Blanket Accident
Insurance Certificate

Inova Health System

RIGHT TO FILE A COMPLAINT

KEEP THIS NOTICE WITH YOUR INSURANCE PAPERS.

PROBLEMS WITH YOUR INSURANCE? Your satisfaction is very important to us. If you are having problems with your insurance, do not hesitate to contact the insurance company to resolve your problem.

Cigna Consumer Advocacy
Attn: Meredith A. Long
25600 North Norterra Drive
Phoenix, AZ 85085-8201
Email: CGIConsumerAdvocacy@cigna.com
Phone: 800-547-5515
Fax: 646-706-4296

You can also contact the Bureau of Insurance and file a complaint. You can contact the Bureau of Insurance by contacting:

State Corporation Commission
Bureau of Insurance
Post Office Box 1157
Richmond, VA 23218
Tel: (804) 371-9185
Toll-free: 1-877-310-6560
Fax: (804) 371-9944

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

BLANKET ACCIDENT
CERTIFICATE OF INSURANCE

We, Life Insurance Company of North America, called We, Us or Our, have issued a Blanket Accident Policy, ABL 980092 to Inova Health System.

We certify that We insure all Eligible Persons who are enrolled according to the terms of the Blanket Accident Policy. Your coverage will begin according to the terms set forth in the Eligibility for Insurance and Effective Date of Insurance provisions shown in the *Eligibility, Effective Date and Termination Provisions.*

This Certificate describes the benefits and basic provisions of your coverage. You should read it with care so You will understand Your coverage.

This is not the insurance contract. It does not waive or alter any terms of the Policy. You may examine the Policy at the office of the Policyholder.

This Certificate replaces any and all Certificates which may have been issued to You in the past under the Blanket Accident Policy.

William J Smith, President

THIS CERTIFICATE PROVIDES LIMITED COVERAGE FOR ACCIDENT ONLY.
PLEASE READ YOUR CERTIFICATE CAREFULLY.
IT DOES NOT PAY BENEFITS FOR LOSS DUE TO SICKNESS.
THIS CERTIFICATE PAYS BENEFITS FOR SPECIFIC LOSSES FROM ACCIDENT ONLY.

BA-01-CE1000.00

TABLE OF CONTENTS

SECTION **PAGE NUMBER**

SCHEDULE OF BENEFITS

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

The *Schedule of Benefits* provides a brief outline of your coverage and benefits provided by this Certificate. Please read the *Conditions of Coverage* and *Description of Indemnity Benefits* sections for full details.

Certificate Effective Date: January 1, 2020

Re-Issue Date: January 1, 2021

The Policy reflects the terms and conditions of coverage applicable on this date. References throughout the Policy to the Policy Effective Date mean the effective date of the prior Policy. If this Policy includes an Active Service requirement and an insured in a Covered Class is not in Active Service on the Re-issue Date, coverage for the insured will be determined on the basis of the prior policy and any subsequent amendments until the insured returns to Active Service.

Policy Aggregate Maximum $2,500,000
Applies To All benefits provided by this Policy

Not more than the Policy Aggregate Maximum specified above will be paid for all Covered Losses for all Covered Persons as the result of any one Covered Accident. If this amount does not allow all Covered Persons to be paid the amounts this policy otherwise provides, the amount paid will be the proportion of the Covered Person's loss to the total of all losses, multiplied by the Policy Aggregate Maximum.

Eligible Persons: Class 3 - All active, full-time Employees of the Employer regularly working a minimum of 30 hours per week, excluding Employees classified as Executives, Organ Transplant Physicians, Organ Transplant Nurses and Organ Transplant Team Members.

CONDITIONS OF COVERAGE
The benefits provided by this Policy will be paid, subject to applicable conditions, limitations and exclusions, under the following coverages.

Business Travel Coverage
Personal Deviations covered No

Exposure and Disappearance Coverage

BA-01-CE1100.00

ACCIDENTAL DEATH AND DISMEMBERMENT BENEFITS

Principal Sum: $100,000
Loss must occur within: 365 days of the Covered Accident

SCHEDULE OF COVERED LOSSES

Covered Loss	Benefit
Loss of Life	100% of the Principal Sum
Loss of Two or More Hands or Feet	100% of the Principal Sum
Loss of Sight of Both Eyes	100% of the Principal Sum
Loss of One Hand or One Foot and Sight in One Eye	100% of the Principal Sum
Loss of Speech and Hearing (in both ears)	100% of the Principal Sum
Quadriplegia	100% of the Principal Sum
Paraplegia	75% of the Principal Sum
Hemiplegia	50% of the Principal Sum
Uniplegia	25% of the Principal Sum

Covered Loss	Benefit
Coma	
Monthly Benefit	1% of the Principal Sum
Number of Monthly Benefits	11
When Payable	At the end of each month during which the Covered Person remains comatose
Lump Sum Benefit	100% of the Principal Sum
When Payable	Beginning of the 12th month
Loss of One Hand or Foot	50% of the Principal Sum
Loss of Sight in One Eye	50% of the Principal Sum
Loss of Speech	50% of the Principal Sum
Loss of Hearing (in both ears)	50% of the Principal Sum
Severance and Reattachment of One Hand or Foot	50% of the Principal Sum
Loss of Thumb and Index Finger of the Same Hand	25% of the Principal Sum
Loss of all Four Fingers of the Same Hand	25% of the Principal Sum
Loss of all the Toes of the Same Foot	20% of the Principal Sum

Age Reductions

The Covered Person's Accidental Death and Dismemberment Benefit will be reduced to the percentage of his Benefit in effect on the date preceding the first reduction, as shown below.

Age	Percentage of Benefit Amount
65 but less than 70	65%
70 but less than 75	45%
75 but less than 80	30%
80 and over	20%

ADDITIONAL ACCIDENTAL DEATH AND DISMEMBERMENT BENEFITS

Any benefits payable under these Additional Accident Benefits shown below are in addition to any other Accidental Death and Dismemberment benefits payable.

ACCIDENTAL BURN AND DISFIGUREMENT BENEFIT

75-100% Body Disfigurement	100% of the Principal Sum
50-74% Body Disfigurement	75% of the Principal Sum
25-49% Body Disfigurement	50% of the Principal Sum
Burn Classification	second degree

Reconstructive or Cosmetic Surgery must be performed within 12 months of a Covered Accident.

HEPATITIS C OCCUPATIONAL DUTIES ACCIDENT BENEFIT

Benefit	25% of the Principal Sum subject to a maximum of $20,000

HIV OCCUPATIONAL ACCIDENT

Benefit	25% of the Principal Sum subject to a maximum of $20,000

SEATBELT AND AIRBAG BENEFIT

Seatbelt Benefit	10% of the Principal Sum subject to a maximum of $10,000
Airbag Benefit	10% of the Principal Sum subject to a maximum of $10,000
Default Benefit	$1,000

BA-01-1101.00

GENERAL DEFINITIONS

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

Aircraft
A vehicle which:
1. has a valid certificate of airworthiness; and
2. is being flown by a pilot with a valid license to operate the Aircraft.

Covered Accident
A sudden, unforeseeable, external event that results, directly and independently of all other causes, in a Covered Injury or Covered Loss and meets all of the following conditions:
1. occurs while the Covered Person is insured under this Policy;
2 occurs under one of the Conditions of Coverage specified in the *Schedule of Benefits;*
3. is not contributed to by disease, Sickness, or mental or bodily infirmity;
4. is not otherwise excluded under the terms of this Policy.

Covered Injury
Any bodily harm that results, directly and independently of all other causes, from a Covered Accident.

Covered Person
An Eligible Person, as defined in the *Schedule of Benefits*, for whom required premium has been paid when due and for whom coverage under this Policy remains in force.

Employee
An Employee of the Employer who is in one of the Covered Classes.

Employer
The Policyholder and any affiliates, subsidiaries or divisions shown in the S*chedule of Affiliates* covered under this Policy on its effective date or a later date agreed to by Us.

He, His, Him
Refers to any individual, male or female.

Personal Deviation
An activity which:
1. is neither reasonably related to or incidental to the purpose of travel for which coverage is provided by this Policy; and
2. the Covered Person performs before, during or after covered travel.

When coverage is provided during a Personal Deviation, the time period covered is shown in the *Conditions of Coverage* section of the *Schedule of Benefits.*

Physician
A licensed health care provider practicing within the scope of his license and rendering care and treatment to the Covered Person that is appropriate for the condition and locality, and who is not:
1. the Covered Person;
2. a parent, sibling, spouse or child of either the Covered Person or the Covered Person's spouse;
3. a person living in the Covered Person's household;
4. a person employed or retained by the Policyholder; or
5. a person providing homeopathic, aroma-therapeutic, or herbal therapeutic services.

Policyholder
The entity, named on this Policy’s face page, to which We issue this Policy.

Private Passenger Automobile
A validly registered, four wheel private passenger car, including Policyholder-owned cars, campers, motor homes, station wagons, sport utility vehicles, pick-up trucks and van-type cars that are not licensed commercially or being used for commercial purposes. Any vehicle being used as a taxicab, bus, or other public conveyance will not be considered a Private Passenger Automobile.

Sickness
A physical or mental illness, including pregnancy.

We, Us, Our
Life Insurance Company of North America

BA-01-1200.47

ELIGIBILITY, EFFECTIVE DATE AND TERMINATION PROVISIONS

Policy Effective Date
The Insurance Company agrees to provide Accident Insurance Benefits described in this Policy in consideration of the Policyholder's application and payment of the Initial Premium when due. Insurance begins on the Policy Effective Date shown on this Policy's first page.

Effective Date for Newly-Acquired Affiliates
Insurance becomes effective for any newly-acquired affiliate of the Policyholder on the date it is acquired, if: We have been notified in writing within the time period specified in the *Schedule of Affiliates* and have agreed to provide insurance, and additional premium has been paid when due. If We are not notified within the required time period, insurance for the affiliate will become effective on the date we agree in writing to insure it and receive any additional premium due. Individuals who are employees of an affiliate on its effective date of insurance under this Policy will be eligible for insurance on that date.

Eligibility
A person is eligible for insurance under this Policy when he meets the definition of Eligible Person shown in the *Schedule of Benefits.* An Eligible Person may be insured under only one Covered Class, even though he may be eligible under more than one Covered Class.

Effective Date for Individuals
Insurance becomes effective for the Eligible Person on the latest of the following dates:
1. the Policy Effective Date;
2. the date the person becomes eligible.

In no event will insurance for the Eligible Person become effective before the Policy Effective Date.

Effective Date of Changes
Any increase or decrease in the amount of insurance for the Covered Person resulting from:
1. a change in benefits provided by this Policy; or
2. a change in the Employee's Covered Class will take effect on the date of such change.

Termination of Insurance
Insurance for the Covered Person will end on the earliest of:
1. the date the person is no longer in an Eligible Class; and
2. the date the person enters full time active duty in any Armed Forces. We will refund any premium paid for any period of active duty when We receive proof of active duty. Active duty does not include Reserve or National Guard duty for training; and
3. the end of the period for which the last premium is paid; and
4. the date this Policy ends.

Termination does not affect a claim for a Covered Loss due to a Covered Accident that occurs before the termination date. However, in no instance will benefits extend beyond the earliest of:
1. the end of the Benefit Period; and
2. the date benefits equal to any applicable Benefit Limit, as shown in the *Schedule of Benefits,* have been paid; and
3. the date benefits equal to any applicable Policy Aggregate Maximum, as shown in the *Schedule of Benefits,* have been paid.

BA-01-1300.00

COMMON EXCLUSIONS

In addition to any benefit-specific exclusion, benefits will not be paid for any Covered Injury or Covered Loss which directly or indirectly, in whole or in part, is caused by or results from any of the following unless coverage is specifically provided for by name in the *Conditions of Coverages* and *Description of Indemnity Benefits* sections.

1. Intentionally self-inflicted Injury, suicide or any attempt thereat while sane or insane;
2. commission or attempt to commit a felony or an assault;
3. commission of or active participation in a riot or insurrection;
4. declared or undeclared war or act of war, not including terrorist act;
5. flight in, boarding or alighting from an Aircraft or any craft designed to fly above the Earth's surface:
    a. except as a fare-paying passenger on a regularly scheduled commercial or charter airline;
    b. being flown by the Covered Person or in which the Covered Person is a member of the crew;
    c. being used for:
        i. crop dusting, spraying or seeding, giving and receiving flying instruction, fire fighting, sky writing, sky diving or hang-gliding, pipeline or power line inspection, aerial photography or exploration, racing, endurance tests, stunt or acrobatic flying; or
        ii. any operation that requires a special permit from the FAA, even if it is granted (this does not apply if the permit is required only because of the territory flown over or landed on);
    d. an ultra-light or glider;
    e. being used by any military authority, except an Aircraft used by the Air Mobility Command or its foreign equivalent;
    f. being used for the purpose of parachuting or skydiving;
    g. designed for flight above or beyond the earth's atmosphere;
6. Sickness, disease, bodily or mental infirmity, bacterial or viral infection or medical or surgical treatment thereof, including exposure, whether or not accidental, to viral, bacterial or chemical agents except for any bacterial infection resulting from an accidental external cut or wound or accidental ingestion of contaminated food;
7. travel in any Aircraft owned, leased or controlled by the Policyholder, or any of its subsidiaries or affiliates. An Aircraft will be deemed to be 'controlled' by the Policyholder if the Aircraft may be used as the Policyholder wishes for more than 10 straight days, or more than 15 days in any year;
8. voluntary ingestion of any narcotic, drug, poison, gas or fumes, unless prescribed or taken under the direction of a Physician and taken in accordance with the prescribed dosage;
9. a Covered Accident that occurs while engaged in the activities of active duty service in the military, navy or air force of any country or international organization. Covered Accidents that occur while engaged in Reserve or National Guard training are not excluded until training extends beyond 31 days;
10. operating any type of vehicle while under the influence of alcohol or any drug, narcotic or other intoxicant including any prescribed drug for which the Covered Person has been provided a written warning against operating a vehicle while taking it. Under the influence of alcohol, for purposes of this exclusion, means intoxicated, as defined by the law of the state in which the Covered Accident occurred.

In addition, benefits will not be paid for services or treatment rendered by any person who is:
1. employed or retained by the Policyholder;
2. living in the Covered Person's household;
3. a parent, sibling, spouse or child of either the Covered Person or the Covered Person's spouse;
4. the Covered Person.

BA-01-1403.47

CLAIM PROVISIONS

Beneficiary
The beneficiary is the person or persons the Covered Person names or changes on a form executed by him and satisfactory to Us. This form may be in writing or by any electronic means agreed upon between Us and the Policyholder. Consent of the beneficiary is not required to affect any changes, unless the beneficiary has been designated as an irrevocable beneficiary, or to make any assignment of rights or benefits permitted by this Policy.

A beneficiary designation or change will become effective on the date the Covered Person executes it. However, We will not be liable for any action taken or payment made before We record notice of the change at our Home Office.

If more than one person is named as beneficiary, the interests of each will be equal unless the Covered Person has specified otherwise. The share of any beneficiary who does not survive the Covered Person will pass equally to any surviving beneficiaries unless otherwise specified.

If there is no named beneficiary or surviving beneficiary, or if the Covered Person dies while benefits are payable to him, We may make direct payment to the first surviving class of the following classes of persons:
1. spouse;
2. child or children;
3. parents;
4. siblings;
5. estate of the Covered Person.

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

Legal Actions
No action at law or in equity will be brought to recover benefits under this Policy less than 60 days after satisfactory proof of loss has been furnished as required by this Policy. No such action will be brought after expiry of three years from the time proof of loss is required to be furnished.

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

Payment of Claims
All benefits will be paid in United States currency. Benefits for loss of life will be payable in accordance with the Beneficiary provision and these Claim Provisions. All other proceeds payable under this Policy, unless otherwise stated, will be payable to the Covered Person or to his estate. If any payee of benefits is a minor or otherwise legally incompetent, we will pay benefits to the person designated as his legal guardian or conservator.

If We are to pay benefits to the estate or to a person who is a minor or otherwise incapable of giving a valid release, We may pay up to $1,000 to a relative by blood or marriage whom We believe is equitably entitled. Any payment made by Us in good faith pursuant to this provision will release the Company for that portion of the benefit that has been paid.

Claims Experience
Upon the request of the Policyholder, We will provide a complete record of the Policyholder's medical claims experience or medical costs incurred under this policy. This record shall include all claims incurred for the lesser of (i) the period of time since the policy was issued or (ii) the period of time since the policy was last renewed, reissued or extended, if already issued. This record shall be made available promptly to the Policyholder upon request made not less than 30 days prior to the date upon which the premiums or contractual terms of the policy may be amended. Nothing in this section shall require the disclosure of personal or privileged information about an individual that is protected from disclosure under Chapter 6 of

Title 38.2 of the Virginia Annotated Code, or under any other applicable federal or state law or regulation. No policyholder shall be required to pay for information requested pursuant to this section.

Physical Examination and Autopsy
We, at Our own expense, have the right and opportunity to examine the Covered Person when and as often as We may reasonably require while a claim is pending and to make an autopsy in case of death where it is not forbidden by law.

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

Recovery of Overpayment
If benefits are overpaid, We have the right to recover the amount overpaid by either of the following methods.
1. A request for lump sum payment of the overpaid amount.
2. A reduction of any amounts payable under this Policy.

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

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

ADMINISTRATIVE PROVISIONS

Premiums
Premium rates are expressed in, and premiums are payable in, United States currency. The premiums for this Policy will be based on the rates set forth in the *Rate Table*, the plan and amounts of insurance in effect for Covered Persons and the premium mode selected, as shown in the *Schedule of Benefits*. If Your coverage amounts are reduced due to age, premium will be based on the amounts of coverage in force on the day after the reduction took place. We will provide notifications of premiums due or premium changes, by mail to the most current address in our files, to the Policyholder.

Premium Rate Changes
We may change premium rates at the end of any Policy Term or any Premium Rate Guarantee Period with at least 31 days advance notice mailed to the last known address of the Policyholder. We will not increase premium rates more frequently than annually, unless certain changes shown in the Policy occur.

Any increase or decrease in rate will take effect on the date of the applicable change specified above. A pro rata adjustment will apply from the date of the change to the end of any period for which premium has been paid.

BA-01-CE1601.00

GENERAL PROVISIONS

Assignment
We will be bound by an assignment of the Covered Person's insurance under this Policy only when the original assignment or a certified copy of the assignment, signed by the Covered Person and any irrevocable beneficiary, is filed with Us. The assignee may exercise all rights and receive all benefits assigned only while the assignment remains in effect and insurance under this Policy for the Covered Person remains in force.

This insurance may not be levied on, attached, garnisheed, or otherwise taken for a person's debts unless contrary to law.

Clerical Error
A person's coverage will not be affected by error or delay in keeping records of insurance under this Policy. If such error or delay is found, We will adjust the premium fairly.

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

Misstatement of Fact
If the Policyholder has misstated any fact, all amounts payable under this Policy will be such as the premium paid would have purchased had such fact been correctly stated.

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

BA-01-CE1700.47

CONDITIONS OF COVERAGE

This Section describes the Conditions of Coverage under which benefits provided by this Policy become payable. Any benefits are payable only once, even though more than one Condition of Coverage may apply. Please read these and the *Common Exclusions* sections in order to understand all of the terms, conditions and limitations of coverage.

BA-01-2000.00

BUSINESS TRAVEL COVERAGE

We will pay benefits provided by this Policy, subject to all applicable conditions and exclusions, if the Covered Person suffers a Covered Loss caused, directly and independently of all other causes, by a Covered Accident which occurs while the Covered Person is:

1. travelling:
   a. on business of the Policyholder; and
   b. in the course of the business of the Policyholder; and
   c. on a trip authorized in advance by the Policyholder; and
   d. away from the premises of the Policyholder; or
2. making a Short Stay away from the Policyholder's premises in his City of Permanent Assignment.

Definitions
For purposes of this coverage:

Short Stay means a trip on business for the Employer and authorized in advance by the Employer and lasting less than 60 days.

City of Permanent Assignment means the city where the Covered Person normally works.

Exclusions
Coverage for business travel is not provided during any of the following:

1. normal commuting between the Covered Person's home and place of work;
2. travel to another location where the Covered Person is expected to be assigned for more than 60 days;
3. any activity not authorized or organized, or not reimbursable, by the Policyholder;
4. the Covered Person's Personal Deviation, unless shown in the *Schedule of Benefits*;
5. the Covered Person's driving any vehicle or Private Passenger Automobile for pay or hire;
6. Business Travel Coverage is not in effect while the Covered Person is performing job duties: (a) during work hours; and (b) in a residence work area, which are specified in a written telecommuting agreement between him and his employer.

Other exclusions that apply to this coverage are in the *Common Exclusions* Section.

BA-01-2003.00 2229a

EXPOSURE AND DISAPPEARANCE COVERAGE

We will pay benefits provided by this Policy, subject to all applicable conditions and exclusions, if the Covered Person suffers a Covered Loss which results, directly and independently of all other causes, from a Covered Accident that causes the Covered Person's unavoidable exposure to the elements following the forced landing, sinking, stranding or wrecking of a vehicle.

If the Covered Person disappears and is not found within one year from the date of wrecking, sinking or disappearance of the conveyance in which the Covered Person was riding in the course of a trip which would otherwise be covered under this Policy, it will be presumed that the Covered Person’s death resulted directly and independently of all other causes from a Covered Accident.

Travel or trip must have been authorized in advance by the Policyholder.

Exclusions
Exclusions that apply to this coverage are in the *Common Exclusions* Section.

BA-01-2006.00

DESCRIPTION OF INDEMNITY BENEFITS

This *Description of Indemnity Benefits* section describes the Accident Indemnity Benefits provided by this Policy. Benefit amounts, benefit periods and any applicable aggregate and benefit-specific maximums are shown in the *Schedule of Benefits.* Please read these and the *Common Exclusions* sections in order to understand all of the terms, conditions and limitations applicable to these Benefits.

BA-01-2200.00

ACCIDENTAL DEATH AND DISMEMBERMENT BENEFIT

Covered Loss We will pay the benefit for any one of the Covered Losses listed in the *Schedule of Benefits*, subject to all applicable conditions and exclusions, if the Covered Person suffers a Covered Loss resulting, directly and independently of all other causes, from a Covered Accident within the applicable time period specified in the *Schedule of Benefits*.

If the Covered Person sustains more than one Covered Loss as a result of the same Covered Accident, We will pay the Benefit for the Covered Loss for which the largest benefit is payable. If a Covered Accident causes the Covered Person's death, the total of all Benefits We will pay for Accidental Death and any other Covered Losses will not exceed the Principal Sum.

Definitions **Loss of a Hand or Foot** means complete Severance through or above the wrist or ankle joint.

Loss of Sight means the total, permanent Loss of Sight of one eye. The Loss of Sight must be irrecoverable by natural, surgical or artificial means.

Loss of Speech means total and permanent loss of audible communication which is irrecoverable by natural, surgical or artificial means.

Loss of Hearing means total and permanent loss of ability to hear any sound in both ears which is irrecoverable by natural, surgical or artificial means.

Loss of a Thumb and Index Finger of the Same Hand or Loss of Four Fingers of the Same Hand means complete Severance through or above the metacarpophalangeal joints of the same hand (the joints between the fingers and the hand).

Loss of Toes means complete Severance through the metatarsalphalangeal joint.

Paralysis or Paralyzed means total loss of use. A Physician must determine the loss of use to be complete and not reversible at the time the claim is submitted.

Quadriplegia means total Paralysis of both upper and lower limbs.

Hemiplegia means total Paralysis of the upper and lower limbs on one side of the body.

Paraplegia means total Paralysis of both lower limbs or both upper limbs.

Uniplegia means total Paralysis of one upper or one lower limb.

Coma means a profound state of unconsciousness from which the Covered Person is not likely to be aroused through powerful stimulation. The Coma must begin within 30 days of the Covered Accident, continue for 60 consecutive days and must be diagnosed and treated regularly by a Physician. Coma does not mean any state of unconsciousness intentionally induced during the course of treatment of a Covered Injury unless the state of unconsciousness results from the administration of anesthesia in preparation for surgical treatment of injuries sustained in that Covered Accident.

Severance means complete separation and dismemberment of the part from the body.

Exclusions Exclusions that apply to this benefit are in the *Common Exclusions* section.

BA-01-2202.00

ACCIDENTAL BURN AND DISFIGUREMENT BENEFIT

We will pay the benefit shown in the *Schedule of Benefits*, subject to all applicable conditions and exclusions, if the Covered Person suffers a Covered Injury that results in Disfigurement or loss of physical abilities, and that Covered Injury resulted, directly and independently of all other causes, from a Covered Accident. Disfigurement or loss of physical abilities must satisfy all of the conditions below.

1. Reconstructive or cosmetic surgery is required to restore the Covered Person's physical abilities or correct Disfigurement, within the time period specified in the *Schedule of Benefits.*
2. A Physician must determine that the burn satisfies all of the following:
   a. involves the minimum percentage shown in the *Schedule of Benefits*; and
   b. be classified as shown in the *Schedule of Benefits*; and
   c. results in Disfigurement or loss of physical abilities.

Definitions
For purposes of this benefit:
Disfigurement or Disfigured means spoiled or deformed appearance that can be corrected by means of reconstructive or cosmetic surgery.

Exclusions
Exclusions that apply to this benefit are in the *Common Exclusions* Section.

BA-01-2204.00

HEPATITIS C OCCUPATIONAL DUTIES ACCIDENT BENEFIT

We will pay the benefit shown in the *Schedule of Benefits*, subject to all applicable conditions and exclusions, when the Covered Person suffers a Covered Injury resulting, directly and independently of all other causes, from a Covered Accident. Such Covered Accident must occur during the performance of Occupational Duties and result in the Covered Person acquiring and testing positive for Hepatitis C within one year of the Covered Injury.

In order to receive this benefit, the Covered Person must satisfy all of the following:

1. submit an injury report to his employer, including any report required for purposes of any applicable Workers' Compensation Law, within 48 hours of a Covered Accident that occurs during the performance of Occupational Duties;
2. test negative for Hepatitis C within 48 hours of such Covered Accident;
3. test positive for Hepatitis C in a subsequent Blood Test within one year of the date of the Covered Accident.

Definitions For purposes of this benefit:
Occupational Duties means the performance of duties that are:

1. Normally performed on behalf of the Policyholder; and
2. Assisting, caring for or otherwise involved with, sick or injured persons.

Blood Test means a positive (reactive) Enzyme-linked Immunosorbent Assay (ELISA) test, confirmed by the Western Blot Test, or other tests that may be approved by the Centers for Disease Control and Prevention and accepted by Us.

Exclusions Exclusions that apply to this benefit are in the *Common Exclusions* Section.

BA-01-2246.00

HIV OCCUPATIONAL ACCIDENT BENEFIT

We will pay the benefit shown in the *Schedule of Benefits*, subject to all applicable conditions and exclusions, when the Covered Person suffers a Covered Injury resulting, directly and independently of all other causes, from a Covered Accident. Such Covered Accident must occur during the performance of Occupational Duties and result in the Covered Person acquiring and testing positive for Human Immunodeficiency Virus (HIV) antibodies within one year of the Covered Injury.

In order to receive this benefit, the Covered Person must satisfy all of the following:
1. submit an injury report to his employer, including any report required for purposes of any applicable Workers' Compensation Law, within 48 hours of a Covered Accident that occurs during the performance of Occupational Duties;
2. test negative for Human Immunodeficiency Virus (HIV) antibodies within 48 hours of such Covered Accident;
3. test positive for Human Immunodeficiency Virus (HIV) antibodies in a subsequent Blood Test within one year of the date of the Covered Accident.

Definitions
For purposes of this benefit:

Occupational Duties means the performance of duties that are:
1. Normally performed on behalf of the Policyholder; and
2. Assisting, caring for or otherwise involved with, sick or injured persons.

HIV means Human Immunodeficiency Virus, a virus that infects lymphocytes and other cells bearing the CD4 marker, the initial infection of which is known as acute retro viral syndrome.

Blood Test means a positive (reactive) Enzyme-linked Immunosorbent Assay (ELISA) test, confirmed by the Western Blot Test, or other tests that may be approved by the Centers for Disease Control and Prevention and accepted by Us.

Exclusions
Exclusions that apply to this benefit are in the *Common Exclusions* Section.

BA-01-2223.00

SEATBELT AND AIRBAG BENEFIT

We will pay the benefit shown in the *Schedule of Benefits*, subject to all applicable conditions and exclusions, when the Covered Person's death results, directly and independently of all other causes, from a Covered Accident while wearing a seatbelt and operating or riding as a passenger in a Private Passenger Automobile. An additional benefit is provided if the Covered Person was also positioned in a seat protected by a properly-functioning and properly deployed Supplemental Restraint System (Airbag).

Verification of proper use of the seatbelt at the time of the Covered Accident and that the Supplemental Restraint System properly inflated upon impact must be a part of an official police report of the Covered Accident or be certified, in writing, by the investigating officer(s) and submitted with the Covered Person's claim to Us.

If such certification or police report is not available or it is unclear whether the Covered Person was wearing a seatbelt or positioned in a seat protected by a properly functioning and properly deployed Supplemental Restraint System, We will pay a default benefit shown in the *Schedule of Benefits* to the Covered Person's beneficiary.

Definitions
For purposes of this benefit:

Supplemental Restraint System means an airbag that inflates upon impact for added protection to the head and chest areas.

Exclusions
Exclusions that apply to this benefit are in the *Common Exclusions* Section.

BA-01-2233.00

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

DEPENDENT COVERAGE RIDER

This Rider is attached to and made part of this Policy. It is subject to all of this Policy's provisions that do not conflict with its provisions.

Policyholder: Inova Health System
Policy Number: ABL 980092

We will pay an Accidental Death and Dismemberment Benefit specified in this Rider's *Schedule of Benefits* if a Spouse or Dependent Child of the Covered Person suffers a Covered Loss which results, directly and independently of all other causes, from a Covered Accident that occurs:

1. within the time period specified in this Policy's *Schedule of Benefits*; and
2. during Business Travel for which the Policyholder pays part or all of the cost; and
3. under circumstances described in one of the Conditions of Coverage specified in this Rider's *Schedule of Benefits.*

Benefits payable for a Dependent's Covered Loss will equal the applicable Principal Sum shown in this Rider's *Schedule of Benefits* multiplied by the percentage applicable to the Covered Loss, as shown in this Policy's *Schedule of Benefits.*

RIDER SCHEDULE OF BENEFITS CLASS 3

The *Rider Schedule of Benefits* provides a brief outline of the coverage and benefits provided by this Rider. Please read all of the provisions of this rider in addition to the provisions of this Policy for full details.

Conditions of Coverage

Business Travel for Dependents

Benefits

Covered Class	Principal Sum
1. Spouses of Class 3 Covered Persons	$10,000
2. Dependent Children of Class 3 Covered Persons	$5,000

A Spouse's Principal Sum will reduce as specified in the *Age Reductions* section of the *Accidental Death and Dismemberment* section of this Policy's *Schedule of Benefits.*

RIDER DESCRIPTION OF CONDITIONS OF COVERAGE

Business Travel Coverage for Dependents

We will pay the Benefit shown in the *Rider Schedule of Benefits*, subject to all of the conditions and exclusions applicable to Business Travel Coverage provided by this Policy, if a Dependent's Covered Loss results, directly and independently of all other causes, from a Covered Accident.

Business Travel Coverage for a Dependent begins when coverage for the Covered Person begins, or, if later, when a Dependent departs from his place of residence to join the Covered Person on the Covered Trip. Business Travel Coverage for a Dependent ends when coverage for the Covered Person ends, or, if earlier, when a Dependent arrives at his place of residence.

Definitions

Dependent means, for purposes of this Rider, a Covered Person's Spouse or Domestic Partner and Dependent Child, as each of those terms is defined below.

Dependent Child means a Covered Person's unmarried child who meets the following requirements:
1. A child from live birth to 19 years old;
2. A child who is 19 or more years old but less than **23** years old, enrolled in a school as a full-time student and primarily supported by the Covered Person
3. A child who is 19 or more years old, primarily supported by the Covered Person, and incapable of self-sustaining employment by reason of mental or physical handicap.
4. A child who is 19 or more years old, primarily supported by the Covered Person and is enrolled as a full-time student and is unable to continue as a full-time student due to a medical condition, then coverage shall continue for the child for a period of 12 months from the date the child ceases to be a full-time student, or the date the child no longer qualifies as a dependent child under the terms of the group policy.

A child, for purposes of this provision, includes the Covered Person's:
1. natural child;
2. adopted child, beginning with any waiting period pending finalization of the child's adoption. It also means the legally adopted child of the Covered Person's Spouse or Domestic Partner/Partner to a Civil Union provided the child is living with, and is financially dependent upon the Covered Person;
3. stepchild who resides with the Covered Person and is financially dependent upon the Covered Person;
4. child for whom the Covered Person is the court-appointed legal guardian, as long as the child resides with the Covered Person and depends on the Covered Person for financial support. Financial support means that the Covered Person is eligible to claim the dependent for purposes of Federal and State income tax returns;
5. a child of the Covered Person's Domestic Partner /Partner to a Civil Union, provided the child is living with, and is financially dependent upon the Covered Person.

Domestic Partner means a person who:
1. shares the covered Employee's permanent residence;
2. has resided with the covered Employee continuously for at least six months and is expected to reside with the covered Employee indefinitely;
3. is financially interdependent with the covered Employee in each of the following ways:
   a. by holding one or more credit or bank accounts, including a checking account, as joint owners;
   b. by owning or leasing their permanent residence as joint tenants.
4. has signed a Domestic Partner declaration with the covered Employee if the covered Employee resides in a jurisdiction which provides for a Domestic Partner declaration;
5. has not signed a Domestic Partner declaration with any other person within the last 12 months;
6. is no less than 18 years of age;
7. is not legally married to any other person;
8. is not a blood relative any closer than would prohibit legal marriage.

In addition to the above requirements, consent of either party due to the Domestic Partner relationship must not have been obtained by force, duress or fraud.

An employee may insure a Domestic Partner if all of the following conditions are met:
1. the covered Employee has not been married to any person within the past 12 months;
2. the Domestic Partner is the only person meeting this Policy's definition of Domestic Partner with respect to the Covered Person;
3. the covered Employee and the Domestic Partner furnish a notarized affidavit reflecting these requirements, and an agreement to notify Us if the requirements cease to be met, on a form acceptable to Us.

Spouse means the Covered Person's lawful spouse.

To Whom Payable Benefits payable under this Rider will be paid to the Covered Person. If the Covered Person does not survive the Dependent upon whose Covered Loss the Benefit is payable, We will pay the Covered Person's beneficiary, in accordance with the *Beneficiary* provision of this policy.

Exclusions This coverage will be in effect while a Dependent is accompanying the Covered Person during the Covered Person's Personal Deviation only if indicated in the *Schedule of Benefits*.

Other exclusions that apply to this Coverage are in the *Common Exclusions* section.

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

CLAIM PAYMENT AMENDATORY RIDER

Policyholder: Inova Health System
Policy No.: ABL 980092 Effective Date: January 1, 2020

This Amendatory Rider is attached to and made a part of the Policy/Certificate specified above.

The Policy/Certificate is amended as follows under:

CLAIM PROVISIONS

Manner of Payment of Claims
The Policyholder authorizes that any benefit payment due as a lump sum of $5,000 or more shall be credited to a draft account with the Insurance Company, in the name of the beneficiary. The beneficiary may withdraw the entire proceeds at any time by issuing one or more drafts, or may withdraw lesser amounts, subject to a minimum account balance set by the Insurance Company from time to time. Interest shall be credited to such account at rates as determined from time to time by the Insurance Company.

ADMINISTRATIVE PROVISIONS

Draft Accounts
The Insurance Company shall be entitled to retain, as part of its compensation, any earnings on draft accounts created in connection with benefit claims, in excess of interest credited under the terms of the policy.

Life Insurance Company of North America

William J. Smith, President

RA-BA-1000.00

LIFE INSURANCE COMPANY OF NORTH AMERICA
1601 CHESTNUT STREET PHILADELPHIA, PA 19192

AMENDATORY RIDER
TRAVEL ASSISTANCE SERVICES

Policyholder: Inova Health System
Policy No.: ABL 980092 Effective Date: January 1, 2020

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

Travel Assistance Services

We will pay the cost of the Covered Services described below, subject to all applicable conditions and exclusions, resulting, directly and independently of all other causes, from a Covered Medical Emergency. The Covered Medical Emergency must occur and Covered Services must be incurred during the course of travel or other activities covered by the Policy, and while the Covered Person is either more than 100 miles from his permanent residence or outside of his country of permanent residence.

To obtain services, the Covered Person must contact Us or our authorized service provider at the phone number provided by the Policyholder. All services must be provided by our authorized service provider unless authorized by Us.

Covered Services

Covered Services includes the reasonable costs for medically necessary services provided by Us or by our authorized service provider, and which are provided by our authorized service provider unless authorized by Us, for any of the following.

Emergency Medical Evacuation

Medically necessary expenses for Transportation of the Covered Person to the nearest adequate medical facility, if adequate medical care is not available at the Covered Person's location.

Cost of any medically necessary services or equipment that the Covered Person receives during transportation covered under this provision.

Cost of transporting qualified and licensed medical professional(s) or an Immediate Family Member or a Travel Companion if medically required to escort the Covered Person during transportation covered under this provision.

Transportation will be provided by medically equipped specialty aircraft, commercial airline, train or ambulance depending upon the medical needs and available transportation specific to each case.

Return Transportation

Any increase in the cost of the Covered Person's return transportation to his or her home or work location following emergency medical evacuation covered under this benefit, above the cost of the Covered Person's original scheduled return transportation.

Any increased cost of the transportation for an Immediate Family Member or Travel Companion of the Covered Person to return to his or her primary residence, if he or she accompanied the Covered Person on the trip where the emergency occurred, and was as a result not able to return to his or her primary residence when originally scheduled.

Unless it is medically necessary for another means of transportation to be provided, such return transportation costs will be covered for the same class of travel as the Covered Person's original transportation.

In the case of an Immediate Family Members who is a child under age 18, who is left without a parent, guardian or other adult to accompany the child, we will cover the reasonable cost of an escort to accompany the child to the nearest airport. If under the applicable rules of the airline, the child is too young to travel unaccompanied by an adult, we will pay the round trip economy airfare for an adult family member from the child's place of residence to the airport nearest the child.

Immediate Family Member Visit

Expenses for an Immediate Family Member or Friend of the Covered Person to visit the Covered Person during hospitalization away from the Covered Person's primary residence, if the Covered Person is hospitalized or expected to remain hospitalized for 7 or more consecutive days following emergency medical evacuation covered under this benefit. Such expenses shall be limited to one person only, and shall include round-trip economy airfare, and an allowance of $150.00 per day for up to 7 days for meals and lodging.

If a Dependent Child is evacuated, we will pay the expenses of an adult Immediate Family Member who accompanied the Dependent Child on the trip where the emergency occurred, to accompany the Dependent Child during the evacuation and during the Dependent Child's return to his or her place of residence. If the Dependent Child was not accompanied by an adult Immediate Family Member on the trip where the emergency occurred, we will pay expenses described in the preceding paragraph, without regard to the expected duration on the hospitalization.

Repatriation of Remains

If the Covered Person dies as a result of a Covered Medical Emergency, or during a Medical Evacuation covered by this Policy, the following expenses will be covered:

1. Embalming;
2. Cremation in the locality where death occurred and urn for return ashes;
3. A container appropriate for transportation of remains;
4. Autopsy if required by law;
5. Expenses of securing documentation necessary for return of remains;
6. Transportation of the body or remains to the Covered Person's place of permanent residence.

Definitions

"Covered Medical Emergency" means an injury, illness or disease diagnosed by a Physician which causes severe or acute symptoms that, if not provided with immediate care or treatment, would reasonably be expected to result in serious deterioration of the Covered Person's health or place his life in jeopardy; and which first manifests itself suddenly and unexpectedly during the travel or other hazards covered by the Policy.

"Immediate Family Member" means a spouse, parent, child, step-parent, step-child, brother or sister, step-brother or step-sister, grandparent, or Domestic Partner.

"Travel Companion" means an individual, other than an Immediate Family Member, who accompanied the Covered Person on the trip where the emergency occurred.

"Friend" means a person chosen by the Covered Person, other than an Immediate Family Member who is able to visit the Covered Person.

Limitations

Covered Expenses are secondary to, and in excess of, any expenses for medical or transportation services paid or payable under any workers' compensation law.

No payment will be made for services without authorization of those services by Us or the express written approval of Our designated approved vendor.

If coverage for these services is provided under more than one policy issued by the Insurance Company, we will only provide or pay for these services under one such policy.

Exclusions

The exclusions listed in the Policy's Common Exclusions section will not apply to Medical Evacuation and Repatriation Expenses, except for exclusions relating to war or acts of war, suicide or intentionally self-inflicted injury. In addition, the following exclusions apply specifically to this coverage:

1. Non-Emergency, routine or minor medical problems, tests and exams where there is no clear or significant risk of death or imminent serious Injury or harm to the Covered Person;
2. a condition which would allow for treatment at a future date convenient to the Covered Person and which does not require Emergency evacuation or repatriation;
3. expenses incurred if a purpose of the Covered Person's trip is to obtain medical treatment;
4. services provided for which no charge is normally made, in the absence of insurance;
5. transportation for the Covered Person's vehicle and/or other personal belongings;
6. Initial transport by ambulance following a Covered Medical Emergency occurring in the United States;
7. services incurred while serving in the armed forces of any country;
8. services required or obtained in any location which, due to war, insurrection, natural disaster or other reasons, is not reasonably accessible to our designated service provider, unless approved in advance by us;
9. claim payments that are illegal under applicable law;
10. expenses which are paid or payable under any workers' compensation law;
11. Medical care or services scheduled for your or your doctor's convenience which are not considered an emergency.

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

LIFE INSURANCE COMPANY OF NORTH AMERICA

William J. Smith, President

BA-01-2410b.VA

SUPPLEMENTAL INFORMATION
for

Inova Business Travel Accident ("Plan")

required by the Employee Retirement
Income Security Act of 1974

As a Plan participant in Inova Health System's Plan, you are entitled to certain information, rights and protection under the Employee Retirement Income Security Act of 1974 (ERISA).

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

IMPORTANT INFORMATION ABOUT THE PLAN

- The Plan is established and maintained by Inova Health System, the Plan Sponsor.
- The Employer Identification Number (EIN) is 54-0620889.
- The Plan Number is 502.
- The Insurance Plan is administered directly by the Plan Administrator with benefits provided, in accordance with the provisions of the group insurance contract, ABL 980092 ("Policy"), issued by LIFE INSURANCE COMPANY OF NORTH AMERICA ("Insurance Company").
- The Plan Administrator is: Inova Health Care Services
  8110 Gatehouse Road
  Falls Church, VA 22042
  877-466-8201

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

YOUR RIGHTS AS SET FORTH BY ERISA

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

Receive Information About Your Plan and Benefits

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

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

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

Prudent Actions by Plan Fiduciaries

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

Enforce Your Rights

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

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

Assistance with Your Questions

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

WHAT YOU SHOULD DO AND EXPECT IF YOU HAVE A CLAIM

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

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

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

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

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

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

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

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

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

A written request for appeal must be received by the Insurance Company within 180 days from the date the claimant received the adverse decision. If an appeal request is not received within that time, the right to appeal will have been waived. The Insurance Company has 45 days from the date it receives a request for appeal to provide its decision. Under special circumstances, the Insurance Company may require more time to review the claim and can extend the time for decision, once, by an additional 45 days. If this should happen, the Insurance Company must provide the extension notice, in writing, before expiration of the initial decision period, indicating the special circumstances and the date a decision is expected. If the extension is made because additional information must be furnished, the claimant has 45 days within which

to provide the requested information and the time for the Insurance Company's decision shall be tolled (stopped) from the date on which the notification of the extension was sent until the date the Insurance Company receives the claimant's response or upon the date the requested information is required to be furnished expires, whichever is sooner.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Class 3

03/2021