The Regents of the University of California

Critical Illness Coverage

Prudential

NOTICE FOR TEXAS RESIDENTS

Have a complaint or need help?

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

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

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

Call: Prudential Life Claim Division
Toll-free: 1-8 55-483 -1438
Mail: P.O. Box 8517, Philadelphia, PA 19176

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

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

¿Tiene una queja o necesita ayuda?

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

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

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

Llame a: Prudential Life Claim Division
Teléfono gratuito: 1-855 - 483- 1438
Dirección postal: P.O. Box 8517, Philadelphia, PA 19176

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

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

Disclosure Notice

IMPORTANT INFORMATION FOR RESIDENTS OF CERTAIN STATES: *There are state-specific requirements that may change the provisions under the Coverage described in this Group Insurance Certificate. If you live in a state that has such requirements, those requirements will apply to your Coverage and are made a part of your Group Insurance Certificate. This means the requirements of the state where you reside at the time of loss could change the benefits to which you may be entitled under the Group Insurance Certificate. Prudential has a website that describes these state-specific requirements. You may access the website at www.prudential.com/etonline. When you access the website, you will be asked to enter your state of residence and your Access Code.* ***Your Access Code is CR1.***

If you are unable to access this website, want to receive a printed copy of these requirements or have any questions, call Prudential at 1-866-439-9026.

FOR ARKANSAS RESIDENTS

Prudential's Customer Service Office:

The Prudential Insurance Company of America
Customer Services Department
Prudential Insurance Company
Voluntary Benefit Services
P.O. Box 696035
San Antonio, TX 78269-6035

Telephone: 1-855-483-1438

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

Arkansas Insurance Department
Consumer Services Division
1200 West Third Street
Little Rock, Arkansas 72201-1904
1-800-852-5494

FOR ARIZONA RESIDENTS

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

FOR CALIFORNIA RESIDENTS

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

FOR COLORADO RESIDENTS

THIS IS A SUPPLEMENTAL PLAN THAT IS NOT INTENDED TO PROVIDE THE MINIMUM ESSENTIAL COVERAGE REQUIRED BY THE AFFORDABLE CARE ACT (ACA). UNLESS YOU HAVE ANOTHER PLAN (SUCH AS MAJOR MEDICAL COVERAGE) THAT PROVIDES MINIMUM ESSENTIAL COVERAGE IN ACCORDANCE WITH THE ACA, YOU MAY BE SUBJECT TO A FEDERAL TAX PENALTY. ALSO, THE BENEFITS PROVIDED BY THIS PLAN CANNOT BE COORDINATED WITH THE BENEFITS PROVIDED BY OTHER COVERAGE. PLEASE REVIEW THE BENEFITS PROVIDED BY THIS PLAN CAREFULLY TO AVOID DUPLICATION OF COVERAGE.

FOR FLORIDA RESIDENTS

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

FOR IDAHO RESIDENTS

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

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

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

FOR INDIANA RESIDENTS

Questions regarding your policy or coverage should be directed to:

The Prudential Insurance Company of America
1-855-438-1438

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

State of Indiana Department of Insurance
Consumer Services Division

311 West Washington Street, Suite 300
Indianapolis, Indiana 46204

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

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

FOR MARYLAND RESIDENTS

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

FOR NORTH CAROLINA RESIDENTS

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

FOR NEW MEXICO RESIDENTS

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

FOR NEVADA RESIDENTS

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

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

FOR OKLAHOMA RESIDENTS

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

FOR TEXAS RESIDENTS

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

NOTICE FOR VERMONT RESIDENTS

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

FOR WISCONSIN RESIDENTS

KEEP THIS NOTICE WITH YOUR INSURANCE PAPERS

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

Prudential's Customer Service Office:
Prudential Insurance Company
Voluntary Benefit Services
P.O. Box 696035
San Antonio, TX 78269-6035
1-855-483-1438

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

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

THE PRUDENTIAL INSURANCE COMPANY OF AMERICA

Certificate of Coverage

Prudential certifies that insurance is provided according to the Group Contract(s) for each Insured Employee. Your Booklet's Schedule of Benefits shows the Contract Holder and the Group Contract Number.

Insured Employee: You are eligible to become insured under the Group Contract if you are in the Covered Classes of the Booklet's Schedule of Benefits and meet the requirements in the Booklet's Who is Eligible section. The When You Become Insured section of the Booklet states how and when you may become insured for the Coverage. Your insurance will end when the rules in the When Your Insurance Ends section so provide. Your Booklet and this Certificate of Coverage together form your Group Insurance Certificate.

Coverage and Amounts: The available Coverage and the amounts of insurance are described in the Booklet.

If you are insured, your Booklet and this Certificate of Coverage form your Group Insurance Certificate. Together they replace any older booklets and certificates issued to you for the Coverage in the Booklet's Schedule of Benefits. All Benefits are subject in every way to the entire Group Contract which includes the Group Insurance Certificate.

Changes: The Certificate is guaranteed renewable. We will not change any provision of the Certificate except that we may change premium rates by class for all those insured under this form in your state. In lieu of changing premium rates, We may change Definitions for all those insured under this form in Your state. Any rate change or Definitions change would first be approved by appropriate governing authority in the state.

Right to Examine this Group Insurance Certificate: You may return this Group Insurance Certificate to Prudential, for any reason, within 31 days after you receive it. If you return it within this period, the insurance will be void from the date it would otherwise take effect, and Prudential will refund your contributions, if any within 31 days after we receive the returned certificate.

Prudential's Address:

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

THIS CERTIFICATE IS NOT A MEDICARE SUPPLEMENT CERTIFICATE. If you are eligible for Medicare, review the Guide to Health Insurance for People with Medicare available from the company.

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

This Certificate is not in place of and does not affect any requirement for coverage by Workers' Compensation Insurance.

The Group Contract provides specified disease coverage ONLY.

CRITICAL ILLNESS COVERAGE

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Schedule of Benefits

Covered Classes: The “Covered Classes" are these Employees of the Contract Holder (and its Associated Companies): All active Full-time Employees.

Program Date: January 1, 2025. This Booklet describes the benefits under the Group Program as of the Program Date.

- This Booklet and the Certificate of Coverage together form your Group Insurance Certificate. The Coverage in this Booklet is insured under a Group Contract issued by Prudential. All benefits are subject in every way to the entire Group Contract which includes the Group Insurance Certificate. It alone forms the agreement under which payment of insurance is made.

CRITICAL ILLNESS COVERAGE FOR YOU AND YOUR DEPENDENTS

The items below are only highlights of your coverage. For a full description please read this entire Group Insurance Certificate.

BENEFIT AMOUNTS FOR YOU:

The amount of insurance is the amount for your Benefit Class. You may enroll for the plan shown below. If you may choose the amount of insurance or if there are options from which to select, the amount for which you enroll will be recorded by your Employer and reported to Prudential.

Amount of Insurance For Each Benefit Class:

Benefit Classes	Amount of Insurance
All Employees	
Option 1	$10,000.
Option 2	$30,000.

BENEFIT AMOUNTS FOR YOUR DEPENDENTS:

The amount of insurance is the amount for your Benefit Class. You may enroll your Qualified Dependents for the plan shown below. If you may choose the amount of insurance or if there are options from which to select, the amount for which you enroll will be recorded by your Employer and reported to Prudential. Your Benefit Class is determined by the classification of your Qualified Dependents and the amount for which you enroll as shown in this table.

Qualified Dependents Classification	Amount of Insurance*
Your Spouse or Domestic Partner	
Option 1	$10,000.
Option 2	$30,000.
Your Children	
Option 1	$5,000.
Option 2	$15,000.

- The amount of insurance on your Qualified Dependent Spouse or Domestic Partner will not exceed 100% of the amount for which you are insured under the Critical Illness Coverage. The amount of insurance on each of your Qualified Dependent Children will not exceed 50% of the amount for which you are insured under the Critical Illness Coverage.

ADDITIONAL BENEFIT AMOUNTS FOR YOU AND YOUR DEPENDENTS UNDER THE CRITICAL ILLNESS COVERAGE

For the purposes of determining benefits under the Coverage, Amount of Insurance does not include any additional amount payable as shown below.

Wellness Benefit Amount Payable: $100.

Wellness Benefit Daily Limit: The Wellness Benefit is limited to payment of one benefit per Covered Person, per day.

Wellness Benefit Annual Limit: The Wellness Benefit is limited to one benefit payment per Calendar Year for each Covered Person.

National Cancer Institute (NCI) Evaluation Benefit Amount Payable: An amount equal to:

(1) $500; plus

(2) $250 for the transportation and lodging of the Covered Person requiring the evaluation if the NCI facility is more than 100 miles from the Covered Person's primary residence.

NCI Evaluation Benefit Lifetime Limit: The NCI Evaluation Benefit is payable once during the lifetime of each Covered Person.

Transportation Benefit Amount Payable: An amount equal to the lesser of:

(1) the actual charges incurred for travel by train, plane or bus, plus $0.50 per mile for travel by personal car; and

(2) $1,000.

Transportation Benefit Annual Limit: The Transportation Benefit is limited to one benefit payment per Calendar Year for each Covered Person receiving treatment during that visit.

Lodging Benefit Amount Payable: $100 per day.

Lodging Benefit Annual Limit: The Lodging Benefit is limited to 60 days per Calendar Year for each Covered Person receiving treatment during that visit.

OTHER INFORMATION

Contract Holder: THE REGENTS OF THE UNIVERSITY OF CALIFORNIA

Group Contract No.: GC-97000-CA

Associated Companies: Associated Companies are employers who are the Contract Holder's subsidiaries or affiliates and are reported to Prudential in writing for inclusion under the Group Contract, provided that Prudential has approved such request. This Certificate applies to the Contract Holder and its Associated Companies, if any.

Cost of Insurance: The insurance in this Booklet is Contributory Insurance. You will be informed of the amount of your contribution when you enroll.

Employment Waiting Period: You may need to work for the Employer for a continuous full-time period before you become eligible for the Coverage. The period must be agreed upon by the Employer and Prudential. Your Employer will inform you of any such Employment Waiting Period for your class.

Prudential's Address:

The Prudential Insurance Company of America
213 Washington Street
Newark, New Jersey 07102

Complaints and Notices: Complaints and notices should be sent to:

The Prudential Insurance Company of America
Prudential Insurance Company
Voluntary Benefit Services
P.O. Box 696035
San Antonio, TX 78269-6035

Telephone: 1-855-483-1438

Should you have a dispute concerning your coverage you should contact Prudential first. If the dispute is not resolved, you may contact the California Department of Insurance at the following address and phone number:

California Department of Insurance
Consumer Services Division
300 South Spring Street
Los Angeles, California 90013
1-800-927-HELP

Certificate Endorsement to Group Contract

Group Contract No.: GC-97000-CA

Effective Date: January 1, 2025

This certificate endorsement is attached to and made part of the Group Contract.

Your Group Insurance Certificate is changed as follows:

- The **ADDITIONAL BENEFIT AMOUNTS FOR YOU AND YOUR DEPENDENTS UNDER THE CRITICAL ILLNESS COVERAGE** section of the **Schedule of Benefits** your Group Insurance Certificate is enlarged to include the following:

  Infectious Disease Requiring Hospitalization Limit: The Infectious Disease benefit is payable for a Covered Person who is confined to a Hospital for 5 consecutive days.

  Infectious Disease Requiring Hospitalization Benefit Amount Payable: The additional amount payable is 25% on the First Occurrence. Amount payable for a Recurrence for an Infectious Diseases is 10%.

- The **Additional Benefits under Critical Illness Coverage** pages of your Group Insurance Certificate is enlarged to include the following:

  BENEFIT FOR INFECTIOUS DISEASE REQUIRING HOSPITALIZATION.

  This additional benefit for Infectious Disease Requiring Hospitalization pays for a Covered Person diagnosed by a Doctor for the following diseases:

  (1) anthrax

  (2) bacterial cerebrospinal meningitis

  (3) COVID-19

  (4) Lyme disease

  (5) methicillin-resistant staphylococcus aureus (MRSA)

  (6) osteomyelitis; or

  (7) pertussis (whooping cough)

  The Infectious Disease Requiring Hospitalization benefit is payable for a Covered Person who is confined to a Hospital for 5 consecutive days.

  Infectious Disease Requiring Hospitalization Amount Payable: The additional amount payable is 25% on the First Occurrence. Amount payable for a Recurrence for an Infectious Disease is 10%. Benefit is payable when a Covered Person is hospitalized 5 consecutive days due to the diagnosis of an Infectious Disease.

All other provisions in your Group Insurance Certificate remain unchanged.

———————————

THE PRUDENTIAL INSURANCE COMPANY OF AMERICA

Margaret M. Foran

Secretary

General Definitions

FOR YOU AND YOUR DEPENDENTS

Some of the terms used in the Coverage:

Active Work Requirement: A requirement that you be actively at work on a full-time basis at the Employer's place of business, or at any other place that the Employer's business requires you to go. You are considered actively at work during weekends or Employer-approved vacations, holidays or business closures if you were actively at work on the last scheduled work day preceding such time off.

Calendar Year: A year starting January 1.

Contract Holder: The Employer to whom the Group Contract is issued.

Contributory Insurance, Non-contributory Insurance: Contributory Insurance is insurance for which you must contribute toward the cost of the premium. Non-contributory Insurance is insurance for which the Employer pays the entire premium. The Schedule of Benefits shows whether insurance under the Coverage is Contributory Insurance or Non-contributory Insurance.

Coverage: A part of the Booklet consisting of:

(1) A benefit page labeled as a Coverage in its title.

(2) Any page or pages that continue the same kind of benefits.

(3) A Schedule of Benefits entry and other benefit pages or forms that by their terms apply to that kind of benefits.

Covered Person: An Employee who is insured under the Coverage; a Qualified Dependent for whom an Employee is insured, if any, under the Coverage.

Dependents Insurance: Insurance on the person of a dependent.

Doctor: A licensed practitioner of the healing arts acting within the scope of the license. Prudential will not recognize any relative including, but not limited to, you, your Spouse, your Domestic Partner, or a Child, brother, sister, or parent of you or your Spouse or Domestic Partner as a doctor for a claim that you send to us.

Employee: A person employed by the Employer.

Employee Insurance: Insurance on the person of an Employee.

The Employer: Collectively, all employers included under the Group Contract.

First Occurrence: The first time the person is diagnosed with the Critical Illness while a Covered Person.

Life Event: Any of the following which constitute a change in family status:

(1) your marriage or divorce;

(2) becoming or ceasing to be a Domestic Partner;

(3) the death of your Spouse, Domestic Partner, or Child;

(4) the birth or adoption of your Child;

(5) employment or termination of employment of your Spouse or Domestic Partner;

(6) switching from part-time to full-time employee status (or vice versa) by you or your Spouse or Domestic Partner;

(7) you or your Spouse or Domestic Partner taking an unpaid leave of absence;

(8) a significant change in your health coverage that is attributable to your Spouse's or Domestic Partner's employment.

Prudential: The Prudential Insurance Company of America.

You: An Employee.

Who is Eligible to Become Insured

FOR EMPLOYEE INSURANCE

You are eligible for Employee Insurance while:

- you are a full-time Employee of the Employer; and
- you are in a Covered Class; and
- you have completed the Employment Waiting Period, if any. You may need to work for the Employer for a continuous full-time period before you become eligible for the Coverage. The period must be agreed upon by the Employer and Prudential. Your Employer will inform you of any such Employment Waiting Period for your class.

You are full-time if you are regularly working for the Employer at least the number of hours in the Employer's normal full-time work week for your class.

Your class is determined by the Contract Holder. This will be done under its rules, on dates it sets. The Contract Holder must not discriminate among persons in like situations. You cannot belong to more than one class for insurance on each basis, Contributory or Non-contributory Insurance, under the Coverage. "Class" means Covered Class, Benefit Class or anything related to work, such as position or Earnings, which affects the insurance available.

This applies if you are an Employee of more than one employer included under the Group Contract: For the insurance, you will be considered an Employee of only one of those employers. Your service with the others will be treated as service with that one.

The rules for obtaining Employee Insurance are in the When You Become Insured section.

FOR DEPENDENTS INSURANCE

You are eligible for Dependents Insurance while:

- you are eligible for Employee Insurance; and
- you have a Qualified Dependent.

Qualified Dependents:

These are the persons for whom you may obtain Dependents Insurance:

- A person who is your Spouse or Domestic Partner prior to their enrollment for Dependents Insurance.

  Your Spouse means your lawful Spouse.

  Your Domestic Partner is a person of the same or opposite sex who:

  (1) Satisfies the requirements for being a domestic partner, registered domestic partner or party to a civil union under the law of your jurisdiction of residence; or

(2) Is a person of the same or opposite sex who satisfies all of the following:

(a) is age 18 or older; and

(b) is not related to you by blood or a degree of closeness that would prohibit marriage in the law of the jurisdiction in which you reside; and

(c) is mentally competent to consent to contract; and

(d) is not married to another person under statutory or common law nor in a domestic partnership, registered domestic partnership or civil union with another person; and

(e) is not otherwise a Qualified Dependent under the Program; and

(f) is in a single dedicated, serious and committed relationship with you; and

(g) has shared a single permanent residence with you for at least 12 consecutive months; and

(h) is financially interdependent with you.

Where requested by Prudential, you and/or your Domestic Partner certify that all of the above requirements are satisfied.

Either a Spouse or a Domestic Partner may be a Qualified Dependent under the Program at any one time, but not both at the same time.

- Your Children from live birth to 26 years old.

  Your Children include your:

  (1) Biologic children;

  (2) Legally adopted children, children placed with you for adoption prior to legal adoption, and each of your stepchildren. A Child placed with you for adoption prior to legal adoption is considered your Qualified Dependent from the date of placement for adoption, and is treated as though the Child was your newborn child;

  (3) Foster children;

  (4) Domestic Partner's children; and

  (5) Child(ren) for whom you, your Spouse or your Domestic Partner:

  (a) have been appointed the legal guardian; and

  (b) claim as a dependent on your, your Spouse's or your Domestic Partner's federal income tax returns.

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

- Your Incapacitated Children.

Your Incapacitated Children means each Child (as defined above) who satisfies all of the following:

(1) Your Child is incapable of self-sustaining employment because of a mental or physical Injury or Illness.

(2) Your Child is so incapacitated before the Child reaches the age limit for a Qualified Dependent Child.

You must provide Prudential with proof that your Child satisfies the above conditions within 31 days of:

(1) the covered Child's attainment of the age limit for a Qualified Dependent Child; or

(2) the date you first become eligible for Coverage with respect to that Child over the age limit for a Qualified Dependent Child.

Periodically, Prudential may request that you provide proof that your Child continues to satisfy the above conditions.

Failure to provide the proof required or requested above will cause your Coverage with respect to that Child to end.

Exceptions:

Your Spouse, Domestic Partner or Child is not your Qualified Dependent while:

(1) on active duty in the armed forces of any country; or

(2) insured under the Group Contract as an Employee; or

(3) the Spouse, Domestic Partner or Child has protection under any Employee Coverage of the Group Contract after the Spouse's, Domestic Partner's or Child's insurance under that Coverage ends.

A Child will not be considered the Qualified Dependent of more than one Employee. If this would otherwise be the case, the Child will be considered the Qualified Dependent of the Employee named in a written agreement of all such Employees filed with the Contract Holder. If there is no written agreement, the Child will be considered the Qualified Dependent of:

(1) the Employee who became insured under the Group Contract with respect to the Child, while the Child was a Qualified Dependent of only that Employee; and otherwise

(2) the Employee who has the longest continuous service with the Employer, based on the Contract Holder's records.

The rules for obtaining Dependents Insurance are in the When You Become Insured section.

When You Become Insured

FOR EMPLOYEE INSURANCE

Your Employee Insurance under the Coverage will begin the first day on which:

- you have enrolled, if the Coverage is Contributory; and
- you are eligible for Employee Insurance; and
- you are in a Covered Class for that insurance; and
- your insurance is not being delayed under the Delay of Effective Date section below; and
- that Coverage is part of the Group Contract.

You must enroll on a form approved by Prudential and agree to pay the required contributions. You may enroll within 31 days of when you could first be covered, or within 31 days of a Life Event. Your Employer will tell you whether contributions are required and the amount of any contribution when you enroll.

At any time, the benefits for which you are insured are those for your class, unless otherwise stated.

The General Definitions section explains what “Life Event” means.

FOR DEPENDENTS INSURANCE

Your Dependents Insurance under the Coverage for a person will begin the first day on which all of these conditions are met:

- You have enrolled for Dependents Insurance under the Coverage, if the Coverage is Contributory.
- The person is your Qualified Dependent.
- You are in a Covered Class for that insurance.
- You are insured for Employee Insurance under the Coverage.
- Your insurance for that Qualified Dependent is not being delayed under the Delay of Effective Date section below.
- Dependents Insurance under that Coverage is part of the Group Contract.

You must enroll on a form approved by Prudential and agree to pay the required contributions. You may enroll within 31 days of when you could first be covered, or within 31 days of a Life Event. Your Employer will tell you whether contributions are required and the amount of any contribution when you enroll.

At any time, the Dependents Insurance benefits for which you are insured are those for your class, unless otherwise stated.

The General Definitions section explains what “Life Events” means.

Change in Family Status: It is important that you inform the Employer promptly when you first acquire a Qualified Dependent. You should also inform the Employer if your Dependents Insurance status changes from one to another of these categories:

- No Qualified Dependents.
- Qualified Dependent Spouse or Domestic Partner only.
- Qualified Dependent Spouse or Domestic Partner and Children.
- Qualified Dependent Children only.

If you are insured under the Coverage for one or more Children, you need not report additional Children.

Forms are available for reporting these changes.

Delay of Effective Date

FOR EMPLOYEE INSURANCE

Your Employee Insurance under the Coverage will be delayed if you do not meet the Active Work Requirement on the day your insurance would otherwise begin. Instead, it will begin on the first day you meet the Active Work Requirement and the other requirements for the insurance. The same delay rule will apply to any increase in your insurance that is subject to this section. If you do not meet the Active Work Requirement on the day that change would take effect, it will take effect on the first day you meet that requirement. This delay rule does not apply to any decreases in your insurance.

FOR DEPENDENTS INSURANCE

A Qualified Dependent may be confined for medical care or treatment, at home or elsewhere. If a Qualified Dependent is so confined on the day that your Dependents Insurance under the Coverage for that Qualified Dependent, or any change in that insurance that is subject to this section, would take effect, it will not then take effect. The insurance or change will take effect upon the Qualified Dependent's final medical release from all such confinement. The other requirements for the insurance or change must also be met.

Newborn Child Exception: This section does not apply to a Child of yours at that Child's birth if the Child is born to you and either:

(1) is your first Qualified Dependent; or

(2) becomes a Qualified Dependent while you are insured for Dependents Insurance under the Coverage for any other Qualified Dependent.

Also, this section does not apply to any age increase in the amount of insurance for a Child under the Dependents Coverage.

Critical Illness Coverage

FOR YOU AND YOUR DEPENDENTS

This Coverage pays benefits for certain Critical Illnesses.

Critical Illnesses means the person's:

- **Alzheimer's Disease:** Alzheimer's Disease means permanent and significant loss of cognitive ability. **It does not include any other type of dementia.** Medical evidence of a definite clinical diagnosis of Alzheimer's Disease by a qualified medical professional is required as proof of claim.

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

- **Blindness:** Blindness means central visual acuity of not more than 20/200 in the better eye, after correction, or visual acuity greater than 20/200 but with a limitation in the fields of vision so that the widest diameter of the visual field subtends an angle no greater than 20 degrees. This must be certified by a licensed physician and surgeon who specializes in diseases of the eye or a licensed optometrist.

- **Cancer:** Cancer means any malignant tumor positively diagnosed with histological confirmation and characterized by the uncontrolled growth of malignant cells and invasion of tissue. The term malignant tumor includes leukemia, lymphoma, sarcoma and multiple myeloma.

  Cancer does not include the following:

  (a) pre-malignant lesions;

  (b) benign tumors or polyps.

  The benefit that applies to Cancer depends on whether the Cancer is ***Full Benefit Cancer; Partial Benefit Other Than Skin Cancer***; or ***Partial Benefit Cancer, Skin Cancer***.

  ***Full Benefit Cancer* means** any type of Cancer except Partial Benefit Other Than Skin Cancer or Partial Benefit Skin Cancer**.**

  Partial Benefit Other Than Skin Cancer means:

  (a) Cancer classified as TisN0M0, provided that surgery, radiotherapy or chemotherapy has been determined to be medically necessary by a qualified medical professional in the medical specialty that is appropriate for the type of Cancer involved;

  (b) malignant tumors classified as T1N0M0 or greater which are treated by endoscopic procedures alone;

(c) malignant melanomas classified as T1N0M0, for which a pathology report shows maximum thickness less than or equal to 1.0 millimeters using the Breslow method of determining tumor thickness;

(d) tumors of the prostate classified as T1bN0M0, or T1cN0M0, provided that they are treated with a prostatectomy or radiotherapy.

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

Partial Benefit Cancer, Skin Cancer means any malignancy of the skin diagnosed with histological confirmation and characterized by uncontrolled growth of malignant cells and invasion of tissue. It includes:

(1) basal cell carcinoma; and

(2) squamous cell carcinoma.

It does not include malignant melanoma, or any condition which may be considered precancerous, such as leukoplakia; actinic keratosis; carcinoid; hyperplasia; non-malignant melanoma; moles; or similar diseases or lesions.

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

- **Cerebral Palsy:** Cerebral Palsy means a non-progressive neurological defect affecting muscle control which is characterized by spasticity and lack of co-ordination of movements. Medical evidence of a definite diagnosis of Cerebral Palsy by a qualified medical professional is required as proof of claim.

- **Cleft Lip or Cleft Palate:** Cleft Lip means a narrow opening or gap in the skin of the upper lip that extends all the way to the base of the nose, including unilateral clefting and bilateral clefting. Cleft Palate means an opening between the roof of the mouth and the nasal cavity. Medical evidence of a definite diagnosis of Cleft Lip or Cleft Palate by a Doctor before or after live birth is required as proof of claim.

- **Coma:** Coma means a state of unconsciousness with no reaction to external stimuli or internal needs which requires the use of life support systems and results in permanent neurological deficit with persistent clinical symptoms continuously for at least 96 hours. **It does not include:**

  (a) coma due to either alcohol or drug abuse;

  (b) persistent vegetative state; or

  (c) medically-induced coma.

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

- **Cystic Fibrosis:** Medical evidence of a definite diagnosis of Cystic Fibrosis by a qualified medical professional based on diagnostic tests either before or after birth is required as proof of claim.

- **Deafness:** Deafness means permanent and irreversible loss of hearing in both ears to the extent that the loss is greater than 70 decibels across all frequencies in both ears using a pure

tone audiogram. Medical evidence of a definite diagnosis of Deafness by a Doctor is required as proof of claim.

- **Down Syndrome:** Down Syndrome means a congenital disorder arising from a chromosome defect involving chromosome 21, causing intellectual impairment, physical abnormalities and developmental delays. Down Syndrome includes but is not limited to:

  (a) Trisomy 21: An individual has three instead of two chromosome 21's;

  (b) Translocation: An extra part of chromosome 21 is attached to another chromosome; or

  (c) Mosaicism: The individual has an extra chromosome 21 in only some of the cells but not all of them. The other cells have the usual pair of chromosome 21's.

  Medical evidence of a definite diagnosis of Down Syndrome through the study of chromosome 21 before or after live birth is required as proof of claim.

- **Heart Attack:** Heart Attack means death of heart muscle, as a result of a primary cardiac condition, due to inadequate blood supply, that has resulted in both of the following evidence of acute myocardial infarction, as certified by a Doctor:

  (a) new characteristic electrocardiographic changes; and

  (b) characteristic rise of cardiac enzymes or troponins recorded at the following levels of higher - troponin T>1.0ng/ml, AccuTnl>0.5ng/ml.

  It does not include heart attack that occurs during a non-cardiac surgical procedure.

  Medical evidence of a definite diagnosis of Heart Attack by a qualified medical professional is required as proof of claim.

  Heart Attack Covered Condition:

  - Myocardial Infarction or
  - Sudden Cardiac Arrest.

  Myocardial Infarction means the death of a portion of the heart muscle as a result of obstruction of one or more coronary arteries due to atherosclerosis, spasm, thrombus or emboli. Myocardial Infarction does not include Sudden Cardiac Arrest.

  Sudden Cardiac Arrest means the sudden, unexpected loss of heart function, breathing and consciousness resulting when the heart suddenly, and unexpectedly, stops beating because of an internal electrical disturbance of the heart, which results in a Covered Person being pronounced deceased by a Physician.

  Occurs or **Occurrence**, with respect to a Heart Attack Covered Condition, means a Covered Person is Diagnosed with such Covered Condition while coverage is in effect under this Certificate for such Covered Person. A Heart Attack Covered Condition will be deemed to Occur on the date that a Diagnosis of a Heart Attack Covered Condition is made.

- **Loss of Speech:** Loss of Speech means total, permanent and irreversible loss of the ability to speak as a result of physical injury or disease. It includes loss of speech due to surgery or medical treatment for an illness. **It does not include loss of speech due to Stroke or Full**

Benefit Cancer. Medical evidence of a definite diagnosis of Loss of Speech by a Doctor is required as proof of claim.

- **Major Organ Failure:** Major Organ Failure means the irreversible failure of a Major Organ due to an End Stage Disease, the result of which is the need to be placed on an organ transplant waiting list. Major Organ means heart, liver, lung, pancreas or bone marrow. End Stage Disease means end stage heart disease, end stage liver disease, end stage lung disease, total pancreas failure or severe bone marrow failure. Failure of more than one Major Organ due to an End Stage Disease is considered a single Major Organ Failure for the purpose of determining benefits under this critical illness plan.

  Proof of claim for Major Organ Failure must show:

  (1) medical evidence of a definite diagnosis of Major Organ Failure by a Doctor; and

  (2) approval for participation on an organ transplant waiting list, or approval for a bone marrow or stem cell transplant.

- **Multiple Sclerosis:** Multiple Sclerosis means a current clinical impairment of motor or sensory function, which must have persisted for a continuous period of at least six months. Medical evidence of a definite diagnosis of Multiple Sclerosis by a qualified medical professional is required as proof of claim.

- **Paralysis of Limbs:** Paralysis of Limbs means total and irreversible loss of muscle function to the whole of any two limbs. **It does not include paralysis of limbs due to Stroke.** Medical evidence of a definite diagnosis of Paralysis of Limbs by a Doctor is required as proof of claim.

- **Parkinson's Disease:** Parkinson's Disease means permanent clinical impairment of motor function with associated tremor, rigidity of movement and postural instability. Medical evidence of a definite diagnosis of Parkinson's Disease by a qualified medical professional is required as proof of claim.

- **Renal (kidney) Failure:** Renal Failure means chronic and end stage (irreversible) failure of both kidneys to function, the result of which is the need for regular dialysis for a period of at least three months. Medical evidence of a definite diagnosis of Renal Failure by a Doctor is required as proof of claim.

- **Severe Coronary Artery Disease:** Severe Coronary Artery Disease means:

  (1) more than 50% blockage in the left main coronary artery;

  (2) more than 70% blockage in the proximal left anterior coronary artery; or

  (3) more than 50% blockages in all three of the following arteries: the left anterior descending artery, the left circumflex artery and the right coronary artery.

  Medical evidence of a definite diagnosis of Severe Coronary Artery Disease by a qualified medical professional is required as proof of claim.

- **Spina Bifida:** Spina Bifida means a congenital defect of the spine in which part of the spinal cord and its meninges are exposed through a gap in the backbone. Spina Bifida includes Meningocele or Myelomeningocele. Spina Bifida does not include a diagnosis of spina bifida occulta. Medical evidence of a definite diagnosis of Spina Bifida by a Doctor before or after live birth is required as proof of claim.

- **Stroke:** Stroke means death of brain tissue due to inadequate blood supply or hemorrhage within the skull resulting in a permanent and significant neurological deficit with persistent clinical symptoms. **It does not include transient ischemic attacks ("TIA").** Medical evidence of a definite diagnosis of Stroke by a qualified medical professional is required as proof of claim.

- **Systemic Lupus Erythematosus:** Proof of claim for Systemic Lupus Erythematosus must show a definite diagnosis of Systemic Lupus Erythematosus by a qualified medical professional resulting in either of the following:

  (a) permanent neurological deficit with persistent clinical symptoms; or

  (b) permanent impairment of kidney function such that the calculated glomerular filtration rate is less than 30 ml/min, as measured on two occasions, one month apart.

- **Third Degree Burns:** Third Degree Burns means burns covering either 20% of the body's surface area or 50% of the surface area of the face, requiring skin grafting. Medical evidence of a definite diagnosis of Third Degree Burns by a Doctor is required as proof of claim.

See the Benefit Definitions for a definition of each Critical Illness.

A. BENEFITS.

Benefits for a Critical Illness are payable only if:

(1) the person is diagnosed with the Critical Illness while a Covered Person; and

(2) that diagnosis occurs during the Covered Person's lifetime.

Not all such Critical Illnesses are covered. See Critical Illnesses Not Covered below.

First Occurrence Benefit Amount Payable: The amount payable for the First Occurrence of a Critical Illness depends on the type of Critical Illness as shown below.

Critical Illness:	**Percent of the Person's Amount of Insurance or Benefit Amount Payable**
Benign Brain Tumor	100%
Blindness	100%
Cerebral Palsy	100%
Cleft Lip or Cleft Palate	100%
Coma	100%
Cystic Fibrosis	100%
Deafness	100%
Down Syndrome	100%
Cancer - ***Full Benefit***	100%
Heart Attack	100%
Loss of Speech	100%
Major Organ Failure	100%
Paralysis of Limbs	100%
Renal (kidney) Failure	100%
Severe Coronary Artery Disease	100%
Spina Bifida	100%
Stroke	100%

Third Degree Burns 100%

Alzheimer's Disease 50%
Cancer - ***Partial Benefit Other Than Skin Cancer*** 50%
Parkinson's Disease 50%

Multiple Sclerosis 25%
Systemic Lupus Erythematosus 25%

Cancer - ***Partial Benefit, Skin Cancer*** $250

Reoccurrence Benefit Amount Payable for Critical Illness other than Partial Benefit Cancer, Skin Cancer: The amount payable for a Reoccurrence of a Critical Illness other than Partial Benefit Cancer, Skin Cancer is 100% of the amount paid to the person for the First Occurrence of the Critical Illness.

Reoccurrence of a Critical Illness other than Skin Cancer means:

(1) a person is positively diagnosed by a Doctor as having an additional occurrence or reoccurrence of a Critical Illness other than Skin Cancer for which a benefit was paid under this Coverage; and

(2) the date of the diagnosis of the additional occurrence or reoccurrence is more than 90 days after the date of the last medical treatment for the previous occurrence.

Reoccurrence Benefit Amount Payable for Partial Benefit Cancer, Skin Cancer: The amount payable for a Reoccurrence of Partial Benefit Cancer, Skin Cancer is $250, subject to the Annual Limit for Partial Benefit Cancer, Skin Cancer.

Reoccurrence of Skin Cancer means a person is positively diagnosed by a Doctor as having an additional occurrence or reoccurrence of Partial Benefit Cancer, Skin Cancer for which a benefit was paid under this Coverage.

Annual Limit for Skin Cancer: $250 per Calendar Year for each Covered Person.

B. CRITICAL ILLNESSES NOT COVERED.

A Critical Illness is not covered if it is caused by any of these:

(1) Attempted suicide, while sane or insane.

(2) Intentionally self-inflicted Injuries, or any attempt to inflict such Injuries.

(3) War, or any act of war. "War" means declared or undeclared war and includes resistance to armed aggression.

(4) Travel or flight in any vehicle used for aerial navigation. This (4) does not apply if the person is riding as a fare paying passenger in a licensed aircraft provided by a common carrier on a regularly scheduled route.

(5) Commission of a crime for which you have been convicted under state or federal law.

(6) Being intoxicated or under the influence of any controlled substance unless administered on the advice of a Doctor.

The Claim Rules apply to the payment of the benefits.

Additional Benefits under Critical Illness Coverage

FOR YOU AND YOUR DEPENDENTS

An additional benefit may be payable under this Coverage. Any such benefit is payable in addition to any other benefit payable under this Coverage. A Covered Person's Lifetime Maximum Benefit under this Coverage will not be reduced by the amount of any additional benefit payable under this part of the Coverage. Any additional conditions that apply to an additional benefit are shown below. An additional benefit is payable only if those conditions are met.

A. WELLNESS BENEFIT.

This additional benefit for wellness pays benefits for a Covered Person's health screening test, upon submission of proof, only if the Covered Person receives one of the following health screening tests, or any other generally medically accepted cancer screening tests, while not confined in a hospital:

- routine health check-up exam;
- biopsies for cancer;
- blood chemistry panel;
- blood test to determine total cholesterol;
- blood test to determine triglycerides;
- bone marrow testing;
- breast MRI;
- breast ultrasound;
- breast sonogram;
- cancer antigen 15-3 blood test for breast cancer (CA 15-3);
- cancer antigen 125 blood test for ovarian cancer (CA 125);
- carcinoembryonic antigen blood test for colon cancer (CEA);
- carotid doppler;
- chest x-rays;
- clinical testicular exam;
- colonoscopy;
- complete blood count (CBC);

- digital rectal exam (DRE);
- Doppler screening for cancer;
- Doppler screening for peripheral vascular disease;
- echocardiogram;
- electrocardiogram (EKG);
- electroencephalogram (EEG);
- endoscopy;
- fasting blood glucose test;
- fasting plasma glucose test;
- flexible sigmoidoscopy;
- hemoccult stool specimen;
- hemoglobin A1C;
- human papillomavirus (HPV) vaccination;
- immunization;
- lipid panel;
- oral cancer screening;
- pap smears or thin prep pap test;
- prostate-specific antigen (PSA) test;
- serum cholesterol test to determine LDL and HDL levels;
- serum protein electrophoresis;
- skin cancer biopsy;
- skin cancer screening;
- skin exam;
- stress test on bicycle or treadmill;
- successful completion of smoking cessation program;
- thermography;
- two hour post-load plasma glucose test;
- ultrasounds for cancer detection;
- ultrasound screening of the abdominal aorta for abdominal aortic aneurysms;

- virtual colonoscopy.

Wellness Benefit Amount Payable: The additional amount payable is shown in the Schedule of Benefits.

Wellness Benefit Limits: The Wellness Benefit is not payable for a test if benefits are paid or are payable for that same test under another section of this Certificate.

Wellness Benefit Daily Limit: The Wellness Benefit is limited to payment of one benefit per Covered Person, per day.

Wellness Benefit Annual Limit: The Wellness Benefit is limited to one benefit payment per Calendar Year for each Covered Person.

B. BENEFIT FOR NATIONAL CANCER INSTITUTE (NCI) EVALUATION.

This additional benefit for NCI evaluation pays benefits for a Covered Person's evaluation or consultation at an NCI-designated cancer center only if both of these conditions are met:

(1) The Covered Person is seeking the evaluation or consultation as a result of receiving a diagnosis of Cancer.

(2) The purpose of the evaluation or consultation is to determine the appropriate course of treatment.

NCI Evaluation Benefit Amount Payable: The additional amount payable is shown in the Schedule of Benefits.

NCI Evaluation Benefit Lifetime Limit: The NCI Evaluation Benefit is payable once during the lifetime of each Covered Person.

C. TRANSPORTATION BENEFIT.

This additional benefit for transportation pays benefits for the travel expenses associated with a Covered Person's round trip travel between the Covered Person's primary residence and a hospital or medical facility only if both of these conditions are met:

(1) The Covered Person needs to travel to the hospital or medical facility to receive treatment for a Critical Illness.

(2) The hospital or medical facility is more than 50 miles from the Covered Person's primary residence.

Transportation Benefit Amount Payable: The additional amount payable is shown in the Schedule of Benefits.

Transportation Benefit Annual Limit: The Transportation Benefit is limited to one benefit payment per Calendar Year for each Covered Person receiving treatment during that visit.

C. LODGING BENEFIT.

This additional benefit for lodging pays benefits for a Covered Person's lodging expenses only if all of these conditions are met:

(1) The Covered Person needs to stay overnight in order to receive treatment for a Critical Illness at a hospital or medical facility.

(2) The hospital or medical facility is more than 75 miles from the Covered Person's primary residence.

(3) The lodging occurs not more than 24 hours prior to the treatment, and not more than 24 hours after the treatment.

Lodging Benefit Amount Payable: The additional amount payable is shown in the Schedule of Benefits.

Lodging Benefit Annual Limit: The Lodging Benefit is limited to 60 days per Calendar Year for each Covered Person receiving treatment during that visit.

When Your Insurance Ends

EMPLOYEE AND DEPENDENTS INSURANCE

Your Employee Insurance under the Coverage or your Dependents Insurance under the Coverage will end on the first of these to occur:

- Your membership in the Covered Classes for the insurance ends because your employment ends (see below) or for any other reason.
- Your class is removed from the Covered Classes for the insurance.
- The date the Group Contract providing the insurance ends.
- You reach age 100.
- You die.
- For Contributory Insurance under the Coverage, you fail to pay, when due, any required contribution. But, if Employee Insurance is Contributory, failure to contribute for Dependents Insurance will not cause your Employee Insurance to end.
- The Insurance is Dependents Insurance and your Employee Insurance under the Coverage ends.

Your Dependents Insurance for a Qualified Dependent under the Coverage will end when that person ceases to be a Qualified Dependent for the Coverage. A Spouse or Domestic Partner will cease to be a Qualified Dependent at age 100. (See Continued Coverage for an Incapacitated Child below.)

End of Employment: For insurance purposes, your employment will end when you are no longer a full-time Employee actively at work for the Employer. But, under the terms of the Group Contract, the Employer may consider you as still employed in the Covered Classes during certain types of absences from full-time work. This is subject to any time limits or other conditions stated in the Group Contract.

Your employment in the Covered Classes will not be considered to end while you are absent from work due to leave for which insurance is required to be continued under the Federal Family and Medical Leave Act of 1993 or a state law requiring similar continuation, as reported to Prudential by the Employer.

If you stop active full-time work for any reason, you should contact the Employer at once to determine what arrangements, if any, have been made to continue any of your insurance.

Continued Coverage for an Incapacitated Child: This applies only to the Dependents Insurance you have for a Child under the Coverage. The insurance for the Child will not end on the date the age limit in the definition of Qualified Dependent is reached if both of these are true:

(1) The Child is then mentally or physically incapable of earning a living. Prudential must receive proof of this within the next 31 days.

(2) The Child otherwise meets the definition of Qualified Dependent.

If these conditions are met, the age limit will not cause the Child to stop being a Qualified Dependent under that Coverage. This will apply as long as the Child remains so incapacitated.

Continued Insurance during Absence from Work Because of a Labor Dispute: These provisions apply only if any part of the premium for the insurance under the Coverage is paid by the Employer under the terms of a collective bargaining agreement. They apply when your Employee or Employee and Dependents Insurance under the Coverage would otherwise end on any date because of your absence from work as a result of a labor dispute. Your insurance under the Coverage will not end on that date. It will be continued during such absence from work from the date it would have ended until the first of these occurs:

(1) The end of the six month period immediately following the first day of your absence from work.

(2) The date you become actively engaged in work on a full-time basis for another employer.

(3) The first day you fail to pay, when due, any contribution required for the continued insurance. Your contribution will not be more than the premium that applies to your Covered Class on the first day of your absence from work.

(4) The first day the entity responsible for collecting Employee contributions fails to pay, when due, the premium required for the continued insurance.

(5) The part of the Group Contract providing the insurance ends.

Continuation of Coverage at Your Option:

Your coverage becomes portable and you may elect to continue Coverage for you and your Qualified Dependents if all of these conditions are met:

(1) Coverage for you and your Qualified Dependents under the Group Contract would have ended because:

  (a) your employment ended for a reason other than gross misconduct; or

  (b) your work hours were reduced.

(2) You have been continuously insured under the Group Contract and/or the Employer's prior plan for at least 30 days just before the date your employment ended or your work hours were reduced.

The Coverage that may be continued is that which you had on the date your employment ended or your work hours were reduced.

Your Employer will give to you or mail to you a notice of your right to continue the Coverage. The notice will state the amount of the payments required for the portable Coverage and the manner in which payments must be made.

If you want to continue the Coverage, the election notice must be completed and returned to your Employer, along with the required first payment, by the later of:

(1) the thirty-first day after the Coverage would otherwise have ended; and

(2) the fifteenth day after you receive the notice informing you of your right to continue. But, in no event may election be made if you do not apply for continuation of Coverage and pay the first payment prior to the ninety-second day after you cease to be covered for the Coverage.

If this is done, the portable Coverage will be continued from the date it would have ended until the first of these occurs:

(1) You reach age 100.

(2) You die.

(3) You fail to make, when due, any payment required for the continued Coverage. But failure to contribute for Dependents Insurance will not cause your Employee Insurance to end.

(4) The insurance is Dependents Insurance, and your Employee Insurance under the Coverage ends.

(5) You become covered under any other group critical illness plan.

Your Dependents Insurance for a Qualified Dependent under the continued Coverage will end on the first of these to occur:

(1) The Qualified Dependent reaches the Lifetime Maximum Benefit for that Qualified Dependent.

(2) That person ceases to be a Qualified Dependent for the Coverage. A Spouse or Domestic Partner will cease to be a Qualified Dependent at age 100. (See Continued Coverage for an Incapacitated Child above.)

While Critical Illness Coverage is continued under this part, all other terms of the Group Contract apply, except:

(1) Your Amount of Insurance may not be more than 100% of your Amount of Insurance under the Group Contract when the Coverage would have ended, but not less than $10,000. The Amount of Insurance on each dependent may not be more than the Amount of Insurance on the dependent under the Group Contract when the Coverage would have ended.

(2) Your Amount of Insurance under the continued Coverage may not be increased.

(3) The Amount of Insurance on each dependent under the continued Coverage may not be increased.

(4) Once Coverage is being continued under this part, no other continuation provisions may apply, except for the Continued Coverage for an Incapacitated Child provision above.

General Information

A. CLAIM RULES.

These rules apply to payment of benefits under the Coverage.

Notice of Claim: Written notice of claim must be given to Prudential within 20 days after the occurrence or commencement of any loss covered by the Group Contract, or as soon thereafter as is reasonably possible. Notice given by or on behalf of the Covered Person to Prudential at Voluntary Benefit Services, P.O. Box 696035, San Antonio, TX 78269-6035, or to any authorized agent of Prudential, with information sufficient to identify the Covered Person, shall be deemed notice to Prudential.

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

Use a claim form, and follow the instructions on the form.

If you do not have a claim form, contact your Employer, or you can request a claim form from us. If you do not receive the form within 15 days of your request, send Prudential written proof of claim without waiting for the form.

Proof of Loss: Written proof of loss must be sent to Prudential within 90 days of the date of such loss. Failure to furnish such proof within the time required shall not invalidate nor reduce any claim if it was not reasonably possible to give proof within such time, provided such proof is furnished as soon as reasonably possible and in no event, except in the absence of legal capacity, later than one year from the time proof is otherwise required.

Time of Payment of Claim: Prudential will pay benefits immediately after receiving written proof of loss.

Payment of Claims: Critical Illness benefits are payable to you. But benefits that are unpaid at your death will be payable to the first of the following: Your (a) surviving spouse or Registered Domestic Partner; (b) surviving child(ren) in equal shares; (c) surviving parents in equal shares; (d) surviving siblings in equal shares; (e) estate.

Physical Examinations: Prudential, at its own expense, shall have the right and opportunity to examine the Covered Person for whom the claim is made. Prudential may do this when and as often as it may reasonably require during the pendency of a claim hereunder.

Legal Actions: No action at law or in equity shall be brought to recover on this Group Insurance Certificate prior to the expiration of 60 days after written proof of loss has been furnished in accordance with the requirements of this Group Insurance Certificate. No such action shall be brought after the expiration of three years after the time written proof of loss is required to be furnished.

B. TIME LIMIT ON CERTAIN DEFENSES.

After two years from the date of issue of this Group Insurance Certificate, no misstatements, except fraudulent misstatements, made by the person in the application for coverage shall be used to void the coverage or to deny a claim for loss incurred commencing after the expiration of the two-year period.

C. PAYMENT OF PREMIUMS - GRACE PERIOD.

Premiums are to be paid by you to the Contract Holder. Each Premium must be paid by the Premium Payment Date.

Premium Payment Date: The first premium is due on the date you become insured under the Group Contract. Subsequent premiums are due semi-annually. But, at your written request, you may elect to pay premiums monthly, quarterly or annually, or change back to semi-annually. The Premium Payment Date for each subsequent Premium is the first day of each subsequent payment period.

Grace Period: You may pay each Premium other than the first within 31 days of the Premium Payment Date without being charged interest. Those days are known as the grace period.

If you fail to pay any Premium required for an insurance of the Group Contract by the end of its grace period, your insurance will end when the grace period ends. You are liable to pay Premiums to the Contract Holder for the time your insurance is in force.

D. REINSTATEMENT.

If your insurance ends because you did not pay any Premium by the end of its grace period, you may be eligible to reinstate the insurance subject to these rules:

(1) You must request reinstatement within 180 days of the date of the first unpaid Premium;

(2) You must pay all overdue Premiums; and

(3) If you request reinstatement more than 60 days after the end of the grace period, you must complete a Request for Reinstatement with attestation of good health.

If Prudential approves your request, the reinstatement will be effective on the first day of the month coinciding with or next following the approval date.

The Incontestability provisions will apply as of the date the reinstatement is effective.

CERTIFICATE ENDORSEMENT TO GROUP CONTRACT

Group Contract No.: GC-97000-CA

Effective Date: January 1, 2025

This certificate endorsement is attached to and made part of the Group Contract.

Your Critical Illness Group Insurance Certificate is changed as follows:

- The following **Critical Illnesses** are being added to the list of **Critical Illnesses** for which benefits are payable under the Critical Illness Coverage of your Group Insurance Certificate:

  (1) Autism

  (2) Diabetes Juvenile Type 1

  (3) Mammography

  (4) Phenylalanine Hydrolase Deficiency Disease (PKU)

  (5) Sudden Cardiac Arrest

Critical Illness: Payable	**Amount of Insurance or Benefit Amount**
Autism	$3,000
Diabetes Juvenile Type 1	100%
Mammography	$200
Phenylalanine Hydrolase Deficiency Disease (PKU)	100%
Sudden Cardiac Arrest	100%

- The **Benefit Definitions** pages of your Group Insurance Certificate is amended to include the following:

  (1) **Autism:** Autism Spectrum Disorder is a biological based neurodevelopment disorder characterized by impairment in two major domains:

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

  A Doctor must Diagnose Autism Spectrum Disorder and include a severity level specifier for both major domains listed above.

  (2) **Diabetes Juvenile Type 1:** Type I Diabetes means a form of diabetes mellitus causing total insulin deficiency of a Dependent Child along with continuous dependence on exogenous insulin in order to maintain life. A Doctor/Qualified Medical Professional must Diagnose Type I Diabetes based on one of the following diagnostic tests:

  - Glycated hemoglobin (A1C) test
  - Random blood sugar test
  - Fasting blood sugar test

(3) **Mammography benefit:** We will pay the amount shown in the Benefit Schedule for Mammography tests performed while an Insured's coverage is in force. This benefit is payable as follows:

a) A baseline mammogram for women age 35 to 39, inclusive.

b) A mammogram for women age 40 to 49, inclusive, every two years or more frequently based on the women's physicians' recommendations.

c) A mammogram every year for women age 50 and over.

(4) **Phenylalanine Hydrolase Deficiency Disease (PKU):** Phenylalanine Hydroxylase Deficiency Disease (PKU) is an autosomal recessive metabolic genetic disorder characterized by homozygous or compound heterozygous mutations in the gene for the hepatic enzyme phenylalanine hydroxylase (PAH), rendering it nonfunctional. A Doctor/Qualified Medical Professional must Diagnose this disease based on a PKU test.

(5) **Sudden Cardiac Arrest:** Sudden Cardiac Arrest is the sudden, unexpected loss of heart function in which the heart, abruptly and without warning, stops working as a result of an internal electrical system heart malfunction due to Coronary Artery Disease, Cardiomyopathy, or Hypertension. Sudden Cardiac Arrest is not a Heart Attack (Myocardial Infarction). A Sudden Cardiac Arrest benefit is not payable if the Sudden Cardiac Arrest is caused by or contributed to by a Heart Attack (Myocardial Infarction).

- The list of health screenings under the **Wellness Benefit** of the **Additional Benefits under Critical Illness Coverage** pages of your Group Insurance Certificate is amended to include the following:

(1) Cancer Screening
- Bone mass density measurement (DEXA, DXA)
- Spiral CT Screening (lung)
- Cytological Screening
- DNA Stool analysis
- HIV test via nucleic acid

- The **Qualified Dependents** section of the **Who is Eligible to Become Insured** provision is revised as follows:

Domestic Partner: A domestic partnership (same or opposite sex) registered with the State of California or a substantially equivalent partnership established in another jurisdiction is a domestic partnership for UC benefits purposes. A domestic partnership (same or opposite sex) that has not been registered with the State of California or is not a substantially equivalent partnership established in another jurisdiction must meet the following criteria to be a domestic partnership for UC benefits purposes:

a) Parties must be each other's sole domestic partner in a long-term, committed relationship and must intend to remain so indefinitely.
b) Neither party may be legally married or be a partner in another domestic relationship.
c) Parties must not be related to each other by blood to a degree that would prohibit marriage in the law of the state in which the Employee resides.
d) Both parties must be at least 18 years old and capable of consenting to the relationship.
e) Parties must be financially interdependent.
f) Parties must share a common residence.

- The list under EMPLOYEE AND DEPENDENTS INSURANCE of the **When Your Insurance Ends** provision of your Group Insurance Certificate is amended to include the following:

  - You waive your coverage

- The **Continuation of Coverage at Your Option** section of the **When Your Insurance Ends** provision of your Group Insurance Certificate is revised as follows:

  Your coverage becomes portable and you may elect to continue Coverage for you and your Qualified Dependents if all of these conditions are met:

  (1) Coverage for you and your Qualified Dependents under the Group Contract would have ended because:

  (a) your employment ended for a reason other than gross misconduct; or

  (b) your work hours were reduced.

  (2) You have been continuously insured under the Group Contract and/or the Employer's prior plan for at least 30 days just before the date your employment ended or your work hours were reduced.

  The Coverage that may be continued is that which you had on the date your employment ended or your work hours were reduced.

  Prudential will give to you or mail to you a notice of your right to continue the Coverage. The notice will state the amount of the payments required for the portable Coverage and the manner in which payments must be made.

  If you want to continue the Coverage, the election notice must be completed and returned to Prudential, along with the required first payment, by the later of:

  (1) the thirty-first day after the Coverage would otherwise have ended; and

  (2) the fifteenth day after you receive the notice informing you of your right to continue. But, in no event may election be made if you do not apply for continuation of Coverage and pay the first payment prior to the ninety-second day after you cease to be covered for the Coverage.

  If this is done, the portable Coverage will be continued from the date it would have ended until the first of these occurs:

  (1) You reach age 100.

  (2) You reach your Lifetime Maximum Benefit.

  (3) You die.

  (4) You fail to make, when due, any payment required for the continued Coverage. But failure to contribute for Dependents Insurance will not cause your Employee Insurance to end.

  (5) The insurance is Dependents Insurance, and your Employee Insurance under the Coverage ends.

  (6) You become covered under any other group critical illness plan.

Your Dependents Insurance for a Qualified Dependent under the continued Coverage will end on the first of these to occur:

(1) The Qualified Dependent reaches the Lifetime Maximum Benefit for that Qualified Dependent.

(2) That person ceases to be a Qualified Dependent for the Coverage. A Spouse or Domestic Partner will cease to be a Qualified Dependent at age 100. (See Continued Coverage for an Incapacitated Child above.)

While Critical Illness Coverage is continued under this part, all other terms of the Group Contract apply, except:

(1) Your Amount of Insurance may not be more than 100% of your Amount of Insurance under the Group Contract when the Coverage would have ended, but not less than $10,000. The Amount of Insurance on each dependent may not be more than the Amount of Insurance on the dependent under the Group Contract when the Coverage would have ended.

(2) Your Amount of Insurance under the continued Coverage may not be increased.

(3) The Amount of Insurance on each dependent under the continued Coverage may not be increased.

(4) Once Coverage is being continued under this part, no other continuation provisions may apply, except for the Continued Coverage for an Incapacitated Child provision above.

- The **Continued Dependents Critical Illness Insurance at Your Spouse's or Domestic Partner's Option After Your Death** provision is added as follows:

  If an Employee dies while covered under his Certificate and his Spouse is also insured under this Plan at this time of his death, then his surviving Spouse may elect to become the primary Insured at the current Spouse Face Amount. This would include continuation of any Dependent Child coverage that is in force at that time.

  To become the primary Insured and keep coverage in force, the surviving Spouse must:
  - Notify the Company in writing within 31 days after the date of the Employee's death; and
  - Pay the required premium to the Company no later than 31 days after the date of the Employee's death, and on each premium due date thereafter.

  If the Certificate does not cover a surviving Spouse, the Certificate will terminate on the next premium due date following the Employee's death.

- The **Payment of Claims** provision is revised as follows:

  (1) If you are not living, benefits that are unpaid at your death will be payable to the designated beneficiary on file. If you do not have a beneficiary designation on file, the benefits will be payable to the first of the following: Your (a) surviving spouse or Registered Domestic Partner; (b) surviving child(ren) in equal shares; (c) surviving parents in equal shares; (d) surviving siblings in equal shares; (e) estate.

  (2)If You are not living, benefits for a dependent's Losses are payable to Your Spouse or Domestic Partner if Your Spouse or Domestic Partner is living.

  (3) If neither You nor Your Spouse or Domestic Partner is living, then benefits for a Spouse's or Domestic Partner's Losses will be paid to Your Spouse's or Domestic Partner's estate.

(4)If neither You nor Your Spouse or Domestic Partner is living, then benefits for a Qualified Dependent Child's Losses will be paid to the Child who suffered the Loss. If that Qualified Dependent Child is not living, the benefits will be paid to the Child's estate.

All other provisions in your Group Insurance Certificate remain unchanged.

THE PRUDENTIAL INSURANCE COMPANY OF AMERICA

Margaret M. Foran
Secretary

The Claims and Appeals section

is not part of the

Group Insurance Certificate.

CLAIMS AND APPEALS

Plan Benefits Provided by

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

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

Claim Procedures

1. Determination of Benefits

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

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

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

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

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

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

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

2. Appeals of Adverse Determination

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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