fraudulent misstatements.

Contract

This Rider is part of the Critical Illness Certificate. It will terminate when:

- The Certificate terminates,
- Premiums are no longer paid for this Rider, or
- The covered Dependent Child reaches age 26 (details in the **Definitions** section of your Certificate).

This Rider is subject to all of the terms of the Certificate to which it is attached unless any such terms are inconsistent with the terms of this Rider.

Signed for the Company at its Home Office,

Virgil R. Miller, President

J. Matthew Loudermilk, Secretary

Childhood Conditions Rider Schedule Benefits

Cystic Fibrosis	See Covered Dependent Children Amount in the Certificate Schedule
Cerebral Palsy	See Covered Dependent Children Amount in the Certificate Schedule
Cleft Lip or Cleft Palate	See Covered Dependent Children Amount in the Certificate Schedule
Down Syndrome	See Covered Dependent Children Amount in the Certificate Schedule
Phenylalanine Hydroxylase Deficiency Disease (PKU)	See Covered Dependent Children Amount in the Certificate Schedule
Spina Bifida	See Covered Dependent Children Amount in the Certificate Schedule
Type I Diabetes	See Covered Dependent Children Amount in the Certificate Schedule
Autism Spectrum Disorder	
Mild Severity (Level 1)	$3,000
Moderate Severity (Level 2)	$3,000
Severe Severity (Level 3)	$3,000

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Please call the toll-free number above with any questions about this coverage.

Amendment to Childhood Conditions Rider for Group Critical Illness

This Amendment is subject to all of the provisions of the Policy, Certificate, and Rider to which it is attached. Additions or changes have been made to the Rider and are indicated below.

The benefits are available to covered Dependent Children as defined in your Certificate. Diagnosis must occur while the Rider is in force.

Effective Date

If issued at the same time as the Rider, this Amendment becomes effective when the Rider becomes effective. If issued after the Rider, this Amendment will have a later Effective Date.

Definitions

When the terms below are used in this Amendment, the following definitions apply (other applicable terms and definitions are included in the **Definitions** section of your Certificate and Rider):

Date of Diagnosis is defined as follows:

- ***Autism Spectrum Disorder:*** The date a Doctor Diagnoses a Dependent Child as having Autism Spectrum Disorder and where such Diagnosis is supported by medical records.

Autism Spectrum Disorder is a biological based neurodevelopment disorder characterized by impairment in two major domains:

- Deficits in social communication and interaction; and
- Restricted repetitive patterns of behavior, interests, and activities.

A Doctor must Diagnose Autism Spectrum Disorder based on DSM-V diagnostic criteria. The Diagnosis must include the DSM-V severity level specifier for both major domains listed above.

Benefit Provision

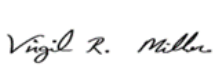
We will pay the benefit shown on the Rider Schedule if a Dependent Child is first Diagnosed with Autism Spectrum Disorder and if the Date of Diagnosis is while this Amendment is in force. If there are multiple DSM-V severity levels, we will pay the benefit for the highest level of severity. No benefit is payable if the DSM-V severity level is less than Level 1.

Payment of the benefit contained in this Amendment is subject to the Critical Illness Benefit provisions in your Certificate. The benefit contained in this Amendment is considered to be a Critical Illness as defined in your Certificate.

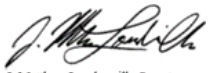
CONTRACT

This Amendment is part of the Policy, Certificate, and Rider and will terminate when the Policy, Certificate, or Rider terminates.

Signed for the Company at its Home Office,



Virgil R. Miller, President



J. Matthew Loudermilk, Secretary

CONTINENTAL AMERICAN INSURANCE COMPANY

Columbia, South Carolina

800.433.3036

Progressive Diseases Rider
To Certificate of Insurance for Group Critical Illness

This Rider is part of the Certificate to which it is attached. We have issued this Rider because:

- You paid the additional premium for this Rider, and
- We have accepted your Application.

This Rider is subject to all the definitions, exclusions, limitations, terms, and other provisions of the Certificate to which it is attached, unless those terms are inconsistent with this Rider.

The benefits are available to those Insureds designated in the Certificate Schedule. Diagnosis must occur while this Rider is in force.

Effective Date

If issued at the same time as the Certificate, this Rider becomes effective when the Certificate becomes effective. If issued after the Certificate, this Rider will have a later Effective Date.

Definitions

When the terms below are used in this Rider, the following definitions apply (other applicable terms and definitions are included in the **Definitions** section of your Certificate):

Date of Diagnosis is defined as follows:

- **Amyotrophic Lateral Sclerosis (ALS or Lou Gehrig's Disease):** The date a Doctor Diagnoses an Insured as having ALS and where such Diagnosis is supported by medical records.
- **Sustained Multiple Sclerosis:** The date a Doctor Diagnoses an Insured as having Multiple Sclerosis and where such Diagnosis is supported by medical records.

Amyotrophic Lateral Sclerosis (ALS or Lou Gehrig's Disease) means a chronic, progressive motor neuron disease occurring when nerve cells in the brain and spinal cord that control voluntary movement degenerate, causing muscle weakness and atrophy, eventually leading to paralysis.

Sustained Multiple Sclerosis means a chronic degenerative disease of the central nervous system in which gradual destruction of myelin occurs in the brain or spinal cord or both, interfering with the nerve pathways. Sustained Multiple Sclerosis results in one of the following symptoms for at least 90 consecutive days:

- Muscular weakness,
- Loss of coordination,
- Speech disturbances, **or**
- Visual disturbances.

Benefit Provisions

We will pay the benefit shown if an Insured is Diagnosed with one of the diseases that is listed in the Rider Schedule if the Date of Diagnosis is while this Rider is in force.

Payment of benefits contained in this Rider is subject to the Critical Illness Benefit provisions in your Certificate. The benefits contained in this Rider are considered to be Critical Illnesses as defined in your Certificate.

General Provisions

Time Limit on Certain Defenses

After two years from the Insured's Effective Date of coverage, the Company may not void coverage or deny a claim for any loss because of misstatements made on the Application. This does not apply to fraudulent misstatements.

Contract

This Rider is part of the Critical Illness Certificate. It will terminate when:

- That Certificate terminates, **or**
- Premiums are no longer paid for this Rider.

This Rider is subject to all of the terms of the Critical Illness Certificate to which it is attached unless those terms are inconsistent with this Rider.

Signed for the Company at its Home Office,

Virgil R. Miller, President

J. Matthew Loudermilk, Secretary

PROGRESSIVE DISEASE RIDER SCHEDULE

Progressive Disease Benefits

Amyotrophic Lateral Sclerosis (ALS)	100% of applicable Face Amount
Multiple Sclerosis	100% of applicable Face Amount

CONTINENTAL AMERICAN INSURANCE COMPANY

Columbia, South Carolina
800.433.3036

Please call the toll-free number above with any questions about this coverage.

Specified Disease Rider
To Certificate of Insurance for Group Critical Illness

This Rider is part of the Certificate to which it is attached. We have issued this Rider because:

- You paid the additional premium for this Rider, and
- We have accepted your Application.

This Rider is subject to all the definitions, exclusions, terms, and other provisions of the Certificate to which it is attached, unless those terms are inconsistent with this Rider.

The benefits are available to those Insureds designated in the Certificate Schedule. Diagnosis must occur while this Rider is in force.

EFFECTIVE DATE

If issued at the same time as the Certificate, this Rider becomes effective when the Certificate becomes effective. If issued after the Certificate, this Rider will have a later Effective Date.

DEFINITIONS

When the terms below are used in this Rider, the following definitions apply (other applicable terms and definitions are included in the **Definitions** section of your Certificate):

Date of Diagnosis is defined for each Specified Disease as follows:

- ***Adrenal Hypofunction (Addison's Disease):*** The date a Doctor Diagnoses an Insured as having Adrenal Hypofunction and where such Diagnosis is supported by medical records.
- ***Cerebrospinal Meningitis:*** The date a Doctor Diagnoses an Insured as having Cerebrospinal Meningitis and where such Diagnosis is supported by medical records.
- ***Diphtheria*:** The date a Doctor Diagnoses an Insured as having Diphtheria based on clinical and/or laboratory findings as supported by medical records.
- ***Human Coronavirus:*** The date a Doctor Diagnoses an Insured as having Human Coronavirus based on laboratory findings as supported by viral testing or a blood test.
- ***Huntington's Chorea:*** The date a Doctor Diagnoses an Insured as having Huntington's Chorea based on clinical findings as supported by medical records.
- ***Legionnaire's Disease:*** The date a Doctor Diagnoses an Insured as having Legionnaire's Disease by finding
- *Legionella* bacteria in a clinical specimen taken from the Insured.
- ***Malaria*:** The date a Doctor Diagnoses an Insured as having Malaria and where such Diagnosis is supported by medical records.
- ***Muscular Dystrophy:*** The date a Doctor Diagnoses an Insured as having Muscular Dystrophy and where such Diagnosis is supported by medical records.
- ***Myasthenia Gravis:*** The date a Doctor Diagnoses an Insured as having Myasthenia Gravis and where such Diagnosis is supported by medical records.

- ***Necrotizing Fasciitis:*** The date a Doctor Diagnoses an Insured as having Necrotizing Fasciitis and where such Diagnosis is supported by medical records.
- ***Osteomyelitis*****:** The date a Doctor Diagnoses an Insured as having Osteomyelitis and where such Diagnosis is supported by medical records.
- ***Poliomyelitis*****:** The date a Doctor Diagnoses an Insured as having Poliomyelitis and where such Diagnosis is supported by medical records.
- ***Rabies*****:** The date a Doctor Diagnoses an Insured as having Rabies and where such Diagnosis is supported by medical records.
- ***Sickle Cell Anemia:*** The date a Doctor Diagnoses an Insured as having Sickle Cell Anemia and where such Diagnosis is supported by medical records.
- ***Systemic Lupus:*** The date a Doctor Diagnoses an Insured as having Systemic Lupus and where such Diagnosis is supported by medical records.
- ***Systemic Sclerosis (Scleroderma):*** The date a Doctor Diagnoses an Insured as having Systemic Sclerosis and where such Diagnosis is supported by medical records.
- ***Tetanus:*** The date a Doctor Diagnoses an Insured as having Tetanus by finding Clostridium tetani bacteria in a clinical specimen taken from the Insured.
- ***Tuberculosis:*** The date a Doctor Diagnoses an Insured as having Tuberculosis by finding Mycobacterium tuberculosis bacteria in a clinical specimen taken from the Insured.

Adrenal Hypofunction (Addison's Disease) means a disease occurring when the body's adrenal glands do not produce sufficient steroid hormones.

Adrenal Hypofunction does not include secondary and tertiary adrenal insufficiency.

Cerebrospinal Meningitis means a disease resulting in the inflammation of the meninges of both the brain and spinal cord caused by infection from viruses, bacteria, or other microorganisms or from Cancer.

Diphtheria means an infectious disease caused by the bacterium *Corynebacterium diphtheriae* and characterized by the production of a systemic toxin and the formation of a false membrane lining of the mucous membrane of the throat and other respiratory passages, causing difficulty in breathing, high fever, and/or weakness.

Diphtheria can be Diagnosed either through laboratory tests that confirm Diphtheria through a culture obtained from the infected area or through clinical observation of visible symptoms.

Hospital means a place that meets all of the following criteria:
- Is legally licensed and operated as a hospital,
- Provides overnight care of injured and sick people,
- Is supervised by a Doctor,
- Has full-time nurses supervised by a registered nurse, and
- Has on-site use of X-ray equipment, laboratory, and surgical facilities.

The term *Hospital* specifically excludes any facility not meeting the definition of Hospital as defined in this Plan, including but not limited to:
- A nursing home,
- An extended-care facility,
- A skilled nursing facility,
- A rest home or home for the aged,
- A rehabilitation facility,
- A facility for the Treatment of alcoholism or drug addiction, or
- An assisted living facility.

Hospital Intensive Care Unit means a place that meets all of the following criteria:

- Is a specifically designated area of the Hospital called a Hospital Intensive Care Unit;
- Provides the highest level of medical care;
- Is restricted to patients who are critically ill or injured and who require intensive comprehensive observation and care;
- Is separate and apart from the surgical recovery room and from rooms, beds, and wards customarily used for patient confinement;
- Is permanently equipped with special life-saving equipment for the care of the critically ill or injured;
- Is under close observation by a specially trained nursing staff assigned exclusively to the Hospital Intensive Care Unit 24 hours a day; and
- Has a Doctor assigned to the Hospital Intensive Care Unit on a full-time basis.

The term *Hospital Intensive Care Unit* specifically excludes any type of facility not meeting the definition of Hospital Intensive Care Unit as defined in this Plan, including but not limited to private monitored rooms, surgical recovery rooms, observation units, and the following step-down units:

- A progressive care unit,
- A sub-acute intensive care unit, or
- An intermediate care unit.

Human Coronavirus means a severe type of virus having a lipid envelope studded with club-shaped spike proteins that infects humans, leading to an upper respiratory infection or Pneumonia, and spread through the air by coughing, sneezing, close personal contact, or touching a contaminated object or surface. This does not include the following Human Coronaviruses: 229E, NL63, OC43, and HKU1.

Huntington's Chorea means a hereditary disease characterized by gradual loss of brain function and voluntary movement due to degenerative changes in the cerebral cortex and basal ganglia.

Legionnaire's Disease means an infectious lung disease caused by species of the aerobic bacteria belonging to the genus
Legionella.

Malaria means an infectious disease characterized by cycles of chills, fever, and sweating, caused by the bite of an anopheles mosquito infected with a protozoan of the genus *Plasmodium*.

Muscular Dystrophy means a genetic disease that causes progressive weakness and degeneration in the musculoskeletal system and where such muscles are replaced by scar tissue and fat. Muscular Dystrophy is characterized by progressive skeletal muscle weakness, defects in muscle proteins, and the death of muscle cells and tissues.

Myasthenia Gravis means a disease characterized by progressive weakness and exhaustibility of voluntary muscles without atrophy or sensory disturbance and caused by an autoimmune attack on acetylcholine receptors at the neuromuscular junction.

Necrotizing Fasciitis means a severe soft tissue infection by bacteria that is marked by edema and necrosis of subcutaneous tissues with involvement of adjacent fascia and by painful red swollen skin over the affected areas.

Osteomyelitis means an infectious inflammatory disease of the bone that typically results from a bacterial infection and may result in the death of bone tissue.

Pneumonia means a lung disease characterized by inflammation of the airspaces in the lungs and caused by viral or bacterial infections or fungi. This does not include pneumonia caused by trauma such as, but not limited to, inhalation of water, smoke or chemicals or traumatic chest or thoracic injuries.

Poliomyelitis (Polio) means an acute infectious disease caused by the poliovirus and characterized by fever, motor paralysis, and atrophy of skeletal muscles. It often results in permanent disability and deformity, and marked by inflammation of nerve cells in the anterior gray matter in each lateral half of the spinal cord.

Rabies means an acute viral disease of the nervous system caused by a rhabdovirus, which is usually transmitted through the bite of a rabid animal. It is typically characterized by increased salivation, abnormal behavior, and eventual paralysis.

Sickle Cell Anemia means a hereditary disease caused by a genetic blood disorder. It is characterized by red blood cells that assume an abnormal, rigid, sickle shape due to a mutation on the hemoglobin gene.

Systemic Lupus means an autoimmune disease where the body's immune system attacks healthy tissue, leading to long-term inflammation. This disease is primarily characterized by joint pain and swelling.

Systemic Sclerosis (Scleroderma) means a progressive autoimmune disease characterized by the hardening and tightening of the skin and connective tissues.

Tetanus means a disease marked by rigidity and spasms of the voluntary muscles, caused by the bacterium Clostridium tetani.

Tuberculosis means an infectious disease caused by Mycobacterium tuberculosis bacteria. It is characterized by the growth of nodules in the bodily tissues, as well as by fever, cough, difficulty breathing, caseation, pleural effusions, and fibrosis.

BENEFIT PROVISIONS

Tier I – Specified Disease Benefit: We will pay the Benefit shown on the Rider Schedule if an Insured is Diagnosed with one of the Tier I Specified Diseases listed below, and if the Date of Diagnosis is while this Rider is in force:

- Adrenal Hypofunction
- Cerebrospinal Meningitis
- Diphtheria
- Huntington's Chorea
- Legionnaire's Disease
- Malaria
- Muscular Dystrophy
- Myasthenia Gravis
- Necrotizing Fasciitis
- Osteomyelitis
- Poliomyelitis
- Rabies
- Sickle Cell Anemia
- Systemic Lupus
- Systemic Sclerosis (Scleroderma)
- Tetanus

- Tuberculosis

For any subsequent Tier I Specified Disease to be covered, the Date of Diagnosis of the subsequent Tier I Specified Disease must be 180 days or more after the date the Insured first qualified for any previously paid Tier I Specified Disease Benefit.

Tier II – Specified Disease Benefit: We will pay the Benefit shown on the Rider Schedule if an Insured is Diagnosed with one of the Tier II Specified Diseases listed below, and such Diagnosis results in either a period of Hospital confinement or a period of Hospital Intensive Care Unit confinement as a direct result of the Tier II Specified Disease. Furthermore, the Date of Diagnosis must be while this Rider is in force.

In order to receive a Tier II Specified Disease Benefit the Insured must be confined to a Hospital or confined to a Hospital Intensive Care Unit as a direct result of a Tier II Specified Disease. In addition, the Insured must be receiving Treatment for the Tier II Specified Disease for the minimum number of days shown in the Rider Schedule. Only the highest eligible benefit amount shown on the Rider Schedule will be payable under these benefits. In the event a lower benefit amount was previously paid under these benefits for any period of Hospital confinement and that confinement is extended or the Insured is moved to an Intensive Care Unit triggering a higher payment, the difference between the previous paid benefit amount and the new benefit amount will be provided:

- Human Coronavirus

For any subsequent Tier II Specified Disease to be covered, the Date of Diagnosis of the subsequent Tier II Specified Disease must be 180 days or more after the date the Insured first qualified for any previously paid Tier II Specified Disease Benefit.

This benefit is limited to the maximum shown in the Rider Schedule.

GENERAL PROVISIONS

Time Limit on Certain Defenses
After two years from your Effective Date of coverage, the Company may not void coverage or deny a claim for any loss because of misstatements made on your Application. This does not apply to fraudulent misstatements.

CONTRACT

This Rider is part of the Critical Illness Certificate. It will terminate when:

- That Certificate terminates, or
- Premiums are no longer paid for this Rider, subject to the Grace Period.

This Rider is subject to all of the terms of the Critical Illness Certificate to which it is attached unless those terms are inconsistent with this Rider.

Signed for the Company at its Home Office,

Virgil R. Miller, President

J. Matthew Loudermilk, Secretary

Specified Disease Rider Schedule

Benefits

Tier I Specified Disease Benefit:

Adrenal Hypofunction (Addison's Disease)	25% of applicable Face Amount
Cerebrospinal Meningitis	25% of applicable Face Amount
Diphtheria	25% of applicable Face Amount
Huntington's Chorea	25% of applicable Face Amount
Legionnaire's Disease	25% of applicable Face Amount
Malaria	25% of applicable Face Amount
Muscular Dystrophy	25% of applicable Face Amount
Myasthenia Gravis	25% of applicable Face Amount
Necrotizing Fasciitis	25% of applicable Face Amount
Osteomyelitis	25% of applicable Face Amount
Poliomyelitis (Polio)	25% of applicable Face Amount
Rabies	25% of applicable Face Amount
Sickle Cell Anemia	25% of applicable Face Amount
Systemic Lupus	25% of applicable Face Amount
Systemic Sclerosis (Scleroderma)	25% of applicable Face Amount
Tetanus	25% of applicable Face Amount
Tuberculosis	25% of applicable Face Amount

Tier II Specified Disease Benefit:

Human Coronavirus	10% of applicable Face Amount if confined to a Hospital for 4-9 days
	25% of applicable Face Amount if confined to a Hospital for 10 or more days
	40% of applicable Face Amount if confined to an Intensive Care Unit
Maximum per Insured per lifetime	1 time

CONTINENTAL AMERICAN INSURANCE COMPANY

Columbia, South Carolina 800.433.3036

Cancer Survivor Benefit Rider
To Certificate of Insurance for Group Critical Illness

This Rider is part of the Certificate to which it is attached. We have issued this Rider because:

- You paid the additional premium for this Rider, and
- We have accepted your Application.

This Rider is subject to all the definitions, exclusions, limitations, terms, and other provisions of the Certificate to which it is attached, unless those terms are inconsistent with this Rider.

This benefit is available to those Insureds designated in the Certificate Schedule.

Effective Date

If issued at the same time as the Certificate, this Rider becomes effective when the Certificate becomes effective. If issued after the Certificate, this Rider will have a later Effective Date.

Benefit

We will pay the amount shown on the Rider Schedule on the anniversary date of an Insured's Diagnosis of Cancer (internal or invasive) if:

- A benefit for the Diagnosis of Cancer (internal or invasive) was paid under the Critical Illness Certificate to which this Rider is attached,
- The Date of Diagnosis of the Cancer (internal or invasive) was while this Rider was in force,
- The Certificate and Rider are in force on each anniversary date, and
- The Insured is alive on each anniversary date.

This benefit is payable annually up to five years. Only one benefit is payable per Insured per Calendar Year.

Limitations

This benefit is not payable for Non-Invasive Cancer or Skin Cancer. For this benefit to be payable, the Insured must have received a benefit for the Diagnosis of Cancer (internal or invasive) under the Critical Illness Certificate to which this Rider is attached while this Rider was in force.

General Provisions

Time Limit on Certain Defenses

After two years from the Insured's Effective Date of coverage, the Company may not void coverage or deny a claim for any loss because of misstatements made on the Application. This does not apply to fraudulent misstatements.

Contract

This Rider is part of the Critical Illness Certificate. It will terminate when:

- The Certificate terminates, or
- Premiums are no longer paid for this Rider.

This Rider is subject to all of the terms of the Critical Illness Certificate to which it is attached unless those terms are inconsistent with this Rider.

Signed for the Company at its Home Office,

Virgil R. Miller, President

J. Matthew Loudermilk, Secretary

Cancer Survivor Benefit Rider Schedule

Benefits

Cancer Survivor Benefit	5% of applicable Face Amount
Maximum number of annual payments per Diagnosis of Cancer (internal or invasive) (per Insured)	5
Maximum payments per calendar year (per Insured)	1

CONTINENTAL AMERICAN INSURANCE COMPANY

Columbia, South Carolina
800.433.3036

NOTICE OF NON-INSURANCE BENEFITS ENDORSEMENT

This Endorsement is added to and part of the Policy to which it is attached.

Continental American Insurance Company (CAIC) may offer or provide goods and/or services that are not related to insurance. The services will fall under the same benefit plan that includes or is related to the applicable CAIC coverage, individual wellness programs, and related services.

The services may be offered by the Policyholder, at the Policyholder's discretion, to its group employees. While the Endorsement is attached to the Policy, it is at the group employee's sole discretion to utilize the services listed below. Any one or more of the services listed below may be available, but may not represent the group employee's exact selection.

Though CAIC has arranged these goods, services, and/or third-party provider discounts, the third-party providers—**not CAIC**—are liable to group employeesfor these goods and services. CAIC is not responsible for providing the goods and/or services, nor is CAIC liable to group employeesfor the negligent provision of these goods and/or services by third-party service providers. The third-party providers will address inquiries from group employees about the provision of these goods, services, and/or third-party discounts. In the event the third-party provider cannot meet contractual obligations, CAIC will pursue a new contract with a similar vendor to provide the services listed below. Access to these services will end when Plan coverage ends, as described in the Termination provisions in the Master Policy.

The services listed below incur a $2/month service charge. This service charge is included in the premium amount shown on the Certificate Schedule.

- **Fraud Protection** – this third-party service offers fraud protection that will secure and monitor personal information and provide identity restoration services in the event of identity theft or fraud.
- **Core Advocacy** – this third-party service offers access to a dedicated, Personal Health Advocate who can help solve a wide variety of health- and insurance-related issues, such as:
  - Reviewing and explaining medical coverage and offering advice on care options and costs.
  - Locating providers for second opinions.
  - Scheduling appointments with specialists.
  - Clarifying complex conditions.
  - Resolving insurance claims.
  - Addressing eldercare issues and coordinating long-distance support for family members.
- **Medical Bill Saver** – this third-party service offers highly skilled negotiators to work on the group employees' behalf to obtain a discount on any medical or dental bill over $400 not covered by insurance, regardless of insurance or benefit status.
- **Telemedicine** – this third-party service offers a low-cost option for medical care by enabling group employees to connect with a medical provider online and receive personalized treatment. The Telemedicine visit could cost between $25 and $195. When medically appropriate, providers submit an e-prescription to a local pharmacy for purchase, pick up, and review (in person) with a local pharmacist.
- **Discount Bundle –** this third-party service offers discounts on dental, vision, pharmacy and hearing care services to group employees through a web portal. The discounts for the dental, hearing, and vision

services are available with a purchase of a $12 pass, which allows access to a network of providers in the group employee's geographical location.

- **Personal Wellness** – this third-party services helps group employees develop a healthy lifestyle plan to achieve their wellness goals through online workshops and tools related to weight loss, nutrition, stress management, tobacco cessation, and related issues.
- **Financial and Legal Fitness** – this third-party service assists group employees with online tools for financial and legal preparedness on topics such as eldercare, estate and retirement planning, college savings plans and budgeting, financial calculators, webinars and tutorials, and articles providing general financial education. Service also provides limited complementary access to consultative services from licensed professionals to assist with legal and financial matters.
- **Online Family Care Resource** – this third-party service offers access to a comprehensive online resource enabling group employees to manage their family care needs through services such as locating emergency child care, nanny services and elder care, daycare, tutors, dog-sitters/walkers, home companions and personal care services.
- **Student Loan Assistance** – this third-party service offers employers an administrative service to assist them in coordinating the payment of their group employee's student loans. The service also provides a refinancing market to assist group employees in paying down their student loans quicker.
- **College Advisory Service** – this third-party service provides assistance to group employees by helping to create a long-term plan for their children's educational future. The service helps the group employee navigate the intricacies of applying for college, financing college tuition, and understanding financial aid.
- **Employee Assistance Program** - this third-party service offers counseling with available licensed professional counselors to address stress, depression, family issues, substance abuse, and other topics.
- **Funeral Concierge** - this third-party service provides personal advisors who are available 24-hours a day to help with all funeral-related issues, including developing a personal funeral plan, and negotiation assistance for funeral services.
- **Travel Assistance** - this third-party service provides 24-hour, toll-free service for a comprehensive range of information, referral, coordination and arrangement services designed to respond to most medical care situations and many other emergencies group employees may encounter when they travel.
- **Flexible Spending Administration** – this third-party service administers funds designated by the group employee for payment of tax qualified medical expenses and dependent-care expenses.

Signed for the Company at its Home Office,

Virgil R. Miller, President

J. Matthew Loudermilk, Secretary

For assistance or information about this notice, call 800.433.3036.

How you're protected if your life or health insurance company fails

The Texas Life and Health Insurance Guaranty Association protects you by paying your covered claims if your life or health insurance company is insolvent (can't pay its debts). **This notice summarizes your protections.**

The Association will pay your claims, with some exceptions required by law, if your company is licensed in Texas and a court has declared it insolvent. You must live in Texas when your company fails. If you don't live in Texas, you may still have some protections.

For each insolvent company, the Association will pay a person's claims only up to these dollar limits set by law:

- **Accident, accident and health, or health insurance (including HMOs):**
  - Up to $500,000 for health benefit plans, with some exceptions.
  - Up to $300,000 for disability income benefits.
  - Up to $300,000 for long-term care insurance benefits.
  - Up to $200,000 for all other types of health insurance.

- **Life insurance:**
  - Up to $100,000 in net cash surrender or withdrawal value.
  - Up to $300,000 in death benefits.

- **Individual annuities:** Up to $250,000 in the present value of benefits, including cash surrender and net cash withdrawal values.

- **Other policy types:** Limits for group policies, retirement plans and structured settlement annuities are in Chapter 463 of the Texas Insurance Code.

- **Individual aggregate limit:** Up to $300,000 per person, regardless of the number of policies or contracts. A limit of $500,000 may apply for people with health benefit plans.

- **Parts of some policies might not be protected:** For example, there is no protection for parts of a policy or contract that the insurance company doesn't guarantee, such as some additions to the value of variable life or annuity policies.

To learn more about the Association and your protections, contact:	For questions about insurance, contact:
Texas Life and Health Insurance Guaranty Association 515 Congress Avenue, Suite 1875 Austin, TX 78701 1-800-982-6362 or www.txlifega.org	**Texas Department of Insurance** P.O. Box 149104 Austin, TX 78714-9104 1-800-252-3439 or www.tdi.texas.gov

Note: You're receiving this notice because Texas law requires your insurance company to send you a summary of your protections under the Texas Life and Health Insurance Guaranty Association Act (Insurance Code, Chapter 463). These protections apply to insolvencies that occur on or after September 1, 2019. **There may be other exceptions that aren't included in this notice.** When choosing an insurance company, you should not rely on the Association's coverage. Texas law prohibits companies and agents from using the Association as an inducement to buy insurance or HMO coverage.

Chapter 463 controls if there are differences between the law and this summary.

CONTINENTAL AMERICAN INSURANCE COMPANY

Columbia, South Carolina
800.433.3036

Endorsement
to Policy and Certificate of Insurance

This Endorsement alters the Policy and the Certificate to which it is attached. Unless specifically addressed by this Endorsement, all other Policy and Certificate provisions, definitions, and terms continue to apply.

Continental American Insurance Company's mailing addresses for claims and premium payments are changed as listed below.

Notice of Claim and **Proof of Loss** should be mailed to the Company at:

P.O. Box 84075, Columbus, Georgia, 31993-9103

Premium Payments should be mailed to the Company at:

P.O. Box 84069, Columbus, Georgia, 31908-4069

If applicable, references to 2801 Devine Street, Columbia, SC 29205 are deleted.

Signed for the Company at its Home Office,

Virgil R. Miller, President

J. Matthew Loudermilk, Secretary

Have a complaint or need help?

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

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

Continental American Insurance Company

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

Call: Continental American Insurance Company at 1-800-433-3036 Toll-free:

1-800-433-3036

Email: cscmail@aflac.com

Mail: Continental American Insurance Company
Post Office Box 427
Columbia, South Carolina 29202

The Texas Department of Insurance

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

Call: 1-800-252-3439

Online: www.tdi.texas.gov

Email: ConsumerProtection@tdi.texas.gov

Mail: MC 111-1A, P.O. Box 149091, Austin, TX 78714

¿Tiene una queja o necesita ayuda?

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

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

Continental American Insurance Company

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

Llame a: Continental American Insurance Company al 1-800-433-3036 Teléfono gratuito:

1-800-433-3036

Correo electrónico: cscmail@aflac.com

Dirección postal: Continental American Insurance Company Post Office Box 427
Columbia, South Carolina 29202

El Departamento de Seguros de Texas

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

Llame: 1-800-252-3439

En línea: www.tdi.texas.gov

Correo electrónico: ConsumerProtection@tdi.texas.gov

Dirección postal: MC 111-1A, P.O. Box 149091, Austin, TX 78714

Accident Plan

CONTINENTAL AMERICAN INSURANCE COMPANY

Columbia, South Carolina
800.433.3036

Please call the toll-free number above with any questions about this coverage.

Group Accidental Injury Insurance Policy

This limited Plan provides supplemental benefits only. It does not constitute comprehensive health insurance coverage and does not satisfy the requirement of Minimum Essential Coverage under the Affordable Care Act.

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

THIS IS NOT A POLICY OF WORKERS' COMPENSATION INSURANCE. THE EMPLOYER DOES NOT BECOME A SUBSCRIBER TO THE WORKERS' COMPENSATION SYSTEM BY PURCHASING THIS POLICY, AND IF THE EMPLOYER IS A NON-SUBSCRIBER, THE EMPLOYER LOSES THOSE BENEFITS WHICH WOULD OTHERWISE ACCRUE UNDER THE WORKERS' COMPENSATION LAWS. THE EMPLOYER MUST COMPLY WITH THE WORKERS' COMPENSATION LAW AS IT PERTAINS TO NON-SUBSCRIBERS AND THE REQUIRED NOTIFICATIONS THAT MUST BE FILED AND POSTED.

This Plan provides the benefits listed in the Benefit Schedule. Please read it carefully.

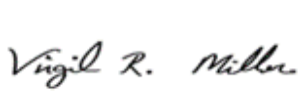
The Policyholder as shown on the Policy Schedule applied for coverage under this Group Accidental Injury Insurance Policy (the "Plan"). This Plan is issued by Continental American Insurance Company (the "Company," "CAIC," "we," "us," or "our"). Based on the Master Application and the timely payment of premiums, the Company agrees to pay the benefits provided on the following pages. (Please note that male pronouns—such as "he," "him," and "his"—are used for both males and females, unless the context clearly shows otherwise.) The Policyholder may add new Insureds from time to time, according to the Plan's terms.

You will notice that certain words and phrases (including some medical terms and the names of Plan documents) in this document are capitalized. The capitalized words refer to terms with very specific definitions as they apply to this insurance Plan.

This Plan is a legal contract between the Company and the Policyholder. All matter printed or written by the Company on the following pages is part of this Plan. This Plan is delivered in and is governed by the laws of the jurisdiction shown on the Policy Schedule.

In witness whereof, the Company executes this Plan at its home office in Columbia, South Carolina, on the Effective Date.

Signed for the Company at its Home Office,



Virgil R. Miller, President

J. Matthew Loudermilk, Secretary

Group Accidental Injury Insurance Non-Participating

Continental American Insurance Company (CAIC), a proud member of the Aflac family of insurers, is a wholly-owned subsidiary of Aflac Incorporated and underwrites group coverage.

SECTION I: Eligibility, Effective Date, And Termination

PRIMARY INSURED

Eligibility
An Employee is eligible to be covered under this Plan if he is Actively at Work for the Policyholder and included in the class that is eligible for coverage, as shown on the Master Application.

Insureds are defined as those who might be eligible for coverage under this Plan in the following categories:

- **Employee Coverage –** We insure only the Employee. The Employee is the ***Primary Insured*** under this Plan.
- **Employee and Spouse Coverage –** We insure the Employee and Spouse.
- **Employee and Children Coverage –** We insure the Employee and any Dependent Children.
- **Family Coverage –** We insure the Employee, Spouse, and any Dependent Children.

Employees should refer to *Type of Coverage* in their Certificate Schedule to determine who is covered under the Certificate.

Details for adding Insureds to Plan coverage are outlined in the Effective Date provision and the Dependent Coverage – Effective Date provision.

Effective Date
The Plan's Effective Date is shown on the Policy Schedule. This Plan becomes effective on the Policy Effective Date at 12:01 a.m., as determined by the Policyholder's address.

"An eligible Employee must be enrolled in this Plan and the required premiums paid for coverage to become effective. He must be enrolled within 31 days of the date he first becomes eligible for coverage."

The Employee's Effective Date is the date his insurance takes effect. After we receive and approve the Application, that date is either:

- The date shown on the Certificate Schedule if the Employee is Actively at Work on that date, or
- The date the Employee returns to an Actively-at-Work status if he was not Actively at Work on the date shown on the Certificate Schedule.

Termination of an Employee's Insurance
An Employee's insurance will terminate on whichever occurs first:

- The date the Company terminates the Plan.
- The 31st day after the premium due date (the last day of the Grace Period), if the premium has not been paid.
- The date he no longer belongs to an eligible class.

If an Insured's coverage terminates, we will provide benefits for valid claims that arose while his coverage was active.

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DEPENDENT COVERAGE

Eligibility

Dependents may be eligible for coverage under this Plan. **Employees should refer to the Type of Coverage on their Certificate Schedule to determine Dependent eligibility.** A ***Dependent*** is the Spouse of an Employee or the Dependent Child of an Employee. An eligible Spouse must be at least age 18.

Dependent Child or ***Dependent Children*** means an Employee's or an Employee's Spouse's natural children, step-children, grandchildren who are in the Employee's legal custody and residing with the Employee, foster children, children subject to legal guardianship, adopted children, or Children Placed for Adoption, who are younger than age 26. However, we will continue coverage for Dependent Children insured under the Plan after the age of 26 if they are incapable of self-sustaining employment due to mental or physical disability, and are chiefly dependent on a parent for support and maintenance. The Employee or the Employee's Spouse must furnish proof of this incapacity and dependency to the Company within 31 days following the Dependent Child's 26th birthday.

Children Placed for Adoption are children for whom the Employee has entered a decree of adoption, has initiated adoption proceedings, or is a party to a suit in which the Employee seeks to adopt the child. A decree of adoption must be entered within one year from the date proceedings were initiated, unless extended by order of the court. The Employee must continue to have custody pursuant to the decree of the court.

Effective Date

- A Dependent may be added to the Plan after the Employee's Effective Date within 31 days after a Life Event or during an approved enrollment period.
- If Employee and Children **or** Family Coverage is already in force, no additional notice or premium is required to add another Dependent Child.
- If Dependent Spouse or Dependent Child coverage is **not** in force, the Employee must complete an Application to add a Dependent to the Plan. The Company will assign a Dependent Effective Date for a Dependent's coverage after approving the Application. For Dependent coverage to become effective, the premium for the Dependent must be included in the premium payment. Spouse and Dependent Child coverage will begin on the date of the Life Event if notice was provided within 31 days after the Life Event.
- If Dependent Child coverage is not already in force, newborn children are automatically covered from the moment of birth for 60 days. Newly adopted children are automatically covered from the earlier of a) placement for adoption, b) the date of entry of an order granting custody of the child for the purposes of adoption, or c) the effective date of adoption, for 60 days. To extend coverage beyond 60 days with no gap in coverage, the Employee must apply to the Company within the 60-day time period following the child's birth or adoption. No premium is due for the first 60 days of newborn/newly adopted coverage.

Termination of Dependent Insurance

Dependent coverage will terminate on the earliest of the following:

- When the Certificate terminates,
- On the premium due date following the date we receive the Employee's written request to terminate Dependent coverage,
- When premiums are no longer paid for Dependent coverage (subject to the Grace Period),
- For Spouse coverage, when the Insured no longer meets the definition of Spouse because of annulment, divorce, or other reason, or
- For Dependent Child coverage, when the Child no longer qualifies as a Dependent because he reaches age 26 or other reason. (Dependent Children who reach age 26 will have coverage continued until the last day

of the month in which they turn age 26.)

Plan Termination

The **Company** has the right to cancel the Plan on any premium due date for the following reasons:

- The premium is not paid before the end of the Grace Period,
- The number of participating Employees is less than the number mutually agreed upon by the Company and the Policyholder,
- The number of participating Employees changes by 25% or more,
- The Policyholder fails to perform any of the obligations that relate to this Policy or that are required by applicable law,
- The Policyholder no longer offers coverage to a particular class of Employees,
- The Policyholder no longer serves a class of Employees who reside in a particular geographical area, or
- The Policyholder does not provide timely information that is reasonably required.

The **Policyholder** has the right to cancel the Plan on any premium due date.

- To do this, the Policyholder must give the Company at least 31 days' written notice.
- The Plan will end on the date in the written notice or the date the Company receives the notice, whichever is later.

All outstanding premiums are due upon Plan termination. If the Company receives premium payments after the Plan terminates, this will not reinstate the Plan.

The Policyholder has the sole responsibility of notifying Certificateholders in writing of the Plan's termination as soon as reasonably possible. If the Plan terminates, it—and all Certificates and Riders issued under the Plan—will terminate on the specified termination date. The termination occurs as of 12:01 a.m. at the Policyholder's address.

Continuation Privilege

When an Employee is no longer a member of an eligible class and his coverage would otherwise end, he may elect to continue his coverage under this Plan. He may continue the coverage he had on the date his Certificate would otherwise terminate, including any in-force Spouse or Dependent Child coverage, without any additional underwriting requirements.

To keep his coverage in force, the Employee must:

- Notify the Company within 31 days after the date his coverage would otherwise terminate. He may notify us by sending written notice to P.O. Box 84078, Columbus, Georgia 31993-9102 or by calling the Customer Service number at 800.433.3036, and
- Pay the required premium directly to the Company no later than 31 days after the date his coverage would otherwise terminate and on each premium due date thereafter.

The Employee's ported coverage will end on the earliest of the following dates:

- 31 days after the premium due date (the last day of the Grace Period), if the premium has not been paid, or
- The date the Group Plan is terminated.

If the Employee qualifies for this Continuation Privilege, then the Company will apply the same Benefits, Premium Rate, and Plan Provisions as shown in his previously-issued Certificate. Notification of any changes in the Plan will be provided directly by the Company.

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SECTION II: Premium Provisions

Premium Payments

Premiums should be paid to the Company at its Home Office in Columbia, South Carolina. The first premiums are due on the Plan's Effective Date. After that, premiums are due on the first day of each month that the Plan remains in effect.

Payment of any premium will not keep the Plan in force beyond the due date of the next premium, except as set forth in the Grace Period provision.

Premium Changes

Unless we have agreed in writing not to increase premiums, the premium may change:

- On the Group Policy Anniversary Date based on renewal underwriting. (The Group Policy Anniversary Date is shown on the Policy Schedule and falls on the same date each year thereafter.)
- Whenever the terms or conditions of the Plan are modified. The new premium rates will apply only to premiums due on or after the rate change takes effect.

We will provide the Policyholder a 60-day advance written notice of any change in premiums.

Grace Period

This Plan has a 31-day Grace Period. If a premium is not paid on or before its due date, the premium may be paid during the next 31 days. During the Grace Period, the Plan will stay in force, unless the Policyholder has given the Company written notice of its intention to discontinue the Plan. If the Plan is discontinued, the Plan's termination date will be the latest date for which premium has been paid.

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SECTION III: Definitions

When the terms below are used in this Plan, the following definitions apply:

Accidental Injury means accidental bodily damage to an Insured resulting from an unforeseen and unexpected traumatic event. This must be the direct result of an accident and not the result of disease or bodily infirmity. A ***Covered Accidental Injury*** is an Accidental Injury that occurs while coverage is in force. A ***Covered Accident*** is an accident that occurs on or after an Insured's Effective Date while coverage is in force, and that is not specifically excluded by the Plan.

Actively at Work refers to an Employee's ability to perform his regular employment duties for a full normal workday. The Employee may perform these activities either at his employer's regular place of business or at a location where he is required to travel to perform the regular duties of his employment.

Ambulatory Surgical Center is defined as a licensed surgical center consisting of an operating room; facilities for the administration of general anesthesia; and a post-surgery recovery room in which the patient is admitted and discharged within a period of less than 24 hours.

Calendar Year means the period beginning on the Policy Effective Date and ending on December 31 of the same year. Thereafter, it is the period beginning on January 1 and ending on December 31 of each following year.

Claimant means a person who is authorized to make a claim under the Certificate.

Doctor is a person who is duly qualified as a practitioner of the healing arts acting within the scope of his license, and:

- Is licensed to practice medicine; prescribe and administer drugs; or to perform surgery, or
- Is a duly qualified medical practitioner according to the laws and regulations in the state in which Treatment is made.

A Doctor ***does not*** include the Insured or an Insured's Family Member.

For the purposes of this definition, ***Family Member*** includes the Employee's Spouse as well as the following members of the Employee's immediate family:

- Son.
- Daughter.
- Mother.
- Father.
- Sister.
- Brother.

This includes step-Family Members and Family-Members-in-law.

Employee is a person who meets Eligibility requirements under **Section I – Eligibility**, **Effective Date, and Termination**
and who is covered under this Plan. The Employee is the Primary Insured under this Plan.

Hospital means a place that meets all of the following criteria:

- Is legally licensed and operated as a Hospital,
- Provides overnight care of injured and sick people,
- Is supervised by a Doctor,
- Has full-time nurses supervised by a registered nurse, and
- Has on-site use of X-ray equipment, laboratory, and surgical facilities.

The term *Hospital* specifically excludes any facility not meeting the definition of Hospital as defined in this Plan, including but not limited to:

- A nursing home,
- An extended-care facility,
- A skilled nursing facility,

- A rest home or home for the aged,
- A Rehabilitation Facility,
- A facility for the Treatment of alcoholism or drug addiction, or
- An assisted living facility.

Hospital Intensive Care Unit means a place that meets all of the following criteria:

- Is a specifically designated area of the Hospital called a Hospital Intensive Care Unit;
- Provides the highest level of medical care;
- Is restricted to patients who are critically ill or injured and who require intensive comprehensive observation and care;
- Is separate and apart from the surgical recovery room and from rooms, beds, and wards customarily used for patient confinement;
- Is permanently equipped with special life-saving equipment for the care of the critically ill or injured;
- Is under close observation by a specially trained nursing staff assigned exclusively to the Hospital Intensive Care Unit 24 hours a day; and
- Has a Doctor assigned to the Hospital Intensive Care Unit on a full-time basis.

The term *Hospital Intensive Care Unit* specifically excludes any type of facility not meeting the definition of Hospital Intensive Care Unit as defined in this Plan, including but not limited to private monitored rooms, surgical recovery rooms, observation units, and the following step-down units:

- A progressive care unit,
- A sub-acute intensive care unit, or
- An intermediate care unit.

Intermediate Intensive Care Step-Down Unit means any of the following:

- A progressive care unit,
- A sub-acute intensive care unit,
- An intermediate care unit, or
- A pre- or post-intensive care unit.

An Intermediate Intensive Care Step-Down Unit is **not** a Hospital Intensive Care Unit as defined in this Plan.

Life Event means an event that qualifies an Employee to make changes to benefits at times other than his enrollment period. Events qualifying as Life Events are established solely by the Policyholder.

Rehabilitation Facility is a unit or facility providing coordinated multidisciplinary physical restorative services. These services must be provided to inpatients under a Doctor's direction. The Doctor must be knowledgeable and experienced in rehabilitative medicine. Beds must be set up in a unit or facility specifically designated and staffed for this service. This is not a facility for the Treatment of alcoholism or drug addiction.

Spouse is an Employee's legal wife or husband, including a legally-recognized same-sex Spouse, or a person of either gender who is in a legally recognized and registered domestic partnership, civil union, reciprocal beneficiary relationship, or similar relationship with the Employee.

Telemedicine Service means a medical inquiry with a Doctor via audio or video communication that assists with a patient's assessment, diagnosis, and consultation.

Treatment is the consultation, care, or services provided by a Doctor. This includes receiving any diagnostic measures and taking prescribed drugs and medicines. Treatment does **not** include Telemedicine Services.

Urgent Care is a walk-in clinic that delivers ambulatory, outpatient care in a dedicated medical facility for illnesses or injuries that require immediate care but that are not serious enough to require a visit to an emergency room.

SECTION IV: Benefit Provisions

Initial Treatment Category Initial Treatment Benefit
We will pay the amount shown in the Benefit Schedule if an Insured receives Initial Treatment for a Covered Accidental
Injury. This benefit is payable for Initial Treatment received under the care of a Doctor when an Insured visits a(n):

- Hospital emergency room with X-Ray.
- Hospital emergency room without X-Ray.
- Urgent Care facility with X-Ray.
- Urgent Care facility without X-Ray.
- Doctor's office or facility (other than a Hospital emergency room or Urgent Care) with X-Ray.
- Doctor's office or facility (other than a Hospital emergency room or Urgent Care) without X-Ray.

Initial Treatment means the first Treatment an Insured receives for a Covered Accidental Injury.

The Initial Treatment must be received within 168 hours after the Covered Accident for benefits to be payable. This benefit is not payable for Telemedicine services.

This benefit is limited to the maximum number of payments per Covered Accident, per Insured, shown in the Benefit Schedule.

Ambulance Benefit
We will pay the appropriate amount shown in the Benefit Schedule if, because of a Covered Accident, the Insured:

- Is injured, and
- Receives transportation by a professional ambulance service. This transportation must occur within 90 days after the accident for a benefit to be payable.

Ambulance service includes air ambulance service.

This benefit is limited to the maximum number of payments per Covered Accident, per Insured, shown in the Benefit Schedule.

Major Diagnostic Testing Benefit
We will pay the amount shown in the Benefit Schedule if, because of Injuries sustained in a Covered Accident, the Insured requires one of the following exams:

- Computerized tomography (CT scan).
- Magnetic resonance imaging (MRI).
- Computerized axial tomography (CAT).
- Electroencephalography (EEG).

These exams must be performed in a Hospital, a Doctor's office, a Medical Diagnostic Imaging Center, or an Ambulatory Surgical Center. The exam must be performed within six months after the accident for a benefit to be payable.

For the purposes of this Plan, a ***Medical Diagnostic Imaging Center*** is defined as a facility with the equipment to produce various types of radiologic and electromagnetic images, and a professional staff to interpret the images obtained.

This benefit is limited to the maximum number of payments per Covered Accident, per Insured, shown in the Benefit Schedule.

Emergency Room Observation Benefit

The daily benefit amount shown in the Benefit Schedule is payable for each 24-hour period of observation that, because of a Covered Accidental Injury, an Insured:

- Receives Treatment in a Hospital emergency room,
- Is held in a Hospital for observation without being admitted as an inpatient, and
- Receives initial Treatment within 168 hours after the accident.

For periods of observation lasting fewer than 24 hours but more than four hours, a limited benefit amount as shown in the Benefit Schedule is payable.

Prescriptions Benefit
We will pay the amount shown in the Benefit Schedule for a prescription filled. The prescription must meet three criteria: (1) be ordered by a Doctor due to a Covered Accidental Injury; (2) be dispensed by a licensed pharmacist; and (3) be medically necessary for the care and Treatment of the Insured due to a Covered Accidental Injury. The prescription must be received within six months after the accident for a benefit to be payable.

This benefit does not include benefits for: (a) therapeutic devices or appliances; (b) experimental drugs; (c) drugs, medicines or insulin used by or administered to a person while he is confined to a Hospital, rest home, extended-care facility, convalescent home, nursing home or similar institution; or (d) immunization agents, biological sera, blood or blood plasma.

This benefit is not payable for pain management techniques for which a benefit is paid under the Pain Management Benefit (if available).

This benefit is limited to the maximum number of payments per Covered Accident, per Insured, shown in the Benefit Schedule.

Pain Management Benefit
We will pay the amount shown in the Benefit Schedule when an Insured is prescribed and receives:

- A nerve ablation and/or block, or
- An epidural injection administered into the spine.

The benefit is only payable for pain management techniques (as shown above) that are administered in a Hospital or Doctor's office, and are due to a Covered Accidental Injury. For a benefit to be payable, the pain management technique must be administered within six months after the Covered Accident. This benefit is not payable for an epidural administered during a surgical procedure.

This benefit is limited to the maximum number of payments per Covered Accident, per Insured, shown in the Benefit Schedule.

Blood/Plasma/Platelets Benefit
We will pay the amount shown in the Benefit Schedule for each day that an Insured receives blood, plasma, or platelets due to a Covered Accidental Injury. The Insured must receive the blood, plasma, or platelets within six months after the accident for a benefit to be payable.

This benefit is limited to the maximum number of payments per Covered Accident, per Insured, shown in the Benefit Schedule.

Concussion Benefit
We will pay the amount shown in the Benefit Schedule if the Insured has a concussion due to a Covered Accident. The concussion must be diagnosed by a Doctor. The diagnosis must be made within six months after the accident

for a benefit to be payable.

This benefit is limited to the maximum number of payments per Covered Accident, per Insured, shown in the Benefit Schedule.

Traumatic Brain Injury Benefit
We will pay the amount shown in the Benefit Schedule if the Insured is diagnosed by a neurologist with Traumatic Brain Injury (TBI) due to a Covered Accident. *Traumatic Brain Injury (TBI)* is an injury that is caused by a traumatic blow to the head, neck, or shoulders; and results in neurological deficit. To qualify as TBI, the neurological deficit must require:

- Treatment by a neurologist, and
- Prescribed course of physical, speech, and/or occupational therapy under the direction of a neurologist.

The diagnosis must be made within six months after the accident for a benefit to be payable.

This benefit is limited to the maximum number of payments per Covered Accident, per Insured, shown in the Benefit Schedule.

Burns Benefit
We will pay the amount shown in the Benefit Schedule if the Insured has burns in a Covered Accident**.** We will pay the Burns Benefit according to the percentage of body surface burned. The Insured must be treated for burns by a Doctor within six months after the accident for a benefit to be payable. First-degree burns are not covered.

This benefit is limited to the maximum number of payments per Covered Accident, per Insured, shown in the Benefit Schedule.

Emergency Dental Work Benefit
We will pay the amount shown in the Benefit Schedule if the Insured has an Accidental Injury to natural teeth as the result of a Covered Accident. We will pay for extraction or repair with a crown as shown in the Benefit Schedule. The dental work must be performed within six months of the accident for a benefit to be payable.

Eye Injuries Benefit
We will pay the amount shown in the Benefit Schedule for eye injuries requiring removal of a foreign body if, because of a Covered Accident, a Doctor removes a foreign body from the eye, with or without anesthesia.

Dislocation Benefit
Dislocation refers to a completely separated joint. If a joint is dislocated in a Covered Accident, and it is diagnosed and treated by a Doctor within 90 days after the accident, we will pay the amount shown in the Benefit Schedule.

If the dislocation requires open reduction, we will pay 200% of the amount shown in the Benefit Schedule.

We will pay benefits only for the first dislocation of a joint. We will not pay for recurring dislocations of the same joint. If the Insured dislocated a joint before the Effective Date of his Certificate and then dislocates the same joint again, it will not be covered by this Plan.

Multiple dislocations refer to more than one dislocation requiring either open or closed reduction in any one Covered Accident. For each covered dislocation, we will pay the amounts shown in the Benefit Schedule. However, we will pay no more than 200% of the benefit amount for the dislocated joint that has the higher dollar amount.

Partial dislocation is one in which the joint is not completely separated. If a Doctor diagnoses and treats the Accidental Injury as a partial dislocation, we will pay 25% of the amount shown in the Benefit Schedule for the affected joint. (*Partial dislocation* includes subluxation.)

Laceration Benefit
We will pay the amount shown in the Benefit Schedule if an Insured receives a laceration in a Covered Accident. The laceration must be repaired with stitches by a Doctor within 168 hours after the accident for a benefit to be payable. (*Stitches* can also include liquid skin adhesive.) The amount paid will be based on the length of the laceration. (Receiving stitches to repair a laceration is not payable under the Outpatient Surgery and Anesthesia Benefit or Inpatient Surgery and Anesthesia Benefit, if any.)

The Insured may receive Treatment for a laceration that does not require stitches. However, if that laceration is treated by a Doctor within 168 hours after the Covered Accident, we will pay the amount shown in the Benefit Schedule.

If the Insured suffers multiple lacerations in a Covered Accident, and the lacerations are repaired with stitches by a Doctor within 168 hours after the accident, we will pay this benefit based on the largest single laceration that requires stitches, as shown in the Benefit Schedule. However, we will pay no more than 200% of the benefit amount for the laceration that has the higher dollar amount.

Fracture Benefit
Fracture is a break in a bone that can be seen by X-ray. If a bone is fractured in a Covered Accident, and it is diagnosed and treated by a Doctor within 90 days after the accident, we will pay the appropriate amount shown in the Benefit Schedule.

If the fracture requires open reduction, we will pay 200% of the amount shown in the Benefit Schedule.

Multiple fractures refer to more than one fracture requiring either open or closed reduction. If these fractures occur in any one Covered Accident, we will pay the appropriate amounts shown in the Benefit Schedule for each fracture. However, we will pay no more than 200% of the benefit amount for the bone fractured that has the highest dollar amount.

Chip fracture refers to a piece of bone that is completely broken off near a joint. If a Doctor diagnoses the fracture as a chip fracture, we will pay 25% of the amount shown in the Benefit Schedule for the affected bone.

Fracture does not include stress fractures, which are tiny cracks in a bone that can arise by the repetitive application of force, or from normal use of a weakened bone. Benefits are not payable for stress fractures.

Outpatient Surgery and Anesthesia Benefit
We will pay the daily benefit amount shown in the Benefit Schedule when, due to a Covered Accidental Injury, an Insured has an outpatient surgical procedure performed by a Doctor. “Surgical procedure” does not include laceration repair. If an outpatient surgical procedure is covered under another benefit in this Plan, we will pay the ***higher*** of that benefit amount **or** the Outpatient Surgery and Anesthesia Benefit. For a benefit to be payable, the surgery must be performed within one year after the Covered Accident.

This benefit is limited to the maximum number of payments per Covered Accident, per Insured, shown in the Benefit Schedule.

The surgery can be performed:

- In a Hospital on an outpatient basis,
- In an Ambulatory Surgical Center,
- In a Doctor's office, including Urgent Care facilities, or
- In an emergency room.

Inpatient Surgery and Anesthesia Benefit
We will pay the daily benefit amount shown in the Benefit Schedule when, due to a Covered Accidental Injury, an Insured has an inpatient surgical procedure performed by a Doctor. The surgery must be performed while the Insured is confined to a Hospital as an inpatient. If an inpatient surgical procedure is covered under another benefit in this Plan, we will pay the ***higher*** of that benefit amount **or** the Inpatient Surgery and Anesthesia Benefit. For a benefit to be payable, the surgery must be performed within one year after the Covered Accident.

Transportation Benefit
We will pay the amount shown in the Benefit Schedule for transportation. The amount payable will be based on the type of transportation taken. This benefit is payable if, because of a Covered Accident, the Insured:

- Is injured, and
- Requires Doctor-recommended Hospital Treatment or diagnostic study that is not available in the Insured's resident city.

Use of such transportation must begin within six months after the Covered Accident date. The distance to the Hospital Treatment or diagnostic study must be greater than 100 miles from the Insured's residence.

This benefit is limited to the maximum number of payments per Covered Accident, per Insured, shown in the Benefit Schedule.

Coma Benefit
We will pay the amount shown in the Benefit Schedule if the Insured is in a Coma lasting 30 days or more as the result of a Covered Accident. For the purposes of this benefit, *Coma* means a profound state of unconsciousness caused by a Covered Accident.

This benefit is limited to the maximum number of payments per Covered Accident, per Insured, shown in the Benefit Schedule.

Hospitalization Category

Hospital Admission Benefit
We will pay this benefit when an Insured is admitted to a Hospital and confined as an inpatient because of a Covered Accidental Injury. To be eligible to receive this benefit, an Insured must be admitted to a Hospital within six months of the date of the Covered Accident.

We will pay the Hospital Admission Benefit amount shown in the Benefit Schedule. We will not pay benefits for confinement to an observation unit, or for emergency room Treatment or outpatient Treatment. We will pay this benefit once per period of Hospital Confinement.

This benefit is limited to the maximum number of payments per Covered Accident, per Insured, shown in the Benefit Schedule.

Hospital Confinement Benefit
We will pay the amount shown in the Benefit Schedule for each day that an Insured is confined to a Hospital as an inpatient as the result of a Covered Accidental Injury. To be eligible to receive this benefit, the Insured must be

confined to a Hospital within six months of the date of the Covered Accident.

The length of time shown for Hospital Confinement in the Benefit Schedule is the maximum period for which an Insured can collect benefits for Hospital Confinements from Covered Accidental Injuries received in the same Covered Accident. This benefit is not payable for confinement to an observation unit or a Rehabilitation Facility.

If we pay benefits for confinement and the Insured becomes confined again within six months because of the same Accidental Injury, we will treat this confinement as the same period of confinement.

This benefit is payable for only one Hospital Confinement at a time, even if it is caused by more than one Covered Accidental Injury.

Hospital Intensive Care Benefit
If an Insured is confined in a Hospital Intensive Care Unit because of a Covered Accidental Injury, we will pay the daily benefit amount shown in the Benefit Schedule. To be eligible to receive this benefit an Insured must be admitted to a Hospital Intensive Care Unit within six months of the date of the Covered Accident.

We will pay this amount for each day of such confinement, but not to exceed the maximum benefit period shown on the Benefit Schedule during any one period of confinement.

We will pay benefits for only one confinement in a Hospital Intensive Care Unit at a time, even if it is caused by more than one Covered Accidental Injury.

If we pay benefits for confinement in a Hospital Intensive Care Unit and an Insured becomes confined to a Hospital Intensive Care Unit again within six months because of the same Accidental Injury, we will treat this confinement as the same period of confinement.

This benefit is payable in addition to the Hospital Confinement Benefit.

Intermediate Intensive Care Step-Down Unit Benefit
If an Insured is confined in an Intermediate Intensive Care Step-Down Unit because of a Covered Accidental Injury, we will pay the daily benefit amount shown on the Benefit Schedule. The Insured must be admitted to an Intermediate Intensive Care Step-Down Unit within six months of the date of the Covered Accident.

We will pay this amount for each day of such confinement, not to exceed the maximum benefit period shown in the Benefit Schedule during any one period of confinement.

We will pay benefits for only one confinement in an Intermediate Intensive Care Step-Down Unit at a time, even if it is caused by more than one Covered Accidental Injury.

If we pay benefits for confinement in a Hospital's Intermediate Intensive Care Step-Down Unit and the Insured becomes confined to a Hospital's Intermediate Intensive Care Step-Down Unit again within six months because of the same condition, we will treat this confinement as the same period of confinement.

This benefit is payable in addition to the Hospital Confinement Benefit.

Family Member Lodging Benefit
We will pay this benefit in the amount and up to the maximum number of days shown in the Benefit Schedule. We will pay this benefit for each night's lodging in a motel/hotel/rental property for an adult member of the Insured’s immediate family. For this benefit to be payable, because of a Covered Accident:

- The Insured must be confined to a Hospital for Treatment of an Accidental Injury,
- The Hospital and motel/hotel must be more than 100 miles from the Insured's residence, and
- The Treatment must be prescribed by the Insured's treating Doctor.

The Treatment must take place within six months after the Covered Accident for a benefit to be payable.

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After Care Category

Appliances Benefit
We will pay the amount shown in the Benefit Schedule if a Doctor advises the Insured to use a medical appliance. *Medical appliance* means a cane, ankle brace, walking boot, walker, crutches, leg brace, wheelchair, knee scooter, body jacket, back brace, or cervical collar. (Refer to the Benefit Schedule for the amount payable for each type of appliance.) The medical appliance must be used as the result of an Injury received in a Covered Accident. It must be used as an aid in personal locomotion. Proof of Loss for this benefit must include discharge instructions.

For a benefit to be payable, the Doctor's advice to use a medical appliance must be within six months after the Covered Accident.

Accident Follow-Up Treatment Benefit
For injuries received in a Covered Accident, we will pay this benefit under the following conditions:

- The Insured receives initial Treatment within 168 hours after the Covered Accident.
- The Insured receives Doctor-prescribed follow-up Treatment.
- The follow-up Treatment begins within six months after the Covered Accident or discharge from the Hospital.

Follow-up Treatments do not include physical, occupational, or speech therapy. Chiropractic or acupuncture procedures are not considered Follow-up Treatment.

This benefit is limited to the maximum number of payments per Covered Accident, per Insured, shown in the Benefit Schedule.

Post-Traumatic Stress Disorder Benefit
Post-Traumatic Stress Disorder (PTSD) is a mental health condition triggered by a Covered Accident. We will pay the amount shown in the Benefit Schedule if the Insured is diagnosed with Post-traumatic Stress Disorder. An Insured must meet the diagnostic criteria for PTSD, stipulated in the Diagnostic and Statistical Manual of Mental Disorders IV (DSM IV-TR), and be under the active care of either a Psychiatrist or Ph.D.-level Psychologist. The diagnosis must take place within six months after the Covered Accident for a benefit to be payable.

For the purposes of this benefit:

- ***Psychiatrist*** is a Doctor of medicine who specializes in the diagnosis and Treatment of mental disorders.
- ***Psychologist*** is a clinical, mental health professional who works with patients. A Psychologist is not a Doctor of medicine who typically provides medical interventions and drug therapies, but provides analysis and counseling.

This benefit is limited to the maximum number of payments per Covered Accident, per Insured, shown in the Benefit Schedule.

Rehabilitation Unit Benefit
We will pay the daily benefit amount shown in the Benefit Schedule for each day that, due to a Covered Accidental Injury, an Insured receives Treatment as an inpatient at a Rehabilitation Facility. For this benefit to be payable, the Insured must be transferred to the Rehabilitation Facility for Treatment following an inpatient Hospital Confinement.

This benefit is limited to the Calendar Year Maximum and maximum days per Hospital Confinement shown in the Benefit Schedule. We will not pay the Rehabilitation Facility Benefit for the same days that the Hospital Confinement Benefit is paid. We will pay the highest eligible benefit.

Therapy Benefit
For injuries received in a Covered Accident, we will pay this benefit under the following conditions:

- The Insured receives initial Treatment within 168 hours after the Covered Accident.
- The Insured receives Doctor-prescribed therapy Treatment in one of the following categories: physical therapy provided by a licensed physical therapist, occupational therapy provided by a licensed occupational therapist, or speech therapy provided by a licensed speech therapist.
- The therapy Treatment begins within 90 days after the Covered Accident or discharge from the Hospital.

This benefit is limited to the maximum number of payments per Covered Accident, per Insured, shown in the Benefit Schedule.

Chiropractic or Alternative Therapy Benefit
For injuries received in a Covered Accident, we will pay this benefit under the following conditions:

- The Insured receives initial Treatment within 168 hours after the Covered Accident.
- The Insured receives acupuncture or chiropractic Treatment for the Covered Accident.
- The Treatment begins within 90 days after the Covered Accident or discharge from the Hospital.

This benefit is limited to the maximum number of payments per Covered Accident, per Insured, shown in the Benefit Schedule.

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Life Change Events Category

Dismemberment Benefit
We will pay the appropriate amount shown in the Benefit Schedule if, because of a Covered Accident, the Insured:

- Is injured, and
- Loses a hand, a foot, or sight within six months after the accident as a result of the Injury.

If the Insured loses one hand, one foot, or the sight of one eye in a Covered Accident, we will pay the single loss benefit shown in the Benefit Schedule.

If the Insured loses both hands, both feet, the sight of both eyes, or a combination of any two, we will pay the double loss benefit shown in the Benefit Schedule.

If the Insured loses one or more fingers or toes in a Covered Accident, we will pay the finger/toe benefit shown in the Benefit Schedule.

Dismemberment means:

- **Loss of a hand –**The hand is removed at or above the wrist joint; or
- **Loss of a foot –**The foot is removed at or above the ankle; or
- **Loss of sight–**At least 80% of the vision in one eye is lost (such loss of sight must be permanent and irrecoverable); **or**
- **Loss of a finger/toe–**The finger or toe is removed at or above the joint where it is attached to the hand or foot.

If the Insured does not qualify for the Dismemberment Benefit but loses at least one joint of a finger or toe, we will pay the Partial Dismemberment Benefit shown in the Benefit Schedule.

This benefit is limited to the maximum number of payments per Covered Accident, per Insured, shown in the Benefit Schedule.

If the Dismemberment Benefit is paid and the Insured later dies as a result of the same Covered Accident, we will pay the appropriate death benefit (if available), less any amounts paid under this benefit.

Paralysis Benefit
Paralysis means the permanent loss of movement of two or more limbs. We will pay the appropriate amount shown in the Benefit Schedule if, because of a Covered Accident:

- The Insured is injured,
- The Accidental Injury causes paralysis which lasts more than 90 days, and
- The paralysis is diagnosed by a Doctor within six months after the accident.

The amount paid will be based on the number of limbs paralyzed.

This benefit is limited to the maximum number of payments per Covered Accident, per Insured, shown in the Benefit Schedule.

Prosthesis Benefit
We will pay the amount shown in the Benefit Schedule when an Insured receives a Prosthetic Device, prescribed by a Doctor, as a result of a Covered Accidental Injury.

For the purposes of this benefit, ***Prosthetic Device/Prosthesis*** means an artificial device designed to replace a

missing part of the body.

This benefit is not payable for:

- Hearing aids, wigs, or dental aids (to include false teeth).
- Repair or replacement of Prosthetic Devices.*
- Joint replacements.

The amount paid will be based on the number (single or multiple) of Prosthetics received.

* We will pay this benefit again **once** to cover the replacement of a Prosthesis for which a benefit has been paid, provided the replacement takes place within three years of the initial benefit payment.

This benefit is limited to the maximum number of payments per Covered Accident, per Insured, shown in the Benefit Schedule.

Residence/Vehicle Modification Benefit
We will pay the amount shown on the Benefit Schedule for a permanent structural modification to an Insured's primary residence or vehicle when the Insured suffers total and permanent or irrevocable loss of one of the following, due to a Covered Accidental Injury:

- The sight of one eye;
- The use of one hand/arm; or
- The use of one foot/leg.

The modification must occur within one year after the accident.

This benefit is limited to the maximum number of payments per Covered Accident, per Insured, shown in the Benefit Schedule.

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SECTION V: Exclusions

We will not pay benefits for Accidental Injury, disability, or death contributed to, caused by, or resulting from:

- **War** – voluntarily participating in war, any act of war, or military conflicts, declared or undeclared, or voluntarily participating or serving in the military, armed forces, or an auxiliary unit thereto, or contracting with any country or international authority. (We will return the prorated premium for any period not covered by the certificate when the Insured is in such service.) War also includes voluntary participation in an insurrection, riot, civil commotion, or civil state of belligerence. War does not include acts of terrorism.
- **Suicide** – committing or attempting to commit suicide, while sane or insane.
- **Sickness –** having any disease or bodily/mental illness or degenerative process. We also will not pay benefits for:
    - Allergic reactions.
    - Any bacterial, viral, or microorganism infection or infestation or any condition resulting from insect, arachnid, or other arthropod bites or stings.
    - An error, mishap, or malpractice during medical, diagnostic, or surgical treatment or procedure for any sickness.
    - Any related medical/surgical Treatment or diagnostic procedures for such illness.
- **Self-Inflicted Injuries** – injuring or attempting to injure oneself intentionally.
- **Racing** – riding in or driving any motor-driven vehicle in a race, stunt show, or speed test in a professional or semi-professional capacity.
- **Illegal Occupation** – voluntarily participating in, committing, or attempting to commit a felony or illegal act or activity, or voluntarily working at, or being engaged in, an illegal occupation or job.
- **Sports –** participating in any organized sport in a professional or semi-professional capacity for pay or profit.
- **Cosmetic Surgery –** having cosmetic surgery or other elective procedures that are not medically necessary or having dental Treatment except as a result of a Covered Accident.

For 24-Hour Coverage, the following exclusions will not apply:

- An Injury arising from any employment.
- An Injury or sickness covered by Worker's Compensation

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SECTION VI: Claim Provisions

Notice of Claim
The Insured must give written notice of claim:

- No later than the 20th day after a Covered Accidental Injury, or
- As soon as reasonably possible.

When we receive written Notice of Claim, we will send a claim form. If the Claimant does not receive the claim form within 15 days after the notice is sent, written Proof of Loss can be sent to us without waiting for the form. Notice must include the Employee's name and the Certificate number. Notice can be mailed to the Company at the following address:

P.O. Box 84075 Columbus, GA 31993

Proof of Loss
Proof of Loss refers to documentation that supports a claim. (This information is often found in standardized medical documents, such as Hospital bills and operative reports. It can include a statement by the treating Doctor.) Proof of Loss establishes the nature and extent of the loss, the Company's obligation to pay the claim, and the Claimant's right to receive payment.

The Claimant must provide Proof of Loss to the Company at the following address:

P.O. Box 84075 Columbus, GA 31993

Proof of Loss must be given to us within 90 days of the Covered Accidental Injury. Failure to give Proof of Loss within such time shall not invalidate or reduce any claim if such Proof of Loss is given as soon as reasonably possible. The Company will not accept Proof of Loss any later than one year and three months after the Covered Accidental Injury, except in the absence of the Claimant's legal mental capacity.

The Claimant will be responsible for the cost of obtaining a completed claim form. We may request additional Proof of Loss, such as records from Hospitals or Doctors. The Claimant will be responsible for the cost of obtaining these records.

We may require authorizations to obtain medical and psychiatric information as well as non-medical information, including personal financial information.

When we receive the claim and due Proof of Loss, we will review the Proof of Loss. If we approve the claim, we will pay the benefits subject to the terms of the Certificate.

Physical Examination and Autopsy
The Company may have an Insured examined as often as reasonably necessary while a claim is pending. In the case of death, the Company may also require an autopsy, unless prohibited by law. The Company will cover all costs for exams and/or autopsy.

Time of Payment of Claims
For benefits other than for loss of time, the Company will, once we receive the required Proof of Loss, pay, deny, or settle each submitted claim no later than the 60th day after the date Proof of Loss is received. Subject to written Proof of Loss, all accrued benefits payable under the Policy for loss of time will be paid at least monthly during the period for which the Company is liable. Any balance remaining unpaid at the end of that time will be paid as soon as possible after Proof of Loss is received.

Payment of Claims
We will pay all benefits to the Employee unless otherwise assigned. For any benefits that remain unpaid at the time of death, we will pay those benefits in the following order:

- To the beneficiary designated by the Insured or the beneficiary's assignee,
- To the Insured's surviving Spouse,
- To the Insured's estate.

Unpaid Premium
When a claim is paid, we may deduct any premium due and unpaid from the claim payment.

Changing of Beneficiary
A change in beneficiary must be submitted in writing to our Home Office and signed by the Employee. Unless otherwise specified by the Employee, a change in beneficiary will take effect on the date the notice of change is signed. We will not be liable for any action taken before notice is received and recorded at the Home Office.

Claim Review
If a claim is denied, the Employee will be given written notice of:

- The reason for the denial,
- The Plan provision that supports the denial, and
- His right to ask for a review of the claim.

Appeals Procedure
Before filing any lawsuit—and no later than 60 days after notice of denial of a claim—the Employee, the Claimant, or an authorized representative of either must appeal any denial of benefits under the Plan by sending a written request for review of the denial to our Home Office.

Legal Action
The Employee may not take Legal Action against us for benefits under this Plan:

- Within 60 days after he has sent us written Proof of Loss, or
- More than three years from the time written proof is required to be given.

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SECTION VII: General Provisions

Entire Contract Changes
This insurance is provided under a contract of Group Accidental Injury Insurance with the Policyholder. The Entire Contract of Insurance is made up of:

- The Policy;
- The Certificates of Insurance;
- The Application of the Policyholder, a copy of which is attached to and made part of the Policy when issued; and
- Any Riders, Endorsements, or Amendments to the Policy or Certificate.

In the absence of fraud, a statement made by the Policyholder or an Insured is considered a representation and not a warranty. A statement made by the Policyholder or an Insured will not be used in any contest under the Plan, unless a copy of the written instrument containing the statement is or has been provided to:

- The person making the statement; or
- If the statement was made by the Insured, and the Insured has died or become incapacitated, the Insured's beneficiary or personal representative.

Changes to the Plan:

- Will not be valid unless approved in writing by an executive officer of the Company.
- Must be noted on or attached to the Contract.
- May not be made by any agent or producer (nor can an agent or producer waive any Plan provisions).

Misstatement of Age
If an age has been misstated on the Application, the benefits will be those that the paid premium would have purchased at the correct age.

Successor Insured
If an Employee dies while covered under his Certificate and his Spouse is also insured under this Plan at the time of the Employee's death, then his surviving Spouse may elect to become the Primary Insured. This would include continuation of any Dependent Child Rider coverage that is in force at that time.

To become the Primary Insured and keep coverage in force, the surviving Spouse must:

- Notify the Company in writing within 31 days after the date of the Employee's death; and
- Pay the required premium to the Company no later than 31 days after the date of the Employee's death, and on each premium due date thereafter.

If the Certificate does not cover a surviving Spouse, the Certificate will terminate on the next premium due date following the Employee's death.

Time Limit on Certain Defenses
After two years from the Employee's Effective Date of coverage, the Company may not void coverage or deny a claim for any loss because of intentional misstatements, of a material fact, made on the Employee's Application. This does not apply to fraudulent misstatements.

Clerical Error
Clerical error by the Policyholder will not end coverage or continue terminated coverage. In the event of a clerical error, the Company will make a premium adjustment.

Individual Certificates

The Company will make available to the Policyholder a Certificate for Employees. The Certificate will set forth:

- The coverage,
- To whom benefits will be paid, and
- The rights and privileges under the Plan.

Required Information

The Policyholder will be responsible for furnishing all information and proofs that the Company may reasonably require with regard to the Plan.

Conformity with State Statutes

This Plan was issued on its Effective Date in the state noted on the Master Application. Any Plan provision that conflicts with that state's statutes is amended to conform to the minimum requirements of those statutes.

POLICY SCHEDULE

Group Policyholder:	T Mobile USA
Group Policy Number:	0003254505
Group Policy Effective Date:	January 1, 2025
Group Policy Anniversary Date:	January 1, 2026
Jurisdiction:	Texas

24-Hour Coverage

*Initial premium includes the premium for any Riders purchased at the same time as the coverage provided by an

Employee's Certificate. This Plan is delivered in and governed by the laws of the jurisdiction shown above.

BENEFIT SCHEDULE

	Primary Insured	Spouse	Child(ren)
Initial Treatment Category			
Initial Treatment Benefit			
Hospital emergency room with X-Ray	$250	$250	$250
Hospital emergency room without X-Ray	$200	$200	$200
Urgent Care facility with X-Ray	$250	$250	$250
Urgent Care facility without X-Ray	$200	$200	$200
Office or facility (other than a Hospital emergency room or Urgent Care) with X-Ray	$225	$225	$225
Office or facility (other than a Hospital emergency room or Urgent Care) without X-Ray	$175	$175	$175
Maximum number of payments per Covered Accident, per Insured	1	1	1
Ambulance Benefit	$300	$300	$300
Maximum number of payments per Covered Accident, per Insured	1	1	1
Air Ambulance Benefit	$1,250	$1,250	$1,250
Maximum number of payments per Covered Accident, per Insured	1	1	1
Major Diagnostic Testing Benefit	$200	$200	$200
Maximum number of payments per Covered Accident, per Insured	1	1	1
Emergency Room Observation Benefit			
Per each 24 hour period of observation	$100	$100	$100
Period of observation at least 4 hours and up to 24 hours	$35	$35	$35
Prescriptions Benefit	$5	$5	$5
Maximum number of payments per Covered Accident, per Insured	2	2	2
Pain Management Benefit	$100	$100	$100
Maximum number of payments per Covered Accident, per Insured	1	1	1
Blood/Plasma/Platelets Benefit	$500	$500	$500
Maximum number of payments per Covered Accident, per Insured	3	3	3
Concussion Benefit	$250	$250	$250
Maximum number of payments per Covered Accident, per Insured	1	1	1
Traumatic Brain Injury Benefit	$2,500	$2,500	$2,500
Maximum number of payments per Covered Accident, per Insured	1	1	1
Burns Benefit			
Second Degree			
Less than 10%	$100	$100	$100
At least 10% but less than 25%	$200	$200	$200
At least 25% but less than 35%	$500	$500	$500
35% or more	$1,000	$1,000	$1,000
Third Degree			
Less than 10%	$1,000	$1,000	$1,000
At least 10% but less than 25%	$5,000	$5,000	$5,000
At least 25% but less than 35%	$10,000	$10,000	$10,000
35% or more	$20,000	$20,000	$20,000
Maximum number of payments per Covered Accident, per Insured	1	1	1
Emergency Dental Work Benefit			
Repair with crown	$300	$300	$300
Extraction	$75	$75	$75
Eye Injuries Benefit	$100	$100	$100
Dislocation Benefit			
Hip	$7,500	$7,500	$7,500
Knee (not knee cap)	$4,875	$4,875	$4,875

	Primary Insured	Spouse	Child(ren)
Shoulder	$3,750	$3,750	$3,750
Foot/ankle	$3,000	$3,000	$3,000
Hand	$2,625	$2,625	$2,625
Lower jaw	$2,250	$2,250	$2,250
Wrist	$1,875	$1,875	$1,875
Elbow	$1,500	$1,500	$1,500
Finger/toe	$600	$600	$600
Laceration Benefit			
Over 15 centimeters	$500	$500	$500
5 to 15 centimeters	$250	$250	$250
Under 5 centimeters	$50	$50	$50
Lacerations not requiring stitches	$25	$25	$25
Fracture Benefit			
Hip/thigh	$5,000	$5,000	$5,000
Vertebrae	$4,200	$4,200	$4,200
Pelvis	$4,000	$4,000	$4,000
Skull (depressed)	$5,000	$5,000	$5,000
Skull (simple)	$1,750	$1,750	$1,750
Leg	$2,800	$2,800	$2,800
Foot/ankle/knee cap	$2,500	$2,500	$2,500
Forearm/hand/wrist	$2,500	$2,500	$2,500
Lower jaw	$2,000	$2,000	$2,000
Shoulder blade/collar bone	$2,500	$2,500	$2,500
Upper arm/upper jaw	$2,750	$2,750	$2,750
Facial bones (except teeth)	$1,400	$1,400	$1,400
Vertebral processes	$2,000	$2,000	$2,000
Coccyx/rib/finger/toe	$600	$600	$600
Sternum	$3,600	$3,600	$3,600
Sacral/Sacrum	$2,000	$2,000	$2,000
Outpatient Surgery and Anesthesia Benefit			
Hospital Outpatient or Ambulatory Surgical Center	$650/day	$650/day	$650/day
Doctor's Office or Emergency Room	$25/day	$25/day	$25/day
(Maximum is applicable only to Doctor's office or Emergency Room)			
Maximum number of payments per Covered Accident, per Insured	2	2	2
Inpatient Surgery and Anesthesia Benefit	$1,000/day	$1,000/day	$1,000/day
Transportation Benefit			
Plane	$650	$650	$650
Any Ground Transportation	$650	$650	$650
Maximum number of payments per Covered Accident, per Insured	3	3	3
Coma Benefit	$14,500	$14,500	$14,500
Maximum number of payments per Covered Accident, per Insured	1	1	1

	Primary Insured	Spouse	Child(ren)
Hospitalization Category			
Hospital Admission Benefit	$1,125	$1,125	$1,125
Maximum number of payments per Covered Accident, per Insured	1	1	1
Hospital Confinement Benefit	$350/day	$350/day	$350/day
Maximum Benefit Period: 365 days			
Hospital Intensive Care Benefit	$175/day	$175/day	$175/day
Maximum Benefit Period: 30 days			
Intermediate Intensive Care Step-Down Unit Benefit	$100/day	$100/day	$100/day
Maximum Benefit Period: 30 days			
Family Member Lodging Benefit	$150/day	$150/day	$150/day
Maximum Benefit Period: 30 days			

	Primary Insured	Spouse	Child(ren)
After Care Category			
Appliances Benefit			
Cane	$25	$25	$25
Ankle Brace	$25	$25	$25
Walking Boot	$100	$100	$100
Walker	$100	$100	$100
Crutches	$100	$100	$100
Leg Brace	$100	$100	$100
Wheelchair	$200	$200	$200
Knee Scooter	$200	$200	$200
Body Jacket	$200	$200	$200
Back Brace	$200	$200	$200
Cervical Collar	$100	$100	$100
Accident Follow-Up Treatment Benefit	$75	$75	$75
Maximum number of payments per Covered Accident, per Insured	6	6	6
Post-Traumatic Stress Disorder Benefit	$200	$200	$200
Maximum number of payments per Covered Accident, per Insured	1	1	1
Rehabilitation Unit Benefit	$150/day	$150/day	$150/day
Maximum Benefit Period per Hospital confinement	90 days	90 days	90 days
Calendar Year Maximum	180 days	180 days	180 days
Therapy Benefit	$40	$40	$40
Maximum number of payments per Covered Accident, per Insured	6	6	6
Chiropractic or Alternative Therapy Benefit	$40	$40	$40
Maximum number of payments per Covered Accident, per Insured	6	6	6

	Primary Insured	Spouse	Child(ren)
Life Change Events Category			
Dismemberment Benefit			
Loss of hand, foot, or sight:			
Single loss	$12,500	$5,000	$2,500
Double loss	$25,000	$10,000	$5,000
Loss of one or more fingers or toes	$1,250	$500	$250
Partial amputation of finger or toe	$125	$125	$125
Maximum number of payments per Covered Accident, per Insured	1	1	1
Paralysis			
Four limbs (quadriplegia)	$20,000	$20,000	$20,000
Two limbs (paraplegia)	$13,500	$13,500	$13,500
Maximum number of payments per Covered Accident, per Insured	1	1	1
Prosthesis Benefit			
Single	$750	$750	$750
Multiple	$1,500	$1,500	$1,500
Maximum number of payments per Covered Accident, per Insured	1	1	1
Residence/Vehicle Modification Benefit	$500	$500	$500
Maximum number of payments per Covered Accident, per Insured	1	1	1

Incorporation Of Rider Provisions

The attached listed Riders are made a part of this Plan.

Rider Name	Form Number
Continuation of Coverage Endorsement	C00704TX
Wellness Rider	C70301TX
Organized Athletic Activity Rider	C70304TX
Accidental Death Rider	C70305TX

Classification and Schedule of Premiums

Schedule of Weekly Premiums (52)
EE: $2.20
EE & Dependent Spouse: $3.56
EE & Dependent Child(ren) $4.61
Family: $5.97

CONTINENTAL AMERICAN INSURANCE COMPANY

Columbia, South Carolina 800.433.3036

Please call the toll-free number above with any questions about this coverage.

Amendment
to Policy and Certificate of Insurance for Group Accidental Injury

This Amendment is subject to all of the provisions of the Policy and Certificate to which it is attached. Additions or changes have been made to the Policy and Certificate and are indicated below.

EFFECTIVE DATE
If issued at the same time as the Certificate, this Amendment becomes effective at the same time as the Certificate. If issued after the Certificate, this Amendment will have a later Effective Date.

The definition of Dependent Child or Dependent Children is deleted and replaced with the following:
Dependent Child or ***Dependent Children*** means your or your Spouse's natural children, step-children, grandchildren who are in your legal custody and residing with you, foster children, children subject to legal guardianship, adopted children, or Children Placed for Adoption, who are younger than age 26. However, we will continue coverage for Dependent Children insured under the Plan after the age of 26 if they are incapable of self-sustaining employment due to mental or physical disability, and are chiefly dependent on a parent for support and maintenance. You or your Spouse must furnish proof of this incapacity and dependency to the Company within 31 days following the Dependent Child's 26th birthday.

The insurance on any Dependent Child will terminate on the last day of the month in which the Dependent Child turns age 26; it is your responsibility to notify us in writing when coverage on a Dependent Child terminates. Termination will be without prejudice to any claim originating prior to the date of termination. Our acceptance of premium after such date will be considered as premium for only the remaining persons who qualify as Insureds under this Plan.

When coverage on all Dependent Children terminates, you must notify the Company, in writing, and elect whether to continue this Plan on an Employee or Employee and Spouse Coverage basis. After such notice, we will arrange for the payment of the appropriate premium due, including returning any unearned premium.

Children Placed for Adoption are children for whom you have entered a decree of adoption, have initiated adoption proceedings, or are a party to a suit in which you seek to adopt the child. A decree of adoption must be entered within one year from the date proceedings were initiated, unless extended by order of the court. You must continue to have custody pursuant to the decree of the court.

CONTRACT
This Amendment is part of the Policy and Certificate and will terminate when the Policy or Certificate terminates.

Signed for the Company at its Home Office,

Virgil R. Miller, President

J. Matthew Loudermilk, Secretary

CONTINENTAL AMERICAN INSURANCE COMPANY

Columbia, South Carolina
800.433.3036

Please call the toll-free number above with any questions about this coverage.

Continuation of Coverage Endorsement

This Endorsement is part of the Policy and Certificate to which it is attached. This Endorsement is subject to all the definitions, terms, and other provisions of the Policy and Certificate to which it is attached, unless those terms are inconsistent with this Endorsement.

EFFECTIVE DATE
If issued at the same time as the Certificate, this Endorsement becomes effective when the Certificate becomes effective. If issued after the Certificate, this Endorsement will have a later Effective Date.

The following provisions are added after the Continuation Privilege provision in your Certificate:
CONTINUATION OF COVERAGE
If the Group Policy is terminated by the Policyholder and is not replaced with another group policy you may apply to continue the coverage you had on the Group Policy termination date. This includes any in-force Spouse or Dependent Child coverage. The Group Policy will be continued as if the Group Policy is in force for those who have applied to continue their coverage under this provision. The members will continue to have coverage, with their Certificates remaining in force.

The Company will apply the same benefits and plan provisions as shown in your Certificate on the date you are eligible to continue coverage under this provision. Your continued coverage is subject to all of the provisions, exclusions and limitations of the Group Policy.

To keep your Certificate in force, you must:

- Apply to the Company in writing under this Continuation of Coverage provision within 31 days after the date your Certificate would terminate, **and**
- Pay the required premium no later than 31 days after the date the Certificate would terminate and on each premium due date thereafter to the Company at our Customer Service Center in Columbus, Georgia.

PREMIUMS
Initial premium rates will be based on the rates in effect at the time you apply to continue your coverage. Premium rates can be changed by the Company at any time upon 60 days written notice to you. Any such change will be applied to all Certificates in your class and will not be based on your or your Spouse and Dependent Children's health or other individual factors.

You may decrease, but not increase, the amount of your coverage, and the amount of your Spouse's coverage, if any.

TERMINATION
Your continued coverage, including any in-force Spouse or Dependent Child coverage, will end:

- 31 days after the date you fail to pay any required premium.

- When coverage is terminated by the Company. We will provide you a 31-day advance written notice of any termination.
- On the date you die (unless your Spouse elects to become the Primary Insured under the Successor Insured provision, if applicable).

Once continued coverage is cancelled it cannot be reinstated. If your coverage terminates, we will provide benefits for valid claims that arose while your coverage was active.

CONTRACT

This Endorsement is part of the Certificate. It will terminate when:

- The Certificate terminates.

Signed for the Company at its Home Office,

Virgil R. Miller, President

J. Matthew Loudermilk, Secretary

CONTINENTAL AMERICAN INSURANCE COMPANY

Columbia, South Carolina
800.433.3036

Please call the toll-free number above with any questions about this coverage.

Wellness Rider
To Certificate of Insurance for Group Accidental Injury Insurance Policy

This Rider is part of the Certificate to which it is attached. We have issued this Rider because:

- We have accepted your Application, and
- You have paid the additional premium for this Rider.

This Rider is subject to all the definitions, exclusions, limitations, terms, and other provisions of the Certificate to which it is attached, unless those terms are inconsistent with this Rider.

EFFECTIVE DATE

If issued at the same time as the Certificate, this Rider becomes effective when the Certificate becomes effective. If issued after the Certificate, this Rider will have a later Effective Date.

WELLNESS BENEFIT

We will pay the amount shown in the Benefit Schedule for the following:

- Annual physical exams.
- Mammograms.
- Pap smears.
- Eye examinations.
- Immunizations.
- Flexible sigmoidoscopy.
- PSA tests.
- Ultrasounds.
- Blood screening.

This benefit is only payable for Wellness Tests performed as the result of preventive care, including tests and diagnostic procedures ordered in connection with routine examinations.

This benefit is limited to the maximum number of payments shown in the Benefit Schedule.

GENERAL PROVISIONS

Time Limit on Certain Defenses

After two years from the Insured's Effective Date of coverage, the Company may not void coverage or deny a claim for any loss because of intentional misstatements, of a material fact, made on the Application. This does not apply to fraudulent misstatements.

CONTRACT

This Rider is part of the Group Accidental Injury Insurance Policy. It will terminate when:

- The Certificate terminates, or
- Premiums are no longer paid for this Rider.

Signed for the Company at its Home Office,

Virgil R. Miller, President

J. Matthew Loudermilk, Secretary

WELLNESS RIDER BENEFITS SCHEDULE

	Primary Insured	Spouse	Child
Wellness	$60	$60	$60
Maximum number of payments per Calendar Year, per Insured	1	1	1

CONTINENTAL AMERICAN INSURANCE COMPANY

Columbia, South Carolina
800.433.3036

Please call the toll-free number above with any questions about this coverage.

Organized Athletic Activity Rider
To Certificate of Insurance for Group Accidental Injury Insurance Policy

This Rider is part of the Certificate to which it is attached. We have issued this Rider because:

- We have accepted your Application, and
- You have paid the additional premium for this Rider.

This Rider is subject to all the definitions, exclusions, limitations, terms, and other provisions of the Certificate to which it is attached, unless those terms are inconsistent with this Rider.

EFFECTIVE DATE

If issued at the same time as the Certificate, this Rider becomes effective when the Certificate becomes effective. If issued after the Certificate, this Rider will have a later Effective Date.

DEFINITIONS

Organized Athletic Activity means an athletic competition or supervised organized practice for an athletic competition. Organized Athletic Activities take place on a regularly occurring and scheduled basis, often during a pre-determined season. The competition must be governed by a set of written rules and officiated by someone certified to act in that capacity. The competition must also be overseen by a legal entity such as a public school system or sports conference. The legal entity must have a set of bylaws and competition must take place on a regulation playing surface. Participation must be on an amateur basis.

ORGANIZED ATHLETIC ACTIVITY BENEFIT

We will pay an additional 25 percent of the benefit amount payable under this Plan for Covered Accidental Injuries sustained while participating in an Organized Athletic Activity.

LIMITATIONS

The Organized Athletic Activity Benefit is not payable for Accidental Injuries that are caused by or occur as a result of an Insured's participating in any sport or sporting activity for wage, compensation, or profit, including officiating or coaching; or racing any type vehicle in an organized event. Refer to your Certificate for other limitations or exclusions applicable to this coverage.

This benefit is also not payable for Accidental Injuries which occur during or are due to physical education classes.

GENERAL PROVISIONS

Time Limit on Certain Defenses

After two years from the Insured's Effective Date of coverage, the Company may not void coverage or deny a claim for any loss because of intentional misstatements, of a material fact, made on the Application. This does not apply to fraudulent misstatements.

CONTRACT

This Rider is part of the Group Accidental Injury Insurance Policy. It will terminate when:

- The Certificate terminates, or
- Premiums are no longer paid for this Rider.

Signed for the Company at its Home Office,

Virgil R. Miller, President

J. Matthew Loudermilk, Secretary

ORGANIZED ATHLETIC ACTIVITY RIDER BENEFITS SCHEDULE

	Primary Insured	Spouse	Child
Organized Athletic Activity Benefit			
Percentage of Benefit Amount Payable	25%	25%	25%

CONTINENTAL AMERICAN INSURANCE COMPANY

Columbia, South Carolina
800.433.3036

Please call the toll-free number above with any questions about this coverage.

Accidental Death Rider
To Certificate of Insurance for Group Accidental Injury Insurance Policy

This Rider is part of the Certificate to which it is attached. We have issued this Rider because:

- We have accepted your Application, and
- You have paid the additional premium for this Rider.

This Rider is subject to all the definitions, exclusions, limitations, terms, and other provisions of the Certificate to which it is attached, unless those terms are inconsistent with this Rider.

EFFECTIVE DATE

If issued at the same time as the Certificate, this Rider becomes effective when the Certificate becomes effective. If issued after the Certificate, this Rider will have a later Effective Date.

DEFINITIONS

When the terms below are used in this Rider, the following definitions will apply (other applicable terms and definitions are included in the **Definitions** section of your Certificate):

Common Carrier means:

- An airline carrier that is licensed by the United States Federal Aviation Administration and operated by a licensed pilot on a regular schedule between established airports;
- A railroad train that is licensed and operated for passenger service only; or
- A boat or ship that is licensed for passenger service and operated on a regular schedule between established ports.

BENEFITS

Accidental Death Benefit

We will pay the amount shown in the Rider Schedule if, because of a Covered Accident:

- The Insured is injured, and
- The Injury causes the Insured to die within 90 days after the accident.

We will pay the Accidental Death Benefit in addition to the Accidental Common-Carrier Death Benefit.

Accidental Common-Carrier Death Benefit

We will pay the amount shown in the Rider Schedule if the Insured:

- Is a fare-paying passenger on a Common Carrier,
- Is injured in a Covered Accident, and
- Dies within 90 days after the Covered Accident.

We will pay the Accidental Common-Carrier Death Benefit in addition to the Accidental Death Benefit.

GENERAL PROVISIONS

Time Limit on Certain Defenses
After two years from the Insured's Effective Date of coverage, the Company may not void coverage or deny a claim for any loss because of intentional misstatements, of a material fact, made on the Application. This does not apply to fraudulent misstatements.

CONTRACT

This Rider is part of the Group Accidental Injury Insurance Policy. It will terminate when:

- The Certificate terminates, or
- Premiums are no longer paid for this Rider.

Signed for the Company at its Home Office,

Virgil R. Miller, President

J. Matthew Loudermilk, Secretary

ACCIDENTAL DEATH RIDER BENEFITS SCHEDULE

	Primary Insured	Spouse	Child
Accidental Death	$50,000	$25,000	$10,000
Accidental Common-Carrier Death	$100,000	$50,000	$20,000

CONTINENTAL AMERICAN INSURANCE COMPANY

Columbia, South Carolina
800.433.3036

NOTICE OF NON-INSURANCE BENEFITS ENDORSEMENT

This Endorsement is added to and part of the Policy to which it is attached.

Continental American Insurance Company (CAIC) may offer or provide goods and/or services that are not related to insurance. The services will fall under the same benefit plan that includes or is related to the applicable CAIC coverage, individual wellness programs, and related services.

The services may be offered by the Policyholder, at the Policyholder's discretion, to its group employees. While the Endorsement is attached to the Policy, it is at the group employee's sole discretion to utilize the services listed below. Any one or more of the services listed below may be available, but may not represent the group employee's exact selection.

Though CAIC has arranged these goods, services, and/or third-party provider discounts, the third-party providers—**not CAIC**—are liable to group employeesfor these goods and services. CAIC is not responsible for providing the goods and/or services, nor is CAIC liable to group employeesfor the negligent provision of these goods and/or services by third-party service providers. The third-party providers will address inquiries from group employees about the provision of these goods, services, and/or third-party discounts. In the event the third-party provider cannot meet contractual obligations, CAIC will pursue a new contract with a similar vendor to provide the services listed below. Access to these services will end when Plan coverage ends, as described in the Termination provisions in the Master Policy.

The services listed below incur a $2/month service charge. This service charge is included in the premium amount shown on the Certificate Schedule.

- **Fraud Protection** – this third-party service offers fraud protection that will secure and monitor personal information and provide identity restoration services in the event of identity theft or fraud.
- **Core Advocacy** – this third-party service offers access to a dedicated, Personal Health Advocate who can help solve a wide variety of health- and insurance-related issues, such as:
  - Reviewing and explaining medical coverage and offering advice on care options and costs.
  - Locating providers for second opinions.
  - Scheduling appointments with specialists.
  - Clarifying complex conditions.
  - Resolving insurance claims.
  - Addressing eldercare issues and coordinating long-distance support for family members.
- **Medical Bill Saver** – this third-party service offers highly skilled negotiators to work on the group employees' behalf to obtain a discount on any medical or dental bill over $400 not covered by insurance, regardless of insurance or benefit status.
- **Telemedicine** – this third-party service offers a low-cost option for medical care by enabling group employees to connect with a medical provider online and receive personalized treatment. The Telemedicine visit could cost between $25 and $195. When medically appropriate, providers submit an e-prescription to a local pharmacy for purchase, pick up, and review (in person) with a local pharmacist.
- **Discount Bundle –** this third-party service offers discounts on dental, vision, pharmacy and hearing

care services to group employees through a web portal. The discounts for the dental, hearing, and vision services are available with a purchase of a $12 pass, which allows access to a network of providers in the group employee's geographical location.

- **Personal Wellness** – this third-party services helps group employees develop a healthy lifestyle plan to achieve their wellness goals through online workshops and tools related to weight loss, nutrition, stress management, tobacco cessation, and related issues.
- **Financial and Legal Fitness** – this third-party service assists group employees with online tools for financial and legal preparedness on topics such as eldercare, estate and retirement planning, college savings plans and budgeting, financial calculators, webinars and tutorials, and articles providing general financial education. Service also provides limited complementary access to consultative services from licensed professionals to assist with legal and financial matters.
- **Online Family Care Resource** – this third-party service offers access to a comprehensive online resource enabling group employees to manage their family care needs through services such as locating emergency child care, nanny services and elder care, daycare, tutors, dog-sitters/walkers, home companions and personal care services.
- **Student Loan Assistance** – this third-party service offers employers an administrative service to assist them in coordinating the payment of their group employee's student loans. The service also provides a refinancing market to assist group employees in paying down their student loans quicker.
- **College Advisory Service** – this third-party service provides assistance to group employees by helping to create a long-term plan for their children's educational future. The service helps the group employee navigate the intricacies of applying for college, financing college tuition, and understanding financial aid.
- **Employee Assistance Program** - this third-party service offers counseling with available licensed professional counselors to address stress, depression, family issues, substance abuse, and other topics.
- **Funeral Concierge** - this third-party service provides personal advisors who are available 24-hours a day to help with all funeral-related issues, including developing a personal funeral plan, and negotiation assistance for funeral services.
- **Travel Assistance** - this third-party service provides 24-hour, toll-free service for a comprehensive range of information, referral, coordination and arrangement services designed to respond to most medical care situations and many other emergencies group employees may encounter when they travel.
- **Flexible Spending Administration** – this third-party service administers funds designated by the group employee for payment of tax qualified medical expenses and dependent-care expenses.

Signed for the Company at its Home Office,

Virgil R. Miller, President

J. Matthew Loudermilk, Secretary

For assistance or information about this notice, call 800.433.3036.

How you're protected if your life or health insurance company fails

The Texas Life and Health Insurance Guaranty Association protects you by paying your covered claims if your life or health insurance company is insolvent (can't pay its debts). **This notice summarizes your protections.**

The Association will pay your claims, with some exceptions required by law, if your company is licensed in Texas and a court has declared it insolvent. You must live in Texas when your company fails. If you don't live in Texas, you may still have some protections.

For each insolvent company, the Association will pay a person's claims only up to these dollar limits set by law:

- **Accident, accident and health, or health insurance (including HMOs):**
  - Up to $500,000 for health benefit plans, with some exceptions.
  - Up to $300,000 for disability income benefits.
  - Up to $300,000 for long-term care insurance benefits.
  - Up to $200,000 for all other types of health insurance.

- **Life insurance:**
  - Up to $100,000 in net cash surrender or withdrawal value.
  - Up to $300,000 in death benefits.

- **Individual annuities:** Up to $250,000 in the present value of benefits, including cash surrender and net cash withdrawal values.

- **Other policy types:** Limits for group policies, retirement plans and structured settlement annuities are in Chapter 463 of the Texas Insurance Code.

- **Individual aggregate limit:** Up to $300,000 per person, regardless of the number of policies or contracts. A limit of $500,000 may apply for people with health benefit plans.

- **Parts of some policies might not be protected:** For example, there is no protection for parts of a policy or contract that the insurance company doesn't guarantee, such as some additions to the value of variable life or annuity policies.

To learn more about the Association and your protections, contact:	For questions about insurance, contact:
Texas Life and Health Insurance Guaranty Association 515 Congress Avenue, Suite 1875 Austin, TX 78701 1-800-982-6362 or www.txlifega.org	**Texas Department of Insurance** P.O. Box 149104 Austin, TX 78714-9104 1-800-252-3439 or www.tdi.texas.gov

Note: You're receiving this notice because Texas law requires your insurance company to send you a summary of your protections under the Texas Life and Health Insurance Guaranty Association Act (Insurance Code, Chapter 463). These protections apply to insolvencies that occur on or after September 1, 2019. **There may be other exceptions that aren't included in this notice.** When choosing an insurance company, you should not rely on the Association's coverage. Texas law prohibits companies and agents from using the Association as an inducement to buy insurance or HMO coverage.

Chapter 463 controls if there are differences between the law and this summary.

C00502.1TX

CONTINENTAL AMERICAN INSURANCE COMPANY

Columbia, South Carolina
800.433.3036

Endorsement
to Policy and Certificate of Insurance

This Endorsement alters the Policy and the Certificate to which it is attached. Unless specifically addressed by this Endorsement, all other Policy and Certificate provisions, definitions, and terms continue to apply.

Continental American Insurance Company's mailing addresses for claims and premium payments are changed as listed below.

Notice of Claim and **Proof of Loss** should be mailed to the Company at:

P.O. Box 84075, Columbus, Georgia, 31993-9103

Premium Payments should be mailed to the Company at:

P.O. Box 84069, Columbus, Georgia, 31908-4069

If applicable, references to 2801 Devine Street, Columbia, SC 29205 are deleted.

Signed for the Company at its Home Office,

Virgil R. Miller, President

J. Matthew Loudermilk, Secretary

Have a complaint or need help?

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

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

Continental American Insurance Company

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

Call: Continental American Insurance Company at 1-800-433-3036 Toll-free:

1-800-433-3036

Email: cscmail@aflac.com

Mail: Continental American Insurance Company
Post Office Box 427
Columbia, South Carolina 29202

The Texas Department of Insurance

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

Call: 1-800-252-3439

Online: www.tdi.texas.gov

Email: ConsumerProtection@tdi.texas.gov

Mail: MC 111-1A, P.O. Box 149091, Austin, TX 78714

¿Tiene una queja o necesita ayuda?

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

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

Continental American Insurance Company

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

Llame a: Continental American Insurance Company al 1-800-433-3036 Teléfono gratuito:

1-800-433-3036

Correo electrónico: cscmail@aflac.com

Dirección postal: Continental American Insurance Company
Post Office Box 427
Columbia, South Carolina 29202

El Departamento de Seguros de Texas

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

Llame: 1-800-252-3439

En línea: www.tdi.texas.gov

Correo electrónico: ConsumerProtection@tdi.texas.gov

Dirección postal: MC 111-1A, P.O. Box 149091, Austin, TX 78714

Hospital Indemnity Plan

CONTINENTAL AMERICAN INSURANCE COMPANY

Columbia, South Carolina
800.433.3036

Please call the toll-free number above with any questions about this coverage.

Group Supplemental Hospital Indemnity Policy

This limited Plan provides supplemental benefits only. It does not constitute comprehensive health insurance coverage and does not satisfy the requirement of Minimum Essential Coverage under the Affordable Care Act.

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

This Policy is not a Medicare Supplement Policy. If you are eligible for Medicare, review the Guide to Health Insurance for People with Medicare available from the company.

THIS IS NOT A POLICY OF WORKERS' COMPENSATION INSURANCE. THE EMPLOYER DOES NOT BECOME A SUBSCRIBER TO THE WORKERS' COMPENSATION SYSTEM BY PURCHASING THIS POLICY, AND IF THE EMPLOYER IS A NON-SUBSCRIBER, THE EMPLOYER LOSES THOSE BENEFITS WHICH WOULD OTHERWISE ACCRUE UNDER THE WORKERS' COMPENSATION LAWS. THE EMPLOYER MUST COMPLY WITH THE WORKERS' COMPENSATION LAW AS IT PERTAINS TO NON-SUBSCRIBERS AND THE REQUIRED NOTIFICATIONS THAT MUST BE FILED AND POSTED.

This Plan provides the benefits listed in the Benefit Schedule. Please read it carefully.

The Policyholder as shown on the Policy Schedule applied for coverage under this Group Supplemental Hospital Indemnity Insurance Policy (the "Plan"). This Plan is issued by Continental American Insurance Company (the "Company," "CAIC," "we," "us," or "our"). Based on the Master Application and the timely payment of premiums, the Company agrees to pay the benefits provided on the following pages. (Please note that male pronouns—such as "he," "him," and "his"—are used for both males and females, unless the context clearly shows otherwise.) The Policyholder may add new Insureds from time to time, according to the Plan's terms.

You will notice that certain words and phrases (including some medical terms and the names of Plan documents) in this document are capitalized. The capitalized words refer to terms with very specific definitions as they apply to this insurance Plan.

This Plan is a legal contract between the Company and the Policyholder. All material printed by the Company on the following pages is part of the Plan. This Plan is delivered in and governed by the laws of the jurisdiction shown on the Policy Schedule.

In witness whereof, the Company executes this Plan at its home office in Columbia, South Carolina, on the Effective Date.

Signed for the Company at its Home Office,

Virgil R. Miller, President

J. Matthew Loudermilk, Secretary

Group Supplemental Hospital Indemnity Insurance Non-Participating

Continental American Insurance Company (CAIC), a proud member of the Aflac family of insurers, is a wholly-owned subsidiary of Aflac Incorporated and underwrites group coverage.

Notice of Non-Insurance Benefits

The Company may offer or provide goods and/or services that are not related to insurance. These goods and services, which could be offered or provided to some people who apply for Continental American Insurance Company (CAIC) coverage or become insured by CAIC, may include (but are not limited to) the following:

- Enrollment services
- Educational services
- Benefit statement services
- Payroll or plan administration services

- The services listed above will fall under the same benefit plan that includes or is related to the applicable CAIC coverage, individual wellness programs, and related services.

In addition, CAIC may arrange for third-party service providers to provide discounted goods and services to people who apply for CAIC coverage or who become insured by CAIC.

Though CAIC has arranged these goods, services, and/or third-party provider discounts, the third-party providers—**not CAIC**—are liable to applicants/insureds for these goods and services. CAIC is not responsible for providing the goods and/or services, nor is CAIC liable to applicants/insureds for the negligent provision of these goods and/or services by third-party service providers.

For information about this notice, call 800.433.3036.

SECTION I: Eligibility, Effective Date, And Termination

Eligibility

An Employee is eligible to be covered under this Plan if he is Actively at Work for the Policyholder and included in the class that is eligible for coverage, as shown on the Master Application.

Insureds are defined as those who might be eligible for coverage under this Plan in the following categories:

- **Employee Coverage –** We insure only the Employee.
- **Employee and Spouse Coverage** – We insure the Employee and spouse (as defined in the applicable rider).
- **Employee and Children Coverage –** We insure the Employee and any dependent children (as defined in the applicable rider).
- **Family Coverage –** We insure the Employee, spouse, and any dependent children (as defined in the applicable rider).

We will not insure anyone specifically excluded from coverage by Endorsement to the Certificate or by application, even if that person would otherwise be eligible for coverage.

Details for adding Insureds to Plan coverage are outlined in the Effective Date section.

Effective Date

The Plan's Effective Date is shown on the Policy Schedule. This Plan becomes effective on the Policy Effective Date at 12:01 a.m., as determined by the Policyholder's address.

"An eligible Employee must be enrolled in this Plan and the required premiums paid for coverage to become effective. He must be enrolled within 31 days of the date he first becomes eligible for coverage."

We may require evidence of insurability satisfactory to us if we do not receive the Application within 31 days after the Employee was first eligible for coverage. Evidence of insurability may also be required based on an agreement between the Policyholder and us.

An Employee's Effective Date is the date his insurance takes effect. After we receive and approve the Application, that date is either:

- The date shown on the Certificate Schedule if the Employee is Actively at Work on that date, or
- The date the Employee returns to an Actively-at-Work status if he was not Actively at Work on the date shown on the Certificate Schedule.

If Employee and Spouse, Employee and Children, or Family Coverage is offered:

- A Dependent may be added to the Plan after the Employee's Effective Date within 31 days of a Life Event or during an approved enrollment period.
- If Dependent Child Rider coverage **is already in force**, no additional notice or premium is required to add another dependent child.
- If Dependent Spouse Rider or Dependent Child Rider coverage is **not** in force, the Employee must complete an Application to add a Dependent to the Plan. The Company will assign a Dependent Rider Effective Date for a Dependent's coverage after approving the Application. For Dependent coverage to become effective, the premium for the Dependent must be included in the premium payment.
- If Dependent Child Rider coverage is not already in force, ***newborn*** children are automatically covered from the moment of birth for 60 days. ***Newly adopted*** children are automatically covered from the earlier of a) placement for adoption, b) the date of entry of an order granting custody of the child for the purposes

of adoption, or c) the effective date of adoption, for 60 days. To extend coverage beyond 60 days with no gap in coverage, the Employee must contact the Company within the 60-day time period following the child's birth or adoption. No premium is due for the first 60 days of newborn/newly adopted coverage.

A day begins at 12:01 a.m. standard time at the Employee's place of residence.

Plan Termination

The **Company** has the right to cancel the Plan on any premium due date for the following reasons:

- The premium is not paid before the end of the Grace Period,
- The number of participating Employees is less than the number mutually agreed upon by the Company and the Policyholder,
- The number of participating Employees changes by 25% or more,
- The Policyholder fails to perform any of the obligations that relate to this policy or that are required by applicable law,
- The Policyholder no longer offers coverage to a particular class of Employees,
- The Policyholder no longer serves a class of Employees who reside in a particular geographical area, or
- The Policyholder does not provide timely information that is reasonably required.

The **Policyholder** has the right to cancel the Plan on any premium due date.

- To do this, the Policyholder must give the Company at least 31 days' written notice.
- The Plan will end on the date in the written notice or the date the Company receives the notice, whichever is later.

All outstanding premiums are due upon Plan termination. If the Company accepts premium payments after the Plan terminates, this will not reinstate the Plan; we will refund any excess premium.

The Policyholder has the sole responsibility of notifying Certificateholders in writing of the Plan's termination as soon as reasonably possible. If the Plan terminates, it—and all Certificates and Riders issued under the Plan—will terminate on the specified termination date. The termination occurs as of 12:01 a.m. at the Policyholder's address.

Termination of an Employee's Insurance

An Employee's insurance will terminate on whichever occurs first:

- The date the Company terminates the Plan.
- The 31st day after the premium due date (the last day of the Grace Period), if the premium has not been paid.
- The date he no longer belongs to an eligible class.

If an Insured's coverage terminates, we will provide benefits for valid claims that arose while his coverage was active.

Continuation Privilege

When an Employee is no longer a member of an eligible class and his coverage would otherwise end, he may elect to continue his coverage under this Plan. He may continue the coverage he had on the date his Certificate would otherwise terminate, including any in-force Dependent Spouse Rider or Dependent Child Rider coverage, without any additional underwriting requirements.

To keep his coverage in force, the Employee must:

- Notify the Company within 31 days after the date his coverage would otherwise terminate. He may notify us by sending written notice to P.O. Box 84078, Columbus, Georgia 31993-9102 or by calling the Customer Service number at 800.433.3036, and

- Pay the required premium directly to the Company no later than 31 days after the date his coverage would otherwise terminate and on each premium due date thereafter.

The Employee's ported coverage will end on the earliest of the following dates:

- 31 days after the premium due date (the last day of the Grace Period), if the premium has not been paid, or
- The date the Group Plan is terminated.

If the Employee qualifies for this Continuation Privilege, then the Company will apply the same Benefits, Plan Provisions, and Premium Rate as shown in his previously-issued Certificate. Notification of any changes in the Plan will be provided directly by the Company.

SECTION II: Premium Provisions

Premium Payments

Premiums should be paid to the Company at its Home Office in Columbia, South Carolina. The first premiums are due on the Plan's Effective Date. After that, premiums are due on the first day of each month that the Plan remains in effect.

Payment of any premium will not keep the Plan in force beyond the due date of the next premium, except as set forth in the Grace Period provision.

Premium Changes

Unless we have agreed in writing not to increase premiums, the premium may change:

- On the Group Policy Anniversary Date based on renewal underwriting. (The Group Policy Anniversary Date is shown on the Policy Schedule and falls on the same date each year thereafter.)
- Whenever the terms or conditions of the Plan are modified. The new premium rates will apply only to premiums due on or after the rate change takes effect.

We will provide the Policyholder a 60-day advance written notice of any change in premiums.

Grace Period

This Plan has a 31-day Grace Period. If a premium is not paid on or before its due date, the premium may be paid during the next 31 days. During the Grace Period, the Plan will stay in force, unless the Policyholder has given the Company written notice of its intention to discontinue the Plan. If the Plan is discontinued, the Plan's termination date will be the latest date for which premium has been paid.

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SECTION III: Definitions

When the terms below are used in this Plan, the following definitions apply:

Accidental Injury means accidental bodily damage to an Insured. This must be the direct result of an accident and not the result of disease or bodily infirmity. A ***Covered Accidental Injury*** is an Accidental Injury that occurs while coverage is in force. A ***Covered Accident*** is an accident that occurs on or after an Insured's Effective Date while coverage is in force, and that is not specifically excluded by the Plan.

Actively at Work refers to an Employee's ability to perform his regular employment duties for a full normal workday. The Employee may perform these activities either at his employer's regular place of business or at a location where he is required to travel to perform the regular duties of his employment.

Calendar Year means the period beginning on the policy Effective Date and ending on December 31 of the same year. Thereafter, it is the period beginning on January 1 and ending on December 31 of each following year.

Claimant means a person who is authorized to make a claim under the Certificate.

Dependent means an Employee's spouse or dependent children, as defined in the applicable rider, who have been accepted for coverage.

Doctor is a person who is duly qualified as a practitioner of the healing arts acting within the scope of his license, and:

- Is licensed to practice medicine; prescribe and administer drugs; or to perform surgery, or
- Is a duly qualified medical practitioner according to the laws and regulations in the state in which Treatment is made.

A Doctor ***does not*** include the Insured or an Insured's Family Member.

For the purposes of this definition, ***Family Member*** includes the Employee's Spouse as well as the following members of the Employee's immediate family:

Son	Mother	Sister
Daughter	Father	Brother

This includes step-Family Members and Family-Members-in-law.

Employee is a person who meets Eligibility requirements under **Section I – Eligibility**, **Effective Date, and Termination** and who is covered under this Plan. The Employee is the primary Insured under this Plan.

Hospital means a place that meets all of the following criteria:

- Is legally licensed and operated as a Hospital,
- Provides overnight care of injured and sick people,
- Is supervised by a Doctor,
- Has full-time nurses supervised by a registered nurse, and
- Has on-site use of X-ray equipment, laboratory, and surgical facilities.

The term *Hospital* specifically excludes any facility not meeting the definition of Hospital as defined in this Plan, including but not limited to:

- A nursing home,
- An extended-care facility,
- A skilled nursing facility,
- A rest home or home for the aged,

- A Rehabilitation Facility,
- A facility for the Treatment of alcoholism or drug addiction, or
- An assisted living facility.

Hospital Intensive Care Unit means a place that meets all of the following criteria:

- Is a specifically designated area of the Hospital called a Hospital Intensive Care Unit;
- Provides the highest level of medical care;
- Is restricted to patients who are critically ill or injured and who require intensive comprehensive observation and care;
- Is separate and apart from the surgical recovery room and from rooms, beds, and wards customarily used for patient confinement;
- Is permanently equipped with special life-saving equipment for the care of the critically ill or injured;
- Is under close observation by a specially trained nursing staff assigned exclusively to the Hospital Intensive Care Unit 24 hours a day; and
- Has a Doctor assigned to the Hospital Intensive Care Unit on a full-time basis.

The term *Hospital Intensive Care Unit* specifically excludes any type of facility not meeting the definition of Hospital Intensive Care Unit as defined in this Plan, including but not limited to private monitored rooms, surgical recovery rooms, observation units, and the following step-down units:

- A progressive care unit,
- A sub-acute intensive care unit, or
- An intermediate care unit.

Intermediate Intensive Care Step-Down Unit means any of the following:

- A progressive care unit,
- A sub-acute intensive care unit,
- An intermediate care unit, or
- A pre- or post-intensive care unit.

An Intermediate Intensive Care Step-Down Unit is **not** a Hospital Intensive Care Unit as defined in this Plan.

Life Event means an event that qualifies an Employee to make changes to benefits at times other than his enrollment period. Events qualifying as Life Events are established solely by the Policyholder.

Rehabilitation Facility is a unit or facility providing coordinated multidisciplinary physical restorative services. These services must be provided to inpatients under a Doctor's direction. The Doctor must be knowledgeable and experienced in rehabilitative medicine. Beds must be set up in a unit or facility specifically designated and staffed for this service. This is not a facility for the Treatment of alcoholism or drug addiction.

Related – a Related Accidental Injury or Sickness is one that is in correlation to, or occurs as a result of, the initial Accidental Injury or Sickness, and would not otherwise have been sustained if that initial condition had not occurred.

Sickness means an illness, infection, disease, or any other abnormal physical condition or pregnancy that is not caused solely by, or the result of, any injury. A ***Covered Sickness*** is one that is not excluded by name, specific description, or any other provision in this Plan. For a benefit to be payable, loss arising from the Covered Sickness must occur while the applicable Insured's coverage is in force.

Spouse is an Employee's legal wife or husband.

Telemedicine Service means a medical inquiry with a Doctor via audio or video communication that assists with a

patient's assessment, diagnosis, and consultation.

Treatment is the consultation, care, or services provided by a Doctor. This includes receiving any diagnostic measures and taking prescribed drugs and medicines. Treatment does **not** include Telemedicine Services.

SECTION IV: Benefit Provisions

Hospitalization Benefits

Hospital Admission Benefit
We will pay this benefit when an Insured is admitted to a Hospital and confined as an inpatient because of a Covered Accidental Injury or Covered Sickness. To be eligible to receive this benefit for Accidental Injuries resulting from a Covered Accident, an Insured must be admitted to a Hospital within six months of the date of the Covered Accident.

We will pay the Hospital Admission Benefit amount shown in the Benefit Schedule. We will not pay benefits for confinement to an observation unit, or for emergency room Treatment or outpatient Treatment.

We will pay this benefit once per period of Hospital Confinement. This benefit is limited to the maximum shown in the Benefit Schedule. We will only pay this benefit once for each Covered Accident or Covered Sickness per Calendar Year. If an Insured is confined to the Hospital because of the same or Related Accidental Injury or Sickness, we will not pay this benefit again in the same Calendar Year.

Hospital Confinement Benefit
We will pay the amount shown in the Benefit Schedule for each day that an Insured is confined to a Hospital as an inpatient as the result of a Covered Accidental Injury or Covered Sickness. To be eligible to receive this benefit for Accidental Injuries resulting from a Covered Accident, the Insured must be confined to a Hospital within six months of the date of the Covered Accident.

The length of time shown for Hospital Confinement in the Benefit Schedule is the maximum period for which an Insured can collect benefits for Hospital Confinements resulting from Covered Sickness or from Covered Accidental Injuries received in the same Covered Accident.

If we pay benefits for confinement and the Insured becomes confined again within six months because of the same or a Related condition, we will treat this confinement as the same period of confinement.

This benefit is payable for only one Hospital Confinement at a time, even if it is caused by more than one Covered Accidental Injury, more than one Covered Sickness, or a Covered Accidental Injury and a Covered Sickness.

Hospital Intensive Care Benefit
If an Insured is confined in a Hospital Intensive Care Unit because of a Covered Accidental Injury or Covered Sickness, we will pay the daily benefit amount shown in the Benefit Schedule. To be eligible to receive this benefit for Accidental Injuries resulting from a Covered Accident, an Insured must be admitted to a Hospital Intensive Care Unit within six months of the date of the Covered Accident.

We will pay this amount for each day of such confinement, but not to exceed the maximum benefit period shown on the Benefit Schedule during any one period of confinement.

We will pay benefits for only one confinement in a Hospital Intensive Care Unit at a time, even if it is caused by more than one Covered Accidental Injury, more than one Covered Sickness, or a Covered Accidental Injury and a Covered Sickness.

If we pay benefits for confinement in a Hospital Intensive Care Unit and an Insured becomes confined to a Hospital Intensive Care Unit again within six months because of the same or a Related condition, we will treat this confinement as the same period of confinement.

This benefit is payable in addition to the Hospital Confinement Benefit.

Treatment Benefits

Rehabilitation Facility Benefit
We will pay the daily benefit amount shown in the Benefit Schedule for each day that, due to a Covered Accidental Injury or a Covered Sickness, an Insured receives Treatment as an inpatient at a Rehabilitation Facility. For this benefit to be payable, the Insured must be transferred to the Rehabilitation Facility for Treatment following an inpatient Hospital Confinement.

This benefit is limited to the Calendar Year Maximum and maximum days per Hospital Confinement shown in the Benefit Schedule. We will not pay the Rehabilitation Facility Benefit for the same days that the Hospital Confinement Benefit is paid. We will pay the highest eligible benefit.

SECTION V: Exclusions

Exclusions

We will not pay for loss due to:

- War – voluntarily participating in war, any act of war, or military conflicts, declared or undeclared, or voluntarily participating or serving in the military, armed forces, or an auxiliary unit thereto, or contracting with any country or international authority. (We will return the prorated premium for any period not covered by the certificate when the Insured is in such service.) War also includes voluntary participation in an insurrection, riot, civil commotion or civil state of belligerence. War does not include acts of terrorism.
- Suicide – committing or attempting to commit suicide, while sane or insane.
- Self-Inflicted Injuries – injuring or attempting to injure oneself intentionally.
- Racing – riding in or driving any motor-driven vehicle in a race, stunt show or speed test in a professional or semi-professional capacity.
- Illegal Occupation – voluntarily participating in, committing, or attempting to commit a felony or illegal act or activity, or voluntarily working at, or being engaged in, an illegal occupation or job.
- Sports – participating in any organized sport in a professional or semi-professional capacity.
- Custodial Care – this is non-medical care that helps individuals with the basic tasks of everyday life, the preparation of special diets, and the self-administration of medication which does not require the constant attention of medical personnel.
- Treatment for being overweight, gastric bypass or stapling, intestinal bypass, and any related procedures, including any resulting complications.
- Services performed by a Family Member.
- Services related to sex or gender change, sterilization, in vitro fertilization, vasectomy or reversal of a vasectomy, or tubal ligation.
- Elective Abortion – an abortion for any reason other than to preserve the life of the person upon whom the abortion is performed.
- Dental Services or Treatment.
- Cosmetic surgery, except when due to:
    - Reconstructive surgery, when the service is related to or follows surgery resulting from a Covered Accidental Injury or a Covered Sickness, or is related to or results from a congenital disease or anomaly of a covered dependent child.
    - Congenital defects in newborns.

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SECTION VI: Claim Provisions

Notice of Claim
Written Notice of Claim must be given to us:

- Within 60 days after the Covered Accidental Injury or Covered Sickness, or
- As soon as reasonably possible.

When we receive written Notice of Claim, we will send a claim form. If the Claimant does not receive the claim form within 15 days after the notice is sent, written Proof of Loss can be sent to us without waiting for the form. Notice must include the Employee's name and the Certificate number. Notice can be mailed to the Company at the following address:

P.O. Box 427, Columbia, South Carolina, 29202

Proof of Loss
Proof of Loss refers to documentation that supports a claim. (This information is often found in standardized medical documents, such as Hospital bills and operative reports. It can include a statement by the treating Doctor.) Proof of Loss establishes the nature and extent of the loss, the Company's obligation to pay the claim, and the Claimant's right to receive payment.

The Claimant must provide Proof of Loss to the Company at the following address:

P.O. Box 427, Columbia, South Carolina, 29202

Proof of Loss must be given to us within 90 days of the Covered Accidental Injury or Covered Sickness. Failure to give Proof of Loss within such time shall not invalidate or reduce any claim if such Proof of Loss is given as soon as reasonably possible. The Company will not accept Proof of Loss any later than one year and three months after the Covered Accidental Injury or Covered Sickness, except in the absence of the Employee's legal mental capacity.

The Claimant will be responsible for the cost of obtaining a completed claim form. We may request additional Proof of Loss, such as records from Hospitals or Doctors. We will be responsible for the cost of obtaining these records.

We may require authorizations to obtain medical and psychiatric information as well as non-medical information, including personal financial information.

When we receive the claim and due Proof of Loss, we will review the Proof of Loss. If we approve the claim, we will pay the benefits subject to the terms of the Certificate.

Physical Examination and Autopsy
The Company may have an Insured examined as often as reasonably necessary while a claim is pending. In the case of death, the Company may also require an autopsy, unless prohibited by law. The Company will cover all costs for exams or autopsy.

Time of Payment of Claims
For benefits other than for loss of time, the Company will, once we receive the required Proof of Loss, pay, deny, or settle each submitted claim no later than the 60th day after the date Proof of Loss is received. Subject to written Proof of Loss, all accrued benefits payable under the Policy for loss of time will be paid at least monthly during the period for which the Company is liable. Any balance remaining unpaid at the end of that time will be paid as soon as possible after the Proof of Loss is received.

Payment of Claims
We will pay all benefits to the Employee unless otherwise assigned. For any benefits that remain unpaid at the time of death, we will pay those benefits in the following order:

- To the beneficiary designated by the Insured or the beneficiary's assignee.
- To the Insured's surviving Spouse.
- To the Insured's estate.

Unpaid Premium
When a claim is paid, we may deduct any premium due and unpaid from the claim payment.

Changing of Beneficiary
A change in beneficiary must be submitted in writing to our Home Office and signed by the Employee. Unless otherwise specified by the Employee, a change in beneficiary will take effect on the date the notice of change is signed. We will not be liable for any action taken before notice is received and recorded at the Home Office.

Claim Review
If a claim is denied, the Employee will be given written notice of:

- The reason for the denial,
- The Plan provision that supports the denial, and
- His right to ask for a review of the claim.

Appeals Procedure
Before filing any lawsuit—and no later than 60 days after notice of denial of a claim—the Employee, the Claimant, or an authorized representative of either must appeal any denial of benefits under the Plan by sending a written request for review of the denial to our Home Office.

Legal Action
The Employee may not take Legal Action against us for benefits under this Plan:

- Within 60 days after he has sent us written Proof of Loss, or
- More than 3 years from the time written proof is required to be given.

SECTION VII:
General Provisions

Entire Contract Changes
This insurance is provided under a contract of Group Supplemental Hospital Indemnity insurance with the Policyholder. The Entire Contract of Insurance is made up of:

- The Policy;
- The Certificates of insurance;
- The Application of the Policyholder; and
- Any Riders, Endorsements, or Amendments to the Policy or Certificate.

In the absence of fraud, a statement made by the Policyholder or an Insured is considered a representation and not a warranty. A statement made by the Policyholder or an Insured will not be used in any contest under the Plan, unless a copy of the written instrument containing the statement is or has been provided to:

- The person making the statement; or
- If the statement was made by the Insured and the Insured has died or become incapacitated, the Insured's beneficiary or personal representative.

Changes to the Plan:

- Will not be valid unless approved in writing by an executive officer of the Company.
- Must be noted on or attached to the Contract.
- May not be made by any agent or producer (nor can an agent or producer waive any Plan provisions).

Misstatement of Age
If an age has been misstated on the Application, the benefits will be those that the paid premium would have purchased at the correct age.

Successor Insured
If an Employee dies while covered under his Certificate and his Spouse is also insured under this Plan at the time of the Employee's death, then his surviving Spouse may elect to become the primary Insured. This would include continuation of any Dependent Child Rider coverage that is in force at that time.

To become the primary Insured and keep coverage in force, the surviving Spouse must:

- Notify the Company in writing within 31 days after the date of the Employee's death; and
- Pay the required premium to the Company no later than 31 days after the date of the Employee's death, and on each premium due date thereafter.

If the Certificate does not cover a surviving Spouse, the Certificate will terminate on the next premium due date following the Employee's death.

Time Limit on Certain Defenses
After two years from the Employee's Effective Date of coverage, the Company may not void coverage or deny a claim for any loss because of misstatements made on the Employee's Application. This does not apply to fraudulent misstatements.

Clerical Error
Clerical error by the Policyholder will not end coverage or continue terminated coverage. In the event of such clerical error, the Company will make a premium adjustment.

Individual Certificates

The Company will give the Policyholder a Certificate for each Employee. The Certificate will set forth:

- The coverage,
- To whom benefits will be paid, and
- The rights and privileges under the Plan.

Required Information

The Policyholder will be responsible for furnishing all information and proofs that the Company may reasonably require with regard to the Plan.

Conformity with State Statutes

This Plan was issued on its Effective Date in the state noted on the Master Application. Any Plan provision that conflicts with that state's statutes is amended to conform to the minimum requirements of those statutes.

POLICY SCHEDULE

Group Policyholder:	T Mobile USA
Group Policy Number:	0003254505
Group Policy Effective Date:	January 1, 2025
Group Policy Anniversary Date:	January 1, 2026
Jurisdiction:	Texas

*Initial premium includes the premium for any Riders purchased at the same time as the coverage provided by an Employee's Certificate. This Plan is delivered in and governed by the laws of the jurisdiction shown above.

Residents of Massachusetts are eligible only for the following benefits, if they are included in your coverage: Hospital Admission Benefit, Hospital Confinement Benefit, Hospital Intensive Care Benefit, and Intermediate Intensive Care Step-Down Unit Benefit.

BENEFIT SCHEDULE

Hospitalization Category

Hospital Admission Benefit	$1,000 per admission
Payable once per admission	
Maximum per Insured per each Covered Sickness	1 time per Calendar Year
Maximum per Insured per each Covered Accident	1 time per Calendar Year
Hospital Confinement Benefit	$100 per day
Maximum confinement period	30 days per Covered Sickness or Covered Accident
Hospital Intensive Care Benefit	$1,000 per day for first 1 day
$100 per day for each day after 2nd up to maximum confinement period	
Maximum confinement period	30 days per Covered Sickness or Covered Accident

Treatment Category

Rehabilitation Facility Benefit	$100 per day
Maximum per each period of Hospital Confinement	30 days
Maximum per Insured	60 days per Calendar Year

Incorporation Of Rider Provisions

The attached listed Riders are made a part of this Plan.

Rider Name	Form Number
Continuation of Coverage Endorsement	C00704TX
Dependent Spouse Benefit Rider	C80301
Dependent Children Benefit Rider	C80302TX

Schedule Of Premiums

Employee	10.86
Employee and Spouse	24.37
Employee and Children	18.92
Family	32.43

CONTINENTAL AMERICAN INSURANCE COMPANY

Columbia, South Carolina
800.433.3036

Please call the toll-free number above with any questions about this coverage.

Amendment to Policy, Certificate of Insurance, and Dependent Child Rider for Group Supplemental Hospital Indemnity

This Amendment is subject to all of the provisions of the Policy and Certificate to which it is attached. Additions or changes have been made to the Policy, Certificate, and Dependent Child Rider and are indicated below.

EFFECTIVE DATE
If issued at the same time as the Certificate, this Amendment becomes effective at the same time as the Certificate. If issued after the Certificate, this Amendment will have a later Effective Date.

The Plan Termination provision is deleted and replaced with the following:
Plan Termination
The **Company** has the right to cancel the Plan on any premium due date for the following reasons:

- The premium is not paid before the end of the Grace Period,
- The number of participating Employees is less than the number mutually agreed upon by the Company and the Policyholder,
- The number of participating Employees changes by 25% or more,
- The Policyholder fails to perform any of the obligations that relate to this policy or that are required by applicable law,
- The Policyholder no longer offers coverage to a particular class of Employees,
- The Policyholder no longer serves a class of Employees who reside in a particular geographical area, or
- The Policyholder does not provide timely information that is reasonably required.

The **Policyholder** has the right to cancel the Plan on any premium due date.

- To do this, the Policyholder must give the Company at least 31 days' written notice.
- The Plan will end on the date in the written notice or the date the Company receives the notice, whichever is later.

All outstanding premiums are due upon Plan termination. If the Company accepts premium payments after the Plan terminates, this will not reinstate the Plan.

The Policyholder has the sole responsibility of notifying Certificateholders in writing of the Plan's termination as soon as reasonably possible. If the Plan terminates, it—and all Certificates and Riders issued under the Plan—will terminate on the specified termination date. The termination occurs as of 12:01 a.m. at the Policyholder's address.

The definition of Dependent Child or Dependent Children is deleted and replaced with the following:

Dependent Child or ***Dependent Children*** means your or your Spouse's natural children, step-children, grandchildren who are in your legal custody and residing with you, foster children, children subject to legal guardianship, adopted children, or Children Placed for Adoption, who are younger than age 26. However, we will continue coverage for Dependent Children insured under the Plan after the age of 26 if they are incapable of self-sustaining employment due to mental or physical disability, and are chiefly dependent on a parent for support and maintenance. You or your Spouse must furnish proof of this incapacity and dependency to the Company within 31 days following the Dependent Child's 26th birthday.

The insurance on any Dependent Child will terminate on the last day of the month in which the Dependent Child turns age 26; it is your responsibility to notify us in writing when coverage on a Dependent Child terminates. Termination will be without prejudice to any claim originating prior to the date of termination. Our acceptance of premium after such date will be considered as premium for only the remaining persons who qualify as Insureds under this Plan.
When coverage on all Dependent Children terminates, you must notify the Company, in writing, and elect whether to continue this Plan on an Employee or Employee and Spouse Coverage basis. After such notice, we will arrange for the payment of the appropriate premium due, including returning any unearned premium.

Children Placed for Adoption are children for whom you have entered a decree of adoption, have initiated adoption proceedings, or are a party to a suit in which you seek to adopt the child. A decree of adoption must be entered within one year from the date proceedings were initiated, unless extended by order of the court. You must continue to have custody pursuant to the decree of the court.

Your natural Dependent Children born after the Effective Date of this Rider will be covered from the moment of live birth. No notice or additional premium is required.

The definition below is added to the Definitions section:
Observation Unit means a unit in which observation services are given through Hospital outpatient services to help the Doctor decide if the patient needs to be admitted as an inpatient or can be discharged. Observation services may be given in the emergency department or another area of the Hospital.

Hospitalization Benefits

The Hospital Admission Benefit is deleted and replaced with the following: Hospital Admission Benefit
We will pay this benefit when an Insured is admitted to a Hospital and confined as an inpatient because of a Covered Accidental Injury or Covered Sickness. To be eligible to receive this benefit for Accidental Injuries resulting from a Covered Accident, an Insured must be admitted to a Hospital within six months of the date of the Covered Accident.

We will pay the Hospital Admission Benefit amount shown in the Benefit Schedule. We will not pay benefits for confinement to an Observation Unit, or for emergency room Treatment or outpatient Treatment. We will not pay benefits for Hospital Admission of a newborn child following his birth. However, we will pay for a newborn's admission to a Hospital Intensive Care Unit if, following birth, he is confined as an inpatient as a result of a Covered Accidental Injury or Covered Sickness (including congenital defects, birth abnormalities, and/or premature birth).

We will pay this benefit once per period of Hospital Confinement. This benefit is limited to the maximum shown in the Benefit Schedule. We will only pay this benefit once for each Covered Accident or Covered Sickness per Calendar Year. If an Insured is confined to the Hospital because of the same or Related Accidental Injury or Sickness, we will not pay this benefit again in the same Calendar Year.

The Proof of Loss provision is deleted and replaced with the following: Proof of Loss
Proof of Loss refers to documentation that supports a claim. (This information is often found in standardized

medical documents, such as Hospital bills and operative reports. It can include a statement by the treating Doctor.) Proof of Loss establishes the nature and extent of the loss, the Company's obligation to pay the claim, and the Claimant's right to receive payment.

The Claimant must provide Proof of Loss to the Company at the following address:

P.O. Box 84075, Columbus, Georgia, 31993-9103

Proof of Loss must be given to us within 90 days of the Covered Accidental Injury or Covered Sickness. Failure to give Proof of Loss within such time shall not invalidate or reduce any claim if such Proof of Loss is given as soon as reasonably possible. The Company will not accept Proof of Loss any later than one year and three months after the Covered Accidental Injury or Covered Sickness, except in the absence of the Claimant's legal mental capacity.

The Claimant will be responsible for the cost of obtaining a completed claim form. We may request additional Proof of Loss, such as records from Hospitals or Doctors. The Claimant will be responsible for the cost of obtaining these records.

We may require authorizations to obtain medical and psychiatric information as well as non-medical information, including personal financial information.

When we receive the claim and due Proof of Loss, we will review the Proof of Loss. If we approve the claim, we will pay the benefits subject to the terms of the Certificate.

The Individual Certificates provision is deleted and replaced with the following: <u>Individual Certificates</u>
The Company will make available to the Policyholder a Certificate for Employees. The Certificate will set forth:

- The coverage,
- To whom benefits will be paid, and
- The rights and privileges under the Plan.

CONTRACT
This Amendment is part of the Policy and Certificate and will terminate when the Policy or Certificate terminates.

Signed for the Company at its Home Office,

Virgil R. Miller, President

J. Matthew Loudermilk, Secretary

CONTINENTAL AMERICAN INSURANCE COMPANY

Columbia, South Carolina
800.433.3036

Please call the toll-free number above with any questions about this coverage.

Continuation of Coverage Endorsement

This Endorsement is part of the Policy and Certificate to which it is attached. This Endorsement is subject to all the definitions, terms, and other provisions of the Policy and Certificate to which it is attached, unless those terms are inconsistent with this Endorsement.

EFFECTIVE DATE
If issued at the same time as the Certificate, this Endorsement becomes effective when the Certificate becomes effective. If issued after the Certificate, this Endorsement will have a later Effective Date.

The following provisions are added after the Continuation Privilege provision in your Certificate:
CONTINUATION OF COVERAGE
If the Group Policy is terminated by the Policyholder and is not replaced with another group policy you may apply to continue the coverage you had on the Group Policy termination date. This includes any in-force Spouse or Dependent Child coverage. The Group Policy will be continued as if the Group Policy is in force for those who have applied to continue their coverage under this provision. The members will continue to have coverage, with their Certificates remaining in force.

The Company will apply the same benefits and plan provisions as shown in your Certificate on the date you are eligible to continue coverage under this provision. Your continued coverage is subject to all of the provisions, exclusions and limitations of the Group Policy.

To keep your Certificate in force, you must:

- Apply to the Company in writing under this Continuation of Coverage provision within 31 days after the date your Certificate would terminate, **and**
- Pay the required premium no later than 31 days after the date the Certificate would terminate and on each premium due date thereafter to the Company at our Customer Service Center in Columbus, Georgia.

PREMIUMS
Initial premium rates will be based on the rates in effect at the time you apply to continue your coverage. Premium rates can be changed by the Company at any time upon 60 days written notice to you. Any such change will be applied to all Certificates in your class and will not be based on your or your Spouse and Dependent Children's health or other individual factors.

You may decrease, but not increase, the amount of your coverage, and the amount of your Spouse's coverage, if any.

TERMINATION
Your continued coverage, including any in-force Spouse or Dependent Child coverage, will end:

- 31 days after the date you fail to pay any required premium.

- When coverage is terminated by the Company. We will provide you a 31-day advance written notice of any termination.
- On the date you die (unless your Spouse elects to become the Primary Insured under the Successor Insured provision, if applicable).

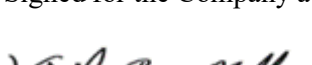
Once continued coverage is cancelled it cannot be reinstated. If your coverage terminates, we will provide benefits for valid claims that arose while your coverage was active.

CONTRACT

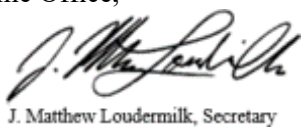
This Endorsement is part of the Certificate. It will terminate when:

- The Certificate terminates.

Signed for the Company at its Home Office,



Virgil R. Miller, President



J. Matthew Loudermilk, Secretary

CONTINENTAL AMERICAN INSURANCE COMPANY

Columbia, South Carolina
800.433.3036

Please call the toll-free number above with any questions about this coverage.

Dependent Spouse Benefit Rider
To Certificate of Insurance for Group Supplemental Hospital Indemnity Policy

This Rider is part of the Certificate to which it is attached. We have issued this Rider because:

- We have accepted your Application, and
- You have paid the additional premium for this Rider.

This Rider is subject to all the definitions, exclusions, limitations, terms, and other provisions of the Certificate to which it is attached, unless those terms are inconsistent with this Rider.

EFFECTIVE DATE

If issued at the same time as the Certificate, this Rider becomes effective when the Certificate becomes effective. If issued after the Certificate, this Rider will have a later Effective Date. Dependent Spouse coverage will become effective on the Effective Date of the Rider if the Dependent Spouse is Active on that date. Otherwise, the Effective Date will be deferred until the day following the date he becomes Active.

DEFINITIONS

When the terms below are used in this Rider, the following definitions apply (other applicable terms and definitions are included in the **Definitions** section of your Certificate):

Active refers to a Dependent Spouse who is not confined in a Hospital and who is able to carry on regular activities customary of a person in good health of the same age and gender.

Dependent Spouse is your legal wife or husband, who is at least age 18 and is listed on your Application.

BENEFITS

If a Dependent Spouse qualifies for benefits under the Certificate to which this Rider is attached because of a Covered Accidental Injury or Covered Sickness, we will provide the benefits shown in the Certificate under the **Benefit Provisions** section.

GENERAL PROVISIONS

If your Dependent Spouse's coverage terminates, we will provide benefits for valid claims that arose while Dependent Spouse coverage was active.

Time Limit on Certain Defenses

After two years from the Insured's Effective Date of coverage, the Company may not void coverage or deny a claim for any loss because of misstatements made on the Application. This does not apply to fraudulent misstatements.

CONTRACT

This Rider is part of the Group Supplemental Hospital Indemnity Certificate. It will terminate:

- When the Certificate terminates,

- On the premium due date following the date the covered Spouse no longer qualifies as a Dependent,
- On the premium due date following the date we receive your written request to terminate coverage for your Spouse, or
- When premiums are no longer paid for this Rider.

Signed for the Company at its Home Office,

Virgil R. Miller, President

J. Matthew Loudermilk, Secretary

CONTINENTAL AMERICAN INSURANCE COMPANY

Columbia, South Carolina
800.433.3036

Please call the toll-free number above with any questions about this coverage.

Dependent Children Benefit Rider
To Certificate of Insurance for Group Supplemental Hospital Indemnity Policy

This Rider is part of the Certificate to which it is attached. We have issued this Rider because:

- We have accepted your Application, and
- You have paid the additional premium for this Rider.

This Rider is subject to all the definitions, exclusions, limitations, terms, and other provisions of the Certificate to which it is attached, unless those terms are inconsistent with this Rider.

EFFECTIVE DATE

If issued at the same time as the Certificate, this Rider becomes effective when the Certificate becomes effective. If issued after the Certificate, this Rider will have a later Effective Date. Dependent Child coverage will become effective on the Effective Date of the Rider if the Dependent Child is Active on that date. Otherwise, the Effective Date will be deferred until the day following the date he becomes Active.

DEFINITIONS

When the terms below are used in this Rider, the following definitions apply (other applicable terms and definitions are included in the **Definitions** section of your Certificate):

Active refers to a Dependent Child who is not confined in a Hospital and who is able to carry on regular activities customary of a person in good health of the same age and gender.

Dependent Child or ***Dependent Children*** means your or your Spouse's natural children, step-children, grandchildren who are in your legal custody and residing with you, foster children, children subject to legal guardianship, adopted children, or Children Placed for Adoption. Dependent Children must be younger than age 26.

Children Placed for Adoption are Children for whom you have entered a decree of adoption or for whom you have initiated adoption proceedings. A decree of adoption must be entered within one year from the date proceedings were initiated, unless extended by order of the court. You must continue to have custody pursuant to the decree of the court.

A child is considered to be the child of an Insured if the Insured is a party to a suit in which the Insured seeks to adopt the child.

There is an exception to the age-26 limit above. This limit will not apply to any Dependent Child who is incapable of self-sustaining employment due to mental or physical handicap and is chiefly dependent on a parent for support and maintenance. You or your Spouse must furnish proof of this incapacity and dependency to the Company

within 31 days following the Dependent Child's 26th birthday.

Your natural Dependent Children born after the Effective Date of this Rider will be covered from the moment of live birth. No notice or additional premium is required.

BENEFITS

If a Dependent Child qualifies for benefits under the Certificate to which this Rider is attached because of a Covered Accidental Injury or Covered Sickness, we will provide the benefits shown in the Certificate under the **Benefit Provisions** section.

If a Dependent Child qualifies for benefits because of a Covered Accidental Injury or Covered Sickness, we will provide the benefits shown in the Dependent Children Benefit Schedule issued with this Rider. The only benefits for which a Dependent Child is eligible are those shown in the Dependent Children Benefit Schedule.

GENERAL PROVISIONS

If your Dependent Child's coverage terminates, we will provide benefits for valid claims that arose while his coverage was active.

Time Limit on Certain Defenses

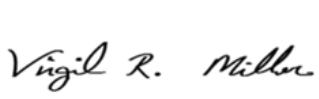
After two years from the Insured's Effective Date of coverage, the Company may not void coverage or deny a claim for any loss because of misstatements made on the Application. This does not apply to fraudulent misstatements.

CONTRACT

This Rider is part of the Group Supplemental Hospital Indemnity Certificate. It will terminate:

- When the Certificate terminates,
- On the premium due date following the date the covered Child no longer qualifies as a Dependent,
- When the covered Dependent Child reaches age 26 (details in the **Definitions** section of this Rider),
- On the premium due date following the date we receive your written request to terminate coverage for your Child, or
- When premiums are no longer paid for this Rider.

Signed for the Company at its Home Office,



Virgil R. Miller, President

J. Matthew Loudermilk, Secretary

CONTINENTAL AMERICAN INSURANCE COMPANY

Columbia, South Carolina 800.433.3036

NOTICE OF NON-INSURANCE BENEFITS ENDORSEMENT

This Endorsement is added to and part of the Policy to which it is attached.

Continental American Insurance Company (CAIC) may offer or provide goods and/or services that are not related to insurance. The services will fall under the same benefit plan that includes or is related to the applicable CAIC coverage, individual wellness programs, and related services.

The services may be offered by the Policyholder, at the Policyholder's discretion, to its group employees. While the Endorsement is attached to the Policy, it is at the group employee's sole discretion to utilize the services listed below. Any one or more of the services listed below may be available, but may not represent the group employee's exact selection.

Though CAIC has arranged these goods, services, and/or third-party provider discounts, the third-party providers—**not CAIC**—are liable to group employeesfor these goods and services. CAIC is not responsible for providing the goods and/or services, nor is CAIC liable to group employeesfor the negligent provision of these goods and/or services by third-party service providers. The third-party providers will address inquiries from group employees about the provision of these goods, services, and/or third-party discounts. In the event the third-party provider cannot meet contractual obligations, CAIC will pursue a new contract with a similar vendor to provide the services listed below. Access to these services will end when Plan coverage ends, as described in the Termination provisions in the Master Policy.

The services listed below incur a $2/month service charge. This service charge is included in the premium amount shown on the Certificate Schedule.

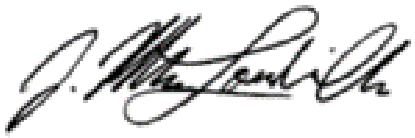
- **Fraud Protection** – this third-party service offers fraud protection that will secure and monitor personal information and provide identity restoration services in the event of identity theft or fraud.
- **Core Advocacy** – this third-party service offers access to a dedicated, Personal Health Advocate who can help solve a wide variety of health- and insurance-related issues, such as:
    - Reviewing and explaining medical coverage and offering advice on care options and costs.
    - Locating providers for second opinions.
    - Scheduling appointments with specialists.
    - Clarifying complex conditions.
    - Resolving insurance claims.
    - Addressing eldercare issues and coordinating long-distance support for family members.
- **Medical Bill Saver** – this third-party service offers highly skilled negotiators to work on the group employees' behalf to obtain a discount on any medical or dental bill over $400 not covered by insurance, regardless of insurance or benefit status.
- **Telemedicine** – this third-party service offers a low-cost option for medical care by enabling group employees to connect with a medical provider online and receive personalized treatment. The Telemedicine visit could cost between $25 and $195. When medically appropriate, providers submit an e-prescription to a local pharmacy for purchase, pick up, and review (in person) with a local pharmacist.
- **Discount Bundle –** this third-party service offers discounts on dental, vision, pharmacy and hearing care services to group employees through a web portal. The discounts for the dental, hearing, and vision

services are available with a purchase of a $12 pass, which allows access to a network of providers in the group employee's geographical location.

- **Personal Wellness** – this third-party services helps group employees develop a healthy lifestyle plan to achieve their wellness goals through online workshops and tools related to weight loss, nutrition, stress management, tobacco cessation, and related issues.
- **Financial and Legal Fitness** – this third-party service assists group employees with online tools for financial and legal preparedness on topics such as eldercare, estate and retirement planning, college savings plans and budgeting, financial calculators, webinars and tutorials, and articles providing general financial education. Service also provides limited complementary access to consultative services from licensed professionals to assist with legal and financial matters.
- **Online Family Care Resource** – this third-party service offers access to a comprehensive online resource enabling group employees to manage their family care needs through services such as locating emergency child care, nanny services and elder care, daycare, tutors, dog-sitters/walkers, home companions and personal care services.
- **Student Loan Assistance** – this third-party service offers employers an administrative service to assist them in coordinating the payment of their group employee's student loans. The service also provides a refinancing market to assist group employees in paying down their student loans quicker.
- **College Advisory Service** – this third-party service provides assistance to group employees by helping to create a long-term plan for their children's educational future. The service helps the group employee navigate the intricacies of applying for college, financing college tuition, and understanding financial aid.
- **Employee Assistance Program** - this third-party service offers counseling with available licensed professional counselors to address stress, depression, family issues, substance abuse, and other topics.
- **Funeral Concierge** - this third-party service provides personal advisors who are available 24-hours a day to help with all funeral-related issues, including developing a personal funeral plan, and negotiation assistance for funeral services.
- **Travel Assistance** - this third-party service provides 24-hour, toll-free service for a comprehensive range of information, referral, coordination and arrangement services designed to respond to most medical care situations and many other emergencies group employees may encounter when they travel.
- **Flexible Spending Administration** – this third-party service administers funds designated by the group employee for payment of tax qualified medical expenses and dependent-care expenses.

Signed for the Company at its Home Office,

Virgil R. Miller, President



J. Matthew Loudermilk, Secretary

For assistance or information about this notice, call 800.433.3036.

How you're protected if your life or health insurance company fails

The Texas Life and Health Insurance Guaranty Association protects you by paying your covered claims if your life or health insurance company is insolvent (can't pay its debts). **This notice summarizes your protections.**

The Association will pay your claims, with some exceptions required by law, if your company is licensed in Texas and a court has declared it insolvent. You must live in Texas when your company fails. If you don't live in Texas, you may still have some protections.

For each insolvent company, the Association will pay a person's claims only up to these dollar limits set by law:

- **Accident, accident and health, or health insurance (including HMOs):**
  - Up to $500,000 for health benefit plans, with some exceptions.
  - Up to $300,000 for disability income benefits.
  - Up to $300,000 for long-term care insurance benefits.
  - Up to $200,000 for all other types of health insurance.

- **Life insurance:**
  - Up to $100,000 in net cash surrender or withdrawal value.
  - Up to $300,000 in death benefits.

- **Individual annuities:** Up to $250,000 in the present value of benefits, including cash surrender and net cash withdrawal values.

- **Other policy types:** Limits for group policies, retirement plans and structured settlement annuities are in Chapter 463 of the Texas Insurance Code.

- **Individual aggregate limit:** Up to $300,000 per person, regardless of the number of policies or contracts. A limit of $500,000 may apply for people with health benefit plans.

- **Parts of some policies might not be protected:** For example, there is no protection for parts of a policy or contract that the insurance company doesn't guarantee, such as some additions to the value of variable life or annuity policies.

To learn more about the Association and your protections, contact:	For questions about insurance, contact:
Texas Life and Health Insurance Guaranty Association 515 Congress Avenue, Suite 1875 Austin, TX 78701 1-800-982-6362 or www.txlifega.org	**Texas Department of Insurance** P.O. Box 149104 Austin, TX 78714-9104 1-800-252-3439 or www.tdi.texas.gov

Note: You're receiving this notice because Texas law requires your insurance company to send you a summary of your protections under the Texas Life and Health Insurance Guaranty Association Act (Insurance Code, Chapter 463). These protections apply to insolvencies that occur on or after September 1, 2019. **There may be other exceptions that aren't included in this notice.** When choosing an insurance company, you should not rely on the Association's coverage. Texas law prohibits companies and agents from using the Association as an inducement to buy insurance or HMO coverage.

Chapter 463 controls if there are differences between the law and this summary.

C00502.1TX

CONTINENTAL AMERICAN INSURANCE COMPANY

Columbia, South Carolina
800.433.3036

Endorsement
to Policy and Certificate of Insurance

This Endorsement alters the Policy and the Certificate to which it is attached. Unless specifically addressed by this Endorsement, all other Policy and Certificate provisions, definitions, and terms continue to apply.

Continental American Insurance Company's mailing addresses for claims and premium payments are changed as listed below.

Notice of Claim and **Proof of Loss** should be mailed to the Company at:

P.O. Box 84075, Columbus, Georgia, 31993-9103

Premium Payments should be mailed to the Company at:

P.O. Box 84069, Columbus, Georgia, 31908-4069

If applicable, references to 2801 Devine Street, Columbia, SC 29205 are deleted.

Signed for the Company at its Home Office,

Virgil R. Miller, President

J. Matthew Loudermilk, Secretary

C00702 1

Have a complaint or need help?

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

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

Continental American Insurance Company

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

Call: Continental American Insurance Company at 1-800-433-3036 Toll-free:

1-800-433-3036

Email: cscmail@aflac.com

Mail: Continental American Insurance Company
Post Office Box 427
Columbia, South Carolina 29202

The Texas Department of Insurance

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

Call: 1-800-252-3439

Online: www.tdi.texas.gov

Email: ConsumerProtection@tdi.texas.gov

Mail: MC 111-1A, P.O. Box 149091, Austin, TX 78714

¿Tiene una queja o necesita ayuda?

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

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

Continental American Insurance Company

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

Llame a: Continental American Insurance Company al 1-800-433-3036

Teléfono gratuito:

1-800-433-3036

Correo electrónico: cscmail@aflac.com

Dirección postal: Continental American Insurance Company
Post Office Box 427

Columbia, South Carolina 29202

El Departamento de Seguros de Texas

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

Llame: 1-800-252-3439

En línea: www.tdi.texas.gov

Correo electrónico: ConsumerProtection@tdi.texas.gov

Dirección postal: MC 111-1A, P.O. Box 149091, Austin, TX 78714