Blue Bottle Coffee, LLC

Critical Illness Coverage

Prudential

NOTICE FOR TEXAS RESIDENTS

Have a complaint or need help?

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

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

The Prudential Insurance Company of America
To get information or file a complaint with your insurance company or HMO:

> **Call: Prudential Life Claim Division**
> **Toll-free: 1-800-524-0542**
> Mail: P.O. Box 8517, Philadelphia, PA 19176

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

> Call with a question: 1-800-252-3439
> File a complaint: www.tdi.texas.gov
> Email: ConsumerProtection@tdi.texas.gov
> Mail: MC 111-1A, P.O. Box 12030, Austin, TX 78711-2030

¿Tiene una queja o necesita ayuda?

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

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

The Prudential Insurance Company of America
Para obtener información o para presentar una queja ante su compañía de seguros o HMO:

Llame a: Prudential Life Claim Division
Teléfono gratuito: 1-800-524-0542
Dirección postal: P.O. Box 8517, Philadelphia, PA 19176

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

Llame con sus preguntas al: 1-800-252-3439
Presente u na queja en: www.tdi.texas.gov
Correo electrónico: ConsumerProtection@tdi.texas.gov
Dirección postal: MC 111-1A, P.O. Box 12030, Austin, TX 78711-2030

Disclosure Notice

IMPORTANT INFORMATION FOR RESIDENTS OF CERTAIN STATES:

There are state-specific requirements that may change the provisions under the Coverage(s) described in this Group Insurance Certificate. If You live in a state that has such requirements, those requirements will apply to Your Coverage(s) and are made a part of Your Group Insurance Certificate. Prudential has a website that describes these state-specific requirements. You may access the website at www.prudential.com/etonline. When You access the website, You will be asked to enter Your state of residence and Your Access Code.

Your Access Code is CI1.

If You are unable to access this website, want to receive a printed copy of these requirements or have any questions, call Prudential at 1-844-455-1002.

THIS DOES NOT APPLY TO NEW MEXICO RESIDENTS.

FOR ARKANSAS RESIDENTS

Prudential's Customer Service Office:

The Prudential Insurance Company of America
Customer Services Department
Voluntary Benefit Services
P.O. Box 71330
Philadelphia, PA 19176-1330

Telephone: 1-844-455-1002

If Prudential fails to provide you with reasonable and adequate service, you may contact:

Arkansas Insurance Department
1 Commerce Way, Suite 102
Little Rock, AR 72202
(501) 371-2640 or (800) 852-5494

FOR ARIZONA RESIDENTS

Notice: This certificate of insurance may not provide all benefits and protections provided by law in Arizona. Please read this certificate carefully.

FOR CALIFORNIA RESIDENTS

This is a supplement to health insurance. It is not a substitute for essential health benefits or minimum essential coverage as defined in federal law.

FOR FLORIDA RESIDENTS

The benefits of the policy providing your coverage are governed by the law of a state other than Florida.

FOR IDAHO RESIDENTS

If you need the assistance of the governmental agency that regulates the business of insurance, you can contact the Idaho Department of Insurance by contacting:

Idaho Department of Insurance
Consumer Affairs
700 W State Street, 3rd Floor
PO Box 83720
Boise ID 83720-0043

1-800-721-3272 or 208-334-4250 or www.DOI.Idaho.gov

FOR ILLINOIS RESIDENTS

You may file a consumer complaint online at the Illinois Department of Insurance's website or by mail. The Department maintains a Consumer Division in Chicago at 115 S. LaSalle Street, 13th Floor, Chicago, IL 60603 and in Springfield at 320 W. Washington Street, Springfield, IL 62767.

This notice is to advise you that should any complaints arise regarding this insurance, you may contact the following:

The Prudential Insurance Company of America
Voluntary Benefit Services
P.O. Box 71330
Philadelphia, PA 19176-1330

1-844-455-1002

FOR INDIANA RESIDENTS

Questions regarding your policy or coverage should be directed to:

The Prudential Insurance Company of America
1-844-455-1002

If you (a) need the assistance of the governmental agency that regulates insurance; or (b) have a complaint you have been unable to resolve with your insurer you may contact the Department of Insurance by mail, telephone or e-mail:

State of Indiana Department of Insurance
Consumer Services Division
311 West Washington Street, Suite 300
Indianapolis, Indiana 46204

Consumer Hotline: (800) 622-4461; (317) 232-2395

Complaints can be filed electronically at www.in.gov/idoi.

FOR MARYLAND RESIDENTS

The Group Insurance Contract providing coverage under this Certificate was issued in a jurisdiction other than Maryland and may not provide all of the benefits required by Maryland law.

FOR NORTH CAROLINA RESIDENTS

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

FOR NEW MEXICO RESIDENTS

NOTICE TO CONSUMER: This is a limited benefits health plan. The benefits provided are supplemental to, and not a substitute for, major medical coverage, even in combination with other limited benefits plans. To apply for an individual or small-group major medical plan, please visit the website of the New Mexico Health Insurance Exchange at www.bewellnm.com or call 1-833-862-3935 (TTY: 711).

FOR NEVADA RESIDENTS

THIS CRITICAL ILLNESS COVERAGE IS NOT COMPREHENSIVE HEALTH INSURANCE COVERAGE (OFTEN REFERRED TO AS "MAJOR MEDICAL COVERAGE").

IT DOES NOT SATISFY THE INDIVIDUAL MANDATE OF THE AFFORDABLE CARE ACT. IT DOES NOT MEET THE REQUIREMENTS OF MINIMUM ESSENTIAL COVERAGE AS DEFINED IN FEDERAL LAW.

FOR OKLAHOMA RESIDENTS

Notice: Certificates issued for delivery in Oklahoma are governed by the certificate and Oklahoma laws not the state where the master policy was issued.

FOR TEXAS RESIDENTS

THE INSURANCE POLICY UNDER WHICH THIS CERTIFICATE IS ISSUED IS NOT A POLICY OF WORKERS' COMPENSATION INSURANCE. YOU SHOULD CONSULT YOUR EMPLOYER TO DETERMINE WHETHER YOUR EMPLOYER IS A SUBSCRIBER TO THE WORKERS' COMPENSATION SYSTEM.

NOTICE FOR VERMONT RESIDENTS

Vermont law prevails over any conflicting provisions of the Group Contract.

FOR WISCONSIN RESIDENTS

KEEP THIS NOTICE WITH YOUR INSURANCE PAPERS

Problems with Your Insurance? - If you are having problems with your insurance company or agent, do not hesitate to contact the insurance company or agent to resolve your problem.

Prudential's Customer Service Office:
Voluntary Benefit Services
P.O. Box 71330
Philadelphia, PA 19176-1330
1-844-455-1002

You can also contact the **OFFICE OF THE COMMISSIONER OF INSURANCE**, a state agency which enforces Wisconsin's insurance laws, and file a complaint. You can file a complaint electronically with the **OFFICE OF THE COMMISSIONER OF INSURANCE** at its website at *http://oci.wi.gov/,* or by contacting:

Office of the Commissioner of Insurance
Complaints Department
P.O. Box 7873
Madison, WI 53707-7873
1-800-236-8517
608-266-0103

THE PRUDENTIAL INSURANCE COMPANY OF AMERICA
751 Broad Street
Newark, New Jersey 07102

Group Critical Illness Insurance Schedule of Benefits

This document provides additional information about the coverage available under this Certificate, including Group Contract information, a description of covered classes, and the benefits covered.

GROUP CONTRACT INFORMATION

Contract Holder: BLUE BOTTLE COFFEE, LLC
Group Contract No: GC-71982-CA
Contract Anniversary: January 1 of each year, beginning in 2027.
Cost of Insurance: The insurance in this Certificate is Contributory Insurance. You will be informed of the amount of Your contribution when you enroll.
Premium Payment Date: first of the month.
Employment Waiting Period: You may need to work for the Employer for a continuous full-time period before You become eligible for the Coverage. The period must be agreed upon by the Employer and Us. Your Employer will inform You of any such Employment Waiting Period for Your class.

COVERED CLASSES

Covered Classes: The Covered Classes are the Employees of the Contract Holder (and its Associated Companies): All Employees.

Coverage Date: January 1, 2026. This Certificate describes the benefits, conditions, and limitations of coverage as of the Coverage Date.

AMOUNT OF INSURANCE

The Amount of Insurance for You and your Qualified Dependent(s) is the amount You elected when enrolling for coverage within the ranges shown below:

Employees

Any multiple of:	$10,000
Minimum Amount:	$10,000
Maximum Amount:	$30,000

Spouse

Any multiple of:	$10,000
Minimum Amount:	$10,000
Maximum Amount:	$30,000

Dependent Child(ren)

Any multiple of:	$5,000
Minimum Amount:	$5,000
Maximum Amount:	$15,000

The Amount of Insurance on Your Qualified Dependent Spouse will not exceed 100% of the amount for which You are insured under this Certificate.

The Amount of Insurance on Your Qualified Dependent Child(ren) will not exceed 50% of the amount for which You are insured under this Certificate.

Critical Illness benefits that do not contribute to the Lifetime Maximum Benefit and are not subject to the Lifetime Maximum Benefit include: Health Screening Benefit, Mental Health Screening, and NCI (National Cancer Institute) Evaluation.

These benefits may have their own limits within this Certificate.

CONTINUED ELIGIBILITY FOR INSURANCE MAXIMUM PERIODS

Family Medical Leave of Absence	84 days
Military Service	365 days

CRITICAL ILLNESS BENEFITS

Benefit Amounts written as a percentage are payable at that percentage of the Covered Person's Amount of Insurance.

Critical Illness	Benefit Amount
Amyotrophic Lateral Sclerosis (ALS) (Lou Gehrig's Disease)	100%
Aneurysm	25%
Autism	25%
Benign Brain Tumor	100%
Blindness	50%
Cancer - Invasive	100%
Cancer - Non-Invasive	25%
Cancer - Limited Skin Cancer	$500
Cerebral Palsy	100%
Cleft Lip or Cleft Palate	100%
Coma	100%
Congenital Heart Disease	100%
Coronary Artery Bypass Graft	100%
Crohn's Disease	100%
Cystic Fibrosis	100%
Deafness	50%
Down Syndrome	100%
Fertility Assistance	
Surgical	25%
Non-Surgical	10%
Gaucher Disease Type 2 or Type 3	100%
Glycogen Storage Disease (Type 4)	100%
Heart Attack	100%
Infantile Tay Sachs Disease	100%
Loss of Speech	50%
Major Organ Failure	100%
Multiple Sclerosis	100%
Muscular Dystrophy	100%

Niemann-Pick Disease	100%
Parkinson's Disease	100%
Pompe Disease	100%
Renal (Kidney) Failure	100%
Sickle Cell Anemia	100%
Stroke	100%
Sudden Cardiac Arrest	25%
Transient Ischemic Attack (TIA)	25%
Type 1 Diabetes	50%
Zellweger Syndrome	100%

ADDITIONAL BENEFITS

Benefit	**Benefit Amount**
Health Screening Benefit	$50
Infectious Disease Confinement Benefit	25%
Mental Health Screening Benefit	$50
National Cancer Institute (NCI) Evaluation Benefit	$500
Transportation and Lodging	$250
Lifetime Maximum Per Covered Person	1x per Covered Person
Recurrence Benefit	
Critical Illness other than Limited Skin Cancer	100%
Limited Skin Cancer	$500
Lifetime Maximum Per Covered Person	1x per Covered Person

THE PRUDENTIAL INSURANCE COMPANY OF AMERICA
751 Broad Street
Newark, New Jersey 07102

Group Critical Illness Insurance Certificate

We are pleased to present You with this Certificate. It describes the Critical Illness coverage We have arranged for You and what You must do to be covered for these benefits. We believe this Critical Illness coverage provides worthwhile protection for You and Your Qualified Dependents.

Please read this Certificate carefully. If You have any questions about the coverage, We will be happy to answer them. This is Your Certificate and it should be kept in a safe place.

This Certificate provides evidence of Your coverage under the Group Contract and the benefits offered. Everything contained in this Certificate is subject to the provisions in the Group Contract. The Contract Holder has a copy of the Group Contract and You may review it at any reasonable time. Only one of Our executive officers may authorize a change to the Group Contract.

Right to Examine this Certificate: You may cancel this Certificate for any reason, within 30 days after You receive it. If You cancel Your coverage within this period, the insurance will be void the date it would otherwise take effect, and We will refund Your Premium contributions, if any. We will deduct any benefits already paid from the refund.

This Certificate replaces all previous certificates and riders regarding this coverage.

THIS CERTIFICATE PROVIDES LIMITED BENEFIT COVERAGE.

THIS CERTIFICATE PAYS REDUCED BENEFITS FOR INVASIVE CANCER, NON-INVASIVE CANCER (IN SITU) AND NON-MELANOMA SKIN CANCER.

SEE DEFINITIONS OF INVASIVE CANCER, NON-INVASIVE CANCER (IN SITU) AND NON-MELANOMA SKIN CANCER, AND EXCLUDED CANCERS.

READ IT CAREFULLY.

THIS COVERAGE IS A SUPPLEMENT TO HEALTH INSURANCE. IT IS NOT A SUBSTITUTE FOR ESSENTIAL HEALTH BENEFITS COVERAGE AS DEFINED IN FEDERAL HEALTH LAW. IT IS NOT MEDICARE SUPPLEMENT INSURANCE. INSUREDS ELIGIBLE FOR MEDICARE SHOULD REVIEW THE GUIDE TO HEALTH INSURANCE FOR PEOPLE WITH MEDICARE AVAILABLE FROM US.

Secretary | Chief Executive Officer

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Definitions

Actively at Work means that You are performing all the regular, material, and substantial duties of Your job on a full-time basis at the Employer's place of business, or at any other place that the Employer's business requires You to go. You must be working at least 28 hours per week and being paid for the work performed. You are considered Actively at Work during weekends or Employer-approved vacations, holidays or business closures if You were Actively at Work on the last scheduled work day preceding such time off.

Annual Enrollment Period means the period each year during which You may enroll for Coverage or request a change in Coverage for the following Calendar Year. The Contract Holder will notify You of when this Annual Enrollment Period begins and ends.

Associated Company means an employer who is the Contract Holder’s subsidiary or affiliate and are reported to Us in writing for inclusion under the Group Contract, provided that We have approved such request.

Calendar Year means the time period that begins on Your coverage effective date and continues through December 31 of that year; thereafter, it means January 1 through December 31.

Certificate means this document and any attached riders, if any, which explains Your insurance coverage.

Child/Children means Your unmarried Children from live birth to 26 years old. Your Children include:
- Biological children;
- Legally adopted children, children placed with You for adoption prior to legal adoption, and each of Your stepchildren including existing children of new domestic partners;
- Foster children;
- Your Spouse’s children; and
- Children for whom You or Your Spouse:
  - have been appointed the legal guardian; and
  - claim as a dependent on Your or Your Spouse's federal income tax returns.

A Child who is Your or Your Spouse’s ward under a legal guardianship will be considered a Qualified Dependent from the effective date of court order granting the legal guardianship and is treated as though the Child was Your newborn Child.

Your Children also include a Child who is older than 25 years of age and is:
- incapable of self-sustaining employment because of a mental or physical disability; and
- chiefly dependent on You for support and maintenance.

Proof of disability must be provided upon Our request. We may request proof of continued disability, but not more than once per year.

Confined or Confinement means the assignment to a bed as a resident inpatient in a Hospital (including an Hospital Intensive Care Unit (ICU)) on the advice of a Doctor; or Confinement in an observation area within a Hospital for a period of more than 24 hours on the advice of a Doctor.

Contributory Insurance means insurance for which the Contract Holder has the right to require You to pay all or any portion of the Premium payments. The Schedule of Benefits shows whether Your insurance is Contributory Insurance or Non-Contributory.

Covered Person means You and Your Spouse and/or Child/Children who are covered under this Certificate**.**

Critical Illness means a condition listed in the Schedule of Benefits for which a benefit is payable as described in this Certificate.

Doctor means a licensed practitioner of the healing arts who is acting within the scope of their license. The term Doctor does not include a Covered Person or any Family Member.

Employee means a person employed by the Employer; a proprietor or partner of the Employer.

Employer means, collectively, all employers included under the Group Contract.

Family Member means a Covered Person's Spouse, parents, stepparents, in-laws, brothers, sisters, stepbrothers, stepsisters, Children or grandchildren.

Group Contract means the insurance contract to which this Certificate is attached that was issued to the Contract Holder shown in the Group Contract Information section on the Schedule of Benefits.

Hospital means an institution that:
- is accredited as a hospital under the Hospital Accreditation Program of the Joint Commission on Accreditation of Healthcare Organizations;
- provides diagnostic, medical, and surgical treatment to sick or injured persons on an inpatient basis (or has such facilities available under a prearranged contract);
- has 24 hour a day supervision by a staff of Doctors; and
- has 24 hour a day nursing service by registered graduate Nurses.

Hospital does not include: a nursing home; a Rehabilitation Facility; an urgent care facility; convalescent facility rest home; hospice care; skilled nursing care for the aged or drug addicts or treatment of alcoholics; or furnishes mainly homelike or custodial care, or training in the routines of daily living; or solely provides psychiatric services to mentally ill patients.

Intensive Care Unit (ICU) means a special, designated area in a Hospital that:
- provides the highest level of care and is restricted to the treatment of patients who are in acute and critical condition;
- is permanently furnished with emergency life-saving equipment and supplies that are immediately at hand;
- staffed 24 hours a day by Nurses who are specially trained to work in such a special area;
- equipped and staffed to monitor each patient's vital signs around-the-clock; and
- operates pursuant to any jurisdictional requirements for Intensive Care Units (ICU) and is listed in the current edition of the American Hospital Association Guide or is eligible to be listed therein. This guide lists three types of units that meet this definition: 1) Intensive Care Units (ICU); 2) cardiac care units (CCU); and 3) infant (neonatal) Intensive Care Units (NICU).

Intensive Care Units (ICU) do not include surgical recovery rooms, privately monitored rooms, observation units, labor or delivery rooms, step-down units, sub-acute Intensive Care Units or any other facilities, regardless of name, that do not meet the above requirements.

Non-Contributory Insurance means insurance for which the Contract Holder does not have the right to require You to pay any portion of the Premium payment. The Schedule of Benefits shows whether Your insurance is Contributory Insurance or Non-Contributory Insurance.

Nurse means a registered professional Nurse (R.N.), licensed practical Nurse (L.P.N.) or licensed vocational Nurse (L.V.N.) who is licensed under the laws where the services are performed.

The term Nurse does not include a Covered Person or any Family Member.

Premium means the amount required to pay for Your insurance.

Qualified Dependent(s) means the Employee's Spouse or Child(ren) who meet the requirements within the Eligibility section of this Certificate.

Qualified Life Event means any of the following which constitute a change in family status:

- Your marriage or divorce or dissolution of partnership;
- the death of Your Spouse or Child(ren);
- the birth or adoption of Your Child(ren);
- employment or termination of employment of Your Spouse;
- switching from part-time to full-time employee status (or vice versa) by You or Your Spouse;
- You or Your Spouse taking an unpaid leave of absence; or
- a significant change in Your health coverage that is attributable to Your Spouse's employment.

Rehabilitation Facility means an appropriately licensed facility that provides rehabilitation care services on an inpatient basis. Rehabilitation care services consist of the combined use of medical, social, educational, and vocational services to enable patients disabled by accidental injury or sickness to achieve the highest possible functional ability. Services are provided by or under the supervision of an organized staff of Doctors. The Rehabilitation Facility may be part of a Hospital or a freestanding facility.

A Rehabilitation Facility is not a nursing home; an urgent care facility; extended care facility; skilled nursing facility; a rest home or home for the aged; a hospice care facility; a place for alcoholics or drug addicts; or an assisted living facility.

Spouse means the person recognized as Your Spouse under the laws of the state in which the marriage was entered into. Whenever the term Spouse appears in this Certificate, it includes your domestic partner as defined by California Family Code Section 297. Whenever the term Spouse appears in this Certificate, it includes a legally recognized civil union partner. Where state law provides for registered domestic partnerships, Spouse includes Your registered domestic partner. We reserve the right to request proof of the legally recognized status of a marriage or domestic partnership or civil union. Any reference in this Certificate or the Group Contract to divorce or dissolution shall also include the legal dissolution of a civil union or domestic partnership.

We, Us, Ours means The Prudential Insurance Company of America.

You, Your, Yours means an Employee.

Benefit Descriptions

This coverage pays benefits upon the diagnosis of certain Critical Illnesses. A Covered Person is eligible for the following benefits if the Covered Person is diagnosed with a covered Critical Illness after their coverage effective date. A benefit is payable up to one time per Critical Illness per Covered Person.

Subsequent diagnosis of the same Critical Illness may be covered under the Recurrence Benefit in the Additional Benefits section. In addition, any benefits that may be payable due to a Covered Person being prescribed a treatment or Confined are only payable if the Covered Person is covered at the time of prescription or Confinement.

Amyotrophic Lateral Sclerosis (ALS) (Lou Gehrig's Disease): We will pay the amount shown in the Schedule of Benefits if a Covered Person is diagnosed with ALS. ALS means a progressive motor neuron disease that results in permanent clinical impairment of motor function. Medical evidence of a definite diagnosis of ALS by a Doctor is required as proof of claim.

Aneurysm: We will pay the amount shown in the Schedule of Benefits if a Covered Person is diagnosed with one of the following Aneurysms:

- Ruptured Brain Aneurysm: an abnormal dilation of a blood vessel in the brain that results in permanent neurological deficits due to rupture or dissection of the brain aneurysm.
- Abdominal Aortic Aneurysm: an enlargement of the abdominal aorta that is 5cm or larger, 4cm or larger and rapidly expanding, or causing symptoms and surgery is recommended by the treating Doctor.
- Thoracic Aortic Aneurysm: an enlargement of the thoracic aorta that is 5.5cm or larger, 4.5cm or larger and rapidly expanding, or causing symptoms and surgery is recommended by the treating Doctor.

Medical evidence of a definite diagnosis of an Aneurysm by a Doctor is required as proof of claim.

Autism: We will pay the amount shown in the Schedule of Benefits if a Covered Person is first diagnosed with Autism Spectrum Syndrome and if the date of diagnosis is while this Certificate is in force.

Autism Spectrum Syndrome is a biological based neurodevelopment disorder characterized by impairment in two major domains:

- Deficits in social communication and interaction; and
- Restricted repetitive patterns of behavior, interests, and activities.

A Doctor must diagnose Autism Spectrum Syndrome and include a severity level specifier for both major domains listed above. Medical evidence of a definite diagnosis of Autism is required as proof of claim.

Benign Brain Tumor: We will pay the amount shown in the Schedule of Benefits if a Covered Person is diagnosed with Benign Brain Tumor. Benign Brain Tumor means a non-malignant tumor or cyst that is one centimeter or greater in size and located in the brain, cranial nerves or meninges within the skull. It does not include tumors of the pituitary gland or tumors of blood vessels known as angiomas or aneurysms. Medical evidence of a definite diagnosis of Benign Brain Tumor by a Doctor is required as proof of claim.

Blindness: We will pay the amount shown in the Schedule of Benefits if a Covered Person is diagnosed with Blindness. Blindness means central visual acuity of not more than 20/200 in the better eye, after correction, or visual acuity greater than 20/200 but with a limitation in the fields of vision so that the widest diameter of the visual field subtends an angle no greater than 20 degrees.

This must be certified by a licensed physician and surgeon who specializes in diseases of the eye or a licensed optometrist.

Cancer - *Invasive*: We will pay the amount shown in the Schedule of Benefits if a Covered Person is diagnosed with Invasive Cancer. Invasive Cancer means any malignant tumor positively diagnosed with histological confirmation (either when practical or when possible) and characterized by the uncontrolled growth of malignant cells and invasion of tissue. The term malignant tumor includes leukemia, lymphoma, sarcoma and multiple myeloma. The following are not Invasive Cancer:

- all cancers which are histologically classified as any of the following: pre-malignant, non-invasive, cancer in situ, borderline malignancy or low potential malignancy;
- all tumors of the prostate unless histologically classified as having a Gleason score of 7 or greater or having progressed to at least clinical TNM classification T2N0M0;
- chronic lymphocytic leukemia unless histologically classified as having progressed to at least Rai Stage II or above;
- any Limited Skin Cancer other than malignant melanoma. This does not apply if the Limited Skin Cancer spreads to other parts of the body; or
- malignant melanomas classified as T1N0M0, for which a pathology report shows maximum thickness less than or equal to 1.0 millimeters using the Breslow method of determining tumor thickness.

Medical evidence of a definite diagnosis of Invasive Cancer by a Doctor is required as proof of claim. A clinical diagnosis will be accepted whenever such diagnosis is consistent with professional medical standards.

Cancer - *Non-Invasive*: We will pay the amount shown in the Schedule of Benefits if a Covered Person is diagnosed with Non-Invasive Cancer. Non-Invasive Cancer means one of the following conditions that meets the TNM Staging classification and other qualifications specified below:

- cancer classified as TisN0M0, provided that surgery, radiotherapy or chemotherapy has been recommended by the treating Doctor;
- malignant tumors classified as T1N0M0 or greater which are treatable by endoscopic procedures alone;
- malignant melanomas classified as T1N0M0, for which a pathology report shows maximum thickness less than or equal to 1.0 millimeters using the Breslow method of determining tumor thickness; and
- tumors of the prostate classified as T1bN0M0, or T1cN0M0 and/or a Gleason score of 6 or less.

PLEASE NOTE: This means, for example, that a partial (reduced) benefit amount may be payable for the diagnosis of certain types of prostate or breast Cancer.

Medical evidence of a definite diagnosis of Non-Invasive Cancer by a Doctor is required as proof of claim. A clinical diagnosis will be accepted whenever such diagnosis is consistent with professional medical standards.

Cancer - ***Limited Skin Cancer*:** We will pay the amount shown in the Schedule of Benefits if a Covered Person is diagnosed with Limited Skin Cancer. Limited Skin Cancer means any malignancy of the skin diagnosed with histological confirmation and characterized by uncontrolled growth of malignant cells and invasion of tissue. It includes:

- basal cell carcinoma; and
- squamous cell carcinoma.

Medical evidence of a definite diagnosis of Limited Skin Cancer by a Doctor is required as proof of claim. A clinical diagnosis will be accepted whenever such diagnosis is consistent with professional medical standards.

Excluded Skin Cancers: malignant melanoma and non-malignant melanoma or any condition which can be considered pre-cancerous such as leukoplakia; actinic keratosis; carcinoid; hyperplasia; moles; or similar diseases or lesions.

Cerebral Palsy: We will pay the amount shown in the Schedule of Benefits if a Covered Person is diagnosed with Cerebral Palsy. Cerebral Palsy means a non-progressive neurological defect affecting muscle control which is characterized by spasticity and lack of co-ordination of movements. Medical evidence of a definite diagnosis of Cerebral Palsy by a Doctor is required as proof of claim.

Cleft Lip or Cleft Palate: We will pay the amount shown in the Schedule of Benefits if a Covered Person is diagnosed with Cleft Lip or Cleft Palate. Cleft Lip means a narrow opening or gap in the skin of the upper lip that extends all the way to the base of the nose, including unilateral clefting and bilateral clefting. Cleft Palate means an opening between the roof of the mouth and the nasal cavity. Medical evidence of a definite diagnosis or confirmation of Cleft Lip or Cleft Palate by a Doctor is required as proof of claim. Initial diagnosis can be made prenatally.

Coma: We will pay the amount shown in the Schedule of Benefits if a Covered Person is diagnosed with Coma. Coma means a state of unconsciousness with no reaction to external stimuli or internal needs which requires the use of life support systems and results in permanent neurological deficit with persistent clinical symptoms continuously for at least 96 hours. It does not include:

- persistent vegetative state; or
- medically-induced coma.

Medical evidence of a definite diagnosis of Coma by a Doctor is required as proof of claim.

Congenital Heart Defect: We will pay the amount shown in the Schedule of Benefits if:

- A Covered Person is diagnosed with Congenital Heart Defect after live birth by a Doctor and before the age of 18; and
- Their Doctor determines that surgery is recommended.

We will accept a clinical diagnosis of a Congenital Heart Defect only if a pathological diagnosis cannot be made because it would be medically inappropriate or life-threatening under generally accepted medical standards. Medical evidence of a definite diagnosis of a Congenital Heart Defect by a Doctor is required as proof of claim. Payable once per Covered Person.

Coronary Artery Bypass Graft: We will pay the amount shown in the Schedule of Benefits if a Covered Person requires a Coronary Artery Bypass Graft as diagnosed by a Doctor. Coronary Artery Bypass Graft means a surgical operation to correct narrowing or blockage of one or more coronary arteries with bypass grafts. Medical evidence of a definite diagnosis of Coronary Artery Bypass prescription or recommendation is required as a proof of claim.

Crohn's Disease: We will pay the amount shown in the Schedule of Benefits if a Covered Person is diagnosed by a Doctor with Crohn's Disease. Crohn's Disease does not include irritable bowel syndrome or ulcerative colitis. Medical evidence of a definite diagnosis of Crohn's Disease by a Doctor is required as proof of claim.

Cystic Fibrosis: We will pay the amount shown in the Schedule of Benefits if a Covered Person is diagnosed with Cystic Fibrosis. Medical evidence of a definite diagnosis of Cystic Fibrosis by a Doctor based on diagnostic tests is required as proof of claim.

Deafness: We will pay the amount shown in the Schedule of Benefits if a Covered Person is diagnosed with Deafness. Deafness means permanent and irreversible loss of hearing in both ears to the extent that the loss is greater than 80 decibels across all frequencies in both ears. Medical evidence of a definite diagnosis of Deafness by a Doctor is required as proof of claim.

Down Syndrome: We will pay the amount shown in the Schedule of Benefits if a Covered Person is diagnosed with Down Syndrome. Down Syndrome means a congenital disorder arising from a chromosome defect involving chromosome 21, causing intellectual impairment, physical abnormalities and developmental delays. Down Syndrome includes but is not limited to:
- Trisomy 21: An individual has three instead of two chromosome 21s;
- Translocation: An extra part of chromosome 21 is attached to another chromosome; or
- Mosaicism: The individual has an extra chromosome 21 in only some of the cells but not all of them. The other cells have the usual pair of chromosome 21s.

Medical evidence of a definite diagnosis or confirmation of Down Syndrome by a Doctor through the study of chromosome 21 is required as proof of claim. Initial diagnosis can be made prenatally.

Fertility Assistance: We will pay the amount shown in the Schedule of Benefits if a Covered Person is diagnosed with Infertility and receives Non-Surgical or Surgical Treatment. Infertility means the inability to have children, despite frequent and unprotected intercourse for at least one year or a diagnosis for an illness that causes Infertility.

Non-Surgical Treatment: A Doctor prescribes one or more of the below Infertility treatments for the Covered Person:
- Intrauterine insemination;
- Prescription of oral or injectable medication.

Surgical Treatment: A Doctor prescribes one or more of the below Infertility treatments for the Covered Person:
- Surgery to remove uterine fibroids, polyps, uterine septum, endometriosis tissue, or fallopian tube scar tissue;
- Embryo transfer;
- Egg retrieval for artificial insemination or in vitro fertilization.

Surgical Treatment is not:
- A vasectomy reversal;
- A tubal ligation reversal;
- A surgery for any reason other than Infertility.

Medical evidence of a definite diagnosis of Infertility by a Doctor is required as proof of claim. If a Covered Person is prescribed both Non-Surgical Treatment and Surgical Treatment, We will pay the greater of the two benefits.

Gaucher Disease Type 2 or Type 3: We will pay the amount shown in the Schedule of Benefits if a Covered Person is diagnosed with Gaucher Disease Type 2 or Type 3. Medical evidence of a definite diagnosis of Gaucher Disease Type 2 or 3 by a Doctor after live birth is required as proof of claim.

Glycogen Storage Disease (Type 4): We will pay the amount shown in the Schedule of Benefits if a Covered Person is diagnosed, through genetic testing, by a Doctor with Glycogen Storage Disease (Type 4). Medical evidence of a definite diagnosis or confirmation of Glycogen Storage Disease (Type 4) by a Doctor is required as proof of claim. Initial diagnosis can be made prenatally.

Heart Attack: We will pay the amount shown in the Schedule of Benefits if a Covered Person is diagnosed with a Heart Attack. Heart Attack means myocardial infarction, which is the death of a portion of the heart muscle as a result of obstruction of one or more coronary arteries due to atherosclerosis, spasm, thrombus or emboli. Heart Attack does not include Sudden Cardiac Arrest.

The Covered Person must be diagnosed by a Doctor with a Heart Attack while coverage is in effect under this Certificate for such Covered Person. Medical evidence of a definite diagnosis of a Heart Attack by a Doctor is required as proof of claim.

Infantile Tay Sachs Disease: We will pay the amount shown in the Schedule of Benefits if a Covered Person is diagnosed with Infantile Tay Sachs Disease. Medical evidence of a definite diagnosis or confirmation of Infantile Tay Sachs Disease by a Doctor is required as proof of claim. Initial diagnosis can be made prenatally.

Loss of Speech: We will pay the amount shown in the Schedule of Benefits if a Covered Person is diagnosed with Loss of Speech. Loss of Speech means total, permanent and irreversible loss of the ability to speak as a result of physical injury or disease. It includes Loss of Speech due to surgery or medical treatment for an illness. It does not include Loss of Speech due to Stroke, Traumatic Brain Injury or Invasive Cancer. Medical evidence of a definite diagnosis of Loss of Speech by a Doctor is required as proof of claim.

Major Organ Failure: We will pay the amount shown in the Schedule of Benefits if a Covered Person is diagnosed with Major Organ Failure. Major Organ Failure means the irreversible failure of a Major Organ due to an End Stage Disease. Major Organ means heart, liver, lung, pancreas bone marrow or stem cell. End Stage Disease means end stage heart disease, end stage liver disease, end stage lung disease, total pancreas failure or severe bone marrow failure. Failure of more than one Major Organ due to an End Stage Disease is considered a single Major Organ Failure for the purpose of determining benefits under this Critical Illness coverage.

Proof of claim for Major Organ Failure must show:

- medical evidence of a definite diagnosis of Major Organ Failure by a Doctor; and
- approval for participation on an organ transplant waiting list, or approval for a bone marrow or stem cell transplant.

Multiple Sclerosis: We will pay the amount shown in the Schedule of Benefits if a Covered Person is diagnosed with Multiple Sclerosis. Multiple Sclerosis means a current clinical impairment of motor or sensory function, which must have persisted for a continuous period of at least 6 months. Medical evidence of a definite diagnosis of Multiple Sclerosis by a Doctor is required as proof of claim.

Muscular Dystrophy: We will pay the amount shown in the Schedule of Benefits if a Covered Person is diagnosed with Muscular Dystrophy. Medical evidence of a definite diagnosis of Muscular Dystrophy by a Doctor is required as proof of claim.

Niemann-Pick Disease: We will pay the amount shown in the Schedule of Benefits if a Covered Person is diagnosed with Niemann-Pick Disease. Medical evidence of a definite diagnosis or confirmation of Niemann-Pick Disease by a Doctor is required as proof of claim. Initial diagnosis can be made prenatally.

Parkinson’s Disease: We will pay the amount shown in the Schedule of Benefits if a Covered Person is diagnosed with Parkinson’s Disease. Parkinson’s Disease means permanent clinical impairment of motor function with associated tremor, rigidity of movement and postural instability. Medical evidence of a definite diagnosis of Parkinson’s Disease by a Doctor is required as proof of claim.

Pompe Disease: We will pay the amount shown in the Schedule of Benefits if a Covered Person is diagnosed with Pompe Disease. Medical evidence of a definite diagnosis or confirmation of Pompe Disease by a Doctor is required as proof of claim. Initial diagnosis can be made prenatally.

Renal (kidney) Failure: We will pay the amount shown in the Schedule of Benefits if a Covered Person is diagnosed with Renal Failure. Renal Failure means chronic and end stage (irreversible) failure of both kidneys to function, the result of which is the need to be placed on an organ transplant waiting list. Medical evidence of a definite diagnosis of Renal Failure by a Doctor is required as proof of claim.

Sickle Cell Anemia: We will pay the amount shown in the Schedule of Benefits if a Covered Person is diagnosed with Sickle Cell Anemia. Medical evidence of a definite diagnosis of Sickle Cell Anemia by a Doctor, confirmed with hemoglobin electrophoresis, is required as proof of claim. Having sickle cell trait alone does not qualify as a valid claim.

Stroke: We will pay the amount shown in the Schedule of Benefits if a Covered Person is diagnosed with a Stroke. Stroke means death of brain tissue due to inadequate blood supply or hemorrhage within the skull resulting in a permanent and significant neurological deficit with persistent clinical symptoms. It does not include transient ischemic attacks (TIA). TIA means a new temporary ischemic event (including prolonged reversible ischemic attacks) in which:

- there are measurable, functional neurological impairments that are focal and confined to an area of the brain perfused by a specific artery;
- there is no evidence of cerebral tissue damage on diagnostic imaging; and
- the reversible functional neurological impairments are confirmed by a Doctor.

Medical evidence of a definite diagnosis of Stroke by a Doctor is required as proof of claim.

Sudden Cardiac Arrest: We will pay the amount shown in the Schedule of Benefits if a Covered Person is diagnosed with Sudden Cardiac Arrest. Sudden Cardiac Arrest means the sudden, unexpected loss of heart function, breathing and consciousness resulting when the heart suddenly, and unexpectedly, stops beating because of an internal electrical disturbance of the heart. Medical evidence of a definite diagnosis of Sudden Cardiac arrest by a Doctor is required as proof of claim.

Transient Ischemic Attack (TIA): We will pay the amount shown in the Schedule of Benefits if a Covered Person is diagnosed with a Transient Ischemic Attack (TIA). TIA means a new temporary ischemic event (including prolonged reversible ischemic attacks) in which:

- there are measurable, functional neurological impairments that are focal and confined to an area of the brain perfused by a specific artery;
- there is no evidence of cerebral tissue damage on diagnostic imaging; and
- the reversible functional neurological impairments are confirmed by a Doctor.

The TIA benefit does not include:

- attacks of vertebrobasilar ischemia; and
- Stroke.

Medical evidence of a definite diagnosis of Transient Ischemic Attack (TIA) by a Doctor is required as proof of claim.

Type 1 Diabetes: We will pay the amount shown in the Schedule of Benefits if a Covered Person is diagnosed by a Doctor with Type 1 Diabetes. Type 1 Diabetes means an autoimmune disease that occurs when a person’s pancreas stops producing insulin. Type 1 Diabetes develops when the insulin-producing pancreatic beta cells are mistakenly destroyed by the body’s immune system. We will pay a benefit when a Covered Person is diagnosed with Type 1 diabetes. Type 1 diabetes, also referred to as Juvenile Diabetes, is not Type 2 diabetes. Medical evidence of a definite diagnosis of Type 1 Diabetes by a Doctor is required as proof of claim.

Zellweger Syndrome: We will pay the amount shown in the Schedule of Benefits if a Covered Person is diagnosed with Zellweger Syndrome. Medical evidence of a definite diagnosis or confirmation of Zellweger Syndrome by a Doctor is required as proof of claim. Initial diagnosis can be made prenatally.

ADDITIONAL BENEFITS

An additional benefit may be payable under this coverage. Any such benefit is payable in addition to any other benefit payable under this coverage. Any additional conditions that apply to an additional benefit are shown below. An additional benefit is payable only if those conditions are met.

HEALTH SCREENING BENEFIT

We will pay the amount shown in the Schedule of Benefits if a Covered Person takes one of the screening prevention measures listed below. Upon submission of proof, We will pay the Health Screening Benefit shown in the Schedule of Benefits for the day that the measure is taken subject to all of the following:

- We will only pay the Health Screening Benefit 1 times per Covered Person, per Calendar Year;
- We will not pay a Health Screening Benefit for a screening/prevention measure if benefits are paid or are payable for that same screening/prevention measure under another section of this Certificate.

We will pay the amount shown in the Schedule of Benefits if the Covered Person receives one of the following health screening tests while not Confined in a Hospital:

- annual physical;
- biopsies for cancer;
- blood chemistry panel;
- blood test to determine total cholesterol;
- blood test to determine triglycerides;
- bone marrow testing;
- breast MRI;
- breast ultrasound;
- breast sonogram;
- cancer antigen 15-3 blood test for breast cancer (CA 15-3);
- cancer antigen 125 blood test for ovarian cancer (CA 125);
- carcinoembryonic antigen blood test for colon cancer (CEA);
- carotid doppler;
- chest x-rays;
- clinical testicular exam;
- colonoscopy;
- complete blood count (CBC);
- dental exam;
- digital rectal exam (DRE);
- doppler screening for cancer;
- doppler screening for peripheral vascular disease;
- echocardiogram;
- electrocardiogram (EKG);
- electroencephalogram (EEG);
- endoscopy;
- eye exam;
- fasting blood glucose test;
- fasting plasma glucose test;
- flexible sigmoidoscopy;
- hearing test;
- hemoccult stool specimen;
- hemoglobin A1C;
- human papillomavirus (HPV) vaccination;
- immunization;

- lipid panel;
- mammogram;
- oral cancer screening;
- other medically accepted cancer screening tests;
- pap smears or thin prep pap test;
- prostate-specific antigen (PSA) test;
- serum cholesterol test to determine LDL and HDL levels;
- serum protein electrophoresis;
- skin cancer biopsy;
- skin cancer screening;
- skin exam;
- stress test on bicycle or treadmill;
- successful completion of smoking cessation program;
- tests for sexually transmitted infections (STIs);
- thermography;
- two-hour post-load plasma glucose test;
- ultrasounds for cancer detection;
- ultrasound screening of the abdominal aorta for abdominal aortic aneurysms;
- virtual colonoscopy.

INFECTIOUS DISEASE CONFINEMENT BENEFIT

We will pay the amount shown in the Schedule of Benefits if a Covered Person is diagnosed by a Doctor with any of the following diseases:

- anthrax;
- bacterial cerebrospinal meningitis;
- cholera;
- COVID-19;
- diphtheria;
- encephalitis;
- legionnaire's disease;
- lyme disease;
- malaria;
- methicillin-resistant staphylococcus aureus (MRSA);
- necrotizing fasciitis;
- osteomyelitis;
- pertussis (whooping cough);
- rabies;
- rocky mountain spotted fever;
- tetanus;
- tuberculosis; or
- typhoid fever.

The Infectious Disease Confinement Benefit is payable for a Covered Person who is Confined to a Hospital for at least 5 consecutive days.

MENTAL HEALTH SCREENING BENEFIT

We will pay the Mental Health Screening Benefit if a Covered Person takes one of the screenings listed below. Upon submission of proof, We will pay the Mental Health Screening Benefit shown in the Schedule of Benefits for the day that the measure is taken subject to all of the following:

- We will only pay the Mental Health Screening Benefit 1 times per Covered Person, per Calendar Year; and

- We will not pay a Mental Health Screening Benefit for a screening if benefits are paid or are payable for that same screening/prevention measure under another section of this Certificate.

We will pay the amount shown in the Schedule of Benefits if the Covered Person receives one of the following screenings:

- Patient Health Questionnaire (PHQ-9);
- Alcohol Use Disorders Identification Test (AUDIT);
- Tobacco, Alcohol, Prescription medication, and other Substance use Tool (TAPS);
- Brief Screener for Tobacco, Alcohol, and other Drugs (BSTAD);
- Screening to Brief Intervention (S2BI);
- CAGE AID;
- Drug Abuse Screen Test (DAST-10);
- Mood Disorder Questionnaire (MDQ);
- Columbia-Suicide Severity Rating Scale (C-SSRS);
- Suicide Assessment Five-Step Evaluation and Triage (SAFE-T);
- Generalized Anxiety Disorder (GAD-7);
- Primary Care PTSD Screen (PC-PTSD);
- Life Event Checklist (LEC);
- PTSD Checklist - Civilian Version.

NATIONAL CANCER INSTITUTE (NCI) EVALUATION BENEFIT

We will pay the amount shown in the Schedule of Benefits if a Covered Person receives evaluation or consultation at an NCI-designated cancer center only if both of these conditions are met:

- The Covered Person receives the evaluation or consultation as a result of receiving a diagnosis of cancer while a Covered Person; and
- The purpose of the evaluation or consultation is to determine the appropriate course of action.

In addition, We will pay the Transportation and Lodging amount shown in the Schedule of Benefits within the National Cancer Institute (NCI) Evaluation Benefit if a Covered Person provides evidence of transportation and lodging associated with the NCI-designated cancer center evaluation. The National Cancer Institute (NCI) Benefit is subject to the Lifetime Maximum per Covered Person shown in the Schedule of Benefits within the National Cancer Institute (NCI) Benefit.

RECURRENCE BENEFIT

Recurrence Benefit for Critical Illness Other than Cancer - Limited Skin Cancer
We will pay a Recurrence Benefit if a Covered Person:

- is positively diagnosed by a Doctor as having an additional occurrence or recurrence of a Critical Illness Other than Cancer - Limited Skin Cancer for which a benefit was paid under this coverage; and
- the date of the diagnosis of the additional occurrence or recurrence is more than 90 days after the date of the last medical treatment for the previous occurrence.

The amount payable for a Recurrence of a Critical Illness other than Cancer - Limited Skin Cancer is equal to the Recurrence Benefit percentage of the original benefit amount payable for the diagnosis of the Critical Illness as shown in the Schedule of Benefits. A Recurrence Benefit for Critical Illness Other than Cancer - Limited Skin Cancer is payable 1 times per Critical Illness per Covered Person.

Recurrence is not available for the following benefits: Fertility Assistance and Mental Health Screening.

Recurrence Benefit for Limited Skin Cancer

We will pay the amount shown in the Schedule of Benefits if a Covered Person:

- is positively diagnosed by a Doctor as having an additional occurrence or recurrence of Limited Skin Cancer for which a benefit was paid under this coverage; and
- the date of the diagnosis of the additional occurrence or recurrence is more than 90 days after the date of the last medical treatment for the previous occurrence.

A Recurrence Benefit for Limited Skin Cancer is payable 1 times per Covered Person.

Eligibility, Effective Date and Termination

ELIGIBILITY

Employee Insurance
You may need to work for Your Employer for a continuous full-time period before You become eligible for the coverage. This is called the Employment Waiting Period. The Employment Waiting Period must be agreed upon by the Employer and Us and it will be shown in the Schedule of Benefits if applicable.

Subject to the Employment Waiting Period, You are eligible for Employee Insurance if You are a member of a Covered Class as shown in the Schedule of Benefits. You must also be Actively at Work and under the age of 100.

If You are an Employee of more than one Employer included under the Group Contract, You will be considered an Employee of only one of those Employers. Your service with the others will be treated as service with that one.

Qualified Dependent Insurance
A Spouse or Child is eligible for Dependent Insurance on the later of:
- the date You are eligible for Employee Insurance; or
- the date they become a Qualified Dependent.

A Spouse may be a Qualified Dependent or an Employee under the Certificate, but not both at the same time.

A Child will not be considered the Qualified Dependent of more than one Employee. If this would otherwise be the case, the Child will be considered the Qualified Dependent of the Employee who has the longest continuous service with the Employer, based on the Contract Holder's records.

Your Spouse or Child is not Your Qualified Dependent while they:
- are on active duty in the armed forces of any country; or
- are insured under the Group Contract as an Employee.

EFFECTIVE DATE

Enrollment
For Contributory Insurance, You must enroll an approved form and agree to pay the required contributions. You may enroll for Contributory Insurance:
- Within 31 days of when You could first be covered;
- Within 31 days of a Qualified Life Event; or
- During the Annual Enrollment Period.

Employee Insurance
If You enroll in coverage under this Certificate during the Annual Enrollment Period or when You could first be covered, Your coverage starts on the date Your enrollment is approved, so long as the required Premium, including Your Cost of Insurance, is paid when due.

If You enroll in coverage under this Certificate due to a Qualified Life Event, Your coverage becomes effective on the date of the Qualified Life Event.

Qualified Dependent Insurance
If You have a Qualified Dependent when You become eligible for coverage and You elect Dependent coverage, Your Qualified Dependent's coverage will begin on the date Your coverage begins. If

additional Premium is required for Qualified Dependent coverage, it must be paid when due for coverage to be valid.

If You enroll a Qualified Dependent in coverage under this Certificate due to a Qualified Life Event, their coverage becomes effective on the date of the Qualified Life Event.

There are special rules for Qualified Dependent Children described below.

Newborn or Newly Adopted Qualified Dependent Child(ren) Insurance
Your Qualified Dependent Child(ren) who are born or placed in Your home for adoption while You are covered under the Group Contract are covered automatically for 31 days from the moment of live birth or date of placement for adoption.

If You have not elected Qualified Dependent Child(ren) insurance coverage at the time of the birth or date of placement, You must notify Us within 31 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 31 day period.

Effective Date Delay for Employee Insurance
Your Employee Insurance will be delayed if You are not Actively at Work on the day Your insurance would otherwise begin. Instead, it will begin on the first day You are Actively at Work and meet the other requirements for the insurance. The same delay rule will apply to any increase in Your insurance that is subject to this section. If You are not Actively at Work on the day that change would take effect, it will take effect on the first day You are Actively at Work. This Effective Date Delay rule does not apply to any decreases in Your insurance.

Effective Date Delay for Qualified Dependent Insurance
If a Qualified Dependent is confined for medical care or treatment, at home or elsewhere, on the day that Your Qualified Dependent Insurance, or any change in that insurance that is subject to this section, would take effect, it will not then take effect. The insurance or change will take effect upon the Qualified Dependent's final medical release from all such confinement.

CHANGES TO COVERAGE

Increases and Decreases - Employee
You may elect to have Your Amount of Insurance under the coverage changed within 31 days of a Qualified Life Event. You must do this on an approved form and agree to make any required Premium contributions.

If You request a decrease, the amount of Your insurance will be decreased on the first of the month following the date of Your written request.

Increases and Decreases - Qualified Dependents
You may elect to have the Amount of Insurance on Your Qualified Dependents changed within 31 days of a Qualified Life Event. You must do this on an approved form and agree to make any required Premium contributions.

If You request a decrease in the Amount of Insurance for a Qualified Dependent, the Amount of Insurance for the Qualified Dependent will be decreased on the first of the month following the date of Your written request.

Changing Coverage at Annual Enrollment - Employee
You may elect to have Your Amount of Insurance under the coverage changed during the Annual Enrollment Period. You must do this on an approved form and agree to make any required Premium contributions.

Changes will become effective on the date designated by the Contract Holder. The Effective Date Delay section applies to all changes except decreases.

Changing Coverage at Annual Enrollment - Qualified Dependents
You may elect to have Your Qualified Dependent's Amount of Insurance under the coverage changed during the Annual Enrollment Period. You must do this on an approved form and agree to make any required Premium contributions.

Changes will become effective on the date designated by the Contract Holder. The Effective Date Delay section applies to all changes except decreases.

TERMINATION

Your Employee Insurance, subject to the continuation options, will end on the date the first of the following occurs:

- You are no longer a member of a Covered Class;
- Your class is removed from the Covered Classes for the insurance;
- the Group Contract providing the insurance ends;
- You reach age 100;
- You die; or
- for Contributory Insurance, You fail to pay, when due, any required Premium contribution for Your insurance.

- The Qualified Dependent Spouse reaches age 100;
- the Qualified Dependent dies;
- We receive written notice of Your request to terminate coverage for one or more of Your Qualified Dependents, applicable only to the Qualified Dependent(s) identified in Your request for termination; or
- the dissolution of Your marriage or partnership for Qualified Dependent Spouse coverage.

Continuation of Coverage

Continuation of Your Coverage
You may elect to continue coverage for You and Your Qualified Dependents when coverage for You and Your Qualified Dependents under the Group Contract would have otherwise ended due to Your termination of coverage for the following reasons:

- You are no longer part of a Covered Class; or
- Your insurance would have ended because the Group Contract, in the absence of this provision, would have ended.

To qualify for continuation of coverage, You must have been continuously insured under the Group Contract and/or the Employer's prior coverage for at least 30 days immediately prior to the date Your insurance would have otherwise ended for one of the reasons shown above.

The coverage that may be continued is that which You had on the date Your coverage would have ended. We will mail to You a notice of Your right to continue the coverage. The notice will state the amount of the payments required for the continued coverage and the manner in which payments must be made.

If You want to continue coverage, Your first Premium payment must be sent to Us within 30 days after You elect to continue coverage.

Your continued coverage will end on the date the first of the following occurs:

- You reach age 100;
- You reach Your Lifetime Maximum Benefit;
- You die; or
- You fail to make, when due, any Premium payment required for the continued coverage.

Qualified Dependent coverage will end on the date the first of the following occurs:

- Your continued coverage ends;
- the Qualified Dependent reaches the Lifetime Maximum Benefit for that Qualified Dependent;
- the Qualified Dependent ceases to be a Qualified Dependent;
- the Qualified Dependent Spouse reaches age 100;
- the Qualified Dependent dies;
- We receive written notice of Your request to terminate coverage for one or more of Your Qualified Dependents, applicable only to the Qualified Dependent(s) identified in Your request for termination; or
- the dissolution of Your marriage or partnership for Qualified Dependent Spouse coverage.

Continued Eligibility for Insurance
Subject to the limitations described within this provision, We will continue to consider You eligible for insurance under the Group Contract if You cease to be Actively at Work as a result of one or more of the following:

- **Family Medical Leave of Absence:** If Your Actively at Work status ends due to an Employer approved family or medical leave, Your eligibility for insurance will continue up to the Maximum Period shown in the Schedule of Benefits
- **Military Service:** If Your Actively at Work status ends due to entry into the armed forces that is subject to Uniform Services Employment and Reemployment Rights Act of 1994 (USERRA), Your eligibility for insurance will continue up to the Maximum Period shown in the Schedule of Benefits.

Continued eligibility for insurance under this provision will end upon the earliest of the following:

- The end of the Maximum Period shown in the Schedule of Benefits that is applicable to the specific reason for continued eligibility;

- The date that You become employed on a full-time basis with another employer, or in a different position with the Employer;
- The end of the period for which any required Premium contribution is not made, subject to the Grace Period.
- If continued eligibility is the result of military service, the day You fail to return to Actively at Work status following the end of military service subject to USERRA.

Premiums are required to continue Your eligibility for insurance under this provision, including Your Premium contributions, if any.

Unless otherwise stated, continued eligibility for insurance begins when You are no longer Actively at Work. If more than one continued eligibility provision applies, only the one with the longer duration will be applicable.

Notwithstanding any other provision of the Group Contract, if You are no longer Actively at Work due to termination of Your employment with the Employer, Your coverage under the Group Contract will terminate and continued eligibility under this provision will not apply.

Premium Provisions

Contributory Insurance Payment of Premiums
Premium contributions are to be paid by You to the Contract Holder. If Premium is not paid when due according to the Premium Payment Date shown in the Schedule of Benefits, insurance will end, subject to the Grace Period provision below.

General Provisions

Entire Contract
This policy and the application of the employer constitute the entire contract between the parties, and any statement made by the employer shall, in the absence of fraud, be deemed a representation and not a warranty. No statement made by any employee whose eligibility has been accepted by the insurer shall (avoid the insurance or reduce the benefits under this policy or) be used in defense to a claim hereunder.

Time Limit on Certain Defenses
After three years from the date of issue of this policy, no misstatement of the employer, except a fraudulent misstatement, made in the employer's application shall be used to void the policy; and after three years from the effective date of the coverage with respect to which any claim is made no misstatement of any employee eligible for coverage under the policy, except a fraudulent misstatement, made in an application under the policy shall be used to deny a claim for loss incurred or disability (as defined in the policy) commencing after expiration of such three years.

Grace Period
A grace period of 31 days will be granted for the payment of premiums accruing after the first premium, during which grace period the policy shall continue in force, but the employer shall be liable to the insurer for the payment of the premium accruing for the period the policy continues in force.

Changes to the Contract
No change to the contract will be valid unless it was approved by Our executive officer and attached in writing. No agent has the authority to change the Group Contract or this Certificate or to waive any of its provisions.

Unpaid Premiums
If You owe Us Premiums when a claim is made, We may recover the unpaid Premium by reducing the benefit amount payable.

Workers' Compensation
The coverage provided by this insurance doesn't replace Workers' Compensation or affect any requirement for Workers' Compensation coverage.

Conformity with State Statutes
Any provision of this Certificate that conflicts with the laws of the state where the Group Contract is issued on Your coverage effective date is amended to conform to the requirements of the state's laws.

Misstatement of Age
If Your age was misstated on Your enrollment form, We may adjust Premiums or benefit amounts to reflect the coverage that would have been provided for the correct age or void coverage if the correct age exceeds the maximum eligible age.

Claim Provisions

Notice of Claim
Written notice of claim must be given to the insurer within 20 days after the occurrence or commencement of any loss covered by the policy, or as soon thereafter as is reasonably possible. Notice given by or on behalf of the claimant to the insurer at Voluntary Benefit Services, P.O. Box 71330, Philadelphia, PA 19176-1330 or to any authorized agent of the insurer, with information sufficient to identify the insured employee, shall be deemed notice to the insurer.

Claim Forms
The insurer, upon receipt of a written notice of claim, will furnish to the claimant such forms as are usually furnished by it for filing proofs of loss. If such forms are not furnished within 15 days after the giving of such notice the claimant shall be deemed to have complied with the requirements of this policy as to proof of loss upon submitting, within the time fixed in the policy for filing proofs of loss, written proof covering the occurrence, the character and the extent of the loss for which claim is made.

Proof of Loss
Written proof of loss must be furnished to the insurer, in case of claim for loss for which this policy provides any periodic payment contingent upon continuing loss, within 90 days after the termination of the period for which the insurer is liable, and in case of claim for any other loss, within 90 days after the date of such loss. Failure to furnish such proof within the time required shall not invalidate nor reduce any claim if it was not reasonably possible to give proof within such time, provided such proof is furnished as soon as reasonably possible and in no event, except in the absence of legal capacity of the employee, later than one year from the time proof is otherwise required.

Time of Payment of Claim
Indemnities payable under this policy for any loss other than loss for which this policy provides periodic payments will be paid (to the insured employee) as they accrue immediately upon receipt of due written proof of such loss. Subject to due written proof of loss, all accrued indemnity for loss for which this policy provides periodic payment will be paid (to the insured employee) monthly and any balance remaining unpaid upon the termination of the period of liability will be paid immediately upon receipt of due written proof.

Payment of Claims
We will pay all benefits to You. Any benefits that We owe You that have not been paid before You die will be paid to the first of the following: Your (a) surviving Spouse; (b) surviving Child(ren) in equal shares; (c) surviving parents in equal shares; (d) surviving siblings in equal shares; (e) estate.

Limits on Assignments
You have the right to assign Your interests and obligations under the Group Contract. This includes, but is not limited to, the obligation to make contributions to keep the insurance in force and the right to benefits payable. We will recognize an assignment made by You if it is duly executed and a copy of the assignment is provided to Us and acknowledged.

Physical Examination and Autopsy
The insurer at its own expense shall have the right and opportunity to examine the person of any individual whose injury or sickness is the basis of claim when and as often as it may reasonably require during the Pendency of a claim hereunder and to make an autopsy in case of death, where it is not forbidden by law.

Legal Actions
No action at law or in equity shall be brought to recover on this policy prior to the expiration of 60 days after written proof of loss has been furnished in accordance with the requirements of this policy.

No such action shall be brought after the expiration of three years after the time written proof of loss is required to be furnished.

Exclusions

Exclusions
We will not pay benefits for loss caused by or resulting from any of the following:

- suicide or attempted suicide.
- intentionally self-inflicted Injuries, or any attempt to inflict such Injuries.
- taking part in any riot or insurrection.
- war, or any act of war. War means declared or undeclared war and includes resistance to armed aggression.
- commission of or attempt to commit a felony or engaging in an illegal occupation.
- being intoxicated or under the influence of any narcotic or controlled substance unless administered on the advice of a physician.
- participation in these hazardous activities: scuba diving; bungee jumping; base jumping; skydiving; ziplining; parachuting; hang gliding; paragliding; paramotoring; parascending; or ballooning.

THIS NOTICE IS FOR NEW HAMPSHIRE RESIDENTS ONLY

N.H. Rev. Stat. § 151:21
151:21 Patients' Bill of Rights.
Effective: July 1, 2022

Rights and responsibilities of each patient admitted to a facility, except those admitted by a home health care provider:

I. The patient shall be treated with consideration, respect, and full recognition of the patient's dignity and individuality, including privacy in treatment and personal care and including being informed of the name, licensure status, and staff position of all those with whom the patient has contact, pursuant to RSA 151:3-b.

II. The patient shall be fully informed of a patient's rights and responsibilities and of all procedures governing patient conduct and responsibilities. This information must be provided orally and in writing before or at admission, except for emergency admissions. Receipt of the information must be acknowledged by the patient in writing. When a patient lacks the capacity to make informed judgments the signing must be by the person legally responsible for the patient.

III. The patient shall be fully informed in writing in language that the patient can understand, before or at the time of admission and as necessary during the patient's stay, of the facility's basic per diem rate and of those services included and not included in the basic per diem rate. A statement of services that are not normally covered by medicare or medicaid shall also be included in this disclosure.

IV. The patient shall be fully informed by a health care provider of his or her medical condition, health care needs, and diagnostic test results, including the manner by which such results will be provided and the expected time interval between testing and receiving results, unless medically inadvisable and so documented in the medical record, and shall be given the opportunity to participate in the planning of his or her total care and medical treatment, to refuse treatment, and to be involved in experimental research upon the patient's written consent only. For the purposes of this paragraph “health care provider” means any person, corporation, facility, or institution either licensed by this state or otherwise lawfully providing health care services, including, but not limited to, a physician, hospital or other health care facility, dentist, nurse, optometrist, podiatrist, physical therapist, or psychologist, and any officer, employee, or agent of such provider acting in the course and scope of employment or agency related to or supportive of health care services.

V. The patient shall be transferred or discharged after appropriate discharge planning only for medical reasons, for the patient's welfare or that of other patients, if the facility ceases to operate, or for nonpayment for the patient's stay, except as prohibited by Title XVIII 1 or XIX 2 of the Social Security Act. No patient shall be involuntarily discharged from a facility because the patient becomes eligible for medicaid as a source of payment.

VI. The patient shall be encouraged and assisted throughout the patient's stay to exercise the patient's rights as a patient and citizen. The patient may voice grievances and recommend changes in policies and services to facility staff or outside representatives free from restraint, interference, coercion, discrimination, or reprisal.

VII. The patient shall be permitted to manage the patient's personal financial affairs. If the patient authorizes the facility in writing to assist in this management and the facility so consents, the assistance shall be carried out in accordance with the patient's rights under this subdivision and in conformance with state law and rules.

VIII. The patient shall be free from emotional, psychological, sexual and physical abuse and from exploitation, neglect, corporal punishment and involuntary seclusion.

IX. The patient shall be free from chemical and physical restraints except when they are authorized in writing by a physician for a specific and limited time necessary to protect the patient or others from injury. In an emergency, restraints may be authorized by the designated professional staff member in order to protect the patient or others from injury. The staff member must promptly report such action to the physician and document same in the medical records.

X. The patient shall be ensured confidential treatment of all information contained in the patient's personal and clinical record, including that stored in an automatic data bank, and the patient's written consent shall be required for the release of information to anyone not otherwise authorized by law to receive it. Medical information contained in the medical records at any facility licensed under this chapter shall be deemed to be the property of the patient. The patient shall be entitled to a copy of such records upon request. The charge for the copying of a patient's medical records shall not exceed $15 for the first 30 pages or $.50 per page, whichever is greater; provided, that copies of filmed records such as radiograms, x-rays, and sonograms shall be copied at a reasonable cost.

XI. The patient shall not be required to perform services for the facility. Where appropriate for therapeutic or diversional purposes and agreed to by the patient, such services may be included in a plan of care and treatment.

XII. The patient shall be free to communicate with, associate with, and meet privately with anyone, including family and resident groups, unless to do so would infringe upon the rights of other patients. The patient may send and receive unopened personal mail. The patient has the right to have regular access to the unmonitored use of a telephone.

XIII. The patient shall be free to participate in activities of any social, religious, and community groups, unless to do so would infringe upon the rights of other patients.

XIV. The patient shall be free to retain and use personal clothing and possessions as space permits, provided it does not infringe on the rights of other patients.

XV. The patient shall be entitled to privacy for visits and, if married, to share a room with his or her spouse if both are patients in the same facility and where both patients consent, unless it is medically contraindicated and so documented by a physician. The patient has the right to reside and receive services in the facility with reasonable accommodation of individual needs and preferences, including choice of room and roommate, except when the health and safety of the individual or other patients would be endangered.

XVI. The patient shall not be denied appropriate care on the basis of age, sex, gender identity, sexual orientation, race, color, marital status, familial status, disability, religion, national origin, source of income, source of payment, or profession.

XVII. The patient shall be entitled to be treated by the patient's physician of choice, subject to reasonable rules and regulations.

XVIII. The patient shall be entitled to have the patient's parents, if a minor, or spouse, or next of kin, unmarried partner, or a personal representative chosen by the patient, if an adult, visit the facility, without restriction, if the patient is considered terminally ill by the physician responsible for the patient's care.

XIX. The patient shall be entitled to receive representatives of approved organizations as provided in RSA 151:28.

XX. The patient shall not be denied admission to the facility based on medicaid as a source of payment when there is an available space in the facility.

XXI. Subject to the terms and conditions of the patient's insurance plan, the patient shall have access to any provider in his or her insurance plan network and referral to a provider or facility within such network shall not be unreasonably withheld pursuant to RSA 420-J:8, XIV.

XXII. The patient shall not be denied admission, care, or services based solely on the patient's vaccination status.

XXIII. (a) In addition to the rights specified in paragraph XVIII, the patient shall be entitled to designate a spouse, family member, or caregiver who may visit the facility while the patient is receiving care. A patient who is a minor may have a parent, guardian, or person standing in loco parentis visit the facility while the minor patient is receiving care.

(b)(1) Notwithstanding subparagraph (a), a health care facility may establish visitation policies that limit or restrict visitation when:

(A) The presence of visitors would be medically or therapeutically contraindicated in the best clinical judgment of health care professionals;

(B) The presence of visitors would interfere with the care of or rights of any patient;

(C) Visitors are engaging in disruptive, threatening, or violent behavior toward any staff member, patient, or another visitor; or

(D) Visitors are noncompliant with written hospital policy.

(2) Upon request, the patient or patient's representative, if the patient is incapacitated, shall be provided the reason for denial or revocation of visitation rights under this paragraph.

(c) A health care facility may require visitors to wear personal protective equipment provided by the facility, or provided by the visitor and approved by the facility. A health care facility may require visitors to comply with reasonable safety protocols and rules of conduct. The health care facility may revoke visitation rights for failure to comply with this subparagraph.

(d) Nothing in this paragraph shall be construed to require a health care facility to allow a visitor to enter an operating room, isolation room, isolation unit, behavioral health setting or other typically restricted area or to remain present during the administration of emergency care in critical situations. Nothing in this paragraph shall be construed to require a health care facility to allow a visitor access beyond the rooms, units, or wards in which the patient is receiving care or beyond general common areas in the health care facility.

(e) The rights specified in this paragraph shall not be terminated, suspended, or waived by the health care facility, the department of health and human services, or any governmental entity, notwithstanding declarations of emergency declared by the governor or the legislature. No health care facility licensed pursuant to RSA 151:2 shall require a patient to waive the rights specified in this paragraph.

(f) Each health care facility licensed pursuant to RSA 151:2 shall post on its website:

(1) Informational materials explaining the rights specified in this paragraph;

(2) The patients' bill of rights which applies to the facility on its website; and

(3) Hospital visitation policy detailing the rights and responsibilities specified in this paragraph, and the limitations placed upon those rights by written hospital policy on its website.

(g) Unless expressly required by federal law or regulation, the department or any other state agency shall not take any action arising out of this paragraph against a health care facility for:

(1) Giving a visitor individual access to a property or location controlled by the health care facility;

(2) Failing to protect or otherwise ensure the safety or comfort of a visitor given access to a property or location controlled by the health care facility;

(3) The acts or omissions of any visitor who is given access to a property or location controlled by the health care facility.

Additional Information About Your Plan

The Certificate of Coverage and the following Additional Information (together, the Booklet), are intended to comply with the disclosure requirements of the regulations issued by the U.S. Department of Labor under the Employee Retirement Income Security Act (ERISA) of 1974. ERISA requires that your employer provide you with a "Summary Plan Description" which describes the plan and informs you of your rights under it. Information about eligibility rules, benefits amounts, benefit limitations, and exclusions from coverage is contained in the Certificate of Coverage. The following Additional Information about your plan is provided at the request of your Employer/Plan Sponsor.

Plan Name

Blue Bottle Coffee, LLC Critical Illness Insurance Plan

Plan Number

501

Type of Plan

Employee Welfare Benefit Plan

Plan Sponsor

Blue Bottle Coffee, LLC
2261 Market Street
Suite 22513
San Francisco, California 94114

Employer Identification Number

46-0805567

Plan Administrator

Blue Bottle Coffee, LLC
Attention: Human Resources Department
2261 Market Street
Suite 22513
San Francisco, California 94114

415-508-6896

Agent for Service of Legal Process

Blue Bottle Coffee, LLC
Attention: Human Resources Department
2261 Market Street
Suite 22513
San Francisco, California 94114

Service of legal process may also be made upon the plan administrator at the address above.

Plan Year Ends

December 31

Plan Benefits Provided by

The Prudential Insurance Company of America
751 Broad Street
Newark, New Jersey 07102

Plan Sponsor's Designation of Prudential As Claims Administrator

It is the Plan Sponsor's intention and direction that The Prudential Insurance Company of America as Claims Administrator has the sole discretion to interpret the terms of the plan, to make factual findings, and to determine eligibility for benefits. The Plan Sponsor has determined that benefits are payable under the plan only if The Prudential Insurance Company of America, in its sole discretion, determines that they are due. The decision of the Claims Administrator shall not be overturned unless arbitrary and capricious. *

* This paragraph does not apply to residents of AK, AR, CA, CO, DC, IL, KY, MD, ME, MI, NJ, NY, OR, PR, RI, SD, TX, VT, WA

Plan Sponsor, Policyholder and Employer not Agents of Prudential

The Group Contract underwritten by The Prudential Insurance Company of America provides insured benefits under your Employer/Policyholder/Plan Sponsor's ERISA plan(s). For all purposes associated with the plan or the Group Contract under which The Prudential Insurance Company of America provides benefits, the Employer/Policyholder/Plan Sponsor acts on its own behalf or as an agent of its employees. Under no circumstances will the Employer/Policyholder/Plan Sponsor be deemed the agent of The Prudential Insurance Company of America, absent a written authorization of such status executed between the Employer/Policyholder/Plan Sponsor and The Prudential Insurance Company of America. Nothing in these documents shall, of themselves, be deemed to be such a written authorization.

Allocation of Contributions

The insurance benefit coverages described in this Booklet are being offered to you under a single ERISA plan. Coverages described as non-contributory or as being paid entirely by the Employer/Policyholder/Plan Sponsor (if any) are those paid for directly by the Employer/Policyholder/Plan Sponsor such that you have no out of pocket expense for such coverages. However, the premium rate that the Employer/Policyholder/Plan Sponsor pays for insurance coverage offered to you under the Plan may be determined, or in some cases, reduced, in part, based on your contributions for other coverages or other benefits offered under the Plan. When this occurs, your contributions for one benefit coverage may cover some or all of the costs or plan expenses for another benefit coverage offered to you under the Plan.

Loss of Benefits

You must continue to be a member of a class of eligible employees or beneficiaries to which the plan pertains and continue to make any contributions or payments that are due, including those you agreed to when you enrolled for coverage. Failure to make required contributions may result in partial or total loss of your benefits.

Plan Sponsor May Amend or Terminate the Plan at any Time

It is intended that this plan will be continued for an indefinite period of time. But, the Plan Sponsor reserves the right to change or terminate the plan at any time. This Booklet elsewhere describes your rights upon termination of the plan.

Claim Procedures

1. Determination of Benefits

Prudential shall notify you of the claim determination within 45 days of the receipt of your claim. This period may be extended by 30 days if such an extension is necessary due to matters beyond the control of the plan. A written notice of the extension, the reason for the extension and the date by which the plan expects to decide your claim, shall be furnished to you within the initial 45-day period. This period may be extended for an additional 30 days beyond the original 30-day extension if necessary due to matters beyond the control of the plan. A written notice of the additional extension, the reason for the additional extension and the date by which the plan expects to decide on your claim, shall be furnished to you within the first 30-day extension period if an additional extension of time is needed. However, if a period of time is extended due to your failure to submit information necessary to decide the claim, the period for making the benefit determination by Prudential will be tolled (i.e., suspended) from the date on which the notification of the extension is sent to you until the earlier of the date on which you respond to the request for additional information, or the 45th day following the expiration of the initial 45-day claim review period.

If your claim for benefits is denied, in whole or in part, you or your authorized representative will receive a written notice from Prudential of your denial. The notice will include:

(a) the specific reason(s) for the denial, which will include a discussion of the decision describing, if applicable, the basis for disagreeing with or not following (i) the views of healthcare professionals treating you and vocational experts who evaluated you, (ii) the views of medical or vocational experts whose advice was obtained on behalf of the plan in connection with your adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination, and (iii) an award of Social Security Administration disability benefits,

(b) references to the specific plan provisions on which the benefit determination was based,

(c) a description of any additional material or information necessary for you to perfect a claim and an explanation of why such information is necessary,

(d) a statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim for benefits,

(e) a description of Prudential's appeals procedures and applicable time limits, including a statement of your right to bring a civil action under section 502(a) of ERISA following your appeals,

(f) a statement that, if an adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, an explanation of the scientific or clinical judgment for the determination will be provided free of charge upon written request, and

(g) copies of any internal rules, guidelines, protocols, standards or other similar criteria relied upon in making this determination or, alternatively, a statement that such rules, guidelines, protocols, standards or other similar criteria do not exist.

2. Appeals of Adverse Determination

If your claim for benefits is denied, you or your representative may appeal your denied claim in writing to Prudential within 180 days of the receipt of the written notice of denial or 180 days from the date such claim is deemed denied. Similarly, if Prudential does not decide your claim within the time described in Section 1 above, you may appeal, although you are not required to do so. You may submit with your appeal any written comments, documents, records and any other information relating to your claim. Upon your request, you will also have access to, and the right to obtain copies of, all documents, records and information relevant to your claim free of charge.

A full review of the information in the claim file and any new information submitted to support the appeal will be conducted by Prudential, utilizing individuals not involved in the initial benefit determination. This review will not afford any deference to the initial benefit determination.

Prudential shall make a determination on your appeal within 45 days of the receipt of your appeal request. This period may be extended by up to an additional 45 days if Prudential determines that special circumstances require an extension of time. A written notice of the extension, the reason for the extension and the date that Prudential expects to render a decision shall be furnished to you within the initial 45-day period. However, if the period of time is extended due to your failure to submit information necessary to decide the appeal, the period for making the benefit determination will be tolled (i.e., suspended) from the date on which the notification of the extension is sent to you until the earlier of the date on which you respond to the request for additional information or the 45th day from the expiration of the initial 45-day appeal review period.

Prudential will provide you, free of charge and prior to any adverse decision on appeal, with any new or additional evidence that is considered by Prudential in connection with the claim (including evidence that may be the basis for denial as well as any evidence that may support granting the claim), and any new or additional rationale that will form the basis for the Prudential's decision on appeal. Any such evidence will be provided as soon as possible and sufficiently in advance of the date on which the notice of adverse benefit determination must be provided in order to give you a reasonable opportunity to respond prior to that date.

If the appeal is denied in whole or in part, you will receive a written notification from Prudential of the denial. The notice will include:

(a) the specific reason(s) for the adverse determination, which will include a discussion of the decision describing, if applicable, the basis for disagreeing with or not following (i) the views of healthcare professionals treating you and vocational experts who evaluated you, (ii) the views of medical or vocational experts whose advice was obtained on behalf of the plan in connection with your adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination, and (iii) an award of Social Security Administration disability benefits,

(b) references to the specific plan provisions on which the determination was based,

(c) a statement that you are entitled to receive upon request and free of charge reasonable access to, and make copies of, all records, documents and other information relevant to your benefit claim upon request,

(d) a description of Prudential's review procedures and applicable time limits,

(e) a statement that if an adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, an explanation of the scientific or clinical judgment for the determination will be provided free of charge upon written request,

(f) copies of any internal rules, guidelines, protocols, standards or other similar criteria relied upon in making this determination or, alternatively, a statement that such rules, guidelines, protocols, standards or other similar criteria do not exist, and

(g) a statement describing any appeals procedures offered by the plan, and your right to bring a civil suit under ERISA.

If a decision on appeal is not furnished to you within the time frames mentioned above, the claim shall be deemed denied on appeal.

If the appeal of your benefit claim is denied, you or your representative may make a second, voluntary appeal of your denial in writing to Prudential within 180 days of the receipt of the written notice of denial or 180 days from the date such claim is deemed denied. Similarly, if Prudential does not decide your appeal within the time described in Section 1 above, you may appeal again, although you are not required to do so. You may submit with your second appeal any written comments, documents, records and any other information relating to your claim. Upon your request, you will also have access to, and the right to obtain copies of, all documents, records and information relevant to your claim free of charge.

Prudential shall make a determination on your second claim appeal within 45 days of the receipt of your appeal request. This period may be extended by up to an additional 45 days if Prudential determines that special circumstances require an extension of time. A written notice of the extension, the reason for the extension and the date by which Prudential expects to render a decision shall be furnished to you within the initial 45-day period. However, if the period of time is extended due to your failure to submit information necessary to decide the appeal, the period for making the benefit determination will be tolled from the date on which the notification of the extension is sent to you until the earlier of the date on which you respond to the request for additional information or the 45th day following the expiration of the second 45-day appeal review period.

Your decision to submit a benefit dispute to this voluntary second level of appeal has no effect on your right to any other benefits under this plan. If you elect to initiate a lawsuit without submitting to a second level of appeal, the plan waives any right to assert that you failed to exhaust administrative remedies. If you elect to submit the dispute to the second level of appeal, the plan agrees that any statute of limitations or other defense based on timeliness is tolled during the time that the appeal is pending.

If the claim on appeal is denied in whole or in part for a second time, you will receive a written notification from Prudential of the denial. The notice will be written in a manner calculated to be understood by the applicant and shall include the same information that was included in the first adverse determination letter. If a decision on appeal is not furnished to you within the time frames mentioned above, the claim shall be deemed denied on appeal.

Time Limit To File Suit

If your claim for benefits and any required appeals are denied (or not decided within the time periods discussed above), you may file suit as discussed below. If you elect to file suit, you should do so as soon as possible. However, you must file suit no later than three years after proof of your claim was first due as explained elsewhere in this Booklet, regardless of whether your claim is still pending in the claim or appeal process.

Rights and Protections

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

Receive Information about Your Plan and Benefits

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

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

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

Prudent Actions by Plan Fiduciaries

In addition to creating rights for plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your plan, called "fiduciaries" of the plan, have a duty to do so prudently and in the interest of you and other plan participants and beneficiaries. No one, including the Plan Sponsor, 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 a fine that accrues on a daily basis (based on amounts set by the Department of Labor) from the time the materials were due to you 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 Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Office of Outreach, Education and Assistance, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, DC 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.