

**Group Critical Illness
Insurance Certificate**

AHS Management Company, Inc. dba Ardent Health
Services

IMPORTANT NOTICES
GROUP CRITICAL ILLNESS

If you reside in one of the following states, please read the important notice applicable to you.

Arizona residents:

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

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.

REVIEW THIS CERTIFICATE CAREFULLY. IF YOU ARE 65 OR OLDER ON THE EFFECTIVE DATE OF THIS CERTIFICATE, YOU MAY RETURN IT TO US WITHIN 30 DAYS FROM THE DATE YOU RECEIVE IT AND WE WILL REFUND ANY PREMIUM YOU PAID. IN THIS CASE, THIS CERTIFICATE WILL BE CONSIDERED TO NEVER HAVE BEEN ISSUED.

Florida residents:

The benefits of the policy providing Your coverage are governed primarily by the laws of a state other than Florida.

To make an inquiry, obtain information about your coverage or to resolve a complaint call 1-800-547-5515.

Idaho residents:

30 Day Right To Examine Policy

If a Covered Person does not like the Policy for any reason, it may be returned to Us within 30 days after receipt. We will return any premium that has been paid and the Policy will be void as if it had never been issued.

THIS COVERAGE IS NOT GUARANTEED RENEWABLE

IMPORTANT CANCELLATION INFORMATION – PLEASE READ “POLICY TERMINATION” PROVISION IN THE GENERAL PROVISIONS SECTION

THIS POLICY IS RENEWABLE AT THE OPTION OF THE POLICYHOLDER AND/OR US

Louisiana residents:

THIS CERTIFICATE DOES NOT CONSTITUTE COMPREHENSIVE HEALTH INSURANCE COVERAGE. THIS COVERAGE DOES NOT SATISFY THE INDIVIDUAL MANDATE OF THE AFFORDABLE CARE ACT (ACA).

Maryland residents:

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

Nevada residents:

THIS CERTIFICATE DOES NOT CONSTITUTE COMPREHENSIVE HEALTH INSURANCE COVERAGE. THIS COVERAGE DOES NOT SATISFY THE INDIVIDUAL MANDATE OF THE AFFORDABLE CARE ACT (ACA).

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 law.

THIS CERTIFICATE IS NOT A MEDICARE SUPPLEMENT CERTIFICATE. IF YOU ARE ELIGIBLE FOR MEDICARE, REVIEW THE GUIDE TO HEALTH INSURANCE FOR PEOPLE WITH MEDICARE, WHICH IS AVAILABLE FROM LIFE INSURANCE COMPANY OF NORTH AMERICA.

The Policy is a legal contract between the Policyholder and Us.

**THIS IS A CRITICAL ILLNESS ONLY POLICY.
BENEFITS PROVIDED ARE NOT INTENDED TO COVER ALL MEDICAL EXPENSES**

IMPORTANT CANCELLATION INFORMATION – PLEASE READ "POLICY TERMINATION" PROVISION IN YOUR CERTIFICATE OF INSURANCE

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.

Utah residents:

NOTICE TO BUYER:

This is a specified disease Policy. This Policy provides limited benefits. Benefits provided are supplemental and are not intended to cover all medical expenses. Read your Policy carefully with the Outline of Coverage and the Buyer's Guide.

Vermont residents:

IN THE EVENT OF A CONFLICT BETWEEN THE LAWS OF THE STATE WHERE THE POLICY IS ISSUED AND THE LAWS OF VERMONT, THE LAWS OF VERMONT WILL CONTROL.

THIS POLICY DOES NOT MEET THE MINIMUM COVERAGE REQUIREMENTS OF THE AFFORDABLE CARE ACT. YOU SHOULD NOT PURCHASE THIS POLICY UNLESS YOU ARE ALREADY COVERED BY COMPREHENSIVE MAJOR MEDICAL INSURANCE.

Life Insurance Company of North America
1601 Chestnut Street, Philadelphia, Pennsylvania 19192-2235
A Stock Insurance Company

GROUP CRITICAL ILLNESS CERTIFICATE

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

We, the Life Insurance Company of North America, have issued a Group Policy, CI961234 to Trustee of the Group Insurance Trust for Employers in the Services Industry.

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

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

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



William J. Smith, President

30 DAY RIGHT TO EXAMINE CERTIFICATE

Within 30 days of receipt of this Certificate, You can return it to Us for any reason if not satisfied with the insurance provided under this Certificate. We will return any premium that has been paid and this Certificate will be void as if it had never been issued.

**THIS IS A CRITICAL ILLNESS ONLY POLICY.
BENEFITS PROVIDED ARE NOT INTENDED TO COVER ALL MEDICAL EXPENSES.**

Series 2.1

GCI-02-CE1000.00

TABLE OF CONTENTS

SECTION	PAGE NUMBER
SCHEDULE OF BENEFITS	1
SCHEDULE OF BENEFITS FOR CLASS 1.....	2
DESCRIPTION OF COVERAGES AND BENEFITS	6
GENERAL DEFINITIONS.....	8
ELIGIBILITY	19
ENROLLMENT.....	20
EFFECTIVE DATE PROVISIONS.....	20
DEFERRED EFFECTIVE DATE PROVISIONS	21
TERMINATION OF INSURANCE	22
CONTINUATION OF COVERAGE PROVISIONS.....	23
PORTABILITY PROVISIONS	23
EXCLUSIONS	25
CLAIM PROVISIONS.....	26
ADMINISTRATIVE PROVISIONS	28
GENERAL PROVISIONS.....	29
HEALTH SCREENING TEST BENEFIT RIDER.....	31
DOMESTIC PARTNER/CIVIL UNION PARTNER RIDER	33
MODIFYING PROVISIONS AMENDMENT	35

GCI-02-CE1000.00

SCHEDULE OF BENEFITS

The Schedule of Benefits provides a brief outline of the coverage and benefits including the maximum benefit amount, benefit periods, and any limitations applicable to benefits provided in this Policy for each Covered Person, unless otherwise indicated.

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

Covered Classes:

Class 1	All active, Full-time and Part-time Employees of the Employer who are regularly working in the United States a minimum of 20 hours per week and regularly residing in the United States and who are United States citizens or permanent resident aliens and their Spouse and Dependent Children who are United States citizens or permanent resident aliens and who are residing in the United States.
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The following pages contain a Schedule of Benefits for each class of eligible Employees. For an explanation of these benefits, please see the *Description of Benefits* section.

GCI-02-1100.00

SCHEDULE OF BENEFITS FOR CLASS 1

Subscriber: AHS Management Company, Inc. dba Ardent Health Services

Effective Date of Subscriber: January 01, 2020

Minimum Subscriber Participation Requirements:

10% of eligible Employees or 10 enrolled Employees, whichever is greater

Eligibility Waiting Period:

First of month coincident with or next following 30 days from date of hire or Active Service. Credit will be given for the period of time of Active Service before the Policy effective date.

Rehire:

If the Employee's employment ends and He is rehired within 12 months, His Eligibility Waiting Period will be first of the month following date of rehire. All other Policy provisions apply.

Maximum Lifetime Limits per Covered Person:

Total Critical Illness Benefits payable: *The lesser of 5 times the elected Benefit Amount or \$150,000.*

CRITICAL ILLNESS BENEFITS FOR EMPLOYEE

All Employee benefits are payable as shown for the Eligible Employee.

EMPLOYEE BENEFITS

Critical Illness Benefit

Benefit Type	Benefit Amount
Voluntary Critical Illness Coverage	
Initial Benefit Amounts	\$10,000, \$20,000, \$30,000
Maximum Benefit	\$30,000

New Enrollees

Guaranteed Issue Amount	
Initial Group Enrollment	\$30,000
Annual Group Enrollment	\$30,000
Life Status Change	\$30,000
New Hire	\$30,000

Current Insureds

Guaranteed Issue Amount	
Annual Group Enrollment	\$30,000
Life Status Change	\$30,000

Benefit Waiting Period: None

CONTINUATION OPTION(S):

Applicable Coverage(s)

Critical Illness Benefits and Optional Benefits for the Employee, His Spouse and Dependent Child(ren)

For Family Medical Leave
Maximum Benefit Period

the later of the period of the approved FMLA leave or the leave period required by law in the state in which the Employee is employed

For Leave of Absence
Maximum Benefit Period

up to 26 weeks

Portability

Maximum Port Age
Portable Period
Amount of Portable Coverage
Coverage(s) that may be ported
Benefit(s) that may be ported

100 as of the date of porting
Coverage continues to age 100
100% of inforce coverage amount
Employee
All Voluntary Critical Illness Coverage and Optional Benefits

CRITICAL ILLNESS BENEFITS FOR SPOUSE

**SPOUSE BENEFITS
Critical Illness Benefit**

Benefit Type	Benefit Amount
Voluntary Critical Illness Coverage	
Benefit Amount	50% of Employee Benefit Amount
Maximum Benefit	\$15,000
New Enrollees	
Guaranteed Issue Amount	
Initial Group Enrollment	\$15,000
Annual Group Enrollment	\$15,000
Life Status Change	\$15,000
New Hire	\$15,000
Current Insureds	
Guaranteed Issue Amount	
Annual Group Enrollment	\$15,000
Life Status Change	\$15,000
Benefit Waiting Period:	None
Portability	
Maximum Port Age	100 as of the date of porting
Portable Period	Coverage continues to age 100
Amount of Portable Coverage	100% of inforce coverage amount
Coverage(s) that may be ported	Spouse
Benefit(s) that may be ported	All Voluntary Critical Illness Coverage and Optional Benefits

CRITICAL ILLNESS BENEFITS FOR DEPENDENT CHILD(REN)

DEPENDENT CHILD(REN) BENEFITS

Critical Illness Benefit

Benefit Type	Benefit Amount
Voluntary Critical Illness Coverage	
Benefit Amount	25% of Employee Benefit Amount
Maximum Benefit:	\$7,500
New Enrollees	
Guaranteed Issue Amount	
Initial Group Enrollment	\$7,500
Annual Group Enrollment	\$7,500
Life Status Change	\$7,500
New Hire	\$7,500
Current Insureds	
Guaranteed Issue Amount	
Annual Group Enrollment	\$7,500
Life Status Change	\$7,500
Benefit Waiting Period:	None
Portability	
Maximum Port Age	26 as of the date of porting
Portable Period	Coverage continues to age 26
Amount of Portable Coverage	100% of inforce coverage amount
Coverage(s) that may be ported	Dependent Child
Benefit(s) that may be ported	All Voluntary Critical Illness Coverage and Optional Benefits

CRITICAL ILLNESS COVERAGE - LIST OF COVERED CONDITIONS

<u>Cancer Conditions</u>	<u>% of Initial Benefit Amount</u>	<u>Recurrence % of Initial Benefit Amount</u>
Invasive Cancer	100%	100%
Carcinoma In Situ	25%	25%
	<u>Benefit Amount</u>	
Skin Cancer	\$250 1x per lifetime	Not Available
<u>Vascular Conditions</u>	<u>% of Initial Benefit Amount</u>	<u>Recurrence % of Initial Benefit Amount</u>
Heart Attack	100%	100%
Stroke	100%	100%
Coronary Artery Disease	25%	25%
<u>Nervous System Conditions</u>	<u>% of Initial Benefit Amount</u>	<u>Recurrence % of Initial Benefit Amount</u>
Advanced Alzheimer's Disease	25%	Not Available
Amyotrophic Lateral Sclerosis (ALS)	25%	Not Available
Parkinson's Disease	25%	Not Available
Multiple Sclerosis	25%	Not Available

<u>Other Specified Conditions</u>	<u>% of Initial Benefit Amount</u>	<u>Recurrence % of Initial Benefit Amount</u>
Benign Brain Tumor	100%	100%
Blindness	100%	Not Available
Coma	25%	25%
End-Stage Renal (Kidney) Disease	100%	100%
Major Organ Failure	100%	100%
Paralysis	100%	100%
<u>Occupational Conditions</u>	<u>% of Initial Benefit Amount</u>	<u>Recurrence % of Initial Benefit Amount</u>
Occupational Hepatitis-B	100%	100%
Occupational Hepatitis-C	100%	100%
Occupational HIV	100%	100%

OPTIONAL BENEFITS

HEALTH SCREENING TEST BENEFIT RIDER

All Employee benefits under this Rider are payable at 100% of the Benefit Amount shown for the Eligible Employee.
 All Spouse benefits are payable at 100% of the Benefit Amount shown for the Employee.
 All Dependent Child(ren) benefits are payable at 100% of the Benefit Amount shown for the Employee.

PREMIUM INFORMATION

INITIAL PREMIUM

Premium: Refer to your Schedule of Rates
 Contribution(s): The cost of coverage is paid by the Employee

PREMIUM DUE DATES

The Policy Effective Date and the first day of each succeeding modal period.

Premium rates are subject to change in accordance with the Changes in Premium Rates provision of the *Administrative Provisions* section of this Policy. An Employee's premium is based on His Age and will increase on the Policy Anniversary Date after the Employee enters a new Age bracket.

GCI-02-1100.00

DESCRIPTION OF COVERAGES AND BENEFITS

This Description of Coverages and Benefits Section describes the Critical Illness Coverages and Benefits provided by this Policy. Benefit amounts, benefit periods and any applicable benefit maximums are shown in the *Schedule of Benefits* and may be subject to a Benefit Waiting Period and/or an Elimination Waiting Period before benefits can be paid. The Benefit Amounts shown in the *Schedule of Benefits* will be paid regardless of the actual expenses incurred. Certain words capitalized in the text of these descriptions have special meanings within this Policy and are defined in the *General Definitions* section. Please read these and the *Common Exclusions* sections in order to understand all of the terms, conditions and limitations applicable to these coverages and benefits.

INITIAL CRITICAL ILLNESS BENEFIT

We will pay the Initial Critical Illness Benefit to a Covered Person for the Covered Conditions shown in the *Schedule of Benefits* that are diagnosed while coverage is in force, subject to the conditions and limitations set forth below, and the terms, conditions, limitations and exclusions applicable to all coverage under the Policy.

Initial Critical Illness Benefit Amount

The amount of the Initial Critical Illness Benefit is the Initial Benefit Amount shown in the *Schedule of Benefits*. The amount payable per Covered Condition is the Initial Benefit Amount multiplied by the applicable percentage for the diagnosis of the Covered Condition shown in the *Schedule of Benefits*.

Benefit Conditions

The Initial Critical Illness Benefit will only be payable if:

1. The Date of Diagnosis occurs after the Benefit Waiting Period, if applicable;
2. The Date of Diagnosis occurs while the Covered Person's coverage under this Policy is in force;
3. The Critical Illness is a different Covered Condition than any of the Covered Conditions for which an Initial Critical Illness Benefit has been paid;
4. The Date of Diagnosis for the Covered Condition occurs more than 180 days after the Date of Diagnosis for which the last Initial Critical Illness Benefit was paid;
5. The Covered Condition satisfies the Definition in the Policy.

Benefit Limitations

These limitations apply to payments under the Initial Critical Illness Benefit:

1. No more than one Initial Critical Illness Benefit payment will be made regardless of percentage for each Covered Condition shown in the *Schedule of Benefits*;
2. No more than one Initial Critical Illness Benefit will be paid per Covered Condition per Covered Person;
3. The Skin Cancer Benefit is not payable as an Initial Critical Illness Benefit.

RECURRENCE CRITICAL ILLNESS BENEFIT

We will pay the Recurrence Critical Illness Benefit to a Covered Person when diagnosed with the Recurrence of an eligible Covered Condition shown in the *Schedule of Benefits* while coverage is in force, subject to the conditions and limitations set forth below, and the terms, conditions, limitations and exclusions applicable to all coverage under the Policy.

Recurrence Critical Illness Benefit Amount

The amount of the Recurrence Critical Illness Benefit payable per Covered Condition is the Initial Benefit Amount shown in the *Schedule of Benefits* multiplied by the applicable Recurrence percentage for each Recurrence diagnosis also shown on the *Schedule of Benefits*.

Benefit Conditions

The Recurrence Critical Illness Benefit will only be payable if:

1. The Date of Diagnosis occurs while the Covered Person's coverage under this Policy is in force;
2. The Covered Condition satisfies the Definition in the Policy;
3. The Covered Condition is the same as a Covered Condition for which an Initial Critical Illness Benefit has been paid;
4. Except for Invasive Cancer, the Date of Diagnosis for the same Covered Condition occurs more than 12 months after the Date of Diagnosis for which an Initial Critical Illness Benefit was paid; and

5. For Invasive Cancer the Covered Person has not received treatment for the Covered Condition during the 12 month period between the two Dates of Diagnosis. As used herein, "treatment" does not include medications and follow-up visits to the Covered Person's Physician.

"Medications" means any form of pharmacotherapy which is primarily used to improve or maintain general physical condition or health, or which is used for routine, long term, or maintenance care that is provided after the resolution of the acute medical problem and where the pharmacotherapy is not expected itself to provide significant therapeutic improvement.

Benefit Limitations

These limitations apply to payments under the Recurrence Critical Illness Benefit:

1. In no event will benefits be paid under the Recurrence Critical Illness Benefit for Major Organ Failure for an Organ for which a benefit was previously paid.

SKIN CANCER BENEFIT

We will pay the Skin Cancer Benefit to a Covered Person as shown in the *Schedule of Benefits* that is diagnosed while coverage is in force, subject to the conditions and limitations set forth below, and the terms, conditions, limitations and exclusions applicable to all coverage under the Policy.

Skin Cancer Benefit Amount

The amount payable for Skin Cancer is the Skin Cancer Benefit Amount shown in the *Schedule of Benefits*.

The Skin Cancer Benefit will not reduce the Initial Critical Illness Benefit Amount(s) available.

If a separate Skin Cancer Benefit Amount is available under the Policy, as shown in the *Schedule of Benefits*, such benefit shall be subject to the *Benefit Conditions* and *Benefit Limitations* as provided below.

Benefit Conditions

The Skin Cancer Benefit will only be payable if:

1. The Date of Diagnosis occurs after the Benefit Waiting Period, if applicable;
2. The Date of Diagnosis occurs while the Covered Person's coverage under this Policy is in force; and
3. The Covered Condition satisfies the Definition in the Policy.

Benefit Limitations

These limitations apply to payments under the Skin Cancer Benefit:

1. No more than 1 Skin Cancer Benefit(s) will be paid per Covered Person.

GCI-02-1200.00

GENERAL DEFINITIONS

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

Active Service

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

1. one of the Employer's scheduled work days on which the Employee is performing His regular duties on a Full-time basis, either at one of the Employer's usual places of business or at some other location to which the Employer's business requires the Employee to travel; or
2. a scheduled holiday or holiday period, vacation day or period of Employer-approved paid leave of absence, other than disability or sick leave after 7 days, only if the Employee was in Active Service on the preceding scheduled workday.

A Covered Person is not considered in Active Service if He is:

1. Inpatient in a Hospital, receiving hospice or confined in a rehabilitation or convalescence center or custodial care facility or receiving Outpatient care for chemotherapy or radiation therapy;
2. confined at home under the care of a Physician for Sickness or Injury;
3. receiving disability benefits from any source due to his or her Sickness or Injury or Totally Disabled; or
4. unable to perform any of the Activities of Daily Living without human supervision or assistance.

Activities of Daily Living

Activities used in measuring levels of personal functioning capacity. These activities are normally performed without assistance, allowing personal independence in everyday living. These activities include the following:

1. Transfer and mobility - The ability to move into or out of a bed, chair or wheelchair or to move from place to place, either via walking, a wheelchair, cane, crutches, walker or other equipment;
2. Continence - The ability to maintain control of bowel and bladder function; or, when unable to maintain control of bowel or bladder function, the ability to perform associated personal hygiene (including caring for catheter, urostomy, or colostomy bag);
3. Dressing – Putting on and taking off all items of clothing and any necessary braces, fasteners or artificial limbs;
4. Toileting – Getting to and from the toilet, transferring on and off the toilet and performing associated personal hygiene;
5. Eating – Feeding oneself by getting food into the body from a receptacle (such as a plate, cup or table) or by a feeding tube or intravenously; or
6. Bathing - Washing oneself by sponge bath; or in either a tub or a shower, including the task of getting into or out of the tub or shower.

Advanced Alzheimer's Disease

A progressive, degenerative disorder that attacks the brain's nerve cells, or neurons with accumulation and deposition of beta amyloid protein that results in the inability to perform 3 or more of the Activities of Daily Living.

The Date of Diagnosis is the date of the Covered Person's inability to perform Activities of Daily Living from this disorder, as confirmed by a Physician.

Age

For purposes of Initial Premium calculations upon initial eligibility unless otherwise stated, a Covered Person's age is His Age attained on the date coverage becomes effective for Him under this Policy.

1. For purposes of increases to coverage, including Enrollment Events and Life Status Changes, a Covered Person's Age, will be His Age as of the effective date of such increase.
2. For purposes of premium calculation for Portability prior to group policy termination, a Covered Person's Age is His Age as of His last birthday.
3. For the purposes of Portability, except as to premium calculations, Extension of Benefits, Waiver of Premium, or Continuation due to Disability, a Covered Person's Age is His Age as of His last birthday.
4. For all other purposes, changes in rates due to age and age-based terminations, a Covered Person's Age will be His Age on the Policy Anniversary Date coinciding with or following the Covered Person's birthday.

Amyotrophic Lateral Sclerosis (ALS)

A progressive, degenerative motor neuron disease, marked by muscular weakness and atrophy with spasticity and hyperreflexia due to a loss of motor neurons of the spinal cord, medulla and cortex that results in Impairment. ALS is often referred to as Lou Gehrig's disease.

"Impairment" means persistent clinical findings of at least 3 of the following:

1. Trouble swallowing (dysphagia) or choking;
2. Restrictive respiratory distress;
3. Slurring of the speech or dysphonia;
4. Weakness of the extremities;
5. Twitching (fasciculation) of the tongue.

The Date of Diagnosis is the date the Covered Person displays Impairment from this disease as confirmed by a neurologist.

Annual Group Enrollment Period

The period in each calendar year agreed upon by the Employer and Us when an eligible Employee may enroll for or change his or her benefit elections under the Policy as shown in the *Schedule of Benefits*.

Benefit Waiting Period

The period of time, shown in the *Schedule of Benefits*, immediately following the effective date of the Covered Person's coverage, including the effective date of any increase to coverage. No benefits will be paid under the Policy for any Critical Illness Benefits or Optional Benefits for a covered event or a Covered Loss that occurs during the Benefit Waiting Period, as shown in the *Schedule of Benefits*.

Benign Brain Tumor

A localized mass of abnormal cells in the brain that is non-cancerous, non-inflammatory, and non-infectious.

The Date of Diagnosis is the date the tissue specimen is taken on which the diagnosis of Benign Brain Tumor is based.

Blindness Clinically proven irreversible reduction of sight in both eyes, due to a disease or Sickness resulting in:

1. 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
2. visual field restriction to 20° or less in both eyes.

The Date of Diagnosis is the date an ophthalmologist diagnoses an irreversible vision loss.

Carcinoma in Situ A malignant tumor which is non- invasive and is confined only to the superficial layer of cells from which it arose. The term Carcinoma in Situ does not include:

1. pre-malignant conditions or conditions with malignant potential;
2. basal cell carcinoma and squamous cell carcinoma of the skin; or
3. melanoma or melanoma in situ.

For purposes of this Covered Condition, prostate cancer that is classified as T-1a, b, or c, N-0, and M-0 on a TNM classification scale, will be considered Carcinoma in Situ.

The Date of Diagnosis is the date the tissue specimen, blood sample, titer(s), or medically-accepted diagnostic or laboratory study is taken on which the diagnosis of Carcinoma in Situ is based.

Certificate The Certificate, including the Certificate Schedule, amendments, riders and supplements, if any, is a written statement prepared by Us to set forth a summary of:

1. benefits to which the Covered Person is entitled;
2. to whom the benefits are payable; and
3. limitations or requirements that may apply.

Clinical Diagnosis A diagnosis that is based on generally accepted medical principles. This type of diagnosis applies only when:

1. a Pathological Diagnosis cannot be made because it is medically inappropriate or life-threatening; and
2. there is medical evidence to support the diagnosis; and
3. a Physician is treating the Covered Person for Invasive Cancer and/or Carcinoma in Situ.

Coma A profound state of unconsciousness lasting at least 96 continuous hours as the result of disease or Sickness from which the Covered Person and cannot be aroused through visual auditory, and noxious physical stimuli. Coma does not mean any state of unconsciousness intentionally or medically induced from which the Covered Person is able to be aroused.

The Date of Diagnosis is the date a Covered Person meets the requirements of a Coma.

Coronary Artery Disease A narrowing or blockage of the inner lining of the coronary arteries by lipid-bearing plaques. The resulting blockage restricts blood flow to the heart and requires Coronary Artery Bypass Graft (CABG) surgery.

Coronary Artery Disease does not include:

1. Angioplasty (percutaneous coronary intervention)
2. Stent implantation

The Date of Diagnosis is the date the Physician prescribes the CABG surgical procedure for Coronary Artery Disease.

Covered Loss	<p>Is a loss that is:</p> <ol style="list-style-type: none"> 1. specified in the <i>Schedule of Benefits</i> and included in the <i>Description of Coverages</i>; and 2. suffered by the Covered Person within the applicable time period described in the <i>Schedule of Benefits</i>.
Covered Person	<p>An eligible person, as defined in the <i>Schedule of Benefits</i>, who is enrolled and for whom the Evidence of Insurability, where required, has been accepted by Us, required premium has been paid when due and coverage under this Policy remains in force.</p>
Critical Illness	<p>A disease or Sickness, as diagnosed by a Physician, that is specified as a Covered Condition in the Policy where the Date of Diagnosis occurs while coverage is in force. For purposes of the Policy:</p> <p>Amyotrophic Lateral Sclerosis (ALS), Advanced Alzheimer’s Disease, Benign Brain Tumor, Blindness, Carcinoma In Situ, Coma, Coronary Artery Disease, End Stage Renal (Kidney) Disease, Heart Attack, Invasive Cancer, Major Organ Failure, Multiple Sclerosis, Occupational Hepatitis B, Occupational Hepatitis C, Occupational HIV, Paralysis, Parkinson’s Disease, Skin Cancer, and Stroke.</p>
Date of Diagnosis	<p>The date a Physician renders the Pathological Diagnosis as defined by the Critical Illness. If a Pathological Diagnosis cannot be made, the date a Physician renders a Clinical Diagnosis.</p>
Dependent Child	<p>An Employee’s child who meets the following requirements:</p> <ol style="list-style-type: none"> 1. A child from live birth to 26 years old; 2. A child who is 26 or more years old, primarily supported by the Employee and incapable of self-sustaining employment by reason of mental or physical handicap. <p>A child, for purposes of this provision, includes an Employee’s:</p> <ol style="list-style-type: none"> 1. natural child; 2. adopted child, beginning with the date of the filing of the petition for adoption. It also means the legally adopted child of the Employee’s Spouse or domestic partner/Partner to a Civil Union provided the child is living with, and is financially dependent upon the Employee; 3. stepchild who resides with the Employee and is financially dependent upon the Employee; 4. child, grandchild for whom the Employee is the court-appointed legal guardian, as long as the child resides with the Employee and primarily depends on the Employee for financial support. Financial support means that the Employee is eligible to claim the dependent for purposes of Federal and State income tax returns; 5. a child of the Employee’s domestic partner/Partner to a Civil Union, provided the child is living with, and is financially dependent upon the Employee.
Eligibility Waiting Period	<p>The cumulative period of time during a continuous period of employment that an Employee must be in Active Service in order to be eligible for coverage under the Policy. It will be extended by the number of days the Employee is not in Active Service.</p>
Employee	<p>For eligibility purposes, an Employee of the Employer who is in one of the Covered Classes.</p>
Employer	<p>The Subscriber and any affiliates, subsidiaries or divisions shown in the <i>Schedule of Affiliates</i> and which are covered under this Policy on the date of issue or subsequently agreed to by Us. The term "employer" refers to an employer of a Spouse.</p>
Employer’s Plan	<p>A program established and maintained by the Employer to provide benefits to plan participants and their beneficiaries.</p>

End Stage Renal (Kidney) Failure

The chronic irreversible failure of the function of both kidneys, such that regular hemodialysis or peritoneal dialysis is required to sustain life.

The Date of Diagnosis is the date a Physician prescribes that the Covered Person begins dialysis.

Evidence of Insurability

Evidence of good health that is submitted by the Eligible Person and is satisfactory to Us before the coverage subject to this requirement becomes effective. An eligible person satisfies the insurability requirement on the day We agree in writing to accept him as insured for the amount subject to this requirement. We may require that the evidence of good health be provided at the eligible person's expense.

Full-time

Full-time means the number of hours set by the Subscriber as a regular work week for Employees in the Employee's eligibility class.

Heart Attack

An identifiable clinical event that results in ischemic death of a portion of the heart muscle confirmed by diagnostic testing through:

1. electrocardiographic (EKG) changes indicative of myocardial infarction. In the case of myocardial infarction ST wave changes, Q wave changes and/or T wave inversion must be documented and included as one of the criteria on establishing a diagnosis; and,
2. elevation of cardiac enzyme markers of myocardial injury.

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

The Date of Diagnosis is the date that the ischemic death of a portion of the heart muscle occurred.

He, His, Him, Himself

Refers to any individual, male or female.

Hospital

An institution that meets all of the following:

1. It is licensed as a Hospital pursuant to applicable law.
2. It is primarily and continuously engaged in providing medical care and treatment to sick and injured persons.
3. It is managed under the supervision of a staff of medical doctors.
4. It provides 24-hour nursing services by or under the supervision of a graduate registered Nurse (R.N.).
5. It has medical, diagnostic and treatment facilities, with major surgical facilities on its premises, or available to it on a prearranged basis.

The term Hospital does not include a clinic, facility, or unit of a Hospital for:

1. rehabilitation, convalescent, custodial, educational, hospice or skilled nursing care;
2. the aged, drug addicts or alcoholics; or
3. A facility primarily or solely providing psychiatric services to mentally ill patients.

Initial Open Enrollment Period

The period agreed upon by the Employer and Us when an eligible Employee who was hired on or before the Policy Effective Date may enroll for the first time for coverage under this Policy.

Injury

Any accidental loss or bodily harm.

Inpatient

A Covered Person who is formally admitted and confined to a Hospital or facility under a Physician's order for a period of time requiring at least one overnight stay and is charged for at least one full day's Hospital room and board.

Invasive Cancer

A disease involving an Organ of the body which is identified by the presence of malignant cells or a malignant tumor characterized by the uncontrolled and abnormal growth and spread of invasive malignant cells. The term Invasive Cancer does not include:

1. pre-malignant conditions or conditions with malignant potential;
2. Carcinoma in Situ;
3. basal cell carcinoma;
4. squamous cell carcinoma of the skin, unless metastatic disease develops;
5. melanoma that is diagnosed as Clark's Level I or II or Breslow less than 0.75mm, or melanoma in situ; or
6. a prostate tumor that is classified as T-1a,b, or c, N-0, and M-0 on a TNM classification scale.

The Date of Diagnosis is the date the tissue specimen, blood samples, and/or titer(s) are taken on which the diagnosis of Invasive Cancer is based.

For the purpose of the Initial Critical Illness Benefit, the Date of Diagnosis includes the recurrence or spread (metastasis) of a previously diagnosed cancer as long as the Covered Person has not undergone any form of treatment for the previously diagnosed Invasive Cancer for a period of 12 months prior to the Date of Diagnosis for Invasive Cancer that occurs while coverage is in force.

"Treatment" does not include any form of pharmacotherapy which is used to improve or maintain general physical condition or health or which is used for routine, long term, or maintenance care that is provided after the resolution of the acute medical problem and is not expected to provide significant therapeutic improvement. "Treatment" also does not include routine examinations to verify whether cancer has returned.

Major Organ Failure

A life-threatening inability or lack of function of Organs that is the result of Sickness or disease and is not the result of physical Injury or trauma. Major Organ Failure requires a Physician recommend or prescribe that the Covered Person undergo a human to human transplantation of the Organ. If the Covered Person has a combination transplant (i.e. heart and lung), a single benefit amount will be payable.

The Date of Diagnosis is the date when the latter of both of the following occurs:

1. the date the Physician diagnoses, prescribes or recommends that the Covered Person undergo the transplant; and
2. the date the Covered Person is placed on a national registry for organ matching administered by UNOS.

Multiple Sclerosis

A chronic, progressive, inflammatory, demyelinating disease involving damage to cells in the brain and spinal cord, and leading to the following Signs:

"Signs" means:

- a. Radiologic findings of plaque upon Magnetic Resonance Imaging (MRI); and
- b. Clinical findings of at least 3 of the following motor deficits and 3 of the following sensory deficits:

Motor

1. weakness;
2. spasticity;
3. atrophy;
4. incontinence; or
5. instability of gait

Sensory

1. loss of sensation (hypoesthesia);
2. self-reported pain;
3. visual disturbances;
4. dizziness or vertigo; or
5. numbness and tingling (paresthesia)

The Date of Diagnosis is the date when the latter of both of the following occurs:

1. MRI diagnostic test, or similar diagnostic imagery of the brain;
2. The Covered Person displays clinical Signs of this disease as confirmed by a Neurologist.

Nurse

A licensed graduate registered nurse (R.N.), a licensed practical nurse (L.P.N.), or a licensed vocational nurse (L.V.N.) who is not:

1. living in the Covered Person's household; or
2. a parent, sibling, spouse or child of the Covered Person.

Occupational Hepatitis B

Diagnosis of Hepatitis-B infection resulting from an unintended contact with Hepatitis-B contaminated body fluids.

The unintended contact must occur during the normal course of performing an occupation for which remuneration is earned and in which the Covered Person is regularly engaged for the Employer.

The contact with the Hepatitis-B contaminated body fluids must occur while the Covered Person's coverage under this Policy is in force.

To qualify as Occupational Hepatitis-B, these requirements apply:

1. within 5 days of the unintended contact, a report or recording is provided to the appropriate person according to the legislation, regulations, standards or guidelines that apply to the Covered Person's occupation or profession;
2. the unintended contact is investigated and a written investigation report is provided to Us by the Covered Person's Employer;
3. a confirmatory antibody Hepatitis-B test is taken within 5 days of the unintended contact and Hepatitis-B is not present;
4. all Hepatitis-B tests are performed by a state certified and licensed laboratory or Physician; and

5. a follow-up confirmatory Hepatitis-B serologic test (Confirmatory Test) is taken, within 185 days after the unintended contact, and the result is positive for both surface antigen and core antibodies of Hepatitis-B.

Occupational Hepatitis-B does not include any Hepatitis-B infection:

1. that results from intravenous drug use;
2. that results from sexual transmission.

The Date of Diagnosis is the date the Confirmatory Test is performed.

Occupational Hepatitis C

Diagnosis of Hepatitis-C infection resulting from an unintended contact to Hepatitis-C contaminated body fluids.

The unintended contact must occur during the normal course of performing an occupation for which remuneration is earned and in which the Covered Person is regularly engaged for the Employer.

The contact with the Hepatitis-C-contaminated body fluids must occur while the Covered Person's coverage under this Policy is in force.

To qualify as Occupational Hepatitis-C, these requirements apply:

1. within 5 days of the unintended contact, a report or recording is provided to the appropriate person according to the legislation, regulations, standards or guidelines that apply to the Covered Person's occupation or profession;
2. the unintended contact is investigated and a written investigation report is provided to Us by the Covered Person's Employer;
3. a confirmatory surface antibody Hepatitis-C test is taken within 5 days of the unintended contact and Hepatitis-C is not present;
4. all Hepatitis-C tests are performed by a state certified and licensed laboratory or Physician; and
5. a follow-up confirmatory Hepatitis-C RNA test (Confirmatory Test) is taken, within 185 days after the unintended contact, and the result is positive.

Occupational Hepatitis-C does not include any Hepatitis-C infection:

1. that results from intravenous drug use;
2. that results from sexual transmission.

The Date of Diagnosis is the date the Confirmatory Test is performed.

Occupational Human Immunodeficiency Virus (Occupational HIV)

Diagnosis of Human Immunodeficiency Virus (HIV) infection resulting from an unintended contact to HIV-contaminated body fluids.

The unintended contact must occur during the normal course of performing an occupation for which remuneration is earned and in which the Covered Person is regularly engaged for the Employer.

The contact with the HIV-contaminated body fluids must occur while the Covered Person's coverage under this Policy is in force.

To qualify as Occupational HIV, these requirements apply:

1. within 5 days of the unintended contact, a report or recording is provided to the appropriate person according to the legislation, regulations, standards or guidelines that apply to the Covered Person's occupation or profession;
2. the unintended contact is investigated and a written investigation report is provided to Us by the Covered Person's Employer;
3. a confirmatory antibody HIV test is taken within 5 days of the unintended contact and HIV is not present;
4. all HIV tests are performed by a state certified and licensed laboratory; and
5. a follow-up confirmatory antibody HIV test (Confirmatory Test) is taken, between 35 days and 185 days after the unintended contact, and the result is positive.

Occupational HIV does not include any HIV infection:

1. that results from intravenous drug use;
2. that results from sexual transmission.

The Date of Diagnosis is the date the Confirmatory Test is performed.

Organ

Liver, lung or lungs, pancreas, kidney, heart or bone marrow.

Outpatient

A Covered Person who receives medical tests, treatment, or services from an Ambulatory Surgical Center, Hospital, lab, medical clinic, Physician's office, or radiologic center and is not confined for a day's room and board.

Paralysis

The complete, irreversible and permanent loss of the use of two or more non-severed limbs, as a result of a disease or Sickness. Paralysis as a result of Stroke and Multiple Sclerosis is excluded.

The Date of Diagnosis is the date a Physician makes a diagnosis based on clinical and/or laboratory findings as supported by the Covered Person's medical records.

Parkinson's Disease

A progressive, degenerative neurologic disease that is characterized by loss of the neurotransmitter dopamine and leads to the following Signs:

"Signs" means clinical findings of at least 3 of the following:

1. tremors at rest;
2. slowed, physical movement (bradykensia) or difficulty initiating movement;
3. difficulty with speech (monotone voice, lack of inflection, etc.);
4. muscular rigidity;
5. inexpressive face;
6. festinating gait;
7. rapid, persistent blinking (blephoraspasm).

The Date of Diagnosis is the date the Covered Person displays Signs of this disease as confirmed by a Neurologist.

Part-Time	Regularly working the number of hours set by the Subscriber as a regular work week for Employees, other than Full-time, temporary or seasonal, in the Employee's eligibility class.
Pathological Diagnosis	A diagnosis that is based on a microscopic study of fixed tissue or preparations from the hemic (blood) system. This type of diagnosis must be done by a certified Pathologist whose diagnosis of malignancy is in keeping with the standards set up by the American Board of Pathology.
Pathologist	A Physician who is licensed to practice pathological anatomy by the American Board of Pathology. Pathologist also means an osteopathic pathologist who is certified by the Osteopathic Board of Pathology.
Physician	A licensed medical, osteopathic or podiatric practitioner who is practicing within the scope of his license and who is licensed to prescribe and administer medication and to perform surgery that is appropriate for the condition and locality and who is not: <ol style="list-style-type: none">1. living in the Covered Person's household; or2. a parent, sibling, spouse or child of the Covered Person.
Recurrence	For purposes of this policy, means: <ol style="list-style-type: none">1. The return of signs and symptoms of a medical condition or disease with the reappearance of the same histologic pathology.2. The signs and symptoms of a medical condition or disease that occurs again (reoccurs) with or without a shared or related histologic pathology to a previous disease or condition.
Sickness	A physical or mental illness.
Skin Cancer	An uncontrolled growth of abnormal skin cells that is: <ol style="list-style-type: none">1. basal cell carcinoma or2. squamous cell carcinoma or3. melanoma that is diagnosed as Clark's Level I or II or Breslow less than 0.75mm <p>The Date of Diagnosis is the date the tissue specimen is taken on which the diagnosis of Skin Cancer is based.</p>
Spouse	The Employee's current lawful Spouse who is at least Age 18 for any coverage requiring Evidence of Insurability but not yet Age 100. Except for purposes of determining initial eligibility, the term includes a Spouse who is widowed or divorced or legally separated from an Employee. The term includes a common-law Spouse who is recognized as a common-law Spouse under the laws of the jurisdiction where the common-law marriage was formed.
Stroke	A cerebrovascular event resulting in: <ol style="list-style-type: none">1. damage of brain tissue as a result of ischemia or hemorrhage and confirmed by findings on neuroimaging studies, including Brain CT, MRI, MRA or similar diagnostic study, or a lumbar puncture (spinal tap); or2. at least 96 hours after the event:<ol style="list-style-type: none">a. clinical evidence of persistent neurological deficits diagnosed by a Physician; orb. confirmatory findings on neuroimaging studies, including Brain CT, MRI, MRA, or similar diagnostic study, or lumbar puncture (spinal tap) consistent with a cerebrovascular event.

Stroke does not include:

1. transient ischemic attack;
2. brain injury related to trauma or infection;
3. brain injury associated with hypoxia or anoxia;
4. vascular disease affecting the eye or optic nerve; or
5. ischemic disorders of the vestibular system.

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

The Date of Diagnosis is the date the cerebrovascular event occurs, and confirmed by:

1. neuroimaging studies or lumbar puncture (spinal tap); or
2. clinical evidence of signs, symptoms, and findings, including neurological deficits, consistent with a cerebrovascular event.

Subscriber

Any participating organization that subscribes to the Trust to which this Policy is issued.

**Totally Disabled
or Total Disability**

Either:

1. the inability of the Covered Person who is currently employed to do any type of work for which He is or may become qualified by reason of education, training or experience;
or
2. the inability of the Covered Person who is not currently employed to perform all of the Activities of Daily Living without human supervision or assistance.

Trust

The Group Insurance Trust for Employers named on the face page of this Policy.

**We, Us, Our,
Insurance Company**

Life Insurance Company of North America.

GCI-02-1300.00

ELIGIBILITY

Employee

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

Except as noted in the Reinstatement Provision, if an Employee terminates coverage and later wishes to reapply, or if a former Employee is rehired, a new Eligibility Waiting Period must be satisfied. An Employee is not required to satisfy a new Eligibility Waiting Period if coverage ends because he or she is no longer in a Class of Eligible Employees, but continues to be employed by the Employer, and within one year becomes a member of an eligible class.

Spouse and Dependent Children

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

Limitations on Multiple Eligibility

A Covered Person may be insured only once under this Policy even though he or she may be eligible under more than one class of insureds.

Eligible Employee Insured As Spouse – Loss of Eligibility as a Spouse

If an Employee is eligible and has enrolled as the Spouse of another Employee, but ceases to be eligible to maintain the amount of coverage for which he or she has enrolled as a Spouse, that Employee may, within 31 days, enroll for coverage as an Employee, in an amount equal to the lesser of:

1. The amount of the Spouse's coverage terminating; or
2. The maximum amount of Employee coverage of the class for which he or she is eligible.

Evidence of Insurability is not required. If this amount is not equal to an available Benefit Amount, it will be adjusted to the next higher available Benefit Amount.

An Employee shall not also be eligible for an increase in coverage due to a Life Status Change when eligible under this provision. Premium will be based upon the Employee's Age as of the Effective Date of the Employee's coverage under this provision.

Eligible Spouse Insured As Employee – Loss of Eligibility as an Employee

If a Spouse is eligible and has enrolled for coverage as an Employee but ceases to be eligible to maintain the amount of coverage for which he or she has enrolled as an Employee, that Spouse may, within 31 days, be enrolled for coverage as a Spouse in an amount equal to the lesser of:

1. The amount of Employee coverage terminating; or
2. The maximum amount of Spouse coverage for which he or she is eligible.

Evidence of Insurability is not required. If this amount is not equal to an available Benefit Amount, it will be adjusted to the next higher available Benefit Amount.

A Spouse shall not also be eligible for an increase in coverage due to a Life Status Change when eligible under this provision. Premium will be based upon the Employee's Age as of the Effective Date of the Spouse's coverage under this provision.

Special Rules for Dependent Children

An Employee who is insured will not be insured as a Dependent Child of another Employee.

A Dependent Child of two or more Employees may only be insured once under the Policy. If a Dependent Child of two or more Employees who have enrolled Dependent Children incurs a claim, then any payable benefit will be divided equally among the Employees who have insured the Dependent Child unless the Employees otherwise agree.

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

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

ENROLLMENT

An Employee may only enroll or apply for coverage at such times, and during such Enrollment Events, as specified in the Policy.

Group Enrollment Events

New Enrollees

Subject to the *Deferred Effective Date Provisions*, an Employee who is newly eligible to apply, or has been eligible but did not previously enroll, may apply for coverage for Himself or any eligible Spouse or Dependent Child for an amount shown as Guaranteed Issue without satisfying any Evidence of Insurability, during the Enrollment Events shown in the *Schedule of Benefits*.

Current Insureds

Subject to the *Deferred Effective Date Provisions*, an eligible Employee insured under this Policy, may apply for an increase in coverage for Himself or for coverage on any insured Spouse or Dependent Child for an amount shown as Guaranteed Issue without satisfying any Evidence of Insurability, during the Enrollment Events shown in the *Schedule of Benefits*.

An eligible Employee must apply for Himself and be insured for coverage for which He is required to contribute to the cost of coverage in order to apply for coverage for an eligible Spouse or Dependent Child.

EFFECTIVE DATE PROVISIONS

Policy Effective Date

We agree to provide the coverage described in this Policy in consideration of the Subscriber's application and payment of the initial premium when due. Coverage begins on the Policy Effective Date shown on this Policy's first page as long as the Minimum Participation Requirements shown in the *Schedule of Benefits* have been satisfied.

Subscriber Effective Date

Coverage becomes effective for each Subscriber in consideration of the Subscriber's application, Subscription Agreement and payment of the initial premium when due. Coverage for the Subscriber becomes effective on the Effective date of Subscriber Participation as long as the Minimum Participation Requirements shown in the *Schedule of Benefits* have been satisfied.

Effective Date for Individuals (*Newly Eligible and Life Status*)

Voluntary Benefit

For all Employee coverage up to the Guaranteed Issue amount, Evidence of Insurability is not required.

If the Employee is eligible for Guaranteed Issue coverage, applies for coverage within the Guaranteed Issue amount and agrees to make required contributions within 31 days after the date He becomes eligible and, subject to the *Deferred Effective Date Provisions* section below, coverage becomes effective on the later of:

1. the effective date of the Subscriber's participation under this Policy;
2. the first of the month following the date We receive the Employee's completed enrollment form.

For all Spouse coverage up to the Guaranteed Issue amount, Evidence of Insurability is not required.

If the Spouse is eligible for Guaranteed Issue coverage, and the Employee applies for coverage within the Guaranteed Issue amount and agrees to make required contributions within 31 days after the date the Spouse becomes eligible and, subject to the *Deferred Effective Date Provisions* section, coverage becomes effective on the later of:

1. the effective date of the Subscriber's participation under this Policy;
2. the date the Employee becomes eligible at the end of the Eligibility Waiting Period;
3. the date the Employee's coverage becomes effective;
4. the date the dependent meets the definition of Spouse as applicable;
5. the first of the month following the date We or the Employer receive the completed enrollment form.

For all Dependent Child coverage, Evidence of Insurability is not required.

If the Dependent Child is eligible for Guaranteed Issue coverage, and the Employee applies for coverage and agrees to make required contributions within 31 days after the date the Dependent Child becomes eligible and, subject to the *Deferred Effective Date Provisions* section below, coverage becomes effective on the later of:

1. the effective date of the Subscriber's participation under this Policy;
2. the date the Employee becomes eligible at the end of the Eligibility Waiting Period;
3. the date the Employee's coverage becomes effective;
4. the date the dependent meets the definition of Dependent Child as applicable;
5. the first of the month following the date We or the Employer receive the completed enrollment form for Dependent Child coverage.

If coverage for a Dependent Child is in force and another Dependent Child becomes eligible, coverage for that child is effective on the date the child qualifies as a Dependent Child.

Effective Date of Certain Changes

Any increase or decrease in the amount of coverage for the Covered Person resulting from:

1. a change in benefits provided by this Policy; or
2. a change in the Employee's Covered Class,

will take effect on the date of such change and not result in any change in Age for Premium purposes. Increases will take effect subject to any Active Service requirement.

DEFERRED EFFECTIVE DATE PROVISIONS

Not in Active Service

The effective date of coverage will be deferred for any Employee or any eligible Spouse or Dependent Child who is not in Active Service on the date coverage would otherwise become effective. Coverage will become effective on the later of the date He returns to Active Service, or the date coverage would otherwise have become effective.

INDIVIDUAL ENROLLMENT EVENTS

Life Status Change

A Life Status Change is an event that the Employer has determined qualifies an Employee to apply for coverage or to increase coverage on Himself, His Spouse or Dependent Child due to a Life Status Change under this Policy.

Life Status Changes that qualify an Employee to apply or increase coverage for Himself include:

1. marriage;
2. loss of a Spouse; whether by death, divorce, annulment or legal separation;
3. birth or adoption of a child, or acquiring a child through marriage;
4. a change in the group benefit plan available to the Employee's Spouse;
5. a change in the Employee's employment status that affects eligibility for group benefits for either the Employee or His Spouse;
6. termination of a Spouse's employment; and
7. an event as specified in the Employer's Plan which this Policy insures.

Life Status Changes that qualify an Employee to apply or increase coverage for His eligible Spouse and Dependent Child include:

1. marriage;
2. loss of a Spouse; whether by death, divorce, annulment or legal separation;
3. birth or adoption of a child, or acquiring a child through marriage;
4. a change in the group benefit plan available to the Spouse;
5. a change in the Spouse's employment status that affects eligibility for group benefits for either the Employee or His Spouse;
6. termination of a Spouse's employment; and
7. an event as specified in the Employer's Plan which this Policy insures.

Any coverage elected as a result of a Life Status Change, shall be effective in accordance with the *Effective Date for Individuals Provision*.

Group Enrollment Effective Dates

Coverage up to the Guaranteed Issue amount for which an Employee, Spouse and Dependent Child is eligible, will be effective on the effective date of this Policy's anniversary following the enrollment period.

Coverage in excess of the Guaranteed Issue amount will be effective on the later of:

1. the effective date of this Policy's anniversary following the enrollment period, if the Employee's and Spouse's Evidence of Insurability is approved by Us prior to the effective date of this Policy's anniversary;
2. the date We approve the Employee's and Spouse's completed Evidence of Insurability form;
3. the first of the month following the date We approve the Employee's and Spouse's Evidence of Insurability form.

For all Employee and Spouse coverage up to the Guaranteed Issue amount, Evidence of Insurability is not required. For all Employee and Spouse coverage in excess of the Guaranteed Issue amount, Evidence of Insurability is required.

The Employee may apply for an increase in coverage on an insured Spouse or for coverage on a Spouse who is eligible to be insured but was not previously enrolled by the Employee.

For all Dependent Child coverage Evidence of Insurability is not required.

The Dependent Child who is eligible to apply, but was not previously enrolled by the Employee, the Employee may apply or is insured the Employee may apply for an increase for coverage.

TERMINATION OF INSURANCE

Coverage on a Covered Person will end on the earliest date below:

1. the date this Policy or coverage for a Covered Class is terminated.
2. the date the Subscriber's participation under this Policy ends.
3. the date the Employee is no longer in Active Service.
4. the date the Employee is no longer in a Covered Class or satisfies eligibility requirements under this Policy.
5. the last day of the last period for which premium is paid.
6. the next premium due date after the Covered Person attains the maximum Age for coverage under this Policy, as shown in the *Schedule of Benefits*.
7. with respect to a Spouse or Dependent Child, the date of the death of the covered Employee or the date of divorce from the covered Employee. See the *Portability Provisions* section.
8. for a Spouse, the date the Spouse reaches age 100.
9. for a Dependent Child, the date the Dependent Child reaches age 26, unless primarily supported by the Employee and incapable of self-sustaining employment by reason of mental or physical handicap.
10. as to each Covered Person, the date all benefits under this Policy have been exhausted for that individual.

Termination will not affect a claim that arises while coverage was in effect.

CONTINUATION OF COVERAGE PROVISIONS

If an Employee is no longer in Active Service, coverage may be continued. The following provisions explain the continuation options available under this Policy. Please see the *Schedule of Benefits*, to determine the applicability of these benefits on a class level.

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

Continuation for Leave of Absence or Family Medical Leave

If an Employee's Active Service ends due to an approved leave pursuant to the Family and Medical Leave Act (FMLA), coverage will continue up to the later of the end of the period of His approved FMLA leave or the end of the leave period required by law in the state in which He is employed. Premiums are required for this coverage and are to be remitted directly to the Subscriber.

If an Employee's Active Service ends due to any other leave of absence approved in writing by the Employer prior to the date the Employee ceases work, coverage will continue up to the Maximum Benefit Period as shown in the *Schedule of Benefits*. Premiums are required for this coverage and are to be remitted directly to the Subscriber. An approved leave of absence does not include Furlough, Temporary Layoff or termination of employment.

PORTABILITY PROVISIONS

Coverage provided by this Policy is portable, except as provided for specific benefits or coverages and except upon termination of the Policy, for an Employee as shown in the *Schedule of Benefits* and satisfies all of the conditions below.

Whose Insurance is Portable

A covered Employee who:

1. has not attained the Maximum Age for Portability shown in the *Schedule of Benefits*;
2. agrees to pay required premiums, may remain covered under this Policy for the Portable Period shown in the *Schedule of Benefits*.

Any Spouse or Dependent Child coverage provided under the covered Employee's Certificate is portable when the Employee ports His coverage.

A covered Spouse and Dependent Child who:

1. has not attained the Maximum Age for Portability shown in the *Schedule of Benefits*;
2. agrees to pay required premiums, may remain covered under a Certificate issued to Him for the Portable Period shown in the *Schedule of Benefits*.

Amount of Portable Insurance

The amount of portable coverage is shown in the *Schedule of Benefits* and will be subject to the provisions of the Policy that reduce the coverage amount because of age or a change in class. Any additional coverages and benefits for which the Covered Person was insured are portable only if shown in the *Schedule of Benefits*.

Effective Date of Ported Insurance

Ported coverage will become effective under this section on the date the Covered Person's coverage under the Policy would otherwise have terminated, as described above, if the Covered Person has applied and agreed to pay required premiums within 31 days of the date He would otherwise have ceased to be eligible. The Covered Person need not show Us He is insurable.

Termination of Ported Insurance

Coverage will end on the earliest of the following dates:

1. the day after the end of the last period for which premiums are paid;
2. the end of the Portable Period.
3. the date the Covered Person reaches the Maximum Age for Portability shown in the *Schedule of Benefits*.
4. the date the Employee's ported coverage terminates.

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EXCLUSIONS

In addition to any benefit-specific exclusions, benefits will not be paid for any Covered Loss which, directly or indirectly, in whole or in part, is caused by or results from any of the following unless coverage is specifically provided for by name in the *Description of Benefits* section:

1. intentionally self-inflicted Injury, suicide or any attempt thereat while sane or insane;
2. commission or attempt to commit a felony or an assault;
3. declared or undeclared war or act of war;
4. a Covered Loss that results from active duty service in the military, naval or air force of any country or international organization. Upon Our receipt of proof of service, We will refund any premium paid for this time. Reserve or National Guard active duty training is not excluded unless it extends beyond 31 days.
5. voluntary ingestion of any narcotic, drug, poison, gas or fumes, unless prescribed or taken under the direction of a Physician and taken in accordance with the prescribed dosage;
6. operating any type of vehicle while under the influence of alcohol or any drug, narcotic or other intoxicant. "Under the influence of alcohol", for purposes of this exclusion, means intoxicated, as defined by the law of the state in which the Covered Loss occurred.
7. a diagnosis not in accordance with generally accepted medical principles prevailing in the United States at the time of the diagnosis.

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CLAIM PROVISIONS

Notice of Claim

Written or authorized electronic, or telephonic notice of claim must be given to Us within 31 days after a Covered Loss occurs or begins or as soon as is reasonably possible. If written or authorized electronic, or telephonic notice is not given in that time, the claim will not be invalidated or reduced if it is shown that written or authorized electronic, or telephonic notice was given as soon as was reasonably possible. Notice can be given to Us at Our Home Office in Philadelphia, Pennsylvania, such other place as We may designate for the purpose, or to Our authorized agent. Notice should include the Subscriber's name and Policy number and the Covered Person's name, address, Policy and Certificate number.

Claim Forms

We will send claim forms with written instructions for filing proof of loss when We receive notice of a claim. If such forms are not sent within 15 days after We receive notice, the proof requirements will be met by submitting, within the time fixed in this Policy for filing proof of loss, written or authorized electronic proof of the nature and extent of the loss for which the claim is made.

Claimant Cooperation Provision

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

Proof of Loss

Written or authorized electronic proof of loss satisfactory to Us must be given to Us at Our office, within 90 days of the loss for which claim is made. If (a) benefits are payable as periodic payments and (b) each payment is contingent upon continuing loss, then proof of loss must be submitted within 90 days after the termination of each period for which We are liable. If written or authorized electronic notice is not given within that time, no claim will be invalidated or reduced if it is shown that such notice was given as soon as was reasonably possible. In any case, written or authorized electronic proof must be given not more than one year after the time it is otherwise required, except if proof is not given solely due to the lack of legal capacity.

Time of Payment of Claims

We will pay benefits due under this Policy for any loss other than a loss for which this Policy provides any periodic payment not more than 60 days upon Our receipt of due written or authorized electronic proof of such loss. Due proof of loss means all essential information needed to make a determination on the claim. Subject to due written or authorized electronic proof of loss, all accrued benefits for loss for which this Policy provides periodic payment will be paid monthly unless otherwise specified in the benefits descriptions and any balance remaining unpaid at the termination of liability will be paid immediately upon receipt of proof satisfactory to Us.

Payment of Claims

All benefits will be paid in United States currency. All benefits payable under the Policy are payable to the Covered Person, if living, except if the Covered Person is a Dependent Child, then the benefits will be payable to the Employee. If the Covered Person dies while any of these benefits remain unpaid, benefits payable under the Policy will be paid to the Covered Person's Spouse, if living, or otherwise to the executors or administrators of the Covered Person's estate.

Benefits will be reduced by any outstanding premium due.

If We are to pay benefits to the estate or to a person who is incapable of giving a valid release, We may pay \$1,000 to a relative by blood or marriage whom We believe is equitably entitled.

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

Physical Examination and Autopsy

We, at Our own expense, have the right and opportunity to examine the Covered Person when and as often as We may reasonably require while a claim is pending 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 may be brought to recover under this Policy less than 60 days after written or authorized electronic proof of loss has been furnished as required by this Policy. No such action will be brought more than three years after the time such written proof of loss must be furnished.

Recovery of Overpayment

If benefits are overpaid, We have the right to recover the amount overpaid by either of the following methods.

1. A request for lump sum payment of the overpaid amount.
2. A reduction of any amounts payable under this Policy.

If there is an overpayment due when the Covered Person dies, We may recover the overpayment from the Covered Person's estate.

GCI-02-CE1700.00

ADMINISTRATIVE PROVISIONS

Premiums

All premium rates are expressed in, and all premiums are payable in, United States currency. The premiums for this Policy will be based on the rates determined by written agreement between the Subscriber and Us, the plan and amounts of coverage in effect.

Payment of Premium

Covered Person

The Covered Person may be responsible for the payment of premium directly to Us, as determined by the Employer from the Policy Effective Date, or following the expiration of 60 days from the date coverage is continued for a Covered Person under the *Continuation of Coverage Provisions* section of the Policy. Premium shall be due monthly, unless the Covered Person and We agree on some other period for premium payment. If premium is not paid when due, coverage will end as of the premium due date, except as provided in the Covered Person Grace Period provision below.

Grace Period

Covered Person

A Grace Period of 31 days will be granted for payment of required premiums under this Policy. A Covered Person's coverage under this Policy will remain in force during the Grace Period. We will reduce any benefits payable for any claims incurred during the Grace Period by the amount of premium due. If no such claims are incurred and premium is not paid during the Grace Period, coverage will end on the last day of the period for which premiums were paid.

Reinstatement of Insurance

If an Employee's Active Service ended due to an Employer-approved leave pursuant to the Family and Medical Leave Act (FMLA) and *Continuation of Coverage* is not applicable, an Employee's coverage may be reinstated at the conclusion of the FMLA leave.

If an Employee's Active Service ends due to the Employer-approved unpaid leave of absence, other than an approved FMLA leave, coverage may be reinstated only:

1. if the reinstatement occurs within 12 weeks from the date coverage ends; or
2. when returning from military service pursuant to the Uniformed Services Employment Act of 1994 (USERRA).

Effective Date of Reinstated Insurance

Reinstated coverage will be effective on the date the Employee returns to Active Service if Evidence of Insurability is not required. If Evidence of Insurability must be satisfied, the reinstated coverage will be effective as provided in the *Effective Date Provisions* section. If the Employee did not fully satisfy the Eligibility Waiting Period, Benefit Waiting Period, or the Pre-Existing Condition Limitation (if any) before coverage ended due to an approved unpaid leave of absence, credit will be given for any time that was satisfied.

GCI-02-CE1800.00

GENERAL PROVISIONS

Entire Contract; Changes

This Policy, including the endorsements, amendments and any attached papers constitutes the entire contract of coverage. No change in this Policy will be valid until approved by one of Our executive officers and endorsed on or attached to this Policy. No agent has authority to change this Policy or to waive any of its provisions.

Subscriber Participation Under This Policy

An organization may elect to participate under this Policy by submitting a signed Subscriber participation agreement to the Policyholder. No participation by an organization is in effect until approved by Us.

Misstatement of Age and Tobacco

If the Covered Person has misstated His Age or tobacco status, all amounts payable under this Policy will be such as the premium paid would have purchased had such fact been correctly stated.

Certificates

Where required by law, We will provide a Certificate for delivery to the Covered Person. Each Certificate will list the benefits, conditions and limits of this Policy. It will state to whom benefits will be paid.

30 Day Right To Examine Certificate

If a Covered Person does not like the Certificate for any reason, it may be returned to Us within 30 days after receipt. We will return any premium that has been paid and the Certificate will be void as if it had never been issued.

Multiple Certificates

The Covered Person may have in force only one Certificate at a time under this Policy. If at any time the Covered Person has been issued more than one Certificate, then only the Certificate insuring the Covered Person as an Employee shall be in effect. We will refund premiums paid for the others for any period of time that more than one Certificate was issued.

A Covered Person is not eligible for coverage under more than one Certificate providing similar benefits for critical illness coverage under group policies issued by Us. If premium is being paid for more than one such Certificate as an Employee or a Dependent, then coverage will be in effect under the Certificate with the earliest effective date and premiums paid for Certificates which are not in effect will be refunded.

Assignment

The rights and benefits provided by this Policy, except as provided herein, may not be assigned. The payee may, after a benefit or series of benefits has become payable, assign only those benefits. Such assignment will be valid only if We receive it before any of those benefits have been paid and only for benefits payable for claims arising from the same Covered Loss. Any other attempt to assign will be void.

Incontestability

This Policy or Participation Under This Policy

All statements made by the Subscriber to obtain this Policy or to participate under this Policy are considered representations and not warranties. No statement will be used to deny or reduce benefits or be used as a defense to a claim, or to deny the validity of this Policy or of participation under this Policy unless a copy of the instrument containing the statement is, or has been, furnished to the Subscriber.

After two years from the Policy Effective Date, no such statement will cause this Policy to be contested except for fraud or lack of eligibility for coverage.

A Covered Person's Insurance

All statements made by a Covered Person are considered representations and not warranties. No statement will be used to deny or reduce benefits or be used as a defense to a claim, unless a copy of the instrument containing the statement is, or has been, furnished to the claimant.

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

In the event of death or incapacity, the beneficiary or representative shall be given a copy.

Policy Termination

We may terminate coverage on or after the first anniversary of the Policy Effective Date. We or the Subscriber may terminate coverage on any Premium Due Date. Written or authorized electronic notice by certified mail must be given at least 31 days prior to such Premium Due Date. Failure by the Subscriber to pay premiums when due or within the Grace Period shall be deemed notice to Us to terminate coverage at the end of the period for which premium was paid.

Termination will not affect a claim for a Covered Loss that is the result, directly and independently of all other causes, of a loss that occurs while coverage was in effect.

Agency

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

Clerical Error

A Covered Person's coverage will not be affected by error or delay in keeping records of coverage under this Policy. If such an error is found, the premium will be adjusted fairly. A failure to perform, including perform in a timely manner or in a manner prescribed by the Policy, any of the following shall not constitute a clerical error under this provision:

1. enroll or apply for coverage;
2. submit Evidence of Insurability;
3. report notice or provide proof of claim;
4. pay premiums.

Conformity with Statutes

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

Policy Changes

We may agree with the Subscriber to modify coverage without the Covered Person's consent.

Workers' Compensation Insurance

This Policy is not in place of and does not affect any requirements for coverage under any Workers' Compensation law.

Examination of the Policy

This Policy will be available for inspection at the Subscriber's or Our office during regular business hours.

Examination of Records

We will be permitted to examine all of the Subscriber's records relating to this Policy. Examination may occur at any reasonable time while the Policy is in force. Examination may also occur:

1. at any time for two years after the expiration of this Policy; or, if later,
2. upon the final adjustment and settlement of all claims under this Policy.

Ownership of Records

All records maintained by Us are, and shall remain, Our property.

GCI-02-CE1900.00

HEALTH SCREENING TEST BENEFIT RIDER

This Rider is attached to and made a part of your group insurance Policy. It is subject to the terms, conditions, limitations and exclusions contained in the Policy as well as those set forth in this Rider.

Rider Effective Date: January 01, 2020

DESCRIPTION OF COVERAGES AND BENEFITS

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

This Rider provides limited Health Screening Test Benefits. Benefits will be paid for each 1 hour period of treatment, examination, testing, procedure or service. For purposes of benefit payment, each treatment, examination, testing, procedure or service for the Health Screening Test Benefit will be deemed to have occurred over a minimum 1 hour period.

We will pay the per day benefit shown in the *Schedule of Benefits*, if a Covered Person undergoes or receives Health Screening testing as set forth below, under direction of a Physician while coverage under this Rider is in force. Benefits are subject to any applicable Benefit Waiting Period, Maximum Benefit, and Elimination Period.

Maximum Lifetime Limits

Coverage under this Rider is not subject to the Maximum Lifetime Limits set forth in the *Schedule of Benefits* for the Employee's Class.

Benefit Waiting Period

The Benefit Waiting Period shown in the *Schedule of Benefits* applies to this Rider.

HEALTH SCREENING TESTS

- Mammography;
- Pap Smear for women over Age 18;
- Flexible Sigmoidoscopy;
- Hemocult Stool Specimen;
- Colonoscopy;
- Prostate Specific Antigen (for prostate cancer);
- Stress test on a bicycle or treadmill;
- Fasting blood glucose test;
- Blood test for triglycerides;
- Serum cholesterol test to determine levels of HDL and LDL;
- Bone marrow testing;
- Breast ultrasound;
- CA 15-3 (blood test for breast cancer);
- CA125 (blood test for ovarian cancer);
- CEA (blood test for colon cancer);
- Chest X-ray;
- Serum Protein Electrophoresis (blood test for myeloma); and
- Thermography

EXCLUSIONS

The *Common Exclusions* section of the Policy does not apply to this Rider.

Renewability/Termination of Coverage

This Rider is renewable. However, this Rider shall automatically terminate on the earliest of the following dates:

1. the date the Covered Person's coverage ends for any reason under the Policy to which this Rider is attached;
2. the last day of the period for which premium is paid for this Rider, subject to the Policy's Grace Period provision; or
3. the end of the period for which premium is paid for coverage under the Policy, to which this Rider is attached, subject to the Policy's Grace Period provision.

Portability Provision

Coverage under this Rider is portable. Coverage may only be ported if the Covered Person elects to port coverage under the Policy.

Reinstatement

If the Employee applies for reinstatement of insurance under the Policy, the Employee may apply to reinstate this Rider at that time.

LIFE INSURANCE COMPANY OF NORTH AMERICA

William J. Smith, President

WPB-GCI-02-7000-1.00

AMENDATORY RIDER
DOMESTIC PARTNER/CIVIL UNION PARTNER COVERAGE

Subscriber: AHS Management Company, Inc. dba Ardent Health Services

Policy No.: CI961234

Effective Date: January 01, 2020

This rider amends the Policy and Certificate to which it is attached. It is effective on the Effective Date shown above, and expires when the Policy expires.

Domestic Partner/Civil Union Partner means any of the following:

1. A person with whom the Employee or Former Employee has a registered civil union or domestic partnership under state law which imposes legal obligations on the parties substantially similar to marriage. Such person will continue to be recognized as a Domestic Partner or Civil Union Partner unless and until: (1) the civil union or domestic partnership is dissolved under applicable law; or (2) either the Employee or the Domestic Partner/Civil Union Partner marries another person.
2. A person meeting all of the following requirements, with respect to an Employee or Former Employee:
 - a. Shares a permanent residence with the Employee or Former Employee;
 - b. Has resided with the Employee for at least 6 months and is expected to continue to reside with the Employee indefinitely;
 - c. Has not been legally married to any other person within the previous six months, and has no Domestic Partner other than the Employee or Former Employee during the previous six months, and is the Employee or Former Employee's sole Domestic Partner;
 - d. Has signed a Domestic Partner declaration with the Employee or Former Employee, if the Employee or Former Employee resides in a jurisdiction which provides for Domestic Partner declarations;
 - e. Has not signed a Domestic Partner declaration with any other person within the last 6 months;
 - f. Is interdependent with the Employee or Former Employee in three or more of the following ways:
 1. Both partners are registered under any municipal ordinance as domestic partners.
 2. Both partners are jointly parties to a lease, mortgage or deed.
 3. Both partners jointly own one or more motor vehicles.
 4. Both partners jointly own one or more bank or credit accounts.
 5. The Employee or Former Employee has named the Domestic Partner as attorney-in-fact under a durable power of attorney with authority over health care decisions.
 6. The Employee or Former Employee has designated the Domestic Partner as beneficiary under a retirement plan or a life insurance policy.
 7. The Employee or Former Employee has designated the Domestic Partner as beneficiary of the Employee or Former Employee's will.
 8. Each partner has agreed in writing to assume the financial responsibility for the welfare of the other.
 - g. Is not so closely related by blood to the Employee or Former Employee as to prohibit legal marriage in their state of residence.
 - h. Is no less than 18 years of age.

The Employee or Former Employee and Domestic Partner must furnish the Employer and Insurance Company with a signed declaration that the above requirements are met, at the time of enrollment.

All references in the policy to "Spouse" shall be changed to read "Spouse, Domestic Partner, and Civil Union Partner except as follows:

1. The definition of "Spouse" remains unchanged.
2. For purposes of any provision of the policy providing for payment of benefits to relatives of the Employee or Former Employee, a Domestic Partner/Civil Union Partner shall be included only if:
 - a. the Domestic Partner/Civil Union Partner meets the requirements of the definition of Domestic Partner/Civil Union Partner referenced in item 1, or;
 - b. the Employee or Former Employee, and Domestic Partner/Civil Union Partner have furnished the Employer or the Insurance Company with a signed statement affirming that the requirements referenced in item 2 within the definition of Domestic Partner/Civil Union Partner are met.
3. A Domestic Partner/Civil Union Partner shall be deemed eligible to be enrolled for insurance on the latest of:
 - a. the date of registration under Item 1 of the definition of Domestic Partner/Civil Union Partner;
 - b. the date that the Employee or Former Employee is eligible for insurance under the Policy; or;
 - c. the effective date of this Amendment to the Policy.
4. A child of a Domestic Partner/Civil Union Partner may only be eligible to be insured if:
 - a. the child is primarily dependent on the Employee for financial support;
 - b. the Employee has a legal obligation of support of the child; or
 - c. the Employee is the child's legal guardian.

Except for the above this rider does not change the Policy or Certificate to which it is attached.

LIFE INSURANCE COMPANY OF NORTH AMERICA



William J. Smith, President

TL-007153GCI

MODIFYING PROVISIONS AMENDMENT

Subscriber: AHS Management Company, Inc. dba Ardent Health Services Policy No.: CI961234

Amendment Effective Date: January 01, 2020

This Amendment is attached to and made part of this Policy. Its provisions are intended to conform the Policy/Certificate to the laws of the state in which the insured resides.

The Policy/Certificate is amended as follows:

Arkansas residents:

- 1) Under the *General Definitions* section, items 2 and 3 of the second paragraph of the definition of Dependent Child are replaced with the following:
 2. In the case of minor children under an Employee's charge, care and control for whom the Employee has filed a petition to adopt, coverage will be effective:
 - a. From the date of birth if the petition for adoption is filed and a request for coverage is made within 60 days of the date of birth; or
 - b. On the date of the filing of the petition for adoption if a request for coverage is made within 60 days of the date of filing.Coverage shall terminate upon the dismissal of a petition for adoption.
 3. An unmarried dependent child who is incapable of sustaining employment by reason of mental retardation or physical disability, who became so incapacitated prior to the attainment of age 26 years and who is chiefly dependent on the Employee for support and maintenance. Coverage shall continue so long as the coverage of the Employee remains in force and so long as the dependent remains in such condition. At Our request and expense, proof of the incapacity or dependency must be furnished to Us by the Employee, except in no event shall this requirement preclude eligible dependents, regardless of age. If the incapacity or dependency is thereafter removed or terminated, the Employee shall so notify Us.

- 2) Under the *Effective Date Provisions* section, the following paragraph is added to the Effective Date for Individuals provision:

The Employee must give Us notice of any newborn children within ninety (90) days of the birth or before the next premium due date, whichever is later.

- 3) Under the *General Provisions* section, the following provision is added:

New Entrants

To the group originally insured may be added from time to time eligible new Employees or dependents, as the case may be, in accordance with the terms of the Policy.

California residents:

- 1) The following state specific change applies to CA Certificate holders ONLY when issued out-of-state via DE trust for an employer situated within California:

Coverage for Occupational Human Immunodeficiency Virus (Occupational HIV) is not available. Reference to this covered condition is deleted, as follows:

- a. Schedule of Benefits: from the List of Covered Conditions sub-section;
- b. General Definitions: from the definition of Critical Illness. Also, the definition of Occupational Human Immunodeficiency Virus (Occupational HIV) is deleted.

Florida residents:

- 1) Under the *General Definitions* section, item 2 of the second paragraph of the *Dependent child* definition includes adopted and foster child as follows:
 2. adopted or foster child, beginning with the moment of placement in the residence of the Employee. For a newborn adopted child, coverage begins at the moment of birth if writing agreement to adopt the newborn adopted child has been entered into by the Insured. Writing agreement must be received not less than 30 days after birth or placement in the residence of the Insured. If notice is received timely, no additional premium will be charged for coverage of the child for the duration of the notice period. If timely notice is not given, We may charge an additional premium from the date of birth or placement of the adopted child. Coverage will not be denied if notice is given within 60 days of the birth or placement of the adopted child. Benefits applicable for natural children shall be provided to adopted and foster child or other child in court-ordered temporary or other custody of the Insured. It also means the legally adopted child of the Employee's Spouse or Domestic Partner/Partner to a Civil Union provided the child is living with and is financially dependent upon the Employee;

Georgia residents:

- 1) Under the *Claim Provisions* section, the Claim Forms provision is replaced with the following:

Claim Forms

We will send claim forms with written instructions for filing proof of loss when We receive notice of a claim. If such forms are not sent within 10 working days after We receive notice, the proof requirements will be met by submitting, within the time fixed in this Policy for filing proof of loss, written or authorized electronic proof of the nature and extent of the loss for which the claim is made.

- 2) Under the *General Definitions* section, item 2 of the standard first paragraph of the *Dependent child* definition is replaced with the following:
 2. A child shall continue to be insured up to and including age 25 so long as the coverage of the Employee continues in effect, the child remains a dependent of the insured parent or guardian, and the child, in each calendar year since reaching age 19, has been enrolled for five calendar months or more as a full-time student at a postsecondary institution of higher learning or, if not so enrolled, would have been eligible to be so enrolled and was prevented from being so enrolled due to Sickness or Injury.

Idaho residents:

- 1) Must deliver Outline of Coverage form GCI-OOC.ID to the certificate holder, at the time the Certificate is delivered.
- 2) Under the *Schedule of Benefits* section:
 - a. The Benefit Waiting Period cannot exceed 30 days.
- 3) Under the *General Definitions* section, the following changes apply:
 - a. The definition of Active Service is replaced with the following:

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

1. one of the Employer’s scheduled work days on which the Employee is performing His regular duties on a Full-Time basis, either at one of the Employer’s usual places of business or at some other location to which the Employer’s business requires the Employee to travel; or
2. a scheduled holiday or holiday period, vacation day or period of Employer-approved paid leave of absence, other than disability or sick leave after 7 days, only if the Employee was in Active Service on the preceding scheduled workday.

A Covered Person is not considered in Active Service if He is:

1. Inpatient in a Hospital, hospice;
2. confined at home under the care of Physician for Sickness or Injury;
3. Totally Disabled; or
4. receiving disability benefits from any source due to his or her Sickness or Injury or Total Disability.

- b. The definition of **Activities of Daily Living** has been removed.
- c. The definition of **Advanced Alzheimer’s Disease** is replaced with the following:

Advanced Alzheimer’s Disease A progressive, degenerative disorder that attacks the brain's nerve cells, or neurons with accumulation and deposition of beta amyloid protein that results in the inability to perform the normal activities for one of like age and sex.

The Date of Diagnosis is the date of the Covered Person’s inability to perform the normal activities of like age and sex and who is under the regular care of a Physician.

- d. The definition for **Congenital Anomaly** is added:

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

The Date of Diagnosis is the date a Physician makes a diagnosis of Congenital Anomaly that is based on generally accepted principles of medicine at the time the diagnosis is made.

- e. The Dependent Child definition is replaced with the following:

Dependent Child An Employee's child who meets the following requirements:

1. A child from live birth to 26 years old;
2. A child who is 26 or more years old, primarily supported by the Employee and incapable of self-sustaining employment by reason of intellectual disability or physical disability.

A child, for purposes of this provision, includes an Employee's:

1. natural child;
2. adopted child, beginning on the date of the child's birth if Placement occurs within 60 days after the child's birth, or otherwise on the date of Placement for the purpose of adoption. As used in this paragraph, "Placement" means physical placement in the Employee's care. If physical placement is prevented due to the medical needs of the child, Placement means the date the Employee signs an agreement for adoption of such child and assumes financial responsibility for such child;
3. stepchild who resides with the Employee and is financially dependent upon the Employee;
4. child, grandchild for whom the Employee is the court-appointed legal guardian, as long as the child resides with the Employee and primarily depends on the Employee for financial support. Financial support means that the Employee is eligible to claim the dependent for purposes of Federal and State income tax returns;
5. a child of the Employee's domestic partner/Partner to a Civil Union, provided the child is living with, and is financially dependent upon the Employee.

- f. The definition of *Spouse* is replaced with the following:

Spouse The Employee's current lawful Spouse who is at least Age 18 for any coverage requiring Proof of Good Health but not yet Age 100. Except for purposes of determining initial eligibility, the term includes a Spouse who is widowed or divorced or legally separated from an Employee.

- g. The definition of *Totally Disabled or Total Disability* is replaced with the following:

Totally Disabled or Total Disability Either:

1. the inability of the Covered Person who is currently employed to do any type of work for which he is or may become qualified by reason of education, training or experience;
- or
2. the inability of the Covered Person who is not currently employed to perform the normal activities of like age and sex without human supervision or assistance.

- 4) Under the *Eligibility and Effective Date* Provision, the following changes are made:

- a. Under Effective Date for Individuals, add the following:

If the Dependent Child other than a newborn Dependent Child or a newly adopted Dependent Child, is eligible for Guaranteed Issue coverage, and the Employee applies for coverage and agrees to make required contributions within 31 days after the date the Dependent Child becomes eligible and, subject to the *Deferred Effective Date Provisions* section below, coverage becomes effective on the later of:

1. the effective date of the Subscriber's participation under this Policy;
2. the date the Employee becomes eligible at the end of the Eligibility Waiting Period;
3. the date the Employee's coverage becomes effective;
4. the date the dependent meets the definition of Dependent Child as applicable;

5. the first of the month following the date We or the Employer receive the completed enrollment form for Dependent Child coverage.

If the Dependent Child who is a newborn Dependent Child or a newly adopted Dependent Child, is eligible for Guaranteed Issue coverage, and the Employee applies for coverage and agrees to make required contributions within 31 days after the date the Dependent Child becomes eligible and, subject to the *Deferred Effective Date Provisions* section below, coverage becomes effective on the later of:

1. the effective date of the Subscriber's participation under this Policy;
2. the date the Employee becomes eligible at the end of the Eligibility Waiting Period;
3. the date the Employee's coverage becomes effective;
4. the date the dependent meets the definition of Dependent Child as applicable;
5. the first of the month following the date We or the Employer receive the completed enrollment form for Dependent Child coverage.

- b. Under the *Effective Date Provisions* section, the following provision is added:

Newborn and Newly Adopted Children

If notice and payment of additional premium are required for dependent coverage under this Policy, the Policy may require notice of birth, placement or adoption and payment of required premium as a condition of coverage for newborn and newly adopted children. The notification period shall be not less than 60 days from the date of birth for a newborn child or, for newly adopted children, 60 days from the earlier of the date of adoption or placement for adoption. The due date for payment of any additional premium, if required, shall be not less than 31 days following receipt by the health plan member of a billing for the required premium.

Coverage for newborns and newly adopted children shall include coverage for Sickness caused by a Congenital Anomaly.

- c. Under *Group Enrollment Effective Dates*, the following is added:

The Dependent Child other than a newborn Dependent Child or a newly adopted Dependent Child, who is eligible to apply, but was not previously enrolled by the Employee, the Employee may apply or is insured the Employee may apply for an increase for coverage.

The Dependent Child who is a newborn Dependent Child or a newly adopted Dependent Child, who is eligible to apply, but was not previously enrolled by the Employee, the Employee may apply or is insured the Employee may apply for an increase for coverage.

- d. Under *Termination of Insurance* section, the following item is added:

for a Dependent Child, the date the Dependent Child, ceases to qualify as a Dependent Child.

- 5) Under Exclusions section, the following changes are made:

- a. The list of exclusions is replaced with the following:

1. intentionally self-inflicted Injury, suicide or any attempt thereof while sane or insane;
2. active participation in a felony, riot or insurrection;
3. declared or undeclared war or act of war;
4. a Covered Loss that results from active duty service in the military, naval or air force of any country or international organization. Upon Our receipt of proof of service, We will refund any premium paid for this time. Reserve or National Guard active duty training is not excluded unless it extends beyond 31 days.

- 6) Under the *Claims Provision* section, the following changes are made:

Time of Payment of Claim provision is replaced with the following:

Time of Payment of Claims

We will pay benefits due under this Policy for any loss other than a loss for which this Policy provides any periodic payment immediately upon Our receipt of due written or authorized electronic proof of such loss. Due proof of loss means all essential information needed to make a determination on the claim. Subject to due written or authorized electronic proof of loss, all accrued benefits for loss for which this Policy provides periodic payment will be paid monthly unless otherwise specified in the benefits descriptions and any balance remaining unpaid at the termination of liability will be paid immediately upon receipt of proof satisfactory to Us.

- 7) Under *Administrative Provision* section, the following changes have been made:

Add the following *Refund of Unearned Premium* provision:

Refund of Unearned Premium

If the Policyholder cancels this Policy for any reason, We shall refund the pro rata portion of the Unused Collected Premium to the beginning of the next monthly billing cycle. “Unused Collected Premium” as used herein means that portion of any premium collected which is not used, on a pro rata basis to the beginning of the next monthly billing cycle at the time of cancellation, by Us to insure against loss as there is no risk of loss from Covered Persons, or that portion of any collected premium which would have not been collected had the premium been paid monthly.

- 8) Under *General Provisions* section, add the following Consumer Affairs contact information:

Contact Information for the Idaho Department of Insurance

Idaho Department of Insurance
Consumer Affairs
700 W. State Street, 3rd Floor
P.O. Box 83720
Boise, ID 83720-0043
1-800-721-3272 or 208-334-4250 or www.DOI.Idaho.gov

Indiana residents:

- 1) Under the *Claims Provisions*, the Time of Payment of Claims is replaced with the following:

Time of Payment of Claims

We will pay benefits due under this Policy for any loss other than a loss for which this Policy provides any periodic payment immediately after receipt of due written or authorized electronic proof of such loss. Subject to due written or authorized electronic proof of loss, all accrued benefits for loss for which this Policy provides periodic payment will be paid monthly unless otherwise specified in the benefits descriptions and any balance remaining unpaid at the termination of liability will be paid immediately upon receipt of proof satisfactory to Us.

We shall pay or deny each Clean Claim as follows: (1) if the claim is filed electronically, within 30 days after the date We receive the claim; or (2) if the claim is filed on paper, within 45 days after the date We receive the claim. We shall notify a claimant of any deficiencies in a submitted claim not more than: (1) 30 days for a claim that is filed electronically; or (2) 45 days for a claim that is filed on paper; and describe any remedy necessary to establish a Clean Claim. Our failure to notify a claimant as required above establishes the submitted claim as a Clean Claim. If We fail to pay or deny a Clean Claim in the time required above, and We subsequently pay the claim, We shall pay the claimant interest, at the rate prescribed by Indiana law, on the allowable amount of the claim paid. Interest accrues beginning: (1) 31 days after the date the electronic claim is filed; or (2) 46 days after the date the paper claim is filed; and stops on the date the claim is paid.

A "Clean Claim" means a claim submitted for payment that has no defect, impropriety, or particular circumstance requiring special treatment preventing payment.

- 2) Under the *General Provisions*, the following "Internal and External Grievance Procedures" provision is added:

Internal and External Grievance Procedures

INTERNAL GRIEVANCE PROCEDURE

A "grievance" means any dissatisfaction expressed by or on behalf of a Covered Person regarding matters pertaining to the contractual relationship between:

1. a Covered Person and Us; or
2. the Subscriber and Us;

and for which the Covered Person has a reasonable expectation that action will be taken to resolve or reconsider the matter that is the subject of dissatisfaction.

A Covered Person may file a grievance orally or in writing. We shall make available to Covered Persons a toll free telephone number through which a grievance may be filed. A grievance is considered to be filed on the first date it is received, either by telephone or in writing. We have established procedures to assist Covered Persons in filing grievances. A Covered Person may designate a representative to file a grievance for the Covered Person and to represent the Covered Person in a grievance.

Our grievance procedures include the following:

1. Acknowledgment of the grievance, given orally or in writing, to the Covered Person within 5 business days after receipt of the grievance.
2. Documentation of the substance of the grievance and any actions taken.
3. Notification to the Covered Person of the disposition of the grievance and the right to appeal.
4. Standards for timeliness in:
 - a. responding to grievances; and
 - b. providing notice to Covered Persons of the disposition of the grievance, and the right to appeal; that accommodate the clinical urgency of the situation.

A grievance shall be resolved as expeditiously as possible, but not more than 20 business days after We receive all information reasonably necessary to complete the review. If We are unable to make a decision regarding the grievance within the 20 day period due to circumstances beyond Our control, We shall:

1. before the 20th business day, notify the Covered Person in writing of the reason for the delay; and
2. issue a written decision regarding the grievance within an additional 10 business days.

We shall notify a Covered Person in writing of the resolution of a grievance within 5 business days after completing an investigation. The grievance resolution notice must include the following:

1. A statement of the decision reached by Us.
2. A statement of the reasons, policies, and procedures that are the basis of the decision.
3. Notice of the Covered Person's right to appeal the decision.
4. The department, address, and telephone number through which a Covered Person may contact a qualified representative to obtain additional information about the decision or the right to appeal.

Appeals of Grievance Decisions

A Covered Person may file an appeal of a grievance decision orally or in writing. Our appeal procedures include the following:

1. Written or oral acknowledgment of the appeal not more than 5 business days after the appeal is filed.
2. Documentation of the substance of the appeal and the actions taken.
3. Notification to the Covered Person:
 - a. of the disposition of an appeal; and
 - b. that the Covered Person may have the right to further remedies allowed by law.
4. Standards for timeliness in:
 - a. responding to an appeal; and
 - b. providing notice to Covered Persons of the disposition of an appeal, and of the right to initiate an external grievance review under IC 27-8-29; that accommodate the clinical urgency of the situation.

An appeal of a grievance decision shall be resolved:

1. as expeditiously as possible, reflecting the clinical urgency of the situation; and
2. not later than 45 days after the appeal is filed.

We shall notify a Covered Person in writing of the resolution of an appeal of a grievance decision within 5 business days after completing the investigation. The appeal resolution notice shall include the following:

1. A statement of the decision reached by Us.
2. A statement of the reasons, policies, and procedures that are the basis of the decision.
3. Notice of the Covered Person's right to further remedies allowed by law, including the right to external grievance review by an independent review organization under IC 27-8-29.
4. The department, address, and telephone number through which a Covered Person may contact a qualified representative to obtain more information about the decision or the right to an external grievance review.

EXTERNAL REVIEW OF GRIEVANCES

An external grievance procedure is available for the resolution of external grievances regarding:

1. an adverse determination of appropriateness;
2. an adverse determination of medical necessity;
3. a determination that a proposed service is experimental or investigational; or
4. a denial of coverage based on a waiver described in IC 27-8-5-2.5 or IC 27-8-5-19.2; made by Us or an agent of Ours regarding a service proposed by the treating health care provider.

Our external grievance procedure shall:

1. allow a Covered Person or a Covered Person's representative to file a written request with Us for an external grievance review of Our:
 - a. appeal resolution of a grievance; or
 - b. denial of coverage based on a waiver described in IC 27-8-5-2.5 or IC 27-8-5-19.2; not more than 45 days after the Covered Person is notified of the resolution; and
2. provide for:
 - a. an expedited external grievance review for a grievance related to an illness, a disease, a condition, an injury, or a disability if the time frame for a standard review would seriously jeopardize the Covered Person's life or health, or ability to reach and maintain maximum function; or
 - b. standard external grievance review for a grievance not described in item 2.a. above.

A Covered Person may file not more than one external grievance of Our appeal resolution.

A Covered Person shall not pay any of the costs associated with the services of an independent review organization under this external review procedure. All costs must be paid by Us.

A Covered Person who files an external grievance:

1. shall not be subject to retaliation for exercising the Covered Person's right to an external grievance;
2. shall be permitted to utilize the assistance of other individuals, including health care providers, attorneys, friends, and family members throughout the review process;
3. shall be permitted to submit additional information relating to the proposed service throughout the review process; and
4. shall cooperate with the independent review organization by:
 - a. providing any requested medical information; or
 - b. authorizing the release of necessary medical information.

We shall cooperate with an independent review organization by promptly providing any information requested by the independent review organization.

An independent review organization shall:

1. for an expedited external grievance, within 3 business days after the external grievance is filed; or
2. for a standard appeal, within 15 business days after the appeal is filed; make a determination to uphold or reverse Our appeal resolution of a grievance based on information gathered from the Covered Person or the Covered Person's designee, Us, and the treating health care provider, and any additional information that the independent review organization considers necessary and appropriate.

When making the determination, the independent review organization shall apply:

1. standards of decision making that are based on objective clinical evidence; and
2. the terms of the Covered Person's accident and sickness insurance policy.

In an external grievance, We bear the burden of proving that We properly denied coverage for a condition, complication, service, or treatment because the condition, complication, service, or treatment is directly related to a condition for which coverage has been waived under IC 27-8-5-2.5 or IC 27-8-5-19.2.

The independent review organization shall notify Us and the Covered Person of their determination:

1. for an expedited external grievance, within 24 hours after making the determination; and
2. for a standard external grievance, within 72 hours after making the determination.

Upon the request of a Covered Person who is notified that the independent review organization has made a determination, the independent review organization shall provide to the Covered Person all information reasonably necessary to enable the Covered Person to understand the:

1. effect of the determination on the Covered Person; and
2. manner in which We may be expected to respond to the determination.

A determination made under this external review of grievances procedure is binding on Us.

If, at any time during an external review performed, the Covered Person submits information to Us that is relevant to Our resolution of the Covered Person's appeal of a grievance decision and that was not considered by Us:

1. We may reconsider the resolution; and
2. if We choose to reconsider, the independent review organization shall cease the external review process until the reconsideration is completed.

If We reconsider the resolution of an appeal of a grievance decision due to the submission of new information, We shall reconsider the resolution based on the information, and notify the Covered Person of Our decision:

1. within 72 hours after the information is submitted, for a reconsideration related to an illness, a disease, a condition, an injury, or a disability that would seriously jeopardize the Covered Person's life or health, or ability to reach and maintain maximum function; or
2. within 15 days after the information is submitted, for a reconsideration not described in item 1. above.

If the decision reached is adverse to the Covered Person, the Covered Person may request that the independent review organization resume the external review. If We choose not to reconsider Our resolution of a grievance, We shall forward the submitted information to the independent review organization not more than 2 business days after Our receipt of the information.

Louisiana residents:

- 1) The definition of Dependent Child is replaced with the following:

Dependent Child

An Employee's natural child, stepchild, foster child, legally adopted child, child of adopting parents pending finalization of adoption procedures, and child for whom coverage has been court-ordered, as follows:

1. unmarried child from live birth under 26 years of age;
2. unmarried grandchild under 26 years of age who is in the Employee's legal custody and residing in the Employee's home;
3. the otherwise applicable limiting age shown above shall not apply to the Employee's unmarried child or grandchild who is incapable of self-support due to a mental or physical incapacity.

Any unmarried child who is placed in the Employee's home pursuant to an adoption placement agreement executed with a licensed adoption agency shall be considered a Dependent Child of the Employee from the date of placement in the Employee's home.

Any unmarried child who is placed in the Employee's home following execution of an act of voluntary surrender in favor of the Employee or the Employee's legal representative shall be considered a Dependent Child of the Employee effective on the date on which the act of voluntary surrender becomes irrevocable.

A child, for purposes of this provision, includes a child of the Employee's Domestic Partner/Partner to a Civil Union, provided the child is living with, and is financially dependent upon the Employee.

- 2) Under the *Claim Provisions* section, the Time of Payment of Claims provision is replaced with the following:

Time of Payment of Claims

All claims arising under the terms of the Policy shall be paid not more than 30 days from the date upon which written or authorized electronic notice and proof of claim, in the form required by the terms of the Policy, are furnished to Us unless reasonable grounds, such as would put a reasonable and prudent businessman on His guard, exist. Failure to comply with this provision shall subject Us to a penalty payable to the Employee of double the amount of the benefits due under the terms of the Policy during the period of delay, together with attorney's fees to be determined by the court.

- 3) Under the *Administrative Provisions* section, the following changes apply:

1. Under the Changes in Premium Rates section, a 45 day notice is required for change of premiums.
2. The Reinstatement Provision is modified as follows:
 - a. If Your Active Service ends due to the Employer-approved unpaid leave of absence, other than an approved FMLA leave, insurance may be reinstated only if the reinstatement occurs within 12 weeks from the date insurance ends.

- 4) Under the *General Provisions* section, the following changes are made:

- a. The following provision is added:

New Entrants

All new Employees becoming eligible for insurance in one of the Covered Classes shall be added.

- b. The first paragraph of the Policy Termination provision is replaced with the following:

We may terminate insurance on or after the first anniversary of the Policy Effective Date. The Subscriber or We may terminate insurance on any Premium Due Date. Written notice with the reason for such termination, by certified mail, must be given at least 60 days prior to such Premium Due Date. Failure by the Subscriber to pay premiums when due or within the Grace Period shall be deemed notice to Us to terminate insurance at the end of the period for which premium was paid.

Massachusetts residents:

Under the *Continuation of Insurance Provisions* section, the following provision is added:

CONTINUATION OF INSURANCE PROVISIONS

Additional Continuation of Insurance Provisions

If an Employee leaves the group due to termination of employment resulting from a Plant Closing or Partial Closing, insurance for such Employee will be continued until the earliest of the following dates:

1. 90 days from the date of the Plant Closing or Partial Closing;
2. The date the Employee becomes eligible for similar benefits.

As used in this provision:

"Plant Closing" means a permanent cessation or reduction of business at a facility which results or will result as determined by the director in the permanent separation of at least 90% of the employees of said facility within a period of six months prior to the date of certification or with such other period as the director shall prescribe, provided that such period shall fall within the six month period prior to the date of certification.

"Partial Closing" means a permanent cessation of a major discrete portion of the business conducted at a facility which results in the termination of a significant number of the employees of said facility and which affects workers and communities in a manner similar to that of Plant Closings.

If an Employee leaves the group for a reason other than as a result of a Plant Closing or Partial Closing, insurance for such Employee will be continued until the earliest of the following dates:

1. 31 days from the date the Employee leaves the group;
2. The date the Employee becomes eligible for similar benefits.

Minnesota residents:

Under the *Exclusions* section, the list of exclusions is replaced with the following:

1. intentionally self-inflicted Injury;
2. commission or attempt to commit a felony;
3. declared or undeclared war or act of war;
4. a Covered Loss that results from active duty service in the military, naval or air force of any country or international organization. Upon Our receipt of proof of service, We will refund any premium paid for this time. Reserve or National Guard active duty training is not excluded unless it extends beyond 31 days;
5. being under the influence of any narcotic, unless the narcotic is administered on the advice of a Physician;
6. operating any type of vehicle while under the influence of alcohol or any drug, narcotic or other intoxicant. "Under the influence of alcohol", for purposes of this exclusion, means intoxicated, as defined by the law of the state in which the Covered Loss occurred.

New Hampshire residents:

1) Under the *Claim Provisions* section, the following changes are made:

a. The Proof of Loss provision is replaced with the following:

Proof of Loss

Written or authorized electronic proof of loss satisfactory to Us must be given to Us at Our office, within 90 days of the loss for which claim is made. If (a) benefits are payable as periodic payments and (b) each payment is contingent upon continuing loss, then proof of loss must be submitted within 90 days after the termination of each period for which We are liable. If written or authorized electronic notice is not given within that time, no claim will be invalidated or reduced if it is shown that such notice was given as soon as was reasonably possible.

b. The Time of Payment of Claims provision is replaced with the following:

Time of Payment of Claims

We will pay benefits due under this Policy for any loss other than a loss for which this Policy provides any periodic payment not more than 30 days after receipt of due written or authorized electronic proof of such loss. Subject to due written or authorized electronic proof of loss, all accrued benefits for loss for which this Policy provides periodic payment will be paid monthly unless otherwise specified in the benefits descriptions and any balance remaining unpaid at the termination of liability will be paid immediately upon receipt of proof satisfactory to Us.

c. The Payment of Claims provision is replaced with the following:

Payment of Claims

All benefits will be paid in United States currency. All benefits payable under the Policy are payable to the Covered Person, if living, except if the Covered Person is a Dependent Child, then the benefits will be payable to the Employee. If the Covered Person dies while any of these benefits remain unpaid, benefits payable under the Policy will be paid to the Covered Person's Spouse, if living, or otherwise to the executors or administrators of the Covered Person's estate.

Benefits will be reduced by any outstanding premium due.

If We are to pay benefits to the estate or to a person who is incapable of giving a valid release, We may pay up to an amount not exceeding \$1,000 to a relative by blood or marriage whom We believe is equitably entitled.

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

2) Under the *General Provisions* section, the following changes are made:

a. If the Subscriber Participation Under This Policy provision does not apply.

b. The 30 Day Right To Examine Certificate provision does not apply within this section and is added to the Certificate Face Page.

c. The Assignment provision is replaced with the following:

Assignment

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

- d. The Incontestability provision is replaced with the following:

Incontestability

This Policy

All statements made by the Employer to obtain this Policy are considered representations and not warranties. No statement will be used to deny or reduce benefits or be used as a defense to a claim, or to deny the validity of this Policy, unless a signed copy of the instrument containing the statement is, or has been, furnished to the Employer.

After two years from the Policy Effective Date, no such statement will cause this Policy to be contested except for non-payment of premium.

A Covered Person's Insurance

All statements made by a Covered Person are considered representations and not warranties. No statement will be used to deny or reduce benefits or be used as a defense to a claim, unless a signed copy of the instrument containing the statement is, or has been, furnished to the claimant.

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

In the event of death or incapacity, the beneficiary or representative shall be given a copy.

- e. The Policy Termination provision is replaced with the following:

Policy Termination

The Employer may terminate insurance on any Premium Due Date. We may terminate insurance on or after the first anniversary of the Policy Effective Date if:

1. there is a change in the factors bearing on the risk assumed;
2. all policies in the state of delivery are terminated; or
3. all policies providing this coverage are terminated.

Written notice by certified mail must be given at least 45 days prior to such Premium Due Date. Failure by the Employer to pay premiums when due or within the Grace Period shall be deemed notice to Us to terminate insurance at the end of the period for which premium was paid.

Termination will not affect a claim for a Covered Loss that is the result, directly and independently of all other causes, of a loss that occurs while insurance was in effect.

- f. The following provision is added at the end of the section:

Important Notice

A Covered Person may contact the Insurance Company, using the address or toll-free telephone number given below, with questions or problems with respect to the Covered Person's Certificate:

Life Insurance Company of North America
1601 Chestnut Street
Philadelphia, PA 19192-2235
Telephone: 1.800.547.5515

North Carolina residents:

- 1) Benefit Waiting Period cannot exceed 30 days.
- 2) Under the *General Definitions* section, the following definitions are replaced with the following:
 - a. Under the Active Service definition, the following is added as the last sentence in item 2:
Employment shall be considered continuous and not be considered broken except for unexcused absences from work for reasons other than illness or injury.
 - b. Under the Date of Diagnosis definition, the following is added as the last sentence:
A Clinical Diagnosis that can only be made postmortem will also be accepted.
 - c. The Dependent Child definition is replaced with the following:
Dependent Child An Employee's child who meets the following requirements:
 1. A child from live birth to 26 years old;
 2. A child who is 26 or more years old, and incapable of self-sustaining employment by reason of mental or physical handicap.

A child, for purposes of this provision, includes an Employee's:

 1. natural child;
 2. adopted child, foster child, beginning from the moment of placement in the home. It also means the legally adopted child or foster child of the Employee's Spouse or domestic partner/Partner to a Civil Union;
 3. stepchild;
 4. child, grandchild for whom the Employee is the court-appointed legal guardian;
 5. a child of the Employee's domestic partner/Partner to a Civil Union.
 - d. The definition of Hospital has been modified to include the following paragraph below item #6:
Hospital The term Hospital also includes a duly licensed state tax-supported institution functioning as a specialty facility for treatment of a particular type of illness. Facilities for the performance of surgery are not required.
- 3) *The Eligibility, Enrollment and Effective Date* section, is modified as follows:
 - a. Under the **Group Enrollment Events** section for **Current Insureds**, the following is added next to the last paragraph:

In the event an Employee or His eligible Spouse is the parent of an otherwise eligible Dependent Child, and is required by a court or administrative order to provide coverage under this Policy to the Dependent Child, then We will allow the parent to enroll such Dependent Child without regard to any enrollment season restrictions described in this Policy.
 - b. Under the **Deferred Effective Date** Provisions section, under **Life Status Change**, modify item 3 of the third paragraph and fourth paragraphs to read:
 3. birth or adoption of a child, or acquiring a child through marriage, or adding a foster child;
- 4) *The Exclusions* section, is modified as follows:
The following war or act of war exclusion is replaced with the following:
 4. declared or undeclared war or act of war. This Exclusion does not apply to acts of terrorism;

- 5) Under the *Claim Provisions* section, the Proof of Loss, Time of Payment of Claims and Payment of Claims provision are replaced with the following:

Proof of Loss

Written or authorized electronic proof of loss satisfactory to Us must be given to Us at Our office, within 180 days of the loss for which claim is made. If (a) benefits are payable as periodic payments and (b) each payment is contingent upon continuing loss, then proof of loss must be submitted within 180 days after the termination of each period for which We are liable. If written or authorized electronic notice is not given within that time, no claim will be invalidated or reduced if it is shown that such notice was given as soon as was reasonably possible. In any case, written or authorized electronic proof must be given not more than one year after the time it is otherwise required, except if proof is not given solely due to the lack of legal capacity.

Time of Payment of Claims

We will pay benefits due under this Policy for any loss other than a loss for which this Policy provides any periodic payment immediately upon Our receipt of due written or authorized electronic proof of such loss. Due proof of loss means all essential information needed to make a determination on the claim. Subject to due written or authorized electronic proof of loss, all accrued benefits for loss for which this Policy provides periodic payment will be paid monthly unless otherwise specified in the benefits descriptions and any balance remaining unpaid at the termination of liability will be paid immediately upon receipt of proof satisfactory to Us.

Payment of Claims

All benefits will be paid in United States currency. All benefits payable under the Policy are payable to the Covered Person, if living, except if the Covered Person is a Dependent Child, then the benefits will be payable to the Employee. If the Covered Person dies while any of these benefits remain unpaid, benefits payable under the Policy will be paid to the Covered Person's Spouse, if living, or otherwise to the executors or administrators of the Covered Person's estate.

Benefits will be reduced by any outstanding premium due.

If We are to pay benefits to the estate or to a person who is incapable of giving a valid release, We may pay an amount not exceeding \$3,000, to a relative by blood or marriage whom We believe is equitably entitled.

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

- 6) Under the *Administrative Provisions* section, the following changes apply:

- a. The first paragraph of the Changes in Premium Rates provision is replaced with the following:

The premium rates may be changed by the Insurance Company from time to time with at least 45 days advance written notice. No change in rates will be made until 24 months after the Effective Date. An increase in rates will not be made more often than once in a 6 month period. However, the Insurance Company reserves the right to change the rates even during a period for which the rate is guaranteed, if any of the following events take place:

- b. The Reinstatement of Insurance provision is replaced with the following:

Reinstatement of Insurance

If an Employee's Active Service ended due to an Employer-approved leave pursuant to the Family and Medical Leave Act (FMLA) and *Continuation of Coverage* is not applicable, an Employee's coverage may be reinstated at the conclusion of the FMLA leave.

If an Employee's Active Service ends due to the Employer-approved unpaid leave of absence, other than an approved FMLA leave, coverage may be reinstated only:

1. if the reinstatement occurs within 12 weeks from the date coverage ends; or
2. when returning from military service pursuant to the Uniformed Services Employment Act of 1994 (USERRA).

Effective Date of Reinstated Insurance

Reinstated coverage will be effective on the date the Employee returns to Active Service if Evidence of Insurability is not required. If Evidence of Insurability must be satisfied, the reinstated coverage will be effective as provided in the *Effective Date Provisions* section. If the Employee did not fully satisfy the Eligibility Waiting Period, Benefit Waiting Period, or the Pre-Existing Condition Limitation (if any) before coverage ended due to an approved unpaid leave of absence, credit will be given for any time that was satisfied.

7) Under the *General Provisions* section, the following changes apply:

1. The Incontestability provision has been modified to remove the following: "except for fraud or lack of eligibility for coverage".
2. The Policy Termination provision is changed to read as follows:

Policy Termination

We may terminate coverage on or after the first anniversary of the Policy Effective Date. We or the Subscriber may terminate coverage on any Premium Due Date. Written or authorized electronic notice by certified mail must be given at least 45 days prior to such Premium Due Date. Failure by the Subscriber to pay premiums when due or within the Grace Period shall be deemed notice to Us to terminate coverage at the end of the period for which premium was paid.

Termination will not affect a claim for a Covered Loss that is the result, directly and independently of all other causes, of a loss that occurs while coverage was in effect.

Oregon residents:

If the Policy provides coverage/benefits to a Spouse, a *Domestic Partner* will be afforded the same coverage/benefits provided to a Spouse.

Domestic Partner means any of the following:

1. A person with whom the Employee has a registered domestic partnership under state law which imposes legal obligations on the parties substantially similar to marriage. Such person will continue to be recognized as a Domestic Partner unless and until: (1) the domestic partnership is dissolved under applicable law; or (2) either the Employee or the Domestic Partner marries another person.

All references in the policy to "Spouse" shall be changed to read "Spouse and Domestic Partner" except as follows:

1. A Domestic Partner shall be deemed eligible to be enrolled for insurance or eligible for Additional Benefits on the latest of:
 - a. the date of registration under Item 1 of the definition of Domestic Partner;
 - b. the date that the Employee is eligible for insurance under the Policy; or;
 - c. the effective date of this Rider to the Policy.
2. A child of a Domestic Partner may only be eligible to be insured or eligible for Additional Benefits if:
 - a. the child is primarily dependent on the Employee for financial support;
 - b. the Employee has a legal obligation of support of the child; or
 - c. the Employee is the child's legal guardian.

South Carolina residents:

- 1) Under the *Exclusions* section, the following changes are made.
 - a. The list of exclusions is replaced with the following:
 1. intentionally self-inflicted Injury, suicide or any attempt thereat while sane or insane;
 2. commission or attempt to commit a felony or an assault;
 3. declared or undeclared war or act of war;
 4. a Covered Loss that results from active duty service in the military, naval or air force of any country or international organization. Upon Our receipt of proof of service, We will refund any premium paid for this time. Reserve or National Guard active duty training is not excluded unless it extends beyond 31 days;
 5. any loss resulting from being Intoxicated or under the influence of alcohol or any drug, narcotic or other intoxicant or under the influence of a narcotic unless taken on the advice of a Physician. "Under the influence of alcohol" or "Intoxicated", for purposes of this exclusion, means intoxicated, as defined by the law of the state in which the Covered Loss occurred;
 6. diagnosis not in accordance with generally accepted medical principles prevailing in the United States at the time of the diagnosis.

- 2) Under the *Claim Provisions* section, the following changes are made:
 - a. The Physical Examination and Autopsy provision is replaced with the following:

Physical Examination and Autopsy

We, at Our own expense, may examine the Covered Person for whom claim is made as often as reasonably necessary while a claim is pending and, in the case of death of the Covered Person, We, at Our own expense, also may have an autopsy performed during the period of contestability unless prohibited by law. The autopsy must be performed in South Carolina.

- b. The Legal Actions provision is replaced with the following:

Legal Actions

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

- 3) Under the *General Provisions* section, the following changes are made:
 - a. The Entire Contract; Changes provision is replaced with the following:

Entire Contract; Changes

This Policy, including the endorsements, amendments, group application form if any and any attached papers constitutes the entire contract of insurance. No change in this Policy will be valid until approved by one of Our executive officers and endorsed on or attached to this Policy. No agent has authority to change this Policy or to waive any of its provisions.

- b. The Policy Termination provision is amended to include the following as last paragraph:

However, if the premium is to be collected in weekly, monthly, or other periodic installments by authority of a payroll deduction order executed by the Employee and delivered to Us or the Employer authorizing the deduction of premium installments from the Employee's salary or wages, We may not, during the period for which the Policy is issued and while the Employee remains employed by the authorized Employer, declare forfeited or lapsed the Policy until and unless a written or printed notice of the failure of the Employer to remit the premium or installment thereof, stating the amount or portion thereof due on the Policy and to whom it must be paid, has been duly addressed and mailed to the Employee who is insured under the Policy at least fifteen days before the Policy is terminated or lapsed.

South Dakota residents:

Under the *Exclusions* section, the list of exclusions is replaced with the following:

1. intentionally self-inflicted Injury, suicide or any attempt thereat while sane or insane;
2. commission or attempt to commit a felony or an assault;
3. declared or undeclared war or act of war;
4. a Covered Loss that results from active duty service in the military, naval or air force of any country or international organization. Upon Our receipt of proof of service, We will refund any premium paid for this time. Reserve or National Guard active duty training is not excluded unless it extends beyond 31 days.
5. diagnosis not in accordance with generally accepted medical principles prevailing in the United States at the time of the diagnosis.

Texas residents:

- 1) Under the *General Definitions* section, the Dependent Child definition is replaced with the following:

Dependent Child

An Employee's child who meets the following requirements:

1. A child who is less than 26 years old;
2. A child of any age who is dependent on an Employee, and is either medically certified as disabled, or is incapable of self-support due to mental retardation or physical handicap.

A child, for purposes of this provision, includes an Employee's:

1. natural child;
2. adopted child, beginning with any waiting period pending finalization of the child's adoption. It also means a child of an Employee who is a party to a suit in which the Employee seeks to adopt the child, or the legally adopted child of the Employee's Spouse or Domestic Partner/Partner to a Civil Union provided the child is living with, and is financially dependent upon the Employee;
3. stepchild who resides with the Employee and is financially dependent upon the Employee;
4. child for whom the Employee is the court-appointed legal guardian, as long as the child resides with the Employee and primarily depends on the Employee for financial support. Financial support means that the Employee is eligible to claim the dependent for purposes of Federal and State income tax returns;
5. a child of the Employee's domestic partner /Partner to a Civil Union, provided the child is living with, and is financially dependent upon the Employee;
6. child for whom the Employee must provide medical support under an order issued under Chapter 154, Texas Family Code, or enforceable by a court in Texas;
7. grandchild, if the grandchild is under 26 years old and is a dependent of the Employee for Federal and State income tax return purposes at the time application for coverage of the grandchild is made. Coverage for the grandchild may not be terminated solely because the covered child is no longer a dependent of the Employee for Federal and State income tax return purposes.

- 2) Under the *General Provisions* section, the Policy Termination provision is replaced with the following:

Policy Termination

We may terminate insurance, with 60 days advance written notice, on or after the first anniversary of the Policy Effective Date. The Subscriber or We may terminate insurance on any Premium Due Date. Written notice by certified mail must be given at least 60 days prior to such Premium Due Date. Failure by the Subscriber to pay premiums when due or within the Grace Period shall be deemed notice to Us to terminate insurance at the end of the period for which premium was paid.

Termination will not affect a claim for a Covered Loss that is the result, directly and independently of all other causes, of a loss that occurs while insurance was in effect.

- 3) Under the *Administrative Provisions* section, the Changes in Premium Rates provision is replaced with the following

Changes in Premium Rates

The premium rates may be changed by the Insurance Company from time to time with at least 60 days advance written notice. The Insurance Company's notice will also give the date on which a premium rate increase is to take effect. The Insurance Company will not require a response from the Employer to renew the Policy, or take other action relating to the renewal or extension of the Policy, before the 45th day after the date such notice of the premium rate increase is given.

No change in rates will be made until 12 months after the Effective Date. An increase in rates will not be made more often than once in a 12 month period. However, the Insurance Company reserves the right to change the rates even during a period for which the rate is guaranteed, if any of the following events take place:

1. The Policy terms change.
2. A division, subsidiary, eligible company, or class is added or deleted.
3. There is a change of more than 10% in the number of eligible Employees.
4. Federal or state laws or regulations affecting benefit obligations change.
5. Other changes occur in the nature of the risk that would affect the Insurance Company's original risk assessment.
6. The Insurance Company determines the Employer fails to furnish necessary information.

If an increase or decrease in rates takes place on a date that is not a Premium Due Date, a pro rata adjustment will apply from the date of the change to the next Premium Due Date.

The Employer must, upon request, give the Insurance Company any information required to determine who is insured, the amount of insurance in force and any other information needed to administer the plan of insurance.

Vermont residents:

- 1) To the extent the Policy provides insurance coverage to a spouse, the identical consideration must be applied to same sex marriages and civil unions. The language is as follows:
 1. Civil Union Partner means:
 - a. A person with whom the Employee has a registered civil union under Vermont law which imposes obligations on the parties substantially similar to marriage. Such person will continue to be recognized as a Civil Union Partner unless and until: (1) the civil union is dissolved under applicable law; or (2) either the Employee or the Civil Union Partner marries another person.
 2. Spouse means:
 - a. "Lawful spouse" and includes a lawful spouse of the same sex.
 - b. This also includes a partner to a civil union recognized under Vermont Law.
- 2) Portability is replaced with the Continuation for Loss of Eligibility. The Maximum Port Age does not apply.

The following Continuation of Loss of Eligibility benefit periods have been added:

Loss of Eligibility

Maximum Benefit Period	
Employee	to age 100
Spouse	to age 100
Dependent Children	to age 26

3) Under *General Definitions*, the following changes apply:

1. The definition of **Active Service** includes Part-time employees. Item #1 under the definition of Active Service is replaced as follows:
 1. one of the Employer's scheduled work days on which the Employee is performing His regular duties on a Full-Time or Part-Time basis, either at one of the Employer's usual places of business or at some other location to which the Employer's business requires the Employee to travel; or
2. Under the **Age** definition, all references to Portability language are removed.
3. The **Benefit Waiting Period** definition has been removed.
4. The **Covered Loss** definition read as follows:

Covered Loss A loss that is:

1. one of the Covered Conditions specified in the *Schedule of Benefits*; and
2. Suffered by the Covered Person within the applicable time period described in this Policy.

5. The definition of **Employee** is replaced with the following:

Employee For eligibility purposes, an Employee of the Employer who is in one of the Covered Classes. The term does not include employees who work less than 17 ½ hours per week for the Employer.

6. The definition of **Full Time** has been removed.
7. The definition of **Hospital** cannot exclude clinics, facilities, or units of a Hospital for drug addicts or alcoholics, and facilities primarily or solely providing psychiatric services to mentally ill patients.
8. The definition of **Subscriber** has been removed.
9. The definition of **Spouse** is replaced with the following:

Spouse The Employee's current lawful Spouse or Civil Union Partner who is at least Age 18 for any coverage requiring Evidence of Insurability but not yet Age 100. Except for purposes of determining initial eligibility, the term includes a Spouse who is widowed or divorced or legally separated from an Employee. The term includes a common-law Spouse or Civil Union Partner who is recognized as a common-law Spouse or Civil Union Partner under the laws of the jurisdiction where the common-law marriage was formed.

4) Under *Eligibility/Effective Date/Termination/Continuation of Insurance*, the following changes are made:

- a) The Termination of Insurance provision is replaced with the following:

Coverage on a Covered Person will end on the earliest date below:

1. the date this Policy or coverage for a Covered Class is terminated.
2. the date the Policyholder's participation under this Policy ends.
3. the date the Employee is no longer in Active Service.
4. the next premium due date after the date the Employee is no longer in a Covered Class or satisfies eligibility requirements under this Policy.
5. the last day of the last period for which premium is paid for which a grace period will be granted for 31 days for payment of required premiums under this Policy.
6. the next premium due date after the Covered Person attains the maximum Age for coverage under this Policy, as shown in the *Schedule of Benefits*.
7. the next premium due date after the Employee ceases to be an Employee in good standing of the Policyholder.

8. with respect to a Spouse or Dependent Child, the date of the death of the covered Employee or the date of divorce from the covered Employee, unless the Spouse elects to continue coverage, including coverage on any Dependent Child.
9. the date that the plan of benefits under which the Covered Person is covered is terminated.
10. for a Spouse, the date the Spouse reaches age 100.
11. for a Dependent Child, the date the Dependent Child reaches age 26, except for children that are incapable of self-sustaining employment..
12. as to each Covered Person, the date all benefits under this Policy have been exhausted for that individual.

Termination will not affect a claim that arises while coverage was in effect.

For Continuation for Loss of Eligibility, the coverage on a Covered Person will end of the earliest date below due to a Qualifying Event:

at any time after 12 months if the Covered Person is considered to reside outside of the United States. The Covered Person will be considered to reside outside the United States when the Covered Person has been outside the United States for a total period of 12 months or more during any 12 consecutive months.

b) The following provision is added to the the *Continuation of Insurance* provision:

If an Employee is no longer in Active Service, coverage may be continued. The following provisions explain the continuation options available under this Policy. Please see the *Schedule of Benefits*, to determine the applicability of these benefits on a class level. Premiums are required for this coverage and are to be remitted in accordance with the *Payment of Premium* provision.

Continuation for Loss of Eligibility

If an Employee's coverage ends due to Loss of Eligibility from a qualifying event as defined in this section, coverage will continue up to the Maximum Benefit Period as shown in the *Schedule of Benefits*. The qualifying event means:

1. loss of employment, including a reduction in hours that results in ineligibility for employer-sponsored coverage;
2. divorce, dissolution, or legal separation of the covered employee from the employee's spouse or civil union partner;
3. a dependent child ceasing to qualify as a dependent child under the generally applicable requirements of the policy; or
4. death of the covered employee or member.

The Provisions of this section will not apply if

1. the deceased person or Employee was not insured under the group policy on the date of the qualifying event;
2. the person is covered by Medicare;
3. the person is covered by any other group insured or uninsured arrangement which provides dental coverage or hospital and medical coverage for individuals in a group and under which the person was not covered immediately prior to such qualifying event, and no preexisting condition exclusion applies.

5) Under *Exclusions* the Common Exclusions provision is modified as follows:

1. intentionally self-inflicted Injury, suicide or any attempt thereat while sane;
2. commission or attempt to commit a felony;
3. declared or undeclared war or act of war;
4. service in the armed forces or units auxiliary thereto. Upon Our receipt of proof of service, We will refund any premium paid for this time on a pro rata basis. Reserve or National Guard active duty training is not excluded unless it extends beyond 31 days.

- 6) Under the *Claim Provisions*, the Time of Payment provision is replaced with the following:

Time of Payment of Claims

We will pay benefits due under this Policy for any loss other than a loss for which this Policy provides any periodic payment immediately upon Our receipt of due written or authorized electronic proof of such loss. Due proof of loss means all essential information needed to make a determination on the claim. Subject to due written or authorized electronic proof of loss, all accrued benefits for loss for which this Policy provides periodic payment will be paid monthly unless otherwise specified in the benefits descriptions and any balance remaining unpaid at the termination of liability will be paid immediately upon receipt of proof satisfactory to Us.

- 7) Under the *General Provisions*, the Incontestability provision is replaced with the following:

Incontestability

This Policy

All statements made by the Policyholder to obtain this Policy or to participate under this Policy are considered representations and not warranties. No statement will be used to deny or reduce benefits or be used as a defense to a claim, or to deny the validity of this Policy or of participation under this Policy unless a copy of the instrument containing the statement is, or has been, furnished to the Policyholder.

After three years from the Policy Effective Date, no such statement will cause this Policy to be contested except for fraud.

A Covered Person's Insurance

All statements made by a Covered Person are considered representations and not warranties. No statement will be used to deny or reduce benefits or be used as a defense to a claim, unless a copy of the instrument containing the statement is, or has been, furnished to the claimant.

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

In the event of death or incapacity, the beneficiary or representative shall be given a copy.

- 8) When the *Wellness Treatment Rider WPB-GCI-02-7000.00* is included under your plan, the following changes apply:

Portability is not available under the Rider, but Rider benefits can be included in Continuation due to Loss of Eligibility.

Wisconsin residents:

With respect to Wisconsin certificate holders when policy is issued to employers outside of Wisconsin and covers residents of Wisconsin the Pre-existing Condition Limitation may not be more restrictive than 12/12.

Signed for the
Life Insurance Company of North America



William J. Smith, President

**SUPPLEMENTAL INFORMATION
for**

Ardent Health Services Welfare Benefit Plan (“Plan”)

**required by the Employee Retirement
Income Security Act of 1974**

As a Plan participant in AHS Management Company, Inc. dba Ardent Health Services's Plan, you are entitled to certain information, rights and protection under the Employee Retirement Income Security Act of 1974 (ERISA).

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

IMPORTANT INFORMATION ABOUT THE PLAN

- The Plan is established and maintained by AHS Management Company, Inc. dba Ardent Health Services, the Plan Sponsor.
- The Employer Identification Number (EIN) is 62-1743438.
- The Plan Number is 501.
- The Insurance Plan is administered directly by the Plan Administrator with benefits provided, in accordance with the provisions of the group insurance contract, CI961234 (“Policy”), issued by LIFE INSURANCE COMPANY OF NORTH AMERICA (“Insurance Company”).
- The Plan Administrator is: Benefits Committee, AHS Management Company, Inc.
One Burton Hills Blvd., Suite 250
Nashville, TN 37215
615-296-3000

The Plan Administrator has authority to control and manage the operation and administration of the Plan.

- The Plan Sponsor may terminate, suspend, withdraw or amend the Plan, in whole or in part, at any time, subject to the applicable provisions of the Policy. (Your rights upon termination or amendment of the Plan are set forth in your Certificate.)
- The agent for service of legal process is the Plan Administrator.
- The Plan of benefits is financed by the Employees.
- The date of the end of the Plan Year is December 31.

YOUR RIGHTS AS SET FORTH BY ERISA

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

Receive Information About Your Plan and Benefits

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

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

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

Prudent Actions by Plan Fiduciaries

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

Enforce Your Rights

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

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

Assistance with Your Questions

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

WHAT YOU SHOULD DO AND EXPECT IF YOU HAVE A CLAIM

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

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

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

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

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

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

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

9. A notice provided in a culturally and linguistically appropriate manner, to the extent required by ERISA.

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

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

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

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

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

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

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

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

6. A discussion of the decision, including an explanation of the basis for disagreeing with or not following: (i) the views presented by the claimant to the Insurance Company of the health care professionals treating the claimant and vocational professionals who evaluated the claimant; (ii) the views of medical or vocational experts whose advice was obtained on behalf of the Insurance Company in connection with the adverse decision, without regard to whether the advice was relied upon in making the adverse decision; and (iii) a disability decision regarding the claimant presented by the claimant to the Insurance Company made by the Social Security Administration;
7. Either the specific internal rules, guidelines, protocols, standards or other similar plan criteria the Insurance Company relied upon in making the decision, or, alternatively, a statement that such rules, guidelines, protocols, standards or other similar plan criteria do not exist;
8. If the adverse decision is based upon medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the decision, applying the terms of the Policy to the claimant's medical circumstances, or a statement that such explanation will be provided free of charge upon request; and
9. A notice provided in a culturally and linguistically appropriate manner, to the extent required by ERISA.

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

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

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

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

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

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

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

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

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

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

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

ER-03-2

UNDERWRITTEN BY:
LIFE INSURANCE COMPANY OF NORTH AMERICA
a Cigna company

Class 1

02/2020

