Docusign Envelope ID: CA949AC0-8DFA-802E-8299-163FB9151576

# National Conference on Public Employee Retirement Systems

## Critical Illness Coverage

Prudential

Docusign Envelope ID: CA949AC0-8DFA-802E-8299-163FB9151576

# NOTICE FOR TEXAS RESIDENTS

## Have a complaint or need help?

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

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

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

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

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

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

## ¿Tiene una queja o necesita ayuda?

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

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

Docusign Envelope ID: CA949AC0-8DFA-802E-8299-163FB9151576

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

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

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

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

Docusign Envelope ID: CA949AC0-8DFA-802E-8299-163FB9151576

# Disclosure Notice

## IMPORTANT INFORMATION FOR RESIDENTS OF CERTAIN STATES:

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

**Your Access Code is CI1.**

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

**THIS DOES NOT APPLY TO NEW MEXICO RESIDENTS.**

## FOR ARKANSAS RESIDENTS

Prudential's Customer Service Office:

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

Telephone: 1-844-455-1002

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

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

## FOR ARIZONA RESIDENTS

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

## FOR CALIFORNIA RESIDENTS

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

Docusign Envelope ID: CA949AC0-8DFA-802E-8299-163FB9151576

## FOR FLORIDA RESIDENTS

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

## FOR IDAHO RESIDENTS

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

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

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

## FOR ILLINOIS RESIDENTS

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

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

The Prudential Insurance Company of America
Voluntary Benefit Services
P.O. Box 71330
Philadelphia, PA 19176-1330
1-844-455-1002

## FOR INDIANA RESIDENTS

**Questions regarding your policy or coverage should be directed to:**

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

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

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

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

Docusign Envelope ID: CA949AC0-8DFA-802E-8299-163FB9151576

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

## FOR MARYLAND RESIDENTS

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

## FOR NORTH CAROLINA RESIDENTS

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

## FOR NEW MEXICO RESIDENTS

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

## FOR NEVADA RESIDENTS

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

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

## FOR OKLAHOMA RESIDENTS

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

## FOR TEXAS RESIDENTS

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

Docusign Envelope ID: CA949AC0-8DFA-802E-8299-163FB9151576

**DETERMINE WHETHER YOUR EMPLOYER IS A SUBSCRIBER TO THE WORKERS' COMPENSATION SYSTEM.**

## FOR WISCONSIN RESIDENTS

## KEEP THIS NOTICE WITH YOUR INSURANCE PAPERS

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

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

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

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

Docusign Envelope ID: CA949AC0-8DFA-802E-8299-163FB9151576

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

# Group Critical Illness Insurance Schedule of Benefits

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

## GROUP CONTRACT INFORMATION

**Contract Holder:** NATIONAL CONFERENCE ON PUBLIC EMPLOYEE RETIREMENT SYSTEMS
**Group Contract No:** GC-92860-DC
**Contract Anniversary:** July 1 of each year, beginning in 2027.
**Cost of Insurance:** The insurance in this Certificate is Contributory Insurance. You will be informed of the amount of Your contribution when you enroll.
**Premium Payment Date:** First of the month.

## COVERED CLASSES

**Covered Classes:** All Active Members of NCPERS other than residents of the state of New Mexico.

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

## AMOUNT OF INSURANCE

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

**Members**

| | |
|---|---|
| Any multiple of: | $5,000 |
| Minimum Amount: | $5,000 |
| Maximum Amount: | $10,000 |

**Spouse**

| | |
|---|---|
| Any multiple of: | $5,000 |
| Minimum Amount: | $5,000 |
| Maximum Amount: | $10,000 |

**Dependent Child(ren)**

| | |
|---|---|
| Any multiple of: | $2,500 |
| Maximum Amount: | $5,000 |

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

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

Docusign Envelope ID: CA949AC0-8DFA-802E-8299-163FB9151576

## CONTINUED ELIGIBILITY FOR INSURANCE MAXIMUM PERIODS

| | |
|---|---|
| Family Medical Leave of Absence | 84 days |
| Military Service | 365 days |

## CRITICAL ILLNESS BENEFITS

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

| Critical Illness | Benefit Amount |
|---|---|
| Cancer - Invasive | 100% |
| Cancer - Non-Invasive | 25% |
| Cancer - Skin Cancer | $500 |
| Heart Attack | 100% |
| Stroke | 100% |

### ADDITIONAL BENEFITS

| Benefit | Benefit Amount |
|---|---|
| Recurrence Benefit | |
| Critical Illness other than Skin Cancer | 100% |
| Skin Cancer | $500 |
| Lifetime Maximum Per Covered Person | 1x per Covered Person |

Docusign Envelope ID: CA949AC0-8DFA-802E-8299-163FB9151576

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

# Group Critical Illness Insurance Certificate

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

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

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

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

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

**THIS CERTIFICATE PROVIDES LIMITED BENEFIT COVERAGE. READ IT CAREFULLY.**

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

Margaret M. Foray — Secretary

Andrew F. Sullivan — Chief Executive Officer

**IMPORTANT INFORMATION FOR RESIDENTS OF CERTAIN STATES:** You may have additional or different rights if you are a resident of certain States pursuant to the laws of such State. If you are a resident of one of these States, these rights apply to your coverage and are made a part of your Group Insurance Certificate. Please contact Prudential at 1-844-455-1002 for more information.

Docusign Envelope ID: CA949AC0-8DFA-802E-8299-163FB9151576

# Table of Contents

DEFINITIONS.....5
BENEFIT DESCRIPTIONS.....7
ELIGIBILITY, EFFECTIVE DATE AND TERMINATION.....10
PREMIUM PROVISIONS.....13
CLAIM PROVISIONS.....14
GENERAL PROVISIONS.....15
EXCLUSIONS.....16

Docusign Envelope ID: CA949AC0-8DFA-802E-8299-163FB9151576

# Definitions

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

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

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

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

**Child/Children** means Your unmarried Children from live birth to 26 years old. Your Children include:

- Biological children;
- Legally adopted children, children placed with You for adoption prior to legal adoption, and each of Your stepchildren;
- Foster children;
- Your Spouse's children; and
- Children for whom You or Your Spouse:
    - have been appointed the legal guardian; and
    - claim as a dependent on Your or Your Spouse's federal income tax returns.

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

Your Children also include a Child who is older than 25 years of age and is:

- incapable of self-sustaining employment because of a mental or physical disability; and
- chiefly dependent on You for support and maintenance.

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

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

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

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

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

Docusign Envelope ID: CA949AC0-8DFA-802E-8299-163FB9151576

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

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

**Member** means a person who is an active, dues paying member in good standing of the National Conference on Public Employee Retirement Systems. The term also applies to that person for any rights after insurance ends.

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

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

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

**Premium** means the amount required to pay for Your insurance.

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

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

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

**Spouse** means the person recognized as Your Spouse under the laws of the state in which the marriage was entered into. Whenever the term Spouse appears in this Certificate, it includes a civil union partner and domestic partnerships as defined below.

**Civil Union Partner** means a same sex relationship similar to marriage that is recognized as a Civil Union by the District of Columbia.

**Domestic Partner** means an unmarried person of the same or opposite sex who resides with the insured and has registered in a state or local domestic partner registry with the insured.

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

**You, Your, Yours** means a Member.

Docusign Envelope ID: CA949AC0-8DFA-802E-8299-163FB9151576

# Benefit Descriptions

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

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

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

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

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

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

- carcinoma in situ classified as TisN0M0, provided that surgery, radiotherapy or chemotherapy has been determined to be medically necessary by the treating Doctor who is board certified in the medical specialty that is appropriate for the type of carcinoma in situ involved;
- malignant tumors classified as T1N0M0 or greater which are treatable by endoscopic procedures alone;
- malignant melanomas classified as T1N0M0, for which a pathology report shows maximum thickness less than or equal to 1.0 millimeters using the Breslow method of determining tumor thickness; and
- tumors of the prostate classified as T1bN0M0, or T1cN0M0 and/or a Gleason score of 6 or less.

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

**Cancer** - ***Skin Cancer*:** We will pay the amount shown in the Schedule of Benefits if a Covered Person is diagnosed with Skin Cancer. Skin Cancer means any malignancy of the skin diagnosed

Docusign Envelope ID: CA949AC0-8DFA-802E-8299-163FB9151576

with histological confirmation and characterized by uncontrolled growth of malignant cells and invasion of tissue. It includes:

- basal cell carcinoma; and
- squamous cell carcinoma.

It does not include malignant melanoma, or any condition which may be considered pre-cancerous, such as leukoplakia; actinic keratosis; carcinoid; hyperplasia; non-malignant melanoma; moles; or similar diseases or lesions. Medical evidence of a definite diagnosis of Skin Cancer by a Doctor is required as proof of claim. A clinical diagnosis will be accepted whenever such diagnosis is consistent with professional medical standards.

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

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

**Stroke:** We will pay the amount shown in the Schedule of Benefits if a Covered Person is diagnosed with a Stroke. Stroke means death of brain tissue due to inadequate blood supply or hemorrhage within the skull resulting in a permanent and significant neurological deficit with persistent clinical symptoms. It does not include transient ischemic attacks (TIA). Medical evidence of a definite diagnosis of Stroke by a Doctor is required as proof of claim.

# ADDITIONAL BENEFITS

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

## RECURRENCE BENEFIT

**Recurrence Benefit for Critical Illness Other than Cancer - Skin Cancer**

We will pay a Recurrence Benefit if a Covered Person:

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

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

**Recurrence Benefit for Skin Cancer**

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

- is positively diagnosed by a Doctor as having an additional occurrence or recurrence of Skin Cancer for which a benefit was paid under this coverage; and

Docusign Envelope ID: CA949AC0-8DFA-802E-8299-163FB9151576

- the date of the diagnosis of the additional occurrence or recurrence is more than 90 days after the date of the last medical treatment for the previous occurrence.

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

Docusign Envelope ID: CA949AC0-8DFA-802E-8299-163FB9151576

# Eligibility, Effective Date and Termination

## ELIGIBILITY

### Member Insurance

You are eligible for Member Insurance if You are a member of a Covered Class as shown in the Schedule of Benefits. You must also be Actively at Work at time of enrollment.

### Qualified Dependent Insurance

A Spouse or Child is eligible for Dependent Insurance on the later of:

- the date You are eligible for Member Insurance; or
- the date they become a Qualified Dependent.

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

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

Your Spouse or Child is not Your Qualified Dependent while they:

- are on active duty in the armed forces of any country; or
- are insured under the Group Contract as a Member.

## EFFECTIVE DATE

### Enrollment

For Contributory Insurance, You must enroll on a form approved by Us and agree to pay the required contributions. You may enroll for Contributory Insurance:

- Within 31 days of when You could first be covered;
- Within 31 days of a Qualified Life Event; or
- During the Annual Enrollment Period.

### Member Insurance

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

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

### Qualified Dependent Insurance

If You have a Qualified Dependent when You become eligible for coverage and You elect Dependent coverage, Your Qualified Dependent's coverage will begin on the date Your coverage begins. If additional Premium is required for Qualified Dependent coverage, it must be paid when due for coverage to be valid.

Docusign Envelope ID: CA949AC0-8DFA-802E-8299-163FB9151576

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

There are special rules for Qualified Dependent Children described below.

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

If You have not elected Qualified Dependent Child(ren) insurance coverage at the time of the birth or date of placement, You must notify Us within 31 days of the newly eligible Dependent Child's birth or date of placement for adoption and pay the required additional Premium for Dependent Child insurance to continue coverage beyond the initial 31 day period.

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

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

## CHANGES TO COVERAGE

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

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

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

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

**Changing Plans at Annual Enrollment - Member**
You may elect to have Your Amount of Insurance under the coverage changed during the Annual Enrollment Period. You must do this on a form approved by Us and agree to make any required Premium contributions.

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

Docusign Envelope ID: CA949AC0-8DFA-802E-8299-163FB9151576

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

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

## TERMINATION

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

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

Insurance for a Qualified Dependent will end on the date the first of the following occurs:

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

Docusign Envelope ID: CA949AC0-8DFA-802E-8299-163FB9151576

# Premium Provisions

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

**Grace Period**
You may pay each Premium other than the first within a Grace Period of 31 days without being charged interest if You are billed directly for insurance. Your coverage will remain in force during the Grace Period. Coverage will end on the last day of the Grace Period if the required Premium has not been paid.

We may cancel this coverage at any time by written notice delivered or mailed to the last known address We have in Our records for You not less than 5 days prior to the cancellation date.

**Reinstatement**
If any Premium is not paid when due, a later acceptance of Premium by Us or by any agent duly authorized by Us to accept such Premium, without requiring an application for reinstatement, shall reinstate Your coverage. However, if We or Our agent require an application for reinstatement, Your coverage will be reinstated upon the earlier of the approval of the application by Us, or the 45$^{th}$ day following the date the Premium was received by Us, unless We have previously notified You in writing of Our disapproval of the application.

The reinstated insurance shall cover only loss that occurs more than 10 days after the date of reinstatement. In all other respects, all parties shall have the same rights as under the Group Contract immediately before the due date of the defaulted Premium.

Any Premium accepted in connection with a reinstatement shall be applied to a period for which Premium has not been previously paid, but not to any period more than 60 days prior to the date of reinstatement.

Docusign Envelope ID: CA949AC0-8DFA-802E-8299-163FB9151576

# Claim Provisions

**Notice of Claim**
Notice of claim must be submitted to Us within 365 days of the date of loss. If You are not able to provide notice within this time, You must send it as soon as reasonably possible. Notice given to Us or to Our authorized agent with information sufficient to identify the Covered Person is considered notice to Us.

**Claim Forms**
Upon receipt of a notice of claim, We will provide claim forms to the claimant. If claim forms are not provided within 15 days after receiving notice of claim, the claimant can satisfy the proof of loss requirements of this Certificate by submitting written proof covering the occurrence, the character and the extent of the loss for which claim is made within the time required in this Certificate for providing proofs of loss.

**Proof of Loss**
You must send Us proof of loss satisfactory to Prudential by mail or electronically within 90 days after the date of loss. If it was not reasonably possible to provide proof of loss in that time, Your claim will not be invalidated or reduced due to late proof of loss. However, no proof of loss provided later than one year from time of diagnosis will be accepted, unless You did not have the legal capacity to provide it.

**When Benefits are Paid**
Benefits that are payable for a covered loss will be paid immediately, but no later than the 30th day, after Our receipt of the necessary proof of loss.

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

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

**Physical Exam**
We, at Our own expense, have the right to examine the person whose loss is the basis of claim. We may do this when and as often as is reasonable while the claim is pending.

**Legal Action**
You may not initiate a legal action to recover benefits under Your coverage until 60 days after We receive sufficient proof of loss regarding the claim. No legal action shall be brought after 3 years from the time written proof of loss was required to be provided.

Docusign Envelope ID: CA949AC0-8DFA-802E-8299-163FB9151576

# General Provisions

**Time Limit on Certain Defenses**
We have the right to void coverage if misstatements are made in the application for coverage. After 2 years from a Covered Person's coverage effective date, no misstatements, except fraudulent misstatements, made in the application for coverage will be used to void the Covered Person's coverage or deny a claim for a loss occurring after that 2-year period.

Any statement made by a Covered Person is a representation and not a warranty. No statement made by a Covered Person will be used to contest coverage unless the statement is in writing and signed, and a copy of the statement is given to the Covered Person, their representative, or beneficiary.

**Entire Contract**
The Group Contract, the Contract Holder's signed application, Your enrollment form, this Certificate, and any other attached riders, endorsements, or papers make up the entire contract of insurance.

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

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

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

**Conformity with State Statutes**
Any provision of this Certificate that conflicts with the requirements of any state and/or federal law that apply to this Certificate are automatically changed to satisfy the minimum requirements of such laws.

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

Docusign Envelope ID: CA949AC0-8DFA-802E-8299-163FB9151576

# Exclusions

**Exclusions**
We will not pay benefits for loss caused by, contributed to by, or resulting from, directly or indirectly, any of the following:

- suicide or attempted suicide.
- intentionally self-inflicted Injuries, or any attempt to inflict such Injuries.
- taking part in any riot or insurrection when a person willfully engages in a riot or willfully incites or urges other persons to engage in a riot. For purposes of this exclusion, “Riot” means a public disturbance involving an assemblage of 5 or more persons which by tumultuous and violent conduct or the threat thereof creates grave danger of damage or injury to property or persons.
- war, or any act of war. War means declared or undeclared war and includes resistance to armed aggression.
- commission of a crime for which You have been convicted under state or federal law.
- being under the influence of or taking any non-prescription drug, prescription drug, narcotic, stimulant, hallucinogen, barbiturate, amphetamine, gas, fumes or inhalants, poison or any other controlled substance as defined in Title II of the Comprehensive Drug Abuse Prevention and Control Act of 1970, as now or hereafter amended, unless prescribed by and administered in accordance with the advice of the Covered Person’s Doctor.
- participation in these hazardous activities: scuba diving; bungee jumping; base jumping; skydiving; ziplining; parachuting; hang gliding; paragliding; paramotoring; parascending; or ballooning.

Docusign Envelope ID: CA949AC0-8DFA-802E-8299-163FB9151576

# The Claims and Appeals section is not part of the Group Insurance Certificate.

Docusign Envelope ID: CA949AC0-8DFA-802E-8299-163FB9151576

# CLAIMS AND APPEALS

**Plan Benefits Provided by**

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

This Group Contract underwritten by The Prudential Insurance Company of America provides insured benefits. For all purposes of this Group Contract, the Employer/Policyholder acts on its own behalf or as an agent of its employees. Under no circumstances will the Employer/Policyholder be deemed the agent of The Prudential Insurance Company of America, absent a written authorization of such status executed between the Employer/Policyholder and The Prudential Insurance Company of America. Nothing in these documents shall, of themselves, be deemed to be such written execution.

Claim Procedures

**1. Determination of Benefits**

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

If your claim for benefits is denied, in whole or in part, you or your authorized representative will receive a written notice from Prudential of your denial. The notice will be written in a manner calculated to be understood by you and shall include:

(a) the specific reason(s) for the denial,

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

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

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

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

**2. Appeals of Adverse Determination**

If your claim for benefits is denied or if you do not receive a response to your claim within

Docusign Envelope ID: CA949AC0-8DFA-802E-8299-163FB9151576

the appropriate time frame (in which case the claim for benefits is deemed to have been denied), you or your representative may appeal your denied claim in writing to Prudential within 180 days of the receipt of the written notice of denial or 180 days from the date such claim is deemed denied. You may submit with your appeal any written comments, documents, records and any other information relating to your claim. Upon your request, you will also have access to, and the right to obtain copies of, all documents, records and information relevant to your claim free of charge.

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

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

If the claim on appeal is denied in whole or in part, you will receive a written notification from Prudential of the denial. The notice will be written in a manner calculated to be understood by the applicant and shall include:

(a) the specific reason(s) for the adverse determination,

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

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

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

(e) a statement that you have the right to obtain upon request and free of charge, a copy of internal rules or guidelines relied upon in making this determination, and

(f) a statement describing any appeals procedures offered by the plan.

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

If the appeal of your benefit claim is denied or if you do not receive a response to your appeal within the appropriate time frame (in which case the appeal is deemed to have been denied), you or your representative may make a second, voluntary appeal of your denial in writing to Prudential within 180 days of the receipt of the written notice of denial or 180 days from the date such claim is deemed denied. You may submit with your second appeal any written comments, documents, records and any other information relating to your claim. Upon your request, you will also have access to, and the right to obtain copies of, all documents, records and information relevant to your claim free of charge.

Prudential shall make a determination on your second claim appeal within 45 days of the receipt of your appeal request. This period may be extended by up to an additional 45 days

Docusign Envelope ID: CA949AC0-8DFA-802E-8299-163FB9151576

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

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

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

Docusign Envelope ID: CA949AC0-8DFA-802E-8299-163FB9151576