Group Critical Illness
Insurance Certificate

Spectrum Brands, Inc.
Certificate Effective Date: 01/01/2026

IMPORTANT NOTICE

If you reside in the following state, please read the important notice below:

MARYLAND RESIDENTS:

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

New York Life Insurance and Annuity Corporation
(A Stock Insurance Company)
51 Madison Avenue, New York, NY 10010
1-800-225-5695
http://www.newyorklife.com

GROUP CRITICAL ILLNESS INSURANCE
CERTIFICATE OF COVERAGE

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

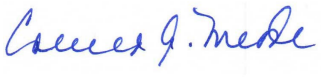
We, the New York Life Insurance and Annuity Corporation, have issued a Group Policy, GCI0100222 to NATIONAL GROUP BENEFITS INSURANCE TRUST on behalf of Spectrum Brands, Inc., Subscriber Group ID 109945.

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

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

Please Read the Certificate Carefully.

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



Corporate Secretary, Colleen Meade



Chair, President, & CEO, Craig DeSanto

NOTICE: THE POLICY IS A CRITICAL ILLNESS POLICY. THIS IS NOT A SUBSTITUTE FOR MAJOR MEDICAL COVERAGE. The Policy provides limited benefits. Benefits provided are supplemental and are not intended to cover all medical expenses.

THIS IS NOT MEDICARE SUPPLEMENT INSURANCE COVERAGE.
If You are eligible for Medicare, review the Guide to Health Insurance for People with Medicare available from New York Life.

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SECTION I. SCHEDULE OF BENEFITS FOR CRITICAL ILLNESS INSURANCE

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

This *Schedule of Benefits* shows maximums, durations, and any limitations applicable to benefits provided in the Policy for each Covered Person unless otherwise indicated. Critical Illness Insurance Benefits, when referred to in this Schedule, mean the Covered Person's Critical Illness Insurance Benefits in effect on the date of a Diagnosed Critical Illness unless otherwise specified.

On the pages following the description of eligible Employees there is a Schedule of Benefits for each Class of Eligible Employees listed below. For an explanation of these benefits, please see the Description of Benefits.

CLASSES OF ELIGIBLE EMPLOYEES

Class 1	All active, full-time Employees of the Employer regularly scheduled to work a minimum of 30 hours per week in the United States, who are citizens or permanent resident aliens of the United States, excluding Employees classified as St. Louis Union - Painters District Council #58.

SCHEDULE OF BENEFITS FOR CLASS 1, VOLUNTARY

Class 1	All active, full-time Employees of the Employer regularly scheduled to work a minimum of 30 hours per week in the United States, who are citizens or permanent resident aliens of the United States, excluding Employees classified as St. Louis Union - Painters District Council #58.

Eligibility Waiting Period

The Eligibility Waiting Period is the period of time the Employee must continuously be in Active Service to be eligible for coverage, including any period during which the Employee was insured or eligible to be insured under a Prior Plan. It will be extended by the number of days the Employee is not in Active Service.

Class Description	Eligibility Waiting Period
Class 1	None

CRITICAL ILLNESS INSURANCE BENEFITS

Critical Illness Benefit Amount

Employee	Choice of $5,000 to $30,000 in increments of $5,000
Spouse	Choice of $5,000 to $15,000 in increments of $5,000
Dependent Child	Choice of $5,000 or $10,000
Childhood Diseases and Conditions	100% of the Dependent Child Critical Illness Benefit Amount

Recurrence Benefit Amount

Employee	100% of the initial benefit paid
Spouse	100% of the initial benefit paid
Dependent Child	100% of the initial benefit paid

Guaranteed Issue Amount

Employee	$30,000
Spouse	$15,000
Dependent Child	$10,000

COVERED CRITICAL ILLNESS

Core Critical Illness Conditions	Percentage of the Critical Illness Benefit Amount
Stroke	100.0%
Heart Attack	100.0%
Coronary Artery Disease	
Coronary Artery Disease (with Bypass)	25.0%
Coronary Artery Disease (with Coronary Intervention)	25.0%
Major Organ Failure	100.0%
End Stage (Renal) Kidney Failure	100.0%
Cancer-Related Conditions	
Invasive Cancer	100.0%
Non-Invasive Cancer	25.0%
Skin Cancer	10.0%
Childhood Diseases and Conditions	
Cerebral Palsy	100.0%
Cleft Lip/Cleft Palate	100.0%
Congenital Heart Illnesses	100.0%
Down Syndrome	100.0%
Spina Bifida	100.0%
More Diseases and Conditions	
Functional Loss	
Coma	100.0%
Paralysis	100.0%
Progressive Diseases	
Advanced Dementia (including advanced Alzheimer's Disease)	25.0%
Amyotrophic Lateral Sclerosis (ALS)	25.0%
Advanced Parkinson's Disease	25.0%
Multiple Sclerosis	50.0%

ADDITIONAL BENEFITS

	Employee	Spouse	Child
Health Screening Benefit	$50	$50	$50

The above items are only highlights of the Policy. For a full description of Your coverage, including any additional benefits, exclusions or limitations that may apply, continue reading Your Certificate of Coverage.

CONTINUATION OF INSURANCE

For Family Medical Leave Maximum Benefit Period:	The latest of: 1. the period of the approved FMLA leave; or 2. the leave period required by the laws of the state in which the Employee is employed.

SECTION II. DESCRIPTION OF BENEFITS

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

CRITICAL ILLNESS BENEFIT
We will pay the Critical Illness Benefit if a Covered Person is Diagnosed by a Doctor with a Critical Illness while coverage is in force for the Covered Person. The amount payable is the percentage of the Critical Illness Benefit Amount shown in the Schedule of Benefits in effect for the Covered Person.

For the purpose of determining the date of a Diagnosis, a confirmation of a prior Diagnosis or a second opinion related to the course of Treatment for a prior Diagnosis is not the date of Diagnosis.

A Critical Illness Benefit is payable no more than one time for each Critical Illness. If you are subsequently Diagnosed with the same Critical Illness, a Recurrence Benefit may be payable.

The Critical Illnesses categorized as Childhood Conditions in the Schedule of Benefits are payable only for a Diagnosis in a Dependent Child. The amount payable is the percentage of the Critical Illness Benefit Amount applicable to Dependent Children for Childhood Conditions.

RECURRENCE BENEFIT

We will pay the Recurrence Benefit if a Covered Person is Diagnosed by a Doctor with a Critical Illness for which the same Covered Person previously received a benefit under the Critical Illness Benefit, subject to any of the following conditions:
1. The subsequent Diagnosis must be made while coverage is in force for the Covered Person.
2. The subsequent Diagnosis of Invasive Cancer or Non-Invasive Cancer or Skin Cancer must occur at least 180 Days after the date of Diagnosis of the Invasive Cancer or Non-Invasive Cancer or Skin Cancer for which the Critical Illness Benefit was previously paid.
3. The subsequent Diagnosis of any other Critical Illness must occur at least 180 Days after the date of Diagnosis of the Critical Illness for which the Critical Illness Benefit was previously paid.

The amount payable is equal to the initial Critical Illness Benefit Amount paid for the first Diagnosis of the Critical Illness as shown in the Schedule of Benefits.

A confirmation of a prior Diagnosis is not considered a subsequent Diagnosis and is not eligible for payment of a Recurrence Benefit.

The Recurrence Benefit is not available for Critical Illnesses categorized as Childhood Conditions in the Schedule of Benefits. These are payable only once per Dependent Child.

The Recurrence Benefit is not available for Paralysis, Advanced Dementia (including advanced Alzheimer's Disease), Amyotrophic Lateral Sclerosis (ALS), Advanced Parkinson's and Multiple Sclerosis which are payable only once per Covered Person.

There is no limit on the number of Recurrence Benefits payable.

ADDITIONAL CRITICAL ILLNESS BENEFIT
We will pay the Additional Critical Illness Benefit if a Covered Person is Diagnosed with a different Critical Illness after the same Covered Person already received a Critical Illness Benefit, subject to the following conditions:
1. The subsequent Diagnosis must be made while coverage is in force for the Covered Person.

The amount payable is the percentage of the Critical Illness Benefit Amount shown in the Schedule of Benefits in effect for the Covered Person.

HEALTH SCREENING BENEFIT
We will pay the Health Screening Benefit Amount shown in the Schedule of Benefits each day a Covered Person receives a Health Screening service. This benefit is payable only once per day even if multiple Health Screenings are provided in a single day. No more than 1 Health Screening Benefits are payable per Covered Person per Calendar Year.

Health Screening services include:
- safety/injury prevention class;
- mental health screening;
- baseline concussion screening;
- abdominal aortic aneurysm ultrasonography;
- blood test for lipids including total cholesterol, LDL, HDL, and triglycerides;
- bone marrow testing, bone density screening;
- breast ultrasound or mammography;
- CA15-3 blood test for breast cancer;
- CA 125 blood test for ovarian cancer;
- carotid doppler;
- CEA blood test for colon cancer;
- chest x-ray;
- colonoscopy;
- electrocardiogram;
- double contrast barium enema;
- fasting blood glucose test;
- flexible sigmoidoscopy;
- hemoccult stool analysis;
- mammogram;
- pap smear, (including ThinPrep);
- PSA;
- serum cholesterol test to determine level of HDL and LDL;
- serum protein electrophoresis (blood test for myeloma);
- stress test;
- thermography;
- CT angiography;
- Testicular Ultrasound;
- Smoking Cessation Program;
- Weight Reduction Program;
- Cancer Genetic Mutation Test (BRCA);
- Skin Cancer Screening;
- Biopsies for Cancer;
- Lymphocyte Genome Sensitivity Test (LGS) (universal blood test for cancer);
- Routine Eye Exam;
- Routine Dental Exam;
- Hearing Screening;
- Well child/preventative exams age 1 to 18;
- Adult annual exam;
- Biometric Screenings;
- Wellness Fair;
- Immunizations; or
- any other medically accepted health screening examination.

SECTION III. ELIGIBILITY FOR INSURANCE

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

A Spouse and Dependent Child(ren) of an eligible Employee become eligible for any dependent insurance provided by the Policy on the later of the date the Employee becomes eligible or the date the Spouse or Dependent Child(ren) meet the applicable definition shown in the General Definitions section of this Certificate. The Employee must be insured under the Policy in order to elect coverage for a Spouse or Dependent Child(ren).

LIMITATIONS ON MULTIPLE ELIGIBILITY

A Covered Person may be insured only once under the Critical Illness Insurance coverage of the Policy even though they may be eligible under more than one class.

Special Rules for Employees Who are Spouses of Other Employees

An Employee who is the Spouse of another Employee may not be insured for Critical Illness Insurance as both an Employee and as a Spouse at the same time.

If an Employee is eligible and has enrolled as the Spouse of another Employee, but later ceases to be eligible as a Spouse, that Employee may, within 31 days, enroll for coverage as an Employee.

Special Rules for Dependent Children

An Employee who is the Dependent Child of another Employee may not be insured for Critical Illness Insurance as both an Employee and as a Dependent Child at the same time.

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

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

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

SECTION IV. ENROLLING FOR CRITICAL ILLNESS INSURANCE

GROUP ENROLLMENT EVENTS

An eligible Employee may enroll for Critical Illness insurance coverage as follows:
1. During an Initial Group Enrollment Period, as established by the Subscriber and agreed to by Us, prior to the Effective Date of the Policy.
2. During Annual Group Enrollment periods established by the Subscriber.
3. At other times agreed to by Us.

INDIVIDUAL ENROLLMENT EVENTS

A. Initial Enrollment Period for Newly Eligible Employees
During an initial enrollment period for newly eligible Employees, within 31 days following the Employee's date of eligibility, an eligible Employee may enroll for Critical Illness insurance coverage as stated in the Schedule of Benefits. An eligible Employee may not enroll an eligible Spouse or Dependent Child(ren) without enrolling for Employee coverage.

B. Life Status Change for Employees
An eligible Employee may also enroll within 60 days of a Life Status Change.

Life Status Changes that qualify an Employee to apply for coverage, including coverage for an eligible Spouse or Dependent Child(ren) include:
1. Becoming newly married;
2. Loss of a Spouse; whether by death, divorce, annulment, or legal separation;
3. Birth or adoption of a child, or acquiring a child through marriage;
4. A change in the group benefit plan available to the Employee's Spouse;
5. A change in the Employee's employment status that affects eligibility for group benefits for either the Employee or the Employee's Spouse;
6. Termination of a Spouse’s employment.

C. Resumption of Critical Illness Insurance After a Period of Unpaid Leave of Absence
Unless the Employee has agreed in writing to terminate Critical Illness insurance, coverage will resume for an Employee upon his or her return to Active Service, if an Employee's insurance ended because the Employee was on an unpaid leave of absence approved by the Employer.

If the Employee agreed to terminate Critical Illness insurance, the Employee must enroll for any Critical Illness insurance and pay the required Premium.

D. Returning Military Service Enrollment for Employees
Unless the Employee has agreed in writing to terminate Critical Illness insurance, coverage will resume for an Employee that returns to Active Service after a period of active military duty subject to the Uniformed Services Employment and Reemployment Rights Act (“USERRA”) and applicable state law.

If the Employee agreed to terminate Critical Illness insurance, the Employee must apply for Critical Illness insurance and pay the required premium. In this situation, the Eligibility Waiting Period will be waived.

E. Late Enrollment for Employees
Enrollment outside of the conditions listed above is not permitted.

SECTION V. EFFECTIVE DATE OF INSURANCE

Effective Date of Coverage for Enrollment During a Group Enrollment Event
Your coverage begins at 12:01 a.m. Local Time at the Employer's address on the Policy Anniversary Date following the date You enroll, if You enroll during a Group Enrollment Event as described in the Enrolling for Accident Insurance Section and agree to pay the required Premium Contributions, if any.

Coverage for Your Spouse or Dependent Child(ren) begins at 12:01 a.m. Local Time at the Employer's address on the Policy Anniversary Date following the date You enroll Your eligible Spouse or Dependent Child(ren), if You enroll them during a Group Enrollment Event as described in the Enrolling for Accident Insurance Section and You agree to pay the required Premium Contributions, if any.

Effective Date of Coverage for an Enrollment During an Initial Enrollment Period for Newly Eligible Employees
Your coverage begins at 12:01 a.m. Local Time at the Employer's address on the date You become eligible for coverage, if You enroll within the Initial Enrollment Period for Newly Eligible Employees as described in the Enrolling for Accident Insurance Section and agree to pay the required Premium Contributions, if any.

Coverage for Your Spouse or Dependent Child(ren) begins at 12:01 a.m. Local Time at the Employer's address on the date the Spouse or Dependent Child(ren) becomes eligible for coverage, if You enroll Your eligible Spouse or Dependent Child(ren) within the Initial Enrollment Period for Newly Eligible Employees as described in the Enrolling for Accident Insurance Section and You agree to pay the required Premium Contributions, if any.

Effective Date of Coverage for an Enrollment as the Result of a Life Status Change
Your coverage begins at 12:01 a.m. Local Time at the Employer's address on the date You become eligible for coverage, if You enroll within the time period established for Life Status Changes as described in the Enrolling for Accident Insurance Section and agree to pay the required Premium Contributions, if any.

Coverage for Your Spouse or Dependent Child(ren) begins at 12:01 a.m. Local Time at the Employer's address on the date You enroll Your eligible Spouse or Dependent Child(ren), if You enroll them during the time period established for Life Status Changes as described in the Enrolling for Accident Insurance Section and You agree to pay the required Premium Contributions, if any.

Effective Date of Coverage for Newly Born or Adopted Children
An Employee's Dependent Child(ren) who are born or placed in the Employee's home for adoption while the Employee is covered under the Policy are covered for 60 days from the moment of live birth or date of placement for adoption.

If the Employee has not elected Dependent Child(ren) insurance coverage at the time of the birth or date of placement, the Employee must notify us within 60 days of the newly eligible Dependent Child's birth or date of placement for adoption and pay the required additional premium for Dependent Child insurance to continue coverage beyond the initial 60 day period.

SECTION VI. TERMINATION OF INSURANCE

The insurance on a Covered Person will end on the earliest date below:

1. The date the Policy is terminated or amended to terminate insurance for an Eligible Class.
2. The date the Subscriber's participation under the Policy ends.
3. The date the Employee is no longer in Active Service.
4. The date the Employee is no longer in an Eligible Class or no longer satisfies the eligibility requirements under the Policy.
5. The last day of the period for which Premium is paid, subject to any Grace Period.
6. The date the Employee, Spouse, or Dependent Child(ren) enters full-time active duty in the Uniformed Services of the United States for more than 30 consecutive days. We will provide a pro-rata premium refund.
7. The next Premium due date after the Covered Person ceases to be a member in good standing of the Subscriber.
8. a. For a Spouse or Dependent Child(ren), on the date that the Employee's insurance ends.
   b. For a Spouse, on the next Premium due date after the date that the Spouse is no longer eligible due to death of the Employee, upon divorce, legal separation, or other termination of marriage.
   c. For a Dependent Child(ren), on the next Premium due date after the date that the Dependent Child no longer meets the Policy's definition of Dependent Child, or reaches any age limit provided under the Policy.

Please refer to the Continuation of Insurance provision for situations under which coverage can be continued following Termination of Insurance.

Termination will not affect a claim that is the result, directly and independently of all other causes, of a covered Critical Illness that was Diagnosed while coverage was in effect.

SECTION VII. CONTINUATION OF INSURANCE BENEFITS

If an Employee is no longer in Active Service, the Employee may be eligible to continue insurance. The following provisions explain the continuation options available under the Policy. Please see the Schedule of Benefits to determine the applicability of these benefits.

Premiums are required to continue insurance. Unless the Employee has agreed in writing to terminate Critical Illness Insurance, the Subscriber is responsible for all Premium payments to continue insurance, and for collecting any Premium Contributions required of Employees.

Unless otherwise stated, continuation begins when the Employee's Active Service ends. If more than one continuation provision applies, only the one with the longer duration will be applicable.

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

Continuation for Family Medical Leave of Absence
If an Employee's Active Service ends due to an approved family and medical leave, insurance will continue up to the maximum period shown in the Schedule of Benefits.

SECTION VIII. PORTABILITY OPTIONS FOR CRITICAL ILLNESS INSURANCE

Portability rights may be only exercised by U.S. citizens or permanent resident aliens.

A. Eligibility for Portability Coverage

Employee
You are eligible for Portability coverage if:
1. You end Active Service with Your Employer;
2. You are no longer a member of an Eligible Class; or
3. The Subscriber terminates this coverage and doesn't replace it within 30 days.

Your group Critical Illness Insurance under the Policy must be in effect at the time of the event that made You eligible for Portability Coverage.

If You want Your covered Spouse or covered Dependent Child(ren) to continue coverage under the Portability plan, You must elect Portability coverage for Yourself.

Spouse
Your covered Spouse may request their own Portability coverage:
1. if You die; or
2. if You and Your Spouse divorce (including the equivalent of divorce for civil union or Domestic Partners).

If You die and Your Spouse elects coverage under this Portability provision, the Spouse may elect Portability coverage for Your covered Dependent Child(ren).

If Your Spouse elects coverage under this Portability provision, the Spouse will become the primary insured for the purposes of Portability coverage.

Dependent Child(ren)
Your Dependent Child(ren) are eligible for Portability coverage if the Dependent Child(ren) were covered under the Policy when You became eligible for Portability coverage and You elect to insure the Dependent Child(ren) under the Portability coverage or if You die and Your covered Spouse elects to insure both themselves and the Dependent Child(ren) under the Portability coverage.

B. Amount of Portability Coverage

Employee
The maximum amount of insurance that can be continued under the Portability provision is the amount that was in effect on the date You became eligible for Portability coverage. You may decrease but not increase the continued coverage amount upon request.

Dependents
The maximum amount of insurance that can be continued for a Spouse or Dependent Child(ren) under the Portability provision is the amount that was in effect for Your Spouse or Dependent Child(ren) on the date they became eligible for Portability coverage. You may decrease but not increase the continued coverage amount upon request.

C. Applying for Portability Coverage

The Subscriber or We will provide You with the information needed to continue Your coverage under this provision. Continuation of coverage must be elected within 60 days of the Employee's termination of employment or membership in an eligible class under the Policy. The initial Premium must be paid within 60 days of billing.

This continued Critical Illness Insurance will be effective on the date that Critical Illness insurance would otherwise have ended under the Policy, as long as the above requirements are met.

Your Spouse or Dependent Child must apply for Portability coverage and pay the first Premium within 60 days after the date they become eligible for Portability coverage.

The Incontestability provision will apply to Portability coverage and will run from the date of the Covered Person's effective date of coverage under the Policy.

D. Portability Coverage Under the Group Policy

Any insurance continued under this Portability section will be provided under the group Policy. The terms and conditions of the Covered Person's continued insurance will be the same as those in effect on the date the Covered Person became eligible for Portability coverage, except for the right to add new dependent coverage.

E. Premiums for Portability Coverage

You will be directly billed for all Premiums due under this provision. We will notify You of the amount of Premium due, the frequency of Premium payments and the Premium due dates. If any Premium is not paid when due, You will have a 31 day Grace Period. This is the period following the Premium due date which Premium may be made by You. Insurance will end at the end of the Grace Period if You fail to make the required Premium payment within that time.

We will not change the Premium rate more than once in any period of 6 consecutive months and We will give You 31 days advance Written notice of any change in rates. If Your Spouse is eligible to apply separately and has done so, then Your Spouse will be responsible for Premium payments and will be directly billed for all Premiums due, and all benefit payments due will be paid directly to Your Spouse.

F. When Portability Coverage Ends

Employee
Portability coverage for You will end on the earliest of:
1. the date You fail to pay any required Premium, subject to the Grace Period;
2. the date You cancel Your coverage; or
3. the date You die.

Dependents
Portability for a Spouse will end on the earliest of the following:
1. When Portability for the Spouse is exercised with Employee Portability:
    a. the date You fail to pay any required Premium;
    b. the date You cancel Your coverage; or
    c. the date You or Your Spouse die.
2. When Portability for Your Spouse is exercised on their own:
    a. the date Your Spouse fails to pay any required Premium;
    b. the date Your Spouse cancels coverage; or
    c. the date Your Spouse dies.

Portability coverage for a Dependent Child(ren) will end on the earliest of the following:

1. When Portability for the Dependent Child(ren) is exercised with Employee Portability:
    a. the date Your coverage ends;
    b. the date Your Dependent Child no longer qualifies as a Dependent Child; or
    c. the date Your Dependent Child dies.
2. When Portability for Your Dependent Child(ren) is exercised by Your Spouse due to Your death:
    a. the date Your Spouse's coverage ends;
    b. the date Your Dependent Child no longer qualifies as a Dependent Child; or
    c. the date Your Dependent Child dies.

If Portability coverage ends due to failure to pay required Premium, Portability coverage cannot be reinstated.

The group Policy will remain in force for the purpose of continuing Portability coverage, but without further obligation of the Subscriber. However, We may terminate Portability coverage provided by this provision upon 60 days' notice if the Policy terminates.

SECTION IX. CLAIM PROVISIONS

Notice of Claim
Written notice must be given to Us within 31 days after a Covered Loss occurs or begins or as soon as reasonably possible. If Written notice is not given in that time, the claim will not be invalidated or reduced if it is shown that notice was given as soon as was reasonably possible. Notice can be given at Our home office in 51 Madison Ave, New York, NY 10010, such other place as We may designate for the purpose, or to Our authorized agent. Notice should include the Subscriber Name, the Policy Number and the claimant's name, address and certificate number.

Claim Forms
When We receive notice of claim, We will send claim forms with Written instructions for filing Proof of Loss. If such claim forms are not sent by Us within 15 days after notice is received by Us, You shall be deemed to have complied with the requirements of proof of claim when You submit Written proof that covers the occurrence, character and extent of the loss for which a claim is made.

Proof of Loss
You must send Us Written proof of Your claim no later than 90 days after a Covered Loss. Failure to give such proof within this timeframe shall not invalidate or reduce any payable claim if it can be shown that it was not reasonably possible to give such proof within that time, and the proof was given as soon as reasonably possible. You must provide proof of claim no later than 1 year after the time proof is otherwise required, except in the absence of legal capacity.

Time of Payment of Claims
Benefits payable under the Policy will be paid immediately, but no later than the 60th day, upon Our receipt of due Written proof of loss.

Payment of Claims
All benefits are payable to the Employee. Any benefits unpaid at the time of Your death will be paid to the first surviving class of the following classes of persons:

1. spouse;
2. child or children, in equal shares;
3. mother or father; in equal shares;
4. siblings; in equal shares;
5. Your estate.

If a survivor entitled to receive a payment dies before receiving it, We will make payment to that person’s estate.

If a survivor entitled to receive a payment has a special needs trust established, We will make payment to that person’s trust instead of the person directly.

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

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

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

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

Physical Examination and Autopsy
We, at Our expense, will have the right to examine any person for whom a claim is pending as often as it may reasonably be required. We may, at Our expense, require an autopsy unless prohibited by law.

SECTION X. GENERAL PROVISIONS

Entire Contract
The insurance for Covered Persons is provided under a contract of group Critical Illness insurance with the Subscriber, and the entire contract with the Subscriber consists of:
1. all Policy provisions and any amendments and endorsements to the Policy;
2. the Certificate of Coverage and any amendments and endorsements to the Certificate of Coverage; and
3. the Subscriber's signed application.

Certificate of Coverage
This Certificate of Coverage (or Certificate) is a Written statement prepared by Us and may include attachments. It tells You:
1. the coverage to which You may be entitled;
2. to whom We will make a payment; and
3. the limitations, exclusions and requirements that apply within the Policy.

Any conflict between the terms of the individual Certificate and the Policy will be decided in favor of the Policy. We have written your Certificate of Coverage in understandable terms. However, a few terms and provisions are written as required by insurance law. If You have any questions about any of the terms and provisions, please consult Our claims paying office. We will assist You in any way to help You understand Your benefits.

Policy Changes
The Policy can be changed:
1. at any time by Written agreement between Us and the Subscriber; and
2. without the consent of any other person.

The Policy may also be changed by Us by amendment to the Policy and without the consent of the Subscriber or any other person, if such amendment is signed by an officer of Us and:
1. results from the exercise of a right reserved to Us in the Policy; or
2. is issued to conform to any law and/or regulation which applies to the insurance under the Policy. No agent of Ours can make or change the Policy or waive any of its provisions.

Notice of Cancellation
The Subscriber or We may cancel the Policy as of any Premium Due Date on or after the first Policy Anniversary Date by giving 60 days advance written notice.

If a Premium is not paid when due, the Policy will automatically be canceled as provided in the Policy Grace Period provision.

Termination will not affect a claim for a Covered Loss that is the result of a Critical Illness that occurred while insurance was in effect.

Incontestability
All statements made by a Covered Person are considered representations and not warranties. No statement will be used to deny or reduce benefits or be used as a defense to a claim, unless the statement is in writing and signed, and a copy of the instrument containing the statement is, or has been, furnished to the claimant. In the event of death or incapacity, the beneficiary or representative shall be given a copy.

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

Misstatement of Age or Tobacco Use Status
If a Covered Person's age or tobacco use status has been misstated, We will adjust all benefits to the amounts that would have been purchased for the correct age or tobacco use status.

Clerical Error
Clerical error or omission by Us or the Subscriber will not:
1. revoke insurance otherwise in force, if You are entitled to coverage under the terms of the Policy; or
2. cause coverage to begin or continue for You when the coverage would not otherwise be effective.

If We or the Subscriber make a clerical error in keeping data that is required to compute Premiums and administer the terms of the Policy, We will:
1. based upon the facts, decide whether You have coverage under the Policy and in what amounts; and
2. make a fair adjustment of the Premium and/or insurance to correct the error.

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

Unpaid Premium
Any unpaid Premium due for a Covered Person's coverage under this Certificate may be recovered by Us by offsetting against amounts otherwise payable under this Certificate.

Worker's Compensation
The Policy does not replace or affect the requirements for coverage by any workers' compensation insurance.

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

SECTION XI. GENERAL DEFINITIONS

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

Active Service

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

1. One of the Subscriber's scheduled work days on which the Employee is performing the regular duties of the Employee's regular occupation and hours required for class eligibility, either at one of the Subscriber's usual places of business or at some other location the Subscriber has authorized the Employee to work; or
2. A scheduled holiday, vacation day or period of the Subscriber- approved paid leave of absence, other than disability or sick leave after 7 days, only if the Employee was in Active Service on the preceding scheduled workday.

An Employee is considered in Active Service on a day which is not one of the Subscriber's scheduled work days only if they were in Active Service on the preceding scheduled work day.

Activities of Daily Living

Includes the following activities:

1. Bathing (i.e. washing oneself in a shower or tub, or getting into or out of the tub or shower; or washing oneself by sponge bath.)
2. Dressing oneself by putting on and taking off from one's body all items of clothing and needed braces, fasteners and artificial limbs.
3. Continence (i.e. the ability to maintain control of one's own bowel and bladder function; or when unable to maintain bowel or bladder function, the ability to perform associated hygiene, including caring for a catheter or colostomy bag).
4. Toileting oneself by getting to and from the toilet, getting on and off the toilet, and performing personal hygiene associated with toileting.
5. Feeding oneself by getting nourishment into one's own body either from eating food that is made available to you in a receptacle such as a plate, cup, or table, or by feeding oneself by a feeding tube or intravenously.
6. Transferring (i.e. the ability to get oneself into or out of bed, a chair or wheelchair; or the ability to move from place to place either by walking, use of a wheelchair, or some other means).

Advanced Dementia (including advanced Alzheimer's Disease)

A progressive degenerative disease of the brain that is Diagnosed as advanced dementia or advanced Alzheimer's Disease by a Doctor. The Covered Person must:

1. exhibit the loss of intellectual capacity involving impairment of memory and judgment, which results in a significant reduction in mental and social functioning; and
2. be certified by a Doctor as requiring Substantial Physical Assistance from another adult to perform at least 2 Activities of Daily Living.

The date of Diagnosis is the date a Doctor certifies that the Covered Person requires Substantial Physical Assistance from another adult to perform at least 2 Activities of Daily Living.

We will not pay benefits for Advanced Dementia if the Covered Person was Diagnosed with Alzheimer's Disease, regardless of the Covered Person's symptoms or incapacities, prior to the Covered Person's effective date of coverage.

Advanced Parkinson's Disease

A brain disorder that is Diagnosed as Parkinson's Disease by a Doctor. The Covered Person must:

1. Exhibit 2 or more of the following clinical manifestations: muscle rigidity, tremor, or bradykinesia (abnormal slowness of movement or sluggishness of physical and mental responses); and
2. be certified by a Doctor as requiring Substantial Physical Assistance from another adult to perform at least 2 Activities of Daily Living.

The date of Diagnosis for Parkinson's Disease is the date a Doctor certifies that the Covered Person requires Substantial Physical Assistance from another adult to perform at least 2 Activities of Daily Living.

We will not pay benefits for Advanced Parkinson's Disease if the Covered Person was Diagnosed with Parkinson's Disease, regardless of the Covered Person's symptoms or incapacities, prior to the effective date of coverage.

Amyotrophic Lateral Sclerosis (ALS)

A motor neuron disease, marked by muscular weakness and atrophy with spasticity and hyperreflexia due to a loss of motor neurons of the spinal cord, medulla and cortex.

The date of Diagnosis is the date a Doctor confirms the presence of the disease.

Calendar Year

The period beginning on the Coverage 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.

Cerebral Palsy

A group of non-progressive disorders of movement and posture attributed to abnormal development of, or damage to motor control centers of the brain while a child's brain is still developing before, during, and immediately after birth. The motor disorders of Cerebral Palsy are often accompanied by disturbances of sensation, cognition, communication, perception, and behavior, as well as seizures and secondary musculoskeletal problems.

The date of Diagnosis is the date a Doctor confirms the clinical Diagnosis of the condition. This Diagnosis must be confirmed after birth.

Cleft Lip/Cleft Palate

Cleft Lip is a narrow opening or gap in the skin of the upper lip that extends all the way to the base of the nose.

Cleft Palate is an opening between the roof of the mouth and the nasal cavity, including clefts that occur on one side of the mouth or both sides.

The date of Diagnosis is the date a Doctor confirms the clinical Diagnosis of the condition. This Diagnosis must be confirmed after birth.

Coma

Complete unconsciousness with inability to respond to external or internal stimuli. The diagnosis of a Coma must be made by a Doctor and includes an admission Glasgow Coma Scale score of 7 or less. Coma includes a medically induced Coma.

The date of Diagnosis is the date the Doctor confirms the clinical Diagnosis of a Coma as described above.

Congenital Heart Illnesses

A structural malformation involving the heart that arises in utero and results in significant medical, social or cosmetic consequences for the affected individual, and requires medical Treatment. Examples of Congenital Heart Illnesses include, but are not limited to, aortic stenosis, coarctation of the aorta, and tetralogy of Fallot.

A Congenital Heart Illness must be Diagnosed and named by a Doctor according to clinically accepted diagnostic criteria. The Doctor must establish a Treatment plan specific to the condition.

The date of Diagnosis is the date a Doctor confirms the Diagnosis of a Congenital Heart Illness that satisfies the diagnostic requirements described above. This Diagnosis must be confirmed after birth.

A Critical Illness Benefit will not be paid for:

1. A condition that arises secondary to maternal alcohol use or use of drugs that are not prescribed for clinically accepted reasons for Treatment of a maternal medical condition.
2. Minor heart illnesses that pose little or no significant health problems, have limited social or cosmetic consequences for the affected insured Child, and do not require medical Treatment.

Contribution

The amount the Subscriber may require a Covered Person to pay towards the total Premium that We charge for the insurance provided under the Policy. The Premium due on any Premium Due Date is determined by the total amount of insurance provided under the Policy on such date, multiplied by the appropriate Premium rate(s) that are in effect on that date, subject to any Premium adjustments, if applicable.

Contributory Insurance

Insurance for which the Subscriber requires the Covered Person to pay all or a portion of the Premium. The Certificate of Coverage specifies who pays the cost of the coverage.

Coronary Artery Disease (with Bypass)

A heart disease or angina of sufficient severity that a Doctor has recommended coronary artery bypass surgery, which is a surgical procedure to bypass a narrowing or blockage of one or more coronary arteries utilizing venous or arterial grafts. The Doctor must deem the surgery necessary to correct the blockage of the coronary arteries.

If heart disease or angina of sufficient severity that coronary artery bypass would be necessary, but the Covered Person is too ill to undergo the surgery the requirement that coronary artery bypass be recommended is waived.

The date of Diagnosis is the date the Doctor recommends coronary artery bypass surgery.

Only one benefit is payable no matter how many arteries involved.

Coronary Artery Disease (with Coronary Intervention)

A heart disease or angina that is treatable with percutaneous coronary intervention (balloon angioplasty, stent implantation or related procedures) to increase the flow of blood through the coronary arteries is included. If heart disease or angina of sufficient severity that the percutaneous coronary intervention would be necessary, but the Covered Person is too ill to undergo the coronary intervention the requirement that percutaneous coronary intervention be recommended is waived.

The date of Diagnosis is the date the Doctor recommends percutaneous coronary intervention.

Only one benefit is payable no matter how many arteries involved.

Covered Person

The Employee and any Spouse and Dependent Child(ren), who has met the enrollment requirements of the Policy, for whom the required Premium has been paid when due, and whose coverage under this Policy remains in force.

Critical Illness

Any of the conditions listed in the Critical Illness Benefits section of the Benefits Schedule.

Dependent Child

An Employee's child who meets the following requirements:

1. A child from birth but less than 26 years old;
2. A child who has reached age 26, who:
    a. Is unable to support themselves due to mental or physical incapacity; and
    b. Resides with and is chiefly financially dependent on the Employee; and
    c. Is eligible as a Dependent Child under the Employee's health care plan, and is covered under that plan, or under a separate health care plan.

A child's age shall be determined as of the last Policy Anniversary Date.

The term "child" means:
1. A natural child.
2. A foster child.
3. A legally adopted child, beginning with any waiting period pending finalization of the adoption of the child.
4. A stepchild who resides with the Employee and is financially dependent upon such Employee.
5. A child of an Employee's covered Spouse, who resides with the Employee and is financially dependent upon such Employee.
6. A child, including a grandchild, for whom the Employee is the court-appointed legal guardian, as long as the child resides with the Employee and primarily depends on the Employee for financial support. Financial support means that the Employee is eligible to claim the child for purposes of Federal and State income tax returns.

If the Employee who is the legal guardian of a child is not a step-parent, grandparent, aunt or uncle, then the child must have resided with Employee for at least 6 consecutive months and intend to reside with the Employee for an indefinite period of time.

Diagnosis, Diagnosed

A Doctor, specializing in a particular field of medicine, where applicable, has definitively identified a disease or irregularity in a Covered Person. Such Diagnosis must:
1. be based upon the use of diagnostic evaluations, clinical and/or laboratory investigations, tests and observations and where the results are documented in and supported by the Covered Person’s medical records; and
2. meet all diagnostic requirements stated in this Certificate for the particular condition being Diagnosed.

Doctor

A person performing tasks that are within the limits of their medical license and:
1. who is licensed to practice medicine and prescribe and administer drugs or to perform surgery; or
2. who is a legally qualified medical practitioner according to the laws and regulations of the governing jurisdiction.

This may include a government-licensed practitioner of the healing arts acting within the scope of license and rendering care and Treatment to a Covered Person that is appropriate for the condition.

Domestic Partner

Means either of the following, with respect to any unmarried Employee:

1. Any person who is registered with the Employee as a Domestic Partner, or partner to a civil union, under any state domestic partnership or civil union law which creates legal rights and obligations similar to marriage.
2. Any person who meets the following requirements:
    a. Is at least 18 years of age.
    b. Shares a permanent residence with the Employee and has resided with the Employee continuously for at least 12 months and is expected to continue to reside with the Employee indefinitely.
    c. Is the Employee's sole Domestic Partner, and is not married and has no other Domestic Partner as defined.
    d. Is not so closely related by blood to the Employee as to preclude legal marriage.
    e. Has agreed with the Employee that the Employee and Domestic Partner are mutually financially responsible for the welfare of the other.
    f. Is financially interdependent with the Employee in one or more of the following ways:
        1. Joint bank, savings or brokerage accounts.
        2. Joint ownership of real property or joint leasing of a primary residence.
        3. Joint credit obligations.
        4. Being named as beneficiary under a last will.
        5. Being named as attorney in fact under a durable or healthcare power of attorney.
    g. A person who has not signed a Domestic Partner affidavit or declaration with any other person within the last 12 months.
3. Is eligible as a Domestic Partner under the Employer's health care plan, and is covered under that plan, or under a separate health care plan.

Down Syndrome

A congenital disorder arising from a chromosome defect involving chromosome 21, causing intellectual impairment, physical abnormalities and developmental delays. Down Syndrome includes:

1. Trisomy 21: when the individual has three instead of two chromosomes;
2. Translocation: when an extra part of the 21st chromosome is attached to another chromosome;
3. Mosaicism: when the individual has an extra 21st chromosome in only some of the cells but not all of them. The other cells have the usual pair of 21st chromosomes.

Diagnosis of Down Syndrome must be supported by the study of chromosome 21 and made after birth.

The Date of Diagnosis is the date a Doctor confirms the Diagnosis of the condition. This Diagnosis must be confirmed after birth.

Employee

For the purpose of eligibility, an Employee is an Employee of the Subscriber in one of the "Classes of Eligible Employees". Otherwise, Employee means an Employee of the Subscriber who is insured under the Policy.

Employer

The Subscriber and any affiliates or subsidiaries covered under the Policy. The Employer is not Our agent with respect to any transactions relating to this insurance.

End-Stage (Renal) Kidney Failure

Chronic and irreversible failure of both of the Covered Person's kidneys:
1. which requires the Covered Person to undergo peritoneal dialysis or hemodialysis; or
2. for which a Doctor has determined that a kidney transplant is necessary to be performed as soon as an appropriate donor is located.

The date of Diagnosis is any of the following:
1. the date a Doctor recommends the Covered Person undergo regular peritoneal dialysis or hemodialysis;
2. the date a Doctor determines that the Covered Person must undergo a kidney transplant; or
3. the date the Covered Person is placed on the UNOS (United Network for Organ Sharing) list for a kidney transplant.

Heart Attack

The death of a portion of the heart muscle (myocardium) resulting from a blockage of one or more coronary arteries.

Diagnosis of a Heart Attack requires two of the following criteria:
1. Clinical picture of myocardial infarction;
2. New EKG findings consistent with myocardial infarction;
3. Elevation of cardiac enzymes above standard laboratory levels of normal (in case of CPK, a CPK-MB measurement must be used).

The date of Diagnosis is the date a Doctor confirms the Diagnosis of a Heart Attack is satisfied by medically accepted diagnostic measures. In the event of death, an autopsy report and/or death certificate identifying a Heart Attack or myocardial infarction as a cause of death will be accepted as evidence of a Heart Attack.

A Sudden Cardiac Arrest is not in itself considered a Heart Attack.

Initial Group Enrollment Period

The period agreed upon by the Subscriber and Us when an eligible Employee may first enroll for his or her benefit elections under the Policy as shown in the Schedule of Benefits.

Invasive Cancer

A group of diseases characterized by the uncontrolled growth and/or spread of abnormal cells. Invasive Cancer is limited to malignancies of solid tissue, blood or lymph tissue and includes leukemia and lymphoma.

The Diagnosis is generally made by examining tissue under a microscope. This requires looking at the suspect tumor, tissue or specimen at the microscopic level such that malignancy may be determined using established medical standards for cancer Diagnosis. In some circumstances, a cancer Diagnosis can be made on a clinical or postmortem basis. If your Doctor makes a diagnosis of invasive cancer based on sound clinical judgment or by examining tissues under a microscope, then it is considered Invasive Cancer under the Policy.

The date of Diagnosis is the date the tissue sample or medically accepted diagnostic or laboratory study is taken or the date diagnosis is made based on sound clinical judgement.

For the purposes of the Policy, the following are not considered Invasive Cancer:
1. Basal cell carcinoma and squamous cell carcinoma of the skin;
2. Non-Invasive Cancer;
3. Skin Cancer;
4. Melanoma that is diagnosed as Breslow's classification less than 0.75mm;
5. Pre-malignant conditions or polyps; and
6. Any other histologically benign or nonmalignant condition.

Major Organ Failure

A disease of organs and tissues which causes major organ(s) failure requiring the malfunctioning organ(s) or tissue of the Covered Person to be replaced with an organ(s) or tissue (other than the Covered Person's) under generally accepted medical procedures. The condition in the absence of an organ transplant would result in a drastically limited life span. The organs and tissues covered by this definition are limited to: liver, lung, entire heart, small intestine, or pancreas.

The date of Diagnosis is any of the following:

1. the date a Doctor confirms the Diagnosis of Major Organ Failure when the Covered Person is deemed not healthy enough to move forward with an organ transplant or if the Covered Person is rejected from the UNOS (United Network for Organ Sharing) list for an organ transplant;
2. the date the Covered Person is placed on the UNOS (United Network for Organ Sharing) list for an organ transplant; or
3. the date the Covered Person has been recommended and scheduled to receive an organ transplant when the Covered Person is not placed on the UNOS (United Network for Organ Sharing) list for an organ transplant.

Multiple Sclerosis

A condition evidenced by demonstrated neurological deficits that have been persistent. Diagnosis must be made on the basis of:

1. neurological examination demonstrating functional impairments;
2. imaging studies of the brain or spine demonstrating lesions consistent with MS; and
3. analysis of cerebrospinal fluid consistent with the diagnosis.

The date of Diagnosis is the date a Doctor confirms the presence of the disease that satisfies the diagnostic requirements above.

Non-Invasive Cancer (In Situ)

The presence of tumor cells tending toward malignancy but that do not invade the underlying tissue (i.e. malignant cells confined to the epithelium without penetration of the basement membrane). Because this cannot be Diagnosed on a clinical basis, a biopsy must be performed and examined by a Doctor familiar with the microscopic Diagnosis of Invasive Cancer for it to be considered Invasive Cancer under the Policy.

The date of Diagnosis, is the date the tissue sample or medically accepted diagnostic or laboratory study is taken.

For purposes of the Policy, the following are not considered Non-invasive Cancer:

1. Basal cell carcinoma and squamous cell carcinoma of the skin;
2. Invasive Cancer;
3. Skin Cancer;
4. Melanoma that is diagnosed as Breslow's classification less than 0.75mm; and
5. Pre-malignant conditions or conditions with malignant potential.

Paralysis

Damage to the brain or spinal cord that results in quadriplegia, paraplegia, hemiplegia, or diplegia (complete and permanent loss of use or permanent loss of movement of two or more limbs) Diagnosed by the Covered Person's attending Doctor.

The date of Diagnosis is the date a Doctor confirms the Diagnosis satisfies the diagnostic requirements described above.

Policy

The insurance contract issued to the Subscriber under the policy number shown on the cover page of this Certificate.

Policyholder

The Employer to whom the policy is issued and who sponsored the coverage for its Employees.

Premium

The amount the Subscriber must pay to Us, and We must receive, for the Policy to take effect and/or for the Policy to continue in force. Premium includes contributions made by Covered Persons, if applicable.

Prior Plan

The Prior Plan refers to the plan of insurance providing similar benefits sponsored by the Subscriber offered under a group policy to Employees of the Subscriber in effect directly prior to the Policy Effective Date. A Prior Plan will include the plan of a Subscriber in effect on the day prior to:

1. That Subscriber's addition to the Policy; or
2. With Our approval, the addition of all Employee, or all of a defined group of Employees, of the Subscriber, as a result of an agreement to which that Subscriber (or a parent or shareholder of that Subscriber) is a party.

To be covered under the Policy, required Premium must be paid for all covered Employees.

Retiree

A former Employee who is currently receiving a retirement benefit under a pension or other retirement plan administered by the Subscriber.

Skin Cancer

The presence of tumor cells tending toward malignancy and which invade the underlying tissue. Because Skin Cancer can often not be confirmed without a tissue sample being evaluated under a microscope (biopsy), a Skin Cancer must have been biopsied and examined under a microscope by a Doctor experienced in the Diagnosis of such specimens. Skin Cancer include melanoma of Clark's Level I or II (Breslow depth of less than .75mm), basal cell carcinoma, or squamous cell carcinoma of the skin. For the purposes of this definition:

1. Clark's level measures how deep the tumor has penetrated into the layers of the skin.
2. Breslow depth refers to how deeply tumor cells have invaded.

For purposes of the Policy, the following are not considered Skin Cancer:

1. Invasive Cancer;
2. Non-Invasive Cancer (In-Situ);
3. Pre-malignant conditions or conditions with malignant potential.

The date of Diagnosis, is the date the tissue sample or medically accepted diagnostic or laboratory study is taken.

Spina Bifida

A congenital defect of the spine in which part of the spinal cord and its meninges are exposed through a gap in the backbone. Spina Bifida includes Meningocele or Myelomeningocele. It does not include spina bifida occulta.

The date of Diagnosis is the date a Doctor confirms the clinical Diagnosis of the condition. This Diagnosis must be made after birth.

Spouse

The current lawful Spouse of an Employee. Spouse includes Your Domestic Partner.

Wherever in the Certificate of Coverage there is a reference to "divorce" or "divorced", it also means dissolution of a civil union, domestic partnership, or other family or domestic relations law of the governing jurisdiction.

Stroke

An acute cerebral vascular incident producing permanent, neurological impairment and resulting in measurable objective neurological deficit.

A Stroke with neurologic impairment must be:

1. confirmed by a clinical Diagnosis or neuroimaging study;
2. a result of damage to brain tissue caused by either thrombosis, hemorrhage or embolism;
3. determined by a Doctor that neurologic impairment resulted from the cerebral vascular event currently being Diagnosed and was not previously present.

Stroke does not include Transient Ischemic Attacks (TIA) or attacks of vertebrobasilar ischemia.

The date of Diagnosis is the date a Doctor confirms the Diagnosis of a Stroke based on the criteria provided above. In the event of death, an autopsy report and/or death certificate will be accepted as evidence of a Stroke.

Subscriber	Any participating organization that subscribes to the trust to which the Policy is issued, and which is insured under the Policy.
Substantial Physical Assistance	The physical assistance of another person without which the Covered Person would not be able to perform an Activity of Daily Living; or the constant presence of another person within arm's reach that is necessary to prevent, by physical intervention, injury to the Covered Person while the Covered Person is performing an Activity of Daily Living.
Treatment	Means medical advice, diagnosis, care or services (including diagnostic measures) received by a Covered Person, or the use of drugs or medicines by a person. It does not include regular follow-up visits or drugs or medicines as a result of preventative measures due to no evidence on an active diagnosis.
We, Us, Our,	New York Life Insurance and Annuity Corporation
Written	A record which is on or transmitted by paper, electronic or telephonic media, and which is consistent with applicable law.
You, Your, Yours	The person to whom the certificate is issued. You, Your, Yours means the Employee.

New York Life Insurance and Annuity Corporation
51 Madison Avenue
New York, New York 10010

TAKEOVER PROVISION BENEFIT RIDER

POLICYHOLDER: NATIONAL GROUP BENEFITS INSURANCE TRUST **SUBSCRIBER GROUP ID: 109945**
POLICY NUMBER: GCI0100222 **RIDER EFFECTIVE DATE: 01/01/2026**
SUBSCRIBER: Spectrum Brands, Inc.

This rider is attached to and made part of the Policy and any Certificates delivered under the Policy and is subject to all provisions, limitations, and exclusions of this Policy, unless changed by this rider. Unless expressly changed by this rider, the terms used in this rider have the same meaning as in the Certificate.

Policyholder and We hereby agree that the Policy and any Certificates delivered under the Policy includes the following Takeover Provision-Transitional Coverage for Prior Diagnoses added to the Effective Date of Insurance section of the Certificate.

Takeover Provision – Transitional Coverage for Prior Diagnoses

We will pay a benefit equal to the amount that would have been payable under the Policy had the Covered Person been eligible on the date of Diagnosis providing all of the following conditions are met:

- The Covered Person was covered under a Prior Plan on the day immediately preceding the Effective Date of this Policy;
- The Covered Person is covered under this Policy;
- While covered under the Prior Plan, the Covered Person was Diagnosed with a Covered Critical Illness as defined by this Policy;
- Initial treatment for the Covered Critical Illness occurred on or after the Effective Date of this Policy; and
- The Prior Plan denied the claim based on treatment occurring after termination of the Prior Plan.

Signed for the
New York Life Insurance and Annuity Corporation



President, Craig DeSanto

New York Life Insurance and Annuity Corporation
51 Madison Avenue
New York, New York 10010

MODIFICATIONS FOR RESIDENTS OF CERTAIN STATES FORM

Policyholder: NATIONAL GROUP BENEFITS INSURANCE TRUST Policy Number: GCI0100222

Subscriber: Spectrum Brands, Inc.

Amendment Effective Date: 01/01/2026

Arkansas residents:

Under the **GENERAL DEFINITIONS** section of the Certificate, if your Certificate includes a definition of a **Dependent Child**, then the below language is not included:

> **Dependent Child**
> 3c. Is eligible as a Dependent Child under the Employee's health care plan, and is covered under that plan, or under a separate health care plan.

California residents:

Domestic Partner coverage must be provided to CA Certificate holders when issued out of state via (Trust) on behalf of California Employers.

Colorado residents:

Under the **EXCLUSIONS AND LIMITATIONS** section of the Certificate, if the Certificate includes the **Preexisting Condition Limitation** provision and the limitation is more than six months, then the limitation has been modified to no more than six months.

Under the **EXCLUSIONS AND LIMITATIONS** section of the Certificate, the following **Exclusions** have been modified as follows:

> 3. suicide or attempted suicide, while sane.
> 4. intentionally self-inflicted harm, while sane.

Georgia residents:

Under the **CLAIMS PROVISION** section of the Certificate, the **Claim Forms** provision is replaced with the following:

> **Claim Forms**
> If the provision includes language other than 10 working days, your certificate has been changed to require 10 working days.

Under the **GENERAL DEFINITIONS** section of the Certificate, if the Certificate includes a definition of **Dependent Child**, then the definition is changed as follows:

> **Dependent Child Definition**
> If the definition includes a maximum child age of less than 26 years, then the maximum child age is changed to 26 years.

Idaho residents:

Right to Examine the Certificate for 10 Days: Please examine the Certificate. Within 10 days after Your Certificate is provided, You may return the Certificate to New York Life with a request for cancellation. If the Certificate is returned, the Certificate will be void from the start and a full refund will be made.

The Policy is renewable at the option of the Policyholder unless sufficient notice of nonrenewal is given to the Policyholder in writing by Us.

Under the **SCHEDULE OF BENEFITS** section of the Certificate, the **COVERED CRITICAL ILLNESSES** provision has been modified as follows throughout the Certificate:

- Coronary Artery Disease (with Bypass) has been changed to:
Coronary Artery Disease

- if the Certificate includes Coronary Artery Disease (with Coronary Intervention), then this illness has been removed and does not apply.

Under the **EXCLUSIONS AND LIMITATIONS** section of the Certificate, if your Certificate includes a **Preexisting Condition Limitation** provision, then the period of time before the effective date of coverage has been changed to 6 months.

Under the **EXCLUSIONS AND LIMITATIONS** section of the Certificate, if the Certificate includes an **Exclusions** provision, then the following exclusions have been modified as follows:

3. committing a felony;

B. Additionally, the following exclusions, if shown in your Certificate, are not applicable:

7. voluntary intake or use by any means of any drug, unless:
i. prescribed or administered by a Doctor and taken in accordance with the Doctor's instructions; or
ii. an over-the-counter drug, taken in accordance with the instructions.

Under the **GENERAL DEFINITIONS** section of the Certificate, if your Certificate includes the following definitions they have been modified as follows:

-if included in the Certificate, then the **Coma** definition has been removed and does not apply.
-if included in the Certificate, then the **End-Stage (Renal) Kidney Failure** definition has been modified as follows:

End-Stage (Renal) Kidney Failure
Chronic and irreversible failure of both of the Covered Person's kidneys due to function

The date of Diagnosis is the date a Doctor confirms End-Stage (Renal) Kidney Failure has resulted in total and irreversible loss of renal function, satisfying the definition criteria.

-if included in the Certificate, then the **Paralysis** definition has been removed and does not apply.

Indiana residents:

Under the **EFFECTIVE DATE OF INSURANCE** section of the Certificate, if your Certificate includes coverage for a Newly Born or Adopted child, then the **Effective Date of Coverage for Newly Born or Adopted Children** provision has been modified as follows:

If the first paragraph of the provision includes the following last statement, "...days from the moment of live birth or date of placement for adoption." The statement is changed to "days from the earlier of the moment of birth or date of placement for adoption."

In the second paragraph of the provision the following underlined statement has been added as a requirement to the provision: "If the Employee has not elected Dependent Child(ren) insurance coverage at the time of birth, date of placement, or date of entry of an order granting the Employee Custody."

Under the **GENERAL DEFINITIONS** section of the Certificate, if your Certificate includes coverage for a Dependent Child, then the **Dependent Child** provision has been modified as follows:

If the definition includes "unmarried" child, this requirement will not apply.

If the definition includes a maximum child age of less than 26 years, then this maximum is changed to 26 years.

If the definition for a child who has reached age 26, who is eligible as a Dependent Child under the Employer's or a health care plan

If the definition for **the term "child" means** includes "a legally adopted child, beginning with any waiting period pending finalization of the adoption of the child," the requirement has been changed to "a legally adopted child."

If the definition for **the term "child" means** includes "a stepchild who resides with the Employee and is financially dependent upon such Employee" or a variation of this statement, the requirement has been changed to "a stepchild."

If the definition for **the term "child" means** includes "a child of an Employee's covered Spouse, who resides with the Employee and is financially dependent upon such Employee" or a variation of this statement the requirement has been changed to just "a child of an Employee's covered Spouse."

If the definition for **the term "child" means** includes "a child, including a grandchild, for whom the Employee is the court-appointment legal guardian, as long as the child resides with the Employee and primarily depends on the Employee for financial support" or "a child, including a grandchild, for whom the Employee is the court-appointment legal guardian, as long as the child resides with the Employee and primarily depends on the Employee for financial support. Financial Support means that the Employee is eligible to claim the child for purposes of Federal and State income tax returns." or a variation of these statements, the requirement has been changed to "a child, including a grandchild, for whom the Employee is the court-appointment legal guardian."

Louisiana residents:

Under the **EFFECTIVE DATE OF INSURANCE** section of the Certificate, if the Certificate includes the **Effective Date of Coverage for Newly Born or Adopted Children** then the provision has been modified to include the following language after the first paragraph:

Additionally, the coverage for any child who is placed in Your home following execution of an act of voluntary surrender in favor of the Your or Your legal representative will begin on the date on which the act of voluntary surrender becomes irrevocable. You must complete enrollment for such child and pay any required premium.

Under the **GENERAL DEFINITIONS** section of the Certificate, if your Certificate includes a definition of **Dependent Child**, then the definition is changed as follows:

For an Employee's child who meets the following requirements:

- If the Dependent Child definition includes a maximum child age of less than 21 years, then the maximum child age is changed to 21 years for Coverage.
- If the Dependent Child definition includes a child enrolled in a school as a full-time student and is primarily supported by the Employee, then the minimum age is changed to 22 years or more but less than 24 years. If the child develops a mental or nervous condition, problem, or disorder which renders the child, in the opinion of a qualified psychiatrist, subject to a second opinion if deemed necessary by Us, unable to attend school as a full-time student and from holding self-sustaining employment, the child will be considered a full-time student.
- A child who has reached the maximum child age is unable to support themselves due to intellectual or physical disability.

The term "child" has been modified as follows:

- A grandchild in the custody of and residing with You.
- A legally adopted child, beginning with the placement of the child for adoption or following the execution of an act of voluntary surrender in favor of You or Your legal representative.
- A child of an Employee's Spouse or Domestic Partner, who resides with the Employee and is financially dependent upon such Employee.
- A child for whom the Employee is the court- appointed legal guardian, as long as the child resides with the Employee and primarily depends on the Employee for financial support. Financial support means that the Employee is eligible to claim the child for purposes of Federal and State income tax returns.

Maine residents:

Under the **GENERAL PROVISIONS** section of the Certificate, the Third Party Notice has been included:

> **Third Party Notice**
> The Covered Person may designate an additional person to receive notice of any intent to terminate coverage. You may change this designation at any time. The form is available upon request from the Policyholder. After We have received the completed form, at least 10 days prior to cancellation of Your coverage, We will give notice of the pending cancellation to Your designated third party, if any, at the address You provided. This notice will give the reason for the cancellation.

Massachusetts residents:

The following statement is added to the ***Continuation of Insurance Benefits*** provision of the Certificate:

> If your employment is terminated due to a plant closing or partial closing (as defined in section 71A of Chapter 151A. Massachusetts Statutes), your insurance will continue under the Policy for a period of 90 days unless during that period you are otherwise entitled to similar benefits. Premium payment is required.

Missouri residents:

Under the **EXCLUSIONS** section of the Certificate, the exclusion for **suicide or intentionally self-inflicted harm**, if any, is modified to remove any references to an "insane" person.

Under the **CLAIM PROVISIONS** section of the Certificate, the **Time of Payment of Claims** provision has been replaced with the following:

> If the last paragraph of the provision includes the following statement "Any payment made by Us in good faith pursuant to this provision will fully discharge Us to the extent of such payments and release Us from all liability.", then the statement is changed to "Any payment made by Us in good faith pursuant to this provision will fully discharge Us to the extent of such payments."

Under the **CLAIM PROVISIONS** section of the Certificate, the **Claimant Cooperation Provision** does not apply.

Under the **CLAIM PROVISIONS** section of the Certificate, the **Physical Examination and Autopsy** provision has been replaced with the following:

> **Physical Examination and Autopsy**
> We, at Our expense, will have the right to examine any person for whom a claim is pending as often as it may reasonably be required. We may, at Our expense, require an autopsy in the case of death unless prohibited by law.

Under the **GENERAL PROVISIONS** section of the Certificate, the **Incontestability** provision has been modified as follows:

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

Under the **GENERAL DEFINITIONS** section of the Certificate, if your Certificate includes a definition of **Dependent Child**, then the definition is changed as follows:

> **Dependent Child Definition**
> If the definition includes a maximum child age of less than 26 years, then the maximum child age is changed to 26 years.

South Carolina residents:

Under the **CLAIM PROVISIONS** section of the Certificate, the **Time of Payment of Claims** provision has been modified as follows:

> **Time of Payment of Claims**
> Benefits payable under the Policy will be paid within 60 days of Our receipt of due Written proof of loss.

Under the **CLAIM PROVISIONS** section of the Certificate, the **Physical Examination and Autopsy** provision has been modified as follows:

> **Physical Examination and Autopsy**
> We, at Our expense, will have the right to examine any person for whom a claim is pending as often as it may reasonably be required. We may, at Our expense, require an autopsy unless prohibited by law. Any such autopsy shall be performed in South Carolina.

Under the **CLAIM PROVISIONS** section of the Certificate, the **Legal Actions** provision has been modified to read as follows:

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

Texas residents:

Under the **EFFECTIVE DATE OF INSURANCE** section, if the Certificate includes **the Effective Date of Coverage for Newly Born or Adopted Children** provision, then the following changes will be included:

> -The Time Period for coverage for adopted children will be revised to read a minimum of 31 days.

Under the **GENERAL DEFINITIONS** section, if the Certificate includes a definition of **Dependent Child**, then the definition is changed as follows:

For an Employee's child who meets the following requirements:

If the Dependent Child definition includes a maximum child age of less than 26 years, then the maximum child age is changed to 26 years.

For an Employee's child who has reached the maximum child age, included items are:

-Is chiefly dependent on the Employee for support and maintenance.
-Is the subject of a medical or dental support order under the health coverage of the Employee.

The term "child" includes:
-A child for which the Employee is a party to a suit in which the Employee seeks to adopt the child.

-A stepchild who dependent upon such Employee.

-A child and stepchild of an Employee's or covered Spouse (Note: include "or covered Spouse" only if Spouse coverage is included under the policy

-A grandchild, if a dependent of the Employee for federal income tax purposes at the time of application for coverage of the grandchild.

-A child for whom the Employee is the court-appointed legal guardian.

Utah residents:

Under the **EFFECTIVE DATE OF INSURANCE** section of the Certificate, if your Certificate includes the **Effective Date of Coverage for Newly Born or Adopted Children** provision, then the following language has been modified as follows:

> An Employee's Dependent Child(ren) who are born or adopted while the Employee is covered under the Policy are covered for 60 days from the moment of live birth or date of placement for adoption. For purposes of this Policy, placement means the assumption and retention of a legal obligation for the child.

If the **PORTABILITY or CONTINUATION** provision is not included in the Certificate, then these options will be afforded to residents of Utah. Upon termination, please contact your employer for further information.

Under the **EXCLUSIONS AND LIMITATIONS** section of the Certificate, if the Certificate includes the **Preexisting Condition Limitation** provision and the limitation is more than six months, then the limitation has been modified to no more than six months.

Under the **EXCLUSIONS AND LIMITATIONS** section of the Certificate, if the certificate includes the following **Exclusions**, then the **Exclusions** have been modified as follows:

2. voluntary participation in a riot, insurrection, or terrorist activity
3. voluntary participation in committing or attempting to commit a felony
4. voluntary participation in an illegal occupation or activity

Under the **GENERAL PROVISIONS** section of the Certificate, if the Certificate includes the **Unpaid Premium** provision, then this provision has been removed and does not apply.

Under the **GENERAL DEFINITIONS** section of the Certificate, if the Certificate includes a definition of **Dependent Child**, then the definition is modified as follows:

For an Employee's child who meets the following requirements:

If the Dependent Child definition includes a maximum child age of less than 26 years, then the maximum child age is changed to 26 years.

For an Employee's child who has reached the maximum child age, included items are:

-A child less than 26 years old.
-A child who has reached age 26 who:
a. Is unable to support themselves due to mental or physical impairment

The term "child" includes:

- A natural child.
- A foster child.
- A legally adopted child, beginning with the placement of the child.
- A stepchild.
- A child, including a grandchild.

Washington residents:

Washington Certificate holders when issued out-of-state via direct issue to employers and labor unions outside of Washington.

In addition to those changes, the out-of-state Certificate should be used for WA residents in lieu of the Modifications for Residents of Certain States Form.

SUPPLEMENTAL INFORMATION
for

Spectrum Brands, Inc. Welfare Benefit Plan ("Plan")
required by the Employee Retirement
Income Security Act of 1974

As a Plan participant in Spectrum Brands, Inc., you are entitled to certain information, rights and protection under the Employee Retirement Income Security Act of 1974 (ERISA).

The benefits described in your Certificate are provided under a group insurance Policy issued by the Insurance Company. The Policy is incorporated into the Plan. The Certificate, along with the following Supplemental Information, makes up the Summary Plan Description as required by ERISA.

IMPORTANT INFORMATION ABOUT THE PLAN

- The Plan is established and maintained by Spectrum Brands, Inc., the Plan Sponsor.
- The Employer Identification Number (EIN) is 22-2423556.
- The Plan Number is 501.
- The Insurance Plan is administered directly by the Plan Administrator with benefits provided, in accordance with the provisions of the group insurance contract, GCI0100222 ("Policy"), issued by LIFE INSURANCE COMPANY OF NORTH AMERICA ("Insurance Company").
- The Plan Administrator is: Spectrum Brands, Inc.
  3001 Deming Way
  Middleton, Wisconsin 53562
  (800) 566-7899
- The Plan Administrator has authority to control and manage the operation and administration of the Plan.
- The Plan Sponsor may terminate, suspend, withdraw or amend the Plan, in whole or in part, at any time, subject to the applicable provisions of the Policy. (Your rights upon termination or amendment of the Plan are set forth in your Certificate.)
- The agent for service of legal process is the Plan Administrator.
- The Plan of benefits is financed by the Employees.
- The date of the end of the Plan Year is December 31.

YOUR RIGHTS AS SET FORTH BY ERISA

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

Receive Information About Your Plan and Benefits

Examine, without charge, at the plan administrator's office and at other specified locations, such as worksites and union halls, all documents governing the plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefit Security Administration.

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

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

Prudent Actions by Plan Fiduciaries

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

Enforce Your Rights

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

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report from the plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the plan administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court. If it should happen that plan fiduciaries misuse the plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions

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

WHAT YOU SHOULD DO AND EXPECT IF YOU HAVE A CLAIM

The Plan Administrator designates and names the Insurance Company the named fiduciary for deciding claims and appeals for benefits under the Plan. The Insurance Company shall have the authority, in its discretion, to interpret the terms of the Plan, to decide questions of eligibility for coverage or benefits under the Plan, and to make any related findings of fact. All decisions made by the Insurance Company shall be final and binding on Participants and Beneficiaries to the full extent permitted by applicable law.

Claims for Disability Benefits (applies to all claims filed on or after April 1, 2018)

A disability "claim" is any claim which requires a determination of disability by the Insurance Company regardless of the type of policy under which it arises (for example, short/long term disability, waiver of premium, etc.). A disability claim is "filed" as of the date the Insurance Company first receives, in writing (including electronically) or by telephone (through the Insurance Company's intake department), notice that a claimant is seeking disability benefits under the Policy. The notice of claim received should provide the date of disability/loss, the claimant's name and address, Social Security Number, date of birth, and the group Policyholder's name and address. Properly filed claims will be decided with independence and impartiality.

The Insurance Company has 45 days from the date it receives a claim for disability benefits to determine whether or not benefits are payable in accordance with the terms of the Policy. The Insurance Company may require more time to review the claim if necessary due to matters beyond its control. The review period may be extended for up to two additional 30 day periods. If this should happen, the Insurance Company must provide its extension notice in writing before expiration of the current decision period, explaining the circumstances requiring extension and the date a decision is expected. If the extension is made because additional information must be furnished, the claimant has 45 days within which to provide the requested information and the time for the Insurance Company's decision shall be tolled (stopped) from the date on which the notification of the extension was sent until the date the Insurance Company receives the claimant's response or upon the date the requested information is required to be furnished expires, whichever is sooner.

During the review period, the Insurance Company may require a medical examination of the claimant, at its own expense, or additional information regarding the claim. If a medical examination is required, the Insurance Company will notify the claimant of the date and time of the examination and the physician's name and location. If additional information is required, the Insurance Company will notify the claimant, in writing, stating what information is needed and why it is needed.

If the claim is approved, the Insurance Company will pay the appropriate benefit. If the claim decision is adverse, in whole or in part, the Insurance Company will provide written or electronic notice which will include the following information:

1. The specific reason(s) for the decision;
2. Specific reference to the Policy provision(s) on which the decision was based;
3. A description of any additional information required to perfect the claim, and the reason this information is necessary;
4. A description of the review procedures and the time limits applicable to those procedures, including a statement of the claimant's right to bring a civil action under section 502(a) of ERISA after the claimant appeals and after the claimant receives an adverse decision on appeal;
5. A discussion of the decision, including an explanation of the basis for disagreeing with or not following: (i) the views presented by the claimant to the Insurance Company of the health care professionals treating the claimant and vocational professionals who evaluated the claimant; (ii) the views of medical or vocational experts whose advice was obtained on behalf of the Insurance Company in connection with the claimant's adverse benefit decision, without regard to whether the advice was relied upon in making the benefit decision; and (iii) a disability decision regarding the claimant presented by the claimant to the Insurance Company made by the Social Security Administration;
6. Either the specific internal rules, guidelines, protocols, standards or other similar plan criteria the Insurance Company relied upon in making the decision, or, alternatively, a statement that such rules, guidelines, protocols, standards or other similar plan criteria do not exist;
7. If the adverse decision is based upon medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the decision, applying the terms of the Policy to the claimant's medical circumstances, or a statement that such explanation will be provided free of charge upon request;
8. A statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claim for benefits; and
9. A notice provided in a culturally and linguistically appropriate manner, to the extent required by ERISA.

Appeal of Denied Disability Claims (applies to all claims filed on or after April 1, 2018)

Whenever a claim decision is fully or partially adverse, unless ERISA provides otherwise, the claimant must appeal once to the Insurance Company. As part of the claimant's appeal, the claimant may receive, upon request, free of charge, copies of all documents, records, and other information relevant to the claim for benefits, and the claimant may submit to the Insurance Company, written comments, documents, records, and other information relating to the claim. The review will take into account all comments, documents, records and other information the claimant submits related to the claim, without regard to whether such information was submitted or considered in the initial claim decision. Once an appeal request has been received by the Insurance Company, a full and fair review of the claim appeal will take place.

A written request for appeal must be received by the Insurance Company within 180 days from the date the claimant received the adverse decision. If an appeal request is not received within that time, the right to appeal will have been waived. The Insurance Company has 45 days from the date it receives a request for appeal to provide its decision. Under special circumstances, the Insurance Company may require more time to review the claim and can extend the time for decision, once, by an additional 45 days. If this should happen, the Insurance Company must provide the extension notice, in writing, before expiration of the initial decision period, indicating the special circumstances and the date a decision is expected. If the extension is made because additional information must be furnished, the claimant has 45 days within which to provide the requested information and the time for the Insurance Company's decision shall be tolled (stopped) from the date on which the notification of the extension was sent until the date the Insurance Company receives the claimant's response or upon the date the requested information is required to be furnished expires, whichever is sooner.

The review will give no deference to the original claim decision. The review will not be made by the person who made the initial claim decision, or a subordinate of that person. When deciding an appeal based in whole or in part upon medical judgment, the Insurance Company will consult with a medical professional having the appropriate training and experience in the field of medicine involved in the medical judgment. Any medical or vocational experts consulted by the Insurance Company for the review will be identified and will not be the expert who was consulted during the initial claim decision or a subordinate of that expert.

During the appeal, the Insurance Company may require a medical examination of the claimant, at its own expense, or additional information regarding the claim. If a medical examination is required, the Insurance Company will notify the claimant of the date and time of the examination and the physician's name and location. If additional information is required, the Insurance Company will notify the claimant, in writing, stating what information is needed and why it is needed.

Before the Insurance Company issues an adverse benefit decision on appeal, if the Insurance Company considered, relied upon, or generated any new or additional evidence in connection with the claim, and/or if the Insurance Company intends to rely on any new or additional rationale in connection with that review, then such evidence and/or rationale will be provided to the claimant, free of charge, as soon as possible and sufficiently in advance of the date that the decision on appeal is required to be made, giving the claimant a reasonable opportunity to respond.

If the claim is approved, the Insurance Company will pay the appropriate benefit. If the claim decision on appeal is adverse, in whole or in part, the Insurance Company will provide written or electronic notice that includes:

1. The specific reason(s) for the decision;
2. Specific reference to the Policy provision(s) on which the decision was based;
3. A statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claim for benefits;
4. A statement describing any voluntary appeal procedures offered, and the claimant's right to obtain the information about those procedures;
5. A statement of claimant's right to bring a civil action under section 502(a) of ERISA, including a description of any applicable contractual limitations period that applies to the claimant's right to bring such an action, and the calendar date on which the contractual limitations period expires for the claim;
6. A discussion of the decision, including an explanation of the basis for disagreeing with or not following: (i) the views presented by the claimant to the Insurance Company of the health care professionals treating the claimant and vocational professionals who evaluated the claimant; (ii) the views of medical or vocational experts whose advice was obtained on behalf of the Insurance Company in connection with the adverse decision, without regard to whether the advice was relied upon in making the adverse decision; and (iii) a disability decision regarding the claimant presented by the claimant to the Insurance Company made by the Social Security Administration;
7. Either the specific internal rules, guidelines, protocols, standards or other similar plan criteria the Insurance Company relied upon in making the decision, or, alternatively, a statement that such rules, guidelines, protocols, standards or other similar plan criteria do not exist;
8. If the adverse decision is based upon medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the decision, applying the terms of the Policy to the claimant's medical circumstances, or a statement that such explanation will be provided free of charge upon request; and
9. A notice provided in a culturally and linguistically appropriate manner, to the extent required by ERISA.

Claims for Non-Disability Benefits (applies to all claims filed on or after April 1, 2018)

A non-disability "claim" is any claim which does not require a determination of disability by the Insurance Company regardless of the type of policy under which it arises (for example, a death claim, an accident claim, etc.). A non-disability claim is "filed" as of the date the Insurance Company first receives, in writing or by telephone (through the Insurance Company's intake department), notice that a claimant is seeking benefits under the Policy. The notice of claim should include the group Policy holder's name, the Policy and Certificate number and the claimant's name and address.

The Insurance Company has 90 days from the date the claim is filed to determine whether or not benefits are payable in accordance with the terms of the Policy. The Insurance Company may require more time to review the claim if special circumstances exist. The review period may be extended for up to one additional 90 day period. If this should happen, the Insurance Company will provide the extension notice in writing, before expiration of the initial decision period, indicating the special circumstances and the date a decision is expected.

During the review period, the Insurance Company may require a medical examination of the claimant, at its own expense, or additional information regarding the claim. If a medical examination is required, the Insurance Company will notify the claimant of the date and time of the examination and the physician's name and location. If additional information is required, the Insurance Company must notify the claimant, in writing, stating what information is needed and why it is needed.

If the claim is approved, the Insurance Company will pay the appropriate benefit. If the claim decision is adverse, in whole or in part, the Insurance Company will provide written or electronic notice which will include the following information:

1. The specific reason(s) for the claim decision;
2. Specific reference to the Policy provision(s) on which the decision was based;
3. A description of any additional information required to perfect the claim, and the reason this information is necessary; and
4. A description of the review procedures and the time limits applicable to those procedures, including a statement of the claimant's right to bring a civil action under section 502(a) of ERISA after the claimant appeals and after the claimant receives an adverse decision on appeal.

Appeal of Denied Non-Disability Claims (applies to all claims filed on or after April 1, 2018)

Whenever a claim decision is fully or partially adverse, the claimant must appeal once to the Insurance Company. As part of the claimant's appeal, the claimant may receive, upon request, free of charge, copies of all documents, records, and other information relevant to the claim for benefits, and the claimant may submit to the Insurance Company, written comments, documents, records, and other information relating to the claim. The review will take into account all comments, documents, records and other information the claimant submits related to the claim, without regard to whether such information was submitted or considered in the initial claim decision. Once an appeal request has been received by the Insurance Company, a full and fair review of the claim appeal will take place.

A written request for appeal must be received by the Insurance Company within 60 days from the date the claimant received the adverse decision. If an appeal request is not received within that time, the right to appeal will have been waived. The Insurance Company has 60 days from the date it receives a request for appeal to provide its decision. Under special circumstances, the Insurance Company may require more time to review the claim and extend the time for decision, once, by an additional 60 days. If this should happen, the Insurance Company will provide the extension notice, in writing, before expiration of the initial decision period, indicating the special circumstances and the date a decision is expected.

If the appeal decision is adverse, in whole or in part, the Insurance Company will provide written or electronic notice that includes:

1. The specific reason(s) for the claim decision;
2. Specific reference to the Policy provision(s) on which the decision was based;
3. A statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claim for benefits;
4. A statement describing any voluntary appeal procedures offered, and the claimant's right to obtain the information about those procedures, and
5. A statement of the claimant's right to bring a civil action under section 502(a) of ERISA.