Group Accident
Insurance Certificate

Franklin Square Holdings, LP
Certificate Effective Date: 01/01/2026

IMPORTANT NOTICE

If you reside in the following state, please read the important notice below:

MARYLAND RESIDENTS:

This Certificate may omit some of the benefits required for a Certificate issued and delivered in Maryland.

New York Life Insurance and Annuity Corporation
(A Stock Insurance Company)
51 Madison Avenue, New York, NY 10010
1-800-225-5695
http://www.newyorklife.com

GROUP ACCIDENT INSURANCE
CERTIFICATE OF COVERAGE

THIS CERTIFICATE PROVIDES LIMITED COVERAGE.
PLEASE READ YOUR CERTIFICATE CAREFULLY.

We, the New York Life Insurance and Annuity Corporation, have issued a Group Policy, GAI0100383 to NATIONAL GROUP BENEFITS INSURANCE TRUST on behalf of Franklin Square Holdings, LP, Subscriber Group ID 430828.

We certify that We insure all eligible persons who are enrolled according to the terms of the Group Policy. Your coverage will begin according to the terms set forth in the *Effective Date of Insurance* section.

This Certificate describes the benefits and basic provisions of Your coverage. It is not the insurance contract and does not waive or alter any terms of the Policy. If questions arise, the Policy language will govern. You may examine the Policy at the office of the Subscriber or Our authorized administrator.

This Certificate replaces all prior Certificates issued to You under the Group Policy.

Corporate Secretary, Colleen Meade

Chair, President, & CEO, Craig DeSanto

NOTICE: THE POLICY IS AN ACCIDENT ONLY POLICY. IT DOES NOT PAY BENEFITS FOR LOSS CAUSED BY SICKNESS OR DISEASE. THIS IS NOT A SUBSTITUTE FOR MAJOR MEDICAL COVERAGE. The Policy provides limited benefits. Benefits provided are supplemental and are not intended to cover all medical expenses.

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SECTION I. SCHEDULE OF BENEFITS FOR ACCIDENT INSURANCE

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

This *Schedule of Benefits* shows maximums, durations, and any limitations applicable to benefits provided in the Policy for each Covered Person unless otherwise indicated. Accident Insurance Benefits, when referred to in this Schedule, mean the Covered Person's Accident Insurance Benefits in effect on the date of the Covered Loss unless otherwise specified.

On the pages following the description of eligible Employees there is a Schedule of Benefits for each Class of Eligible Employee listed below. For an explanation of these benefits, please see the Description of Benefits.

CLASSES OF ELIGIBLE EMPLOYEES

Class 1	All active, full-time Employees of the Employer regularly scheduled to work a minimum of 30 hours per week in the United States, who are citizens or permanent resident aliens of the United States.

SCHEDULE OF BENEFITS FOR CLASS 1, LOW

Class 1 **All active, full-time Employees of the Employer regularly scheduled to work a minimum of 30 hours per week in the United States, who are citizens or permanent resident aliens of the United States.**

Accident Type: On the Job & Off the Job Coverage

Eligibility Waiting Period

The Eligibility Waiting Period is the period of time the Employee must continuously be in Active Service to be eligible for coverage, including any period during which the Employee was insured or eligible to be insured under a Prior Plan. It will be extended by the number of days the Employee is not in Active Service.

Class Description	Eligibility Waiting Period
Class 1	None

Covered Losses

Unless otherwise specified, the following benefits will be payable only once for each Accident as applicable.

Losses	Benefit Amount		
	Employee	Spouse	Child
COVERED INJURY BENEFITS			
Fractures			
Open Reduction			
Depressed Skull Fracture (except bones of face or nose)	$5,000.00	$5,000.00	$5,000.00
Simple Non-depressed Skull Fracture (except bones of face or nose)	$2,500.00	$2,500.00	$2,500.00
Hip, Thigh (femur)	$5,000.00	$5,000.00	$5,000.00
Vertebrae, Body of (excluding vertebral processes)	$5,600.00	$5,600.00	$5,600.00
Pelvis (includes ilium, ischium, pubis, acetabulum except coccyx)	$5,500.00	$5,500.00	$5,500.00
Leg (tibia and/or fibula, except lateral, medial and/or posterior malleolus)	$3,600.00	$3,600.00	$3,600.00
Bones of Face or Nose (except mandible or maxilla)	$2,000.00	$2,000.00	$2,000.00
Upper Jaw, Maxilla (except alveolar process)	$2,500.00	$2,500.00	$2,500.00
Upper Arm between Elbow and Shoulder (humerus)	$3,500.00	$3,500.00	$3,500.00
Lower Jaw, Mandible (except alveolar process)	$2,400.00	$2,400.00	$2,400.00
Shoulder Blade (scapula), Collarbone (clavicle, sternum)	$3,000.00	$3,000.00	$3,000.00
Vertebral processes	$2,400.00	$2,400.00	$2,400.00
Forearm (radius and/or ulna), Hand, Wrist (except fingers)	$3,000.00	$3,000.00	$3,000.00
Kneecap (patella)	$3,000.00	$3,000.00	$3,000.00
Foot (except toes)	$3,000.00	$3,000.00	$3,000.00
Ankle (lateral, medial and/or posterior malleolus, talus)	$3,000.00	$3,000.00	$3,000.00

Rib	$700.00	$700.00	$700.00
Coccyx	$600.00	$600.00	$600.00
Finger, Toe	$400.00	$400.00	$400.00
Closed Reduction			
Depressed Skull Fracture (except bones of face or nose)	$2,500.00	$2,500.00	$2,500.00
Simple, Non-Depressed Skull Fracture (except bones of face or nose)	$1,250.00	$1,250.00	$1,250.00
Hip, Thigh (femur)	$2,500.00	$2,500.00	$2,500.00
Vertebrae, Body of (excluding vertebral processes)	$2,800.00	$2,800.00	$2,800.00
Pelvis (includes ilium, ischium, pubis, acetabulum except coccyx)	$2,750.00	$2,750.00	$2,750.00
Leg (tibia and/or fibula, except lateral, medial and/or posterior malleolus)	$1,800.00	$1,800.00	$1,800.00
Bones of Face or Nose (except mandible or maxilla)	$1,000.00	$1,000.00	$1,000.00
Upper Jaw, Maxilla (except alveolar process)	$1,250.00	$1,250.00	$1,250.00
Upper Arm between Elbow and Shoulder (humerus)	$1,750.00	$1,750.00	$1,750.00
Lower Jaw, Mandible (except alveolar process)	$1,200.00	$1,200.00	$1,200.00
Shoulder Blade (scapula), Collarbone (clavicle, sternum)	$1,500.00	$1,500.00	$1,500.00
Vertebral Processes	$1,200.00	$1,200.00	$1,200.00
Forearm (radius and/or ulna), Hand, Wrist (except fingers)	$1,500.00	$1,500.00	$1,500.00
Kneecap (patella)	$1,500.00	$1,500.00	$1,500.00
Foot (except toes)	$1,500.00	$1,500.00	$1,500.00
Ankle (lateral, medial and/or posterior malleolus, talus)	$1,500.00	$1,500.00	$1,500.00
Rib	$350.00	$350.00	$350.00
Coccyx	$300.00	$300.00	$300.00
Finger, Toe	$200.00	$200.00	$200.00
Chip Fracture	$375.00	$375.00	$375.00

Dislocations

Open Reduction			
Hip	$6,400.00	$6,400.00	$6,400.00
Cervical Spine	$6,000.00	$6,000.00	$6,000.00
Knee (except patella)	$4,000.00	$4,000.00	$4,000.00
Ankle - Bone or Bones of the Foot (other than toes)	$2,400.00	$2,400.00	$2,400.00
Collarbone (sternoclavicular)	$1,800.00	$1,800.00	$1,800.00
Lower Jaw	$1,800.00	$1,800.00	$1,800.00
Shoulder (glenohumeral)	$3,000.00	$3,000.00	$3,000.00
Elbow	$1,800.00	$1,800.00	$1,800.00
Wrist	$1,800.00	$1,800.00	$1,800.00
Bone or Bones of the Hand (other than fingers)	$1,800.00	$1,800.00	$1,800.00
Collarbone (acromioclavicular and separation)	$1,800.00	$1,800.00	$1,800.00
One finger or one toe	$500.00	$500.00	$500.00
Closed Reduction			
Hip	$3,200.00	$3,200.00	$3,200.00
Cervical Spine	$3,000.00	$3,000.00	$3,000.00
Knee (except patella)	$2,000.00	$2,000.00	$2,000.00
Ankle - Bone or Bones of the Foot (other than toes)	$1,200.00	$1,200.00	$1,200.00

Collarbone (sternoclavicular)	$900.00	$900.00	$900.00
Lower Jaw	$900.00	$900.00	$900.00
Shoulder (glenohumeral)	$1,500.00	$1,500.00	$1,500.00
Elbow	$900.00	$900.00	$900.00
Wrist	$900.00	$900.00	$900.00
Bone or Bones of the Hand (other than fingers)	$900.00	$900.00	$900.00
Collarbone (acromioclavicular and separation)	$900.00	$900.00	$900.00
One finger or one toe	$250.00	$250.00	$250.00
Partial Dislocation	$350.00	$350.00	$350.00

Other Common Injuries

Burns

Second Degree (percentage of total surface skin area that is burned)			
Less than 10%	$250.00	$250.00	$250.00
10-25%	$550.00	$550.00	$550.00
25-35%	$900.00	$900.00	$900.00
greater than 35%	$1,000.00	$1,000.00	$1,000.00
Third Degree (percentage of total surface skin area that is burned)			
Less than 10%	$3,000.00	$3,000.00	$3,000.00
10-25%	$6,500.00	$6,500.00	$6,500.00
25-35%	$9,800.00	$9,800.00	$9,800.00
greater than 35%	$12,500.00	$12,500.00	$12,500.00
Skin Graft	$1,500.00	$1,500.00	$1,500.00
Coma	$14,500.00	$14,500.00	$14,500.00
Concussion	$500.00	$500.00	$500.00

Paralysis

Quadriplegia	$20,000.00	$20,000.00	$20,000.00
Paraplegia	$13,500.00	$13,500.00	$13,500.00
Hemiplegia	$13,500.00	$13,500.00	$13,500.00

Emergency Dental

Emergency Dental Crown	$300.00	$300.00	$300.00
Emergency Dental Extraction	$75.00	$75.00	$75.00

Eye Injury

Removal of foreign body	$80.00	$80.00	$80.00
Surgical Repair	$275.00	$275.00	$275.00

Lacerations

no sutures	$25.00	$25.00	$25.00
up to 5cm	$50.00	$50.00	$50.00
5.1 cm to 15.5 cm	$200.00	$200.00	$200.00
greater than 15.5 cm	$400.00	$400.00	$400.00

EMERGENCY & HOSPITALIZATION BENEFITS

Ambulance			
Air Ambulance	$1,250.00	$1,250.00	$1,250.00
Ground Ambulance (includes water)	$300.00	$300.00	$300.00
Emergency Room	$200.00	$200.00	$200.00
Urgent Care	$200.00	$200.00	$200.00
Short Stay / Observation (4 hours, no inpatient)	$150.00	$150.00	$150.00
Hospital			
Hospital Admission	$1,125.00	$1,125.00	$1,125.00
Hospital Confinement (per day)	$250.00	$250.00	$250.00
Intensive Care Unit (ICU) Confinement (per day)	$400.00	$400.00	$400.00
Initial Doctor's Visit	$75.00	$75.00	$75.00
Follow-up Doctor's Visit	$75.00	$75.00	$75.00
Therapy Visit	$40.00	$40.00	$40.00
Rehabilitation Unit (per day)	$150.00	$150.00	$150.00
Major Diagnostic Testing	$200.00	$200.00	$200.00
Minor Diagnostic Exam (X-Ray)	$60.00	$60.00	$60.00

TREATMENT AND OTHER SERVICES

Blood/Plasma/Platelet Transfusion	$500.00	$500.00	$500.00
Medical Device	$125.00	$125.00	$125.00
Prosthesis			
One Device	$325.00	$325.00	$325.00
Two or More Devices	$1,000.00	$1,000.00	$1,000.00
Surgery			
Open Abdominal or Thoracic Surgery	$1,000.00	$1,000.00	$1,000.00
Hernia Surgery	$625.00	$625.00	$625.00
Tendon, Ligament, Rotator Cuff Surgery - Repair	$1,000.00	$1,000.00	$1,000.00
Tendon, Ligament, Rotator Cuff Surgery - Exploratory	$675.00	$675.00	$675.00
Knee Cartilage Surgery - Repair	$350.00	$350.00	$350.00
Knee Cartilage Surgery - Exploratory	$60.00	$60.00	$60.00
Ruptured Disc Surgery	$650.00	$650.00	$650.00
Miscellaneous Surgery - with anesthesia	$650.00	$650.00	$650.00
Miscellaneous Surgery - with conscious sedation	$200.00	$200.00	$200.00

ADDITIONAL BENEFITS			
Organized Sports	25% of the applicable Benefit(s)	25% of the applicable Benefit(s)	25% of the applicable Benefit(s)
Organized Sports Maximum	$1,000.00	$1,000.00	$1,000.00
OTHER BENEFITS			
Health Screening	$50.00	$50.00	$50.00

The above items are only highlights of the Policy. For a full description of Your coverage, including any additional benefits, exclusions or limitations that may apply, continue reading Your Certificate of Coverage.

CONTINUATION OF INSURANCE

For Family Medical Leave Maximum Benefit Period:	The latest of: 1. the period of the approved FMLA leave; or 2. the leave period required by the laws of the state in which the Employee is employed

SECTION II. DESCRIPTION OF BENEFITS

The following provisions explain the benefits available under the Policy. Please see the Schedule of Benefits for the applicability of these benefits on a class level.

COVERED INJURY BENEFITS

FRACTURE BENEFIT
We will pay the applicable Fracture Benefit Amount shown in the Schedule of Benefits if, as a result of an Injury, a Covered Person is diagnosed with a Fracture or Chip Fracture. The Covered Person must be diagnosed or treated by a Doctor within 120 days after the date of the Accident. This benefit is payable based on whether the Injury is a Fracture or Chip Fracture and whether a Fracture is treated by surgery (open reduction) or manipulation (closed reduction).

If a Covered Person sustains more than one Fracture and/or Chip Fracture due to the same Accident, the total benefit for all Fractures and Chip Fractures will not exceed 200% of the amount shown in the Benefit Schedule for the bone involved with the highest benefit amount.

DISLOCATION BENEFIT
We will pay the applicable Dislocation Benefit Amount shown in the Schedule of Benefits if, as a result of an Injury, a Covered Person is diagnosed with a dislocation. The Covered Person must be diagnosed or treated by a Doctor within 120 days after the date of the Accident. This benefit is payable based on the joint dislocated, whether the dislocation is a Full Dislocation or Partial Dislocation, and whether the dislocation is treated by surgery (open reduction) or manipulation (closed reduction).

If a Covered Person sustains more than one Full Dislocation or Partial Dislocation due to the same Accident, the total benefit for all dislocations will not exceed 200% of the amount shown in the Benefit Schedule for the joint involved with the highest benefit amount.

BURN BENEFIT
We will pay the Burn Benefit Amount shown in the Schedule of Benefits if, as a result of an Injury, a Covered Person sustains Second or Third Degree Burns. The Covered Person must be treated by a Doctor within 60 days after the date of the Accident. Only one Burn Benefit is payable per Accident per Covered Person. If burns are in multiple degrees, then only the highest benefit will be paid.

If a Covered Person suffers a burn for which the Burn Benefit is payable under the Policy, We will pay an additional benefit if the Covered Person undergoes skin graft Treatment. The amount paid will be equal to the skin graft benefit amount shown in the Schedule of Benefits.

COMA BENEFIT
We will pay the Coma Benefit Amount shown in the Schedule of Benefits if, as a result of an Injury, a Covered Person is diagnosed as being in a Coma. The Covered Person must be diagnosed or treated by a Doctor within 180 days after the date of the Accident. Only one Coma Benefit is payable per Accident per Covered Person.

CONCUSSION BENEFIT
We will pay the Concussion Benefit Amount shown in the Schedule of Benefits if, as a result of an Injury, a Covered Person is diagnosed with a concussion. The Covered Person must be diagnosed by a Doctor within 4 days after the date of the Accident. Only one concussion Benefit is payable per Accident per Covered Person.

PARALYSIS BENEFIT
We will pay the Paralysis Benefit Amount shown in the Schedule of Benefits if, as a result of an Injury, a Covered Person is diagnosed with a Paralysis. The Covered Person must be diagnosed by a Doctor within 30 days after the date of the Accident. Only one Paralysis Benefit is payable per Accident per Covered Person.

EMERGENCY DENTAL BENEFIT
We will pay the Emergency Dental Benefit Amount shown in the Schedule of Benefits if a Covered Person sustains an Injury that results in a broken or lost tooth. The Covered Person must be initially treated by a Dentist within 90 days after the date of the Accident. The Injury must occur to Covered Person's sound, natural tooth. This benefit is payable once per Accident per Covered Person, regardless of the number of teeth involved.

EYE INJURY BENEFIT
We will pay the Eye Injury Benefit Amount shown in the Schedule of Benefits if a Covered Person sustains an eye injury. The Covered Person must require surgery or the removal of a foreign object by a Doctor within 90 days after the date of the Accident. This benefit is payable once per Accident per Covered Person.

LACERATION BENEFIT
We will pay the applicable Laceration Benefit Amount shown in the Schedule of Benefits if, as a result of an Injury, a Covered Person sustains a laceration. The Covered Person must be treated by a Doctor within 7 days after the date of the Accident. This benefit is payable once per Accident per Covered Person. If the Covered Person has more than one laceration from the same Injury, then the total length of all lacerations received will be paid.

EMERGENCY AND HOSPITALIZATION BENEFITS

AIR AMBULANCE BENEFIT
We will pay the Air Ambulance Benefit Amount shown in the Schedule of Benefits if, as a direct result of an Injury, a Covered Person is transported by a licensed professional air ambulance service to or between hospitals. The Covered Person must be transported by an air ambulance within 3 days after the date of the Accident. This benefit is payable only once per Accident per Covered Person.

GROUND AMBULANCE BENEFIT
We will pay the Ground Ambulance Benefit Amount shown in the Schedule of Benefits if, as a direct result of an Injury, a Covered Person is transported by a licensed professional ground ambulance service to or between Hospitals. The Covered person must be transported by a ground ambulance within 90 days after the date of the Accident. This benefit is payable only once per Accident per Covered Person. Ground ambulance transportation includes an ambulance transportation by water.

EMERGENCY ROOM BENEFIT
We will pay the Emergency Room Benefit Amount shown in the Schedule of Benefits if a Covered Person sustains an Injury that results in a visit to the Emergency Room. The Covered Person must be initially treated by a Doctor in the Emergency Room within 10 days after the date of the Accident. This benefit is payable only once per Accident per Covered Person.

URGENT CARE BENEFIT
We will pay the Urgent Care Benefit Amount shown in the Schedule of Benefits if a Covered Person sustains an Injury that results in a visit to an Urgent Care Facility. A visit to an Urgent Care Facility must begin within 10 days after the date of the Accident. The Urgent Care Facility Benefit is not payable for routine health exams and immunizations. No more than 1 Urgent Care Facility day is payable per Accident per Covered Person.

SHORT STAY/OBSERVATION BENEFIT
We will pay the Short Stay/Observation Unit Benefit Amount shown in the Schedule of Benefits if a Covered Person sustains an Injury that is Treated on an outpatient basis in a Hospital, licensed ambulatory surgical facility, Emergency Room, or observational unit for a minimum of 4 hours. The short stay must begin within 180 days after the date of the Accident. No more than 1 Short Stay benefit is payable per Accident per Covered Person.

HOSPITAL ADMISSION
We will pay the Hospital Admission Benefit Amount shown in the Schedule of Benefits if a Covered Person sustains an Injury that results in an admission to the Hospital. Confinement must occur within 180 days after the date of the Accident. The Hospital Admission Benefit is not payable for routine health exams and immunizations, Emergency Room Treatment, Urgent Care Treatment, a Short Stay/Observation, outpatient Treatment. This benefit is payable only once per Accident per Covered Person.

HOSPITAL CONFINEMENT
We will pay the Hospital Confinement Benefit Amount shown in the Schedule of Benefits if a Covered Person sustains an Injury that results in Hospital Confinement. Confinement must begin within 180 days after the date of the Accident. We will not pay the Hospital Confinement Benefit for a day that the ICU Confinement Benefit, the Hospital Admission Benefit or Rehabilitation Unit Benefit is also payable. No more than 365 Hospital Confinement days are payable per Accident per Covered Person.

INTENSIVE CARE UNIT (ICU) CONFINEMENT
We will pay the Intensive Care Unit (ICU) Confinement Benefit Amount shown in the Schedule of Benefits if a Covered Person sustains an Injury that results in Confinement in the ICU. Confinement must begin within 45 days after the date of the Accident. This benefit is not payable on the same day as the Hospital Admission Benefit, Hospital Confinement Benefit, or Rehabilitation Unit Benefit. No more than 15 Intensive Care Unit (ICU) Confinement days are payable per Accident per Covered Person.

INITIAL DOCTOR'S VISIT BENEFIT
We will pay the Initial Doctor's Benefit Amount shown in the Schedule of Benefits if a Covered Person sustains an Injury that results in an initial Doctor's office visit. The Covered Person must be initially treated by a Doctor within 14 days after the date of the Accident. This benefit is payable for telemedicine services. This benefit is payable only once per Accident per Covered Person.

FOLLOW-UP DOCTOR'S VISIT BENEFIT
We will pay the Follow-Up Doctor's Visit Benefit Amount shown in the Schedule of Benefits if a Covered Person sustains an Injury that results in visits to the Doctor following the Accident. Such visits must occur within 270 days after the date of the Accident.

This benefit is payable for telemedicine services. The Follow-Up Doctor's Benefit is not payable for immunizations or routine health examinations. If a Covered Person also receives Treatment in an Emergency Room, during an Initial Doctor Visit, or in an Urgent Care Facility on the same day, only the highest applicable benefit is payable.

This benefit is payable only 6 times per Accident per Covered Person.

THERAPY VISIT BENEFIT
We will pay the Therapy Visit Benefit Amount shown in the Schedule of Benefits for each day a Covered Person receives Therapy Services to treat an Injury. Therapy Services must be provided on an outpatient basis by a practitioner licensed to provide the type of Therapy Service provided and operating within the scope of such license. The Covered Person must receive Therapy Services within 365 days after the date of the Accident. No more than 10 Therapy Benefits are payable per Accident per Covered Person.

REHABILITATION UNIT BENEFIT
We will pay the Rehabilitation Unit Benefit Amount shown in the Schedule of Benefits for each day a Covered Person is Confined in a Rehabilitation Facility following discharge from a Hospital and receiving Therapy Services for an Injury. The Rehabilitation Facility must be prescribed by a Doctor and provided by a practitioner licensed to provide the type of rehabilitation and operating within the scope of such license. The Covered Person must be Confined in the Rehabilitation Facility within 90 days after the date the Covered Person is discharged from the Hospital. We will not pay the Rehabilitation Unit Benefit and Hospital Confinement Benefit concurrently for the same Covered Person. The higher of the two benefits will be paid. No more than 45 days of Rehabilitation Facility Confinement are payable per Accident per Covered Person.

MAJOR DIAGNOSTIC TESTING BENEFIT
We will pay the Major Diagnostic Testing Benefit Amount shown in the Schedule of Benefits if a Covered Person requires one of the following diagnostic examinations to determine the extent of an Injury:
1. Computerized Axial Tomography (CAT);
2. Computed Tomographies (CT Scan);
3. Positron Emission Tomography (PET Scan);
4. Single Photon Emission Computed Tomography (SPECT Scan);
5. Magnetic Resonance Imagings (MRIs); or
6. Electroencephalogram (EEG).

The Covered Person must have the diagnostic exam scheduled within 180 days after the date of the Accident. This benefit is payable once per Accident per Covered Person, regardless of how many diagnostic examinations have occurred.

MINOR DIAGNOSTIC EXAM (X-RAY) BENEFIT
We will pay the X-Ray Benefit Amount shown in the Schedule of Benefits for each day a Covered Person requires an X-ray to determine the extent of an Injury. The Covered Person must receive the X-ray within 90 days after the date of the Accident. Only one X-Ray Benefit is payable per Accident.

TREATMENT AND OTHER SERVICES BENEFITS

BLOOD, PLASMA OR PLATELET TRANSFUSION
We will pay the Blood, Plasma or Platelet Transfusion Benefit Amount shown in the Schedule of Benefits for each day a Covered Person, due to Injury, requires a transfusion, administration, cross matching, typing and processing of blood, plasma or platelets. The blood, plasma or platelet transfusion must be administered within 90 days after the date of the Accident. Only one Blood, Plasma or Platelet Transfusion Benefit is payable per Accident per Covered Person.

MEDICAL DEVICE BENEFIT
We will pay the Medical Device Benefit Amount shown in the Schedule of Benefits if a Covered Person sustains an Injury that results in the need for a Medical Device for aid in personal locomotion, mobility or recovery. The Covered Person must be prescribed the Medical Device by a Doctor within 180 days after the date of the Accident. No more than one Medical Device Benefit is payable per Accident per Covered Person. The types of eligible equipment are:

- Wheelchair
- Knee Scooter
- Body Jacket
- Walking Boot
- Walker
- Crutches
- Leg Brace
- Cervical Collar
- Cane
- Ankle Brace
- Cast
- Splint
- Sling

PROSTHESIS BENEFIT
We will pay the Prosthesis Benefit Amount shown in the Schedule of Benefits if a Covered Person requires a Prosthetic Device as a result of an Injury. The Covered Person must be prescribed the Prosthetic Device within 365 days after the date of the Accident. This benefit is payable only once per Accident per Covered Person.

SURGERY BENEFIT
We will pay the Surgery Benefit Amount shown in the Schedule of Benefits if a Covered Person sustains an Injury that results in a surgical procedure. The surgery may be performed in a Hospital, on an inpatient or outpatient basis, or in a licensed ambulatory surgical facility. Benefits will be payable for exploratory surgery without repair as shown in the Schedule of Benefits. No exploratory surgery benefit will be paid if We are paying a surgical repair benefit for the same operation.

Open Abdominal or Thoracic Surgery
The Covered Person must have the open abdominal or thoracic surgery scheduled within 45 days after the date of the Accident. Two or more surgical procedures through the same incision or entry point are considered one operation. This Benefit is payable only once per Accident per Covered Person.

Hernia Surgery
The Covered Person must have the hernia surgery scheduled within 45 days after the date of the Accident. This Benefit is payable only once per Accident per Covered Person.

Tendon, Ligament, Rotator Cuff Surgery
The Covered Person must have the tendon, ligament, rotator cuff surgery scheduled within 90 days after the date of the Accident. This Benefit is payable only once per Accident per Covered Person. The amount paid will depend on whether the Covered Person experiences a surgery that is a repair or exploratory.

Knee Cartilage Surgery
The Covered Person must have the knee cartilage surgery scheduled within 180 days after the date of the Accident. This Benefit is payable only once per Accident per Covered Person. The amount paid will depend on whether the Covered Person experiences a surgery that is a repair or exploratory.

Ruptured Disc Surgery
The Covered Person must have the ruptured disc surgery scheduled within 90 days after the date of the Accident. This Benefit is payable only once per Accident per Covered Person.

Miscellaneous Surgery
The Covered Person must have the Miscellaneous Surgery scheduled within 90 days after the date of the Accident. This benefit is payable only once per Accident per Covered Person. The amount paid will depend on whether the Covered Person receives general anesthesia or conscious sedation.

ADDITIONAL BENEFITS

ORGANIZED SPORTS BENEFIT
If a Covered Person receives Treatment for an Injury for which a benefit is payable under the Covered Injury Benefits, Emergency and Hospitalization Benefits or Treatment and Other Services Benefits Sections under the Policy, We will pay an additional benefit if a Covered Person suffers an Injury while participating in an Organized Sport. The amount paid will be an additional percentage shown in the Schedule of Benefits multiplied by the amount of eligible benefit(s) payable for the Covered Accident, subject to the Affiliated Health Care Provider Maximum shown in the Schedule of Benefits. This benefit will only apply to benefits as named and is not payable for the Health Screening Benefit.

HEALTH SCREENING BENEFIT
We will pay the Health Screening Benefit Amount shown in the Schedule of Benefits if a Covered Person receives a Health Screening service. This benefit is payable only once per day even if multiple Health Screenings are provided in a single day. No more than 1 Health Screening Benefits are payable per Covered Person per Calendar Year.

Health Screening services include:
- safety/injury prevention class;
- mental health screening;
- baseline concussion screening;
- abdominal aortic aneurysm ultrasonography;
- blood test for lipids including total cholesterol, LDL, HDL, and triglycerides;
- bone marrow testing, bone density screening;
- breast ultrasound or mammography;
- CA15-3 blood test for breast cancer;
- CA 125 blood test for ovarian cancer;
- carotid doppler;
- CEA blood test for colon cancer;
- chest x-ray;
- colonoscopy;
- electrocardiogram;
- double contrast barium enema;
- fasting blood glucose test;
- flexible sigmoidoscopy;
- hemoccult stool analysis;
- mammogram;
- pap smear, (including ThinPrep);
- PSA;
- serum cholesterol test to determine level of HDL and LDL;
- serum protein electrophoresis (blood test for myeloma);
- stress test;
- thermography;
- CT angiography;
- Testicular Ultrasound;
- Smoking Cessation Program;
- Weight Reduction Program;
- Cancer Genetic Mutation Test (BRCA);
- Skin Cancer Screening;
- Biopsies for Cancer;
- Lymphocyte Genome Sensitivity Test (LGS) (universal blood test for cancer);
- Routine Eye Exam;
- Routine Dental Exam;
- Hearing Screening;
- Well child/preventative exams age 1 to 18;
- Adult annual exam;
- Biometric Screenings;
- Wellness Fair;
- Immunizations; or
- any other medically accepted health screening examination.

SECTION III. ELIGIBILITY FOR INSURANCE

An Employee becomes eligible for insurance under the Policy on the date the Employee meets all of the requirements of one of the covered classes described in the Eligible Classes section and completes any Eligibility Waiting Period, as shown in the Schedule of Benefits. The Eligibility Waiting Period will not apply to an Employee in Active Service on the Policy Effective Date, who was covered under the Prior Plan and satisfied the Eligibility Waiting Period, if any, of that plan. Credit will be given for any time that was satisfied under the Prior Plan.

A Spouse and Dependent Child(ren) of an eligible Employee become eligible for any dependent insurance provided by the Policy on the later of the date the Employee becomes eligible or the date the Spouse or Dependent Child(ren) meet the applicable definition shown in the General Definitions section of this Certificate. The Employee must be insured under the Policy in order to elect coverage for a Spouse or Dependent Child(ren).

LIMITATIONS ON MULTIPLE ELIGIBILITY

A Covered Person may be insured only once under the Accident Insurance coverage of the Policy even though they may be eligible under more than one class.

Special Rules for Employees Who are Spouses of Other Employees

An Employee who is the Spouse of another Employee may not be insured for Accident Insurance as both an Employee and as a Spouse at the same time.

If an Employee is eligible and has enrolled as the Spouse of another Employee, but later ceases to be eligible as a Spouse, that Employee may, within 31 days, enroll for coverage as an Employee.

Special Rules for Dependent Children

An Employee who is the Dependent Child of another Employee may not be insured for Accident Insurance as both an Employee and as a Dependent Child at the same time.

A Dependent Child of two or more Employees may only be insured once under the Policy.

If an Employee who has elected to insure Dependent Children ceases to do so, then the Employee's Spouse may, within 31 days, elect to insure Dependent Children, provided they are insured as an Employee.

In all cases, “Dependent Child” shall be defined with respect to the Employee who has enrolled Dependent Children.

SECTION IV. ENROLLING FOR ACCIDENT INSURANCE

GROUP ENROLLMENT EVENTS

An eligible Employee may enroll for Accident insurance coverage as follows:
1. During an Initial Group Enrollment Period, as established by the Subscriber and agreed to by Us, prior to the effective date of the Policy.
2. During Annual Group Enrollment periods established by the Subscriber.
3. At other times agreed to by Us.

INDIVIDUAL ENROLLMENT EVENTS

A. Initial Enrollment Period for Newly Eligible Employees
During an initial enrollment period for newly eligible Employees, within 31 days following the Employee's date of eligibility, an eligible Employee may enroll for Accident insurance coverage as stated in the Schedule of Benefits. An eligible Employee may not enroll an eligible Spouse or Dependent Child(ren) without enrolling for Employee coverage.

B. Life Status Change for Employees
An eligible Employee may also enroll within 31 days of a Life Status Change.

Life Status Changes that qualify an Employee to apply for coverage, including coverage for an eligible Spouse or Dependent Child(ren) include:
1. Becoming newly married;
2. Loss of a Spouse; whether by death, divorce, annulment, or legal separation;
3. Birth or adoption of a child, or acquiring a child through marriage;
4. A change in the group benefit plan available to the Employee's Spouse;
5. A change in the Employee's employment status that affects eligibility for group benefits for either the Employee or the Employee's Spouse;
6. Termination of a Spouse’s employment.

C. Resumption of Accident Insurance After a Period of Unpaid Leave of Absence
Unless the Employee has agreed in writing to terminate Accident insurance, coverage will resume for an Employee upon his or her return to Active Service, if an Employee's insurance ended because the Employee was on an unpaid leave of absence approved by the Employer.

If the Employee agreed to terminate Accident insurance, the Employee must enroll for any Accident insurance and pay the required Premium.

D. Returning Military Service Enrollment for Employees
Unless the Employee has agreed in writing to terminate Accident insurance, coverage will resume for an Employee that returns to Active Service after a period of active military duty subject to the Uniformed Services Employment and Reemployment Rights Act (“USERRA”) and applicable state law.

If the Employee agreed to terminate Accident insurance, the Employee must apply for Accident insurance and pay the required premium.

SECTION V. EFFECTIVE DATE OF INSURANCE

Effective Date of Coverage for Enrollment During a Group Enrollment Event
Your coverage begins at 12:01 a.m. Local Time at the Employer's address on the Policy Anniversary Date following the date You enroll, if You enroll during a Group Enrollment Event as described in the Enrolling for Accident Insurance Section and agree to pay the required Premium Contributions, if any.

Coverage for Your Spouse or Dependent Child(ren) begins at 12:01 a.m. Local Time at the Employer's address on the Policy Anniversary Date following the date You enroll Your eligible Spouse or Dependent Child(ren), if You enroll them during a Group Enrollment Event as described in the Enrolling for Accident Insurance Section and You agree to pay the required Premium Contributions, if any.

Effective Date of Coverage for an Enrollment During an Initial Enrollment Period for Newly Eligible Employees
Your coverage begins at 12:01 a.m. Local Time at the Employer's address on the date You become eligible for coverage, if You enroll within the Initial Enrollment Period for Newly Eligible Employees as described in the Enrolling for Accident Insurance Section and agree to pay the required Premium Contributions, if any.

Coverage for Your Spouse or Dependent Child(ren) begins at 12:01 a.m. Local Time at the Employer's address on the date the Spouse or Dependent Child(ren) becomes eligible for coverage, if You enroll Your eligible Spouse or Dependent Child(ren) within the Initial Enrollment Period for Newly Eligible Employees as described in the Enrolling for Accident Insurance Section and You agree to pay the required Premium Contributions, if any.

Effective Date of Coverage for an Enrollment as the Result of a Life Status Change
Your coverage begins at 12:01 a.m. Local Time at the Employer's address on the date You become eligible for coverage, if You enroll during the time period established for Life Status Changes as described in the Enrolling for Accident Insurance Section and agree to pay the required Premium Contributions, if any.

Coverage for Your Spouse or Dependent Child(ren) begins at 12:01 a.m. Local Time at the Employer's address on the date the Spouse or Dependent Child(ren) becomes eligible for coverage, if You enroll them during the time period established for Life Status Changes as described in the Enrolling for Accident Insurance Section and You agree to pay the required Premium Contributions, if any.

Effective Date of Coverage for Newly Born or Adopted Children
An Employee's Dependent Child(ren) who are born or placed in the Employee's home for adoption while the Employee is covered under the Policy are covered for 60 days from the moment of live birth or date of placement for adoption.

If the Employee has not elected Dependent Child(ren) insurance coverage at the time of the birth or date of placement, the Employee must notify us within 60 days of the newly eligible Dependent Child's birth or date of placement for adoption and pay the required additional premium for Dependent Child insurance to continue coverage beyond the initial 60 day period.

SECTION VI. TERMINATION OF INSURANCE

The insurance on a Covered Person will end on the earliest date below:

1. The date the Policy is terminated or amended to terminate insurance for an Eligible Class.
2. The date the Subscriber's participation under the Policy ends.
3. The date the Employee is no longer in Active Service.
4. The date the Employee is no longer in an Eligible Class or no longer satisfies the eligibility requirements under the Policy.
5. The last day of the period for which Premium is paid, subject to any Grace Period.
6. The date the Employee, Spouse, or Dependent Child(ren) enters full-time active duty in the Uniformed Services of the United States for more than 30 consecutive days. We will provide a pro-rata premium refund.
7. The next Premium due date after the Covered Person ceases to be a member in good standing of the Subscriber.
8. a. For a Spouse or Dependent Child(ren), on the date that the Employee's insurance ends.
   b. For a Spouse, on the next Premium due date after the date that the Spouse is no longer eligible due to death of the Employee, upon divorce, legal separation, or other termination of marriage.
   c. For a Dependent Child(ren), on the next Premium due date after the date that the Dependent Child no longer meets the Policy's definition of Dependent Child, or reaches any age limit provided under the Policy.

Please refer to the Continuation of Insurance provision for situations under which coverage can be continued following Termination of Insurance.

Termination will not affect a claim for a Covered Loss that is the result, directly and independently of all other causes, of a covered Accident that occurred while coverage was in effect.

SECTION VII. CONTINUATION OF INSURANCE BENEFITS

If an Employee is no longer in Active Service, the Employee may be eligible to continue insurance. The following provisions explain the continuation options available under the Policy. Please see the Schedule of Benefits to determine the applicability of these benefits.

Premiums are required to continue insurance. Unless the Employee has agreed in writing to terminate Accident Insurance, the Subscriber is responsible for all Premium payments to continue insurance, and for collecting any Premium Contributions required of Employees.

Unless otherwise stated, continuation begins when the Employee's Active Service ends. If more than one continuation provision applies, only the one with the longer duration will be applicable.

Notwithstanding any other provision of the Policy, if an Employee's Active Service ends due to termination of employment, or any other termination of the employment relationship, insurance will terminate and continuation of insurance under this section will not apply.

Continuation for Family Medical Leave of Absence
If an Employee's Active Service ends due to an approved family and medical leave, insurance will continue up to the maximum period shown in the Schedule of Benefits.

SECTION VIII. PORTABILITY OPTIONS FOR ACCIDENT INSURANCE

Portability rights may be only exercised by U.S. citizens or permanent resident aliens.

A. Eligibility for Portability Coverage

Employee
You are eligible for Portability coverage if:
1. You end Active Service with Your Employer;
2. You are no longer a member of an Eligible Class; or
3. The Subscriber terminates this coverage and doesn't replace it within 30 days.

Your group Accident Insurance under the Policy must be in effect at the time of the event that made You eligible for Portability Coverage.

If You want Your covered Spouse or covered Dependent Child(ren) to continue coverage under the Portability plan, You must elect Portability coverage for Yourself.

Spouse
Your covered Spouse may request their own Portability coverage:
1. if You die; or
2. if You and Your Spouse divorce (including the equivalent of divorce for civil union or Domestic Partners).

If You die and Your Spouse elects coverage under this Portability provision, the Spouse may elect Portability coverage for Your covered Dependent Child(ren).

If Your Spouse elects coverage under this Portability provision, the Spouse will become the primary insured for the purposes of Portability coverage.

Dependent Child(ren)
Your Dependent Child(ren) are eligible for Portability coverage if the Dependent Child(ren) were covered under the Policy when You became eligible for Portability coverage and You elect to insure the Dependent Child(ren) under the Portability coverage or if You die and Your covered Spouse elects to insure both themselves and the Dependent Child(ren) under the Portability coverage.

B. Amount of Portability Coverage

Employee
The maximum amount of insurance that can be continued under the Portability provision is the amount that was in effect on the date You became eligible for Portability coverage. You may decrease but not increase the continued coverage amount upon request.

Dependents
The maximum amount of insurance that can be continued for a Spouse or Dependent Child(ren) under the Portability provision is the amount that was in effect for Your Spouse or Dependent Child(ren) on the date they became eligible for Portability coverage. You may decrease but not increase the continued coverage amount upon request.

C. Applying for Portability Coverage

The Subscriber or We will provide You with the information needed to continue Your coverage under this provision. Continuation of coverage must be elected within 60 days of the Employee's termination of employment or membership in an eligible class under the Policy. The initial Premium must be paid within 60 days of billing.

This continued Accident Insurance will be effective on the date that Accident insurance would otherwise have ended under the Policy, as long as the above requirements are met.

Your Spouse or Dependent Child(ren) must apply for Portability coverage and pay the first Premium within 60 days after the date they become eligible for Portability coverage.

The Incontestability provision will apply to Portability coverage and will run from the date of the Covered Person's effective date of coverage under the Policy.

D. Portability Coverage Under the Group Policy

Any insurance continued under this Portability section will be provided under the group Policy. The terms and conditions of the Covered Person's continued insurance will be the same as those in effect on the date the Covered Person became eligible for Portability coverage, except for the right to add new dependent coverage.

E. Premiums for Portability Coverage

You will be directly billed for all Premiums due under this provision. We will notify You of the amount of Premium due, the frequency of Premium payments and the Premium due dates. If any Premium is not paid when due, You will have a 31 day Grace Period. This is the period following the Premium due date which Premium may be made by You. Insurance will end at the end of the Grace Period if You fail to make the required Premium payment within that time.

We will not change the Premium rate more than once in any period of 6 consecutive months and We will give You 31 days advance Written notice of any change in rates. If Your Spouse is eligible to apply separately and has done so, then Your Spouse will be responsible for Premium payments and will be directly billed for all Premiums due, and all benefit payments due will be paid directly to Your Spouse.

F. When Portability Coverage Ends

Employee
Portability coverage for You will end on the earliest of:
1. the date You fail to pay any required Premium, subject to the Grace Period;
2. the date You cancel Your coverage; or
3. the date You die.

Dependents
Portability for a Spouse will end on the earliest of the following:
1. When Portability for the Spouse is exercised with Employee Portability:
    a. the date You fail to pay any required Premium;
    b. the date You cancel Your coverage; or
    c. the date You or Your Spouse die.
2. When Portability for Your Spouse is exercised on their own:
    a. the date Your Spouse fails to pay any required Premium;
    b. the date Your Spouse cancels coverage; or
    c. the date Your Spouse dies.

Portability coverage for a Dependent Child(ren) will end on the earliest of the following:

1. When Portability for the Dependent Child(ren) is exercised with Employee Portability:
    a. the date Your coverage ends;
    b. the date Your Dependent Child no longer qualifies as a Dependent Child; or
    c. the date Your Dependent Child dies.
2. When Portability for Your Dependent Child(ren) is exercised by Your Spouse due to Your death:
    a. the date Your Spouse's coverage ends;
    b. the date Your Dependent Child no longer qualifies as a Dependent Child; or
    c. the date Your Dependent Child dies.

If Portability coverage ends due to failure to pay required Premium, Portability coverage cannot be reinstated.

The group Policy will remain in force for the purpose of continuing Portability coverage, but without further obligation of the Subscriber. However, We may terminate Portability coverage provided by this provision upon 60 days' notice if the Policy terminates.

SECTION IX. EXCLUSIONS

The Policy does not cover loss caused or contributed to by:

1. disease or infirmity of body, or medical or surgical treatment for such disease or infirmity. This exclusion does not apply in the event of a Hernia Surgery that occurs due to the Accident;
2. an infection not occurring as a direct result or consequence of Injury;
3. suicide or attempted suicide, while sane or insane;
4. intentionally self-inflicted harm, while sane or insane;
5. travel in or descent from an aircraft, if the Covered Person acted in a capacity other than as a passenger;
6. travel in an aircraft or device used for testing or experimental purposes, used by or for any military authority, or used for travel beyond the Earth's atmosphere;
7. war or act of war, whether declared or undeclared;
8. active participation in a riot, insurrection, or terrorist activity;
9. an Accident occurring during any period of time while the Covered Person is incarcerated in any type of penal or detention facility;
10. committing or attempting to commit a felony;
11. voluntary intake or use by any means of:
    a. any drug, unless:
        i. prescribed or administered by a Doctor and taken in accordance with the Doctor's instructions; or
        ii. an over-the-counter drug, taken in accordance with the instructions.
    b. any poison, gas or fumes, unless a direct result of an occupational accident;
12. operating a motorized vehicle while under the influence of alcohol, such that the Covered Person's blood alcohol content meets or exceeds the legal level established for Driving Under the Influence (DUI), Driving While Impaired (DWI), or other similar laws of the jurisdiction where the Accident occurred;
13. riding or driving an air, land or water vehicle in a race;
14. in the case of an Employee, as a result of active duty as a member of the armed forces of any nation;
15. in the case of a Spouse or Dependent Child(ren), an Accident occurring while the Spouse or Dependent Child(ren) is on active duty as a member of the armed forces of any nation. We will refund, upon Written notice of such service, any Premium which has been accepted for any period not covered as a result of this exclusion;
16. participation in any semi-professional or professional athletic contest in which any compensation is received;
17. bungee jumping;
18. dental or plastic surgery except when such surgery is performed to:
    a. treat an Injury;
    b. correct a disorder of normal bodily function that has been impaired due to Injury; or
    c. reconstruct a part of the body which was disfigured or removed as a result of Injury;
19. participation in an illegal occupation or activity;
20. rock or mountain climbing; and
21. aeronautics (hang-gliding, skydiving, parachuting, ultralight, soaring, ballooning and parasailing).

SECTION X. CLAIM PROVISIONS

Notice of Claim
Written notice must be given to Us within 31 days after a Covered Loss occurs or begins or as soon as reasonably possible. If Written notice is not given in that time, the claim will not be invalidated or reduced if it is shown that notice was given as soon as was reasonably possible. Notice can be given at Our home office in 51 Madison Ave, New York, NY 10010, such other place as We may designate for the purpose, or to Our authorized agent. Notice should include the Subscriber Name, the Policy Number and the claimant's name, address and certificate number.

Claim Forms
When We receive notice of claim, We will send claim forms with Written instructions for filing Proof of Loss. If such claim forms are not sent by Us within 15 days after notice is received by Us, You shall be deemed to have complied with the requirements of proof of claim when You submit Written proof that covers the occurrence, character and extent of the loss for which a claim is made.

Proof of Loss
You must send Us Written proof of Your claim no later than 90 days after a Covered Loss. Failure to give such proof within this timeframe shall not invalidate or reduce any payable claim if it can be shown that it was not reasonably possible to give such proof within that time, and the proof was given as soon as reasonably possible. You must provide proof of claim no later than 1 year after the time proof is otherwise required, except in the absence of legal capacity.

Time of Payment of Claims
Benefits payable under the Policy will be paid immediately, but no later than the 60th day, upon Our receipt of due Written proof of loss.

Payment of Claims
All benefits are payable to the Employee. Any benefits unpaid at the time of Your death will be paid to the first surviving class of the following classes of persons:

1. spouse;
2. child or children, in equal shares;
3. mother or father; in equal shares;
4. siblings; in equal shares;
5. Your estate.

If a survivor entitled to receive a payment dies before receiving it, We will make payment to that person’s estate.

If a survivor entitled to receive a payment has a special needs trust established, We will make payment to that person’s trust instead of the person directly.

Any payment made by Us in good faith pursuant to this provision will fully discharge Us to the extent of such payments and release Us from all liability.

Claimant Cooperation Provision
Failure of a claimant to cooperate with Us in the administration of the claim may result in termination of the claim. Such cooperation includes, but is not limited to, providing any information or documentation needed to determine whether benefits are payable or the actual benefit amount due.

We do not assume responsibility for the validity of any designation or change of beneficiary, whether made by You, by an attorney-in-fact under a power of attorney, or otherwise. You should obtain Your own legal advice with respect to designation of beneficiaries, which We cannot provide.

Legal Actions
No action at law or in equity may be brought to recover under the Policy less than 60 days after Written proof of loss has been furnished as required by the Policy. No such action will be brought more than six years after the time such Written proof of loss must be furnished.

Physical Examination and Autopsy
We, at Our expense, will have the right to examine any person for whom a claim is pending as often as it may reasonably be required. We may, at Our expense, require an autopsy unless prohibited by law.

SECTION XI. GENERAL PROVISIONS

Entire Contract
The insurance for Covered Persons is provided under a contract of group Accident insurance with the Subscriber, and the entire contract with the Subscriber consists of:
1. all Policy provisions and any amendments and endorsements to the Policy;
2. the Certificate of Coverage and any amendments and endorsements to the Certificate of Coverage; and
3. the Subscriber's signed application.

Certificate of Coverage
This Certificate of Coverage (or Certificate) is a Written statement prepared by Us and may include attachments. It tells You:
1. the coverage to which You may be entitled;
2. to whom We will make a payment; and
3. the limitations, exclusions and requirements that apply within the Policy.

Any conflict between the terms of the individual Certificate and the Policy will be decided in favor of the Policy. We have written your Certificate of Coverage in understandable terms. However, a few terms and provisions are written as required by insurance law. If You have any questions about any of the terms and provisions, please consult Our claims paying office. We will assist You in any way to help You understand Your benefits.

Policy Changes
The Policy can be changed:
1. at any time by Written agreement between Us and the Subscriber; and
2. without the consent of any other person.

The Policy may also be changed by Us by amendment to the Policy and without the consent of the Subscriber or any other person, if such amendment is signed by an officer of Us and:
1. results from the exercise of a right reserved to Us in the Policy; or
2. is issued to conform to any law and/or regulation which applies to the insurance under the Policy. No agent of Ours can make or change the Policy or waive any of its provisions.

Notice of Cancellation
The Subscriber or We may cancel the Policy as of any Premium Due Date on or after the first Policy Anniversary Date by giving 60 days advance written notice.

If a Premium is not paid when due, the Policy will automatically be canceled as provided in the Policy Grace Period provision.

Termination will not affect a claim for a Covered Loss that is the result of an Accident that occurred while insurance was in effect.

Incontestability
All statements made by a Covered Person are considered representations and not warranties. No statement will be used to deny or reduce benefits or be used as a defense to a claim, unless a copy of the instrument containing the statement is, or has been, furnished to the claimant. In the event of death or incapacity, the beneficiary or representative shall be given a copy.

After two years from the Covered Person's effective date of insurance, or from the effective date of increased benefits, no such statement will cause insurance or the increased benefits to be contested except for fraud or lack of eligibility for insurance.

Misstatement of Age
If a Covered Person's age has been misstated, We will adjust all benefits to the amounts that would have been purchased for the correct age.

Clerical Error
Clerical error or omission by Us or the Subscriber will not:
1. revoke insurance otherwise in force, if You are entitled to coverage under the terms of the Policy; or
2. cause coverage to begin or continue for You when the coverage would not otherwise be effective.

If We or the Subscriber make a clerical error in keeping data that is required to compute Premiums and administer the terms of the Policy, We will:
1. based upon the facts, decide whether You have coverage under the Policy and in what amounts; and
2. make a fair adjustment of the Premium and/or insurance to correct the error.

Agency
The Subscriber is acting as an agent of the Employee for transactions relating to insurance under the Policy. The actions of the Subscriber shall not be considered the actions of Us, and We are not liable for any of their acts or omissions.

Unpaid Premium
Any unpaid Premium due for a Covered Person's coverage under this Certificate may be recovered by Us by offsetting against amounts otherwise payable under this Certificate.

Worker's Compensation
The Policy does not replace or affect the requirements for coverage by any workers' compensation insurance.

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

SECTION XII. GENERAL DEFINITIONS

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

Accident, Accidental

A sudden, unforeseeable external event that causes bodily injury to a Covered Person and meets all of the following conditions:

1. occurs while the Covered Person is insured under the Policy;
2. is not contributed to by disease, sickness, or bodily infirmity;
3. is not otherwise excluded under the terms of the Policy.

Active Service

An Employee will be considered in Active Service with the Subscriber on any day that is either:

1. One of the Subscriber's scheduled work days on which the Employee is performing the regular duties of the Employee's regular occupation and hours required for class eligibility, either at one of the Subscriber's usual places of business or at some other location the Subscriber has authorized the Employee to work; or
2. A scheduled holiday, vacation day or period of the Subscriber- approved paid leave of absence, other than disability or sick leave after 7 days, only if the Employee was in Active Service on the preceding scheduled workday.

An Employee is considered in Active Service on a day which is not one of the Subscriber's scheduled work days only if they were in Active Service on the preceding scheduled work day.

Annual Group Enrollment Period

The period in each Calendar Year agreed upon by the Subscriber and Us when an eligible Employee may enroll for or change their benefit elections under the Policy as shown in the Schedule of Benefits.

Calendar Year

The period beginning on the Coverage Effective Date and ending on December 31 of the same year. Thereafter, it is the period beginning on January 1 and ending on December 31.

Chip Fracture

A Fracture in which a fragment of bone is broken completely away from the main mass of bone. A Chip Fracture must be detected and diagnosed by X-ray or similar diagnostic exam.

Coma

Complete unconsciousness with inability to respond to external or internal stimuli. The diagnosis of a Coma must be made by a Doctor and include a Glasgow Coma Scale score of 7 or less. Coma includes a medically induced Coma.

Confined, Confinement

On the advice of a Doctor, a Covered Person's assignment to a bed on a resident inpatient basis in a medical facility. There must be a charge for room and board, other than a Veteran's Administration Hospital or Federal Government Hospital or Facility where an expense would not occur due to insurance.

Contribution

The amount the Subscriber may require a Covered Person to pay towards the total Premium that We charge for the insurance provided under the Policy. The Premium due on any Premium Due Date is determined by the total amount of insurance provided under the Policy on such date, multiplied by the appropriate Premium rate(s) that are in effect on that date, subject to any Premium adjustments, if applicable.

Covered Loss

A loss that is:

1. The result caused or contributed to, directly and independently of all other causes, of a covered Accident; and
2. A benefit specified in the Schedule of Benefits.
3. Suffered by the Covered Person within the applicable time period specified in the Schedule of Benefits.

Covered Person

The Employee and any Spouse and Dependent Child(ren), who has met the enrollment requirements of the Policy, for whom the required Premium has been paid when due, and whose coverage under this Policy remains in force.

Dentist

An individual who:
1. is licensed as a doctor of dentistry in the jurisdiction where the services are being performed;
2. is legally qualified to practice dentistry; and
3. is performing tasks that are within the limits of their dental license.

Dependent Child

An Employee's child who meets the following requirements:

1. A child from birth but less than 26 years old;
2. A child who has reached age 26, who:
    a. Is unable to support themselves due to mental or physical incapacity; and
    b. Resides with and is chiefly financially dependent on the Employee; and
    c. Is eligible as a Dependent Child under the Employee's health care plan, and is covered under that plan, or under a separate health care plan.

A child's age shall be determined as of the date of change.

The term "child" means:
1. A natural child.
2. A foster child.
3. A legally adopted child, beginning with any waiting period pending finalization of the adoption of the child.
4. A stepchild who resides with the Employee and is financially dependent upon such Employee.
5. A child of an Employee's covered Spouse, who resides with the Employee and is financially dependent upon such Employee.
6. A child, including a grandchild, for whom the Employee is the court-appointed legal guardian, as long as the child resides with the Employee and primarily depends on the Employee for financial support. Financial support means that the Employee is eligible to claim the child for purposes of Federal and State income tax returns.

If the Employee who is the legal guardian of a child is not a step-parent, grandparent, aunt or uncle, then the child must have resided with Employee for at least 6 consecutive months and intend to reside with the Employee for an indefinite period of time.

Doctor

A person performing tasks that are within the limits of their medical license and:
1. who is licensed to practice medicine and prescribe and administer drugs or to perform surgery; or
2. who is a legally qualified medical practitioner according to the laws and regulations of the governing jurisdiction.

This may include a government-licensed practitioner of the healing arts acting within the scope of license and rendering care and Treatment to a Covered Person that is appropriate for the condition.

Domestic Partner

Means either of the following, with respect to any unmarried Employee:

1. Any person who is registered with the Employee as a Domestic Partner, or partner to a civil union, under any state domestic partnership or civil union law which creates legal rights and obligations similar to marriage.
2. Any person who meets the following requirements:
    a. Is at least 18 years of age.
    b. Shares a permanent residence with the Employee and has resided with the Employee continuously for at least 12 months and is expected to continue to reside with the Employee indefinitely.
    c. Is the Employee's sole Domestic Partner, and is not married and has no other Domestic Partner as defined.
    d. Is not so closely related by blood to the Employee as to preclude legal marriage.
    e. Has agreed with the Employee that the Employee and Domestic Partner are mutually financially responsible for the welfare of the other.
    f. Is financially interdependent with the Employee in one or more of the following ways:
        1. Joint bank, savings or brokerage accounts.
        2. Joint ownership of real property or joint leasing of a primary residence.
        3. Joint credit obligations.
        4. Being named as beneficiary under a last will.
        5. Being named as attorney in fact under a durable or healthcare power of attorney.
    g. A person who has not signed a Domestic Partner affidavit or declaration with any other person within the last 12 months.
3. Is eligible as a Domestic Partner under the Employer's health care plan, and is covered under that plan, or under a separate health care plan.

Emergency Room

A specified area of a Hospital that:

1. is dedicated to the provision of emergency care;
2. is staffed and equipped to handle trauma;
3. is supervised by and provides Treatment and care by Doctors; and
4. provides care by registered nurses 24 hours per day, 7 days per week.

This definition includes a separate Emergency Room facility that provides immediate, short-term medical care and Treatment.

Employee

For the purpose of eligibility, an Employee is an Employee of the Subscriber in one of the "Classes of Eligible Employees". Otherwise, Employee means an Employee of the Subscriber who is insured under the Policy.

Employer

The Subscriber and any affiliates or subsidiaries covered under the Policy.

Fracture

A break in a bone that is detected and diagnosed by X-ray or similar diagnostic exam. A Fracture does not include a Chip Fracture.

Full Dislocation

A completely separated joint of a body part. Full Dislocation does not include vertebral subluxation complex (misaligned vertebrae).

Hospital

An institution that meets all of the following:
1. it is licensed as a Hospital pursuant to applicable law;
2. it is accredited as a hospital by the Joint Commission or by the Commission on Accreditation of Rehabilitation Facilities;
3. it is primarily and continuously engaged in providing medical care and Treatment to sick and injured persons;
4. It is managed under the supervision of a staff of Doctors;
5. It provides 24-hour nursing services by or under the supervision of a graduate Registered Nurse (R.N.);
6. It has medical, diagnostic and Treatment facilities, with major surgical facilities on its premises, or available to it on a prearranged basis.

The term Hospital does not include a clinic, facility, or unit of a Hospital for:
1. rehabilitation, convalescent, custodial, educational or nursing care;
2. treatment of the aged, alcohol or substance abuse;
3. A Veteran's Administration Hospital or Federal Government Hospital unless the Covered Person would incur an expense in the absence of insurance;
4. A facility primarily or solely providing psychiatric services to mentally ill patients.

Initial Group Enrollment Period

The period agreed upon by the Subscriber and Us when an eligible Employee may first enroll for his or her benefit elections under the Policy as shown in the Schedule of Benefits.

Injury

A bodily injury that is the direct result of an Accident, independent of disease and not related to any other cause. The Accident causing Injury must occur while the insurance benefit for which a claim is being made is in force for the Covered Person.

Intensive Care Unit

Also referred to as ICU, it means an accredited facility licensed according to state and local laws to provide care and Treatment to patients who are critically ill or injured and who require intensive, comprehensive monitoring and care. An ICU must:
1. be separate and apart from the surgical recovery room and from rooms, beds, and wards customarily used for patient Confinement;
2. be under close observation by a specially trained nursing staff; and
3. have a Doctor assigned exclusively to the unit on a 24-hour basis.

The term Intensive Care Unit includes Hospital units with the following names: intensive care unit; coronary care unit; neonatal intensive care unit; pulmonary care unit; burn unit; or transplant unit.

Medical Device

Any instrument, apparatus, implant or other medical appliance as prescribed by a Doctor.

Miscellaneous Surgery

Surgery that requires general anesthesia or conscious sedation and is not one of the specific surgeries described in the Surgery Benefit.

Organized Sports

A regularly scheduled athletic event or a supervised organized team practice for the athletic event.

An Organized Sport does not include:
1. physical education classes at school.

Paralysis

Means:
1. Quadriplegia: The permanent and irreversible paralysis of all four limbs;
2. Paraplegia: The permanent and irreversible paralysis of both legs;
3. Hemiplegia: The permanent and irreversible paralysis of both limbs on either side of the body.

Partial Dislocation

A dislocation in which the joint is not completely separated.

Policy

The insurance contract issued to the Subscriber under the policy number shown on the cover page of this Certificate.

Policyholder	The Employer to whom the policy is issued and who sponsored the coverage for its Employees.
Premium	The amount the Subscriber must pay to Us, and We must receive, for the Policy to take effect and/or for the Policy to continue in force. Premium includes contributions made by Covered Persons, if applicable.
Prior Plan	The Prior Plan refers to the plan of insurance providing similar benefits sponsored by the Subscriber offered under a group policy to Employees of the Subscriber in effect directly prior to the Policy Effective Date. A Prior Plan will include the plan of a Subscriber in effect on the day prior to: 1. That Subscriber's addition to the Policy; or 2. With Our approval, the addition of all Employee, or all of a defined group of Employees, of the Subscriber, as a result of an agreement to which that Subscriber (or a parent or shareholder of that Subscriber is a party. To be covered under the Policy, required Premium must be paid for all covered Employees.
Prosthetic Device	An artificial device prescribed by a Doctor to replace a body part such as a limb or eye. It does not include a joint replacement, such as a hip or knee replacement. It also does not include hearing aids, dental aids (including false teeth), eyeglasses or cosmetic prostheses such as wigs.
Rehabilitation Facility	An institution that provides Therapy Services on an inpatient basis. The facility must be licensed as a Rehabilitation Facility pursuant to applicable law. The Rehabilitation Facility must be a separate facility within a Hospital, a distinct unit of another facility and physically separated from the rest of such facility, or a freestanding facility. The Rehabilitation Facility must be supervised by or under the direction of a Doctor.
Retiree	A former Employee who is currently receiving a retirement benefit under a pension or other retirement plan administered by the Subscriber.
Second Degree Burns	A burn in which damage penetrates into some of the underlying layers of skin.
Spouse	The current lawful Spouse of an Employee. Spouse includes Your Domestic Partner. Wherever in the Certificate of Coverage there is a reference to "divorce" or "divorced", it also means dissolution of a civil union, domestic partnership, or other family or domestic relations law of the governing jurisdiction.
Subscriber	Any participating organization that subscribes to the trust to which the Policy is issued, and which is insured under the Policy.
Third Degree Burns	A burn which extends to all layers of skin.
Therapy Services	Occupational therapy, physical therapy, and speech therapy. Therapy services do not include chiropractic, homeopathic, aroma-therapeutic, or herbal therapeutic services.
Treatment	Means medical advice, diagnosis, care or services (including diagnostic measures) received by a Covered Person, or the use of drugs or medicines by a person.
Urgent Care Facility	A facility other than a Doctor's office, Hospital or Emergency Room that provides immediate, short-term medical care and Treatment. Such facility may be a 24-hour clinic.
We, Us, Our,	New York Life Insurance and Annuity Corporation
Written	A record which is on or transmitted by paper, electronic or telephonic media, and which is consistent with applicable law.
You, Your, Yours	The person to whom the certificate is issued. You, Your, Yours means the Employee.

New York Life Insurance and Annuity Corporation
51 Madison Avenue
New York, New York 10010

MODIFICATIONS FOR RESIDENTS OF CERTAIN STATES FORM

Policyholder: NATIONAL GROUP BENEFITS INSURANCE TRUST Policy Number: GAI0100383

Subscriber: Franklin Square Holdings, LP

Amendment Effective Date: 01/01/2026

This Amendment is attached to and made part of this Policy and Certificate. Its provisions are intended to conform this Policy and Certificate to the laws of the state in which the insured resides.

Policyholder and Us hereby agree that the Policy and any Certificates delivered under the Policy are amended as follows:

Arkansas residents:

Under the **GENERAL DEFINITIONS** section of the Certificate, if your Certificate includes a definition of a **Dependent Child**, then the below language is not included:

> **Dependent Child**
> 3c. Is eligible as a Dependent Child under the Employee's health care plan, and is covered under that plan, or under a separate health care plan.

California residents:

Domestic Partner coverage must be provided to CA Certificate holders when issued out of state via (Trust) on behalf of California Employers.

Colorado residents:

Under the **EXCLUSIONS AND LIMITATIONS** section of the Certificate, the following **Exclusions** have been modified as follows:

> 3. suicide or attempted suicide, while sane.
> 4. intentionally self-inflicted harm, while sane.

Georgia residents:

Under the **CLAIMS PROVISION** section of the Certificate, the **Claim Forms** provision is replaced with the following:

> **Claim Forms**
> If the provision includes language other than 10 working days, your certificate has been changed to require 10 working days.

Under the **GENERAL DEFINITIONS** section of the Certificate, if your Certificate includes a definition of **Dependent Child**, then the definition is changed as follows:

> **Dependent Child Definition**
> If the definition includes a maximum child age of less than 26 years, then the maximum child age is changed to 26 years.

Idaho Residents:

Right to Examine the Policy for 10 Days: Please examine the Policy. Within 10 days after delivery, the Policyholder may return the Policy to New York Life with a request for cancellation. If the Policy is returned, the Policy will be void from the start and a full refund will be made.

The Policy is renewable at the option of the Policyholder unless sufficient notice of nonrenewal is given to the Policyholder in writing by Us.

Under the **EXCLUSIONS** section of the Certificate, the following exclusions, if included in your Certificate, are modified to read as follows:

10. committing a felony;

B. Additionally, the following exclusions, if shown in your Certificate, are not applicable:

11. voluntary intake or use by any means of:

a. any drug, unless:

i. prescribed or administered by a Doctor and taken in accordance with the Doctor's instructions; or
ii. an over-the-counter drug, taken in accordance with the instructions.

b. any poison, gas or fumes, unless a direct result of an occupational accident;

12. operating a motorized vehicle while under the influence of alcohol, such that the Covered Person's blood alcohol content meets or exceeds the legal level established for Driving Under the Influence (DUI), Driving While Impaired (DWI), or other similar laws of the jurisdiction where the Accident occurred;

Indiana residents:

Under the **DESCRIPTION OF BENEFITS** section of the Certificate, the following benefits have been modified as follows:

If your Certificate includes a **Fracture Benefit**, then the time period between the covered Accident and diagnosis or treatment has been changed to 180 days.

If your Certificate includes an **Urgent Care Benefit**, then the time period between the covered Accident and a visit to an Urgent Care Facility has been changed to 180 days.

If your Certificate includes an **Initial Doctor's Visit Benefit**, then the time period between the covered Accident and initial treatment has been changed to 180 days.

If your Certificate includes a **Minor Diagnostic Exam (X-Ray) Benefit**, then the time period between the covered Accident and receiving an X-Ray has been changed to 180 days.

Under the **EFFECTIVE DATE OF INSURANCE** section of the Certificate, the **Effective Date of Coverage for Newly Born or Adopted Children** provision has been modified as follows:

If the first paragraph of the provision includes the following last statement, "...days from the moment of live birth or date of placement for adoption.", then the statement is changed to "days from the earlier of the moment of birth or date of placement for adoption."

In the second paragraph of the provision the following underlined statement has been added as a requirement to the provision: "If the Employee has not elected Dependent Child(ren) insurance coverage at the time of birth, date of placement, or date of entry of an order granting the Employee Custody."

Under the **GENERAL DEFINITIONS** section of the Certificate, the **Dependent Child** provision has been modified as follows:

If the definition includes "unmarried" child, then this requirement will not apply.

If the definition includes a maximum child age of less than 26 years, then this maximum is changed to 26 years.

If the definition for a child who has reached age 26, who is eligible as a Dependent Child under the Employee's or a health care plan.

If the definition for **the term "child" means** includes "a legally adopted child, beginning with any waiting period pending finalization of the adoption of the child," then the requirement has been changed to "a legally adopted child."

If the definition for **the term "child" means** includes "a stepchild who resides with the Employee and is financially dependent upon such Employee" or a variation of this statement, then the requirement has been changed to "a stepchild."

If the definition for **the term "child" means** includes "a child of an Employee's covered Spouse, who resides with the Employee and is financially dependent upon such Employee" or a variation of this statement then the requirement has been changed to just "a child of an Employee's covered Spouse."

If the definition for **the term "child" means** includes "a child, including a grandchild, for whom the Employee is the court-appointment legal guardian, as long as the child resides with the Employee and primarily depends on the Employee for financial support" or "a child, including a grandchild, for whom the Employee is the court-appointment legal guardian, as long as the child resides with the Employee and primarily depends on the Employee for financial support. Financial Support means that the Employee is eligible to claim the child for purposes of Federal and State income tax returns." or a variation of these statements, then the requirement has been changed to "a child, including a grandchild, for whom the Employee is the court-appointment legal guardian."

Louisiana residents:

Under the **EFFECTIVE DATE OF INSURANCE** section of the Certificate, if the Certificate includes the **Effective Date of Coverage for Newly Born or Adopted Children** then the provision has been modified to include the following language after the first paragraph:

Additionally, the coverage for any unmarried child who is placed in Your home following execution of an act of voluntary surrender in favor of the Your or Your legal representative will begin on the date on which the act of voluntary surrender becomes irrevocable. You must complete enrollment for such child and pay any required premium.

Under the **GENERAL DEFINITIONS** section of the Certificate, if your Certificate includes a definition of **Dependent Child**, then the definition is changed as follows:

For an Employee's child who meets the following requirements:

- If the Dependent Child definition includes a maximum child age of less than 21 years, then the maximum child age is changed to 21 years for Coverage.
- If the Dependent Child definition includes a child enrolled in a school as a full-time student and is primarily supported by the Employee, then the minimum age is changed to 22 years or more but less than 24 years. If the child develops a mental or nervous condition, problem, or disorder which renders the child, in the opinion of a qualified psychiatrist, subject to a second opinion if deemed necessary by Us, unable to attend school as a full-time student and from holding self-sustaining employment, the child will be considered a full-time student.
- A child who has reached the maximum child age is unable to support themselves due to intellectual or physical disability.

The term "child" has been modified as follows:

- A grandchild in the custody of and residing with You.
- A legally adopted child, beginning with the placement of the child for adoption or following the execution of an act of voluntary surrender in favor of You or Your legal representative.
- A child for whom the Employee is the court- appointed legal guardian, as long as the child resides with the Employee and primarily depends on the Employee for financial support. Financial support means that the Employee is eligible to claim the child for purposes of Federal and State income tax returns.

Massachusetts residents:

The following statement is added to the **Continuation of Insurance Benefits** provision of the Certificate:

> If your employment is terminated due to a plant closing or partial closing (as defined in section 71A of Chapter 151A. Massachusetts Statutes), your insurance will continue under the Policy for a period of 90 days unless during that period you are otherwise entitled to similar benefits. Premium payment is required.

Missouri residents:

Under the **EXCLUSIONS** section of the Certificate, the exclusion for **suicide or intentionally self-inflicted harm**, if any, is modified to remove any references to an "insane" person.

Under the **CLAIM PROVISIONS** section of the Certificate, the **Time of Payment of Claims** provision has been replaced with the following:

> If the last paragraph of the provision includes the following statement "Any payment made by Us in good faith pursuant to this provision will fully discharge Us to the extent of such payments and release Us from all liability.", then the statement is changed to "Any payment made by Us in good faith pursuant to this provision will fully discharge Us to the extent of such payments."

Under the **CLAIM PROVISIONS** section of the Certificate, the **Claimant Cooperation Provision** does not apply.

Under the **CLAIM PROVISIONS** section of the Certificate, the **Physical Examination and Autopsy** provision has been replaced with the following:

> **Physical Examination and Autopsy**
> We, at Our expense, will have the right to examine any person for whom a claim is pending as often as it may reasonably be required. We may, at Our expense, require an autopsy in the case of death unless prohibited by law.

Under the **GENERAL PROVISIONS** section of the Certificate, the **Incontestability** provision has been modified as follows:

> **Incontestability**
> After two years from the Covered Person's effective date of insurance, or from the effective date of increased benefits, no such statement will cause insurance or the increased benefits to be contested except for non-payment of premiums or lack of eligibility for insurance.

Under the **GENERAL DEFINITIONS** section of the Certificate, the definition of **Accident, Accidental** is modified removing the reference to an "external" event.

Under the **GENERAL DEFINITIONS** section of the Certificate, if your Certificate includes a definition of **Dependent Child**, then the definition is changed as follows:

> **Dependent Child Definition**
> If the definition includes a maximum child age of less than 26 years, then the maximum child age is changed to 26 years.

South Carolina residents:

Under the **CLAIM PROVISIONS** section of the Certificate, the **Time of Payment of Claims** provision has been modified as follows:

Time of Payment of Claims
Benefits payable under the Policy will be paid within 60 days of Our receipt of due Written proof of loss.

Under the **CLAIM PROVISIONS** section of the Certificate, the **Physical Examination and Autopsy** provision has been modified as follows:

Physical Examination and Autopsy
We, at Our expense, will have the right to examine any person for whom a claim is pending as often as it may reasonably be required. We may, at Our expense, require an autopsy unless prohibited by law. Any such autopsy shall be performed in South Carolina.

Under the **CLAIM PROVISIONS** section of the Certificate, the **Legal Actions** provision has been modified to read as follows:

Legal Actions
No action at law or in equity may be brought to recover under the Policy less than 60 days after Written proof of loss has been furnished as required by the Policy. No such action will be brought more than six years after the time such Written proof of loss must be furnished.

Texas Residents:

Under the **EFFECTIVE DATE OF INSURANCE** section of the Certificate, if your Certificate includes the **Effective Date of Coverage for Newly Born or Adopted Children** provision, then the following changes will be included:

- The Time Period for coverage for adopted children will be revised to read a minimum of 31 days.

- The Time Period for notification of no election of Dependent Child coverage will be revised to read 31 days.

- The Time Period for continued coverage will be revised to read 31 days.

- A child is considered to be the child of an insured if the insured is a party to a suit in which the insured seeks to adopt the child.

Under the **GENERAL DEFINITIONS** section of the Certificate, if your Certificate includes a definition of **Dependent Child**, then the definition is changed as follows:

For an Employee's child who meets the following requirements:

If the Dependent Child definition includes a maximum child age of less than 26 years, then the maximum child age is changed to 26 years.

For an Employee's child who has reached the maximum child age, included items are:

-Is chiefly dependent on the Employee for support and maintenance.
-Is the subject of a medical or dental support order under the health coverage of the Employee.

The term "child" includes:

-A child for which the Employee is a party to a suit in which the Employee seeks to adopt the child.
-A stepchild who dependent upon such Employee.
-A child and stepchild of an Employee's or covered Spouse (Note: include "or covered Spouse" only if Spouse coverage is included under the policy.)
-A grandchild, if a dependent of the Employee for federal income tax purposes at the time of application for coverage of the grandchild.
-A child for whom the Employee is the court-appointed legal guardian.

Utah Residents:

Under the **EFFECTIVE DATE OF INSURANCE** section of the Certificate, if your Certificate includes the **Effective Date of Coverage for Newly Born or Adopted Children** provision, then the following language has been modified as follows:

> An Employee's Dependent Child(ren) who are born or adopted while the Employee is covered under the Policy are covered for 60 days from the moment of live birth or date of placement for adoption. For purposes of this Policy, placement means the assumption and retention of a legal obligation for the child.

If the **PORTABILITY or CONTINUATION** provision is not included in the Certificate, then these options will be afforded to residents of Utah. Upon termination, please contact your employer for further information.

Under the **EXCLUSIONS AND LIMITATIONS** section of the Certificate, if the certificate includes the following **Exclusions**, then the **Exclusions** have been modified as follows:

> 8. voluntary participation in a riot, insurrection, or terrorist activity
> 9. voluntary participation in committing or attempting to commit a felony

Under the **GENERAL PROVISIONS** section of the Certificate, if the Certificate includes the **Unpaid Premium** provision, then this provision has been removed and does not apply.

Under the **GENERAL DEFINITIONS** section of the Certificate, if the Certificate includes a definition of **Dependent Child**, then the definition is modified as follows:

For an Employee's child who meets the following requirements:

> If the Dependent Child definition includes a maximum child age of less than 26 years, then the maximum child age is changed to 26 years.

For an Employee's child who has reached the maximum child age, included items are:

> -A child less than 26 years old.
> -A child who has reached age 26 who:
>
> a. Is unable to support themselves due to mental or physical impairment

The term "child" includes:

> - A natural child.
> - A foster child.
> - A legally adopted child, beginning with the placement of the child.
> - A stepchild.
> - A child, including a grandchild.

Washington residents:

Extraterritorial requirements apply, with respect to Washington Certificate holders when issued out-of-state via direct issue to employers and labor unions outside of Washington.

In addition to those changes, the out-of-state Certificate should be used for WA residents in lieu of the Modifications for Residents of Certain States Form.

Under the **DESCRIPTION OF BENEFITS** section of the Certificate, if the Certificate includes an **Accidental Death Benefit**, then the time period provision between the Covered Accident and Death is changed to **365 days**.

Under the **DESCRIPTION OF BENEFITS** section of the Certificate, if the Certificate includes an **Accidental Death and Dismemberment Benefit**, then the time period provision between the Covered Accident and death is changed to **365 days** and the time period provision between the Covered Accident and Dismemberment is changed to **365 days**.

SUPPLEMENTAL INFORMATION
for

Franklin Square Holdings Health and Welfare Plan ("Plan")

required by the Employee Retirement
Income Security Act of 1974

As a Plan participant in Franklin Square Holdings, LP, you are entitled to certain information, rights and protection under the Employee Retirement Income Security Act of 1974 (ERISA).

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

IMPORTANT INFORMATION ABOUT THE PLAN

- The Plan is established and maintained by Franklin Square Holdings, LP, the Plan Sponsor.
- The Employer Identification Number (EIN) is 26-0196373.
- The Plan Number is 501.
- The Insurance Plan is administered directly by the Plan Administrator with benefits provided, in accordance with the provisions of the group insurance contract, GAI0100383 ("Policy"), issued by LIFE INSURANCE COMPANY OF NORTH AMERICA ("Insurance Company").
- The Plan Administrator is: Franklin Square Holdings, LP
  3025 John F Kennedy Blvd
  5th Floor
  Philadelphia, Pennsylvania 19104
  (215) 495-1175
- The Plan Administrator has authority to control and manage the operation and administration of the Plan.
- The Plan Sponsor may terminate, suspend, withdraw or amend the Plan, in whole or in part, at any time, subject to the applicable provisions of the Policy. (Your rights upon termination or amendment of the Plan are set forth in your Certificate.)
- The agent for service of legal process is the Plan Administrator.
- The Plan of benefits is financed by the Employees.
- The date of the end of the Plan Year is December 31.

YOUR RIGHTS AS SET FORTH BY ERISA

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

Receive Information About Your Plan and Benefits

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

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

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

Prudent Actions by Plan Fiduciaries

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

Enforce Your Rights

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

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

Assistance with Your Questions

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

WHAT YOU SHOULD DO AND EXPECT IF YOU HAVE A CLAIM

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

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

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

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

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

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

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

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

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

A written request for appeal must be received by the Insurance Company within 180 days from the date the claimant received the adverse decision. If an appeal request is not received within that time, the right to appeal will have been waived. The Insurance Company has 45 days from the date it receives a request for appeal to provide its decision. Under special circumstances, the Insurance Company may require more time to review the claim and can extend the time for decision, once, by an additional 45 days. If this should happen, the Insurance Company must provide the extension notice, in writing, before expiration of the initial decision period, indicating the special circumstances and the date a decision is expected. If the extension is made because additional information must be furnished, the claimant has 45 days within which to provide the requested information and the time for the Insurance Company's decision shall be tolled (stopped) from the date on which the notification of the extension was sent until the date the Insurance Company receives the claimant's response or upon the date the requested information is required to be furnished expires, whichever is sooner.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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