BlueCross BlueShield of Texas

Voluntary Specified Disease Insurance

Employee Benefit Booklet

NATION'S BEST HOLDINGS, LLC

GFZ02034-0001

Class 1-01

02/18/2021

This plan is an "employee welfare benefit plan," ("Plan") as defined in Section 3(1) of the Employee Retirement Income Security Act of 1974, as amended ("ERISA").

This document serves to provide important information about the Plan. It is not the entire Plan document, but a summary of important information about the Plan. In addition to this summary plan description ("SPD"), ERISA requires that you receive a Statement of ERISA Rights, a description of Claim Procedures, and other specific information about the Plan. Your employer or Plan Administrator maintains the full Plan Document. If there is a conflict between the Plan Document and this SPD, the Plan Document controls. A copy of the Plan Document is available for review during normal working hours in the office of the Plan Administrator.

The benefits described in your Plan document are provided under a group Plan sponsored by the Employer and insured by Blue Cross and Blue Shield of Texas.

SUMMARY PLAN DESCRIPTION	
1. PLAN NAME: If different, the name by which the plan is commonly known.	Employee Welfare Plan
2. PLAN TYPE:	Welfare Benefit Plan providing a Group Life Insurance Policy and Certificate
3. PLAN SPONSOR/EMPLOYER'S NAME AND ADDRESS: Name and address of employer sponsoring the Plan or employee organization maintaining the Plan	NATION'S BEST HOLDINGS, LLC 9330 LBJ FRWY STE 850 Dallas TX 75243
4. EMPLOYER IDENTIFICATION NUMBER (EIN): Employer identification number assigned by the IRS to the Plan Sponsor	75-1850578
5. PLAN NUMBER: Number assigned by the Plan Sponsor. This number is used for Form 5500 reporting. Each Plan should be assigned a unique number that is not used more than once.	501
6. ERISA PLAN YEAR ENDS ON EACH: This is the end of the Plan Year for maintaining the Plan's fiscal records and may be different from the insurance policy year.	02/28
7. PLAN ADMINISTRATOR'S NAME, ADDRESS, AND TELEPHONE NUMBER:	NATION'S BEST HOLDINGS, LLC 9330 LBJ FRWY STE 850 Dallas TX 75243 903-887-7581
8. AGENT FOR SERVICE OF LEGAL PROCESS ON THE PLAN:	
9. SOURCES OF FUNDING AND CONTRIBUTIONS: Contributions are, for example, employer, employee organization or employee contributions and the method by which the amount of the contributions is calculated. Funding is the medium by which the Plan is funded. For example, the identity of the insurance company or trust fund through which the Plan is funded or benefits are provided.	The Plan is funded as an insured plan under policy number GFZ02034 issued by Blue Cross and Blue Shield of Texas. Contributions to the Plan are made as stated on the Schedule of Benefits in the Group Insurance Certificate. The employer determines the method of funding and contributions, if any, to be made by the participants.

10. TYPE OF ADMINISTRATION:	This plan is administrated by insurer administration.
11. CLAIM ADMINISTRATION:	The Claim Administrator is not the "plan administrator" of your Plan, as defined in Section 3(16)(A) of ERISA. The Plan Administrator has selected Blue Cross and Blue Shield of Texas as the claims administrator of your Plan and has delegated to Blue Cross and Blue Shield of Texas the authority and discretion to administer the terms of the applicable group policy provisions such as making initial claim determinations concerning the availability of benefits, and the final review and benefit determinations for appealed claims.
12. EACH TRUSTEE'S NAME, TITLE, AND ADDRESS OF PRINCIPAL PLACE OF BUSINESS: This is only applicable if the Plan has trustees.	
13. LABOR ORGANIZATION: This is applicable if the Plan is subject to a CBA.	
14. PLAN AMENDMENT AND TERMINATION PROCEDURE:	The Employer reserves full authority, at its sole discretion, to terminate, suspend, withdraw, reduce, amend or modify the Plan (including any related documents and underlying policies), in whole or in part, at any time, without prior notice. Any amendment, modification, or termination must be in writing and endorsed on or attached to the Plan. The Employer also reserves the right to adjust your share of the cost to continue coverage by the same procedures. Rights with respect to termination of insurance benefits are stated in the Policy and Certificate. The employer can request a Policy change, including a change to benefits, rights and obligations under the Policy but only an officer of Blue Cross and Blue Shield of Texas can approve a change to the Policy. The change must be in writing and endorsed on or attached to the Policy
15. ELIGIBILITY FOR PARTICIPATION AND BENEFITS:	These requirements are found in the Policy and Certificate incorporated herein by reference.
16. CIRCUMSTANCES CONCERNING INELIGIBILITY, DISQUALIFICATION, OR DENIAL OR LOSS OF BENEFITS:	These requirements are found in the Policy and Certificate incorporated herein by reference.
17. CLAIMS PROCEDURES: The procedures which govern claims for benefits and requests for review of denied claims.	The Plan's claims procedures are furnished automatically, without charge, as a separate document. Refer to the ERISA Information Statement incorporated herein by reference.

Dearborn Life Insurance Company

Administrative Office:
701 E. 22nd Street
Lombard IL 60148

(A stock life insurance company, herein called “We” “Us” or “Our”)

Having issued Group Policy No. GFZ02034-0001

(herein called the Policy)

to

NATION'S BEST HOLDINGS, LLC

(herein called the Policyholder)

GROUP SPECIFIED DISEASE INSURANCE CERTIFICATE

CERTIFIES that *You* are insured, if *You* qualify under the ELIGIBILITY AND EFFECTIVE DATES provision, and remain insured in accordance with the terms of the *Policy. Your* insurance is subject to all the definitions, limitations and conditions of the *Policy*, and it takes effect as stated in the ELIGIBILITY AND EFFECTIVE DATES provision.

This Certificate describes *Your* eligibility for benefits and the terms and provisions of the *Policy.* It replaces and cancels any other Certificate previously issued to *You* under the *Policy.*

If the terms and provisions of this Group Insurance Certificate (issued to *You*) are different from the *Policy* (issued to the *Policyholder),* the *Policy* will govern. *Your* coverage may be canceled or changed in whole or in part under the terms and provisions of the *Policy.*

READ THIS CERTIFICATE CAREFULLY

Signed for Dearborn Life Insurance Company

Secretary President

Voluntary Group Specified Disease Insurance Certificate

with

Dependent Specified Disease Benefits

Non-Participating

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.

THIS IS A LIMITED BENEFIT CERTIFICATE. IT PROVIDES SPECIFIED DISEASE INSURANCE COVERAGE. THERE IS NO COVERAGE FOR HOSPITAL, MEDICAL-SURGICAL OR MAJOR MEDICAL EXPENSES.

THIS TYPE OF PLAN IS NOT CONSIDERED “MINIMUM ESSENTIAL COVERAGE” UNDER THE AFFORDABLE CARE ACT AND THEREFORE DOES NOT SATISFY THE INDIVIDUAL MANDATE

THAT YOU HAVE HEALTH INSURANCE COVERAGE. IF YOU DO NOT HAVE OTHER HEALTH INSURANCE COVERAGE, YOU MAY BE SUBJECT TO A TAX PENALTY. PLEASE CONSULT YOUR TAX ADVISOR.

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SCHEDULE OF BENEFITS

POLICYHOLDER: NATION'S BEST HOLDINGS, LLC

POLICY NUMBER: GFZ02034-0001

POLICY EFFECTIVE DATE: March 1, 2021

ENROLLMENT PERIOD: 2/18-2/27

ELIGIBILITY:	All full-time Employees of the Policyholder working in the United States of America who are Actively at Work for the Policyholder and who have completed the Eligibility Waiting Period are eligible for the insurance. A full-time *Employee* is one who regularly works a minimum of 30 hours per week for the *Policyholder*. Part-time, seasonal and temporary *Employees* of the *Policyholder* are not eligible.	
Eligibility Waiting Period:	Current *Employees*:	First of the month following 2 Months of continuous, full-time Active Work
	New *Employees*:	First of the month following 2 Months of continuous, full-time Active Work
Policyholder Contribution:	Voluntary Specified Disease	0% of premium

00001-SOB TX

SPECIFIED DISEASE

***Employee* Voluntary Specified Disease Amount**	Incremental selection from a minimum of $5,000 to a maximum of $20,000 in increments of $5,000
***Employee* Guarantee Issue Amount**	Voluntary: $20,000
Reduction of Benefits	Voluntary Group Specified Disease Insurance benefits reduce by 35% of the original amount at age 65 and further reduce to 50% of the original amount at age 70. Benefits terminate at retirement.

DEPENDENT SPECIFIED DISEASE:

Guarantee Issue Amount	*Dependent* Voluntary *Child*: $10,000
Guarantee Issue Amount	*Spouse Voluntary*: $10,000
Spouse Amount	Incremental selection from a minimum of $2,500 to a maximum of $10,000 in increments of $2,500, not to exceed 50% of the Employee amount
Dependent Child Amount	Incremental selection from a minimum of $2,500 to a maximum of $10,000 in increments of $2,500, not to exceed 50% of the Employee amount

00002-SOB TX

COVERED CONDITIONS SCHEDULE:

Covered Condition	**Benefit Percentage**
Benign Brain Tumor	100%
Recurrence Benefit	50%
Coma	100%
Recurrence Benefit	50%

End State Renal Failure	100%
Heart Attack	100%
Recurrence Benefit	50%
Major Heart Surgeries	25%
Loss of Speech, Sight or Hearing	100%
Major Burns	100%
Major Organ Transplant	100%
Paralysis	100%
Severe COVID-19 Infection	100%
Stroke	100%
Recurrence Benefit	50%
Carcinoma in situ	25%
Invasive Cancer	100%
Recurrence Benefit	50%
Wellness Benefit	$50 per *Calendar Year* for each insured Employee and covered Dependent Spouse

00003-SOB

ELIGIBILITY AND EFFECTIVE DATE PROVISIONS

Who is eligible for this insurance?

The eligibility for this insurance is as indicated in the Schedule of Benefits.

The *Eligibility Waiting Period* is further defined in the Schedule of Benefits.
00001

When does Your Contributory insurance become effective?

You may apply for *Voluntary* insurance coverage during the annual Enrollment Period as indicated in the Schedule of Benefits. *Your* coverage will be effective as indicated below, if You are Actively at Work on that date.

Your Contributory coverage for amounts up to the Guarantee Issue Amount will become effective on the latest of the following dates, if You are Actively at Work on that date:

1. If *You* enroll for coverage prior to the *Polic y* effective date, the *Policy* effective date;
2. If *You* enroll for coverage within 31 days of *Your* eligibility date, on the first of the month that falls on or next follows the date *You* sign the *Enrollment Form*;
3. If *You* do not enroll for coverage within 31 days after *Your* eligibility date, *You* must wait until the next *Enrollment Period* to apply, unless *You* qualify because of a *Change in Family Status.*
    a. Initial requests for coverage or requests for changes to existing coverage made during the *Enrollment Period* will become effective on the *Policy* anniversary date.
    b. Coverage requested within 31 days of a *Change in Family Status* will become effective on the first of the month that falls on or next follows the date *You* sign the *Enrollment Form.*

Enrollment Form means the application *You* complete and submit to apply for coverage under the *Policy*.
00003

What is the Enrollment period?

Unless otherwise specified, **Enrollment Period** means a period of time during which Eligible Employees may apply for or request changes to coverage. The Enrollment Period is shown on the Schedule of Benefits.

Eligible Employees may enroll for coverage, apply for additional coverage, or request changes to their current coverage only during the Enrollment Period, unless they qualify because of a Change in Family Status.

Any Employee hired after an Enrollment Period may enroll within 31 days after their eligibility date; otherwise, he must wait for the next Enrollment Period to enroll unless he qualifies because of a Change in Family Status.

Initial requests for coverage or requests for changes to existing coverage made during the Enrollment Period will become effective on the anniversary date.
00005

If You are not Actively at Work, when does coverage become effective?

If You are absent from Active Work on the date Your coverage would otherwise become effective and Your absence is caused by an Injury, Illness or layoff, Your effective date for any initial coverage or increased coverage will be deferred until the date You return to Active Work.

However, You will be considered Actively at Work on any day that is not Your regularly scheduled work day (including but not limited to a weekend, vacation or holiday) if You were Actively at Work on the immediately preceding scheduled work day and You were:

1. not Hospital Confined, or;
2. disabled due to an Injury or Illness.

00006

What happens if We are replacing a Prior Policy?

Effect on Actively at Work Requirement

If You were insured under the Prior Policy on the day before the Policy effective date, coverage begins for this Policy on the Policy effective date and continues until the earliest of:

1. The end of the month following the date You become Actively at Work;
2. The end of any period of continuance or extension provided under the Prior Policy; or
3. The date coverage would otherwise end, according to the provisions of this Policy.

Your coverage under this provision is subject to payment of premium.

Effect on Benefits

The benefits payable under this Policy will be the benefits which would have been payable under the terms of the Prior Policy if it had remained in force; and the benefits payable under this Policy will be reduced by any benefits payable under the Prior Policy for the same Covered Condition for which the prior carrier is liable.

The **Prior Policy** is the group Specified Disease policy issued to the Policyholder whose coverage terminated immediately before the Policy effective date.

Effect on Pre-existing Conditions

If You have a Diagnosis of Covered Condition due to a Pre-existing Condition after the Prior Policy has been replaced by this Policy, benefits may be payable if:

1. You were insured under the Prior Policy at the time the Policyholder changed coverage from the Prior Policy to this Policy; and
2. You have been continuously insured under this Policy from the Policy effective date until the date Your Covered Condition was Diagnosed.

In order for benefits to be paid, You must satisfy the Pre-existing Condition exclusion under:

1. this Policy; or
2. the Prior Policy, if benefits would have been paid had the Prior Policy remained in force.

If You satisfy the Pre-existing Condition exclusion of this Policy, We will determine Your payments according to the Policy's provisions.

If You do not satisfy the Pre-existing Condition exclusion of this Policy, but You do satisfy the Pre-existing Condition provision under the Prior Policy:

Your benefit will be the lesser of:

a. The benefit that would have been payable under the terms of the Prior Policy if it had remained in force; or
b. The benefit under this Policy.

If You do not satisfy the Pre-existing Condition exclusion under either this Policy or the Prior Policy, We will not make any payments.

We will require Proof that You were insured under the Prior Policy.
00007

Changes to Your coverage

A change in Your coverage may occur if:

1. You enroll for a different coverage option; or
2. There is a Policy change; or
3. You enter another class and become eligible for a change in benefits; or
4. You experience a qualified Change in Family Status.

If You are eligible for increased coverage due to a Policy change, the increased coverage will be effective on the date the Policy change is effective, as requested by the Policyholder and agreed on by Us.

Increases in coverage for reasons other than a Policy change will be effective the first of the month following the later of:

1. The date You enroll for the increased coverage; or
2. The date You become eligible for the increased coverage, if enrollment is not required; or
3. The date We approve Your coverage if Evidence of Insurability is required.

In order for Your increased coverage to begin, You must be Actively at Work. Increased Contributory coverage is subject to Our receipt of premium.

A decrease in coverage will take effect immediately.

Increases or decreases to Your benefits elected during the Enrollment Period will become effective on the next anniversary date, if You are Actively at Work on that day.
00008

Eligibility after You Terminate Employment

If Your coverage ends due to termination of employment, You must meet all the requirements of a new Employee if You are rehired by the Policyholder at a later date.
00009

SPECIFIED DISEASE INSURANCE

What is Specified Disease Insurance?

Specified Disease Insurance is a percentage of Your or Your covered Dependents' Voluntary Specified Disease Insurance as indicated in the Schedule of Benefits, which is payable to You or Your covered Dependents if You or Your covered Dependents experience a Covered Condition.

We will pay You or Your covered Dependents on Diagnosis of a Covered Condition if You or Your covered Dependents or Your or Your covered Dependents legal representative submit a claim and provide satisfactory Proof.

You or Your covered Dependents may receive multiple benefit payments if You or Your covered Dependents are Diagnosed with more than one Covered Condition, as long as the sum of all benefits payments does not exceed 300% of the Specified Disease Insurance amount under this Certificate.
00010

How do You or Your covered Dependents qualify for the Specified Disease Insurance Benefit?

You or Your covered Dependents receive benefits listed in the Schedule of Benefits if a Covered Condition occurs after the Policy effective date and it is Your or Your covered Dependents' Initial Diagnosis of the Covered Condition.
00011

What are Pre-Existing Conditions?

A ***Pre-existing Condition*** is any *Illness* or *Injury* for which *You* or Your covered Dependents received medical advice or treatment during the 12 months prior to the *Policy* effective date.

A Pre-existing condition is not covered within the first 12 months of coverage.
00013a TX

How are benefits paid if You or Your covered Dependents experience two or more Covered Conditions?

Payments are made for each Covered Condition You or Your covered Dependents suffer. Each benefit payment is based on the percentage listed in the Covered Conditions Schedule of Benefits. The sum of all benefit payments is limited to 300% of the Specified Disease Insurance amount under this Certificate.

If an Injury or Illness causes more than one Covered Condition, We will pay for the Covered Condition with the greatest benefit percentage.
00014 TX

Are Benefits portable?

No, benefits are not portable.
00015

Are Benefits convertible?

No, benefits are not convertible.
00016

EXCLUSIONS AND LIMITATIONS

Are there any Exclusions and Limitations for Specified Disease Insurance?

In addition to specific exclusions and limitations for a Covered Condition:

1. If an Injury or Illness causes more than one Covered Condition to occur, benefits are only payable under the greatest benefit level percentage and are payable once, up to 300% of the Specified Disease Insurance benefit in the Schedule of Benefits.
2. Benefits for a kidney transplant are covered under the End Stage Renal Failure benefit only.
3. If benefits are paid due to a kidney-pancreas transplant, those benefits are not payable under the End Stage Renal Failure benefit.
4. You or Your covered Dependent must be registered by the United Network of Organ Sharing (UNOS) in order for a Major Organ Transplant, or kidney transplant necessitated by End Stage Renal Failure to be a Covered Condition under this benefit.
5. Benefits are subject to any Reduction of Benefits.
6. No benefits are payable for a Covered Condition if it results directly or indirectly from:
    a. the misuse of alcohol or taking of drugs (except those drugs prescribed by a Physician and used in the manner prescribed or FDA regulated over-the-counter drugs used as recommended by the manufacturer); or
    b. Injury received during active participation in a Riot, strike or civil commotion, or any act incidental thereto; or
    c. Commission of or attempt to commit an illegal activity defined under state or federal law; or
    d. Injury received from driving while intoxicated or under the influence. Under the influence or intoxication is defined by the laws of the jurisdiction in which the Accident causing the Injury occurred or .08% blood alcohol content if the jurisdiction in which the Accident occurred does not define intoxication. Conviction is not necessary for a determination of under the influence or intoxication.

00017 TX

DEPENDENT SPECIFIED DISEASE INSURANCE

What is the Dependent Specified Disease Insurance Benefit?

We will pay You the amount of Specified Disease Insurance set forth in the Schedule of Benefits on Your Dependent(s) while Your insurance is in force. Payment will be in one lump sum.

If You are not living at the time Dependent Specified Disease Insurance benefits become payable, We will pay the benefit:

1. to Your Spouse, if living; if not,
2. in equal shares to Your then living natural or legally adopted children, if any; if none,
3. in equal shares to Your father and mother, if living; if not,
4. in equal shares to Your brothers and sisters, if living; otherwise,
5. to Your estate.

Who is eligible for Dependent Specified Disease Insurance?

If You or Your Spouse are insured for Specified Disease Insurance under the Policy and belong to a class listed in the Schedule of Benefits as eligible for Dependent Specified Disease Insurance benefits, You are eligible to enroll for this benefit. If You or Your Spouse are enrolled for Dependent Specified Disease Insurance and subsequently acquire a new Eligible Dependent, that Dependent will automatically be covered.

Note: No eligible person may be covered more than once under the Policy. If a person is covered as an Employee, he cannot be covered as a Spouse or Dependent child of another Employee. If both parents are covered as insured Employees under the Policy, only one may enroll for Specified Disease Insurance coverage on Eligible Dependent child(ren).

When does Dependent Specified Disease Insurance become effective?

If You:

1. have completed any required Employee Eligibility Waiting Period; and
2. apply for Dependent Specified Disease Insurance no later than 31 days after becoming eligible for this benefit; and
3. have paid any applicable premium.

Specified Disease Insurance for Your Eligible Dependent(s) will become effective on the later of:

1. the first of the month that falls on or next follows the date Your group insurance coverage becomes effective;
2. the first of the month that falls on or next follows the effective date of the Dependent Specified Disease Insurance benefit; or
3. the first of the month that falls on or next follows the date You enroll Your Eligible Dependent(s);
4. the first of the month that falls on or next follows the date You acquire Your Eligible Dependent(s);
5. if Evidence of Insurability is required, the date We determine that evidence is satisfactory and We provide written notice to You or the Policyholder of approval.

If You enroll for Dependent Specified Disease Insurance more than 31 days after You are eligible to do so, You must furnish Evidence of Insurability satisfactory to Us for each Dependent, and coverage will become effective as set forth above.

If an Eligible Dependent is required to submit satisfactory Evidence of Insurability for any reason, insurance in the amount for which We require such evidence will become effective on the date We determine that the evidence is satisfactory and We provide notice of approval to You and the Policyholder.

When do changes in the Dependent Specified Disease Insurance benefit become effective?

If no Evidence of Insurability is required, increases in the amount of Dependent Specified Disease Insurance will become effective on the Policy Anniversary Date.

For amounts on which Evidence of Insurability is required, increases in the amount of Dependent Specified Disease Insurance will be effective on the date We determine that evidence is satisfactory and We provide written notice of approval date of approval to You and the Policyholder.

Any decrease in the amount of Dependent Specified Disease Insurance will become effective immediately on the date of the change.

00019

TERMINATION PROVISIONS

When does Your coverage under the Policy end?

Your coverage terminates on the earliest of the following dates:

1. the date on which the Policy is terminated; or
2. the date You stop making any required contribution toward payment of premiums; or
3. the effective date of an amendment to the Policy which terminates insurance for the class to which You belong; or
4. the date on which the Participating Employer’s participation under the Policy is terminated; or
5. the date You:
    a. die; or
    b. are no longer a member of a class eligible for this insurance; or
    c. request termination of coverage under the Policy; or
    d. the first of the month following the date You reach age 65; or
    e. are no longer Actively at Work as a result of a Disability, layoff, or leave of absence or sabbatical, or military leave.

Termination will not affect Your claim for a covered Loss which occurred while the coverage was in force.

You may continue to be eligible for coverage, as follows:

Disability	Until the end of the twelfth month following the month in which the Disability began, if all premiums are paid when due.
Layoff	Until the end of the month following the month during which the layoff began, if all premiums are paid when due.
Leave of Absence	Until the end of the month following the month during which the leave of absence began, if all premiums are paid when due, as governed by the Policyholder's Human Resource policy on family and medical leaves of absence or in accordance with the FMLA provision below.
Sabbatical	Until the end of the month following the sixth month in which the sabbatical began, if all premiums are paid when due.
Military Leave	Until the end of the twelfth month following the month in which the military leave began, if all premiums are paid when due.

For the purposes of this provision, **Disability** means You are unable to perform all of the Material and Substantial Duties of Your Regular Occupation.
00020

Will coverage be continued if You are eligible for leave under FMLA?

In the event *You* are eligible for and the *Policyholder* approves a leave of absence under the Family and Medical Leave Act of 1993 (FMLA), or any applicable state family and medical leave law (State FML), provided the required premium continues to be paid, *Your* insurance will continue for a period of up to the later of:

1. the leave period permitted by the federal Family and Medical Leave Act of 1993 and any amendments; or
2. the leave period permitted by applicable state law.

You are eligible for leave under this Act in order to provide care:

1. After the birth of a child; or
2. After the legal adoption of a child; or
3. After the placement of a foster child in *Your* home; or
4. To a *Spouse*, child or parent due to their serious *Illness;* or
5. For *Your* own serious health condition; or
6. For any event later added by amendment to the Act.

While granted a Family or Medical Leave of Absence:

1. The *Policyholder* must remit the premium required by the *Policy;* and
2. Coverage will terminate if *You* do not return to work as scheduled according to the terms of *Your* leave of absence agreement with the *Policyholder*.

00021

When does Dependent Specified Disease Insurance coverage end?

Dependent Specified Disease Insurance coverage will end on the earliest of:

1. the date You are no longer Actively at Work except in the case of Disability, layoff or leave of absence as set forth above; or
2. the date the Policy is terminated; or
3. the date You stop making any required contribution toward payment of premiums; or
4. the effective date of an amendment to the Policy which terminates insurance for the class to which You belong; or
5. the date on which the Participating Employer's participation under the Policy is terminated; or
6. the first of the month following the date:
    a. You are no longer a member of a class eligible for this insurance, or
    b. You request termination of coverage under the Policy, or
    c. You reach age 65; or
7. the date a Dependent child or Spouse no longer meets the Policy definition of Eligible Dependent.

Coverage will continue past the age limit for Eligible Dependent children who are primarily dependent on You for support and who cannot work to support themselves due to a physical or mental incapacity which began before the age limit was reached. Written proof of such incapacity must be provided to Us on request.
00022

BENIGN BRAIN TUMOR

Benign Brain Tumor means the Diagnosis of a tumor within the brain cavity, known or presumed to be non-malignant, that results in a fixed neurological deficit. These neurological deficits include, but are not limited to:

- Loss of vision;
- Loss of hearing; or
- Balance disruption

Diagnosis of the tumor and neurological deficit must be confirmed by imaging or examination findings conducted by a Physician board-certified as a neurologist.

Tumors of the skull, pituitary adenomas and germanomas are excluded under this Covered Condition.

Also excluded from this Covered Condition is a Benign Brain Tumor Diagnosed with any of the following conditions prior to *Your or Your covered Dependent's* effective date:

- Neurofibromatosis I;
- Neurofibromatosis II;
- Von Hippel Lindau;
- Tuberous Sclerosis;
- Li Fraumani Syndrome;
- Cowden Disease; or
- Turcot Syndrome

The Date of Diagnosis is the date the Physician confirms the existence of the Benign Brain Tumor by examination of tissue (biopsy or surgical excision) or specific neuroradiological examination.
00027

COMA

Coma or ***Comatose*** means the *Diagnosis* of a state of complete loss of consciousness lasting for a period of 14 or more consecutive days from which *You* cannot be aroused and there is no evidence of response to stimulation.

The *Coma* must be characterized by the absence of:

- Eye opening;
- Verbal response; and
- Motor response

The *Coma* must require intubation for respiratory assistance.
00028

END STAGE RENAL FAILURE

End Stage Renal Failure means the *Diagnosis* of a chronic and irreversible failure of both kidneys for which dialysis on a regular basis (weekly or biweekly) is necessary. *Diagnosis* must be made by a *Physician* board-certified in nephrology.

The *Date of Diagnosis* is the date the *Physician* recommends the *Insured* begin renal dialysis.
00030

HEART ATTACK

Heart Attack or acute ***Myocardial Infarction*** means a *Diagnosis* of an acute *Myocardial Infarction* resulting in the death of a portion of the *Insured's* heart muscle (myocardium) due to a blockage of one or more coronary arteries and resulting in the loss of the normal function of the heart. The *Diagnosis* must be made by a *Physician* board-certified as a cardiologist and based on both:

a. New clinical presentation and electro-cardiographic changes consistent with an evolving *Heart Attack*; and

b. Serial measurement of cardiac biomarkers showing a pattern and to a level consistent with a *Diagnosis of Heart Attack.*

An established (old) *Myocardial Infarction* is excluded under this *Covered Condition.*
00031

MAJOR HEART SURGERY

Major Heart Surgery means the Diagnosis of either: Aortic Surgery, Coronary Artery Bypass Surgery or Heart Valve Replacement/Repair Surgery, as defined below.

(a) **Aortic Surgery.** A disease of the aorta that necessitates actually undergoing surgery of the aorta needing excision and surgical replacement of a portion of the diseased aorta with a graft. The Diagnosis must be made by a Physician board-certified as a cardiologist, cardio-vascular thoracic surgeon or vascular surgeon. For this definition, aorta means the thoracic and abdominal aorta but not its branches. Traumatic Injury of the aorta causing Aortic Surgery is excluded under this Covered Condition. If the Insured is determined to be too ill to undergo the surgery, but otherwise meets the criteria for the need for the surgery, the surgery requirement will be waived.

(b) **Coronary Artery Bypass Surgery.** A disease of the coronary artery that necessitates actually undergoing Coronary Artery Bypass Surgery using either a saphenous vein or internal mammary artery graft for the treatment of coronary heart disease deemed medically necessary to correct a narrowing or blockage of one or more coronary arteries. The Diagnosis must be made by a Physician board-certified as a cardiologist. Other surgical or nonsurgical techniques such as laser relief or any other intra-arterial procedures are excluded under this Covered Condition. If the Insured is determined to be too ill to undergo the surgery, but otherwise meets the criteria for the need for the surgery, the surgery requirement will be waived.

(c) **Heart Valve Replacement/Repair Surgery.** A disease of the heart valve that necessitates the actually undergoing open heart surgery to replace or repair one or more valves. The Diagnosis must be made by a Physician board-certified as a cardiologist or cardio-vascular surgeon. If the Insured is determined to be too ill for surgery, but otherwise meets the criteria for the need for the surgery, the surgery requirement will be waived.
00033

LOSS OF SPEECH, SIGHT OR HEARING

Loss of Speech means the Diagnosis of loss of the ability to speak to the extent that the Insured is unintelligible to another person with normal hearing, for at least 12 months.

The Date of Diagnosis for Loss of Speech is the date a Physician certifies Loss of Speech as defined in the definition of Loss of Speech.

Loss of Sight means Diagnosis of clinically proven irreversible reduction of sight in both eyes with:

- Sight in the better eye reduced to a best corrected visual acuity of less than 6/60 (Metric Acuity) or 20/200 (Snellen or E-Chart Acuity); or
- Visual field restriction to 20 degrees or less in both eyes.

The Date of Diagnosis for Loss of Sight is the date a Physician certifies Loss of Sight as defined in the definition of Loss of Sight.

Loss of Hearing means Diagnosis of permanent reduction in both ears to a point that the Insured is unable to hear sounds at or below 70 decibels. Diagnosis must be made by a board-certified or board-eligible otolaryngologist by audiometric testing.

The Date of Diagnosis for Loss of Hearing is the date the Physician certifies Loss of Hearing as defined in the definition of Loss of Hearing.
00035

MAJOR BURN

Major Burn means the Diagnosis that You or Your covered Dependents have sustained third degree burns covering at least 20% of the surface area of the body.
00036

MAJOR ORGAN TRANSPLANT

Major Organ Transplant means a Diagnosis, supported by clinical evidence of the major organ(s) failure which requires the malfunctioning organ(s) or tissue to be replaced with an organ(s) or tissue from a suitable human donor (excluding the recipient) under generally accepted medical procedures. The organs and tissues covered by this definition are limited to: liver, lung, entire heart, small intestine, pancreas or kidney. Excluded from this Covered Condition is bone marrow transplant. The Insured must be registered by the United Network of Organ Sharing (UNOS) in order for the Major Organ Transplant to be a Covered Condition under the Policy. If the Insured is determined to be too ill for a transplant, but otherwise meets the criteria for being registered by the UNOS, the registration requirement will be waived.

Only one Major Organ Transplant benefit will be paid per Insured.

The Date of Diagnosis is the date the Insured is placed on the UNOS list for transplantation or the NMDP list for marrow donation.
00037

PARALYSIS

Paralysis means the Diagnosis of loss of use without severance of a limb as a result of an Injury to the spinal cord, which has continued for 12 consecutive months. Paralysis must be determined by a Physician to be permanent, total and irreversible. Paralysis includes Hemiplegia, Quadriplegia, Paraplegia and Uniplegia.

Hemiplegia means total Paralysis of one arm and one leg on the same side of the body.

Quadriplegia means total Paralysis of both arms and both legs.

Paraplegia means total Paralysis of both legs.

Uniplegia means total Paralysis of one limb.

The Date of Diagnosis is the date the Injury occurred which caused Paralysis continuing for a period of 12 consecutive months as confirmed by the attending Physician, or immediately if the spinal cord is completely and irreparably transected.
00039

SEVERE COVID-19 INFECTION

Severe COVID-19 Infection means the *Diagnosis* of the *COVID-19* strain of the Human Coronavirus, also known as 2019-nCoV.

Diagnosis means a clinically approved, positive medical test confirmed by a *Physician* showing positive for *COVID-19* and a *Physician* recommends confinement in an Intensive Care Unit and placement on a ventilator due to abnormal oxygen levels in the lungs.

The *Date of Diagnosis* is the date the *Physician* recommends confinement in an Intensive Care Unit and placement on a ventilator due to the *Diagnosis* of *COVID-19*.

Intensive Care Unit means a place which:

- Is a specially designated area of the hospital called an Intensive Care Unit that provides the highest level of medical care and is restricted to patients who are critically ill or injured and who require intensive comprehensive observation and care; and
- Is separate and apart from the surgical recovery room and from rooms, beds, and wards customarily used for patient confinement; and
- Is permanently equipped with special lifesaving equipment for the care of the critically ill or injured; and
- Is under constant and continuous observation by a specially trained nursing staff assigned exclusively to the Intensive Care Unit on a 24-hour basis; and
- Has a Physician assigned to the Intensive Care Unit on a full-time basis.

An Intensive Care Unit is not a progressive care unit, an intermediate care unit, a private monitored room, sub-acute Intensive Care Unit, an observation unit or any facility not meeting the definition of an Intensive Care Unit as defined above.

An Intensive Care Unit that meets the definition above includes hospital units with the following names:

- Intensive Care Unit;

- Coronary Care Unit;

- Neonatal Intensive Care Unit;

- Pulmonary Care Unit;

- Burn Unit; or

- Transplant Unit.

00090 rev.0920

STROKE

Stroke means the Diagnosis of an acute cerebrovascular accident producing neurological impairment, resulting in Paralysis or other measurable objective neurological deficit persisting for at least 96 hours and expected to be permanent, and characterized as Score 3 or higher on the Modified Rankin Scale. Transient ischemic attack (mini-stroke), head Injury, chronic cerebrovascular insufficiency and reversible ischemic neurological deficits are excluded under this Covered Condition.

The Diagnosis must be made by a Physician board-certified as a neurologist.

In the event of death, an autopsy confirmation and/or death certificate identifying Stroke as the cause of death will be accepted.

The Date of Diagnosis is the date a Stroke occurred based on neuroimaging consistent with an acute or subacute abnormality or other neurodiagnostic study and presence of neurological deficits persisting for a period of 30 days or greater.

00040

CARCINOMA IN SITU

Carcinoma in situ means the *Diagnosis* of cancer where the tumor cells still lie within the tissue of origin without having invaded neighboring tissue. *Carcinoma in situ* includes melanoma not invading the dermis.

Carcinoma in situ does not include:

a. Non-malignant or pre-malignant lesions (such as intraepithelial neoplasia); or

b. Benign tumors or polyps.

Carcinoma in situ must be *Diagnosed* pursuant to a *Pathological Diagnosis* or *Clinical Diagnosis.*

Clinical Diagnosis means a *Diagnosis of Carcinoma* in situ based on the study of symptoms and diagnostic test results. *We* will accept a Clinical *Diagnosis* of *Carcinoma* in situ only if the following conditions are met:

a. A *Pathological Diagnosis* cannot be made because it is medically inappropriate or is life threatening;

b. There is medical evidence to support the *Diagnosis*, and

c. A *Physician* is treating the *Insured* for *Carcinoma in situ*.

Pathological Diagnosis means a *Diagnosis* of *Carcinoma in situ* based on a microscopic study of fixed tissue or preparations from the hemic (blood) system. This type of *Diagnosis* must be done by a *Physician* who is a board-certified pathologist and whose *Diagnosis*of malignancy conforms to the standards set by the American College of Pathology.

The *Date of Diagnosis* is the date the tissue specimen, blood samples and/or titer(s) are taken on which the *Diagnosis* of *Carcinoma in situ* is based. If a *Pathological Diagnosis* cannot be made because it is medically inappropriate or life-threatening, *We* will accept a *Clinical Diagnosis.*

00042

INVASIVE CANCER

Invasive Cancer means a Diagnosis of malignant neoplasm which is characterized by the uncontrolled growth and spread of malignant cells and the invasion of tissue, and which is not specifically otherwise excluded. Leukemias and lymphomas are included.

The following are not considered Invasive Cancer:

a. Non-malignant, noninvasive, dysplasia (all grades), or pre-malignant lesions (such as intraepithelial neoplasia); or

b. Benign tumors or polyps; or

c. Carcinoma in situ; or

d. Any Skin Cancer (other than invasive malignant melanoma in the dermis or deeper or skin malignancies that have become metastatic).

Invasive Cancer must be Diagnosed pursuant to a Pathological Diagnosis. If a Pathological Diagnosis is not possible, Diagnosis can be made pursuant to a Clinical Diagnosis.

The Date of Diagnosis is the date the tissue specimen, blood samples and/or titer(s) are taken on which the Diagnosis of Cancer is based. If a Pathological Diagnosis cannot be made because it is medically inappropriate or life-threatening, We will accept a Clinical Diagnosis.

Clinical Diagnosis means a Diagnosis of Invasive Cancer based on the study of symptoms and diagnostic test results. We will accept a Clinical Diagnosis of Invasive Cancer only if the following conditions are met:

a. A Pathological Diagnosis cannot be made because it is medically inappropriate or is life threatening;

b. There is medical evidence to support the Diagnosis, and

c. A Physician is treating the Insured for Invasive Cancer.

Pathological Diagnosis means a Diagnosis of Invasive Cancer based on a microscopic study of fixed tissue or preparations from the hemic (blood) system. This type of Diagnosis must be done by a Physician who is a board-certified pathologist and whose Diagnosis of malignancy conforms to the standards set by the American College of Pathology.

00043

WELLNESS BENEFIT

What is the Wellness Benefit?

If, while insured under the Policy, You or Your covered Dependent Spouse undergo any of the Wellness Tests indicated below, We will pay the amount as set forth in the Schedule of Benefits.

Wellness Tests include:

- Blood test for triglycerides;
- Bone marrow aspiration or biopsy;
- CA 15-3 (blood test for breast cancer);

- CA-125 (blood test for ovarian cancer);
- CEA (blood test for colon cancer);
- Carotid Doppler;
- Chest x-ray;
- Colonoscopy;
- COVID-19 screening;
- Echocardiogram;
- Electrocardiogram;
- Fasting blood glucose test;
- Fasting plasma glucose (FPG);
- Flexible sigmoidoscopy;
- Hemoglobin A1C (HbA1c);
- Hemocult stool analysis;
- Mammography;
- Pap smear;
- PSA (blood test for prostate cancer);
- Serum cholesterol test to determine HDL and LDL levels;
- Serum protein electrophoresis (blood test for myeloma);
- Skin cancer biopsy;
- Stress test on a bicycle or treadmill;
- Thermography;
- Thin prep pap test;
- Two hour post-load plasma glucose; or
- Virtual colonoscopy.

The Wellness Benefit is payable once per Calendar Year for each insured Employee and covered Dependent Spouse.

For the purposes of the Wellness Benefit**,** Calendar Year is the period beginning January 1st and ending December 31st.

The Wellness Tests must be performed while the Insured's coverage under the Policy is in force. Proof must be provided that the test was performed and the Insured incurred an expense.
00050a rev.0920

RECURRENCE BENEFIT

Which Conditions are eligible for a Recurrence Benefit?

The Recurrence Benefit is available for a Diagnosis of a Recurrence of the following Covered Conditions:

- Stroke
- Benign Brain Tumor
- Coma
- Heart Attack
- Invasive Cancer

Recurrence means a Recurrence of the same condition after being treatment free for 12 months from the original payment of the Covered Condition. The Recurrence Benefit can only be paid one time per Covered Condition.
00051

GENERAL PROVISIONS

Entire Contract; Changes

The Policy, the Policyholder's Application, the Employee's Certificate of coverage, and Your application, if any, and any other attached papers, form the entire contract between the parties. Coverage under the Policy can be amended by mutual consent between the Policyholder and Us. No change in the Policy is valid unless approved in writing by one of Our executive officers and unless such approval is endorsed hereon or attached hereto. No agent has the right to change the Policy or to waive any of its provisions.

Statements on the Application

In the absence of fraud, all statements made in any signed application are considered representations and not warranties (absolute guarantees). No representation by:

1. the Policyholder in applying for the Policy will make it void unless the representation is contained in his signed Application; or
2. any Employee in applying for insurance under the Policy will be used to reduce or deny a claim unless a copy of the application for insurance, signed by the Employee, is or has been given to the Employee.

Legal Actions

Unless otherwise provided by federal law, no legal action of any kind may be filed against Us:

1. until 60 days after Proof has been given; or
2. more than 3 years after Proof must be filed, unless the law in the state where You live allows a longer period of time.

Clerical Error

Clerical error or omission by Us to the Policyholder will not:

1. Prevent You from receiving coverage, if You are entitled to coverage under the terms of the Policy; or
2. Cause coverage to begin or coverage to continue for You when the coverage would not otherwise be effective.

If the Policyholder gives Us information about You that is incorrect, We will:

1. Use the facts to decide whether You have coverage under the Policy and in what amounts; and
2. Make a fair adjustment of the premium.

Time Limit on Certain Defenses

The validity of the Policy shall not be contested, except for non-payment of premiums, after it has been in force for two years from the date of issue. The validity of the Policy shall not be contested on the basis of a statement made relating to insurability by any person covered under the Policy after such insurance has been in force for two years during such person's lifetime, and shall not be contested unless the statement is contained in a written instrument signed by the person making such statement.

Premium Provisions

Premiums are payable in United States dollars on or before their due dates. The Policyholder has agreed to deduct from Your pay any premiums payable for Your Voluntary/Supplemental coverage. The Policyholder agrees to remit such premiums for the entire time coverage under the Policy is in effect.
Premium charges for increases in insurance amounts becoming effective during a Policy month will begin on the next premium due date. Premium charges for insurance terminating during a Policy month will cease at the end of the month in which such insurance terminates. This method of charging premium is for accounting purposes only. It will not extend any insurance coverage beyond the date it would otherwise have terminated.

Misstatement of Age

If You have misstated Your age or the age of a Dependent, the true age will be used to determine:

1. the effective date or termination date of insurance; and
2. the amount of insurance; and
3. any other rights or benefits.

Premiums will be adjusted to reflect the premiums that would have been paid if the true age had been known.

Conformity with State Statutes and Regulations

Any provision of the Policy which, on its effective date, conflicts with the statutes and regulations of the state in which the Policy was issued, it is automatically changed to meet the minimum requirements of such statutes.
00052 TX

UNIFORM CLAIM PROVISIONS

Initial Notice of Claim

We must receive written notice of Loss within 30 days of the date of Loss, or as soon as reasonably possible. The Policyholder can assist with the appropriate telephone number and address of Our Claim Department. Notice may be sent to Our Claim Department at the address shown on the claim form or given to any authorized agent of Ours.

Claim Forms

Within 15 days of Our being notified in writing of a claim, We will supply the claimant with the necessary claim forms. The claim form is to be completed and signed by the claimant, the Policyholder and the claimant's Physician. If the appropriate claim forms are not received within 15 days, then the claimant will be considered to have met the requirements for written Proof of loss if We receive written Proof, which describes the occurrence, extent and nature of the Loss.

Time Limit for Filing Your Claim

We must receive written Proof within 90 days after the date a Loss is incurred. If it is not possible to give Us written Proof within 90 days, the claim is not affected if the Proof is given as soon as possible. However, unless the claimant is legally incapacitated, written Proof of loss must be given no later than one year after the time Proof is otherwise due.

No benefits are payable for claims submitted more than 1 year after the time Proof is due. However, benefits may be paid if it can be shown that:

1. It was not reasonably possible to give written Proof during the one year period, and
2. Proof satisfactory to Us was given as soon as was reasonably possible.

We will give You written response to Your claim, usually within 45 days. The time for decision may be extended for two additional 30 day periods provided that, prior to any extension period, We notify You in writing that an extension is necessary due to matters beyond Our control, identify those matters and gives the date by which We expect to render a decision. If the extension is due to Your failure to submit information necessary to decide Your claim, the time for decision shall be tolled from the date on which We send You notice of the extension until the date We receive Your response to Our request. This period will be no longer than 45 days after We have requested the information. At that time We will decide Your claim based on the information We have at that time.

Physical Examination/Autopsy

On receipt of a claim, We may have an Insured examined, at Our expense, at any reasonable time. We may have an autopsy performed, at Our expense, if it is not prohibited by any applicable local law(s).

Who will receive Your Specified Disease Insurance Benefits?

Specified Disease Insurance benefits are payable to You unless such benefits have been assigned. The Policyholder may not be named as beneficiary. In the event of Your death prior to Specified Disease Insurance benefits being paid, benefits will be paid according to the Facility of Payment provision.

Facility of Payment

If no named beneficiary survives You or if You do not name a beneficiary, We will pay the amount of insurance:

1. to Your Spouse, if living; if not,
2. in equal shares to Your then living natural or legally adopted children, if any; if none,
3. in equal shares to Your father and mother, if living; if not,
4. in equal shares to Your brothers and/or sisters, if living; if not,
5. to Your estate.

00053

Do I have the Right to Appeal a Claim Denial?

If Your claim is denied, in whole or in part, You will receive a written notice giving the following:

- the reason or reasons for the denial;
- the Policy provisions on which the denial is based;
- an explanation of what other material or information, if any, may be needed to process the claim and why it is needed;
- the steps that You have to follow to have the claim reviewed;
- a statement that You have the right to bring a civil action under section 502(a) of ERISA after You appeal Our decision and after You receive a written denial on appeal; and
- if an internal rule, guideline, protocol, or other similar criterion was relied upon in making the denial, either (i) the specific rule, guideline, protocol or other similar criterion; or (ii) a statement that such a rule, guideline, protocol or other similar criterion was relied upon in making the denial and that a copy will be provided free of charge to You upon request; and
- if denial is based on medical judgment, either (i) an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to Your medical circumstances, or (ii) a statement that such explanation will be provided to You free of charge upon request.

If the claim has been denied, in whole or in part, You can appeal the denial to Us for a full and fair review. You have at least 180 days to appeal from the claim denial.

You may:

a. request a review upon written application within 180 days of the claim denial;
b. request, free of charge, copies of all documents, records and other information relevant to Your claim; and
c. submit written comments, documents, records and other information relating to Your claim, without regard to whether such information was submitted or considered in the initial benefit determination.

We will make a decision no more than 45 days after We receive Your appeal. The time for decision may be extended for one additional 45 day period provided that, prior to the extension, We notify You in writing that an extension is necessary due to special circumstances, identifies those circumstances and gives the date by which it expects to render its decision. If Your claim is extended due to Your failure to submit information necessary to decide Your claim on appeal, the time for Your decision shall be tolled from the date on which the notification of the extension is sent to You until the date We receive Your response to the request.

The decision on appeal will provide the following:

- the reason or reasons for the decision;
- the Plan provision on which the decision is based;
- a statement that You are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to Your claim for benefits;
- a statement of the claimant’s right to bring an action under section 502(a) of ERISA;
- if an internal rule, guideline, protocol, or other similar criterion was relied upon in making the decision either (i) the specific rule, guideline, protocol or other similar criterion; or (ii) a statement that such a rule, guideline, protocol or other similar criterion was relied upon in making the decision and that a copy will be provided free of charge to You upon request;
- if the decision is based on medical judgment, either (i) an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to Your medical circumstances, or (ii) a statement that such explanation will be provided to You free of charge upon request; and
- the following statement: “You and Your plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact Your local U.S. Department of Labor Office and Your State insurance regulatory agency.”

00054

GENERAL DEFINITIONS

Accident or ***Accidental*** means a sudden, unexpected event that was not reasonably foreseeable.
00055

Actively at Work or Active Work means that *You* must:

1. work for the *Policyholder* on a full-time active basis; or
2. work at least the minimum number of hours set forth in the Schedule of Benefits: and either:
   a. work at the *Policyholder's* usual place of business; or
   b. work at a location to which the *Policyholder's* business requires *You* to travel; and
3. not be a temporary or seasonal *Employee;* and
4. be paid regular earnings by the *Policyholder*.

You will be considered *Actively at Work* if *You* were actually at work on the day immediately preceding:

1. a weekend (except for one or both of these days if they are scheduled days of work);
2. holidays (except when such holiday is a scheduled work day);
3. paid vacations;
4. any non-scheduled work day;
5. excused leave of absence (except medical leave and lay-off); or
6. emergency leave of absence (except emergency medical leave); and

You were not *Hospital Confined* or disabled due to an *Injury* or *Illness.*
00056

Application means the document which sets forth the eligible classes, the amounts of insurance, and other relevant information pertaining to the plan of insurance for which the *Policyholder* applied.
00057

Certificate means this Specified Disease Insurance Certificate.
00059

Change in Family Status means a change in status as defined in the regulations under Internal Revenue Code section 125, unless *Your* employer's cafeteria plan document or human resource *Policy* contains more restrictive provisions. In that event, *Your* employer may restrict the situations where *You* can change *Your* coverage.
00060

Contributory means *You* pay all or a portion of the premium for this insurance coverage.
00061

Covered Conditions means an *Illness* or *Injury* listed in the *Covered Conditions* Schedule.
00062

Date of Diagnosis means the date the *Diagnosis* is made by a *Physician* through the use of clinical and/or laboratory findings as supported by *Your or Your* covered *Dependents* medical records. *Date of Diagnosis* may be further defined for a specific *Covered Condition*; if so, that definition will control over this definition.
00063

Dependent or Eligible Dependent means:

1. Your lawful Spouse or domestic partner; and/or
2. Your unmarried child(ren) who are less than age 26 and are not in active military service.

Eligible Dependents include:

1. Your natural or step child.
2. a child placed with You for adoption from the date of placement or the date You are party in a suit in which You seek the adoption of the child. Eligibility will continue unless the child is removed from placement.
3. a child of Your child who is Your Dependent for federal income tax purposes at the time application for coverage of the child of Your child is made.

00064 TX

Diagnosis/Diagnosed means the definitive establishment of a *Covered Condition* by a *Physician.*
00065

Employee* or *Eligible Employee means an *Actively at Work*, full-time *Employee* as shown in the Schedule of Benefits whose principal employment is with the *Policyholder*, at the *Policyholder's* usual place of business or such place(s) that the *Policyholder's* normal course of business may require, and who is reported on the *Policyholder's* records for Social Security and withholding tax purposes.
00066

Illness means sickness, disease, pregnancy or complications of pregnancy.
00067

Initial Diagnosis means *You* or Your covered Dependents have never been *Diagnosed* with a specific condition or undergone a specific procedure shown in the *Covered Conditions* Schedule.
00068

Injury means bodily harm resulting directly from an *Accident* and independently of all other causes.
00069

Insured means an Employee or Eligible Dependent covered under the Policy.
00070

Male Pronoun whenever used includes the female.
00071

Material and Substantial Duties means duties that are normally required for the performance of Your Regular Occupation and cannot be reasonably omitted or modified.
00072

Physician means a person other than You or Your covered Dependent, a member of Your or Your covered Dependents' immediate family or Your or Your covered Dependents' business associate, who is licensed to and actively practicing medicine in the United States, and is licensed to treat Illness and Injury. The Physician must be providing services within the scope of his license and must be a board certified specialist where required under the terms of a Covered Condition.
00077

Policy means the contract between the Policyholder and Us including the Application, this Certificate and any amendments, riders or endorsements.
00078

Policyholder means the person, firm, or institution to whom the Policy was issued. Policyholder also means any covered subsidiaries or affiliates set forth on the face of the Policy. If the Policyholder is an association the term Participating Employer shall be substituted for Policyholder.
00079

Proof means evidence satisfactory to Us that You or Your covered Dependents has a Covered Condition. We reserve the right to determine, at Our sole discretion, if Proof is acceptable under the terms of the Policy.
00080

Regular Occupation means the occupation that You are routinely performing when Your Specified Disease Insurance terminates due to Disability. We will look at Your occupation as it is normally performed in the national economy, instead of how the work tasks are performed for a specific Policyholder or at a specific location.
00081

Riot means all forms of public violence, disorder, or disturbance of the public peace, by three or more persons assembled together, whether with or without a common intent and whether or not damage to person or property or unlawful act is the intent or the consequence of such disorder.
00082

Spouse means lawful Spouse. Spouse will include Your domestic partner.
00083

Voluntary means coverage for which You pay 100% of the premium.
00086

We, Our and **Us** means Dearborn Life Insurance Company.
00087

You, Your and **Yours** means the Eligible Employee to whom this Certificate is issued and whose insurance is in force under the terms of the Policy.
00088

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.

Dearborn Life Insurance Company
To get information or file a complaint with your insurance company or HMO:
Call: Regulatory Inquiry Representative at 1-630-691-0365
Toll-free: 1-877-442-4207
Email: DOIComplaintsTX@bcbstx.com
Mail: Dearborn Life Insurance Company
Regulatory Oversight & Compliance Department
701 E. 22nd Street
Lombard, IL 60148

The Texas Department of Insurance
To get help with an insurance question or file a complaint with the state:
Call: 1-800-252-3439
Online: www.tdi.texas.gov
Email:
Mail: MC 111-1A
P.O. Box 149091
Austin, TX 78714

¿Tiene una queja o necesita ayuda?

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

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

Dearborn Life Insurance Company
Para obtener información o para presentar una queja ante su compañía de seguros o HMO:
Llame a: Regulatory Inquiry Representative at 1-630-691-0365
Teléfono gratuito: 1-877-442-4207
Correo electrónico: DOIComplaintsTX@bcbstx.com
Dirección postal: Dearborn Life Insurance Company
Regulatory Oversight & Compliance Department
701 E. 22nd Street
Lombard, IL 60148

El Departamento de Seguros de Texas
Para obtener ayuda con una pregunta relacionada con los seguros o para presentar una queja ante el estado:
Llame: 1-800-252-3439
En línea: www.tdi.texas.gov
Correo electrónico: ConsumerProtection@tdi.texas.gov
Dirección postal: MC 111-1A
P.O. Box 149091
Austin, TX 78714

How you're protected if your life or health insurance company fails

The Texas Life and Health Insurance Guaranty Association protects you by paying your covered claims if your life or health insurance company is insolvent (can't pay its debts). This notice summarizes your protections.

The Association will pay your claims, with some exceptions required by law, if your company is licensed in Texas and a court has declared it insolvent. You must live in Texas when your company fails. If you don't live in Texas, you may still have some protections.

For each insolvent company, the Association will pay a person's claims only up to these dollar limits set by law:

- **Accident, accident and health, or health insurance (including HMOs):**
  - Up to $500,000 for health benefit plans, with some exceptions.
  - Up to $300,000 for disability income benefits.
  - Up to $300,000 for long-term care insurance benefits.
  - Up to $200,000 for all other types of health insurance.
- **Life insurance:**
  - Up to $100,000 in net cash surrender or withdrawal value.
  - Up to $300,000 in death benefits.

Individual annuities: Up to $250,000 in the present value of benefits, including cash surrender and net cash withdrawal values.

Other policy types: Limits for group policies, retirement plans and structured settlement annuities are in Chapter 463 of the Texas Insurance Code.

Individual aggregate limit: Up to $300,000 per person, regardless of the number of policies or contracts. A limit of $500,000 may apply for people with health benefit plans.

Parts of some policies might not be protected: For example, there is no protection for parts of a policy or contract that the insurance company doesn't guarantee, such as some additions to the value of variable life or annuity policies.

To learn more about the Association and your protections, contact:

Texas Life and Health Insurance Guaranty Association
515 Congress Avenue, Suite 1875
Austin, Texas 78701
1-800-982-6362 or www.txlifega.org

For questions about insurance, contact:

Texas Department of Insurance
P.O. Box 149104
Austin, Texas 78714-9104
1-800-252-3439 or www.tdi.texas.gov

Note: You're receiving this notice because Texas law requires your insurance company to send you a summary of your protections under the Texas Life and Health Insurance Guaranty Association Act (Insurance Code, Chapter 463). These protections apply to insolvencies that occur on or after September 1, 2019. There may be other exceptions that aren't included in this notice. When choosing an insurance company, you should not rely on the Association's coverage. Texas law prohibits companies and agents from using the Association as an inducement to buy insurance or HMO coverage.

Chapter 463 controls if there are differences between the law and this summary.

END OF CERTIFICATE

STATEMENT OF ERISA RIGHTS

As a participant in the Plan You are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974, 29 U.S.C. §1001, *et seq.*, as amended ("ERISA"). ERISA provides that all plan participants shall be entitled to:

1. Receive Information about Your Plan and Benefits

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

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

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

2. Prudent Actions by Plan Fiduciaries

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

3. Enforce Your Rights

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

   Under ERISA, there are steps You can take to enforce the above rights. For instance, if You request a copy of Plan documents or the latest annual report from the Plan and do not receive them within 30 days, You may file suit in federal court. In such case, the court may require the Plan Administrator to provide the materials and pay You up to $110 a day until You receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan 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 if, for example, it finds Your claims are frivolous.

4. Assistance with Your Questions

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

ERISA INFORMATION STATEMENT

The benefits described in your certificate are insured by a Policy ("Policy") issued by Blue Cross and Blue Shield of Texas (“We” or "Insurer"), pursuant to an "employee welfare benefit plan" (“the Plan”) as defined in Section 3(1) of the Employee Retirement Income Security Act of 1974, as amended ("ERISA"), 29 U.S.C. §1002(1), established by your employer, or where applicable, employee organization (the “Policyholder").

Every employee welfare benefit plan must be established and maintained pursuant to a written instrument that provides for a Plan Administrator. Your Plan Administrator has delegated the authority to administer claims under the Policy to the Insurer. As claims administrator, We will make decisions concerning eligibility and benefit determinations in accordance with the Policy provisions.

A. ADMINISTRATION OF THE PLAN

The Plan Administrator is the person or entity responsible for the administration of the Plan. The Plan Administrator has full discretionary authority and control over the Plan. This authority provides the Plan Administrator with the power necessary to operate, manage and administer the Plan. This authority includes, but is not limited to, the power to interpret the Plan and determine who is eligible to participate, to determine the amount of benefits that may be paid to a participant or his or her beneficiary, and the status and rights of participants and beneficiaries. The Plan Administrator also has the authority to prescribe the rules and procedures under which the Plan shall operate, to request information, and to employ or appoint persons to aid the Plan Administrator in the administration of the Plan.

Failure by the Plan or the Plan Administrator to insist upon compliance with any provisions of the Plan at any time or under any set of circumstances shall not operate to waive or modify the provision or in any manner render it unenforceable as to any other time or as to any other occurrence, whether the circumstances are or are not the same. No waiver of any term or condition of the Plan shall be valid unless contained in a written memorandum expressing the waiver and signed by the person authorized by the Plan Administrator to sign the waiver.

The Plan may be amended, terminated or suspended in whole or in part, at any time without the consent of the Employees or beneficiaries. Any amendment, termination or suspension shall be in writing, and attached to the Plan. Any amendment, termination or suspension shall be executed according to the Employer's authorized procedures. Any such authorization may be specific to the Plan or persons authorized to act on behalf of the Employer or may be general as to duties of such person. Except for termination or suspensions, any amendments affecting the Policy and/or Certificate must also be approved in writing by an officer of the Insurer and shall be effective as of the date agreed to, in writing by the Plan Sponsor and the Insurer. Notwithstanding anything to the contrary in this document, the Policy shall terminate according to the provisions in the Policy.

The Plan has other fiduciaries, advisors and service providers. The Plan Administrator may allocate fiduciary responsibility among the Plan's fiduciaries and may delegate responsibilities to others. Any allocation or delegation must be done in writing and kept with the records of the Plan. As stated above, the Plan's benefits are provided to you pursuant to an insurance Policy issued to the Company. The Insurer shall, with respect to the Policy:

- resolve all matters when a review pursuant to the claims procedures has been requested;
- interpret, establish and enforce rules and procedures for the administration of the Policy and any claim under it; and
- determine eligibility of Employees and dependents for benefits and their entitlement to and the amount of benefits.

Each fiduciary is solely responsible for its own improper acts or omissions. Except to the extent required by ERISA, no fiduciary has the duty to question whether any other fiduciary is fulfilling all of the responsibilities imposed upon the other fiduciary by law. Nor is a fiduciary liable for a breach of fiduciary duty committed before it became, or after it stopped being, a fiduciary. However, a fiduciary may be liable for a breach of fiduciary responsibility of any Plan fiduciary, to the extent provided in ERISA Section 405(a), 29 U.S.C. §1105(a). The Employer makes no promise to continue these benefits in the future and rights to future benefits will never vest. Retirement does not give any retiree any vested right to continue to participate or receive Plan benefits, except as provided in the Plan.

B. CLAIMS PROCEDURE :

When You or Your Beneficiary are eligible to receive benefits, You or Your Beneficiary, or Your authorized representative (collectively, "You") must follow the claim procedures described in Your Group Insurance Certificate by submitting the proper form in writing to the Insurer at:

Claims Department

Blue Cross and Blue Shield of Texas

701 E. 22nd Street

Lombard, IL. 60148

1-877-442-4207

For the purpose of this Section, the terms "written" and "in writing" include "electronic." Any action required to be "written" or "in writing," may be done electronically, where available. If the Insurer uses electronic notices, it will do so in accordance with 29 CFR 2520.104b-1c(i), (iii) and (iv).

Administrative Office:

701 E. 22nd Street • Lombard, Illinois 60148