Toyoda Gosei North America Corporation

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: 1-800-524-0542
Mail: P.O. Box 8517, Philadelphia, PA 19176

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

Call with a question: 1-800-252-3439
File a complaint: www.tdi.texas.gov
Email: ConsumerProtection@tdi.texas.gov
Mail: MC 111-1A, P.O. Box 149091, Austin, TX 78714-9091

¿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: 1-800-524-0542
Dirección postal: P.O. Box 8517, Philadelphia, PA 19176

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

Llame con sus preguntas al: 1-800-252-3439
Presente u na queja en: www.tdi.texas.gov
Correo electrónico: ConsumerProtection@tdi.texas.gov
Dirección postal: MC 111-1A, P.O. Box 149091, Austin, TX 78714-9091

Disclosure Notice

FOR ARKANSAS RESIDENTS

Prudential's Customer Service Office:

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

Telephone: 1-844-455-1002

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
1-844-455-1002

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

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

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

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.

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:
Customer Services address:
Voluntary Benefit Services
P.O. Box 696035
San Antonio, TX 78269-6035
1-844-455-1002

You can also contact the **OFFICE OF THE COMMISSIONER OF INSURANCE**, a state agency which enforces Wisconsin's insurance laws, and file a complaint. You can file a complaint electronically with

the **OFFICE OF THE COMMISSIONER OF INSURANCE** at its website at *http://oci.wi.gov/,* or by contacting:

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

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 Group Insurance Certificate Schedule of Benefits shows the Contract Holder and the Group Contract Number(s).

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

Coverage and Amounts: The available Coverage and the amounts of insurance are described in the Group Insurance Certificate.

If You are insured, this document is Your Group Insurance Certificate. It replaces any older Group Insurance Certificates issued to You for the Coverages in the Group Insurance Certificate's Schedule of Benefits. All Benefits are subject in every way to the entire Group Contract which includes the Group Insurance Certificate.

Renewability. The Group Insurance Certificate is guaranteed renewable. We will not change any provision of the Group Insurance 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 the date it would otherwise take effect, and Prudential will refund Your contributions, if any.

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 CERTIFICATE IS NOT MEDICAL COVERAGE. It does NOT provide any type of medical Coverage and is not a substitute for medical Coverage or disability insurance.

The Group Contract provides critical illness Coverage ONLY.

VOLUNTARY CRITICAL ILLNESS COVERAGE

Welcome Message

We are pleased to present You with this Group Insurance Certificate. It describes the Program of benefits we have arranged for You and what You have to do to be covered for these benefits.

We believe this Program provides worthwhile protection for You and Your family.

Please read this Group Insurance Certificate carefully. If You have any questions about the Program, we will be happy to answer them.

IMPORTANT NOTICE: This is Your Group Insurance Certificate. It is an important document and should be kept in a safe place.

IMPORTANT INFORMATION FOR RESIDENTS OF CERTAIN STATES: There are state-specific requirements that may change the provisions under the Coverage(s) described in this Group Insurance Certificate. If You live in a state that has such requirements, those requirements will apply to Your Coverage(s) and are made a part of Your Group Insurance Certificate. Prudential has a website that describes these state-specific requirements. You may access the website at www.prudential.com/etonline. When You access the website, You will be asked to enter Your state of residence and Your Access Code. **Your Access Code is** VCRI1**.**

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

TABLE OF CONTENTS

Schedule of Benefits

Covered Classes: The “Covered Classes" are these Employees of the Contract Holder (and its Associated Companies): All active, full-time Employees working a minimum of 30 hours per week.

Program Date: January 1, 2024. This Group Insurance Certificate describes the benefits under the Group Program as of the Program Date.

- This document is your Group Insurance Certificate. The Coverage in this Group Insurance Certificate 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.

This Group Insurance Certificate describes all of the options available under the Group Contract.

CRITICAL ILLNESS COVERAGE FOR YOU AND YOUR DEPENDENTS

This Coverage pays benefits for Critical Illnesses. Some Critical Illnesses are not covered or are limited. The items below are only highlights of Your coverage. For a full description please read this entire Group Insurance Certificate.

Benefits for a Critical Illness are payable only if the person is diagnosed by a Doctor with the Critical Illness while a Covered Person.

Not all such Critical Illnesses are covered. See the Exclusions section.

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. Benefits are subject to the Lifetime Maximum Benefit as described below.

Critical Illness:	**Percent of the Person's Amount of Insurance or Benefit Amount Payable**
Alzheimer’s Disease	100%
Benign Brain Tumor	100%
Blindness	100%
Cancer - Invasive	100%
Cerebral Palsy	100%
Cleft Lip or Cleft Palate	100%
Coma	100%
Congenital Heart Disease	100%
Cystic Fibrosis	100%
Deafness	100%
Down Syndrome	100%
Gaucher Disease Type 2 or Type 3	100%
Glycogen Storage Disease (type 4)	100%

Heart Attack	100%
Infantile Tay Sachs Disease	100%
Loss of Speech	100%
Major Organ Failure	100%
Muscular Dystrophy	100%
Niemann Pick Disease	100%
Occupational Exposure to HIV Confirmed Diagnosis Benefit	100%
Paralysis of Limbs	100%
Pompe Disease	100%
Renal (Kidney) Failure	100%
Severe Coronary Artery Disease	100%
Sickle Cell Anemia	100%
Spina Bifida	100%
Stroke	100%
Third Degree Burns	100%
Type 1 Diabetes	100%
Zellweger Syndrome	100%
Autism	25%
Cancer - Noninvasive	25%
Coronary Artery Bypass Graft	25%
Crohn's Disease	25%
Multiple Sclerosis	25%
Transient Ischemic Attack (TIA)	25%
Cancer - Skin Cancer	$250

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

Recurrence of a Critical Illness other than Skin Cancer means:

(1) a person is positively diagnosed by a Doctor as having an additional occurrence or recurrence 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 recurrence is more than 180 days after the date of the last medical treatment for the previous occurrence.

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

Recurrence of Skin Cancer means a person is positively diagnosed by a Doctor as having an additional occurrence or recurrence of Skin Cancer for which a benefit was paid under this Coverage.

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

Lifetime Maximum Benefit for all Critical Illnesses: No more than the Lifetime Maximum Benefit will be paid for all of a Covered Person's Critical Illnesses.

Critical Illness benefits that do not contribute to the Lifetime Maximum Benefit and are not subject to the Lifetime Maximum Benefit include:

- Skin Cancer

The Lifetime Maximum Benefit for a Covered Person is 500% of the person's Amount of Insurance.

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	$20,000.
Option 3	$30,000.

Your **Claims Incurred During Continuation Eligibility Period**

A claim may be payable under this Section if:

(1) the claim is incurred within 31 days after You cease to be a Covered Person; and

(2) You are entitled (under the “When Your Insurance Ends” Section) to continue Your Coverage; and

(3) the claim qualifies for payment based on the provisions defined within this Group Insurance Certificate

The amount of any benefit payable is equal to the amount of the benefit that would have been payable as a member of the active class. It is payable even if You did not elect to continue Your Coverage. It is payable when Prudential receives written proof of claim in addition to any required substantiating documentation that demonstrates that the claim qualifies for payment based on the definitions, requirements, and exclusions outlined in this Group Insurance Certificate.

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	
Option 1	$10,000.
Option 2	$20,000.
Option 3	$30,000.
Your Children	
Option 1	$5,000.
Option 2	$10,000.
Option 3	$15,000.

*The Amount of Insurance on Your Qualified Dependent Spouse 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.

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

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

TO WHOM PAYABLE:

Critical Illness benefits are payable to You with these exceptions:

(1) If You are not living, benefits that are unpaid at Your death will be payable to the first of the following: Your (a) surviving Spouse; (b) surviving child(ren) in equal shares; (c) surviving parents in equal shares; (d) surviving siblings in equal shares; (e) estate.

(2) If You have assigned the insurance, benefits will be paid to the assignee. (See the Limits on Assignments section.)

OTHER INFORMATION

Contract Holder: TOYODA GOSEI NORTH AMERICA CORPORATION

Group Contract No.: GC-70367-MI

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 Group Insurance Certificate 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

WHEN YOU HAVE A CLAIM

Each time a claim is made, it should be made without delay. Use a claim form and follow the instructions on the form.

If You do not have a claim form, contact Your Employer.

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.

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

Calendar Year: A year starting January 1.

Child/Children/Incapacitated Children: Please see the "Who is Eligible to Become Insured" section of this Group Insurance Certificate.

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

Contributory Insurance: Contributory Insurance is insurance for which the Contract Holder has the right to require your contributions.

Non-contributory Insurance: Is insurance for which the Contract Holder does not have the right to require Your contributions. The Schedule of Benefits shows whether insurance under the Coverage is Contributory Insurance or Non-contributory Insurance.

Coverage: A part of the Group Insurance Certificate 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 Condition: A Critical Illness.

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

Critical Illness: A condition or treatments listed in the Schedule for which a benefit is payable as described in this Group Insurance Certificate.

Dependents Insurance: Insurance on the person of a dependent.

Doctor: A coroner, medical examiner, or 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 or a Child, brother, sister, or parent of You or Your Spouse as a doctor for a claim that You send to us.

Employee: A person employed by the Employer; a proprietor or partner of 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.

Hospital: Hospital: An institution that meets either of these tests:

(1) It is accredited as a Hospital under the Hospital Accreditation Program of the Joint Commission on Accreditation of Healthcare Organizations.

(2) It is legally operated, has 24 hour a day supervision by a staff of Doctors, has 24 hour a day nursing service by registered graduate Nurses, and complies with (a) or (b):

   (a) It mainly provides general inpatient medical care and treatment of sick and injured persons by the use of medical, diagnostic and major surgical facilities. All such facilities are in it or under its control.

   (b) It mainly provides specialized inpatient medical care and treatment of sick or injured persons by the use of medical and diagnostic facilities (including X-ray and laboratory). All such facilities are in it, under its control, or available to it under a written agreement with a Hospital (as defined above) or with a specialized provider of those facilities.

But Hospital does not include a nursing home. Neither does it include an institution, or part of one, which: (1) is used mainly as a place for convalescence, rest, hospice, skilled nursing care or for the aged drug addicts; treatment or alcoholics; or (2) furnishes mainly homelike or Custodial Care, or training in the routines of daily living; or (3) is mainly a school; or (4) or solely providing psychiatric services to mentally ill patients.

Injury: Injury to the body of a Covered Person.

Premium: The amount that You are required to pay for Your insurance.

Prudential: The Prudential Insurance Company of America.

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

(1) your marriage or divorce;

(2) the death of your Spouse or child;

(3) the birth or adoption of your child;

(4) employment or termination of employment of your Spouse;

(5) switching from part-time to full-time Employee status (or vice versa) by you or your Spouse;

(6) you or your Spouse taking an unpaid leave of absence;

(7) a significant change in your health coverage that is attributable to your Spouse’s employment.

Sickness: Any disorder of the body or mind of a Covered Person, but not an Injury.

We, Us: The Prudential Insurance Company of America.

You, Your, Yours: An Employee.

Benefit Definitions

FOR YOU AND YOUR DEPENDENTS

This Coverage pays benefits for certain Critical Illnesses.

Alzheimer's Disease: Prudential will pay the amount shown in the Schedule of Benefits if a Covered Person is diagnosed with 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 Doctor is required as proof of claim.

Autism: Prudential will pay the amount shown in the Schedule of Benefits if a Dependent Child is first Diagnosed with Autism Spectrum Syndrome and if the Date of Diagnosis is while this Group Insurance Certificate is in force. No benefit is payable if the DSM-5 severity level is less than Level 1. If there are multiple DSM-5 severity levels, we will pay the benefit for the highest level of severity, Limited to one benefit per Covered Person.

Benefits

Autism Spectrum Disorder

DSM-5 Severity Level 1: 25%

DSM-5 Severity Level 2: 25%

DSM-5 Severity Level 3: 25%

Autism Spectrum Syndrome is a biological based neurodevelopment disorder characterized by impairment in two major domains:

(1) Deficits in social communication and interaction; and

(2) Restricted repetitive patterns of behavior, interests, and activities.

A Doctor must Diagnose Autism Spectrum Syndrome based on DSM-5 diagnostic criteria. The Diagnosis must include the DSM-5 severity level specifier for both major domains listed above.

Benign Brain Tumor: Prudential will pay the amount shown in the Schedule of Benefits if a Covered Person is diagnosed with 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: Prudential will pay the amount shown in the Schedule of Benefits if a Covered Person is diagnosed with Blindness. Blindness means permanent and irreversible loss of sight in both eyes to the extent that even when tested with the use of visual aids, vision is measured at 20/400 or worse in the better eye using a Snellen eye chart. Being legally blind may not qualify as a valid claim. Medical evidence of a definite diagnosis of Blindness by a Doctor is required as proof of claim.

Cancer - *Invasive*: Prudential will pay the amount shown in the Schedule of Benefits if a Covered Person is diagnosed with Invasive Cancer. Invasive Cancer means any malignant tumor positively diagnosed with histological confirmation (either when practical or when possible) and characterized

by the uncontrolled growth of malignant cells and invasion of tissue. The term malignant tumor includes leukemia, lymphoma, sarcoma and multiple myeloma. The following are not Invasive Cancer:

(1) all cancers which are histologically classified as any of the following: pre-malignant, non-invasive, cancer in situ, borderline malignancy or low potential malignancy;

(2) all tumors of the prostate unless histologically classified as having a Gleason score of 7 or greater or having progressed to at least clinical TNM classification T2N0M0;

(3) chronic lymphocytic leukemia unless histologically classified as having progressed to at least Rai Stage II or above;

(4) any skin cancer other than malignant melanoma. This (4) does not apply if the skin cancer spreads to other parts of the body; or

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

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

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

(1) carcinoma in situ classified as TisN0M0, provided that surgery, radiotherapy or chemotherapy has been determined to be medically necessary by the treating Doctor who is board certified in the medical specialty that is appropriate for the type of carcinoma in situ involved;

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

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

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

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

Cancer - *Skin Cancer*: Prudential will pay the amount shown in the Schedule of Benefits if a Covered Person is diagnosed with Skin Cancer. Skin Cancer means any malignancy of the skin diagnosed 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 pre-cancerous, such as leukoplakia; actinic keratosis; carcinoid; hyperplasia; non-malignant melanoma; moles; or similar diseases or lesions. Medical evidence of a definite diagnosis of Skin Cancer by a Doctor is required as proof of claim. A clinical diagnosis will be accepted whenever such diagnosis is consistent with professional medical standards.

Cerebral Palsy: Prudential will pay the amount shown in the Schedule of Benefits if a Covered Person is diagnosed with 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 Doctor is required as proof of claim.

Cleft Lip or Cleft Palate: Prudential will pay the amount shown in the Schedule of Benefits if a Covered Person is diagnosed with 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: Prudential will pay the amount shown in the Schedule of Benefits if a Covered Person is diagnosed with 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:

(1) persistent vegetative state; or

(2) medically-induced coma.
Medical evidence of a definite diagnosis of Coma by a Doctor is required as proof of claim.

Congenital Heart Defect: Prudential will pay the amount shown in the Schedule of Benefits if:

(1) A Covered Person is diagnosed with congenital heart defect after live birth by a Doctor and before the age of , and

(2) Their Doctor determines that surgery is recommended.

We will accept a clinical diagnosis of a Congenital Heart Defect Covered Condition only if a pathological Diagnosis cannot be made because it would be medically inappropriate or life-threatening under generally accepted medical standards. Payable once per covered person.

Coronary Artery Bypass Graft: Prudential will pay the amount shown in the Schedule of Benefits if a Covered Person requires an Coronary Artery Bypass Graft as diagnosed by a Doctor. Coronary Artery Bypass Graft means a surgical operation to correct narrowing or blockage of one or more coronary arteries with bypass grafts.

Crohn's Disease: Prudential will pay the amount shown in the Schedule of Benefits if a Covered Person is diagnosed by a Doctor with Crohn's Disease. Crohn's Disease does not include irritable bowel syndrome or ulcerative colitis.

Cystic Fibrosis: Prudential will pay the amount shown in the Schedule of Benefits if a Covered Person is diagnosed with Cystic Fibrosis. Medical evidence of a definite diagnosis of Cystic Fibrosis

by a Doctor based on diagnostic tests is required as proof of claim.

Deafness: Prudential will pay the amount shown in the Schedule of Benefits if a Covered Person is diagnosed with 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: Prudential will pay the amount shown in the Schedule of Benefits if a Covered Person is diagnosed with 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:

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

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

(3) 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 by a Doctor through the study of chromosome 21 before or after live birth is required as proof of claim.

Gaucher disease type 2 or type 3: Prudential will pay the amount shown in the Schedule of Benefits if a Covered Person is diagnosed with Gaucher Disease Type 2 or Type 3. Medical evidence of a definite diagnosis of Gaucher Disease Type 2 or 3 by a Doctor after live birth is required as proof of claim.

Glycogen Storage Disease (type IV): Prudential will pay the amount shown in the Schedule of Benefits if a Covered Person is diagnosed by a Doctor with Glycogen Storage Disease (Type IV). Medical evidence of a definite diagnosis of Glycogen Storage Disease Type IV by a Doctor after live birth is required as proof of claim.

Heart Attack: Heart Attack Covered Condition means Myocardial Infarction.

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 Doctor.
Occurs or **Occurrence**, with respect to a Heart Attack Covered Condition, means a Covered Person is Diagnosed by a Doctor with such Covered Condition while coverage is in effect under this Group Insurance 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.

Infantile Tay Sachs Disease: Prudential will pay the amount shown in the Schedule of Benefits if a Covered Person is diagnosed with Infantile Tay Sachs Disease. Medical evidence of a definite diagnosis of Infantile Tay Sachs Disease by a Doctor after live birth is required as proof of claim.

Loss of Speech: Prudential will pay the amount shown in the Schedule of Benefits if a Covered Person is diagnosed with 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 Cancer - Invasive. Medical evidence of a definite diagnosis of Loss of Speech by a Doctor is required as proof of claim

Major Organ Failure: Prudential will pay the amount shown in the Schedule of Benefits if a Covered Person is diagnosed with 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 medical evidence of a definite diagnosis of Major Organ Failure by a Doctor.

Multiple Sclerosis: Prudential will pay the amount shown in the Schedule of Benefits if a Covered Person is diagnosed with 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 Doctor is required as proof of claim.

Muscular Dystrophy: Prudential will pay the amount shown in the Schedule of Benefits if a Covered Person is diagnosed with Muscular Dystrophy. Muscular Dystrophy means well-defined neurological abnormalities confirmed by electromyography and muscle biopsy. Medical evidence of a definite diagnosis of Muscular Dystrophy by a Doctor is required as proof of claim.

Niemann-Pick Disease: Prudential will pay the amount shown in the Schedule of Benefits if a Covered Person is diagnosed with Niemann-Pick Disease. Medical evidence of a definite diagnosis of Niemann-Pick Disease, Type A, B, or C by a Doctor after live birth is required as proof of claim.

Occupational Exposure to HIV or Hepatitis Benefit

(Confirmed Diagnosis Benefit): Prudential will pay the amount shown in the Schedule of Benefits if a Covered Person becomes HIV Positive or Hepatitis Positive as a direct result of an exposure subject to all of the following:

(1) We receive proof that the Testing and Diagnosis Requirements for the Confirmed Diagnosis Benefit define below have been met;

(2) Payment of the Confirmed Diagnosis Benefit is subject to the Occupational Exposure Limitations defined below; and

(3) We will pay the Confirmed Diagnosis Benefit no more than one time per Covered Person per lifetime.

Reporting and Investigation Requirements:

(1) An incident report, which describes the nature of the Occupational Exposure must be filed with the employer within 20 days of the exposure;

(2) The Occupational Exposure must be reported in accordance with applicable legislation, regulations, standards, or guidelines that apply to the Covered Person's occupation or profession; and

(3) The Covered Person's Occupational Exposure must be investigated by the Covered Person's employer and the employer's investigation report must be provided to Us.

Testing and Diagnosis Requirements for the Confirmed Diagnosis Benefit:

(1) For an Occupational Exposure to HIV, the Covered Person must have, within 26 weeks after the Occupational Exposure, an HIV Definitive Test, and the results of such test must show the presence of HIV antibodies.

(2) For an Occupational Exposure to Hepatitis, the Covered Person must have, within 26 weeks after the Occupational Exposure, a Hepatitis Definitive Test and the results of such test must show the presence of Hepatitis antibodies.

(3) Following the Occupational Exposure and testing, the Covered Person must be diagnosed by a Doctor as being HIV Positive or Hepatitis Positive.

Occupational Exposure Limitations

- We will not pay the Occupational Exposure Benefit if:

  (1) The Occupational Exposure takes place prior to the effective date of insurance under this Group Insurance Certificate;

  (2) The Occupational Exposure takes place after insurance for the Covered Person under this Group Insurance Certificate ends;

  (3) The Covered Person becomes HIV Positive or Hepatitis Positive as a result of a transmission other than an Occupational Exposure.]

- We will not pay the Occupational Exposure Benefit for an Occupational Exposure to HIV if the Covered Person tested HIV Positive prior to the Occupational Exposure, unless the Covered Person tested positive on an HIV Screening Test and subsequently tested negative for HIV on an HIV Screening Test or an HIV Definitive Test before the date of the Occupational Exposure.

- We will not pay the Occupational Exposure Benefit for an Occupational Exposure to Hepatitis if the Covered Person tested Hepatitis Positive prior to the Occupational Exposure, unless the Covered Person subsequently tested negative for Hepatitis before the Occupational Exposure on a Hepatitis Definitive Test.

Hepatitis means hepatitis infection type B or C.

Hepatitis Definitive Test means a test that definitively determines, based on established testing protocols, whether a person has contracted the type of Hepatitis to which the Covered Person was exposed due to the Occupational Exposure. The test must be approved by the Center for Disease Control or the Food and Drug Administration, and be performed by a licensed laboratory, with results interpreted by a Doctor in accordance with the manufacturer's specifications.

Hepatitis Positive means the presence of Hepatitis B or Hepatitis C antibodies in the Covered Person's blood (indicating Hepatitis infection or, in the case of Hepatitis B, prior immunization) as substantiated through a positive Hepatitis Definitive Test and a diagnosis by a Doctor.

Hepatitis Screening Test means a preliminary test for the type of Hepatitis to which the Covered Person was exposed due to the Occupational Exposure. The test must be approved by the Center for Disease Control or the Food and Drug Administration, and performed by a licensed laboratory, with

results interpreted in accordance with the manufacturer's specifications and by a Doctor.

HIV Definitive Test means a test that definitively determines whether a person is HIV Positive, such as the Western Blot, that is approved by the Center for Disease Control or the Food and Drug Administration, performed by a licensed laboratory, with results interpreted by a Doctor in accordance with the manufacturer's specifications.

HIV Positive means the presence of Human Immunodeficiency Virus (HIV) antibodies in the Covered Person's blood (indicating HIV infection) as substantiated through a positive HIV Definitive Test and a diagnosis by a Doctor.

HIV Screening Test means a preliminary test for HIV, such as the enzyme-lined immunosorbent assay (ELISA), that is approved by the Center for Disease Control or the Food and Drug Administration, performed by a licensed laboratory, with results interpreted in accordance with the manufacturer's specifications and by a Doctor.

Occupational Exposure means that while insured under this Group Insurance Certificate and during the normal course of the Covered Person's regular occupational duties for which remuneration is earned, that the Covered Person is exposed to blood or other bodily fluids of another person that are contaminated with HIV or Hepatitis, or both, through:

(1) cutaneous exposure through abraded skin;

(2) percutaneous exposure; or

(3) mucocutaneous exposure.

Occupational Exposure to HIV Benefit

(Confirmed Diagnosis Benefit): Prudential will pay the amount shown in the Schedule of Benefits if a Covered Person becomes HIV Positive as a direct result of an exposure subject to all of the following:

(1) We receive proof that the Testing and Diagnosis Requirements for the Confirmed Diagnosis Benefit define below have been met;

(2) Payment of the Confirmed Diagnosis Benefit is subject to the Occupational Exposure Limitations defined below; and

(3) We will pay the Confirmed Diagnosis Benefit no more than one time per Covered Person per lifetime.

Reporting and Investigation Requirements:

(1) An incident report, which describes the nature of the Occupational Exposure must be filed with the employer within 20 days of the exposure;

(2) The Occupational Exposure must be reported in accordance with applicable legislation, regulations, standards, or guidelines that apply to the Covered Person's occupation or profession; and

(3) The Covered Person's Occupational Exposure must be investigated by the Covered Person's employer and the employer's investigation report must be provided to Us.

Testing and Diagnosis Requirements for the Confirmed Diagnosis Benefit:

(1) For an Occupational Exposure to HIV, the Covered Person must have, within 26 weeks after the Occupational Exposure, an HIV Definitive Test, and the results of such test must show the presence of HIV antibodies.

(2) Following the Occupational Exposure and testing, the Covered Person must be diagnosed by a Doctor as being HIV Positive.

Occupational Exposure Limitations

- We will not pay the Occupational Exposure Benefit if:

  (1) The Occupational Exposure takes place prior to the effective date of insurance under this Group Insurance Certificate;

  (2) The Occupational Exposure takes place after insurance for the Covered Person under this Group Insurance Certificate ends;

  (3) The Covered Person becomes HIV Positive as a result of a transmission other than an Occupational Exposure.

- We will not pay the Occupational Exposure Benefit for an Occupational Exposure to HIV if the Covered Person tested HIV Positive prior to the Occupational Exposure, unless the Covered Person tested positive on an HIV Screening Test and subsequently tested negative for HIV on an HIV Screening Test or an HIV Definitive Test before the date of the Occupational Exposure.

HIV Definitive Test means a test that definitively determines whether a person is HIV Positive, such as the Western Blot, that is approved by the Center for Disease Control or the Food and Drug Administration, performed by a licensed laboratory, with results interpreted by a Doctor in accordance with the manufacturer's specifications.

HIV Positive means the presence of Human Immunodeficiency Virus (HIV) antibodies in the Covered Person's blood (indicating HIV infection) as substantiated through a positive HIV Definitive Test and a diagnosis by a Doctor.

HIV Screening Test means a preliminary test for HIV, such as the enzyme-lined immunosorbent assay (ELISA), that is approved by the Center for Disease Control or the Food and Drug Administration, performed by a licensed laboratory, with results interpreted in accordance with the manufacturer's specifications and by a Doctor.

Occupational Exposure means that while insured under this Group Insurance Certificate and during the normal course of the Covered Person's regular occupational duties for which remuneration is earned, that the Covered Person is exposed to blood or other bodily fluids of another person that are contaminated with HIV through:

(1) cutaneous exposure through abraded skin;

(2) percutaneous exposure; or

(3) mucocutaneous exposure.

Occupational Exposure to Hepatitis Benefit

(Confirmed Diagnosis Benefit): Prudential will pay the amount shown in the Schedule of Benefits if a Covered Person becomes Hepatitis Positive as a direct result of an exposure subject to all of the following:

(1) We receive proof that the Testing and Diagnosis Requirements for the Confirmed Diagnosis Benefit define below have been met;

(2) Payment of the Confirmed Diagnosis Benefit is subject to the Occupational Exposure Limitations defined below; and

(3) We will pay the Confirmed Diagnosis Benefit no more than one time per Covered Person per lifetime.

Reporting and Investigation Requirements:

(1) An incident report, which describes the nature of the Occupational Exposure must be filed with the employer within 20 days of the exposure;

(2) The Occupational Exposure must be reported in accordance with applicable legislation, regulations, standards, or guidelines that apply to the Covered Person's occupation or profession; and

(3) The Covered Person's Occupational Exposure must be investigated by the Covered Person's employer and the employer's investigation report must be provided to Us.

Testing and Diagnosis Requirements for the Confirmed Diagnosis Benefit:

(1) For an Occupational Exposure to Hepatitis, the Covered Person must have, within 26 weeks after the Occupational Exposure, a Hepatitis Definitive Test and the results of such test must show the presence of Hepatitis antibodies.

(2) Following the Occupational Exposure and testing, the Covered Person must be diagnosed by a Doctor as being Hepatitis Positive.

Occupational Exposure Limitations

- We will not pay the Occupational Exposure Benefit if:

  (1) The Occupational Exposure takes place prior to the effective date of insurance under this Group Insurance Certificate;

  (2) The Occupational Exposure takes place after insurance for the Covered Person under this Group Insurance Certificate ends;

  (3) The Covered Person becomes Hepatitis Positive as a result of a transmission other than an Occupational Exposure.]

- We will not pay the Occupational Exposure Benefit for an Occupational Exposure to Hepatitis if the Covered Person tested Hepatitis Positive prior to the Occupational Exposure, unless the Covered Person subsequently tested negative for Hepatitis before the Occupational Exposure on a Hepatitis Definitive Test.

Hepatitis means hepatitis infection type B or C.

Hepatitis Definitive Test means a test that definitively determines, based on established testing protocols, whether a person has contracted the type of Hepatitis to which the Covered Person was exposed due to the Occupational Exposure. The test must be approved by the Center for Disease Control or the Food and Drug Administration, and be performed by a licensed laboratory, with results interpreted by a Doctor in accordance with the manufacturer's specifications.

Hepatitis Positive means the presence of Hepatitis B or Hepatitis C antibodies in the Covered Person's blood (indicating Hepatitis infection or, in the case of Hepatitis B, prior immunization) as substantiated through a positive Hepatitis Definitive Test and a diagnosis by a Doctor.

Hepatitis Screening Test means a preliminary test for the type of Hepatitis to which the Covered Person was exposed due to the Occupational Exposure. The test must be approved by the Center for Disease Control or the Food and Drug Administration, and performed by a licensed laboratory, with results interpreted in accordance with the manufacturer's specifications and by a Doctor.

Occupational Exposure means that while insured under this Group Insurance Certificate and during the normal course of the Covered Person's regular occupational duties for which remuneration is earned, that the Covered Person is exposed to blood or other bodily fluids of another person that are contaminated with Hepatitis through:

(1) cutaneous exposure through abraded skin;

(2) percutaneous exposure; or

(3) mucocutaneous exposure.

Paralysis of Limbs: Prudential will pay the amount shown in the Schedule of Benefits if a Covered Person is diagnosed with 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.

Pompe Disease: Prudential will pay the amount shown in the Schedule of Benefits if a Covered Person is diagnosed with Pompe Disease. Medical evidence of a definite diagnosis of Pompe Disease by a Doctor after live birth is required as proof of claim.

Renal (kidney) Failure: Prudential will pay the amount shown in the Schedule of Benefits if a Covered Person is diagnosed with Renal 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: Prudential will pay the amount shown in the Schedule of Benefits if a Covered Person is diagnosed with 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 Doctor is required as proof of claim.

Sickle Cell Anemia: Prudential will pay the amount shown in the Schedule of Benefits if a Covered Person is diagnosed with Sickle Cell Anemia. Medical evidence of a definite diagnosis of Sickle Cell Anemia by a Doctor, confirmed with hemoglobin electrophoresis, is required as proof of claim. Having sickle cell trait alone does not qualify as a valid claim.

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

Third Degree Burns: Prudential will pay the amount shown in the Schedule of Benefits if a Covered Person is diagnosed with 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.

Transient Ischemic Attack (TIA): Prudential will pay the amount shown in the Schedule of Benefits if a Covered Person is diagnosed with a Transient Ischemic Attack (TIA). TIA means a new temporary ischemic event (including prolonged reversible ischemic attacks) in which:

(1) there are measurable, functional neurological impairments that are focal and confined to an area of the brain perfused by a specific artery;

(2) there is no evidence of cerebral tissue damage on diagnostic imaging; and

(3) the reversible functional neurological impairments are confirmed by a Doctor.

The TIA benefit does not include:

(1) Attacks of vertebrobasilar ischemia

(2) Stroke.

Type 1 Diabetes: Prudential will pay the amount shown in the Schedule of Benefits if a Covered Person is diagnosed by a Doctor with Type 1 Diabetes. Type 1 Diabetes means an autoimmune disease that occurs when a person's pancreas stops producing insulin. Type 1 Diabetes develops when the insulin-producing pancreatic beta cells are mistakenly destroyed by the body's immune system. Prudential will pay a benefit when a covered person is diagnosed with Type 1 diabetes. Type 1 diabetes, also referred to as Juvenile Diabetes, is not Type 2 diabetes.

Zellweger Syndrome: Prudential will pay the amount shown in the Schedule of Benefits if a Covered Person is diagnosed with Zellweger Syndrome. Medical evidence of a definite diagnosis of Zellweger Syndrome by a Doctor after live birth is required as proof of claim.

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, but not less than 30 hours per week. If You are a partner or proprietor of the Employer, that work must be in the conduct of the Employer's business.

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 prior to their enrollment for Dependents Insurance.

  Your Spouse means Your lawful Spouse.

- Your Child(ren) from to 26 years old.

  Your Children include Your:

(1) Biological 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) Children for whom You or Your Spouse:

(a) have been appointed the legal guardian; and

(b) claim as a dependent on Your, Your Spouse's federal income tax returns.

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

- Your 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 satisfactory 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 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 or Child has protection under any Employee Coverage of the Group Contract after the Spouse'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 following the date on which:

- You have enrolled, if the Coverage is Contributory; and
- The billing period defined by Your Employer begins; 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.

For Contributory Insurance, You must enroll on a form approved by Prudential and agree to pay the required contributions. You may enroll for Contributory Insurance (1) within 31 days of when You could first be covered, (2) within 31 days of a Qualified Life Event, or (3) during the Annual Enrollment Period. 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 “Annual Enrollment Period” and “Qualified Life Event” means.

FOR DEPENDENTS INSURANCE

Your Dependents Insurance under the Coverage for a person, whether Contributory or Non-contributory, will begin the first day following the date on which all of these conditions are met:

(1) You have enrolled for Dependents Insurance under the Coverage, if the Coverage is Contributory; and

(2) The person is Your Qualified Dependent; and

(3) You are in a Covered Class for that insurance; and

(4) You are insured for the Employee Insurance under the Coverage; and

(5) Your insurance for that Qualified Dependent is not being delayed under the Delay of Effective Date section below; and

(6) Dependents Insurance under the Coverage is part of the Group Contract.

For Contributory Insurance, You must enroll on a form approved by Prudential and agree to pay the required contributions. You may enroll for Contributory Insurance (1) within 31 days of when You could first be covered, (2) within 31 days of a Qualified Life Event, or (3) during the Annual Enrollment Period. 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 “Annual Enrollment Period” and “Qualified 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; or
- Qualified Dependent Spouse only; or
- Qualified Dependent Spouse and Children; or
- 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 of Effective Date 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: Your newborn Dependent Children will automatically be covered for 31 days from their date of birth if You are insured. If You wish to continue coverage for Your Dependent Child, You must notify us on or before the end of the 31 day Qualified Life Event period and pay any additional premium. If You already have coverage for Your Dependent Children, then all eligible Dependent Children will be covered, and You do not need to notify us or pay any additional premium for the newly eligible Dependent Child.

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. Any additional conditions that apply to an additional benefit are shown below. An additional benefit is payable only if those conditions are met.

- **INFECTIOUS DISEASE BENEFIT.**

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

(1) anthrax

(2) bacterial cerebrospinal meningitis

(3) cholera

(4) COVID-19

(5) diphtheria

(6) encephalitis

(7) legionnaire's disease

(8) lyme disease

(9) malaria

(10) methicillin-resistant staphylococcus aureus (MRSA)

(11) necrotizing fasciitis

(12) osteomyelitis

(13) pertussis (whooping cough)

(14) rabies

(15) rocky mountain spotted fever

(16) tetanus

(17) tuberculosis; or

(18) typhoid fever

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

For purposes of this benefit, Confined or Confinement means the assignment to a bed as a resident inpatient in a Hospital (including a Hospital Intensive Care Unit (ICU)) on the advice of a Doctor; or Confinement in an observation area within a Hospital for a period of no less than 24 hours on the advice of a Doctor

Infectious Disease Amount Payable: The additional amount payable is shown in the Schedule of Benefits.

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 End of Employment) or for any other reason; or
- Your class is removed from the Covered Classes for the insurance; or
- The date the Group Contract providing the insurance ends; or
- You reach age 100; or
- You reach Your Lifetime Maximum Benefit; or
- You die.
- For Contributory Insurance under the Coverage, You fail to pay, when due, any required contribution; or
- 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 on the first of these to occur:

- The Qualified Dependent reaches the Lifetime Maximum Benefit for that Qualified Dependent; or
- That person ceases to be a Qualified Dependent for the Coverage. A Spouse will cease to be a Qualified Dependent at age 100. A Dependent Child will cease to be a Qualified Dependent at age 26. (See Continued Coverage for an Incapacitated Child below); or
- You reach age 100.

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.

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; or

  (b) You are no longer part of a Covered Class because Your work hours were reduced; or

  (c) Your insurance under the Coverage would have ended because the Group Contract providing the insurance, in the absence of this provision, would have ended.

(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 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, Your first premium payment must be sent to Prudential 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; or

(2) You reach Your Lifetime Maximum Benefit; or

(3) You die; or

(4) You fail to make, when due, any payment required for the continued Coverage; or

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

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; or

(2) That person ceases to be a Qualified Dependent for the Coverage. A Spouse will cease to be a Qualified Dependent at age 100. A Dependent Child will cease to be a Qualified Dependent at age 26. (See Continued Coverage for an Incapacitated Child above.); or

(3) You reach age 100.

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 $1,000. 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) The Amount of Insurance on each dependent under the continued Coverage may not be increased.

(3) 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. BENEFICIARY RULES

The rules in this section apply to Critical Illness Insurance payable on account of Your death, when benefits are payable. But, if there is an assignment, these rules are modified by the Limits on Assignments section.

“Beneficiary" means a person chosen, on a form or in a format approved by Prudential, to receive the insurance benefits.

You have the right to choose a Beneficiary for the Coverage under this Prudential Group Contract.

If there is a Beneficiary for the insurance under the Coverage, it is payable to that Beneficiary. Any Amount of Insurance under the Coverage for which there is no Beneficiary at Your death will be payable to the first of the following: Your (a) surviving Spouse; (b) surviving child(ren) in equal shares; (c) surviving parents in equal shares; (d) surviving siblings in equal shares; (e) estate. This order will apply unless otherwise provided in the Limits on Assignments.

You may change the Beneficiary at any time without the consent of the present Beneficiary. The Beneficiary change form must be filed through the Contract Holder. The change will take effect on the date the form is signed. But it will not apply to any amount paid by Prudential before it receives the form.

If there is more than one Beneficiary but the Beneficiary form does not specify their shares, they will share equally. If a Beneficiary dies before You, that Beneficiary's interest will end. It will be shared equally by any remaining Beneficiaries, unless the Beneficiary form states otherwise.

If You and a Beneficiary die in the same event and it cannot be determined who died first, the insurance will be payable as if that Beneficiary died before You.

B. CLAIM RULES.

These rules apply to payment of benefits under the Coverage.

Notice of Claim: Written notice of claim should be sent to Prudential within 20 days of the date of a loss.

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: Prudential must be given written proof of the loss including any requested documentation, such as a death certificate, an attending Doctor's statement or medical records for which claim is made under the Coverage. This proof must cover the occurrence, character and extent of that loss. Proof of loss must be furnished within 90 days after the date of the loss.

A claim will not be considered valid unless the proof is furnished within this time limit. But failure to meet the time limit will not make the claim invalid or reduce the claim if it was not reasonably possible to give the proof within that time and the proof is given as soon as reasonably possible, and in no event, except in the absence of legal capacity, later than one year after the time proof is otherwise required.

When Benefits are Paid: Prudential will pay benefits within 30 days after receiving satisfactory written proof of the loss including any requested documentation, such as an attending Doctor's statement or medical records.

Physical Exam and Autopsy: Prudential, at its own expense, has the right to examine the person whose loss is the basis of claim. Prudential may do this when and as often as is reasonable while the claim is pending. Prudential, at its own expense, has the right to arrange an autopsy in case of death, if it is not forbidden by law.

Legal Action: No action at law or in equity shall be brought to recover on the Group Contract until 60 days after the written proof described above is furnished. No such action shall be brought more than three years after the end of the time within which proof of claim is required.

C. INCONTESTABILITY OF INSURANCE TO WHICH THE CLAIM RULES APPLY.

This limits Prudential's use of a Covered Person's statements in contesting an amount of that insurance for which the Covered Person is insured. These are statements made to persuade Prudential to effect an amount of that insurance. They will be considered to be made to the best of the Covered Person's knowledge and belief. These rules apply to each statement:

(1) It will not be used in a contest to avoid or reduce that amount of insurance unless:

  (a) it is in a written instrument signed by the Covered Person; and

  (b) a copy of that instrument is or has been furnished to the Covered Person.

(2) It will not be used in the contest after that amount of insurance has been in force, before the contest, for at least two years during the Covered Person's lifetime.

D. LIMITS ON ASSIGNMENTS.

You may assign Your insurance under the Coverage on forms satisfactory to Prudential. Insurance under the Coverage may be assigned only as a gift assignment. Any rights, benefits or privileges that You have as an Employee may be assigned. This includes any right You have to continue Coverage under the Group Contract. Prudential will not decide if an assignment does what it is intended to do. Prudential will not be held to know that one has been made unless it or a copy is filed with Prudential through the Contract Holder.

This paragraph applies only to insurance for which You have the right to choose a Beneficiary, when that right has been assigned. If an assigned Amount of Insurance becomes payable on account of Your death or the death of Your Spouse and, on the date of that death, there is no Beneficiary chosen by the assignee, it will be payable to:

(1) the assignee, if living; or

(2) the estate of the assignee, if the assignee is not living.

It will not be payable as stated in the Beneficiary Rules.

D. 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. During the grace period the Group Insurance Certificate shall continue in force.

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. During the grace period the Group Insurance Certificate shall continue in force. You are liable to pay Premiums to the Contract Holder for the time your insurance is in force.

F. 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 following the approval date.

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

Exclusions

A Critical Illness is not covered if it is caused by, contributed to by, or resulting from, directly or indirectly, any of the following:

- War, or any act of war. War means declared or undeclared war, and includes resistance to armed aggression. Terrorism is not considered an act of war.

  Terrorism means the deliberate use of violence or the threat of violence against civilians to create an emotional response through the suffering of victims or to achieve military, political, religious or social objectives.

- Travel or flight in any vehicle used for aerial navigation, if:

  (a) the person is riding as a passenger in any aircraft not intended or licensed for the transportation of passengers;

  (b) the person is performing as a pilot or a crew member of any aircraft; or

  (c) the person is riding as a passenger in an aircraft owned, operated, controlled or leased by or on behalf of the Contract Holder or any of its subsidiaries or affiliates.

  This includes getting in, out, on or off any such vehicle.

- Your commission of or attempt to commit a felony.

- Your engagement in an illegal occupation or other willful criminal activity at the level of a misdemeanor or a felony. Other willful criminal activity includes operating a vehicle while intoxicated in violation of the Michigan vehicle code or similar law in a jurisdiction outside of Michigan.

- Participation in these hazardous sports: scuba diving; bungee jumping; base jumping; skydiving; ziplining; parachuting; hang gliding; paragliding; paramotoring; parascending; or ballooning.

The Claim Rules and the To Whom Payable part of the Schedule of Benefits apply to the payment of the benefits.

Additional Information About Your Plan

The Certificate of Coverage and the following Additional Information (together, the Booklet), are intended to comply with the disclosure requirements of the regulations issued by the U.S. Department of Labor under the Employee Retirement Income Security Act (ERISA) of 1974. ERISA requires that your employer provide you with a "Summary Plan Description" which describes the plan and informs you of your rights under it. Information about eligibility rules, benefits amounts, benefit limitations, and exclusions from coverage is contained in the Certificate of Coverage. The following Additional Information about your plan is provided at the request of your Employer/Plan Sponsor.

Plan Name

Toyoda Gosei North America Corporation Critical Illness Insurance Plan

Plan Number

501

Type of Plan

Employee Welfare Benefit Plan

Plan Sponsor

Toyoda Gosei North America Corporation
1400 Stephenson Highway
Troy, Michigan 48083

Employer Identification Number

38-3467216

Plan Administrator

Toyoda Gosei North America Corporation
Attention: Human Resources Department
1400 Stephenson Highway
Troy, Michigan 48083

314-989-1887

Agent for Service of Legal Process

Toyoda Gosei North America Corporation
Attention: Human Resources Department
1400 Stephenson Highway
Troy, Michigan 48083

Service of legal process may also be made upon the plan administrator at the address above.

Plan Year Ends

December 31

Plan Benefits Provided by

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

Plan Sponsor's Designation of Prudential As Claims Administrator

It is the Plan Sponsor's intention and direction that The Prudential Insurance Company of America as Claims Administrator has the sole discretion to interpret the terms of the plan, to make factual findings, and to determine eligibility for benefits. The Plan Sponsor has determined that benefits are payable under the plan only if The Prudential Insurance Company of America, in its sole discretion, determines that they are due. The decision of the Claims Administrator shall not be overturned unless arbitrary and capricious. *

* This paragraph does not apply to residents of AK, AR, CA, CO, DC, IL, KY, MD, ME, MI, NJ, NY, OR, PR, RI, SD, TX, VT, WA

Plan Sponsor, Policyholder and Employer not Agents of Prudential

The Group Contract underwritten by The Prudential Insurance Company of America provides insured benefits under your Employer/Policyholder/Plan Sponsor's ERISA plan(s). For all purposes associated with the plan or the Group Contract under which The Prudential Insurance Company of America provides benefits, the Employer/Policyholder/Plan Sponsor acts on its own behalf or as an agent of its employees. Under no circumstances will the Employer/Policyholder/Plan Sponsor be deemed the agent of The Prudential Insurance Company of America, absent a written authorization of such status executed between the Employer/Policyholder/Plan Sponsor and The Prudential Insurance Company of America. Nothing in these documents shall, of themselves, be deemed to be such a written authorization.

Allocation of Contributions

The insurance benefit coverages described in this Booklet are being offered to you under a single ERISA plan. Coverages described as non-contributory or as being paid entirely by the Employer/Policyholder/Plan Sponsor (if any) are those paid for directly by the Employer/Policyholder/Plan Sponsor such that you have no out of pocket expense for such coverages. However, the premium rate that the Employer/Policyholder/Plan Sponsor pays for insurance coverage offered to you under the Plan may be determined, or in some cases, reduced, in part, based on your contributions for other coverages or other benefits offered under the Plan. When this occurs, your contributions for one benefit coverage may cover some or all of the costs or plan expenses for another benefit coverage offered to you under the Plan.

Loss of Benefits

You must continue to be a member of a class of eligible employees or beneficiaries to which the plan pertains and continue to make any contributions or payments that are due, including those you agreed to when you enrolled for coverage. Failure to make required contributions may result in partial or total loss of your benefits.

Plan Sponsor May Amend or Terminate the Plan at any Time

It is intended that this plan will be continued for an indefinite period of time. But, the Plan Sponsor reserves the right to change or terminate the plan at any time. This Booklet elsewhere describes your rights upon termination of the plan.

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 earlier of the date on which you respond to the request for additional information, or the 45th day following the expiration of the initial 45-day claim review period.

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 include:

(a) the specific reason(s) for the denial, which will include a discussion of the decision describing, if applicable, the basis for disagreeing with or not following (i) the views of healthcare professionals treating you and vocational experts who evaluated you, (ii) the views of medical or vocational experts whose advice was obtained on behalf of the plan in connection with your adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination, and (iii) an award of Social Security Administration disability benefits,

(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 statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim for benefits,

(e) a description of Prudential's appeals procedures and applicable time limits, including a statement of your right to bring a civil action under section 502(a) of ERISA following your appeals,

(f) a statement that, 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 written request, and

(g) copies of any internal rules, guidelines, protocols, standards or other similar criteria relied upon in making this determination or, alternatively, a statement that such rules, guidelines, protocols, standards or other similar criteria do not exist.

2. Appeals of Adverse Determination

If your claim for benefits is 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. Similarly, if Prudential does not decide your claim within the time described in Section 1 above, you may appeal, although you are not required to do so. 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 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 earlier of the date on which you respond to the request for additional information or the 45th day from the expiration of the initial 45-day appeal review period.

Prudential will provide you, free of charge and prior to any adverse decision on appeal, with any new or additional evidence that is considered by Prudential in connection with the claim (including evidence that may be the basis for denial as well as any evidence that may support granting the claim), and any new or additional rationale that will form the basis for the Prudential's decision on appeal. Any such evidence will be provided as soon as possible and sufficiently in advance of the date on which the notice of adverse benefit determination must be provided in order to give you a reasonable opportunity to respond prior to that date.

If the appeal is denied in whole or in part, you will receive a written notification from Prudential of the denial. The notice will include:

(a) the specific reason(s) for the adverse determination, which will include a discussion of the decision describing, if applicable, the basis for disagreeing with or not following (i) the views of healthcare professionals treating you and vocational experts who evaluated you, (ii) the views of medical or vocational experts whose advice was obtained on behalf of the plan in connection with your adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination, and (iii) an award of Social Security Administration disability benefits,

(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 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 written request,

(f) copies of any internal rules, guidelines, protocols, standards or other similar criteria relied upon in making this determination or, alternatively, a statement that such rules, guidelines, protocols, standards or other similar criteria do not exist, and

(g) a statement describing any appeals procedures offered by the plan, and your right to bring a civil suit under ERISA.

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, 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. Similarly, if Prudential does not decide your appeal within the time described in Section 1 above, you may appeal again, although you are not required to do so. 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 earlier of the date on which you respond to the request for additional information or the 45th day following the expiration of the second 45-day appeal review period.

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.

Time Limit To File Suit

If your claim for benefits and any required appeals are denied (or not decided within the time periods discussed above), you may file suit as discussed below. If you elect to file suit, you should do so as soon as possible. However, you must file suit no later than three years after proof of your claim was first due as explained elsewhere in this Booklet, regardless of whether your claim is still pending in the claim or appeal process.

Rights and Protections

As a participant in this plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA), as amended. 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 Benefits 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 plan 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 the Plan Sponsor, 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 a fine that accrues on a daily basis (based on amounts set by the Department of Labor) from the time the materials were due to you 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 Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Office of Outreach, Education and Assistance, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, DC 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.