STANDARD INSURANCE COMPANY

A Stock Life Insurance Company
900 SW Fifth Avenue
Portland, Oregon 97204-1282
(503) 321-7000

GROUP ACCIDENT INSURANCE CERTIFICATE

AND SUMMARY PLAN DESCRIPTION

Policyholder:	Pave America
Employer(s):	Pave America
Group Policy Number:	762060-D
Group Policy Effective Date:	10/01/2023
State Of Issue:	Virginia

The Group Policy has been issued to the Policyholder. We certify that you will be insured as provided by the terms of the Group Policy. If your insurance is changed by an amendment to the Group Policy, we will provide the Policyholder or Employer with a revised Certificate and Summary Plan Description or other notice that will be available to you.

Possession of this Certificate and Summary Plan Description does not necessarily mean you are insured. You are insured only if you meet the requirements set out in this Certificate and Summary Plan Description.

"You" and "your" mean the Member. "We", "us" and "our" mean Standard Insurance Company. Other defined terms appear with the initial letters capitalized. Section and provision headings, and references to them, appear in boldface type.

Your Certificate and Summary Plan Description describes the insurance under the Group Policy. Please read your Certificate carefully.

THIS CERTIFICATE IS ISSUED UNDER A LIMITED BENEFIT POLICY THAT PROVIDES ACCIDENT INSURANCE BENEFITS AND IT DOES NOT PAY BENEFITS FOR LOSS FROM SICKNESS. THE POLICY UNDER WHICH THIS CERTIFICATE IS ISSUED DOES NOT PROVIDE COMPREHENSIVE HEALTH INSURANCE COVERAGE. IT IS NOT INTENDED TO SATISFY THE INDIVIDUAL MANDATE OF THE AFFORDABLE CARE ACT (ACA) OR PROVIDE THE MINIMUM ESSENTIAL COVERAGE REQUIRED BY THE ACA (OFTEN REFERRED TO AS "MAJOR MEDICAL COVERAGE"). IT DOES NOT PROVIDE COVERAGE FOR HOSPITAL, SURGICAL, OR MAJOR MEDICAL EXPENSES.

THIS CERTIFICATE IS NOT A MEDICARE SUPPLEMENT POLICY. IF YOU ARE ELIGIBLE FOR MEDICARE, REVIEW THE "GUIDE TO HEALTH INSURANCE FOR PEOPLE WITH MEDICARE" AVAILABLE FROM US.

STANDARD INSURANCE COMPANY

By

President and CEO

Table of Contents

INDEX OF DEFINED TERMS

COVERAGE FEATURES

Employer(s)

Pave America

Member

You are a Member if you are all of the following:

- An active employee of the Employer.
- Regularly working at least 30 hours each week.
- A citizen or resident of the United States.

You are not a Member if you are:

- A temporary or seasonal employee.
- A full time member of the armed forces of any country.
- A leased employee.
- An independent contractor.

Class(es)

All Members

Work (Occupational) Accident Covered: No

Eligibility Waiting Period

If you are a Member on the Group Policy Effective Date, you are eligible on that date.

If you become a Member after the Group Policy Effective Date, you are eligible on the first day of the calendar month coinciding with or next following becoming a Member.

Premium Contributions

For you or your Dependents: Contributory

Contributory means you pay all or part of the premium for insurance.

Table Of Accident Insurance Benefit Amounts

Emergency Care Benefits

Air Ambulance Benefit	$800
Blood, Plasma, and Platelet Benefit	$300
Emergency Dental Benefit	
Crown	$200
Extraction	$100
Emergency Room Benefit	$150
Ground Ambulance Benefit	$300
Initial Care Visit Benefit	$100
Major Diagnostic Exam Benefit	$200
Outpatient X-Ray Benefit	$100
Urgent Care Benefit	$100

Specific Injury Benefits

Burn Benefit		
2nd degree burn less than or equal to 15% of body surface	$200	
2nd degree burn greater than 15% of body surface	$1,000	
3rd degree burn less than or equal to 15% of body surface	$5,000	
3rd degree burn greater than 15% of body surface	$10,000	
Coma Benefit	$7,500	
Concussion Benefit	$150	
Dislocation Benefit	**Non-surgical**	**Surgical**
Ankle	$800	$1,600
Collarbone (sternocalvicular)	$800	$1,600
Collarbone (acromio and separation)	$400	$800
Elbow	$800	$1,600
Finger(s)	$150	$300
Foot (not including toe(s))	$800	$1,600
Hand (not including finger(s))	$800	$1,600
Hip	$2,500	$5,000
Knee (not including kneecap)	$900	$1,800
Lower jaw	$800	$1,600
Rib	$150	$300
Shoulder	$800	$1,600

Spine	$400	$800
Toe(s)	$150	$300
Wrist	$800	$1,600
Partial Dislocation	25% of the non-surgical amount payable for the specific dislocation amount shown above	
Eye Injury Benefit	$200	
Fracture Benefit	**Non-surgical**	**Surgical**
Ankle	$550	$1,100
Arm (elbow to wrist)	$550	$1,100
Arm (shoulder to elbow)	$550	$1,100
Bones of face (other than lower jaw or nose)	$500	$1,000
Coccyx	$500	$1,000
Collarbone	$550	$1,100
Elbow	$550	$1,100
Finger(s)	$100	$200
Foot (not including toe(s))	$550	$1,100
Hand (not including finger(s))	$550	$1,100
Hip	$2,500	$5,000
Kneecap	$550	$1,100
Leg (knee to ankle)	$1,200	$2,400
Leg (hip to knee)	$2,000	$4,000
Lower jaw	$550	$1,100
Nose	$500	$1,000
Pelvis	$1,200	$2,400
Rib	$400	$800
Shoulder blade	$550	$1,100
Skull		
Depressed	$4,000	$8,000
Non-depressed	$1,500	$3,000
Sternum	$550	$1,100
Toe(s)	$100	$200
Vertebrae	$500	$1,000
Vertebral Column	$1,200	$2,400
Wrist	$550	$1,100
Chip Fracture	25% of the non-surgical amount payable for the specific fracture shown above	
Laceration Benefit		
Less than 2 inches combined	$75	

length for all lacerations	
2-6 inches combined length for all lacerations	$200
Over 6 inches combined length for all lacerations	$500
Skin Graft Benefit	25% of Burn Benefit

Surgical Benefits

Abdominal and Thoracic Surgery Benefit	
Exploratory surgery (both laparoscopic and open)	$200
Laparoscopic surgical repair	$750
Open surgical repair	$1,500
Knee Cartilage Benefit	
Exploratory surgery	$200
One surgical repair	$750
Ruptured Disc Benefit	$750
Surgical Facility Benefit	$150
Tendon, Ligament, and Rotator Cuff Surgery Benefit	
Exploratory of any of the above	$200
Repair of one of the above	$750
Repair of more than one of the above	$1,000

Hospital Benefits

Critical Care Unit Admission Benefit	$750
Daily Critical Care Unit Confinement Benefit	$200 per day
Daily Hospital Confinement Benefit	$200 per day
Daily Rehabilitation Facility Benefit	$100 per day
Hospital Admission Benefit	$1,000

Follow Up Care Benefits

Appliance Benefit	$100
Chiropractic Care Benefit	$50 per day
Follow Up Care Benefit	$50 per day
Hearing Device Benefit	$500
Prosthesis Benefit	
One Prosthetic	$500

More than one Prosthetic	$1,000
Therapy Services Benefit	$50 per day

Additional Benefits

Health Maintenance Screening Benefit	$50 per day
Lodging Benefit	$175 per day
Transportation Benefit	$150 per day
Youth Organized Sports Benefit	25% of total Covered Accident benefits payable for Child

Accidental Death and Dismemberment (AD&D) Benefits

Accidental Death Benefit (AD Benefit)	
For you:	$50,000
For your Spouse:	$25,000
For your Child(ren):	$12,500
Accidental Dismemberment Benefit	
One hand or one foot	15% of AD Benefit
Both hands or feet	30% of AD Benefit
One hand and one foot	30% of AD Benefit
One finger or toe	2% of AD Benefit
More than one finger or toe	5% of AD Benefit
Accidental Impairment Benefit	
Loss Of Hearing	
One ear	15% of AD Benefit
Both ears	30% of AD Benefit
Loss Of Sight	
One eye	15% of AD Benefit
Both eyes	30% of AD Benefit
Hemiplegia	30% of AD Benefit
Paraplegia	30% of AD Benefit
Quadriplegia	50% of AD Benefit
Triplegia	30% of AD Benefit
Uniplegia	15% of AD Benefit

Value Added AD&D Benefits

Air Bag Benefit	10% of AD Benefit
Common Carrier Accidental Death Benefit	100% of AD Benefit

Helmet Benefit	10% of AD Benefit
Repatriation Benefit	10% of AD Benefit
Seat Belt Benefit	10% of AD Benefit

Additional Features

Reinstatement

Continuity of Coverage

Continuation of Insurance (Portability) for the Member

ERISA SUMMARY PLAN DESCRIPTION INFORMATION

Name of Plan:	Group Accident Insurance
Name, Address of Plan Sponsor:	Pave America 9469 Hawkins Drive, #3907 Manassas, VA 20109
Plan Sponsor Tax ID Number:	08-7134990
Plan Number:	507
Type of Plan:	Group Insurance Plan
Type of Administration:	Contract Administration
Name, Address, Phone Number of Plan Administrator:	Plan Sponsor 757-778-5295
Name, Address of Registered Agent for Service of Legal Process:	Pave America
If Legal Process Involves Claims For Benefits Under The Group Policy, Additional Notification of Legal Process Must Be Sent To:	Standard Insurance Company 1100 SW 6th Ave Portland OR 97204-1093
Sources of Contributions:	Member
Funding Medium:	Standard Insurance Company - Fully Insured
Plan Fiscal Year End:	September 30

ELIGIBILITY AND ENROLLMENT

Becoming Insured

To become insured you must:

- Be a Member.
- Complete your Eligibility Waiting Period.
- Meet the requirements shown in **When Your Insurance Becomes Effective** and **Active Work Requirement**.

When Your Insurance Becomes Effective

The **Coverage Features** states whether insurance is Contributory or Noncontributory. Subject to the **Active Work Requirement**, your insurance becomes effective as follows:

Contributory Insurance

You must apply in writing for Contributory insurance and agree to pay premiums. Contributory insurance becomes effective on:

- The date you become eligible if you apply on or before that date.
- The first day of the calendar month coinciding with or next following the date you apply, if you apply after you become eligible.

Changes in Your Insurance

Subject to the **Active Work Requirement**, you may apply in writing for any increase in your insurance, for which you are eligible.

Increases become effective the latest of:

- The first day of the calendar month coinciding with or next following the date you apply for the increase.

Decreases become effective on the later of:

- The first day of the calendar month coinciding with or next following the date of change in your Class.
- The first day of the calendar month coinciding with or next following the date the Policyholder or Employer receives your written request for the decrease.

Active Work Requirement

If you are incapable of Active Work because of Sickness, Injury or Pregnancy on the day before the scheduled effective date of your insurance under the Group Policy, your insurance will not become effective until the day after you complete 1 full day(s) of Active Work as an eligible Member.

Active Work and Actively At Work mean performing the material duties of your own occupation at your Employer's usual place of business.

You will also meet the Active Work requirement if you meet all of the requirements shown below:

- You were absent from Active Work because of a regularly scheduled day off, holiday, or vacation day.
- You were Actively At Work on your last scheduled work day before the date of your absence.
- You were capable of Active Work on the day before the scheduled effective date of your insurance.

When Your Insurance Ends

Insurance ends automatically on the earliest of the following:

- For Contributory insurance, the date you notify your Employer or Policyholder in writing that coverage is to be terminated.
- The date the last period ends for which the premium was paid for your insurance.

- The date the Group Policy or your Employer's coverage under the Group Policy terminates, unless you continue your insurance under the **Continuation of Insurance (Portability) for the Member** provision.
- The first day of the calendar month coinciding with or next following the date your employment terminates, unless you continue your insurance under the **Continuation of Insurance (Portability) for the Member** provision.
- The date you cease to be a Member. However, if you cease to be a Member because you are not working the required minimum number of hours, your insurance will be continued with payment of premium:
    - During the first 60 day(s) of a temporary or indefinite administrative leave of absence.
    - During any other scheduled leave of absence approved by your Employer in advance and in writing and lasting not more than 60 day(s).
    - During a leave of absence which is required by the federal or a state-mandated family or medical leave act or law.

CHILD INSURANCE

Eligibility for Child Insurance

You become eligible to insure your Child(ren) on the later of:

- The date your insurance becomes effective if you have a Child on that date.
- The date you first acquire a Child, if you are insured on that date.

A Member may not be insured as both a Member and a Child. A Child may not be insured by more than one Member.

For Contributory Child insurance, if you do not have Child insurance at the time you acquire a newborn or adopted Child, that Child is automatically insured for 31 days from the moment of birth or placement. However, you must apply in writing and pay premium back to the date of birth or placement within 31 days for Child insurance to continue. If your application is received after that 31 days, your automatic Child insurance under this provision ends on the first day after the 31 day period. This provision does not apply to you if you have an existing Child and you previously declined to enroll in Child insurance.

When Child Insurance Becomes Effective

The **Coverage Features** states whether your Child insurance is Contributory or Noncontributory. You must apply in writing for Contributory Child insurance and agree to pay premiums.

Contributory Child insurance becomes effective on the latest of:

- The date your insurance becomes effective if you have a Child on that date and you have applied for Child insurance.
- The first day of the calendar month coinciding with or next following the date you apply to insure your Child.

Changes in Child Insurance

Increases or decreases resulting from changes in your insurance will become effective for the Child on the effective date of your change in insurance.

When Child Insurance Ends

Your insurance for a Child ends automatically on the earliest of:

- The date your insurance ends, unless the Child insurance is continued under the **Continuation of Insurance (Portability) for the Member** provision.
- The date the Child insurance terminates under the Group Policy, unless the Child insurance is

continued under the **Continuation of Insurance (Portability) for the Member** provision.

- The date a Child ceases to meet the definition of Child.
- The date the last period ends for which the premium was paid for your Child insurance.
- The date the Group Policy terminates, unless the Child insurance is continued under the **Continuation of Insurance (Portability) for the Member** provision.

SPOUSE INSURANCE

Eligibility for Spouse Insurance

You become eligible to insure your Spouse on the later of:

- The date you become eligible for insurance if you have a Spouse on that date.
- The date you acquire a Spouse, if you are insured on that date.

A Member may not be insured as both a Member and a Spouse.

When Spouse Insurance Becomes Effective

The **Coverage Features** states whether your Spouse insurance is Contributory or Noncontributory. You must apply in writing for Contributory Spouse insurance and agree to pay premiums.

Contributory Spouse insurance becomes effective on the latest of:

- The date your insurance becomes effective if you apply on or before that date to insure your Spouse.
- The first day of the calendar month coinciding with or next following the date you apply to insure your Spouse.

Changes in Spouse Insurance

Increases or decreases resulting from changes in your insurance will become effective for your Spouse on the effective date of your change in insurance.

When Spouse Insurance Ends

Your insurance for a Spouse ends automatically on the earliest of:

- The date your insurance ends, unless Spouse insurance is continued under the **Continuation of Insurance (Portability) for the Member** provision.
- The date Spouse insurance terminates under the Group Policy.
- The date a Spouse ceases to meet the definition of Spouse.
- The date the last period ends for which the premium was paid for your Spouse insurance.
- The date the Group Policy terminates, unless Spouse insurance is continued under the **Continuation of Insurance (Portability) for the Member** provision.

ACCIDENT INSURANCE BENEFITS

Insuring Clause

If you or your Dependent meet the requirements for Accident Insurance Benefits while insured under the Group Policy, we will pay benefits according to the terms of the Group Policy after we receive Proof Of Loss satisfactory to us.

Emergency Care Benefits

Air Ambulance Benefit

We will pay an Air Ambulance Benefit if you or your Dependent meet all of the following requirements:

- Transportation via air Ambulance is for the same Covered Accident for which a Daily Hospital Confinement Benefit, Hospital Admission Benefit, or Emergency Room Benefit is payable.
- Transportation is to a Hospital or Health Service Facility within 72 hours of the Covered Accident.

We will pay an Air Ambulance Benefit once per Covered Accident per insured person. A Ground Ambulance Benefit and Air Ambulance Benefit may be payable for the same Covered Accident.

Blood, Plasma, and Platelet Benefit

We will pay a Blood, Plasma, and Platelet Benefit if you or your Dependent meet all of the following requirements:

- Require a transfusion of blood, plasma, or platelets (including, the administration, cross matching, typing, and processing of blood, plasma, or platelets) for a Covered Accident.
- The transfusion is administered within 90 days of the Covered Accident.

We will pay a Blood, Plasma, and Platelet Benefit once per Covered Accident per insured person.

Emergency Dental Benefit

We will pay an Emergency Dental Benefit if you or your Dependent meet all of the following requirements:

- Suffer one or more broken teeth as a result of a Covered Accident which is repaired by a Dentist with dental crown(s) and/or dental extraction(s).
- Repair must begin within 90 days of the Covered Accident.

We will pay an Emergency Dental Benefit for 1 dental crown and 1 dental extraction per Covered Accident per insured person, regardless of how many dental crowns and dental extractions occur. We will not pay for routine dental examinations or procedures.

Dentist means a licensed doctor of dentistry, acting within the scope of the license. Dentist does not include you or your Spouse or the brother, sister, parent or child of either you or your Spouse.

Emergency Room Benefit

We will pay an Emergency Room Benefit if you or your Dependent meet all of the following requirements:

- Visit an Emergency Room for a Covered Accident.
- The visit is within 72 hours of the Covered Accident.

We will pay an Emergency Room Benefit once per Covered Accident per insured person.

Ground Ambulance Benefit

We will pay a Ground Ambulance Benefit if you or your Dependent meet all of the following requirements:

- Transportation via ground Ambulance is for the same Covered Accident for which a Daily Hospital Confinement Benefit, Hospital Admission Benefit, or Emergency Room Benefit is payable.
- Transportation is to a Hospital or Health Service Facility within 90 days of the Covered Accident.

We will pay a Ground Ambulance Benefit once per Covered Accident per insured person. A Ground Ambulance Benefit and Air Ambulance Benefit may be payable for the same Covered Accident.

Initial Care Visit Benefit

We will pay an Initial Care Visit Benefit if you or your Dependent meet all of the following requirements:

- Visit a Health Care Provider for Initial Care due to a Covered Accident.
- The visit is within 72 hours of the Covered Accident.

We will pay an Initial Care Visit Benefit once per Covered Accident per insured person.

An Initial Care Visit Benefit is not payable if:

- Initial Care is rendered in an Urgent Care Facility or Emergency Room and an Urgent Care Benefit or Emergency Room Benefit is payable for the same Covered Accident.

- Initial Care occurs in a Health Care Provider's office or clinic and a subsequent visit is made for the same Covered Accident to an Urgent Care Facility or Emergency Room within 24 hours of the Initial Care and an Urgent Care Benefit or Emergency Room Benefit is payable for the same Covered Accident.

Major Diagnostic Exam Benefit

We will pay a Major Diagnostic Exam Benefit if you or your Dependent meet all of the following requirements:

- Undergo a Major Diagnostic Exam due to a Covered Accident.
- The Major Diagnostic Exam is performed within 90 days of the Covered Accident.

Major Diagnostic Exam means:

- Computerized Tomography (CT) scan.
- Magnetic Resonance Imaging (MRI).
- Electroencephalogram (EEG).
- Magnetic Resonance Angiogram scan (MRA).
- Positron Emission Tomography (PET).
- Spectroscopy (SPECT).

We will pay a Major Diagnostic Exam Benefit once per Covered Accident per insured person, regardless of the number of Major Diagnostic Exams.

Outpatient X-Ray Benefit

We will pay an Outpatient X-Ray Benefit if you or your Dependent meet all of the following requirements:

- Undergo an X-ray due to a Covered Accident.
- An X-ray was performed on an Outpatient basis at a Hospital or Health Service Facility within 90 days of the Covered Accident.

We will pay an Outpatient X-Ray Benefit once per Covered Accident per insured person.

Urgent Care Benefit

We will pay an Urgent Care Benefit if you or your Dependent meet all of the following requirements:

- Visit an Urgent Care Facility due to a Covered Accident.
- The visit is within 72 hours of the Covered Accident.

We will pay an Urgent Care Benefit once per Covered Accident per insured person. An Urgent Care Benefit is not payable if an Emergency Room Benefit is payable for the same Covered Accident.

Specific Injury Benefits

Burn Benefit

We will pay a Burn Benefit if you or your Dependent meet all of the following requirements:

- Sustain a second or third degree burn as a result of a Covered Accident.
- Treated by a Physician within 72 hours of the Covered Accident.

We will pay a Burn Benefit once per Covered Accident per insured person. If you or your Dependent sustain a second degree and third degree burn for the same Covered Accident, we will pay both benefit amounts.

Coma Benefit

We will pay a Coma Benefit if you or your Dependent sustain a Coma due to a Covered Accident. We will pay a Coma Benefit once per Covered Accident per insured person.

Coma means a diagnosis for which there is a profound state of mental unconsciousness from which one cannot be aroused and there is no evidence of appropriate response to external stimulation, other than primitive avoidance reflexes. The diagnosis must:

- Be made by a Physician.

- Must last for at least 96 consecutive hours resulting in neurological deficit with persisting clinical symptoms.

Coma which is medically induced or coma as a result of Substance Abuse is not included.

Concussion Benefit

We will pay a Concussion Benefit if you or your Dependent meet all of the following requirements:

- Suffer a Concussion as a result of a Covered Accident.
- The diagnosis is made by a Physician within 72 hours of the Covered Accident.

We will pay a Concussion Benefit once per Covered Accident per insured person.

Concussion means a disruption of brain function resulting from a traumatic blow to the head, neck, or upper body.

Dislocation Benefit

We will pay a Dislocation Benefit if you or your Dependent meet all of the following requirements:

- Suffer a Dislocation or Partial Dislocation as a result of a Covered Accident and it is diagnosed within 90 days of the Covered Accident.
- The Dislocation or Partial Dislocation must require a surgical or nonsurgical procedure by a Physician.
- If a surgical procedure is required, the procedure must begin within 90 days of the Covered Accident.

We will pay a Dislocation Benefit for each Dislocation and Partial Dislocation per Covered Accident per insured person.

Dislocation or Dislocated means a separation of two bones where they meet at a joint.

Partial Dislocation means the partial, abnormal separation of the articular surfaces of a joint. Also, referred to as an incomplete dislocation or subluxation.

Eye Injury Benefit

We will pay an Eye Injury Benefit if you or your Dependent meet one of the following requirements:

- Surgical repair of an eye is performed by a Physician due to a Covered Accident within 90 days of a Covered Accident.
- A Physician removes an embedded foreign body from the eye (with or without anesthesia) due to a Covered Accident within 90 days of a Covered Accident.

We will pay an Eye Injury Benefit once per eye per Covered Accident per insured person. The Eye Injury Benefit is not payable solely for an Injury to the eyelid or for an examination of the eye.

Fracture Benefit

We will pay a Fracture Benefit if you or your Dependent meet all of the following requirements:

- Suffer a Fracture or Chip Fracture as a result of a Covered Accident and it is diagnosed within 90 days of the Covered Accident.
- The Fracture or Chip Fracture must be corrected by a surgical or nonsurgical procedure by a Physician.
- If a surgical procedure is required, the procedure must begin within 90 days of the Covered Accident.

We will pay a Fracture Benefit for each Fracture and Chip Fracture suffered per Covered Accident per insured person.

Chip Fracture means any small fragmental Fracture, usually one involving a bony process near a joint.

Fracture means a break in a bone which is confirmed by X-ray or other diagnostic examination.

Laceration Benefit

We will pay a Laceration Benefit if you or your Dependent meet all of the following requirements:

- Suffer a Laceration as a result of a Covered Accident and it is treated within 72 hours of the Covered Accident.
- A wound closure is performed by a Health Care Provider to repair the Laceration. Wound closure includes, but is not limited to: staples, sutures, stitches, glue, or steristrips.

We will pay a Laceration Benefit once per Covered Accident per insured person. The amount payable is the total length of all lacerations received in any one Covered Accident per insured person.

Laceration means a cut.

Skin Graft Benefit

We will pay a Skin Graft Benefit if you or your Dependent meet all of the following requirements:

- A Burn Benefit is payable for the same Covered Accident.
- Skin grafting is performed by a Physician to repair the Injury.

We will pay a Skin Graft Benefit once per Covered Accident per insured person.

Surgical Benefits

Abdominal and Thoracic Surgery Benefit

We will pay an Abdominal and Thoracic Surgery Benefit if you or your Dependent meet all of the following requirements:

- An abdominal or thoracic surgery is performed by a Physician due to Injuries sustained in a Covered Accident.
- The surgery is performed within 72 hours of a Covered Accident.

We will pay an Abdominal and Thoracic Surgery Benefit once per Covered Accident per insured person. If more than one abdominal or thoracic surgery is performed as a result of the same Covered Accident, we will pay the benefit for the surgery with the highest payable benefit amount.

Knee Cartilage Benefit

We will pay a Knee Cartilage Benefit if you or your Dependent meet one of the following requirements:

- Undergo exploratory surgery by a Physician for a suspected tear, rupture, or severance of the knee cartilage of one or both knees due to a Covered Accident within 90 days after the Covered Accident.
- Suffer a tear, rupture or severance of the knee cartilage of one or both knees due to a Covered Accident with diagnosis within 90 days after the Covered Accident with surgical repair by a Physician completed within 180 days of the Covered Accident.

We will pay a Knee Cartilage Benefit once per Covered Accident per insured person, regardless of whether one or both knees require surgical repair. If exploratory and surgical repair are performed for the same Covered Accident, we will pay the surgical repair benefit amount.

Knee Cartilage means the fibrous cartilage contained in the knee, known as the meniscus.

Ruptured Disc Benefit

We will pay a Ruptured Disc Benefit if you or your Dependent meet all of the following requirements:

- Suffer at least one ruptured disc in the spinal column as a result of a Covered Accident for which surgery is required.
- The ruptured disc must be treated by a Physician within 90 days of a Covered Accident, with completion of the surgery within 180 days of a Covered Accident.

We will pay a Ruptured Disc Benefit once per Covered Accident per insured person, regardless of the number of discs ruptured.

Surgical Facility Benefit

We will pay a Surgical Facility Benefit if you or your Dependent meet all of the following requirements:

- Surgery is performed by a Physician for a Covered Accident.

- Surgery for a Covered Accident is performed on an Outpatient basis at a Hospital or an Ambulatory Surgical Center.
- Surgery is within 90 days of the Covered Accident.

We will pay a Surgical Facility Benefit once per Covered Accident per insured person.

Tendon, Ligament, and Rotator Cuff Surgery Benefit

We will pay a Tendon, Ligament, and Rotator Cuff Surgery Benefit if you or your Dependent meet one of following requirements:

- Undergo exploratory surgery by a Physician for an Injury of the tendon, ligament, or rotator cuff due to a Covered Accident within 90 days of the Covered Accident.
- Suffer an Injury of the tendon, ligament, or rotator cuff due to a Covered Accident with diagnosis within 90 days after the Covered Accident with surgical repair by a Physician completed within 180 days of the Covered Accident.

We will pay a Tendon, Ligament, and Rotator Cuff Surgery Benefit once per Covered Accident per insured person. If we pay for one surgical repair and a second surgical repair is required for the same Covered Accident and the requirements above are met, we will pay the difference between the amount already paid for the first surgical repair and the amount due for the second surgical repair. If an exploratory and surgical repair are performed for the same Covered Accident, we will pay the surgical repair amount.

Hospital Benefits

Critical Care Unit Admission Benefit

We will pay a Critical Care Unit Admission Benefit if you or your Dependent meet all of the following requirements:

- Admitted by a Physician to a Critical Care Unit due to a Covered Accident.
- Admission occurs within 90 days of a Covered Accident for diagnosis or treatment of Injuries sustained in a Covered Accident.

We will pay a Critical Care Unit Admission Benefit once per Covered Accident per insured person, regardless of the number of days Confined in the Critical Care Unit. The Critical Care Unit Admission Benefit may be paid in addition to the Hospital Admission Benefit.

Daily Critical Care Unit Confinement Benefit

We will pay a Daily Critical Care Unit Confinement Benefit for the days you or your Dependent meet all of the following requirements:

- Confined to a Critical Care Unit of a Hospital due to a Covered Accident.
- Confinement occurs within 90 days of a Covered Accident.

We will pay a Daily Critical Care Unit Confinement Benefit for up to 15 days per Covered Accident per insured person. A Daily Critical Care Unit Confinement Benefit may be paid in addition to a Daily Hospital Confinement Benefit.

Only one Daily Critical Care Unit Confinement Benefit is payable at a time, even if Confinement is caused by more than one Covered Accident.

Daily Hospital Confinement Benefit

We will pay a Daily Hospital Confinement Benefit for the days you or your Dependent meet all of the following requirements:

- Confined to a Hospital due to a Covered Accident.
- Confinement occurs within 90 days of the Covered Accident.

We will pay a Daily Hospital Confinement Benefit for up to 365 days per Covered Accident per insured person.

Only one Daily Hospital Confinement Benefit is payable at a time, even if Confinement is caused by more than one Covered Accident.

Daily Rehabilitation Facility Benefit

We will pay a Daily Rehabilitation Facility Benefit for the days you or your Dependent meet all of the following requirements:

- A Physician prescribes Confinement in a Rehabilitation Facility providing rehabilitation care services due to a Covered Accident.
- Confinement in the Rehabilitation Facility immediately follows a Confinement in a Hospital due to a Covered Accident.

We will pay a Daily Rehabilitation Facility Benefit for up to 90 days per Covered Accident per insured person. A Daily Rehabilitation Facility Benefit is not payable if a Daily Hospital Confinement Benefit or Daily Critical Care Unit Benefit is payable for the same days of the same Covered Accident.

Only one Daily Rehabilitation Facility Benefit is payable at a time, even if Confinement is caused by more than one Covered Accident.

Hospital Admission Benefit

We will pay a Hospital Admission Benefit if you or your Dependent meet all of the following requirements:

- Admitted by a Physician to a Hospital due to a Covered Accident.
- Admission occurs within 90 days of the Covered Accident.

We will pay a Hospital Admission Benefit once per Covered Accident per insured person, regardless of the number of days Confined in a Hospital. The Hospital Admission Benefit may be paid in addition to the Critical Care Unit Admission Benefit.

Follow Up Care Benefits

Appliance Benefit

We will pay an Appliance Benefit if you or your Dependent meet all of the following requirements:

- Use an Appliance as prescribed by a Physician, Physical Therapist, or Occupational Therapist as necessary due to an Injury sustained in a Covered Accident.
- Use of the Appliance is within 90 days of the Covered Accident.

We will pay an Appliance Benefit for 1 Appliances per Covered Accident per insured person.

Appliance means a wheelchair, leg or back brace, crutches, walker, cane, a walking boot that extends above the ankle, or a brace for the neck.

Chiropractic Care Benefit

We will pay a Chiropractic Care Benefit if you or your Dependent meet all of the following requirements:

- Suffer a structural imbalance as a result of a Covered Accident and receive chiropractic care services from a Chiropractor in a chiropractic office.
- Visit the Chiropractor within 90 days of the Covered Accident and receive initial treatment within 90 days of a Covered Accident, with completion of the follow up treatment within 365 days of the Covered Accident.

We will pay a Chiropractic Care Benefit for up to 2 day(s) per Covered Accident per insured person.

Chiropractor means an individual who has obtained a professional degree in chiropractic care, is licensed by the state and performs chiropractic services acting within the scope of the license. Chiropractor does not include you or your Spouse or the brother, sister, parent or child of either you or your Spouse.

Follow Up Care Benefit

We will pay a Follow Up Care Benefit if you or your Dependent meet all of the following requirements:

- Visit a Health Care Provider for Follow Up Care of a Covered Accident.
- The Follow Up Care occurs within 90 days after Initial Care for the same Covered Accident, with completion of the Follow Up Care within 365 days of the Initial Care.

We will pay a Follow Up Care Benefit for up to 2 day(s) per Covered Accident per insured person.

A Follow Up Care Benefit is not payable if Follow Up Care is rendered in a Urgent Care Facility or Emergency Room and a Urgent Care Benefit or Emergency Room Benefit is payable for the same Covered Accident.

Follow Up Care means a visit to a Health Care Provider for ongoing medical services due to a Covered Accident. Follow Up Care does not include occupational therapy, speech therapy, physical therapy, or chiropractic treatment.

Hearing Device Benefit

We will pay a Hearing Device Benefit if you or your Dependent meet all of the following requirements:

- Suffer a Moderate Loss Of Hearing due to a Covered Accident and not due to the natural aging process.
- A licensed hearing aid specialist, audiologist, or a Diplomate of the American Board of Otolaryngology recommends a Hearing Device for a Covered Accident within 90 days of a Covered Accident.
- A Hearing Device is procured within 365 days of the recommendation.

We will pay a Hearing Device Benefit once per Covered Accident per insured person.

Hearing Device means an electronic device worn in or on the ear to help a person who has hearing loss to improve one's ability to hear.

Moderate Loss Of Hearing means a loss of between 56-70 dB as certified by a licensed hearing aid specialist, audiologist, or Diplomate of the American Board of Otolaryngology.

Prosthesis Benefit

We will pay a Prosthesis Benefit if you or your Dependent meet all of the following requirements:

- Sustain Injuries due to a Covered Accident for which you or your Dependent receive one or more prosthetic devices or artificial limbs as prescribed by a Physician for functional use.
- Receive an Accidental Dismemberment Benefit for the same Covered Accident for which the prosthetic device or artificial limb replaces.
- The prosthetic devices or artificial limbs must be prescribed by a Physician and received within 365 days of the Covered Accident.

The following are not prosthetic devices or artificial limbs:

- Hearing Devices.
- Dental aids (including false teeth).
- Eyeglasses.
- Artificial joints (including but not limited to hip and knee replacements).
- Cosmetic prosthesis such as hair wigs.

We will pay a Prosthesis Benefit once per Covered Accident per insured person.

Therapy Services Benefit

We will pay a Therapy Services Benefit if you or your Dependent meet all of the following requirements:

- A Health Care Provider prescribes occupational, speech or physical therapy by a licensed Occupational, Speech, or Physical Therapist due to a Covered Accident.
- Treatment must begin within 90 days of the Covered Accident and must be completed within 365 days.

We will pay a Therapy Services Benefit for up to 3 day(s) per Covered Accident per insured person.

Additional Benefits

Health Maintenance Screening Benefit

We will pay a Health Maintenance Screening Benefit if you or your Dependent meet all of the following requirements:

- A Health Maintenance Screening Procedure is performed.

Health Maintenance Screening Procedures are limited to the following:

- Abdominal aortic aneurysm ultrasound.
- Ankle Brachial Index (ABI) screening for peripheral vascular disease.
- Biopsies for cancer.
- Bone density screening.
- Breast ultrasound.
- Cancer antigen 125 blood test for ovarian cancer (CA 125).
- Cancer antigen 15-3 blood test for breast cancer (CA 15-3).
- Carcinoembryonic antigen blood test for colon cancer (CEA).
- Colonoscopy.
- Complete Blood Count (CBC).
- Comprehensive Metabolic Panel (CMP).
- Electrocardiogram (EKG).
- Hemocult stool analysis.
- Hemoglobin AIC.
- Human Papillomavirus (HPV) vaccination.
- Lipid panel.
- Mammography.
- Pap smears or thin prep pap test.
- Prostate specific antigen (PSA) test.
- Stress test on a bicycle or treadmill.
- Mental health assessments, including but not limited to, PHQ-9, Beck's Depression Inventory, Hamilton's Depression Rating Scale.
- Novel infectious disease testing, including testing for antibodies related to novel infectious diseases.

We will pay a Health Maintenance Screening Benefit for 1 day per insured person per Calendar Year.

Lodging Benefit

We will pay a Lodging Benefit for the days you or your Dependent meet all of the following requirements:

- Travel at least 100 miles from your or your Dependent's residence to a place for treatment due to a Covered Accident and for which another Accident Insurance Benefit is payable.
- A lodging expense is incurred by you or your Dependent or another person.

We will pay you a Lodging Benefit for up to 30 days per Covered Accident per insured person. We will pay a total of 90 days during any 365 day period.

Transportation Benefit

We will pay a Transportation Benefit for the days you or your Dependent meet all of the following requirements:

- Travel at least 100 miles from your or your Dependent's residence to a place for treatment due to a Covered Accident.
- Another Accident Insurance Benefit is payable for the same Covered Accident.

We will pay a Transportation Benefit for up to 30 days per Covered Accident per insured person. We will pay a total of 90 days during any 365 day period. The Transportation Benefit is not payable for travel in an Ambulance.

Youth Organized Sports Benefit

We will pay a Youth Organized Sports Benefit if all of the following requirements are met:

- While your Child is participating in an Organized Sport Event or scheduled practice, the Child suffers a Covered Accident and for which another Accident Insurance Benefit is payable for the same Covered Accident.
- Your Child is age 18 or younger.
- You provide proof of your Child's registration in the Organized Sport Event.

We will pay a Youth Organized Sports Benefit once per Covered Accident per Child.

Organized Sport Event means a physical activity which is governed by an organization and requires formal registration to participate. This may include school, church, or other recreational leagues.

AD&D Benefits

Accidental Death Benefit

We will pay an Accidental Death Benefit if you or your Dependent meet all of the following requirements:

- Death is caused solely and directly by a Covered Accident.
- The death occurs independently of all other causes.
- The death occurs within 365 days after the Covered Accident.

Death will be presumed if you or your Dependent disappear and the disappearance:

- Is caused solely and directly by a Covered Accident that reasonably could have caused death.
- Occurs independently of all other causes.
- Continues for a period of 365 days after the date of the Covered Accident, despite reasonable search efforts.

Accidental Dismemberment Benefit

We will pay an Accidental Dismemberment Benefit if you or your Dependent meet all of the following requirements:

- As a result of a Covered Accident suffer one of the following dismemberments:
  - One hand and one foot.
  - Both hands or feet.
  - One hand or one foot.
  - One finger or toe.
  - More than one finger or toe.

  With respect to a hand or foot, dismemberment means actual and permanent severance from the body at or above the wrist or ankle joints, whether or not surgically reattached; or permanent, complete and irreversible loss of function.

  With respect to finger(s), dismemberment means actual and permanent severance from the body at or above the metacarpophalangeal joints, whether or not surgically reattached; or permanent, complete and irreversible loss of function.

  With respect to toe(s), dismemberment means actual and permanent severance from the body at or above the metatarsophalangeal joints, whether or not surgically reattached; or permanent, complete and irreversible loss of function.

  An Accidental Dismemberment Benefit is not payable for the dismemberment of fingers of the same hand if an Accidental Dismemberment Benefit is payable for the dismemberment of the entire hand.

  An Accidental Dismemberment Benefit is not payable for the dismemberment of toes of the same foot if an Accidental Dismemberment Benefit is payable for the dismemberment of the entire foot.
- The dismemberment occurs within 365 days of the Covered Accident.

In the event you or your Dependent suffer more than one dismemberment as a result of the same Covered Accident, we will pay the applicable percentage for each dismemberment as shown in the Table Of Accident Insurance Benefit Amounts in the **Coverage Features,** not to exceed a total of 100% of the Accidental Death Benefit amount.

No Accidental Dismemberment Benefit will be paid for loss of function of a hand or foot if an Accidental Impairment Benefit is payable involving the same hand or foot due to the same Covered Accident.

Accidental Impairment Benefit

We will pay an Accidental Impairment Benefit if you or your Dependent meet all of the following requirements:

- As a result of a Covered Accident suffer one of the following impairments:
    - Uniplegia
    - Hemiplegia
    - Triplegia
    - Paraplegia
    - Quadriplegia
    - Loss Of Hearing (in one or both ears)
    - Loss Of Sight (in one or both eyes)
- The impairment occurs within 365 days of the Covered Accident.

In the event you or your Dependent suffer more than one impairment as a result of the same Covered Accident, we will pay the stated percentage for each impairment as shown in the Table Of Accident Insurance Benefit Amounts in the **Coverage Features**, not to exceed 100% of the Accidental Death Benefit amount.

Hemiplegia means the complete and irreversible loss of function or total paralysis of the upper and lower Limbs on the same side of the body as confirmed by a Physician who is a board certified neurologist.

Loss Of Hearing means an entire, uncorrectable and irrecoverable loss of hearing in one or both ears, as diagnosed by a Physician who is a board certified Otolaryngologist.

Loss Of Sight means entire, uncorrectable and irrecoverable loss of sight in one or both eyes, as diagnosed by a Physician who is a board certified Ophthalmologist.

Paraplegia means the complete and irreversible loss of function or total paralysis of both lower Limbs confirmed by a Physician who is a board certified neurologist.

Quadriplegia means the complete and irreversible loss of function or total paralysis of both upper and lower Limbs confirmed by a Physician who is a board certified neurologist.

Triplegia means the complete and irreversible loss of function or total paralysis of three Limbs, or the complete and irreversible loss of function or total paralysis of two Limbs and the face confirmed by a Physician who is a board certified neurologist.

Uniplegia means the complete and irreversible loss of function or total paralysis of one Limb confirmed by a Physician who is a board certified neurologist.

Value Added AD&D Benefits

Air Bag Benefit

We will pay an Air Bag Benefit if you or your Dependent meet all of the following requirements:

- Travel in an Automobile involved in a Covered Accident and for which an Accidental Death Benefit and Seat Belt Benefit is payable for the same Covered Accident.
- The Automobile is equipped with an Air Bag System that was installed as original equipment by the Automobile manufacturer.
- Seated in the driver's or a passenger's seating position intended to be protected by the Air Bag System and the respective Air Bag System deployed in the crash as evidenced by a police accident report.

- The driver of the Automobile in which you or your Dependent were riding has a current and valid driver's license at the time of the Covered Accident.

Air Bag System means an automatically inflatable passive restraint system that is designed to provide automatic crash protection in front or side impact Automobile accidents and meets the Federal Vehicle Safety Standards of the National Highway Traffic Safety Administration.

Common Carrier Accidental Death Benefit

We will pay a Common Carrier Accidental Death Benefit if you or your Dependent meet all of the following requirements:

- A Covered Accident occurs while riding as a fare-paying passenger on a Common Carrier and for which an Accidental Death Benefit is payable for the same Covered Accident.
- The death occurs within 365 days after the Covered Accident.

The Common Carrier benefit may be paid in addition to the Accidental Death Benefit.

Common Carrier means a licensed commercial airplane, train, bus, trolley, subway, ferry or boat that charges a fare and operates on a regularly scheduled basis between predetermined points or cities. Taxis and privately chartered airplanes or vehicles are not common carriers.

Helmet Benefit

We will pay a Helmet Benefit if you or your Dependent meet all of the following requirements:

- A Covered Accident occurs while operating or riding a motorcycle or bicycle and for which an Accidental Death Benefit is payable for the same Covered Accident.
- Wearing a Helmet at the time of the Covered Accident as evidenced by a police accident report, medical examiner report, or coroner's report.
- The operator of the motorcycle has a current and valid driver's license at the time of the Accident.

Helmet means protective headgear that meets or exceeds the standards established by the Code of Federal Regulations (CFR) in Title 16 Part 1203, Snell Memorial Foundation Standard M-95 or M2000, the American National Standards Institute specification Z 90. 1, or the United States Department of Transportation's Federal Motor Vehicle Safety Standard No. 218, as amended and updated.

Repatriation Benefit

We will pay a Repatriation Benefit if you or your Dependent meet all of the following requirements:

- As a result of a Covered Accident an Accidental Death Benefit is payable.
- Death occurs more than 100 miles from the primary place of residence.
- Expenses are incurred to transport the remains to a mortuary.

Seat Belt Benefit

We will pay a Seat Belt Benefit if you or your Dependent meet all of the following requirements:

- Travel in an Automobile involved in a Covered Accident and for which an Accidental Death Benefit is payable for the same Covered Accident.
- Wearing and properly utilizing a Seat Belt System or restrained in a Child Safety Seat at the time of the Covered Accident, as evidenced by a police accident report.
- The driver of the Automobile in which you or your Dependent were riding has a current and valid driver's license at the time of the Covered Accident.

Child Safety Seat means a removable seat designed to hold a Child while riding in an Automobile and that attaches to a standard seat with hooks or straps that meets the Federal Motor Vehicle Safety Standards of the National Highway Traffic Safety Administration. Child Safety Seat includes: rear-facing, forward facing, and booster seats.

Seat Belt System means a properly installed combination lap and shoulder restraint system that meets the Federal Motor Vehicle Safety Standards of the National Highway Traffic Safety Administration. Seat Belt

System will include a lap belt alone, but only if the Automobile did not have a combination lap and shoulder restraint system when manufactured. Seat Belt System does not include a shoulder restraint alone.

EXCLUSIONS

Benefits are not payable if the Accident is caused or contributed to by any of the following:

- War or act of War. War means declared or undeclared war, whether civil or international, insurrection, and any substantial armed conflict between organized forces of a military nature.
- Suicide or other intentionally self-inflicted Injury, while sane or insane.
- Committing or attempting to commit an assault, felony, act of terrorism, or actively participating in a violent disorder or riot. Actively participating does not include being at the scene of a violent disorder or riot while performing official duties.
- The voluntary use or consumption of any poison, chemical compound, drug, or alcohol in excess of the legal limit in the state in which the Accident occurred, unless used or consumed according to the directions of a Health Care Provider.
- Sickness existing at the time of the Accident, including any medical or surgical treatment or diagnostic procedure for a Sickness.
- Travel or flight in or on any aircraft, except:
    - As a fare-paying passenger on a regularly scheduled commercial flight.
    - As a passenger or pilot in the Policyholder's or Employer's aircraft while flying on the Policyholder's or Employer's business provided:
        - The aircraft has a valid U.S. airworthiness certificate (or foreign equivalent).
        - The pilot has a valid pilot's certificate with a non-student rating authorizing him or her to fly the aircraft.
- Engaging in high risk sports or activities such as, but not limited to, bungee jumping, parachuting, base jumping, mixed martial arts, or mountain climbing.
- Practicing for, or participating in, any semi-professional or professional competitive athletic contests for which any type of compensation or remuneration is received.
- Any Accident which arises out of or in the course of any employment for wage or profit due to your employment with the Employer.
- Routine eye exams and dental procedures other than a crown or extraction for a tooth or teeth as a result of a Covered Accident.
- Riding in or driving any automobile in a race, stunt show, or speed test.
- Surgery or other procedure which is directed at improving your or your Dependent's appearance, unless such surgery or procedure is necessary to correct a deformity or restore bodily function resulting from a Covered Accident.
- Any Accident which arises out of or in the course of your or your Dependent's incarceration in a jail, penal, or correctional institution.

ADDITIONAL FEATURES

Reinstatement

If your insurance ends, you may become insured again as a new Member. However, the following will apply:

- If your insurance ends because you cease to be a Member and if you become a Member again within 90 day(s), the Eligibility Waiting Period will be waived.
- If you ceased to be a Member under the Group Policy and continued insurance under the **Continuation of Insurance (Portability) for the Member** provision and you become a Member again within 90 day(s), your insurance will be for the coverages and amount which you continued under the **Continuation of Insurance (Portability) for the Member** provision on the day before you become a new Member.

In no event will insurance be retroactive.

Continuity of Coverage

Waiver of Active Work Requirement

If you were insured under the Prior Plan on the day before the effective date of the Employer's coverage under the Group Policy, you can become insured on the effective date of your Employer's coverage without meeting the Active Work requirement. See the **Active Work Requirement**.

Continuation of Insurance (Portability) for the Member

Eligibility for the Member:

You become eligible to continue your or your Dependent's insurance on the date one of the following events occurs:

- Your employment terminates with your Employer.
- The Group Policy terminates.
- Your insurance ends because you are no longer a Member.

You are not eligible to continue insurance under this provision if:

- You are disabled.
- You are age 70 or older.

Application, Amount of Insurance, and Premium Payment

You must apply in writing and pay the first premium to us within 31 day(s) after the date you become eligible. Your and your Dependent's continued insurance will be the same insurance amounts provided under the Group Policy on the day before you become eligible under this **Continuation of Insurance (Portability) for the Member** provision. You may decrease insurance amounts, but cannot increase the insurance amounts.

You will be directly billed for all premiums due if you have applied for and been approved for continuation of insurance under this provision. If premium is not paid on or before the Premium Due Date stated below it may be paid during the Grace Period stated below. Your and your Dependent's insurance will remain in force during the Grace Period. You are liable for premium for insurance during the Grace Period.

The Premium Due Date is the first day of each calendar month.

The Grace Period is 60 days from the Premium Due Date.

When Insurance Ends

Insurance continued under this provision ends automatically on the earliest of:

- The date the last period ends for which you made the premium payment.
- The date you die.
- The date you become a full-time member of the armed forces of any country.
- With respect to your Child's insurance, the date the Child ceases to meet the definition of Child.
- The date you reach age 80.
- The date you are sentenced by a court for any reason to a penal or correctional institution.

- With respect to your Spouse's insurance, the date the Spouse ceases to meet the definition of Spouse.
- With respect to insurance for your Spouse or Child, the date your Spouse or Child is sentenced by a court for any reason to a penal or correctional institution.
- The date you become insured again as a Member under the Group Policy.

Once insurance continued under this provision ends it cannot be reinstated. Except as provided above, insurance continued under this provision is subject to all other terms of the Group Policy.

CLAIMS

Notice of Claim

Written notice of claim must be provided to us within 20 days after the date of an Accident or within 20 days after meeting the requirements for an Accident Insurance Benefit, or as soon thereafter as is reasonably possible.

Filing a Claim

Claims should be filed on our forms. If we do not provide our forms within 15 days after they are requested, the claim may be submitted in a letter to us. The letter should include the nature and extent of the benefit claimed as required in the **Proof of Loss** provision. Subject to the time period in the **Notice of Claim** provision, such letter will constitute notice.

Time Limits on Filing Proof Of Loss

Proof Of Loss must be provided within 90 days after the date of meeting the requirements for an Accident Insurance Benefit. If that is not possible, it must be provided as soon as reasonably possible, but not later than one year after that 90-day period.

If Proof Of Loss is filed outside these time limits, the claim will be denied. These limits will not apply while the Member or Beneficiary lacks legal capacity.

Proof Of Loss

Proof Of Loss means written proof that a Covered Accident or entitlement to a Health Maintenance Screening Benefit occurred:

- For which the Group Policy provides benefits.
- Which is not subject to any exclusions.
- Which meets all other conditions for benefits.

Proof Of Loss includes any other information we may reasonably require in support of a claim. Proof Of Loss must be in writing and must be provided at the expense of the claimant. No benefits will be paid until we receive Proof Of Loss satisfactory to us.

Investigation of Claim

We reserve the right to investigate a claim during its pendency at our expense, including an examination conducted by specialists of our choice. In case of death, we have the right and opportunity to request an autopsy, except where prohibited by law.

Notice of Decision on Claim

We will evaluate a claim for benefits promptly after we receive it. Within 60 days after we receive the claim we will send the claimant: (a) a written decision on the claim; or (b) a notice that we are extending the period to decide the claim for an additional 60 days.

If we extend the period to decide the claim, we will notify the claimant of the following: (a) the reasons for the extension and (b) when we expect to decide the claim.

If we deny any part of the claim, we will send the claimant a written notice of denial containing:

- The reasons for our decision.
- Reference to the parts of the Group Policy on which our decision is based.
- A description of any additional information needed to support the claim.
- Information concerning the claimant's right to a review of our decision.
- Information concerning the right to bring a civil action for benefits under section 502(a) of ERISA if the claim is denied on review.

Review Procedure

If all or part of a claim is denied, the claimant may request a review. The claimant must request a review in writing within 60 days after receiving notice of the denial of the claim.

The claimant may send us written comments or other items to support the claim. The claimant may review and receive copies of any non-privileged information that is relevant to the request for review. There will be no charge for such copies. Our review will include any written comments or other items the claimant submits to support the claim.

We will review the claim promptly after we receive the request. With respect to all claims, within 45 days after we receive the request for review we will send the claimant: (a) a written decision on review; or (b) a notice that we are extending the review period for 45 days.

If an extension is due to the claimant's failure to provide information necessary to decide the claim on review, the extended time period for review of the claim will not begin until the claimant provides the information or otherwise responds.

If we extend the review period, we will notify the claimant of the following: (a) the reasons for the extension and (b) when we expect to decide the claim on review.

If we request additional information, the claimant will have 45 days to provide the information. If the claimant does not provide the requested information within 45 days, we may conclude our review of the claim based on the information we have received.

If we deny any part of the claim on review, the claimant will receive a written notice of denial containing:

- The reasons for our decision.
- Reference to the parts of the Group Policy on which our decision is based.
- Information concerning the claimant's right to receive, free of charge, copies of non-privileged documents and records relevant to the claim.
- Information concerning the right to bring a civil action for benefits under section 502(a) of ERISA.

The Group Policy does not provide voluntary alternative dispute resolution options. However, you may contact your local U. S. Department of Labor Office and your State insurance regulatory agency for assistance.

Time of Payment

We will pay benefits within 30 days after Proof Of Loss is satisfied.

Reimbursement

We reserve the right to recover any benefits that you, your Dependent, a claimant or beneficiary were paid but not entitled to under the terms of the Group Policy, state, or federal law.

You, your Dependent, a claimant, or beneficiary must reimburse us in full. We will determine the method by which repayment is to be paid.

Unpaid Premium

Any unpaid premium due for your or your Dependent's insurance under the Group Policy may be recovered by us. Any Accident Insurance Benefits payable to you, your Dependent, a claimant, a beneficiary, or legal representative will be applied to reduce the amount of any unpaid premiums prior to paying you, your Dependent, a claimant, a beneficiary, or a legal representative.

BENEFIT PAYMENT AND BENEFICIARY PROVISIONS

Payment of Benefits

Accident Insurance Benefits payable because of your death will be paid to the Beneficiary you name. See **Naming a Beneficiary**, **Simultaneous Death Provision,** and **No Surviving Beneficiary** provisions below.

Accident Insurance Benefits payable because of the death of your Dependent will be paid to you if you are living. Accident Insurance Benefits payable because of the death of your Dependent which are unpaid at your death will be paid to your named Beneficiary.

Except for the Repatriation Benefit, all other Accident Insurance Benefits will be paid to you. Any such benefits remaining unpaid at your death will be paid according to the **Naming a Beneficiary**, **Simultaneous Death Provision**, and **No Surviving Beneficiary** provisions for payment of a death benefit due to your death.
The Repatriation Benefit will be paid to the person who incurs the transportation expense.

Naming a Beneficiary

Beneficiary means a person you name to receive death benefits.

If you name two or more Beneficiaries in a class:

- Two or more surviving Beneficiaries will share equally, unless you provide for unequal shares.
- If you provide for unequal shares in a class, and two or more Beneficiaries in that class survive, we will pay each surviving Beneficiary his or her designated share. Unless you provided otherwise, we will then pay the share(s) otherwise due to any deceased Beneficiary(ies) to the surviving Beneficiaries pro rata based on the relationship that the designated percentage or fractional share of each surviving Beneficiary bears to the total shares of all surviving Beneficiaries.
- If only one Beneficiary in a class survives, we will pay the total death benefits to that Beneficiary.

You may name or change Beneficiaries at any time without the consent of a Beneficiary.

Any payment we make according to the Beneficiary designation on file with the Policyholder or Employer or their or our designated agents will fully discharge us to the extent of the payment for each line of coverage and each death benefit which has been paid.

You may name or change Beneficiaries in writing. Writing includes a form signed by you; or a verification from us, or our designated agent, the Policyholder's designated agent, the Employer, or the Employer's designated agent of an electronic designation made by you.

Your designation must satisfy all of the following:

- Be dated.
- Be delivered to us, our designated agent, the Policyholder, the Policyholder's designated agent, the Employer, or the Employer's designated agent during your lifetime.
- Relate to the insurance provided under the Group Policy.

The designation will take effect on the date it is delivered or, if an electronic designation, verified by us, our designated agent, the Policyholder, the Policyholder's designated agent, the Employer, or the Employer's designated agent.

If we approve it, a designation which meets the requirements of a Prior Plan will be accepted as your Beneficiary designation under the Group Policy.

Simultaneous Death Provision

If a Beneficiary or a person in one of the classes in the **No Surviving Beneficiary** provision dies on the same day you die, or within 15 days thereafter, benefits will be paid as if that Beneficiary or person had died before you, unless Proof Of Loss with respect to your death is delivered to us before the date of the Beneficiary's death.

No Surviving Beneficiary

If you do not name a Beneficiary, or if you are not survived by one, benefits will be paid in equal shares to the first surviving class below.

- Your Spouse.
- Your children.
- Your parents.
- Your brothers and sisters.
- Your estate.

GENERAL PROVISIONS

Assignment

The rights and benefits under the Group Policy may not be assigned.

Time Limits on Legal Actions

No action at law or in equity may be brought until 60 days after we have been given Proof Of Loss. No such action may be brought more than three years after the earlier of:

- The date we receive Proof Of Loss.
- The time within which Proof Of Loss is required to be given.

Incontestability of Insurance

Any statement made to obtain insurance or to increase insurance is a representation and not a warranty. No misrepresentation will be used to reduce or deny a claim or contest the validity of insurance unless:

- The insurance would not have been approved if we had known the truth.
- We have given you or any other person claiming benefits a copy of the signed written instrument which contains the misrepresentation.

After insurance has been in effect for two years during the lifetime of the insured, we will not use a misrepresentation to reduce or deny the claim, unless it was a fraudulent misrepresentation.

Clerical Error

Clerical error by the Policyholder, your Employer, or their respective employees or representatives will not:

- Cause a person to become insured.
- Invalidate insurance under the Group Policy otherwise validly in force.
- Continue insurance under the Group Policy otherwise validly terminated.

Agency

The Policyholder and your Employer act on their own behalf as your agent, and not as our agent. Individuals selected by the Policyholder or by any Employer to secure coverage under the Group Policy or to perform their administrative function under it, represent and act on behalf of the person selecting them, and do not represent or act on behalf of us. The Policyholder and your Employer have no authority to alter, expand or extend our liability or to waive, modify or compromise any defense or right we may have under the Group Policy.

Misstatement of Age

If a person's age has been misstated, we will make an equitable adjustment of premiums, benefits, or both. The adjustment will be based on the following:

- The amount of insurance based on the correct age.
- The difference between the premiums paid and the premiums which would have been paid if the age had been correctly stated.

DEFINITIONS

Accident or Accidental

An Injury sustained by you or your Dependent as a result of an event or occurrence that was not reasonably foreseen or that you or your Dependent could not have reasonably expected or anticipated.

Admitted

A stay at a Hospital or Critical Care Unit for at least 20 consecutive hours for examination by a Physician for diagnosis or treatment of a Covered Accident.

Ambulance (Ground or Air)

A licensed professional ground or air ambulance company to transport you or your Dependent to a Hospital or a Health Service Facility for diagnosis or treatment of a Covered Accident.

Ambulatory Surgical Center

A licensed facility that is mainly engaged in performing Outpatient surgery. An Ambulatory Surgical Center must:

- Be staffed by Physicians and nurses under the supervision of a Physician.
- Have permanent operating and recovery rooms.
- Be capable of administering anesthesia by a licensed anesthesiologist or licensed nurse anesthetist.
- Be staffed and equipped to give emergency care.
- Have written back-up arrangements with a local Hospital for emergency care.

Automobile

A private passenger motor vehicle licensed for use on public roads and highways.

Calendar Year

The period from January 1 through December 31 of the same year.

Child

Child means one of the following:

- Your child from live birth until age 26.
- Your adopted child until age 26.
- Your stepchild, foster child, dependent grandchild, and the child of your Spouse if living in your home until age 26.
- A child living in your home for whom you are the court appointed legal guardian until age 26.
- Your child, stepchild, foster child, dependent grandchild, and the child of your Spouse who is continuously incapable of self-sustaining employment because of intellectual disability or physical handicap; and chiefly dependent upon you for support and maintenance or institutionalized because of mental or physical handicap.

Child does not include a person who is eligible for insurance as a Member. A Child does not include a full-time member of the armed forces of any country.

Confinement or Confined

You or your Dependent are Admitted to a Hospital or Critical Care Unit, or admitted to a Rehabilitation Facility, as an Inpatient for diagnosis and treatment of a Covered Accident for a period of no less than 20 consecutive hours the first day and overnight for subsequent days. Hours spent in an emergency room immediately prior to being Admitted to a Hospital will count toward the required 20 consecutive hours.

Covered Accident

An Accident that occurs on or after you or your Dependent are insured under the Group Policy and is not excluded by name or specific description.

Critical Care Unit (CCU)

Critical Care Unit (CCU) means a specified area within a Hospital that is restricted to patients who are critically ill or injured and require intensive comprehensive observation and care. This area must:

- Be separate and apart from the surgical recovery room and from rooms, beds and wards customarily used for patient confinement.
- Be permanently equipped with special lifesaving equipment for the care of the critically ill or injured.
- Be under close observation by a specially trained nursing staff assigned exclusively to the unit on a 24-hour basis.
- Have a Physician assigned on a full-time basis.

Dependent(s)

Your Spouse or Child.

Eligibility Waiting Period

The period you must be a Member before you become eligible for insurance. Your Eligibility Waiting Period is shown in the **Coverage Features**.

Emergency Room

A specified area within a Hospital that is staffed and equipped for emergency patient care. This area must:

- Be supervised with treatment provided by Physicians.
- Provide care seven days per week, 24 hours per day.

Employer

An employer (including approved affiliates and subsidiaries) for which coverage under the Group Policy is approved in writing by us.

Group Policy

The Group Accident Insurance Policy issued by us to the Policyholder and identified by the Group Policy Number, the Policyholder's attached application, Group Accident Insurance Certificate with the same Group Policy Number, and any amendments to the policy or certificates.

Health Care Provider

A Physician, Nurse Practitioner, or Physician Assistant.

Health Service Facility or Facilities

Health Service Facility or Facilities means one of the following:

- A Rehabilitation Facility.
- A nursing or convalescent home.
- A long term nursing unit or geriatrics ward.
- A skilled nursing facility.
- An Ambulatory Surgical Center.

- An Urgent Care Facility.
- An assisted living facility.
- A hospice care facility.
- Health Care Provider office or clinic.

Hospital

A legally operated facility providing full-time medical care and treatment under the direction of a full-time staff of licensed Physicians. Hospital does not include Health Service Facilities.

Initial Care

The first visit for Outpatient medical services. Initial Care does not include visits for wellness, annual physicals, acupuncture, preventative treatment, physical therapy, or for treatments for a chiropractic, allergy or immunotherapy, vision, speech, or hearing disorder.

Injury or Injuries

An injury to your or your Dependent's body.

Inpatient

A person who has been Admitted to a Hospital or Critical Care Unit, or admitted to a Rehabilitation Facility, as a registered bed patient for which a charge is incurred for room and board or observation.

Limb

The entire arm from shoulder to fingers, or the entire leg from hip to toes.

Mental Disorder

Any mental, emotional, behavioral, psychological, personality, cognitive, mood or stress-related abnormality, disorder, disturbance, dysfunction or syndrome, regardless of cause (including any biological or biochemical disorder or imbalance of the brain) or the presence of physical symptoms. Mental Disorder includes, but is not limited to, bipolar affective disorder, schizophrenia, psychotic illness, manic depressive illness, depression and depressive disorders or anxiety and anxiety disorders.

Nurse Practitioner (advanced practice registered nurse)

An individual who is licensed by the state as a nurse practitioner to practice medicine under the supervision of a Physician and acting within the scope of the license. Nurse Practitioner does not include you or your Spouse or the brother, sister, parent or child of either you or your Spouse.

Occupational Therapist

An individual who is licensed by the state to practice occupational therapy and performs the occupational services acting within the scope of the license. Occupational Therapist does not include you or your Spouse, or the brother, sister, parent or child of either you or your Spouse.

Outpatient

Treatment for which a stay is not required and no charge is incurred for room and board or observation.

Physician

An individual who is licensed by the state as an M. D. or D. O. and acting within the scope of the license. Physician does not include you or your Spouse, or the brother, sister, parent or child of either you or your Spouse.

Physician Assistant

An individual who is licensed by the state as a physician assistant to practice medicine under the supervision of a Physician and acting within the scope of the license. Physician Assistant does not include you or your Spouse, or the brother, sister, parent or child of either you or your Spouse.

Physical Therapist

An individual who is a licensed physical therapist acting within the scope of the license. Physical Therapist does not include you or your Spouse, or the brother, sister, parent or child of either you or your Spouse.

Pregnancy

Your or your Dependent's pregnancy, childbirth, or related medical conditions, including complications of pregnancy. Pregnancy is treated as a Sickness under the Group Policy.

Prior Plan

An accident insurance plan which is replaced by coverage under the Group Policy and which is the Policyholder's group accident insurance plan in effect on the day before the effective date of the Group Policy.

Rehabilitation Facility

A licensed facility that provides skilled care, intermediate care, intermingled care, custodial care or rehabilitation care services on an Inpatient basis as an alternative to a Hospital. Rehabilitation care services consist of the combined use of medical, social, educational, and vocational services to enable a patient disabled by an Accident to achieve the highest possible functional ability. Services are provided by or under the supervision of an organized staff of Physicians.

A Rehabilitation Facility does not include:

- A nursing or convalescent home.
- A rest home for the aged.
- A hospice care facility.
- An assisted living facility.
- Chemical dependency treatment facility.
- Mental health treatment facility.

Sickness

Your or your Dependent's sickness, illness, or disease. Sickness includes Mental Disorder, Pregnancy, and Substance Abuse.

Speech Therapist

An individual who is licensed by the state as a speech-language pathologist and acting within the scope of the license. Speech Therapist does not include you or your Spouse, or the brother, sister, parent or child of either you or your Spouse.

Spouse

Spouse means:

- A person to whom you are legally married.
- Your Domestic Partner. Domestic Partner means an individual with whom you have established a domestic partnership in accordance with the laws or regulations of a jurisdiction that recognizes domestic partnerships; or an individual you have identified as a domestic partner under your Employer's domestic partnership policy, if applicable.

Spouse does not include a full-time member of the armed forces of any country.

Substance Abuse

Alcoholism, drug abuse, misuse of alcohol or any other substance, or taking of drugs unless used or consumed according to the directions of a Physician.

Urgent Care Facility

A health care facility that is organizationally separate from a Hospital and whose primary purpose is the offering and provision of immediate, short term urgent medical care, without an appointment.

ERISA INFORMATION AND NOTICE OF RIGHTS

Grant of Discretion

Your Plan Sponsor has delegated to us the discretion to determine eligibility for benefits and to construe and interpret the terms and provisions of the Group Policy, subject to any and all remedies that may exist under State and Federal law.

Statement of Your Rights under ERISA

The following information and notice of rights and protections is furnished by the Plan Administrator as required by the Employee Retirement Income Security Act of 1974 (ERISA).

Right to Examine Plan Documents

You have the right to examine all Plan documents, including any insurance contracts or collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed with the U. S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration. These documents may be examined free of charge at the Plan Administrator's office.

Right to Obtain Copies of Plan Documents

You have the right to obtain copies of all Plan documents, including any insurance contracts or collective bargaining agreements, a copy of the latest annual report (Form 5500 Series), and updated summary plan description upon written request to the Plan Administrator. The Plan Administrator may make a reasonable charge for these copies.

Right to Receive a Copy of Annual Report

The Plan Administrator must give you a copy of the Plan's summary annual financial report, if the Plan was required to file an annual report. There will be no charge for the report.

Right to Review of Denied Claims

If your claim for a Plan benefit is denied or ignored, in whole or in part, you have the right: a) to know why this was done; b) to obtain copies of documents relating to the decision, without charge; and c) to have your claim reviewed and reconsidered, all within certain time schedules.

Obligations of Fiduciaries

In addition to creating rights for plan participants, ERISA imposes duties upon the people who are responsible for the operation of the Plan. The people who operate the Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of all 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 Plan benefit or exercising your rights under ERISA.

Enforcing ERISA Rights

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request 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 Plan Administrator.

If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court. If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U. S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Plan and ERISA Questions

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

NOTICE OF PROTECTION PROVIDED BY
VIRGINIA LIFE, AND ACCIDENT AND SICKNESS
INSURANCE GUARANTY ASSOCIATION

This notice provides a **brief summary** of the Virginia Life, Accident and Sickness Insurance Guaranty Association ("the Association") and the protection it provides for policyholders. This safety net was created under Virginia law, which determines who and what is covered and the amounts of coverage.

The Association was established to provide protection in the unlikely event that a life, annuity or accident and sickness insurance company (including a health maintenance organization)L licensed in the Commonwealth of Virginia becomes financially unable to meet its obligations and is taken over by its Insurance Department. If this should happen, the Association will typically arrange to continue coverage and pay claims, in accordance with Virginia law, with funding from assessments paid by other life and health insurance companies licensed in the Commonwealth of Virginia.

The basic protections provided by the Association are:

- Life Insurance
  - $300,000 in death benefits
  - $100,000 in cash surrender or withdrawal values

- Health Insurance
  - $500,000 for health benefit plans
  - $300,000 in disability income insurance benefits
  - $300,000 in long-term care insurance benefits
  - $100,000 in other types of accident and sickness insurance benefits

- Annuities
  - $250,000 in withdrawal and cash values

The maximum amount of protection for each individual, regardless of the number of policies or contracts, is $350,000, except for health benefit plans, for which the limit is increased to $500,000.

Note: Certain policies and contracts may not be covered or fully covered. For example, coverage does not extend to any portion(s) of a policy or contract that the insurer does not guarantee, such as certain investment additions to the account value of a variable life insurance policy or a variable annuity contract. There are also various residency requirements and other limitations under Virginia law.

To learn more about the above protections, please visit the Association's website at www.valifega.org or contact:

VIRGINIA LIFE, ACCIDENT AND SICKNESS
INSURANCE GUARANTY ASSOCIATION
c/o APM Management Services, Inc.

1503 Santa Rosa Road, Suite 101
Henrico, VA 23229-5105
804-282-2240

STATE CORPORATION COMMISSION

Bureau of Insurance
P.O. Box 1157
Richmond, VA 23218-1157
804-371-9741
Toll Free Virginia only: 1-800-552-7945
http://scc.virginia.gov/boi/index/aspx

Insurance companies and agents are not allowed by Virginia law to use the existence of the Association or its coverage to encourage you to purchase any form of insurance. When selecting an insurance company, you should not rely on Association coverage. If there is any inconsistency between this notice and Virginia law, then Virginia law will control.

COMMONWEALTH OF VIRGINIA
REQUIRED POLICY INFORMATION

In the event you need to contact someone regarding your insurance for any reason, please contact your agent. If you have additional questions, you may contact the insurance company issuing this policy at the address and telephone number listed below.

If you have been unable to contact or obtain satisfaction from the company or the agent, you may contact the Virginia Bureau of Insurance at the address and telephone number listed below.

Written correspondence is preferable so that a record of your inquiry is maintained. When contacting your agent, company or the Bureau of Insurance, have your policy number available.

Name and address of the Insurance Company	Standard Insurance Company P.O. Box 711 Portland, OR 97207
Telephone Number	(971) 321-7000
Insurance Department Address	Virginia Bureau of Insurance Life and Health Division P.O. Box 1157 Richmond, VA 23218
Telephone Number	In state: 1-800-552-7945 Out-of-state: (804) 371-9741

STANDARD INSURANCE COMPANY

A Stock Life Insurance Company
900 SW Fifth Avenue
Portland, Oregon 97204-1282
(503) 321-7000

GROUP ACCIDENT INSURANCE POLICY

Policyholder:	Pave America
Group Policy Number:	762060-D
Group Policy Effective Date:	10/01/2023
State of Issue:	Virginia

The consideration for this Group Policy is the application of the Policyholder and the payment by the Policyholder of premiums as provided herein.

Subject to **THE GROUP POLICY** and **THE PREMIUM PAYMENT** sections**,** this Group Policy (a) is issued for the Initial Rate Guarantee Period shown in the **ELIGIBILITY, PREMIUM RATES, and PARTICIPATION REQUIREMENT** section and (b) may be renewed for successive renewal periods by the payment of the premium set by us on each renewal date. The length of each renewal period will be set by us, but will not be less than 12 months.

For purposes of effective dates and ending dates under this Group Policy, all days begin and end at 12:00 midnight Standard Time at the Policyholder's address.

All provisions on this and the following pages are part of this Group Policy. "You" and "your" mean the Member. "We", "us", and "our" mean Standard Insurance Company. Other defined terms appear with their initial letters capitalized. Section and provision headings, and references to them, appear in boldface type.

The Group Policy is a legal contract between the Policyholder and us. Please read the Group Policy carefully.

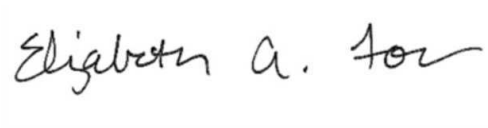
THIS IS A LIMITED BENEFIT POLICY THAT PROVIDES ACCIDENT INSURANCE BENEFITS AND DOES NOT PAY BENEFITS FOR LOSS FROM SICKNESS. THIS POLICY DOES NOT PROVIDE COMPREHENSIVE HEALTH INSURANCE COVERAGE. IT IS NOT INTENDED TO SATISFY THE INDIVIDUAL MANDATE OF THE AFFORDABLE CARE ACT (ACA) OR PROVIDE THE MINIMUM ESSENTIAL COVERAGE REQUIRED BY THE ACA (OFTEN REFERRED TO AS "MAJOR MEDICAL COVERAGE"). IT DOES NOT PROVIDE COVERAGE FOR HOSPITAL, MEDICAL, SURGICAL, OR MAJOR MEDICAL EXPENSES.

THIS LIMITED BENEFIT POLICY IS NOT A MEDICARE SUPPLEMENT POLICY. FOR MEMBERS ELIGIBLE FOR MEDICARE, REVIEW THE "GUIDE TO HEALTH INSURANCE FOR PEOPLE WITH MEDICARE" AVAILABLE FROM US.

STANDARD INSURANCE COMPANY

By

President and CEO



Corporate Secretary

Table of Contents

ELIGIBILITY, PREMIUM RATES, and PARTICIPATION REQUIREMENT

Eligibility

Employer(s):	Pave America
Eligible Class(es):	All Members

Premium Rates and Renewals

Member only:	$7.96
Member and Spouse only:	$15.61
Member and Child only:	$18.64
Member and Dependents:	$22.06
Premium Due Date:	10/01/2023 and the first day of each calendar month thereafter.
Initial Rate Guarantee Period:	10/01/2023 to 10/01/2026
Grace Period:	60 days from Premium Due Date.
Notice of Rate Change:	120 days
Notice of Termination:	31 days

Participation Requirement

Minimum Participation Number:	10 insured Members

THE GROUP POLICY

The Group Policy; Entire Contract

The Group Policy is the entire contract between the Policyholder and us. We will provide benefits according to the terms of the Group Policy.

The Group Policy consists of the following:

- This group accident insurance policy issued by us to the Policyholder and identified by the Group Policy Number.
- The Policyholder's attached application.
- Group accident insurance certificates with the same Group Policy Number.
- Any amendments to the Group Policy or certificates.

The Policyholder's rights or the rights of any Member will only be affected by provisions that are part of the Group Policy. Only an executive officer of Standard Insurance Company may bind us by making a promise or a representation; or accept a representation that relates to the Group Policy.

Changes to the Group Policy

Benefits under the Group Policy are limited to its terms, including any valid amendment. No change or amendment will be valid unless it is approved in writing by one of our executive officers and given to the Policyholder for attachment to the Group Policy. The Policyholder, your Employer, and their respective employees or representatives have no right or authority to change or amend the Group Policy or to waive any of its terms or provisions without our signed written approval.

We may change the Group Policy in whole or in part when any change or clarification in law or governmental regulation affects our obligations under the Group Policy, or with the Policyholder's consent.

Any such change or amendment of the Group Policy may apply to current or future Members or to any separate classes or groups of Members.

Incontestability of Group Policy

Any statement made by the Policyholder to obtain the Group Policy is a representation and not a warranty.

No misrepresentation by the Policyholder will be used to deny a claim or to deny the validity of the Group Policy unless all of the following are true:

- The Group Policy would not have been issued if we had known the truth.
- We have given the Policyholder a copy of a written instrument signed by the Policyholder which contains the misrepresentation.

The validity of the Group Policy will not be contested after it has been in force for two years, except for nonpayment of premiums or fraudulent misrepresentations.

Termination of the Group Policy

The Group Policy may be terminated by us or the Policyholder according to its terms. It will terminate automatically for nonpayment of premium.

The Policyholder may terminate the Group Policy in whole, and may terminate insurance for any class or group of Members, at any time by giving us written notice. The effective date of termination will be the date stated in the notice. If no date is stated in the notice, then the effective date of termination will be the last day of the calendar month for which the premium was paid.

We may terminate the Group Policy as follows:

- On any Premium Due Date if the number of persons insured is less than the Minimum Participation Number shown in the **ELIGIBILITY, PREMIUM RATES, and PARTICIPATION REQUIREMENT**.
- On any Premium Due Date if we determine that the Policyholder has failed to promptly furnish any necessary information requested by us, or has failed to perform any other obligations relating to the Group Policy.

The minimum advance Notice of Termination by us is stated in **ELIGIBILITY, PREMIUM RATES, and PARTICIPATION REQUIREMENT**.

With respect to a Member who has continued insurance under a **Continuation of Insurance (Portability) for the Member** provision, continued coverage will not terminate unless it would otherwise terminate under the terms of the **Continuation of Insurance (Portability) for the Member** provision.

PREMIUM PAYMENT

Premiums

Each premium is payable on or before its Premium Due Date to us. The premium due on each Premium Due Date is the sum of the premiums for all Members and Dependents then insured. Premium Rates are shown in **ELIGIBILITY, PREMIUM RATES, and PARTICIPATION REQUIREMENT**.

The payment of each premium as it becomes due will maintain the Group Policy in force until the next Premium Due Date.

Contributions from Members

The Policyholder determines the amount, if any, of each Member's contribution toward the cost of insurance under the Group Policy.

Changes in Premium Rates

We may change Premium Rates whenever:

- A change or clarification in law or governmental regulation affects the amount payable under the Group Policy. Any such change in Premium Rates will reflect only the change in our obligations.
- Factors material to underwriting the risk we assumed under the Group Policy with respect to an Employer, including, but not limited to, number of persons insured, age, gender, and occupational classification, changes by 25% or more.
- The premium contribution arrangement for Members is changed or varies from that stated in the Group Policy when issued or last renewed.
- We and the Policyholder or the Employer mutually agree to change Premium Rates.

Except as provided above, Premium Rates will not be changed during the Initial Rate Guarantee Period shown in **ELIGIBILITY, PREMIUM RATES, and PARTICIPATION REQUIREMENT**. Thereafter, except as provided above, we may change Premium Rates upon 120 days advance written notice to the Policyholder. Any such change in Premium Rates may be made effective on any Premium Due Date, but no such change will be

made more than once in any contract year. Contract years are successive 12 month periods computed from the end of the Initial Rate Guarantee Period.

Premium Adjustments

Premium adjustments involving a return of unearned premiums to the Policyholder will be limited to the 12 months just before the date we receive a request for premium adjustment.

Grace Period and Termination for Nonpayment

If a premium is not paid on or before its Premium Due Date, it may be paid during the Grace Period shown in **ELIGIBILITY, PREMIUM RATES, and PARTICIPATION REQUIREMENT**. The Group Policy or an Employer's coverage under the Group Policy will remain in force during the Grace Period.

If the premium is not paid during the Grace Period, the Group Policy will terminate automatically at the end of the Grace Period.

The Policyholder is liable for premium for insurance during the Grace Period. We may charge interest at the legal rate for any premium which is not paid during the Grace Period, beginning with the first day after the Grace Period.

GENERAL PROVISIONS

Certificates

We will issue a certificate to the Policyholder showing the coverage under the Group Policy. The Policyholder will distribute a certificate to each insured Member.

Records and Reports

The Policyholder will furnish on our forms all information reasonably necessary to administer the Group Policy. We have the right at all reasonable times to inspect the payroll and other records of the Policyholder which relate to insurance under the Group Policy.

Upon request by the Policyholder, we will promptly provide the Policyholder a complete record of the Policyholder's claims experience under the Group Policy, including claims incurred and amounts paid, for:

- The period of time from the Group Policy Effective Date; or
- The period of time from the last Group Policy renewal date;

whichever is less, provided:

- The Policyholder requests such record at least 30 days before:
  - The next Group Policy renewal date; or
  - The date of any proposed amendment to the Group Policy.

Agency and Release

Individuals selected by the Policyholder or by any Employer to secure coverage under the Group Policy or to perform their administrative function under it, represent and act on behalf of the person selecting them, and do not represent or act on behalf of Standard Insurance Company. The Policyholder, Employer and such individuals have no authority to alter, expand or extend our liability or to waive, modify or compromise any defense or right we may have under the Group Policy. The Policyholder and each Employer hereby release, hold harmless and indemnify Standard Insurance Company from any liability arising from or related to any

negligence, error, omission, misrepresentation or dishonesty of any of them or their representatives, agents or employees.

Notice of Suit

The Policyholder or Employer shall promptly give us written notice of any lawsuit or other legal proceedings arising under the Group Policy.

NOTICE OF PROTECTION PROVIDED BY
VIRGINIA LIFE, AND ACCIDENT AND SICKNESS
INSURANCE GUARANTY ASSOCIATION

This notice provides a **brief summary** of the Virginia Life, Accident and Sickness Insurance Guaranty Association ("the Association") and the protection it provides for policyholders. This safety net was created under Virginia law, which determines who and what is covered and the amounts of coverage.

The Association was established to provide protection in the unlikely event that a life, annuity or accident and sickness insurance company (including a health maintenance organization)L licensed in the Commonwealth of Virginia becomes financially unable to meet its obligations and is taken over by its Insurance Department. If this should happen, the Association will typically arrange to continue coverage and pay claims, in accordance with Virginia law, with funding from assessments paid by other life and health insurance companies licensed in the Commonwealth of Virginia.

The basic protections provided by the Association are:

- Life Insurance
  - $300,000 in death benefits
  - $100,000 in cash surrender or withdrawal values

- Health Insurance
  - $500,000 for health benefit plans
  - $300,000 in disability income insurance benefits
  - $300,000 in long-term care insurance benefits
  - $100,000 in other types of accident and sickness insurance benefits

- Annuities
  - $250,000 in withdrawal and cash values

The maximum amount of protection for each individual, regardless of the number of policies or contracts, is $350,000, except for health benefit plans, for which the limit is increased to $500,000.

Note: Certain policies and contracts may not be covered or fully covered. For example, coverage does not extend to any portion(s) of a policy or contract that the insurer does not guarantee, such as certain investment additions to the account value of a variable life insurance policy or a variable annuity contract. There are also various residency requirements and other limitations under Virginia law.

To learn more about the above protections, please visit the Association's website at www.valifega.org or contact:

VIRGINIA LIFE, ACCIDENT AND SICKNESS
INSURANCE GUARANTY ASSOCIATION
c/o APM Management Services, Inc.

1503 Santa Rosa Road, Suite 101
Henrico, VA 23229-5105
804-282-2240

STATE CORPORATION COMMISSION

Bureau of Insurance
P.O. Box 1157
Richmond, VA 23218-1157
804-371-9741
Toll Free Virginia only: 1-800-552-7945
http://scc.virginia.gov/boi/index/aspx

Insurance companies and agents are not allowed by Virginia law to use the existence of the Association or its coverage to encourage you to purchase any form of insurance. When selecting an insurance company, you should not rely on Association coverage. If there is any inconsistency between this notice and Virginia law, then Virginia law will control.

COMMONWEALTH OF VIRGINIA
REQUIRED POLICY INFORMATION

In the event you need to contact someone regarding your insurance for any reason, please contact your agent. If you have additional questions, you may contact the insurance company issuing this policy at the address and telephone number listed below.

If you have been unable to contact or obtain satisfaction from the company or the agent, you may contact the Virginia Bureau of Insurance at the address and telephone number listed below.

Written correspondence is preferable so that a record of your inquiry is maintained. When contacting your agent, company or the Bureau of Insurance, have your policy number available.

Name and address of the Insurance Company	Standard Insurance Company P.O. Box 711 Portland, OR 97207
Telephone Number	(971) 321-7000
Insurance Department Address	Virginia Bureau of Insurance Life and Health Division P.O. Box 1157 Richmond, VA 23218
Telephone Number	In state: 1-800-552-7945 Out-of-state: (804) 371-9741

STANDARD INSURANCE COMPANY

A Stock Life Insurance Company
900 SW Fifth Avenue
Portland, Oregon 97204-1282
(503) 321-7000

GROUP CRITICAL ILLNESS INSURANCE CERTIFICATE AND SUMMARY PLAN DESCRIPTION

Policyholder:	Pave America
Employer(s):	Pave America
Group Policy Number:	762060-E
Group Policy Effective Date:	10/01/2023
State of Issue:	Virginia

The Group Policy has been issued to the Policyholder. We certify that you will be insured as provided by the terms of the Group Policy. If your insurance is changed by an amendment to the Group Policy, we will provide the Policyholder or Employer with a revised Certificate and Summary Plan Description or other notice that will be available to you.

Possession of this Certificate and Summary Plan Description does not necessarily mean you are insured. You are insured only if you meet the requirements set out in this Certificate and Summary Plan Description.

"You" and "your" mean the Member. "We", "us" and "our" mean Standard Insurance Company. Other defined terms appear with the initial letters capitalized. Section and provision headings, and references to them, appear in boldface type.

Your Certificate describes the insurance under the Group Policy. Please read your Certificate carefully.

THIS CERTIFICATE IS ISSUED UNDER A LIMITED BENEFIT POLICY THAT PROVIDES CRITICAL ILLNESS INSURANCE BENEFITS. THE POLICY UNDER WHICH THIS CERTIFICATE IS ISSUED DOES NOT PROVIDE COMPREHENSIVE HEALTH INSURANCE COVERAGE. IT IS NOT INTENDED TO SATISFY THE INDIVIDUAL MANDATE OF THE AFFORDABLE CARE ACT (ACA) OR PROVIDE THE MINIMUM ESSENTIAL COVERAGE REQUIRED BY THE ACA (OFTEN REFERRED TO AS "MAJOR MEDICAL COVERAGE"). IT DOES NOT PROVIDE COVERAGE FOR HOSPITAL, SURGICAL OR MAJOR MEDICAL EXPENSES.

THIS CERTIFICATE IS NOT A MEDICARE SUPPLEMENT POLICY. IF YOU ARE ELIGIBLE FOR MEDICARE, REVIEW THE "GUIDE TO HEALTH INSURANCE FOR PEOPLE WITH MEDICARE" AVAILABLE FROM US.

STANDARD INSURANCE COMPANY

By

President and CEO

TABLE OF CONTENTS

INDEX OF DEFINED TERMS

COVERAGE FEATURES

Employer(s)

Pave America

Member

You are a Member if you are all of the following:

- An active employee of the Employer.
- Regularly working at least 30 hours each week.
- A citizen or resident of the United States.

You are not a Member if you are:

- A temporary or seasonal employee.
- A full time member of the armed forces of any country.
- A leased employee.
- An independent contractor.

Class(es)

All Members

Eligibility Waiting Period

If you are a Member on the Group Policy Effective Date, you are eligible on that date.

If you become a Member after the Group Policy Effective Date, you are eligible on the first day of the calendar month coinciding with or next following becoming a Member.

Premium Contributions

For you and your Child:	Contributory
For your Spouse:	Contributory

Contributory means you pay all or part of the premium for insurance.

Coverage Amount

The Coverage Amount is the amount of insurance under the Group Policy. The Guarantee Issue Amount is the amount of insurance you may apply for without submitting Evidence Of Insurability. Coverage Amounts requiring Evidence Of Insurability are not effective until approved by us.

For Member:	The amount you elect and we approve in increments of $10,000 from $10,000 - $30,000.
For Child(ren):	50% of your Coverage Amount.
For Spouse:	The amount you elect for your Spouse and we approve in increments of $10,000 from $10,000 - $30,000. Not to exceed 100% of your Coverage Amount.

Guarantee Issue Amount

For Member:	$30,000
For Spouse:	$30,000

Amount Payable

Table of Critical Illness Benefits

The amount payable is the percentage of the Coverage Amount in effect on the date of the Critical Illness. Subject to the Reoccurrence Benefit, only one Critical Illness is payable unless an initial diagnosis or recommendation, as required, for a different and subsequent Critical Illness is made at least 0 days after the preceding Critical Illness.

Advanced Alzheimer's Disease	100% of Coverage Amount
Advanced Multiple Sclerosis	100% of Coverage Amount
Advanced Parkinson's Disease	100% of Coverage Amount
Amyotrophic Lateral Sclerosis (ALS)	100% of Coverage Amount
Benign Brain Tumor	100% of Coverage Amount
Bone Marrow Transplant	100% of Coverage Amount
Cancer	100% of Coverage Amount
Carcinoma in Situ	25% of Coverage Amount
Coma	100% of Coverage Amount
End-Stage Renal (Kidney) Failure	100% of Coverage Amount
Loss of Hearing	100% of Coverage Amount
Loss of Sight	100% of Coverage Amount
Loss of Speech	100% of Coverage Amount
Major Organ Failure	100% of Coverage Amount
Myocardial Infarction (Heart Attack)	100% of Coverage Amount
Occupational Hepatitis	100% of Coverage Amount
Occupational Human Immunodeficiency Virus (HIV)	100% of Coverage Amount
Paralysis (2 or more Limbs)	100% of Coverage Amount
Severe Coronary Artery Disease With a Recommendation of Bypass Surgery	25% of Coverage Amount
Stroke	100% of Coverage Amount
Child Diseases	100% of Coverage Amount for Child
Reoccurrence Benefit	100% of Coverage Amount

If a Critical Illness Benefit is payable and there is a subsequent diagnosis or recommendation for the same Critical Illness, a Reoccurrence Benefit is payable if you and your Dependents meet both of the following:

- You and your Dependents have been continuously insured under the Group Policy between the previous and subsequent diagnosis or recommendation.

- You and your Dependents have served a 6 month Treatment Free Period during such continuous insurance.

A Reoccurrence Benefit is payable only once per each Critical Illness during your or your Dependent's lifetime.

Treatment Free Period means you or your Dependent have not done any of the following in connection with the Critical Illness:

- Consulted a physician or other licensed medical professional.
- Received medical treatment, services or advice.
- Undergone diagnostic procedures, including self-administered procedures.
- Taken prescribed drugs or medications.

Treatment Free Period does not include:

- Maintenance drug therapy (such as: ongoing antiplatelet regimens and statins; ongoing hormonal therapy, immunotherapy or chemoprevention therapy) that is intended to decrease the risk of Critical Illness reoccurrence.
- Routine follow-up visits with a Physician, including necessary tests (such as a stress treadmill) to verify whether or not a Critical Illness has reoccurred.

Additional Benefits

Health Maintenance Screening Benefit	$50

Additional Features

Reinstatement

Continuity of Coverage

Continuation of Insurance (Portability) for the Member

Continuation of Insurance (Portability) for the Spouse

ERISA SUMMARY PLAN DESCRIPTION INFORMATION

Name of Plan:	Group Critical Illness Insurance
Name, Address of Plan Sponsor:	Pave America 9469 Hawkins Drive, #3907 Manassas, VA 20109
Plan Sponsor Tax ID Number:	08-7134990
Plan Number:	508
Type of Plan:	Group Insurance Plan
Type of Administration:	Contract Administration
Name, Address, Phone Number of Plan Administrator:	Plan Sponsor 757-778-5295
Name, Address of Registered Agent for Service of Legal Process:	Pave America
If Legal Process Involves Claims For Benefits Under The Group Policy, Additional Notification of Legal Process Must Be Sent To:	Standard Insurance Company 1100 SW 6th Ave Portland OR 97204-1093
Sources of Contributions:	Member
Funding Medium:	Standard Insurance Company - Fully Insured
Plan Fiscal Year End:	September 30

ELIGIBILITY AND ENROLLMENT

Becoming Insured

To become insured you must:

- Be a Member.
- Complete your Eligibility Waiting Period.
- Meet the requirements shown in **When Your Insurance Becomes Effective** and **Active Work Requirement**.
- Submit Evidence Of Insurability, if required.

When Your Insurance Becomes Effective

The **Coverage Features** states whether insurance is Contributory or Noncontributory. Subject to the **Active Work Requirement,** your insurance becomes effective as follows:

Insurance Not Subject to Evidence Of Insurability

Contributory insurance

You must apply in writing for Contributory insurance and agree to pay premiums. Contributory insurance not subject to Evidence Of Insurability becomes effective on:

- The date you become eligible if you apply on or before that date.
- The date you apply if you apply within 31 days after you become eligible.
- The October 1 next following the Annual Enrollment Period if you apply during the Annual Enrollment Period.
- If you have a Family Status Change the later of:
  - The date of the Family Status Change if you apply on or before the date of the Family Status Change.
  - The date you apply if you apply within 31 days of the Family Status Change.
  - The October 1 next following the Annual Enrollment Period if you apply for the Family Status Change during the Annual Enrollment Period.

Annual Enrollment Period means the period designated each year by your Employer when you may apply for insurance or change insurance elections.

Family Status Change means any of the following events:

- Your marriage or divorce or dissolution of your Domestic Partner relationship.
- The birth of your Child.
- The adoption of a Child by you.
- The death of your Dependent.
- The commencement or termination of your Spouse's employment.
- A change in employment from full-time to part-time by your Spouse.
- A loss of critical illness insurance through your Spouse’s employment.

Changes in Your Insurance

You may apply in writing for any increase in your insurance.

Subject to the **Active Work Requirement**, increases in your insurance become effective as follows:

Increases Not Subject to Evidence Of Insurability

Increases not subject to Evidence Of Insurability become effective on the later of:

- The October 1 next following the Annual Enrollment Period during which you apply for the increase.
- The date of your Family Status Change.

Decreases in Coverage Amounts become effective on:

- The first day of the calendar month coinciding with or next following the date the Policyholder or Employer receives your written request for the decrease.

Active Work Requirement

If you are incapable of Active Work because of sickness, injury, or pregnancy on the day before the scheduled effective date of your insurance or increase in Coverage Amount under the Group Policy, such insurance will not become effective until the day after you complete 1 full day(s) of Active Work as an eligible Member.

Active Work and Actively At Work mean performing the material duties of your own occupation at your Employer's usual place of business.

You will also meet the Active Work requirement if you meet all of the requirements shown below:

- You were absent from Active Work because of a regularly scheduled day off, holiday, or vacation day.
- You were Actively At Work on your last scheduled work day before the date of your absence.
- You were capable of Active Work on the day before the scheduled effective date of your insurance.

When Your Insurance Ends

Insurance ends automatically on the earliest of the following:

- For Contributory insurance, the date you notify the Policyholder or your Employer in writing that coverage is to be terminated.
- The date the last period ends for which the premium was paid for your insurance.
- The date the Group Policy terminates unless you continue your insurance under the **Continuation of Insurance (Portability) for the Member** provision.
- The first day of the calendar month coinciding with or next following the date your employment terminates unless you continue your insurance under the **Continuation of Insurance (Portability) for the Member** provision.
- The date you cease to be a Member. However, if you cease to be a Member because you are not working the required minimum number of hours, your insurance will be continued with payment of premium:
  - During the first 60 days of a temporary or indefinite administrative leave of absence.
  - During any other scheduled leave of absence approved by your Employer in advance and in writing and lasting not more than 60 days.
  - During a leave of absence which is required by the federal or a state-mandated family or medical leave act or law.

CHILD INSURANCE

When Child Insurance Becomes Effective

Insurance for your Child becomes effective as follows:

- The date your insurance becomes effective if you have a Child on that date.
- The date you first acquire a Child, if you are insured on that date.

If you have more than one Child on the effective date, all are insured as of that date. While your insurance is in effect, each new Child becomes insured immediately.

A Member may not be insured as both a Member and a Child. A Child may not be insured by more than one Member.

Changes in Child Insurance

Increases or decreases resulting from changes in your Coverage Amounts will become effective for a Child on the effective date of your change.

When Child Insurance Ends

Your insurance for a Child ends automatically on the earliest of:

- The date your insurance ends unless the Child insurance is continued under the **Continuation of Insurance (Portability) for the Member** provision or **Continuation of Insurance (Portability) for the Spouse** provision.
- The date the Child insurance terminates under the Group Policy unless the Child insurance is continued under the **Continuation of Insurance (Portability) for the Member** provision or **Continuation of Insurance (Portability) for the Spouse** provision.
- The date a Child ceases to meet the definition of Child.
- The date the Group Policy terminates unless the Child insurance is continued under the **Continuation of Insurance (Portability) for the Member** provision.

SPOUSE INSURANCE

Eligibility for Spouse Insurance

You become eligible to insure your Spouse on the later of:

- The date you become eligible for insurance if you have a Spouse on that date.
- The date you acquire a Spouse, if you are insured on that date.

A Member may not be insured as both a Member and a Spouse.

When Spouse Insurance Becomes Effective

The **Coverage Features** states whether your Spouse insurance is Contributory or Noncontributory. You must apply in writing for Contributory Spouse insurance and agree to pay premiums.

Spouse Insurance Not Subject to Evidence Of Insurability

Contributory Spouse insurance becomes effective on:

- The date your insurance becomes effective if you apply on or before that date to insure your Spouse.
- The date you apply to insure your Spouse.
- The October 1 next following the Annual Enrollment Period if you apply during the Annual Enrollment Period.
- If you have a Family Status Change, the later of:
  - The date of the Family Status Change if you apply on or before the date of the Family Status Change.
  - The date you apply, if you apply within 31 days of the Family Status Change.
  - The October 1 next following the Annual Enrollment Period if you apply during the Annual Enrollment Period.

Changes in Spouse Insurance

You may apply in writing for any increase in your Spouse insurance.

Increases in your Spouse's insurance become effective as follows:

Spouse Insurance Increases Not Subject to Evidence Of Insurability

Increases in your Spouse's insurance not subject to Evidence Of Insurability becomes effective on the latest of:

- The date you apply for the increase.
- The October 1 next following the Annual Enrollment Period during which you apply for the increase.
- The date of your Family Status Change.

Decreases in your Spouse's Coverage Amounts become effective on:

- The date your Coverage Amount decreases.
- The first day of the calendar month coinciding with or next following the date the Policyholder or Employer receives your written request for the decrease.

When Spouse Insurance Ends

Your insurance for a Spouse ends automatically on the earliest of:

- The date your insurance ends unless Spouse insurance is continued under the **Continuation of Insurance (Portability) for the Member** provision or **Continuation of Insurance (Portability) for the Spouse** provision.
- The date Spouse insurance terminates under the Group Policy, unless Spouse insurance is continued under the **Continuation of Insurance (Portability) for the Member** provision or **Continuation of Insurance (Portability) for the Spouse** provision.
- The date a Spouse ceases to meet the definition of Spouse.
- The date the last period ends for which the premium was paid for your Spouse insurance.
- The date the Group Policy terminates, unless Spouse insurance is continued under the **Continuation of Insurance (Portability) for the Member** provision.

CRITICAL ILLNESS BENEFITS

Insuring Clause

If you or your Dependent incur a Critical Illness or meet the requirements for the Additional Benefits while insured under the Group Policy, we will pay benefits according to the terms of the Group Policy after we receive Proof Of Loss satisfactory to us.

Critical Illness Definitions

Advanced Alzheimer's Disease means a diagnosis of Alzheimer's Disease which has advanced to a permanent clinical loss of the ability to do all of the following: remember, reason, perceive, understand, express and give ideas.

The diagnosis of Advanced Alzheimer's Disease as defined above must:

- Be made while insured under the Group Policy.
- Be made by a Physician who is board certified as a neurologist and has performed the appropriate neurological examination and cognitive testing including: Functional Assessment Staging Test (FAST) with a Stage 6 (moderately severe) or greater classification requiring substantial assistance in performing at least two or more Activities Of Daily Living (ADL's).

The diagnosis must eliminate other causes of dementia, including: mental health disorders, dementing organic brain disorders, vitamin deficiency or infection. Dementia due to the root cause of vascular dementia (including stroke), drug or alcohol abuse are not included.

Advanced Multiple Sclerosis means a diagnosis of Multiple Sclerosis (MS) which has advanced to the inability to safely and completely perform two or more Activities Of Daily Living without Hands-on Assistance or Standby Assistance due to loss of functional capacity that has persisted for a continuous period of at least 6 months.

The diagnosis of Advanced MS as defined above must:

- Be made while insured under the Group Policy.
- Be made by a Physician who is board certified as a neurologist.
- Be based on at least two episodes of well-defined neurological abnormalities with objective evidence of lesions at more than one site within the central nervous system as documented by Magnetic Resonance Imaging (MRI).
- Supported by modern investigative techniques including, but not limited to, a lumbar puncture.

Advanced Parkinson's Disease means a diagnosis of Parkinson's Disease which has advanced to a classification of Stage 4 or greater on the Hoehn and Yahr scale.

The diagnosis of Advanced Parkinson's Disease as defined above must:

- Be made while insured under the Group Policy.
- Be made by a Physician who is board certified as a neurologist.
- Be based on neurological examination, cognitive testing, and the results of imaging studies.

Parkinson's disease secondary to illegal drug use and other Parkinsonism Syndromes, such as: Progressive Supranuclear Palsy, Corticobasal Degeneration, Multiple System Atrophy, Vascular Parkinsonism, and Dementia with Lewy bodies are not included.

Amyotrophic Lateral Sclerosis (ALS) also known as Lou Gehrig's Disease, means a diagnosis of ALS.

The diagnosis must:

- Be made while insured under the Group Policy.
- Be made by a Physician who is board certified as a neurologist.
- Be based according to the diagnostic criteria for ALS.

All other motor neuron diseases are not included.

Benign Brain Tumor means a diagnosis of a non-malignant tumor or cyst in the brain, cranial nerves, or meninges within the skull, resulting in permanent neurological deficit with persisting clinical symptoms.

The diagnosis must:

- Be made while insured under the Group Policy.
- Be made by a Physician who is board certified as a neurologist.
- Be evidenced on Magnetic Resonance Imaging (MRI) of the brain (with or without contrast) or by pathological diagnosis. If you are unable to undergo a MRI, due to safety or mechanical reasons, a CT scan of the head may evidence the diagnosis of the tumor.

Tumors in the pituitary gland or angiomas are not included.

Bone Marrow Transplant means a diagnosis and recommendation that a bone marrow transplant is necessary due to the compromise of the bone marrow's ability to produce blood cells as a result of cancer.

The diagnosis and recommendation must:

- Be made while insured under the Group Policy.
- Be made by a Physician who is board certified as a hematologist or oncologist.

Cancer means a diagnosis of any malignant tumor or neoplasm with histological confirmation, characterized by the uncontrolled growth of malignant cells and invasion of tissue beyond the initial tissue (invasive).

The diagnosis must:

- Be made while insured under the Group Policy.
- Be made by a Physician who is board certified as a pathologist or oncologist.
- Be based on pathological or clinical evidence.

Cancer includes:

- Leukemia
- Lymphoma
- Sarcoma
- Malignant melanoma
- Other skin malignancies that have been histologically classified as having caused invasion beyond the epidermis with a Clark’s level III or greater, Breslow’s depth of 0.75mm or greater, or AJCC TNM stage II or greater are included.

Conditions that are not invasive cancer are not included. Such conditions include, but are not limited to:

- All cancers which are histologically classified as pre-malignant, non-invasive, carcinoma in situ, having borderline malignancy, or having low malignant potential.
- Benign tumors or polyps.
- Early prostate cancer that is histologically classified as T1N0M0 or equivalent staging.

- Chronic lymphocytic leukemia that is histologically classified as Rai Stage 0 or Binet Stage A.
- Any skin cancer not previously incorporated in this definition, including:
    - Cutaneous lymphoma.
    - Melanoma that is histologically classified as Clark's level I or II; Breslow's depth of less than 0.75mm; or AJCC TNM stage 0 or I.

Carcinoma in Situ means a diagnosis of cancer in which the tumor or cells still lie within the tissue of origin without invading neighboring tissue or regional lymph nodes.

The diagnosis must:

- Be made while insured under the Group Policy.
- Be made by a Physician who is board certified as a pathologist or oncologist.
- Be based on pathological or clinical evidence.

Carcinoma in Situ includes, but is not limited to:

- Early prostate cancer that is histologically classified as T1N0M0 or equivalent staging.
- Chronic lymphocytic leukemia that is histologically classified as Rai Stage 0 or Binet Stage A.
- Cutaneous lymphoma.
- Melanoma not invading the reticular (lower) dermis that is histologically classified as one of the following:
    - Clark's level I or II.
    - Breslow's depth of less than 0.75mm.
    - AJCC TNM stage 0 or I.

Carcinoma in Situ does not include: lesser skin malignancies (such as basal cell and squamous cell carcinomas,) pre-malignant lesions, intraepithelial neoplasia, benign tumors or polyps.

Coma means an initial diagnosis of a profound state of mental unconsciousness from which one cannot be aroused and there is no evidence of appropriate response to external-stimulation, other than primitive avoidance reflexes, due to an accident or disease.

The diagnosis must:

- Be made while insured under the Group Policy.
- Be made by a Physician who is board certified as a neurologist.
- Must last for at least 14 consecutive days resulting in neurological deficit with persisting clinical symptoms.

Coma which is medically induced or Coma as a result of drug or alcohol use is not included.

End-Stage Renal Failure means a diagnosis of chronic and end-stage irreversible failure of both kidneys to function, as a result of which the need for regular, at least weekly and for longer than 6 months, kidney dialysis or kidney transplant is recommended to sustain life.

The diagnosis and recommendation must:

- Be made while insured under the Group Policy.
- Be made by a board certified nephrologist.

Loss of Hearing means an initial diagnosis of entire, uncorrectable, and irrecoverable loss of hearing in both ears that results in one not being able to hear sounds at or below 70 decibels due to an accident or a disease.

The diagnosis must:

- Be made while insured under the Group Policy.
- Be made by a Physician who is board certified as an otolaryngologist.
- Be based on audiometric testing.
- For a Child, occur after age 3.

Loss of Hearing does not include loss of hearing that can be corrected to hear sounds above 70 decibels by the use of any hearing aid or device.

Loss of Sight means an initial diagnosis of entire, uncorrectable, and irrecoverable loss of sight due to an accident or a disease.

The diagnosis must:

- Be made while insured under the Group Policy.
- Be made by a Physician who is board certified as an ophthalmologist.
- Be based on evidence of sight in the better eye being reduced to a best-corrected visual acuity of 20/200 (Snellen or E-Chart Acuity) and visual field restriction to 20° or less in both eyes.
- For a Child, occur after age 3.

Loss of Speech means an initial diagnosis of entire, uncorrectable, and irrecoverable loss of the ability to speak due to an accident or disease.

The diagnosis must:

- Be made while insured under the Group Policy.
- Be made by a Physician who is board certified as a neurologist or otolaryngologist. The date of diagnosis for complete loss of speech is the date of certification of total and permanent loss of speech.
- Not be due to coma, psychiatric impairment, or stroke.
- For a Child, occur after age 3.

Major Organ Failure means a diagnosis of irreversible failure of the heart, liver, lung, small intestine, or pancreas as a result of a disease and, for which a transplantation of the organ(s) or tissue from a suitable human donor is required.

The diagnosis must:

- Be made while insured under the Group Policy.
- Be made by a Physician.
- Be based on clinical evidence of major organ failure of an organ(s) or tissue and requires that your or your Dependent's condition meet the criteria for placement on the registry with the Organ Procurement and Transplantation Network/United Network for Organ Sharing (OPTN/UNOS) or its medically recognized successor organization.

If you or your Dependent do not meet the criteria for placement on the registry because your or your Dependent's condition is too far advanced or you or your Dependent are too ill to proceed with a transplant, this requirement will not apply.

Myocardial Infarction is commonly known as a heart attack and means an episode of rapid onset of chest pain that required immediate medical attention and with a diagnosis of death of a portion of the heart muscle as a result of inadequate blood supply to the heart.

The diagnosis must:

- Be made while insured under the Group Policy.
- Be made by a Physician.
- Be based on new changes consistent with an evolving infarction on electrocardiogram (EKG) and concurrent with elevation of infarction specific enzymes, troponins or other biochemical markers accepted to be indicative of an acute Myocardial Infarction. In the event of death, an autopsy or death certificate indicating Myocardial Infarction as the cause will apply.

Myocardial Infarction does not include a heart attack that occurred during a medical procedure or due to alcohol or drug abuse. Other acute coronary syndromes, including but not limited to angina, are not included.

Occupational Hepatitis means a diagnosis of hepatitis, other than hepatitis A, that occurs as a result of a documented accidental exposure in the workplace to blood or other bodily fluids.

The diagnosis must:

- Be made while insured under the Group Policy.
- Be made by a Physician.
- Be based on blood testing. A blood test is required within 72 hours of the accidental exposure with the results showing as negative for hepatitis. A follow up blood test with the results showing as positive for hepatitis must occur 6 to 12 months after the accidental exposure.
- Be documented by an appropriate accident report at the workplace.

Occupational Hepatitis does not include hepatitis that occurs as a result of intravenous drug use, sexual transmission, or is determined not to be an accident.

Occupational Human Immunodeficiency Virus (HIV) means a diagnosis of HIV that occurs as a result of a documented accidental exposure in the workplace to blood or other bodily fluids.

The diagnosis must:

- Be made while insured under the Group Policy.
- Be made by a Physician.
- Be based on blood testing. A blood test is required within 72 hours of the accidental exposure with the results showing as negative for HIV. A follow up blood test with the results showing positive for HIV must occur 6 to 12 months after the accidental exposure.
- Be documented by an appropriate accident report at the workplace.

Occupational HIV does not include HIV that occurs as a result of intravenous drug use, sexual transmission, or is determined not to be an accident.

Paralysis means a diagnosis of the irreversible loss of all motor function of two or more Limbs due to an accident or a disease.

The diagnosis must:

- Be made while insured under the Group Policy.
- Be made by a Physician who is board certified as a neurologist.

Severe Coronary Artery Disease with a Recommendation of Bypass Surgery means a narrowing or blockage of the arteries and vessels that provide oxygen and nutrients to the heart that result in a diagnosis of severe

coronary artery disease which results in a Physician's recommendation of bypass surgery. Severe Coronary Artery Disease with a Recommendation of Bypass Surgery includes but is not limited to: open heart surgery to increase the flow of blood through the coronary arteries.

The diagnosis and recommendation must:

- Be made while insured under the Group Policy.
- Be made by a Physician who is board certified as a cardiologist or cardiac surgeon.
- Be based on a clinical diagnosis.

Severe Coronary Artery Disease does not include: angioplasty, stenting, percutaneous coronary intervention, or laser procedures.

If a Physician has recommended bypass surgery but you are too ill to proceed with the recommended surgery, the requirement that bypass surgery be recommended will not apply.

Stroke means a diagnosis of: a cerebrovascular accident or infarction (death) of brain tissue caused by hemorrhage, embolism or thrombosis producing measurable, neurological deficit, which is expected to be permanent.

The diagnosis must:

- Be made while insured under the Group Policy.
- Be made by a Physician assigning a Modified Rankin Scale score of 4 (moderately severe disability) or greater.
- Be based on objective clinical evidence of brain tissue damage using current neuroimaging tests, including but not limited to: Computed Tomography scan (CT); Magnetic Resonance Imaging (MRI); Positron Emission Tomography scan (PET); arteriography; or angiography.

Stroke does not include Transient Ischemic Attack (TIA) and traumatic injury to brain tissue or blood vessels.

Child Diseases

Means any of the following Critical Illnesses where an initial diagnosis is made while the Child is insured under the Group Policy or the initial diagnosis was made prior to birth and you were insured under the Group Policy and the Child became insured at birth:

Anal Atresia means a malformation of the anus and rectum.

The diagnosis must:

- Be made at birth with a physical examination, abdominal x-ray, ultrasound or Magnetic Resonance Imaging (MRI); or prior to birth while you are insured under the Group Policy with an initial diagnosis in utero.
- Be made by a board certified pediatrician, neonatologist, pediatric surgeon or other board certified physician who specializes in treating this congenital defect.
- Include a recommendation for surgical intervention.

Anencephaly means an incomplete development of the brain, skull and scalp (neural tube defects).

The diagnosis must:

- Be made at birth with a physical examination; or prior to birth while you are insured under the Group Policy with an initial diagnosis in utero via ultrasound, amniocentesis, or a serum folic acid test.
- Be made by a board certified pediatrician, neonatologist, pediatric surgeon or other board certified Physician who specializes in treating the congenital defect.

Biliary Atresia means a blockage in the bile duct tubes inhibiting bile flow from the liver to the gallbladder.

The diagnosis must:

- Be made by a diagnostic test, including but not limited to: abdominal x-ray; ultrasound; blood tests (to check total and direct bilirubin levels); Hepatobiliary iminodiacetic acid (HIDA) scan; cholescintigraphy; liver biopsy; and x-ray of the bile ducts (cholangiogram); or prior to birth while you are insured under the Group Policy with an initial diagnosis in utero.
- Be made by a board certified pediatrician, neonatologist, pediatric surgeon or other board certified physician who specializes in treating the congenital defect.
- Include a recommendation for surgical intervention.

Cerebral Palsy means a group of disorders affecting development of movement, muscle tone and posture causing activity limitation, attributed to an insult to the immature, developing brain, most often before birth.

The diagnosis must:

- Be made during Childhood.
- Be made by a Physician who is board certified as a neurologist.

Cerebral Palsy does not include other similar conditions such as: degenerative nervous disorders, genetic diseases, muscle diseases, metabolic disorders, nervous system tumors, coagulation disorders, or other injuries or disorders which delay early development, but can be outgrown.

Cleft Lip means a physical split or separation of the two sides of the upper lip appearing as a narrow opening or gap in the skin of the upper lip where the separation often extends beyond the base of the nose and includes the bones of the upper jaw and/or upper gum.

The diagnosis must:

- Be made at birth with a physical examination; or prior to birth while you are insured under the Group Policy with an initial diagnosis in utero via ultrasound or a sample of amniotic fluid (amniocentesis).
- Be made by a board certified pediatrician, neonatologist or other board certified physician who specializes in treating the congenital defect.
- Include a recommendation for surgery to ensure the Child's ability to eat, speak, hear and breathe and to achieve a normal facial appearance.

A Critical Illness Benefit is not payable for a Cleft Lip if a Cleft Palate is payable.

Cleft Palate means a split or opening in the roof of the mouth. A cleft palate can involve the hard palate (the bony front portion of the roof of the mouth), and/or the soft palate (the soft back portion of the roof of the mouth).

The diagnosis must:

- Be made at birth with a physical examination; or prior to birth while you are insured under the Group Policy with an initial diagnosis in utero via ultrasound or a sample of amniotic fluid (amniocentesis).
- Be made by a board certified pediatrician, neonatologist or other board certified physician who specializes in treating the congenital defect.
- Include a recommendation for surgery to ensure the child's ability to eat, speak, hear and breathe and to achieve a normal facial appearance.

Club Foot means a range of foot abnormalities in which the foot is twisted out of shape or position. The tissues connecting the muscles to the bone (tendons) are shorter than usual.

The diagnosis must:

- Be made at birth with a physical examination; or prior to birth while you are insured under the Group Policy with an initial diagnosis in utero via ultrasound or a sample of amniotic fluid (amniocentesis).

- Be made by a board certified pediatrician, neonatologist or other board certified physician who specializes in treating the congenital defect.
- Include a recommendation of corrective techniques such as the Ponseti method and French/Functional method, or corrective surgery.

Coarctation of the Aorta means the severe narrowing of the aorta, causing a decrease in blood flow to the lower part of the body.

The diagnosis must:

- Be made at birth with a physical examination and diagnostic testing, including but not limited to: chest radiography; barium esophagography; cardiac catheterization or electrocardiography (ECG); or prior to birth while you are insured under the Group Policy with an initial diagnosis in utero via a fetal echocardiography.
- Be made by a board certified pediatrician, neonatologist, pediatric cardiac surgeon or other board certified physician who specializes in treating the congenital defect.

Cystic Fibrosis means an inherited, life-threatening disorder that affects the cells that produce mucus, sweat and digestive juices that causes severe damage to the lungs and digestive system.

The diagnosis must:

- Be made during Childhood based on appropriate diagnostic measures, including but not limited to, a sweat test with results of chloride concentrations greater than 60 mmol/L; or prior to birth while you are insured under the Group Policy with an initial diagnosis in utero via diagnostic amniocentesis, chorionic villus biopsy or a blood or saliva sample.
- Be made by a Physician who is board certified as a pediatrician or pulmonologist.

Diaphragmatic Hernia means an abnormal opening in the diaphragm allowing the abdominal organs (stomach, spleen, liver, and intestines) to appear in the chest cavity, impeding the lung tissue on the affected side to completely develop.

The diagnosis must:

- Be made at birth by physical examination with symptoms including, but not limited to: irregular chest movements; absent breath sounds on affected side; bowel sounds heard in the chest or abdomen feels less full on examination by touch (palpation); respiratory distress (retractions, cyanosis, grunting respirations); rapid heart rate (tachycardia); and chest x-ray; or prior to birth while you are insured under the Group Policy with an initial diagnosis in utero via a fetal echocardiography.
- Be made by a board certified pediatrician, neonatologist, pediatric surgeon or other board certified physician who specializes in treating this congenital defect.
- Include a recommendation for surgical repair.

Down's Syndrome means an extra full or partial copy of chromosome 21.

The diagnosis must:

- Be made during Childhood.
- Be made by a Physician who is board certified as a pediatrician.

Gastroschisis means a defect in the anterior abdominal wall through which the abdominal contents protrude (abdominal herniation).

The diagnosis must:

- Be made at birth with a physical examination; or prior to birth while you are insured under the Group Policy with an initial diagnosis in utero via ultrasound or a sample of amniotic fluid (amniocentesis).

- Be made by a board certified pediatrician, neonatologist, pediatric surgeon or other board certified physician who specializes in treating the congenital defect.
- Include a recommendation for surgical intervention.

Hirschsprung's Disease means a disorder of the abdomen where part or all of the large intestine (colon) or antecedent parts of the gastrointestinal tract have no nerves and cannot function which creates an obstruction.

The diagnosis must:

- Be made at birth with a physical examination or diagnostic testing including but not limited to: abdominal x-ray using a contrast dye (barium or other); anal manometry test; rectal biopsy; or barium enema; or prior to birth while you are insured under the Group Policy with an initial diagnosis in utero via ultrasound.
- Be made by a board certified pediatrician, neonatologist, pediatric surgeon or other board certified physician who specializes in treating the congenital defect.
- Include a recommendation for surgical intervention.

Hypoplastic Left Heart Syndrome means severely underdeveloped structures on the left side of the heart unable to support the circulation needed by the body’s organs.

The diagnosis must:

- Be made at birth with a physical examination or shortly thereafter with symptoms including, but not limited to: blue or purple tint to lips, skin and nails (cyanosis), difficulty breathing, difficulty feeding, and lethargy (sleepy or unresponsive) or via diagnostic testing including but not limited to: electrocardiogram; chest x-ray; pulse, cardiac catheterization; or cardiac Magnetic Resonance Imaging (MRI); or prior to birth while you are insured under the Group Policy with an initial diagnosis in utero via a fetal echocardiography.
- Include a recommendation of a heart transplantation with reconstruction via the Norwood (Stage I), Glenn (Stage II) and Fontan (Stage III) procedures or a hybrid procedure (combination of surgery and catheter-based treatment).
- Be made by a board certified pediatrician, neonatologist, pediatric cardiac surgeon or other board certified physician who specializes in treating this congenital defect.

Infantile Hypertrophic Pyloric Stenosis means a narrowing (stenosis) of the opening from the stomach to the first part of the small intestine (duodenum) due to enlargement (hypertrophy) of the muscle surrounding this opening (pylorus) resulting in violent projectile vomiting.

The diagnosis must:

- Be made at birth with a physical examination or diagnostic testing including, but not limited to: upper gastrointestinal series, abdominal ultrasound and/or blood tests; or prior to birth while you are insured under the Group Policy with an initial diagnosis in utero via ultrasound or a sample of amniotic fluid (amniocentesis).
- Be made by a board certified pediatrician, neonatologist, pediatric surgeon or other board certified physician who specializes in treating the congenital defect.
- Include a recommendation for the surgical intervention of pyloromyotomy.

Muscular Dystrophy means a group of genetic diseases characterized by progressive weakness and degeneration of the skeletal or voluntary muscles that control movement.

The diagnosis must:

- Be made by a Physician who is board certified as a neurologist.

- Be based on testing methods, including but not limited to: Electromyography; muscle biopsy; nerve conduction tests; or blood enzyme tests.

Omphalocele means the organs remained enclosed in visceral peritoneum (membrane) and protrude out of the navel.

The diagnosis must:

- Be made at birth with a physical examination; or prior to birth while you are insured under the Group Policy with an initial diagnosis in utero via ultrasound.
- Be made by a board certified pediatrician, neonatologist, pediatric surgeon or other board certified physician who specializes in treating this congenital defect.
- Include a recommendation of surgical intervention.

Patent Ductus Arteriosis (PDA) means a persistent opening between two major blood vessels leading from the heart.

The diagnosis must:

- Be made at birth with a physical examination or diagnostic testing, including but not limited to: echocardiogram; chest x-ray; electrocardiogram; cardiac catheterization; cardiac Computerized Tomography (CT); or Magnetic Resonance Imaging (MRI).
- Be made by a board certified pediatrician, neonatologist, pediatric cardiac surgeon or other board certified physician who specializes in treating the congenital defect.

Spina Bifida Cystica with Myelomeningocele means a malformation of the vertebrae around the spinal cord.

The diagnosis must:

- Be made at birth with a physical examination or a diagnostic test (Magnetic Resonance Image (MRI) or Computed Tomography (CT) scan); or prior to birth while you are insured under the Group Policy with an initial diagnosis in utero via diagnostic prenatal tests: blood test (maternal serum quadruple or triple screen), high resolution fetal ultrasound, or amniocentesis.
- Be made by a board certified pediatrician, neonatologist, pediatric surgeon or other board certified physician who specializes in treating the congenital defect.
- Include a recommendation for surgical intervention.

Tetralogy of Fallot means four heart defects (a large ventricular septal defect (VSD, pulmonary infundibular stenosis, right ventricular hypertrophy, and an overriding aorta) with a recommendation of surgical repair.

The diagnosis must:

- Be made at birth with a physical examination or shortly thereafter with symptoms including, but not limited to: heart murmur; blue or purple tint to lips, skin and nails (cyanosis); difficulty in feeding; failure to gain weight; retarded growth and physical development; dyspnea on exertion; clubbing of the fingers and toes; polycythemia; or "tet spells"; or prior to birth while you are insured under the Group Policy with an initial diagnosis in utero.
- Be made by a board certified pediatrician, neonatologist, pediatric cardiac surgeon or other board certified physician who specializes in treating the congenital defect.

Transposition of the Great Arteries means a transposition of the pulmonary artery and aorta resulting in a cyanotic heart defect (decreased oxygen in the blood being pumped to the rest of the body).

The diagnosis must:

- Be made at birth with a physical examination or shortly thereafter with symptoms including, but not limited to: blue or purple tint to lips, skin and nails (cyanosis), shortness of breath, clubbing of the fingers or toes and poor feeding or via diagnostic testing of at least one of the following: cardiac

catheterization; chest x-ray; electrocardiography (ECG); echocardiogram and Pulse oximetry (to check blood oxygen level); or prior to birth while you are insured under the Group Policy with an initial diagnosis in utero via a fetal echocardiography.

- Be made by a board certified pediatrician, neonatologist, pediatric cardiac surgeon or other board certified physician who specializes in treating the congenital defect.

Additional Benefits

Health Maintenance Screening Benefit

We will pay a Health Maintenance Screening Benefit if you or your Dependent meet all of the following requirements:

- A Health Maintenance Screening Procedure is performed.

Health Maintenance Screening Procedures are limited to the following:

- Abdominal aortic aneurysm ultrasound.
- Ankle Brachial Index (ABI) screening for peripheral vascular disease.
- Biopsies for cancer.
- Bone density screening.
- Breast ultrasound.
- Cancer antigen 125 blood test for ovarian cancer (CA 125).
- Cancer antigen 15-3 blood test for breast cancer (CA 15-3).
- Carcinoembryonic antigen blood test for colon cancer (CEA).
- Colonoscopy.
- Complete Blood Count (CBC).
- Comprehensive Metabolic Panel (CMP).
- Electrocardiogram (EKG).
- Hemocult stool analysis.
- Hemoglobin A1C.
- Human Papillomavirus (HPV) vaccination.
- Lipid panel.
- Mammography.
- Pap smears or thin prep pap test.
- Prostate specific antigen (PSA) test.
- Stress test on a bicycle or treadmill.
- Mental health assessments, including but not limited to, PHQ-9, Beck’s Depression Inventory, Hamilton’s Depression Rating Scale.
- Novel infectious disease testing, including testing for antibodies related to novel infectious diseases.

We will pay a Health Maintenance Screening Benefit for 1 day(s) per insured person per Calendar Year.

Calendar Year means the period from January 1 through December 31 of the same year.

EXCLUSIONS

General Exclusions

Benefits are not payable if Critical Illness is caused or contributed to by any of the following:

- War or act of War. War means declared or undeclared war, whether civil or international, insurrection, and any substantial armed conflict between organized forces of a military nature.
- Attempted suicide or other intentionally self-inflicted injury, while sane or insane.
- Committing or attempting to commit an assault, felony, or act of terrorism, or actively participating in a violent disorder or riot. Actively participating does not include being at the scene of a violent disorder or riot while performing official duties.
- The voluntary use or consumption of any poison, chemical compound, drug, or alcohol in excess of the legal limit in the state in which the Critical Illness occurred, unless used or consumed according to the directions of a Physician.
- Elective surgery or other procedure which:
  - Does not promote the proper function of your or your Dependent's body or prevent or treat sickness or injury.
  - Is directed at improving your or your Dependent's appearance, unless such surgery or procedure is necessary to correct a deformity resulting from a congenital abnormality or disfigurement.

  This exclusion will not apply to a Critical Illness caused or contributed to by your or your Dependent's donation of an organ or tissue.

ADDITIONAL FEATURES

Reinstatement

If your insurance ends, you may become insured again as a new Member. However, the following will apply:

- If your insurance ends because you cease to be a Member and if you become a Member again within 90 days, the Eligibility Waiting Period will be waived.
- If you ceased to be a Member under the Group Policy and continued insurance under the **Continuation of Insurance (Portability) for the Member** provision and you become a Member again within 90 days, your insurance will be for the coverage and amount which you continued under the **Continuation of Insurance (Portability) for the Member** provision on the day before you become a new Member.

In no event will insurance be retroactive.

Continuity of Coverage

Waiver of Active Work Requirement

If you were insured under the Prior Plan on the day before the effective date of the Employer's coverage under the Group Policy, you can become insured on the effective date of your Employer's coverage without meeting the Active Work requirement. See the **Active Work Requirement**.

Continuation of Insurance (Portability) for the Member

Eligibility for the Member

You become eligible to continue your or your Dependent's insurance on the date one of the following events occurs:

- Your employment terminates with your Employer.
- The Group Policy terminates.
- Your insurance ends because you are no longer a Member.

You are not eligible to continue insurance under this provision if:

- You are disabled.
- You are age 80 or older.

Application, Amount of Insurance, and Premium Payment

You must apply in writing and pay the first premium to us within 31 days after the date you become eligible. Your and your Dependent's continued insurance will be the same insurance provided under the Group Policy on the day before you become eligible under this Continuation of Insurance (Portability) for the Member. You may decrease the insurance, but cannot increase the insurance.

You will be directly billed for all premiums due if you have applied for and been approved for continuation of coverage under this provision. If premium is not paid on or before the Premium Due Date stated below it may be paid during the Grace Period as stated below. Your or your Dependent's insurance will remain in force during the Grace Period. You are liable for premium for insurance during the Grace Period.

The Premium Due Date is the first day of each calendar month.

The Grace Period is 60 days from the Premium Due Date.

When Insurance Ends

Insurance continued under this provision ends automatically on the earliest of:

- The date the last period ends for which you made the premium payment.
- The date you die, however your Spouse may apply to continue insurance under the **Continuation of Insurance (Portability) for the Spouse** provision below.
- The date you become a full-time member of the armed forces of any country.
- With respect to your Child's insurance, the date the Child ceases to meet the definition of Child.
- The date you are sentenced by a court for any reason to a penal or correctional institution, however your Spouse may apply to continue insurance under the **Continuation of Insurance (Portability) for the Spouse** provision below.
- With respect to your Spouse's insurance, the date the Spouse ceases to meet the definition of Spouse.
- With respect to coverage for your Dependent, the date your Dependent is sentenced by a court for any reason to a penal or correctional institution.
- The date you become insured again as a Member under the Group Policy.

Once insurance continued under this provision ends it cannot be reinstated. Except as provided above, insurance continued under this provision is subject to all other terms of the Group Policy.

Continuation of Insurance (Portability) for the Spouse

Eligibility for Your Spouse:

Your Spouse becomes eligible to continue insurance on the date one of the following events occurs:

- Your insurance terminates due to your death and your Spouse has not reached age 80.
- You are legally divorced from your Spouse or your Domestic Partnership is legally dissolved.
- Your continued insurance under the provision above ends because you reach age 80 and your Spouse has not reached age 80.
- Dependent insurance is no longer provided under the Group Policy.
- Your continued insurance under the provision above ends because you are sentenced by a court for any reason to a penal or correctional institution.

Except as provided below, all provisions and terms of the Group Policy apply to insurance continued under this **Continuation of Insurance (Portability) for the Spouse** provision. In the event your Spouse continues insurance under this **Continuation of Insurance (Portability) for the Spouse** provision, "you" and "your" will refer to your Spouse in **Exclusions, Claims and Benefit Payment,** and **General Provisions**.

Your Spouse is not eligible to continue insurance for your Child under this provision if the Child is insured under your insurance. Your Spouse is not eligible to continue insurance under this provision if your Spouse is 80 or older.

Application, Amount of Insurance, and Premium Payment

Your Spouse must apply in writing and pay the first premium to us within 31 days after the date your Spouse becomes eligible.

Your Dependent’s continued insurance will be the same insurance provided under the Group Policy or your continued insurance on the day before your Spouse became eligible for continued insurance. Your Spouse may decrease the insurance, but cannot increase the insurance.

Your Spouse will be directly billed for all premiums due if your Spouse has applied and been approved for continuation of insurance under this provision. If premium is not paid on or before the Premium Due Date stated below it may be paid during the Grace Period as stated below. Dependent insurance will remain in force during the Grace Period. Your Spouse is liable for premium for insurance during the Grace Period.

The Premium Due Date is the first day of each calendar month.

The Grace Period is 60 days from the Premium Due Date.

When Insurance Ends

Insurance continued under this provision ends automatically on the earliest of:

- The date the last period ends for which your Spouse made a premium payment.
- The date your Spouse dies.
- The date your Spouse becomes a full-time member of the armed forces of any country.
- With respect to a Child’s insurance, the date the Child ceases to meet the definition of Child.
- With respect to a Dependent’s insurance, the date your Dependent is sentenced by a court for any reason to a penal or correctional institution.
- The date your Spouse is insured as a Member under the Group Policy.

Once insurance continued under this provision ends it cannot be reinstated.

CLAIMS AND BENEFIT PAYMENT

Filing a Claim

Claims should be filed on our forms. If we do not provide our forms within 15 days after they are requested, the claim may be submitted in a letter to us. You must notify us of a claim in writing within 20 days after you become disabled. If you cannot do so, you must notify us as soon as reasonably possible.

Time Limits on Filing Proof Of Loss

Proof Of Loss must be provided within 90 days after the date of the Critical Illness. For Additional Benefits, Proof Of Loss must be provided within 90 days after meeting the requirements for the Additional Benefits. If that is not possible, it must be provided as soon as reasonably possible, but not later than one year after that 90-day period.

If Proof Of Loss is filed outside these time limits, the claim will be denied. These limits will not apply while the claimant lacks legal capacity.

Proof Of Loss

Proof Of Loss means written proof that a Critical Illness or entitlement to an Additional Benefit occurred:

- For which the Group Policy provides benefits.
- Which is not subject to any exclusions.
- Which meets all other conditions for benefits.

Proof Of Loss includes any other information we may reasonably require in support of a claim. Proof Of Loss must be in writing and must be provided at the expense of the claimant. No benefits will be paid until we receive Proof of Loss satisfactory to us.

Investigation of Claim

During the pendency of your claim, we reserve the right to investigate a claim at any time at our expense, including an examination conducted by specialists of our choice. In case of death, we have the right and opportunity to request an autopsy, except where prohibited by law.

Notice of Decision on Claim

We will evaluate a claim for benefits promptly after we receive it. Within 60 days after we receive the claim we will send the claimant: (a) a written decision on the claim; or (b) a notice that we are extending the period to decide the claim for an additional 60 days.

If we extend the period to decide the claim, we will notify the claimant of the following: (a) the reasons for the extension; and (b) when we expect to decide the claim.

If we deny any part of the claim, we will send the claimant a written notice of denial containing:

- The reasons for our decision.
- Reference to the parts of the Group Policy on which our decision is based.
- A description of any additional information needed to support the claim.
- Information concerning the claimant's right to a review of our decision.
- Information concerning the right to bring a civil action for benefits under section 502(a) of ERISA if the claim is denied on review.

Review Procedure

If all or part of a claim is denied, the claimant may request a review. The claimant must request a review in writing within 60 days after receiving notice of the denial of the claim.

The claimant may send us written comments or other items to support the claim. The claimant may review and receive copies of any non-privileged information that is relevant to the request for review. There will be no charge for such copies. Our review will include any written comments or other items the claimant submits to support the claim.

We will review the claim promptly after we receive the request. With respect to all claims, within 45 days after we receive the request for review we will send the claimant: (a) a written decision on review; or (b) a notice that we are extending the review period for 45 days.

If an extension is due to the claimant's failure to provide information necessary to decide the claim on review, the extended time period for review of the claim will not begin until the claimant provides the information or otherwise responds.

If we extend the review period, we will notify the claimant of the following: (a) the reasons for the extension; and (b) when we expect to decide the claim on review.

If we request additional information, the claimant will have 45 days to provide the information. If the claimant does not provide the requested information within 45 days, we may conclude our review of the claim based on the information we have received.

If we deny any part of the claim on review, the claimant will receive a written notice of denial containing:

- The reasons for our decision.
- Reference to the parts of the Group Policy on which our decision is based.
- Information concerning the claimant's right to receive, free of charge, copies of non-privileged documents and records relevant to the claim.
- Information concerning the right to bring a civil action for benefits under section 502(a) of ERISA.

The Group Policy does not provide voluntary alternative dispute resolution options. However, you may contact your local U.S. Department of Labor Office and your State insurance regulatory agency for assistance.

Time of Payment

We will pay benefits within 30 days after Proof Of Loss is satisfied.

Payment of Benefits

Benefits will be paid to you. Any benefits remaining unpaid at your death will be paid as shown below.

Benefits will be paid in equal shares to the first surviving class of the classes below.

- Your Spouse.
- Your children.
- Your parents.
- Your brothers and sisters.
- Your estate.

Reimbursement

We reserve the right to recover any benefits that you or your Dependent or a claimant were paid but not entitled to under the terms of the Group Policy, state or federal law.

You or your Dependent, or a claimant or beneficiary must reimburse us in full. We will determine the method by which repayment is to be paid.

Unpaid Premium

Any unpaid premium due for your or your Dependent's Critical Illness Insurance under the Group Policy may be recovered by us. Any Critical Illness Benefits payable to you or your Dependent, a claimant, a beneficiary or legal representative will be applied to reduce the amount of any unpaid premiums prior to paying you or your Dependent, a claimant, a beneficiary or a legal representative.

GENERAL PROVISIONS

Assignment

The rights and benefits under the Group Policy may not be assigned.

Time Limits on Legal Actions

No action at law or in equity may be brought until 60 days after we have been given Proof Of Loss. No such action may be brought more than three years after the earlier of:

- The date we receive Proof Of Loss.
- The time within which Proof Of Loss is required to be given.

Incontestability of Insurance

Any statement made to obtain insurance or to increase insurance is a representation and not a warranty. No misrepresentation will be used to reduce or deny a claim or contest the validity of insurance unless:

- The insurance would not have been approved if we had known the truth.
- We have given you or any other person claiming benefits a copy of the signed written instrument which contains the misrepresentation.

After insurance has been in effect for two years during the lifetime of the insured, we will not use a misrepresentation to reduce or deny the claim.

Clerical Error

Clerical error by the Policyholder, your Employer, or their respective employees or representatives will not:

- Cause a person to become insured.
- Invalidate insurance under the Group Policy otherwise validly in force.
- Continue insurance under the Group Policy otherwise validly terminated.

Agency

The Policyholder and your Employer act on their own behalf as your agent, and not as our agent. Individuals selected by the Policyholder or by any Employer to secure coverage under the Group Policy or to perform their administrative function under it, represent and act on behalf of the person selecting them, and do not represent or act on behalf of us. The Policyholder and your Employer have no authority to alter, expand or extend our liability or to waive, modify or compromise any defense or right we may have under the Group Policy.

Misstatement of Age

If a person's age has been misstated, we will make an equitable adjustment of premiums, benefits, or both. The adjustment will be based on the following:

- The amount of insurance based on the correct age.
- The difference between the premiums paid and the premiums which would have been paid if the age had been correctly stated.

Misstatement of Tobacco Use

If a person’s use of tobacco has been misstated, we have the right to make an equitable adjustment of premiums, benefits, or both. The adjustment will be based on the following:

- The amount of insurance based on the correct tobacco use status.
- The difference between the premiums paid and the premiums which would have been paid if the tobacco use status had been correctly stated.

DEFINITIONS

Activities of Daily Living

- Bathing means washing oneself, whether in the tub or shower or by sponge bath, with or without the help of adaptive devices.
- Continence means voluntarily controlling bowel and bladder function, or, if incontinent, maintaining a reasonable level of personal hygiene.
- Dressing means putting on and removing all items of clothing, footwear, and medically necessary braces and artificial limbs.
- Eating means getting food and fluid into the body, whether manually, intravenously, or by feeding tube.
- Toileting means getting to and from and on and off the toilet, and performing related personal hygiene.
- Transferring means moving into or out of a bed, chair or wheelchair, with or without adaptive devices.

Child

Child means one of the following:

- Your child from live birth until age 26.
- Your adopted child until age 26.
- Your stepchild, foster child, dependent grandchild, and the child of your Spouse if living in your home until age 26.
- A child living in your home for whom you are the court appointed legal guardian until age 26.
- Your child, stepchild, foster child, dependent grandchild, and the child of your Spouse who is continuously incapable of self-sustaining employment because of intellectual disability or physical handicap; and chiefly dependent upon you for support and maintenance or institutionalized because of mental or physical handicap.

Child does not include a person who is eligible for insurance as a Member. A Child does not include a full-time member of the armed forces of any country.

Childhood

From birth through age 12.

Dependent(s)

Your Spouse, your Child, or your Spouse or Child, or your Spouse and Child.

Domestic Partner

Domestic Partner means an individual with whom you have completed an affidavit of declaration of domestic partnership, submitted that affidavit to the Employer, and filed that affidavit for public record if required by law.

For purposes of insurance under the Group Policy, Domestic Partner receives the same benefits and policy rights as a Spouse.

Eligibility Waiting Period

The period you must be a Member before you become eligible for insurance. Your Eligibility Waiting Period is shown in the **Coverage Features**.

Employer

An employer (including approved affiliates and subsidiaries) for which coverage under the Group Policy is approved in writing by us.

Evidence Of Insurability

You or your Spouse must:

- Complete and sign our medical history statement.
- If required by us, sign our form authorizing us to obtain information about the applicant's health.
- Undergo a physical examination, if required by us, which may include blood testing.
- Provide any additional information about the applicant's insurability that we may reasonably require.

Group Policy

The group critical illness insurance policy issued by us to the Policyholder and identified by the Group Policy Number, the Policyholder's attached application, group critical illness insurance certificates with the same Group Policy Number, and any amendments to the policy or certificates.

Hands-on Assistance

The physical assistance of another person without which the insured would be unable to perform the Activity Of Daily Living.

Limb

The entire arm from shoulder to fingers, or the entire leg from hip to toes.

Physician

An individual who is licensed by the state as an M.D. or D.O. and acting within the scope of the license. Physician does not include you or your Spouse, or the brother, sister, parent or child of either you or your Spouse.

Prior Plan

A critical illness insurance plan which is replaced by coverage under the Group Policy and which is the Policyholder’s group critical illness insurance plan in effect on the day before the effective date of the Group Policy.

Spouse

Spouse means

- a person to whom you are legally married.

Spouse does not include a full-time member of the armed forces of any country.

Standby Assistance

The presence of another person within arm’s reach of the insured that is necessary to prevent, by physical intervention, injury to the insured while the insured is performing the Activity Of Daily Living (such as being ready to catch the insured if the insured falls while getting into or out of the bathtub or shower as part of Bathing, or being ready to remove food from the insured’s throat if the insured chokes while Eating).

ERISA INFORMATION AND NOTICE OF RIGHTS

Grant of Discretion

Your Plan Sponsor has delegated to us the discretion to determine eligibility for benefits and to construe and interpret the terms and provisions of the Group Policy, subject to any and all remedies that may exist under State and Federal law.

Statement of Your Rights under ERISA

The following information and notice of rights and protections is furnished by the Plan Administrator as required by the Employee Retirement Income Security Act of 1974 (ERISA).

Right to Examine Plan Documents

You have the right to examine all Plan documents, including any insurance contracts or collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration. These documents may be examined free of charge at the Plan Administrator's office.

Right to Obtain Copies of Plan Documents

You have the right to obtain copies of all Plan documents, including any insurance contracts or collective bargaining agreements, a copy of the latest annual report (Form 5500 Series), and updated summary plan description upon written request to the Plan Administrator. The Plan Administrator may make a reasonable charge for these copies.

Right to Receive a Copy of Annual Report

The Plan Administrator must give you a copy of the Plan's summary annual financial report, if the Plan was required to file an annual report. There will be no charge for the report.

Right to Review of Denied Claims

If your claim for a Plan benefit is denied or ignored, in whole or in part, you have the right: a) to know why this was done; b) to obtain copies of documents relating to the decision, without charge; and c) to have your claim reviewed and reconsidered, all within certain time schedules.

If we deny any part of your claim for a benefit that relies on a disability determination, you will receive a written notice of denial containing a copy of any internal rule or guideline relied upon in making our decision, or a statement that no such rules or guidelines exist. The notice of denial will also include information concerning your right to receive, free of charge, copies of non-privileged documents and records relevant to your claim.

If all or part of a claim is denied, you may request a review. Before we issue a decision on review for a benefit that relies on a disability decision, we will provide you, free of charge, with any new evidence or rationale considered, relied upon, or generated by us in connection with the claim, and we will provide

such new evidence or rationale sufficiently in advance of the decision deadline date to give you a reasonable opportunity to respond prior to that date.

If our review results in a denial of any part of your claim for a benefit that relies on a disability decision, your written notice of denial will contain a copy of any internal rule or guideline relied upon in making our decision, or a statement that no such rules or guidelines exist. The notice of denial will also include information concerning your right to bring a civil action for benefits under section 502(a) of ERISA and a description of any applicable contractual limitations period that applies to your right to bring such an action, including the calendar date on which the contractual limitations period expires for the claim.

Obligations of Fiduciaries

In addition to creating rights for plan participants, ERISA imposes duties upon the people who are responsible for the operation of the Plan. The people who operate the Plan, called "fiduciaries'" of the Plan, have a duty to do so prudently and in the interest of all 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 Plan benefit or exercising your rights under ERISA.

Enforcing ERISA Rights

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request 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 Plan Administrator.

If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court. If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U. S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Plan and ERISA Questions

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

NOTICE OF PROTECTION PROVIDED BY
VIRGINIA LIFE, AND ACCIDENT AND SICKNESS
INSURANCE GUARANTY ASSOCIATION

This notice provides a **brief summary** of the Virginia Life, Accident and Sickness Insurance Guaranty Association ("the Association") and the protection it provides for policyholders. This safety net was created under Virginia law, which determines who and what is covered and the amounts of coverage.

The Association was established to provide protection in the unlikely event that a life, annuity or accident and sickness insurance company (including a health maintenance organization)L licensed in the Commonwealth of Virginia becomes financially unable to meet its obligations and is taken over by its Insurance Department. If this should happen, the Association will typically arrange to continue coverage and pay claims, in accordance with Virginia law, with funding from assessments paid by other life and health insurance companies licensed in the Commonwealth of Virginia.

The basic protections provided by the Association are:

- Life Insurance
  - $300,000 in death benefits
  - $100,000 in cash surrender or withdrawal values

- Health Insurance
  - $500,000 for health benefit plans
  - $300,000 in disability income insurance benefits
  - $300,000 in long-term care insurance benefits
  - $100,000 in other types of accident and sickness insurance benefits

- Annuities
  - $250,000 in withdrawal and cash values

The maximum amount of protection for each individual, regardless of the number of policies or contracts, is $350,000, except for health benefit plans, for which the limit is increased to $500,000.

Note: Certain policies and contracts may not be covered or fully covered. For example, coverage does not extend to any portion(s) of a policy or contract that the insurer does not guarantee, such as certain investment additions to the account value of a variable life insurance policy or a variable annuity contract. There are also various residency requirements and other limitations under Virginia law.

To learn more about the above protections, please visit the Association's website at www.valifega.org or contact:

VIRGINIA LIFE, ACCIDENT AND SICKNESS
INSURANCE GUARANTY ASSOCIATION
c/o APM Management Services, Inc.

1503 Santa Rosa Road, Suite 101
Henrico, VA 23229-5105
804-282-2240

STATE CORPORATION COMMISSION

Bureau of Insurance
P.O. Box 1157
Richmond, VA 23218-1157
804-371-9741
Toll Free Virginia only: 1-800-552-7945
http://scc.virginia.gov/boi/index/aspx

Insurance companies and agents are not allowed by Virginia law to use the existence of the Association or its coverage to encourage you to purchase any form of insurance. When selecting an insurance company, you should not rely on Association coverage. If there is any inconsistency between this notice and Virginia law, then Virginia law will control.

COMMONWEALTH OF VIRGINIA
REQUIRED POLICY INFORMATION

In the event you need to contact someone regarding your insurance for any reason, please contact your agent. If you have additional questions, you may contact the insurance company issuing this policy at the address and telephone number listed below.

If you have been unable to contact or obtain satisfaction from the company or the agent, you may contact the Virginia Bureau of Insurance at the address and telephone number listed below.

Written correspondence is preferable so that a record of your inquiry is maintained. When contacting your agent, company or the Bureau of Insurance, have your policy number available.

Name and address of the Insurance Company	Standard Insurance Company P.O. Box 711 Portland, OR 97207
Telephone Number	(971) 321-7000
Insurance Department Address	Virginia Bureau of Insurance Life and Health Division P.O. Box 1157 Richmond, VA 23218
Telephone Number	In state: 1-800-552-7945 Out-of-state: (804) 371-9741

STANDARD INSURANCE COMPANY

A Stock Life Insurance Company
900 SW Fifth Avenue
Portland, Oregon 97204-1282
(503) 321-7000

GROUP CRITICAL ILLNESS INSURANCE POLICY

Policyholder:	Pave America
Group Policy Number:	762060-E
Group Policy Effective Date:	10/01/2023
State of Issue:	Virginia

The consideration for this Group Policy is the application of the Policyholder and the payment by the Policyholder of premiums as provided herein.

Subject to **The Group Policy** and **Premium Payment** sections**,** this Group Policy (a) is issued for the Initial Rate Guarantee Period shown in **Eligibility, Premium Rates, And Participation Requirement** and (b) may be renewed for successive renewal periods by the payment of the premium set by us on each renewal date. The length of each renewal period will be set by us, but will not be less than 12 months.

For purposes of effective dates and ending dates under this Group Policy, all days begin and end at 12:00 midnight Standard Time at the Policyholder's address.

All provisions on this and the following pages are part of this Group Policy. "You" and "your" mean the Member. "We", "us", and "our" mean Standard Insurance Company. Other defined terms appear with their initial letters capitalized. Section and provision headings, and references to them, appear in boldface type.

The Group Policy is a legal contract between the Policyholder and us. Please read the Group Policy carefully.

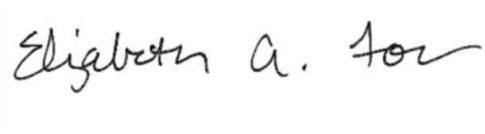
THIS IS A LIMITED BENEFIT POLICY THAT PROVIDES CRITICAL ILLNESS BENEFITS. THIS POLICY DOES NOT PROVIDE COMPREHENSIVE HEALTH INSURANCE COVERAGE. IT IS NOT INTENDED TO SATISFY THE INDIVIDUAL MANDATE OF THE AFFORDABLE CARE ACT (ACA) OR PROVIDE THE MINIMUM ESSENTIAL COVERAGE REQUIRED BY THE ACA (OFTEN REFERRED TO AS "MAJOR MEDICAL COVERAGE"). IT DOES NOT PROVIDE COVERAGE FOR HOSPITAL, MEDICAL, SURGICAL OR MAJOR MEDICAL EXPENSES.

THIS LIMITED BENEFIT POLICY IS NOT A MEDICARE SUPPLEMENT POLICY. FOR MEMBERS ELIGIBLE FOR MEDICARE, REVIEW THE "GUIDE TO HEALTH INSURANCE FOR PEOPLE WITH MEDICARE" AVAILABLE FROM US.

STANDARD INSURANCE COMPANY

By

President and CEO



Corporate Secretary

Table of Contents

ELIGIBILITY, PREMIUM RATES, AND PARTICIPATION REQUIREMENT

Eligibility

Employer(s): Pave America

Eligible Class(es): All Members

Premium Rates and Renewals

Member and Dependents:

The rates below are not combined rates for the Member and Spouse, rather they are for each individually.

	Age of Member on 1st of the month coinciding with or next following birthday Annual rates per $1000 of coverage
Age < 25	$3.840
Age 25-29	$3.840
Age 30-34	$5.880
Age 35-39	$5.880
Age 40-44	$12.000
Age 45-49	$12.000
Age 50-54	$24.840
Age 55-59	$24.840
Age 60-64	$45.960
Age 65-69	$45.960
70+	$116.880

Premium Due Date:	10/01/2023 and the first day of each calendar month thereafter.
Initial Rate Guarantee Period:	10/01/2023 to 10/01/2026
Grace Period:	60 days from Premium Due Date
Notice of Rate Change:	120 days
Notice of Termination:	31 days

Participation Requirement

Minimum Participation Number:	10 insured Members

THE GROUP POLICY

The Group Policy; Entire Contract

The Group Policy is the entire contract between the Policyholder and us. We will provide benefits according to the terms of the Group Policy.

The Group Policy consists of the following:

- This group critical illness insurance policy issued by us to the Policyholder and identified by the Group Policy Number.
- The Policyholder's attached application.
- Group critical illness insurance certificates with the same Group Policy Number.
- Any amendments to the Group Policy or certificates.

The Policyholder's rights or the rights of any Member will only be affected by provisions that are part of the Group Policy. Only an executive officer of Standard Insurance Company may bind us by making a promise or a representation; or accept a representation that relates to the Group Policy.

Changes to the Group Policy

Benefits under the Group Policy are limited to its terms, including any valid amendment. No change or amendment will be valid unless it is approved in writing by one of our executive officers and given to the Policyholder for attachment to the Group Policy. No agent has authority to change the Group Policy, or to waive any of its provisions. The Policyholder, an Employer, and their respective employees or representatives have no right or authority to change or amend the Group Policy or to waive any of its terms or provisions without our signed written approval.

We may change the Group Policy in whole or in part when any change or clarification in law or governmental regulation affects our obligations under the Group Policy, or with the Policyholder's consent.

Any such change or amendment of the Group Policy may apply to current or future Members or to any separate classes or groups of Members.

Incontestability of Group Policy

Any statement made by the Policyholder to obtain the Group Policy is a representation and not a warranty.

No misrepresentation by the Policyholder will be used to deny a claim or to deny the validity of the Group Policy unless all of the following are true:

- The Group Policy would not have been issued if we had known the truth.
- We have given the Policyholder a copy of a written instrument signed by the Policyholder which contains the misrepresentation.

The validity of the Group Policy will not be contested after it has been in force for two years, except for nonpayment of premiums.

Termination of the Group Policy

The Group Policy may be terminated by us or the Policyholder according to its terms. It will terminate automatically for nonpayment of premium.

The Policyholder may terminate the Group Policy in whole, and may terminate insurance for any class or group of Members, at any time by giving us written notice. The effective date of termination will be the date

stated in the notice. If no date is stated in the notice, then the effective date of termination will be the last day of the calendar month for which the premium was paid in full.

We may terminate the Group Policy as follows:

- On any Premium Due Date if the number of persons insured is less than the Minimum Participation Number shown in **Eligibility, Premium Rates, and Participation Requirement**.
- On any Premium Due Date if we determine that the Policyholder has failed to promptly furnish any necessary information requested by us, or has failed to perform any other obligations relating to the Group Policy.

The minimum advance Notice of Termination by us is stated in **Eligibility, Premium Rates, and Participation Requirement.**

With respect to a Member or Spouse who has continued insurance under the **Continuation of Insurance (Portability) for the Member** provision or **Continuation of Insurance (Portability) for the Spouse** provision**,** continued coverage will not terminate unless it would otherwise terminate under the terms of the **Continuation of Insurance (Portability) for the Member** provision or **Continuation of Insurance (Portability) for the Spouse** provision.

PREMIUM PAYMENT

Premiums

Each premium is payable on or before its Premium Due Date to us. The premium due on each Premium Due Date is the sum of the premiums for all Members and Dependents then insured. Premium Rates are shown in **Eligibility, Premium Rates, and Participation Requirement**.

The payment of each premium as it becomes due will maintain the Group Policy in force until the next Premium Due Date.

Contributions from Members

The Policyholder determines the amount, if any, of each Member's contribution toward the cost of insurance under the Group Policy.

Changes in Premium Rates

We may change Premium Rates whenever:

- A change or clarification in law or governmental regulation affects the amount payable under the Group Policy. Any such change in Premium Rates will reflect only the change in our obligations.
- Factors material to underwriting the risk we assumed under the Group Policy with respect to an Employer, including, but not limited to, number of persons insured, age, gender, and occupational classification, change by 25% or more.
- The premium contribution arrangement for Members is changed or varies from that stated in the Group Policy when issued or last renewed.
- We and the Policyholder or the Employer mutually agree to change Premium Rates.

Except as provided above, Premium Rates will not be changed during the Initial Rate Guarantee Period shown in **Eligibility, Premium Rates, and Participation Requirement**. Thereafter, except as provided above, we may change Premium Rates upon 120 days advance written notice to the Policyholder. Any such change in Premium Rates may be made effective on any Premium Due Date, but no such change will be made more than once in any contract year. Contract years are successive 12 month periods computed from the end of the Initial Rate Guarantee Period.

Premium Adjustments

Premium adjustments involving a return of unearned premiums to the Policyholder will be limited to the 12 months just before the date we receive a request for premium adjustment.

Grace Period and Termination for Nonpayment

If a premium is not paid on or before its Premium Due Date, it may be paid during the Grace Period shown in **Eligibility, Premium Rates, And Participation Requirement**. The Group Policy or an Employer's coverage under the Group Policy will remain in force during the Grace Period.

If the premium is not paid during the Grace Period, the Group Policy will terminate automatically at the end of the Grace Period.

The Policyholder is liable for premium for insurance during the Grace Period. We may charge interest at the legal rate for any premium which is not paid during the Grace Period, beginning with the first day after the Grace Period.

GENERAL PROVISIONS

Certificates

We will issue a certificate to the Policyholder showing the coverage under the Group Policy. The Policyholder will distribute a certificate to each insured Member.

Records and Reports

The Policyholder will furnish on our forms all information reasonably necessary to administer the Group Policy. We have the right at all reasonable times to inspect the payroll and other records of the Policyholder which relate to insurance under the Group Policy.

Upon request by the Policyholder, we will promptly provide the Policyholder a complete record of the Policyholder's claims experience under the Group Policy, including claims incurred and amounts paid, for:

- The period of time from the Group Policy Effective Date; or
- The period of time from the last Group Policy renewal date;

whichever is less, provided:

- The Policyholder requests such record at least 30 days before:
    - The next Group Policy renewal date; or
    - The date of any proposed amendment to the Group Policy.

Agency and Release

Individuals selected by the Policyholder or by any Employer to secure coverage under the Group Policy or to perform their administrative function under it, represent and act on behalf of the person selecting them, and do not represent or act on behalf of Standard Insurance Company. The Policyholder, Employer and such individuals have no authority to alter, expand or extend our liability or to waive, modify or compromise any defense or right we may have under the Group Policy. The Policyholder and each Employer hereby release, hold harmless and indemnify Standard Insurance Company from any liability arising from or related to any negligence, error, omission, misrepresentation or dishonesty of any of them or their representatives, agents or employees.

Notice of Suit

The Policyholder or Employer shall promptly give us written notice of any lawsuit or other legal proceedings arising under the Group Policy.

NOTICE OF PROTECTION PROVIDED BY
VIRGINIA LIFE, AND ACCIDENT AND SICKNESS
INSURANCE GUARANTY ASSOCIATION

This notice provides a **brief summary** of the Virginia Life, Accident and Sickness Insurance Guaranty Association ("the Association") and the protection it provides for policyholders. This safety net was created under Virginia law, which determines who and what is covered and the amounts of coverage.

The Association was established to provide protection in the unlikely event that a life, annuity or accident and sickness insurance company (including a health maintenance organization)L licensed in the Commonwealth of Virginia becomes financially unable to meet its obligations and is taken over by its Insurance Department. If this should happen, the Association will typically arrange to continue coverage and pay claims, in accordance with Virginia law, with funding from assessments paid by other life and health insurance companies licensed in the Commonwealth of Virginia.

The basic protections provided by the Association are:

- Life Insurance
  - $300,000 in death benefits
  - $100,000 in cash surrender or withdrawal values

- Health Insurance
  - $500,000 for health benefit plans
  - $300,000 in disability income insurance benefits
  - $300,000 in long-term care insurance benefits
  - $100,000 in other types of accident and sickness insurance benefits

- Annuities
  - $250,000 in withdrawal and cash values

The maximum amount of protection for each individual, regardless of the number of policies or contracts, is $350,000, except for health benefit plans, for which the limit is increased to $500,000.

Note: Certain policies and contracts may not be covered or fully covered. For example, coverage does not extend to any portion(s) of a policy or contract that the insurer does not guarantee, such as certain investment additions to the account value of a variable life insurance policy or a variable annuity contract. There are also various residency requirements and other limitations under Virginia law.

To learn more about the above protections, please visit the Association's website at www.valifega.org or contact:

VIRGINIA LIFE, ACCIDENT AND SICKNESS
INSURANCE GUARANTY ASSOCIATION
c/o APM Management Services, Inc.

1503 Santa Rosa Road, Suite 101
Henrico, VA 23229-5105
804-282-2240

STATE CORPORATION COMMISSION

Bureau of Insurance
P.O. Box 1157
Richmond, VA 23218-1157
804-371-9741
Toll Free Virginia only: 1-800-552-7945
http://scc.virginia.gov/boi/index/aspx

Insurance companies and agents are not allowed by Virginia law to use the existence of the Association or its coverage to encourage you to purchase any form of insurance. When selecting an insurance company, you should not rely on Association coverage. If there is any inconsistency between this notice and Virginia law, then Virginia law will control.

COMMONWEALTH OF VIRGINIA
REQUIRED POLICY INFORMATION

In the event you need to contact someone regarding your insurance for any reason, please contact your agent. If you have additional questions, you may contact the insurance company issuing this policy at the address and telephone number listed below.

If you have been unable to contact or obtain satisfaction from the company or the agent, you may contact the Virginia Bureau of Insurance at the address and telephone number listed below.

Written correspondence is preferable so that a record of your inquiry is maintained. When contacting your agent, company or the Bureau of Insurance, have your policy number available.

Name and address of the Insurance Company	Standard Insurance Company P.O. Box 711 Portland, OR 97207
Telephone Number	(971) 321-7000
Insurance Department Address	Virginia Bureau of Insurance Life and Health Division P.O. Box 1157 Richmond, VA 23218
Telephone Number	In state: 1-800-552-7945 Out-of-state: (804) 371-9741

STANDARD INSURANCE COMPANY

A Stock Life Insurance Company
900 SW Fifth Avenue
Portland, Oregon 97204-1282
(503) 321-7000

GROUP HOSPITAL INDEMNITY INSURANCE CERTIFICATE AND SUMMARY PLAN DESCRIPTION

Policyholder:	Pave America
Employer(s):	Pave America
Group Policy Number:	762060-F
Group Policy Effective Date:	10/01/2023
State Of Issue:	Virginia

The Group Policy has been issued to the Policyholder. We certify that you will be insured as provided by the terms of the Group Policy. If your insurance is changed by an amendment to the Group Policy, we will provide the Policyholder or Employer with a revised Certificate and Summary Plan Description or other notice that will be available to you.

Possession of this Certificate and Summary Plan Description does not necessarily mean you are insured. You are insured only if you meet the requirements set out in this Certificate and Summary Plan Description.

"You" and "your" mean the Member. "We", "us" and "our" mean Standard Insurance Company. Other defined terms appear with the initial letters capitalized. Section and provision headings, and references to them, appear in boldface type.

Your Certificate describes the insurance under the Group Policy. Please read your Certificate carefully.

NOTICE TO BUYER: THIS CERTIFICATE IS ISSUED UNDER A LIMITED BENEFIT POLICY THAT PROVIDES HOSPITAL INDEMNITY BENEFITS. THE POLICY UNDER WHICH THIS CERTIFICATE IS ISSUED DOES NOT PROVIDE COMPREHENSIVE HEALTH INSURANCE COVERAGE. IT IS NOT INTENDED TO SATISFY THE INDIVIDUAL MANDATE OF THE AFFORDABLE CARE ACT (ACA) OR PROVIDE THE MINIMUM ESSENTIAL COVERAGE REQUIRED BY THE ACA (OFTEN REFERRED TO AS "MAJOR MEDICAL COVERAGE"). IT DOES NOT PROVIDE COVERAGE FOR HOSPITAL, SURGICAL OR MAJOR MEDICAL EXPENSES.

THIS CERTIFICATE IS NOT A MEDICARE SUPPLEMENT POLICY. IF YOU ARE ELIGIBLE FOR MEDICARE, REVIEW THE "GUIDE TO HEALTH INSURANCE FOR PEOPLE WITH MEDICARE" AVAILABLE FROM US.

STANDARD INSURANCE COMPANY

By

President and CEO

Table of Contents

INDEX OF DEFINED TERMS

COVERAGE FEATURES

Employer(s)

Pave America

Member

You are a Member if you are all of the following:

- An active employee of the Employer.
- Regularly working at least 30 hours each week.
- A citizen or resident of the United States.

You are not a Member if you are:

- A temporary or seasonal employee.
- A full time member of the armed forces of any country.
- A leased employee.
- An independent contractor.

Class(es)

All Members

Eligibility Waiting Period

If you are a Member on the Group Policy Effective Date, you are eligible on that date.

If you become a Member after the Group Policy Effective Date, you are eligible on the first day of the calendar month coinciding with or next following becoming a Member.

Premium Contributions

For you and your Dependents:	Contributory
For your Spouse:	Contributory

Contributory means you pay all or part of the premium for insurance.

Table Of Hospital Indemnity Insurance Amounts

All benefits are based on a per day schedule.

Hospitalization Benefits

Critical Care Unit Admission Benefit	$1,000 per day
Daily Critical Care Unit Confinement Benefit	$100 per day
Daily Hospital Confinement Benefit	$100 per day
Hospital Admission Benefit	$1,000 per day

Additional Features

Reinstatement

Waiver of Premium

Continuation of Insurance (Portability) for the Member

ERISA SUMMARY PLAN DESCRIPTION INFORMATION

Name of Plan:	Group Hospital Indemnity Insurance
Name, Address of Plan Sponsor:	Pave America 9469 Hawkins Drive, #3907 Manassas, VA 20109
Plan Sponsor Tax ID Number:	08-7134990
Plan Number:	509
Type of Plan:	Group Insurance Plan
Type of Administration:	Contract Administration
Name, Address, Phone Number of Plan Administrator:	Plan Sponsor 757-778-5295
Name, Address of Registered Agent for Service of Legal Process:	Pave America
If Legal Process Involves Claims For Benefits Under The Group Policy, Additional Notification of Legal Process Must Be Sent To:	Standard Insurance Company 1100 SW 6th Ave Portland OR 97204-1093
Sources of Contributions:	Member
Funding Medium:	Standard Insurance Company - Fully Insured
Plan Fiscal Year End:	September 30

ELIGIBILITY AND ENROLLMENT

Becoming Insured

To become insured you must:

- Be a Member.
- Complete your Eligibility Waiting Period.
- Meet the requirements shown in **When Your Insurance Becomes Effective** and **Active Work Requirement**.
- Submit Evidence Of Insurability, if required.

When Your Insurance Becomes Effective

The **Coverage Features** states whether insurance is Contributory or Noncontributory. Subject to the **Active Work Requirement,** your insurance becomes effective as follows:

Insurance Not Subject to Evidence Of Insurability

Contributory Insurance

You must apply in writing for Contributory insurance and agree to pay premiums. Contributory insurance not subject to Evidence Of Insurability becomes effective on:

- The date you become eligible if you apply on or before that date.
- The date you apply if you apply within 31 days after you become eligible.
- The October 1 next following the Annual Enrollment Period if you apply during the Annual Enrollment Period.
- If you have a Family Status Change the later of:
  - The date of the Family Status Change if you apply on or before the date of the Family Status Change.
  - The date you apply if you apply within 31 day(s) of the Family Status Change.
  - The October 1 next following the Annual Enrollment Period if you apply for the Family Status Change during the Annual Enrollment Period.

Annual Enrollment Period means the period designated each year by your Employer when you may apply for insurance or change insurance elections.

Family Status Change means any of the following events:

- Your marriage or divorce or dissolution of your Civil Union or Domestic Partner relationship.
- The birth of your Child.
- The adoption of a Child by you.
- The death of your Dependent.
- The commencement or termination of your Spouse's employment.
- A change in employment from full-time to part-time by your Spouse.
- The loss of hospital indemnity insurance through your Spouse’s employment.

Changes in Your Insurance

You may apply in writing for any increase in your insurance.

Subject to the **Active Work Requirement**, increases in your insurance becomes effective as follows:

Increases Not Subject to Evidence Of Insurability

Increases not subject to Evidence Of Insurability become effective on the latest of:

- The October 1 next following the Annual Enrollment Period during which you apply for the increase.
- The date of your Family Status Change.

Decreases in insurance amounts become effective on:

- The first day of the calendar month coinciding with or next following the date the Policyholder or Employer receives your written request for the decrease.

Active Work Requirement

If you are incapable of Active Work because of Sickness, Injury or Pregnancy on the day before the scheduled effective date of your insurance under the Group Policy, such insurance will not become effective until the day after you complete 1 full day(s) of Active Work as an eligible Member.

Active Work and Actively At Work mean performing the material duties of your own occupation at your Employer's usual place of business.

You will also meet the Active Work requirement if you meet all of the requirements shown below:

- You were absent from Active Work because of a regularly scheduled day off, holiday, or vacation day.
- You were Actively At Work on your last scheduled work day before the date of your absence.
- You were capable of Active Work on the day before the scheduled effective date of your insurance.

When Your Insurance Ends

Insurance ends automatically on the earliest of the following:

- For Contributory insurance, the date you notify your Policyholder or your Employer in writing that coverage is to be terminated.
- The date the last period ends for which the premium was paid for your insurance.
- The date the Group Policy terminates unless you continue your insurance under the **Continuation of Insurance (Portability) for the Member** provision.
- The first day of the calendar month following the date your employment terminates unless you continue your insurance under the **Continuation of Insurance (Portability) for the Member** provision.
- The date you cease to be a Member. However, if you cease to be a Member because you are not working the required minimum number of hours, your insurance will be continued with payment of premium:
  - During the first 60 day(s) of a temporary or indefinite administrative leave of absence.
  - During any other scheduled leave of absence approved by your Employer in advance and in writing and lasting not more than 60 day(s).
  - During a leave of absence which is required by the federal or a state-mandated family or medical leave act or law.

CHILD INSURANCE

Eligibility for Child Insurance

You become eligible to insure your Child(ren) on the later of:

- The date you become eligible for insurance if you have a Child on that date.
- The date you first acquire a Child, if you are insured on that date.

A Member may not be insured as both a Member and a Child. A Child may not be insured by more than one Member.

When Child Insurance Becomes Effective

The **Coverage Features** states whether your Child insurance is Contributory or Noncontributory. You must apply in writing for Contributory Child insurance and agree to pay premiums.

Child Insurance Not Subject to Evidence Of Insurability

Contributory Child insurance becomes effective on the latest of:

- The date your insurance becomes effective if you apply on or before that date to insure your Child.
- The date you apply to insure your Child.
- The October 1 next following the Annual Enrollment Period if you apply during the Annual Enrollment Period.
- If you have a Family Status Change the later of:
    - The date of the Family Status Change if you apply on or before the date of the Family Status Change.
    - The date you apply if you apply within 31 day(s) of the Family Status Change.
    - The October 1 next following the Annual Enrollment Period if you apply for the Family Status Change during the Annual Enrollment Period.

For Contributory Child insurance, if you do not have Child insurance at the time you acquire a newborn or adopted or foster Child, that Child is automatically insured for 31 days from the moment of birth or placement, subject to the hospital confinement exclusion for newborns. However, you must apply in writing and pay premium back to the date of birth or placement within 31 days for Child insurance to continue. If your application is received after that 31 days, your automatic Child insurance under this provision ends on the first day after the 31 day period. This provision does not apply to you if you have an existing Child and you previously declined to enroll in Child insurance.

Changes in Child Insurance

You may apply in writing for any increase in your Child insurance.

Child Insurance Increases Not Subject to Evidence Of Insurability

Increases in your Child insurance not subject to Evidence Of Insurability become effective on the date of your insurance increases.

A decrease in your Child insurance because of a decrease in your insurance becomes effective on the date of your insurance decrease.

except for increases or plan changes during your Employer’s Annual Enrollment Period.

When Child Insurance Ends

Your insurance for a Child ends automatically on the earliest of:

- The date your insurance ends unless the Child insurance is continued under the **Continuation of Insurance (Portability) for the Member** provision.
- The date Child insurance terminates under the Group Policy unless the Child insurance is continued under the **Continuation of Insurance (Portability) for the Member** provision.
- The date a Child ceases to meet the definition of Child.
- The date the last period ends for which the premium was paid for your Child insurance.
- The date the Group Policy terminates unless Child insurance is continued under the **Continuation of Insurance (Portability) for the Member** provision.

SPOUSE INSURANCE

Eligibility for Spouse Insurance

You become eligible to insure your Spouse on the later of:

- The date you become eligible for insurance if you have a Spouse on that date.
- The date you acquire a Spouse, if you are insured on that date.

To become insured your Spouse must be gainfully employed or capable of performing the material duties of an occupation. A Member may not be insured as both a Member and a Spouse.

When Spouse Insurance Becomes Effective

The **Coverage Features** states whether your Spouse insurance is Contributory or Noncontributory. You must apply in writing for Contributory Spouse insurance and agree to pay premiums. Subject to your Spouse being gainfully employed or capable of performing the material duties of an occupation, your Spouse insurance becomes effective as follows:

Spouse Insurance Not Subject to Evidence Of Insurability

Contributory Spouse Insurance becomes effective on the later of:

- The date your insurance becomes effective if you apply on or before that date to insure your Spouse.
- The date you apply to insure your Spouse.
- The October 1 next following the Annual Enrollment Period if you apply during the Annual Enrollment Period.
- If you have a Family Status Change the later of:
  - The date of the Family Status Change if you apply on or before the date of the Family Status Change.
  - The date you apply, if you apply within 31 day(s) of a Family Status Change.
  - The October 1 next following the Annual Enrollment Period if you apply during the Annual Enrollment Period.

Changes in Spouse Insurance

You may apply in writing for any increase in your Spouse insurance.

Subject to your Spouse being gainfully employed or capable of performing the material duties of an occupation, increases in your Spouse insurance become effective as follows:

Spouse Insurance Increases Not Subject to Evidence Of Insurability

Increases in your Spouse insurance not subject to Evidence Of Insurability become effective on the date of your insurance increases.

A decrease in your Spouse insurance because of a decrease in your insurance becomes effective on the date of your insurance decrease.

except for increases or plan changes during your Employer's Annual Enrollment Period.

When Spouse Insurance Ends

Your insurance for a Spouse ends automatically on the earliest of:

- The date your insurance ends unless Spouse insurance is continued under the **Continuation of Insurance (Portability) for the Member** provision.
- The date Spouse insurance terminates under the Group Policy unless Spouse insurance is continued under the **Continuation of Insurance (Portability) for the Member** provision.
- The date a Spouse ceases to meet the definition of Spouse.
- The date the last period ends for which the premium was paid for your Spouse insurance.
- The date the Group Policy terminates unless Spouse insurance is continued under the **Continuation of Insurance (Portability) for the Member** provision.

HOSPITAL INDEMNITY BENEFITS

Insuring Clause

If you or your Dependent incur a Loss while insured under the Group Policy, we will pay benefits according to the terms of the Group Policy after we receive Proof Of Loss satisfactory to us.

Hospitalization Benefits

Critical Care Unit Admission Benefit

We will pay a Critical Care Unit Admission Benefit if you or your Dependent meet the following requirements:

- Admitted by a Physician to a Critical Care Unit due to a Loss.
- For an Injury, Admission occurs within 90 days of the Injury.

We will pay a Critical Care Unit Admission Benefit for the day of admission. We will pay a Critical Care Unit Admission Benefit for up to 1 day(s) per insured person per Calendar Year.

If you or your Dependent are Admitted to a Critical Care Unit within 30 day(s) of a previous Admission for the same or related Loss, we will not pay another Critical Care Unit Admission Benefit.

Daily Critical Care Unit Confinement Benefit

We will pay a Daily Critical Care Unit Confinement Benefit for the days you or your Dependent meet the following requirements:

- Confined to a Critical Care Unit of a Hospital due to a Sickness.
- For an Injury, Confinement in a Critical Care Unit occurs within 90 days of the Injury.

We will pay a Daily Critical Care Unit Confinement Benefit for up to 15 day(s) per Confinement per insured person.

If you or your Dependent become Confined to a Critical Care Unit within 30 days for the same or related Loss, we will treat the period of Confinement as a continuation of the prior Confinement, although no benefits will be payable for any period of non-Confinement. If more than 30 days have passed between periods of Confinement for the same or related Loss, the subsequent Confinement will be treated as a separate period.

Only one Daily Critical Care Unit Confinement Benefit is payable at a time, even if Confinement is caused by more than one Loss.

Daily Hospital Confinement Benefit

We will pay a Daily Hospital Confinement Benefit for the days you or your Dependent meet the following requirements:

- Confined to a Hospital due to a Sickness.
- For an Injury, Confinement occurs within 90 days of the Injury.

We will pay a Daily Hospital Confinement Benefit for up to 15 day(s) per Confinement per insured person.

If you or your Dependent become Confined to a Hospital within 30 days for the same or related Loss, we will treat the period of Confinement as a continuation of the prior Confinement, although no benefits will be payable for any period of non-Confinement. If more than 30 days have passed between periods of Confinement for the same or related Loss, the subsequent Confinement will be treated as a separate period.

Only one Daily Hospital Confinement Benefit is payable at a time, even if Confinement is caused by more than one Loss.

Hospital Admission Benefit

We will pay a Hospital Admission Benefit if you or your Dependent meet the following requirements:

- Admitted by a Physician to a Hospital due to a Loss.
- For an Injury, Admission occurs within 90 days of the Injury.

We will pay a Hospital Admission Benefit for the day of Admission. We will pay a Hospital Admission Benefit for up to 1 day(s) per insured person per Calendar Year.

If you or your Dependent are Admitted to a Hospital within 30 days of a previous Admission for the same or related Loss, we will not pay another Hospital Admission Benefit.

EXCLUSIONS AND LIMITATIONS

Exclusions

Benefits are not payable if an Injury or Sickness is caused or contributed to by any of the following:

- War or act of War. War means declared or undeclared war, whether civil or international, insurrection, and any substantial armed conflict between organized forces of a military nature.
- Attempted suicide or other intentionally self-inflicted injury, while sane or insane.
- Committing or attempting to commit an assault, felony or act of terrorism, or actively participating in a violent disorder or riot. Actively participating does not include being at the scene of a violent disorder or riot while performing official duties.
- Alcoholism, drug abuse, misuse of alcohol or any other substance, the voluntary use or consumption of any drug or alcohol in excess of the legal limit in the state in which the Injury occurred, or taking of drugs unless used or consumed according to the directions of a Health Care Provider.
- Travel or flight in or on any aircraft, except:
    - As a fare-paying passenger on a regularly scheduled commercial flight.

- As a passenger or pilot in the Policyholder's or Employer's aircraft while flying on the Policyholder's or Employer's business provided:
    - The aircraft has a valid U.S. airworthiness certificate (or foreign equivalent).
    - The pilot has a valid pilot's certificate with a non-student rating authorizing him or her to fly the aircraft.
- Dental care or dental procedures, unless treatment is the result of an Injury.
- Routine newborn nursing or well-baby care.
- Hospital Confinement of a newborn Child following the Child's birth unless the Confinement is as a result of an Injury or Sickness.
- Riding in or driving any automobile in a race, stunt show, or speed test.
- Surgery or other procedure which is directed at improving your or your Dependent's appearance, unless such surgery or procedure is necessary to correct a deformity or to restore bodily function resulting from an Injury or Sickness.
- Any Injury of Sickness which arises out of or in the course of your or your Dependent's incarceration in a jail, penal or correctional institution.

ADDITIONAL FEATURES

Reinstatement

If your insurance ends, you may become insured again as a new Member. However, the following will apply:

- If your insurance ends because you cease to be a Member and if you become a Member again within 90 day(s) the Eligibility Waiting Period will be waived.

- If you ceased to be a Member under the Group Policy and continued insurance under the **Continuation of Insurance (Portability) for the Member** provision and you become a Member again within 90 day(s), your insurance will be for the coverage and amount which you continued under the **Continuation of Insurance (Portability) for the Member** provision the day before you become a new Member.

In no event will insurance be retroactive.

Waiver of Premium

Your insurance will continue without payment of premiums if you are Confined in a Hospital for 30 or more consecutive days.

We will waive payment of premium for your insurance from the 31st day of your Confinement until the last day of the month of your Confinement.

Continuation of Insurance (Portability) for the Member

Eligibility for the Member

You are eligible to continue your or your Dependent's insurance on the date one of the following events occurs:

- Your employment terminates with your Employer.
- The Group Policy terminates.
- Your insurance ends because you are no longer a Member.

You are not eligible to continue insurance under this provision if:

- You are disabled.
- You are age 80 or older.

Application, Amount of Insurance, and Premium Payment

You must apply in writing and pay the first premium to us within 31 day(s) after the date you become eligible. Your and your Dependent's continued insurance will be the same insurance provided under the Group Policy on the day before you become eligible under this **Continuation of Insurance (Portability) for the Member**. You may decrease the insurance, but cannot increase the insurance.

You will be directly billed for all premiums due if you have applied for and been approved for continuation of insurance under this provision. If premium is not paid on or before the Premium Due Date stated below it may be paid during the Grace Period as stated below. Your or your Dependent's insurance will remain in force during the Grace Period. You are liable for premium for insurance during the Grace Period.

The Premium Due Date is the first day of each calendar month.

The Grace Period is 60 days from the Premium Due Date.

When Insurance Ends

Insurance continued under this provision ends automatically on the earliest of:

- The date the last period ends for which you made the premium payment.
- The date you die.
- The date you become a full-time member of the armed forces of any country.
- With respect to your Child's insurance, the date the Child ceases to meet the definition of Child.
- The date you reach age 80.
- The date you are sentenced by a court for any reason to a penal or correctional institution.
- With respect to your Spouse's insurance, the date the Spouse ceases to meet the definition of Spouse.
- With respect to coverage for your Dependent, the date your Dependent is sentenced by a court for any reason to a penal or correctional institution.
- The date you become insured again as a Member under the Group Policy.

Once insurance continued under this provision ends it cannot be reinstated. Except as provided above, insurance continued under this provision is subject to all other terms of the Group Policy.

CLAIMS AND BENEFIT PAYMENT

Notice of Claim

Written notice of claim must be provided to us within 20 days after the date of an Accident or within 20 days after meeting the requirements for an Accident Insurance Benefit, or as soon thereafter as is reasonably possible.

Filing a Claim

Claims should be filed on our forms. If we do not provide our forms within 15 days after they are requested, the claim may be submitted in a letter to us. The letter should include the nature and extent of the benefit claimed as required in the **Proof of Loss** provision. Subject to the time period in the **Notice of Claim** provision, such letter will constitute notice.

Time Limits on Filing Proof Of Loss

Proof Of Loss must be provided within 90 days after the date of the Loss. If that is not possible, it must be provided as soon as reasonably possible, but not later than one year after that 90-day period.

If Proof Of Loss is filed outside these time limits, the claim will be denied. These limits will not apply while the claimant lacks legal capacity.

Proof Of Loss

Proof Of Loss means written proof that a Loss occurred:

- For which the Group Policy provides benefits.
- Which is not subject to any exclusions or limitations.
- Which meets all other conditions for benefits.

Proof Of Loss includes any other information we may reasonably require in support of a claim. Proof Of Loss must be in writing and must be provided at the expense of the claimant. No benefits will be paid until we receive Proof Of Loss satisfactory to us.

Investigation of Claim

We reserve the right to investigate a claim during its pendency our expense, including an examination conducted by specialists of our choice. In case of death, we have the right and opportunity to request an autopsy, except where prohibited by law.

Notice of Decision on Claim

We will evaluate a claim for benefits promptly after we receive it. Within 60 days after we receive the claim we will send the claimant: (a) a written decision on the claim; or (b) a notice that we are extending the period to decide the claim for an additional 60 days.

If we extend the period to decide the claim, we will notify the claimant of the following: (a) the reasons for the extension and (b) when we expect to decide the claim.

If we deny any part of the claim, we will send the claimant a written notice of denial containing:

- The reasons for our decision.
- Reference to the parts of the Group Policy on which our decision is based.
- A description of any additional information needed to support the claim.
- Information concerning the claimant's right to a review of our decision.
- Information concerning the right to bring a civil action for benefits under section 502(a) of ERISA if the claim is denied on review.

Review Procedure

If all or part of a claim is denied, the claimant may request a review. The claimant must request a review in writing within 60 days after receiving notice of the denial of the claim.

The claimant may send us written comments or other items to support the claim. The claimant may review and receive copies of any non-privileged information that is relevant to the request for review. There will be no charge for such copies. Our review will include any written comments or other items the claimant submits to support the claim.

We will review the claim promptly after we receive the request. With respect to all claims, within 45 days after we receive the request for review we will send the claimant: (a) a written decision on review; or (b) a notice that we are extending the review period for 45 days.

If an extension is due to the claimant's failure to provide information necessary to decide the claim on review, the extended time period for review of the claim will not begin until the claimant provides the information or otherwise responds.

If we extend the review period, we will notify the claimant of the following: (a) the reasons for the extension and (b) when we expect to decide the claim on review.

If we request additional information, the claimant will have 45 days to provide the information. If the claimant does not provide the requested information within 45 days, we may conclude our review of the claim based on the information we have received.

If we deny any part of the claim on review, the claimant will receive a written notice of denial containing:

- The reasons for our decision.
- Reference to the parts of the Group Policy on which our decision is based.
- Information concerning the claimant's right to receive, free of charge, copies of non-privileged documents and records relevant to the claim.
- Information concerning the right to bring a civil action for benefits under section 502(a) of ERISA.

The Group Policy does not provide voluntary alternative dispute resolution options. However, you may contact your local U.S. Department of Labor Office and your State insurance regulatory agency for assistance.

Time of Payment

We will pay benefits within 30 days after Proof Of Loss is satisfied.

Payment of Benefits

Benefits will be paid to you. Any benefits remaining unpaid at your death will be paid as shown below:

Benefits will be paid in equal shares to the first surviving class of the classes below.

- Your Spouse.
- Your children.
- Your parents.
- Your brothers and sisters.
- Your estate.

Reimbursement

We reserve the right to recover any benefits that you or your Dependent, a claimant or a beneficiary were paid but not entitled to under the terms of the Group Policy, state, or federal law.

You or your Dependent, a claimant or beneficiary must reimburse us in full. We will determine the method by which repayment is to be paid.

Unpaid Premium

Any unpaid premium due for your or your Dependent's Hospital Indemnity Insurance under the Group Policy may be recovered by us. Any Hospital Indemnity Benefits payable to you, a claimant, a beneficiary or legal representative will be applied to reduce the amount of any unpaid premiums prior to paying you or your Dependent, a claimant, a beneficiary or a legal representative.

GENERAL PROVISIONS

Assignment

The rights and benefits under the Group Policy may not be assigned.

Time Limits on Legal Actions

No action at law or in equity may be brought until 60 days after we have been given Proof Of Loss. No such action may be brought more than three years after the earlier of:

- The date we receive Proof Of Loss.
- The time within which Proof Of Loss is required to be given.

Incontestability of Insurance

Any statement made to obtain insurance or to increase insurance is a representation and not a warranty. No misrepresentation will be used to reduce or deny a claim or contest the validity of insurance unless:

- The insurance would not have been approved if we had known the truth.
- We have given you or any other person claiming benefits a copy of the signed written instrument which contains the misrepresentation.

After insurance has been in effect for two years during the lifetime of the insured, we will not use a misrepresentation to reduce or deny the claim.

Clerical Error

Clerical error by the Policyholder, your Employer, or their respective employees or representatives will not:

- Cause a person to become insured.
- Invalidate insurance under the Group Policy otherwise validly in force.
- Continue insurance under the Group Policy otherwise validly terminated.

Agency

The Policyholder and your Employer act on their own behalf as your agent, and not as our agent. Individuals selected by the Policyholder or by any Employer to secure coverage under the Group Policy or to perform their administrative function under it, represent and act on behalf of the person selecting them, and do not represent or act on behalf of us. The Policyholder and your Employer have no authority to alter, expand or extend our liability or to waive, modify or compromise any defense or right we may have under the Group Policy.

Misstatement of Age

If a person's age has been misstated, we will make an equitable adjustment of premiums, benefits, or both. The adjustment will be based on the following:

- The amount of insurance based on the correct age.
- The difference between the premiums paid and the premiums which would have been paid if the age had been correctly stated.

DEFINITIONS

Admitted or Admission

A stay at a Hospital or Critical Care Unit for at least 20 consecutive hours for examination by a Physician for diagnosis or treatment of a Loss.

Calendar Year

The period from January 1 through December 31 of the same year.

Child or Children

Child or Children means one of the following:

- Your child from live birth until age 26.
- Your adopted child until age 26.
- Your stepchild, foster child, dependent grandchild, and the child of your Spouse if living in your home until age 26.
- A child living in your home for whom you are the court appointed legal guardian until age 26.
- Your child, stepchild, foster child, dependent grandchild, and the child of your Spouse who is continuously incapable of self-sustaining employment because of intellectual disability or physical handicap; and chiefly dependent upon you for support and maintenance or institutionalized because of mental or physical handicap.

Child does not include a person who is eligible for insurance as a Member. A Child does not include a full-time member of the armed forces of any country.

Confinement or Confined

You or your Dependent are admitted to a Hospital as an Inpatient for diagnosis and treatment of a Loss for a period of no less than 20 consecutive hours the first day and overnight for subsequent days. Hours spent in an Emergency Room immediately prior to being Admitted to a Hospital will count toward the required 20 consecutive hours.

Critical Care Unit (CCU)

Critical Care Unit (CCU) means a specified area within a Hospital that is restricted to patients who are critically ill or injured and require intensive comprehensive observation and care. This area must:

- Be separate and apart from the surgical recovery room and from rooms, beds and wards customarily used for patient confinement.
- Be permanently equipped with special lifesaving equipment for the care of the critically ill or injured.
- Be under close observation by a specially trained nursing staff assigned exclusively to the unit on a 24-hour basis.
- Have a Physician assigned on a full-time basis.

Dependent(s)

Your Spouse or Child.

Eligibility Waiting Period

The period you must be a Member before you become eligible for insurance. Your Eligibility Waiting Period is shown in the **Coverage Features**.

Employer

An employer (including approved affiliates and subsidiaries) for which coverage under the Group Policy is approved in writing by us.

Evidence Of Insurability

You or your Dependent must:

- Complete and sign our medical history statement.
- If required by us, sign our form authorizing us to obtain information about the applicant's health.
- Undergo a physical examination, if required by us, which may include blood testing.
- Provide any additional information about the applicant's insurability that we may reasonably require.

Group Policy

The group hospital indemnity insurance policy issued by us to the Policyholder and identified by the Group Policy Number, the Policyholder's attached application, group hospital indemnity insurance certificates with the same Group Policy Number, and any amendments to the policy or certificates.

Health Care Provider

A Physician, Nurse Practitioner, or Physician Assistant.

Hospital

A legally operated facility providing full-time medical care and treatment under the direction of a full-time staff of licensed Physicians. Hospital does not include Health Service Facilities.

Injury or Injuries

Damage inflicted on your or your Dependent's body by an external force that occurs after you or your Dependent are insured under the Group Policy.

Inpatient

A person who has been Admitted to a Hospital or Critical Care Unit and is a registered bed patient and for which a charge is incurred for room and board or observation.

Loss

An Injury or Sickness that is not excluded by name or specific description. Injuries must occur after insurance becomes effective.

Mental Disorder

Any mental, emotional, behavioral, psychological, personality, cognitive, mood or stress-related abnormality, disorder, disturbance, dysfunction or syndrome, regardless of cause (including any biological or biochemical disorder or imbalance of the brain) or the presence of physical symptoms. Mental Disorder includes, but is not limited to, bipolar affective disorder, schizophrenia, psychotic illness, manic depressive illness, depression and depressive disorders, or anxiety and anxiety disorders. Mental Disorder does not include:

- Alcohol or drug dependency.
- Dementia as a result of stroke, trauma, viral infection, Alzheimer’s disease or other conditions which are not usually treated by a mental health provider or other qualified provider using psychotherapy, psychotropic drugs, or other similar methods of treatment.

Nurse Practitioner (advanced practice registered nurse)

An individual who is licensed by the state as a nurse practitioner to practice medicine under the supervision of a Physician and acting within the scope of the license. Nurse Practitioner does not include you or your Spouse or the brother, sister, parent or child of either you or your Spouse.

Physician

An individual who is licensed by the state as an M.D. or D.O. acting within the scope of the license. Physician does not include you or your Spouse, or the brother, sister, parent or child of either you or your Spouse.

Physician Assistant

An individual who is licensed by the state as a physician assistant to practice medicine under the supervision of a Physician and acting within the scope of the license. Physician Assistant does not include you or your Spouse, or the brother, sister, parent or child of either you or your Spouse.

Pregnancy

Your or your Spouse's pregnancy, childbirth, or related medical conditions, including complications of pregnancy. Pregnancy is treated as a Sickness under the Group Policy.

Prior Plan

A hospital indemnity insurance plan which is replaced by coverage under the Group Policy and which is the Policyholder's group hospital indemnity insurance plan in effect on the day before the effective date of the Group Policy.

Sickness

Your or your Dependent's sickness, illness, or disease. Sickness includes Pregnancy.

Spouse

Spouse means:

- A person to whom you are legally married.
- Your Domestic Partner. Domestic Partner means an individual with whom you have established a domestic partnership in accordance with the laws or regulations of a jurisdiction that recognizes domestic partnerships; or an individual you have identified as a domestic partner under your Employer's domestic partnership policy, if applicable.

Spouse does not include a full-time member of the armed forces of any country.

ERISA INFORMATION AND NOTICE OF RIGHTS

Grant of Discretion

Your Plan Sponsor has delegated to us the discretion to determine eligibility for benefits and to construe and interpret the terms and provisions of the Group Policy, subject to any and all remedies that may exist under State and Federal law.

Statement of Your Rights under ERISA

The following information and notice of rights and protections is furnished by the Plan Administrator as required by the Employee Retirement Income Security Act of 1974 (ERISA).

Right to Examine Plan Documents

You have the right to examine all Plan documents, including any insurance contracts or collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration. These documents may be examined free of charge at the Plan Administrator's office.

Right to Obtain Copies of Plan Documents

You have the right to obtain copies of all Plan documents, including any insurance contracts or collective bargaining agreements, a copy of the latest annual report (Form 5500 Series), and updated summary plan description upon written request to the Plan Administrator. The Plan Administrator may make a reasonable charge for these copies.

Right to Receive a Copy of Annual Report

The Plan Administrator must give you a copy of the Plan's summary annual financial report, if the Plan was required to file an annual report. There will be no charge for the report.

Right to Review of Denied Claims

If your claim for a Plan benefit is denied or ignored, in whole or in part, you have the right: a) to know why this was done; b) to obtain copies of documents relating to the decision, without charge; and c) to have your claim reviewed and reconsidered, all within certain time schedules.

Obligations of Fiduciaries

In addition to creating rights for plan participants, ERISA imposes duties upon the people who are responsible for the operation of the Plan. The people who operate the Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of all 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 Plan benefit or exercising your rights under ERISA.

Enforcing ERISA Rights

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request 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 Plan Administrator.

If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court. If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U. S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and fees. If

you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Plan and ERISA Questions

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

NOTICE OF PROTECTION PROVIDED BY
VIRGINIA LIFE, AND ACCIDENT AND SICKNESS
INSURANCE GUARANTY ASSOCIATION

This notice provides a **brief summary** of the Virginia Life, Accident and Sickness Insurance Guaranty Association ("the Association") and the protection it provides for policyholders. This safety net was created under Virginia law, which determines who and what is covered and the amounts of coverage.

The Association was established to provide protection in the unlikely event that a life, annuity or accident and sickness insurance company (including a health maintenance organization)L licensed in the Commonwealth of Virginia becomes financially unable to meet its obligations and is taken over by its Insurance Department. If this should happen, the Association will typically arrange to continue coverage and pay claims, in accordance with Virginia law, with funding from assessments paid by other life and health insurance companies licensed in the Commonwealth of Virginia.

The basic protections provided by the Association are:

- Life Insurance
  - $300,000 in death benefits
  - $100,000 in cash surrender or withdrawal values

- Health Insurance
  - $500,000 for health benefit plans
  - $300,000 in disability income insurance benefits
  - $300,000 in long-term care insurance benefits
  - $100,000 in other types of accident and sickness insurance benefits

- Annuities
  - $250,000 in withdrawal and cash values

The maximum amount of protection for each individual, regardless of the number of policies or contracts, is $350,000, except for health benefit plans, for which the limit is increased to $500,000.

Note: Certain policies and contracts may not be covered or fully covered. For example, coverage does not extend to any portion(s) of a policy or contract that the insurer does not guarantee, such as certain investment additions to the account value of a variable life insurance policy or a variable annuity contract. There are also various residency requirements and other limitations under Virginia law.

To learn more about the above protections, please visit the Association's website at www.valifega.org or contact:

VIRGINIA LIFE, ACCIDENT AND SICKNESS
INSURANCE GUARANTY ASSOCIATION
c/o APM Management Services, Inc.

1503 Santa Rosa Road, Suite 101
Henrico, VA 23229-5105
804-282-2240

STATE CORPORATION COMMISSION

Bureau of Insurance
P.O. Box 1157
Richmond, VA 23218-1157
804-371-9741
Toll Free Virginia only: 1-800-552-7945
http://scc.virginia.gov/boi/index/aspx

Insurance companies and agents are not allowed by Virginia law to use the existence of the Association or its coverage to encourage you to purchase any form of insurance. When selecting an insurance company, you should not rely on Association coverage. If there is any inconsistency between this notice and Virginia law, then Virginia law will control.

COMMONWEALTH OF VIRGINIA
REQUIRED POLICY INFORMATION

In the event you need to contact someone regarding your insurance for any reason, please contact your agent. If you have additional questions, you may contact the insurance company issuing this policy at the address and telephone number listed below.

If you have been unable to contact or obtain satisfaction from the company or the agent, you may contact the Virginia Bureau of Insurance at the address and telephone number listed below.

Written correspondence is preferable so that a record of your inquiry is maintained. When contacting your agent, company or the Bureau of Insurance, have your policy number available.

Name and address of the Insurance Company	Standard Insurance Company P.O. Box 711 Portland, OR 97207
Telephone Number	(971) 321-7000
Insurance Department Address	Virginia Bureau of Insurance Life and Health Division P.O. Box 1157 Richmond, VA 23218
Telephone Number	In state: 1-800-552-7945 Out-of-state: (804) 371-9741

STANDARD INSURANCE COMPANY

A Stock Life Insurance Company
900 SW Fifth Avenue
Portland, Oregon 97204-1282
(503) 321-7000

GROUP HOSPITAL INDEMNITY INSURANCE POLICY

Policyholder:	Pave America
Group Policy Number:	762060-F
Group Policy Effective Date:	10/01/2023
State of Issue:	Virginia

The consideration for this Group Policy is the application of the Policyholder and the payment by the Policyholder of premiums as provided herein.

Subject to **The Group Policy** and **Premium Payment** sections, this Group Policy (a) is issued for the Initial Rate Guarantee Period shown in **Eligibility, Premium Rates, and Participation Requirement** and (b) may be renewed for successive renewal periods by the payment of the premium set by us on each renewal date. The length of each renewal period will be set by us, but will not be less than 12 months.

For purposes of effective dates and ending dates under this Group Policy, all days begin and end at 12:00 midnight Standard Time at the Policyholder's address.

All provisions on this and the following pages are part of this Group Policy. "You" and "your" mean the Member. "We", "us", and "our" mean Standard Insurance Company. Other defined terms appear with their initial letters capitalized. Section and provision headings, and references to them, appear in boldface type.

The Group Policy is a legal contract between the Policyholder and us. Please read the Group Policy carefully.

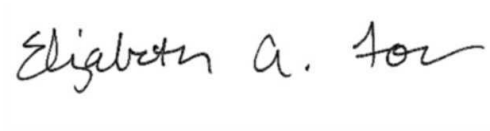
NOTICE TO BUYER: THIS IS A LIMITED BENEFIT POLICY THAT PROVIDES HOSPITAL INDEMNITY BENEFITS. THIS POLICY DOES NOT PROVIDE COMPREHENSIVE HEALTH INSURANCE COVERAGE. IT IS NOT INTENDED TO SATISFY THE INDIVIDUAL MANDATE OF THE AFFORDABLE CARE ACT (ACA) OR PROVIDE THE MINIMUM ESSENTIAL COVERAGE REQUIRED BY THE ACA (OFTEN REFERRED TO AS "MAJOR MEDICAL COVERAGE"). IT DOES NOT PROVIDE COVERAGE FOR HOSPITAL, MEDICAL, SURGICAL OR MAJOR MEDICAL EXPENSES.

THIS LIMITED BENEFIT POLICY IS NOT A MEDICARE SUPPLEMENT POLICY. FOR MEMBERS ELIGIBLE FOR MEDICARE, REVIEW "THE GUIDE TO HEALTH INSURANCE FOR PEOPLE WITH MEDICARE" AVAILABLE FROM US.

STANDARD INSURANCE COMPANY

By

President and CEO



Corporate Secretary

Table of Contents

ELIGIBILITY, PREMIUM RATES, AND PARTICIPATION REQUIREMENT

Eligibility

Employer(s):	Pave America
Eligible Class(es):	All Members

Premium Rates and Renewals

Member only:	$149.16
Member and Spouse only:	$252.96
Member and Child only:	$207.84
Member and Dependents:	$372.60

Premium Due Date:	10/01/2023 and the first day of each calendar month thereafter.
Initial Rate Guarantee Period:	10/01/2023 to 10/01/2026
Grace Period:	60 days from Premium Due Date
Notice of Rate Change:	120 days
Notice of Termination:	31 days

Participation Requirement

Minimum Participation Number:	10 insured Members

THE GROUP POLICY

The Group Policy; Entire Contract

The Group Policy is the entire contract between the Policyholder and us. We will provide benefits according to the terms of the Group Policy.

The Group Policy consists of the following:

- This group hospital indemnity insurance policy issued by us to the Policyholder and identified by the Group Policy Number.
- The Policyholder's attached application.
- Group hospital indemnity insurance certificates with the same Group Policy Number.
- Any amendments to the Group Policy or certificates.

The Policyholder's rights or the rights of any Member will only be affected by provisions that are part of the Group Policy. Only an executive officer of Standard Insurance Company may bind us by making a promise or a representation; or accept a representation that relates to the Group Policy.

Changes to the Group Policy

Benefits under the Group Policy are limited to its terms, including any valid amendment. No change or amendment will be valid unless it is approved in writing by one of our executive officers and given to the Policyholder for attachment to the Group Policy. No agent has authority to change the Group Policy, or to waive any of its provisions. The Policyholder, an Employer, and their respective employees or representatives have no right or authority to change or amend the Group Policy or to waive any of its terms or provisions without our signed written approval.

We may change the Group Policy in whole or in part when any change or clarification in law or governmental regulation affects our obligations under the Group Policy, or with the Policyholder's consent.

Any such change or amendment of the Group Policy may apply to current or future Members or to any separate classes or groups of Members.

Incontestability of Group Policy

Any statement made by the Policyholder to obtain the Group Policy is a representation and not a warranty.

No misrepresentation by the Policyholder will be used to deny a claim or to deny the validity of the Group Policy unless all of the following are true:

- The Group Policy would not have been issued if we had known the truth.
- We have given the Policyholder a copy of a written instrument signed by the Policyholder which contains the misrepresentation.

The validity of the Group Policy will not be contested after it has been in force for two years, except for nonpayment of premiums.

Termination of the Group Policy

The Group Policy may be terminated by us or the Policyholder according to its terms. It will terminate automatically for nonpayment of premium.

The Policyholder may terminate the Group Policy in whole, and may terminate insurance for any class or group of Members, at any time by giving us written notice. The effective date of termination will be the date stated in the notice. If no date is stated in the notice, then the effective date of termination will be the last day of the calendar month for which premium was paid in full.

We may terminate the Group Policy as follows:

- On any Premium Due Date if the number of persons insured is less than the Minimum Participation Number shown in **Eligibility, Premium Rates**, **and Participation Requirement**.
- On any Premium Due Date if we determine that the Policyholder has failed to promptly furnish any necessary information requested by us, or has failed to perform any other obligations relating to the Group Policy.

The minimum advance Notice of Termination by us is stated in **Eligibility, Premium Rates, and Participation Requirement.**

With respect to a Member who has continued insurance under the **Continuation of Insurance (Portability) for the Member** provision, continued coverage will not terminate unless it would otherwise terminate under the terms of the **Continuation of Insurance (Portability) for the Member** provision.

PREMIUM PAYMENT

Premiums

Each premium is payable on or before its Premium Due Date to us. The premium due on each Premium Due Date is the sum of the premiums for all Members and Dependents then insured. Premium Rates are shown in **Eligibility, Premium Rates**, **and Participation Requirement**.

The payment of each premium as it becomes due will maintain the Group Policy in force until the next Premium Due Date.

Contributions from Members

The Policyholder determines the amount, if any, of each Member's contribution toward the cost of insurance under the Group Policy.

Changes in Premium Rates

We may change Premium Rates whenever:

- A change or clarification in law or governmental regulation affects the amount payable under the Group Policy. Any such change in Premium Rates will reflect only the change in our obligations.
- Factors material to underwriting the risk we assumed under the Group Policy with respect to an Employer, including, but not limited to, number of persons insured, age, gender, and occupational classification, changes by 25% or more.
- The premium contribution arrangement for Members is changed or varies from that stated in the Group Policy when issued or last renewed.
- We and the Policyholder or the Employer mutually agree to change Premium Rates.

Except as provided above, Premium Rates will not be changed during the Initial Rate Guarantee Period shown in **Eligibility, Premium Rates, and Participation Requirement**. Thereafter, except as provided above, we may change Premium Rates upon 120 days advance written notice to the Policyholder. Any such change in Premium Rates may be made effective on any Premium Due Date, but no such change will be made more than once in any contract year. Contract years are successive 12 month periods computed from the end of the Initial Rate Guarantee Period.

Premium Adjustments

Premium adjustments involving a return of unearned premiums to the Policyholder will be limited to the 12 months just before the date we receive a request for premium adjustment.

Grace Period and Termination For Nonpayment

If a premium is not paid on or before its Premium Due Date, other than the initial premium payment, it may be paid during the Grace Period shown in **Eligibility, Premium Rates**, **and Participation Requirement**. The Group Policy or an Employer's coverage under the Group Policy will remain in force during the Grace Period.

If the premium is not paid during the Grace Period, the Group Policy will terminate automatically at the end of the Grace Period.

The Policyholder is liable for premium for insurance during the Grace Period. We may charge interest at the legal rate for any premium which is not paid during the Grace Period, beginning with the first day after the Grace Period.

GENERAL PROVISIONS

Certificates

We will issue a certificate to the Policyholder showing the coverage under the Group Policy. The Policyholder will distribute a certificate to each insured Member.

Records and Reports

The Policyholder will furnish on our forms all information reasonably necessary to administer the Group Policy. We have the right at all reasonable times to inspect the payroll and other records of the Policyholder which relate to insurance under the Group Policy.

Upon request by the Policyholder, we will promptly provide the Policyholder a complete record of the Policyholder's claims experience under the Group Policy, including claims incurred and amounts paid, for:

- The period of time from the Group Policy Effective Date; or
- The period of time from the last Group Policy renewal date;

whichever is less, provided:

- The Policyholder requests such record at least 30 days before:
    - The next Group Policy renewal date; or
    - The date of any proposed amendment to the Group Policy.

Agency and Release

Individuals selected by the Policyholder or by any Employer to secure coverage under the Group Policy or to perform their administrative function under it, represent and act on behalf of the person selecting them, and do not represent or act on behalf of Standard Insurance Company. The Policyholder, Employer and such individuals have no authority to alter, expand or extend our liability or to waive, modify or compromise any defense or right we may have under the Group Policy. The Policyholder and each Employer hereby release, hold harmless and indemnify Standard Insurance Company from any liability arising from or related to any negligence, error, omission, misrepresentation or dishonesty of any of them or their representatives, agents or employees.

Notice of Suit

The Policyholder or Employer shall promptly give us written notice of any lawsuit or other legal proceedings arising under the Group Policy.

NOTICE OF PROTECTION PROVIDED BY
VIRGINIA LIFE, AND ACCIDENT AND SICKNESS
INSURANCE GUARANTY ASSOCIATION

This notice provides a **brief summary** of the Virginia Life, Accident and Sickness Insurance Guaranty Association ("the Association") and the protection it provides for policyholders. This safety net was created under Virginia law, which determines who and what is covered and the amounts of coverage.

The Association was established to provide protection in the unlikely event that a life, annuity or accident and sickness insurance company (including a health maintenance organization)L licensed in the Commonwealth of Virginia becomes financially unable to meet its obligations and is taken over by its Insurance Department. If this should happen, the Association will typically arrange to continue coverage and pay claims, in accordance with Virginia law, with funding from assessments paid by other life and health insurance companies licensed in the Commonwealth of Virginia.

The basic protections provided by the Association are:

- Life Insurance
  - $300,000 in death benefits
  - $100,000 in cash surrender or withdrawal values

- Health Insurance
  - $500,000 for health benefit plans
  - $300,000 in disability income insurance benefits
  - $300,000 in long-term care insurance benefits
  - $100,000 in other types of accident and sickness insurance benefits

- Annuities
  - $250,000 in withdrawal and cash values

The maximum amount of protection for each individual, regardless of the number of policies or contracts, is $350,000, except for health benefit plans, for which the limit is increased to $500,000.

Note: Certain policies and contracts may not be covered or fully covered. For example, coverage does not extend to any portion(s) of a policy or contract that the insurer does not guarantee, such as certain investment additions to the account value of a variable life insurance policy or a variable annuity contract. There are also various residency requirements and other limitations under Virginia law.

To learn more about the above protections, please visit the Association's website at www.valifega.org or contact:

VIRGINIA LIFE, ACCIDENT AND SICKNESS
INSURANCE GUARANTY ASSOCIATION
c/o APM Management Services, Inc.

1503 Santa Rosa Road, Suite 101
Henrico, VA 23229-5105
804-282-2240

STATE CORPORATION COMMISSION

Bureau of Insurance
P.O. Box 1157
Richmond, VA 23218-1157
804-371-9741
Toll Free Virginia only: 1-800-552-7945
http://scc.virginia.gov/boi/index/aspx

Insurance companies and agents are not allowed by Virginia law to use the existence of the Association or its coverage to encourage you to purchase any form of insurance. When selecting an insurance company, you should not rely on Association coverage. If there is any inconsistency between this notice and Virginia law, then Virginia law will control.

COMMONWEALTH OF VIRGINIA
REQUIRED POLICY INFORMATION

In the event you need to contact someone regarding your insurance for any reason, please contact your agent. If you have additional questions, you may contact the insurance company issuing this policy at the address and telephone number listed below.

If you have been unable to contact or obtain satisfaction from the company or the agent, you may contact the Virginia Bureau of Insurance at the address and telephone number listed below.

Written correspondence is preferable so that a record of your inquiry is maintained. When contacting your agent, company or the Bureau of Insurance, have your policy number available.

Name and address of the Insurance Company	Standard Insurance Company P.O. Box 711 Portland, OR 97207
Telephone Number	(971) 321-7000
Insurance Department Address	Virginia Bureau of Insurance Life and Health Division P.O. Box 1157 Richmond, VA 23218
Telephone Number	In state: 1-800-552-7945 Out-of-state: (804) 371-9741