COMPANION LIFE INSURANCE COMPANY
P.O. BOX 100102, Columbia, South Carolina 29202-3102
(803) 735-1251

CERTIFICATE OF COVERAGE

POLICYHOLDER:	County of Anson 101 South Greene St, Ste 211 Wadesboro, NC 28170
CERTIFICATEHOLDER	
POLICY NUMBER:	907-14-01769
CERTIFICATE NUMBER:	
EFFECTIVE DATE:	
POLICY ANNIVERSARY DATE:	01/01
STATE OF ISSUE:	NC. The insurance department telephone no. (919) 807-6000.

Companion Life Insurance Company welcomes Your County of Anson Employer as a client.

This is to certify that We have issued and delivered the Group Insurance Policy to the Policyholder shown above and subject to the terms of that Policy You, the Employee, are eligible. This Certificate includes Dependent coverage.

This Certificate of insurance is evidence of Your insurance under the Policy and of the Policy's benefits. Everything contained in this Certificate of insurance is subject to the provisions, definitions and exceptions in the Policy. The Policy is on file with the Policyholder and may be examined at any reasonable time.

This Certificate replaces all Certificates and Certificate Riders, if any, previously issued to the Policyholder by Us to give to You under the Policy.

Also, if the terms of Your Certificate of coverage and the Policy differ, the Policy will govern but in no case will benefits and rights be less than those stated in this Certificate. Your coverage may be terminated or modified in whole or in part under the terms and provisions of the Policy. **READ YOUR CERTIFICATE CAREFULLY.**

IN WITNESS WHEREOF the COMPANION LIFE INSURANCE COMPANY has caused this Certificate to be signed at Columbia, South Carolina.

Andy Folsom
President

Duncan McIntosh
Secretary

GROUP TERM LIFE AND ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE CERTIFICATE
RENEWAL AT THE OPTION OF THE COMPANY, NONPARTICIPATING

YOU SHOULD SEEK ADDITIONAL INFORMATION FROM YOUR PERSONALTAX ADVISOR ABOUT THE TAX STATUS OF THE ACCELERATED DEATH BENEFIT PAYMENT.
Benefits will be reduced if an accelerated death benefit is paid.

For service or questions about this Certificate, please address any inquiries to Companion Life,
P.O. Box 1535, Dubuque, IA 52004-1535 or call 1-877-676-5789 or via website www.companionlife.com.

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SECTION 3 - SCHEDULE OF BENEFITS

ELIGIBLE CLASS OF EMPLOYEES – All Active Employees working 30 hours or more per week who are legal residents or citizens of the U.S.

ELIGIBILITY WAITING PERIOD - Employees are eligible for coverage on the first day of the month following 1 Days of continuous employment.

EMPLOYEE LIFE INSURANCE
Non-Contributory

Benefit Amount
Basic Benefit: $25,000

Satisfactory evidence of insurability is required for amounts in excess of the Guarantee Issue.

In compliance with the Age Discrimination in Employment Act (ADEA), the Employee Life benefit reduces to 65% at age 65. It further reduces to 50% of the original amount at age 70, to 25% at age 75, and terminates at Retirement, whichever occurs first.

DEPENDENT LIFE INSURANCE
Voluntary

Benefit Amount		
Spouse:	If applicable, see separate certificate	
Dependent Child:	6 months to age 26:	If applicable, see separate certificate. Employee coverage required
	14 days to 6 months:	If applicable, see separate certificate.

The Spouse and/or Dependent Child benefit terminate upon termination of the Employee's benefit.

EMPLOYEE ACCIDENTAL DEATH & DISMEMBERMENT INSURANCE
Non-Contributory

Benefit Amount
Basic Benefit: $25,000

Satisfactory evidence of insurability is required for amounts in excess of the Guarantee Issue.

In compliance with the Age Discrimination in Employment Act (ADEA), the Employee Life benefit reduces to to 65% at age 65. It further reduces to 50% of the original amount at age 70, to 25% at age 75, and terminates at Retirement, whichever occurs first.

SECTION 4 - DEFINITIONS

ACCIDENTAL INJURY means a bodily injury sustained by an Insured, which is the direct result of an accident, independent of disease or bodily or mental illness or infirmity or any other cause, and which occurs while the Insured's coverage is in force. Accidental Injury includes bodily injury caused by exposure to the elements when the exposure is a direct result of an accident.

ACTIVE EMPLOYMENT means the Employee must be working:

1. for the Employer and paid regular earnings;
2. at least the minimum number of hours shown in the Schedule of Benefits; and either
3. at Your Employer's usual place of business; or
4. at a location to which the Employer's business requires You to travel.

ACTIVE WORK or **ACTIVELY at WORK** means the Employee is performing the usual and customary duties of the Employee's own occupation at the Employer's usual place of business. The Employee will be considered Actively at Work if:

1. the Employee was absent from Active Work because of a regularly scheduled day off, holiday or vacation;
2. the Employee was Actively at Work on the last scheduled work day before the date of absence; or
3. the Employee was capable of Active Work on the day before the scheduled Effective Date of insurance or increase in insurance.

ADMINISTRATOR means an organization (or entity) that processes all or certain administrative functions for the Company.

ANNUAL SALARY means Your rate of earnings from the Policyholder in effect immediately prior to the date a claim begins.

BENEFICIARY means a person or entity named by the Employee to receive death benefits.

CERTIFICATE means a document that describes the benefits provided to the Insured by the Policy.

CERTIFICATEHOLDER means the Employee who is eligible for benefits provided by the Policyholder's Policy and who has been provided a Certificate of insurance.

COMPANY is Companion Life Insurance Company. Our home office mailing address is P.O. Box 100102, Columbia, SC 29202-3102.

CONFINED means that the Insured is confined because of injury or sickness in a hospital, home or elsewhere. The Insured must be unable to carry on any substantial part of the Insured's normal activities.

DEPENDENT means:

1. an Insured's Spouse; or
2. each Insured's Dependent Child under 26 years of age; and
3. each unmarried child over 26 who is incapable of self-sustaining Employment because of mental or physical handicap and primarily dependent on the Insured for support and maintenance.

Proof of the incapacity and dependency must be furnished to the Company within 31 days of the child's attainment of the limiting age and subsequently as may be required by the Company, but not more frequently than annually after the two-year period following the child's attainment of the limiting age.

DEPENDENT CHILD means (a) the Insured's natural child from moment of birth; (b) the Insured's adopted child from the date of a final court order granting adoption of the child or, if earlier, the date the child is placed by a court in the Insured's home pending such an order; (c) any child living with the Insured in a regular parent-child relationship and primarily dependent on the Insured for support and maintenance, or (d) any child for whom We have notice, pursuant to a medical support order, that the Insured must provide support in the form of insurance from the date of such notice (e) any child required to be covered under civil union, domestic partnership, marriage or other family or domestic relations laws of the state where the Policy is delivered.

For the purpose of this definition, "medical support order" is a valid order of a court, judicial department or government agency at the local, state, or federal level that obligates the Insured to provide a child financial support in the form of

insurance.

EFFECTIVE DATE for the Employer means the first date coverage under the Policy becomes effective. The Effective Date is shown on the Policy cover page. The Effective Date for an Insured is shown on this Certificate. All insurance will begin at 12:01 A.M. standard time at the Policyholder's address on the Effective Date. It will end at 12:01 A.M. standard time at the Policyholder's address on the Termination Date.

ELIGIBILITY WAITING PERIOD means the continuous length of time just before the Employee's date of eligibility during which the Employee must be in an Eligible Class. The Eligibility Waiting Period is stated on the Schedule of Benefits.

ELIGIBLE CLASS means any group of persons insured individually under the group Policy who have a common bond.

EMPLOYEE means a person in Active Employment with the Employer, who is compensated for work done.

EMPLOYER means the Policyholder and includes any division, subsidiary or affiliated company wholly owned by the Policyholder and named in the Policyholder's application.

EVIDENCE OF INSURABILITY means a statement or proof of an individual's current health and medical history upon which We will determine acceptance.

GUARANTEE ISSUE is the maximum amount of life insurance shown in the Employer's Schedule of Benefits, which is available without Evidence of Insurability. The Guarantee Issue only applies at initial eligibility.

INSURED means a person who has qualified for insurance by completing the Eligibility Waiting Period, if any, as shown on the Schedule of Benefits and for whom coverage under the Policy has become effective.

NON-CONTRIBUTORY means the Employer must pay all of the cost of the insurance. The maximum amount that an Employer will be required to contribute to the cost of the insurance must not exceed the premium charged for the amount of such insurance.

PHYSICIAN means a person who is:

1. operating within the scope of his/her license;
2. is licensed to practice medicine and prescribe and administer drugs or to perform surgery; and
3. is legally qualified as a medical practitioner and required to be recognized under the Policy for insurance purposes according to the insurance statutes or the insurance regulations of the governing jurisdiction.

It does not include an Employee or the Employee's Spouse. It does not include children, stepchildren, parents, grandparents, grandchildren and brothers and sisters or their spouses.

POLICY means the group life insurance Policy issued by Us to the Policyholder and identified by the Policy number.

POLICY ANNIVERSARY DATE means the date established and agreed to by the Policyholder and Us from which Policy months, years, and anniversaries are computed.

POLICYHOLDER means the Employer in whose name the Policy is issued, as shown on the cover page of this Certificate. The term Policyholder will also include those subsidiaries, divisions, and affiliates listed in the Policy.

RETIREMENT or "The Date the Insured Retires" means the Effective Date of the Insured's:

1. retirement pension benefits under any plan of a federal, state, county or municipal Retirement system, if such pension benefits include any credit for employment with the Policyholder;
2. retirement pension benefits under any plan which the Policyholder sponsors, or makes or has made contributions;
3. retirement benefits under the United States Social Security Act of 1935, as amended, or under any similar plan or act.

SCHEDULE OF BENEFITS means the document showing the Eligible Class, the amounts of insurance and other relevant information about the plan of insurance applied for by the Employer under the Policy. It is made a part of the Policy and this Certificate for the purposes of defining coverage under the Policy.

SPOUSE means a lawfully recognized Spouse in the state where the Insured resides. Spouse also includes the Insured's domestic partner or civil union partner as defined by state law. The Insured must provide the Policyholder

with proof of such legal domestic partnership or legal civil union partnership required by state law or the Company including as applicable but not limited to a declaration of such partnership, license of such partnership or registration of such partnership, or other documentation as required by state law.

TOTALLY DISABLED or **TOTAL DISABILITY** refers to any condition which results from a sickness or injury. The condition is when the Employee is unable to perform the material duties of the Employee's regular job and is unable to perform any other job for which the Employee is fit by education, training or experience.

WE, US, and OUR means Companion Life Insurance Company or its Administrator.

YOU, YOUR, and YOURS means the Insured.

SECTION 5 - ELIGIBILITY AND EFFECTIVE DATES

EMPLOYEE

DATE OF ELIGIBILITY - You will become eligible upon completion of the Eligibility Waiting Period, if any, shown in the Schedule of Benefits.

EMPLOYEE'S EFFECTIVE DATE OF INSURANCE - An eligible Employee becomes Insured on the later of the following dates:

1. if the Employee enrolls on or prior to becoming an eligible Employee - when the Employee becomes eligible;
2. if the Employee enrolls within 31 days after becoming eligible - when the Employee enrolls;
3. if the Employee enrolls more than 31 days after becoming eligible - when We approve Evidence of Insurability.

DEPENDENT

ELIGIBILITY - Each Employee shall become eligible to cover a Dependent on the later of the following dates:

1. the date the eligible Employee completed the Eligibility Waiting Period, if any, shown in the Schedule of Benefits;
2. the date the eligible Employee acquires a Dependent; and
3. are an Active Employee working 30 hours or more per week who is a legal resident or citizen of the U.S.

Only the members of the class(es) shown in the Schedule of Benefits are eligible.

DATE OF ELIGIBILITY - Each eligible Dependent shall become insured on the later of the following dates:

1. if the Employee applies for Employee insurance, the date the Employee becomes insured. Applications must be received for both the Employee's insurance and the Dependent's insurance prior to the date the Employee becomes eligible or within 31 days after the date the Employee becomes eligible; or
2. the date We approve Evidence of Insurability, if applications are received or postmarked more than 31 days after the date the Employee becomes eligible for Dependent life insurance.

EVIDENCE OF INSURABILITY - Evidence of Insurability, at Our expense, will be required on the Employee and/or Dependent if:

1. the amount of Employee or Dependent insurance exceeds the Guarantee Issue amount;
2. enrollment and/or increases are made more than 31 days after the Employee or Dependent are first eligible; or
3. the Employee enrolls on or after the attainment of age 70.

If the Employee and Dependent were insured under the Employer's prior group term life insurance policy on the day before the Employer's Effective Date under the Policy, they will not have to submit Evidence of Insurability to become insured for the same amount of coverage under the Policy. Evidence of Insurability will be required if the Employee or Dependent increases the amount of life insurance under the Policy if it is over the Guarantee Issue amount.

DELAYED EFFECTIVE DATE

Employee: The Effective Date of any initial, increased or additional insurance for an Employee will be delayed if the Employee is not in Active Employment because of an injury, a sickness, a temporary layoff or a leave of absence on the date that insurance would otherwise be effective. The insurance will start on the date the Employee returns to Active Work.

Dependent: The Effective Date of any initial, increased or additional insurance will be delayed for the Dependent if the Dependent is confined because of an injury or a sickness on the date that insurance would otherwise be effective. Eligibility for such insurance will start on the date Your Dependent is no longer confined.

SECTION 6 - BENEFITS

LIFE INSURANCE BENEFIT

EMPLOYEE

BENEFIT - Upon receiving proof that an Employee died while insured under the Policy, We will pay the amount of insurance in force at the time of his/her death in accordance with the Schedule of Benefits.

BENEFICIARY DESIGNATION The beneficiary or beneficiaries shall be that person or persons indicated on Your enrollment form for this Certificate. This form will be filed with the Policyholder.

CHANGE OF BENEFICIARY Unless You have made an irrevocable assignment of benefits, the beneficiary may be changed by sending a written request on Our form to Companion Life or its Administrator. When such request is received by Us, the change of beneficiary shall take effect as of the date the request is signed, unless otherwise provided.

CONSENT OF BENEFICIARY If You initially name Your spouse as beneficiary, We will require written consent of Your spouse to name or change the beneficiary in community property states.

PREFERENTIAL BENEFICIARY If You die and no beneficiary is living or named, We may, at Our option, pay any benefits due to Your estate or to Your following surviving relatives:
Your:

1. spouse;
2. child or children;
3. parent(s);
4. brothers and sisters; or
5. executors or administrators.

We will not be liable to the extent of any payment so made, unless We receive written notice of a valid claim by some other person before payment is made.

MINOR BENEFICIARY If the beneficiary is a minor or, in the opinion of Companion Life, is not able to give valid release for any payment due, We will pay to the court appointed conservator or administrator of the minor beneficiary's estate. We will not be liable to the extent of any payment so made in good faith.

MORE THAN ONE BENEFICIARY If You have named more than one beneficiary, the Group Term Life and Accidental Death and Dismemberment Benefit shall be paid to the beneficiaries who survive You, in equal shares, unless You have specified a different proportion.

SETTLEMENT OPTIONS You may elect or change a settlement option by filing a written request with Us. The settlement options available will be those offered by Us when the option is chosen. If You do not request a settlement option, the beneficiary may do so after Your death.

DEPENDENT

PAYMENT OF BENEFITS - Upon receipt of due proof that a Dependent died while insured under the Policy, We will pay the amount of insurance in force at the time of his/her death in accordance with the Schedule of Benefits.

BENEFICIARY - We will pay benefits for loss of life to the Employee, if living. Otherwise, We will pay benefits to the decedent's estate.

We will not be liable to the extent of any amount so paid.

SUICIDE EXCLUSION - With respect to the Life Insurance Benefit, in the event an Insured dies through intentionally self-inflicted injuries or any such attempt, while sane or insane, within two years from the Effective Date of coverage, a benefit will not be paid. Our liability shall be only to return premiums paid under the Policy as to such Insured.

The Suicide Exclusion will not apply to the Insured who was insured for Group Life insurance under the prior carrier's policy on its termination date,

If an Insured commits suicide within two years from the date an increase in life insurance (other than a scheduled or automatic increase) took effect, the Company will pay to the Beneficiary the amount of insurance that was in effect before the increase. Any premium paid by the Insured for the increase will be returned to the Beneficiary, and any premium paid by the Policyholder will be returned to the Policyholder.

INTEREST LIFE BENEFITS- Interest shall accrue and be payable from the date of death at the Two Year Treasury Constant Maturity Rate as published by the Federal Reserve on date of death. Additional interest shall also accrue at a rate of 10% annually beginning with the date that is 31 calendar days from the latest of the following dates to the date the claim is paid:

a. The date that due proof of death is received by Us. Due proof of death will consist of a certified copy of the death certificate of the Insured, or other lawful evidence providing equivalent information, and proof of claimant's interest in the proceeds;
b. The date We receive sufficient information to determine Our liability, the extent of the liability, and the appropriate payee legally entitled to the proceeds, or;
c. The date that legal impediments to payment of proceeds that depend on the action of parties other than Us are resolved and sufficient evidence of the same is provided to the Us. Legal impediments to payment include, but are not limited to:
    1. The establishment of guardianships and conservatorships;
    2. The appointment and qualification of trustees, executors and administrators; and
    3. The submission of information required to satisfy state or federal reporting requirements.

WAIVER OF PREMIUM BENEFIT

EMPLOYEE - If an insured Employee becomes Totally Disabled prior to age 60, We will waive premium for the insured Employee's Life Insurance Benefit. The waiver of premium will begin on the first of the month following 12 consecutive months of Total Disability. During this period, all premiums must continue to be paid according to this Certificate. The Insured must file within 12 months after the date of Total Disability to be eligible for this benefit, unless unable to do so. See proofs of loss section. Upon the Company's decision, a written notice will be sent to the Employee advising if the waiver of premium was approved and if approved the premium amount to be waived.

The Employee must send the Company, within 12 months, required proof of Total Disability and that it has continued without interruption until the end of the waiting period. Failure to furnish such proof within such time will not invalidate or reduce any claim if it is shown not to have been reasonably possible to furnish such proof within such time, provided such proof was furnished as soon as reasonably possible. Upon the Company's decision, a written notice will be sent to the Employee advising if the waiver of premium was approved and if approved the premium amount to be waived

With respect to the Employee, this Waiver of Premium Benefit shall end on the earliest of the following:

1. on the date the Employee's Total Disability ends;
2 on the 91st day after We request proof of continuous Total Disability, provided the Employee fails to furnish Us with such proof during such 91-day period;
3 on the premium due date immediately prior to the Employee's 65th birthday;
4. on the Effective Date of any individual life insurance Policy obtained in accordance with the "Right to Convert" provision located in this Certificate; or
5. on the date the Employee retires, as defined in this Certificate.

If the Employee dies during the waiver benefit period, Proof of Loss should be submitted to the Company after death. Proof of Loss includes supporting documentation that Total Disability continued without interruption from the date the waiver benefit started to the date of death. If the Employee had converted the continued coverage to an individual life insurance policy, the Company will pay the continued life insurance if the individual policy is returned.

EXTENSION OF LIFE INSURANCE BENEFIT

If an Employee becomes Totally Disabled, life coverage under the Certificate will continue for 12 months. Premiums are required to be paid for the Certificate during this extension. The Policyholder and the Employee are responsible to pay the

Premium for the continuation on the same basis as Premium was paid on the day before Total Disability began. If at the end of the extension and the Employee is no longer eligible for insurance under this Policy, the Employee may convert the Certificate according to the Right to Convert provision.

A death benefit will be paid if the insured Employee dies while Totally Disabled and no longer insured under the Policy if the Total Disability meets all these requirements:

1. began while the person was both insured under the Policy and under age 60;
2. has been continuous until death; and
3. began within 12 months of the date of death.

In this case, We must receive within one year from the date of death: (A) satisfactory written notice of items 1, 2, and 3; and (B) written proof of death.

The life insurance benefit which is continued during Total Disability under Waiver of Premium Benefit is the applicable amount of life insurance in force for the insured Employee on the date the Insured's Total Disability begins. The benefit is subject to any reductions shown in the Schedule of Benefits.

At any time during the waiver of premium period, We may, at Our expense, require the Employee to submit to a physical examination as often as reasonably necessary.

This Extension of Life Insurance Benefit during Total Disability does not apply to the Accidental Death and Dismemberment Benefit.

RIGHT TO CONVERT

If an Insured is no longer eligible for part or all of the Life Insurance Benefit provided by this Policy, the Policyholder will provide written notice to the Insured of their right to convert at least 15 days prior to the date insurance coverage would end. The right to convert will expire on the later of 16 days after the Employee is given such notice or the end of the conversion period, but in no event will the right to convert extend beyond 60 days after the expiration of the conversion period. Written notice will be given to the Employee by the Policyholder or Company administering the coverage. The notice will be mailed to the Employee's last known address and will constitute notice of the right to convert.

The circumstances for which an Employee may convert this Policy are as follows:

1. the Employee's group term life insurance ends for one or more of the following reasons;
   a. the Employee ceases to be in an eligible class;
   b. the Employee's Employment ends;
   c. the Employee's continuation of insurance, if any, ends;
   d. the Employee's portability coverage, if any, ends;
   e. the group Policy ends; or
   f. the Policy is changed to end life insurance for the eligible class to which the Employee belongs; or
2. the Employee's life insurance is reduced:
   a. on or after the Employee attains a specified age;
   b. because the Employee changes from one eligible class to another; or
   c. due to policy change.

Such Insured is entitled to apply to Us for an individual Policy of life insurance, without submitting Evidence of Insurability provided:

1. the Policy applied for:
   a. is a type of individual life policy, other than term, then being administered/issued by Us or a company of Our choosing; and
   b. does not include Accidental Death and Dismemberment or other Supplemental benefits; and
   c. does not allow for life insurance which ceases solely due to nonpayment of contributions.

2. the amount of life insurance applied for under such individual life policy is in accordance with the **Amount To Convert** provision below; and

3. the Insured agrees to pay the premium for such individual life policy. The premium will be based on the following, as of the effective date of such individual life policy:
   a. Our usual rate for the amount and type of individual life policy;
   b. the Insured's current risk class; and
   c. the Insured's attained age; and

4. the Insured applies for such individual life policy within 31 days following termination or reduction of the Life Insurance Benefit under the Policy. Such individual life policy will become effective on the first day following the end of such 31-day period

AMOUNT TO CONVERT - This conversion privilege is allowed for the term life insurance that ceases as described below:

1. the Insured may convert all or part of the amount of life insurance benefit for which he/she is no longer eligible due to either:
   a. reductions resulting from attainment of a specific age, as shown in the Schedule of Benefits; or
   b. loss of eligibility.

2. if the Insured has been insured under the Policy for at least five years, the lesser of the amounts shown in c (i) or (ii) below may be converted if the Insured is no longer eligible due to any of the following:
   a. termination of the Policy;
   b. termination of the class of Insureds to which the Insured belongs; or
   c. reduction of benefits for the class of Insureds to which the Insured is a member:
      (i) $10,000; or
      (ii) all or part of the amount for which the Insured is no longer eligible. This amount will be reduced by the amount of any life insurance for which the Insured becomes eligible to receive under a Policy issued or reinstated by Us or any other insurer during the 31-day period immediately following termination of insurance under the Policy.

If the Insured dies during the conversion period, the maximum amount of term life insurance to which the Insured would have been entitled shall be payable as a claim under this Certificate. It will be payable whether or not application for the individual Policy or the payment of the first premium has been made.

The rights or benefits granted under this provision are instead of any other rights or benefits granted under this Certificate or the Policy.

This right to convert does not apply to the Accidental Death and Dismemberment Benefit.

DEPENDENT INSURANCE CONVERSION

1. An Employee may convert the Dependent's life insurance if it ends for any reason other than:
   (A) Nonpayment of premium;
   (B) A spouse ceases to be a Spouse as defined in the Certificate; or
   (C) A Child attains the limiting age for coverage under the Certificate.
2. An Employee may convert the Dependent's life insurance if it is reduced:
   (A) On or after the Dependent attains a specified age;
   (B) Because the Employee changes from one eligible class to another; or
   (C) Due to a Policy change;
3. A Spouse may convert life insurance if it ends because the spouse ceases to be a Spouse as defined in the Certificate; or
4. A Child may convert life insurance if it ends because the Child attains the limiting age for coverage under the Certificate;

The conversion provisions apply to the right to convert Dependent insurance as follows:

1. If the Employee elects not to convert a Dependent's reduced amount of life insurance, the Employee will not have the option to convert such reduced amount at a later date;
2. the Company must receive the completed application and required Premium within 31 days after insurance ends or is reduced (the "conversion period");
3. the requirements for providing notice of the right to convert are as follows. The Employee shall be given written notice by the Policyholder of the right to convert Dependent's insurance at least 15 days prior to the date insurance ends or is reduced. The right to convert will expire on the later of 16 days after the Employee

is given such notice or the end of the conversion period, but in no event shall the right to convert extend beyond 60 days after the expiration of the conversion period. Written notice shall be given to the Employee by the policyholder or insurance company administering the coverage. The notice shall be mailed to the Employee's last known address and shall constitute notice of the right to convert;

4. If evidence of insurability is required to port the amount of Dependent life insurance that ends under the Certificate, the provisions shall state that if the initial, timely application for such portability coverage is rejected, the Employee shall be given additional written notice of the right to convert Dependent insurance by the Company, and that right to convert will expire 31 days after the date such notice was given;
5. Premiums for the conversion policy will be based on:
    a. The Company's rates then in use;
    b. The form and amount of insurance;
    c. The Dependent's class of risk; and
    d. The Dependent's attained age when insurance ends or is reduced;
6. The conversion policy may be any form then customarily offered by the Company, other than individual term life insurance. The conversion policy may be issued without any additional benefits, whether or not such benefits were in effect on the date insurance ended or was reduced;
7. The conversion policy will take effect on the day after the conversion period ends;
8. If the Dependent's insurance ends or is reduced for any reason, the maximum amount that may be converted shall be the Dependent's life insurance amount, inclusive of additional benefits, that ends or is reduced under the Certificate, less the amount of Dependent life insurance for which the Employee becomes eligible under any group policy within 31 days after the date the Dependent's insurance ended or was reduced;
9. During the conversion period the Dependent's life insurance will continue under the Certificate. If the Dependent dies during the conversion period, the insurance company shall pay the Dependent life insurance amount, inclusive of additional benefits, that was entitled to be converted under the Certificate. If application and Premium payment is made for the conversion policy, any premiums paid for the conversion policy shall be refunded. In no event shall the insurance company be liable to pay a death benefit under both the group policy and the conversion policy;
10. If the Certificate provides for the portability of Dependent coverage, the provisions shall state that if application and Premium payment is made for Dependent portability coverage and the Dependent dies during the conversion period, the insurance company shall pay the Dependent life insurance amount, inclusive of additional benefits, that was entitled to be converted under the Certificate. Any premiums paid for the portability coverage shall be refunded. In no event shall the insurance company be liable to pay a death benefit for both the coverage that was entitled to be converted and the coverage that was entitled to be ported, whether such portability coverage is to be provided under the same or a different group policy; and
11. If the Certificate provides for portability coverage and allows for porting an amount greater than the amount eligible for conversion, the provisions shall state that:
    a. If application and payment of Premium is made for an amount of Dependent portability coverage greater than the Dependent life insurance amount that could have been converted under the Certificate; and
    b. Such application is approved by the insurance company; then,
    c. If the Dependent dies during the conversion period, the insurance company shall pay the amount of Dependent life insurance, inclusive of additional benefits, for which the Dependent is approved under the terms of the portability provisions of the Certificate, whether such coverage is to be provided under the same or a different group policy. In no event shall the insurance company be liable to pay a death benefit for both the Dependent coverage that was entitled to be converted and the Dependent coverage that was ported, whether such ported coverage was to be provided under the same or a different group policy; and
    d. If the portability application is not approved, and the Dependent dies during the conversion period, the insurance company shall pay the amount of Dependent life insurance, inclusive of additional benefits, that was entitled to be converted under the Certificate. Any premiums paid for portability coverage shall be refunded. In no event shall the insurance company be liable to pay a death benefit for both the Dependent coverage that was entitled to be converted and the Dependent coverage that was ported, whether such ported coverage is to be provided under the same or a different group policy.

THE ACCELERATED BENEFIT PROVISION

THE BENEFIT - The insured Employee or insured Spouse with a Terminal Illness would be eligible to receive the following accelerated benefit:

1. 75% of the group term life insurance benefit in effect on the Employee's last day of active work up to a maximum insured amount of $133,400.
2. The maximum payable under this benefit is $100,000.

AN "ACCELERATED BENEFIT" covered under this contract is a benefit payable to the insured Employee or eligible Spouse if the Insured incurs a Terminal Illness, as described herein. The Insured or his or her legal representative may request the accelerated death benefit for the full amount payable in a lump-sum once during the lifetime of the Insured. No partial request is allowed. The Accelerated Benefit will reduce the death benefit otherwise payable under the life insurance contract. The Accelerated Benefit is payable for the Insured upon the occurrence of a single qualifying event which results in the payment of a benefit amount fixed at the time of acceleration If the Insured dies prior this benefit being paid, the request will be cancelled and the death benefit will be paid according to this Certificate.

The Accelerated Benefit will be payable immediately upon receipt of satisfactory Proof of a Terminal Illness. The Company will provide a statement to you demonstrating the acceleration of the death benefit and the effect on premium:

1. at the time of the request to accelerate the death benefit; and
2. upon the payment of an Accelerated Benefit.

After an Accelerated Benefit is paid the premium may remain the same.

TAX TREATMENT - Benefits paid under this provision may be taxable. The Insured or his or her Beneficiary may incur a tax obligation. As with all tax matters, an Insured should consult with his or her personal tax advisor and/or attorney.

DEFINITION OF TERMINAL ILLNESS - "Terminal Illness" means that the Insured has a medically determinable illness with no reasonable prospect of cure. The illness must be expected to result in death within 12 months of the date of Total Disability. The proof of Terminal Illness satisfactory to the Company must be certified by the Insured's attending Physician and one other Physician. Each Physician must be a licensed Doctor of Medicine (M.D.) or Doctor of Osteopathy (D.O.). The Physician must not be the Insured or a member of the Insured's immediate family. "Immediate family" includes Spouse, children, stepchildren, parents, grandparents, grandchildren, and brothers and sisters and their Spouses.

The Company reserves the right to have the Insured examined at its expense by a second or third Physician of its choice in connection with a request for the Accelerated Benefit.

ELIGIBILITY REQUIREMENTS - All eligible Actively at Work full time Employees and all eligible Spouses who have been covered under the group term life insurance are eligible for the Accelerated Benefit. The benefit terminates at the earliest of:

1. when the group term life insurance terminates on the Employee or covered Spouse;
2. at attained age 70; or
3. for Employees and/or their covered Spouse, at the Employee's Retirement from employment.

The Insured must sign a release acknowledging receipt of the Accelerated Benefit and the reduction of the remaining benefit by the amount of the Accelerated Benefit. Dependent Children are not eligible for the Accelerated Benefit.

EXCLUSIONS AND LIMITATIONS - The Accelerated Benefit will not apply:

1. to any self-inflicted injuries or suicide attempts;
2. to any life insurance benefits for Dependent Children;
3. if an Insured person is Totally Disabled on his or her Effective Date of coverage under the Policy;
4. to a group term life insurance benefit that has been assigned;
5. to a group term life insurance benefit payable to an irrevocable Beneficiary;
6. to a group term life insurance benefit with a face amount of less than $10,000; or
7. if the required group term life insurance premium is due and unpaid.

CONVERSION – The amount of group term life insurance that may be converted is the Employee's group term life insurance reduced by the Accelerated Benefit amount paid.

REDUCTIONS – If a benefit reduces in accordance with a reduction provision, the total amount payable to the Insured will not be affected by the advanced payment.

FREQUENCY – Only one Accelerated Benefit payment will be made to the Insured.

TERMINATION – This provision will terminate for the insured Employee on the earliest of the following dates:

1. the date the Employee's Employer terminates coverage under the Policy;
2. the date the Policy terminates;
3. the date the Employee retires;
4. the date the Employee dies;
5. the date the Employee receives an Accelerated Benefit payment;
6. the date the Employee continues coverage under the Right to Convert Provision of the Policy; or
7. upon written request from a Certificateholder.

This provision will terminate for the insured Spouse on the earliest of the following dates:

1. the date the Spouse received an Accelerated Benefit payment;
2. the date the Spouse continues coverage under the Right to Convert Provision of the Policy;
3. the date the Employee's eligibility for the Accelerated Benefit terminates; or
4. the date the employed Spouse of the insured Spouse is no longer eligible for group term life insurance.

Benefits under this provision will not be denied if the qualifying event occurred while this benefit was in force. If the Accelerated Benefit ends, this will not prejudice the payment of benefits for any qualifying event that occurred while the form was in force.

The Accelerated Benefit does not apply to the Accidental Death and Dismemberment Benefit.

ACCIDENTAL DEATH AND DISMEMBERMENT ("AD&D") BENEFIT

If You suffer any of the following losses We will pay the indicated percentage of the benefit amount. The loss must: (1) result from an Accidental Injury and independent of all other causes. The Accidental Injury must be caused by an accident that occurs while this benefit is in force as to the Insured; and (2) occur within 180 days of that accident. The benefit amount is shown in the Schedule of Benefits.

Accidental Loss of Life	100% of AD&D Benefit
Accidental Loss of Both Hands or Both Feet	100% of AD&D Benefit
Accidental Loss of Entire Sight of Both Eyes	100% of AD&D Benefit
Accidental Loss of One Hand and One Foot	100% of AD&D Benefit
Accidental Loss of One Hand and the Entire Sight of One Eye	100% of AD&D Benefit
Accidental Loss of One Foot and the Entire Sight of One Eye	100% of AD&D Benefit
Accidental Loss of One Hand or One Foot	50% of AD&D Benefit
Accidental Loss of Entire sight of One Eye	50% of AD&D Benefit
Accidental Loss of Arm	50% of AD&D Benefit
Accidental Loss of Leg	50% of AD&D Benefit

"Loss" as used above means:

(1) arm, which means actual severance at or above the elbow;
(2) leg, which means actual severance at or above the knee;
(3) hand, which means: a. actual severance at or above the wrist, but below the elbow; or b. loss of a thumb and index finger on the same hand where the thumb and index finger are permanently severed through or above the third joint from the tip of the index finger and the second joint from the tip of the thumb;
(4) foot, which means actual severance at or above the ankle but below the knee; and
(5) sight, which means: a. removal of the eye; or b. the permanent, uncorrectable loss of sight in at least one eye defined as either the corrected visual acuity of less than 20/200 or a visual field restriction of 20° or less which has persisted for 180 days from the date of loss. No benefit will be paid for loss of sight if, in the Physician's opinion, partial or total restoration of sight could occur naturally, or as a result of surgery or a device or implant.

If You suffer more than one of the above losses as a result of the same accident, the benefit provided under this provision will be paid only for the greatest loss.

The Employee Accidental Death Benefit is payable to the Beneficiary, the Dependent Accidental Death Benefit is payable to the Employee, and the Employee and Dependent Accidental Dismemberment Benefits are payable to the Employee. The benefits are also payable to other persons or entities as designated by the Employee.

The Accidental Death and Dismemberment Benefit will end at the earliest of:

1. Upon written request from an Employee, unless prohibited by federal or state law or the Policyholder's plan;
2. The date a Policyholder's group term life insurance coverage ends under the Certificate;
3. The end of the period for which the last Premium has been paid for a Policyholder, in accordance with the provisions of the Certificate;
4. The date the group term life insurance Policy ends;
5. The date a Policyholder ceases to be in an eligible class under the Certificate; or
6. The date a Policyholder retires

When the Accidental Death and Dismemberment Benefit ends, this will not prejudice the payment of benefits for any accident that occurred while the benefit was in force.

The Accidental Death and Dismemberment Benefit includes the following provisions for insured Employees electing both Employee and family coverage:

SEAT BELT BENEFIT - an additional $10,000 will be paid if the Employee and/or the Employee's insured Dependents die or are dismembered as the result of a covered accident. The covered accident must occur while the Employee or one of the Employee's insured Dependents is driving an automobile and/or riding in an automobile; and all of the following apply:

1. the automobile must be equipped with seat belts;
2. the seat belt must have been in actual use and properly fastened at the time of the accident;
3. the position of the seat belt must be certified in the official report of the accident or by the investigating police officer;

4. the driver of the automobile must be properly licensed and must not have been driving while impaired, intoxicated or under the influence of drugs, unless prescribed by a licensed Physician, at the time of the accident;
5. "Automobile" means a four wheel passenger car, station wagon, jeep, pickup truck and van-type car; and
6. "Seat Belt" means the belts that form an occupant restraint system and includes infant and child restraint systems when properly used with a seat belt.

EXCLUSIONS WITH RESPECT TO THE ACCIDENTAL DEATH AND DISMEMBERMENT BENEFIT:

The Policy does not provide benefits for any loss caused by or resulting from:

1. declared or undeclared war or any act of war;
2. service in the armed forces of any country or international authority;
3. suicide or intentionally self-inflicted injury whether the Insured was sane or insane at the time of the suicide or injury;
4. flying in an aircraft owned, operated, leased or chartered by the Policyholder;
5. participation in, or in consequence of having participated in, the commission of any felony;
6. sickness or disease, ptomaine or bacterial infection (except infections occurring through an accidental cut or wound);
7. loss caused or contributed to by intoxication as defined by the jurisdiction where the accident occurred and intentionally taking a narcotic, drug, barbiturate, hallucinogenic drug, alcohol or any combination of these when not part of a professional medical treatment plan; or
8. participation in a riot or insurrection, or commission of, or attempt to commit an assault or felony, or while engaged in an illegal occupation.

SECTION 7 - TERMINATION PROVISION

TERMINATION OF INDIVIDUAL'S INSURANCE - All provisions listed below also apply to the Accidental Death and Dismemberment Benefit.

WHEN EMPLOYEE LIFE INSURANCE ENDS - The Employee's life insurance ends on the earliest of the following dates:

1. the date the Policy is terminated;
2. the date the Employee is no longer in an Eligible Class;
3. the date the Employee's coverage under the Policy terminates;
4. the date the Employee's class is no longer included for insurance;
5. the end of the month for which the last required Employee premium contribution has been paid; or
6. the date the Employee's employment terminates. Employment will be considered terminated if the Employee ceases Active Employment except as outlined in the following section entitled "Continuation of Employee Insurance During Absences".

CONTINUATION OF EMPLOYEE INSURANCE DURING ABSENCES - An Employee's insurance may be continued in the following situations:

1. **TEMPORARY LAYOFF OR LEAVE OF ABSENCE -** The Employee and Dependent life insurance may be continued until the Employer stops paying premium for the Employee or otherwise cancels the insurance. Such insurance will not continue for more than 3 months past the Employee's last day of Active Work. We may agree in writing to continue the insurance for an additional number of months during lay-off or leave of absence if requested by the Employer; or
2. **INJURY OR SICKNESS -** The Employee and Dependent life insurance may be continued while the Employee remains Totally Disabled as a result of the injury or sickness. Such insurance will not continue past the earlier of either:
    a. 12 months from the date the Employee was no longer Actively at Work; or
    b. the date the Employer stops paying premium for the Employee or otherwise cancels the insurance. The Employee must pay the premium to the Employer during this period in order to continue coverage during injury or sickness.

CONTINUATION OF INSURANCE FOR CHILD WITH MENTAL OR PHYSICAL DISABILITY – A child's insurance may be continued for a child with a mental or physical disability that reaches the age limit of a dependent.

Insurance continues while such child remains incapable of self-sustaining employment because of the disability and continues to meet the definition of child except for the age limit. Proof of the disability shall be sent to the Company within 31 days after the child attains the age limit and at reasonable intervals after such date.

If at the end of the continuation period the child is no longer eligible for insurance under the Certificate, the conversion provision describes the Child's right to convert.

WHEN DEPENDENT LIFE INSURANCE ENDS - The insured Dependent's life insurance ends on the earliest of the following:

1. the date the Employee's insurance ends;
2. the date the Employee becomes ineligible;
3. the date the Employee's employment ends;
4. the date the person ceases to be an insured Dependent as defined in the Policy;
5. the date the insured Dependent enters the Armed Forces of any country;
6. the date the Employer's coverage is cancelled;
7. the date the Policy is cancelled; or
8. the date the required premium contribution is not made.

TERMINATION OF INSURANCE

The Insured's insurance provided under the Policy will terminate at 12:01 A.M., standard time, at the Policyholder's address on the earliest of the following:

1. the date the Policy terminates;
2. the date the Policy is amended or changed to exclude coverage for the class of eligible individuals to which the Insured belongs;

3. the date that the Insured ceases to be a member of the classes for whom insurance is provided;
4. the end of the period for which any required contribution is made; or
5. the date on which an Insured Individual enters the Armed Forces, other than for reserve duty of 30 days or less.

The Dependent's insurance provided under the Policy will terminate at 12:01 A.M., standard time, at the Policyholder's address on the earliest of the following:

1. the date the Policy terminates;
2. the date the Insured's coverage terminates;
3. the date We are notified to terminate the Dependent's coverage;
4. the end of the period for which any required contribution is made;
5. the day in which a Dependent ceases to meet the definition of Dependent. If a Dependent Child, upon reaching the termination age, is unable to sustain employment because of a permanent mental or physical handicap and We are notified in writing within 31 days after the Dependent Child reaches the termination age, We will continue coverage as long as the Insured's coverage continues and the Dependent Child continues to be handicapped and dependent upon the Insured for support; or
6. the date, which an Insured Individual enters the Armed Forces, other than for reserve duty of 30 days or less.

SECTION 8 - PREMIUM PROVISIONS

INITIAL MONTHLY PREMIUM RATES - The first premium is due and payable on the Effective Date of the Policy. Subject to the Policy's grace period provision, all premiums after the first must be paid when or before they are due.

PREMIUM PAYMENTS - Premium payments are due and payable in full to a place designated by the Company or, with respect to the initial premium payment, premium payments may be made to an authorized agent of the Company. The Policy is issued in return for the payment by the Policyholder of required Premiums.

If any insurance is added, increased, or becomes effective after the Policy is in force, the premium charges will begin on:

1) the day the coverage is effective if it is also the first day of a policy month; or
2) the first day of the next policy month.

For insurance which is terminated, premium charges will stop as of the first day of the next policy month.

The Company may use any reasonable method to compute Premiums due under the Policy.

The premium due on any premium due date is determined by the total amount of insurance provided by this Policy on such date, multiplied by the appropriate premium rate(s) which are in effect subject to any premium adjustment, if applicable.

Premium modes will be monthly, quarterly, semi-annually or annually in advance, on the first day of each Policy Month.

The Policyholder will not require the Employee to contribute to the cost of Noncontributory insurance, except where necessary for the Policyholder to comply with applicable tax law.

PREMIUM CHANGES - We have the right to change the premium We charge. If We plan to make a change, We will send a notice to the Policyholder’s last address on record at least 31 days before the date of change.

GRACE PERIOD - After the first premium is paid, the Company will allow the Policyholder no less than a 31-day grace period for the payment of all premiums. During this grace period, the Policy will stay in force. If the premium due is not paid by the end of the grace period, the Policy will terminate on the last day for which premiums were received. If the Policyholder gives the Company written advance notice of an earlier cancellation date, the Policy will terminate on the earlier date. If the Policyholder replaces but does not give the Company written notice, the grace period will apply. Premium is due for each day the Policy is in force. The Policyholder is liable for the premium due for coverage through the grace period.

If the premium is not paid by the due date, the Company will give written notification to the Policyholder that if the premium is not paid by the end of the grace period, the Policy will end on the last day of the grace period. If the Company fails to give such written notice, the insurance provided under the Policy will continue in effect until the date such notice is given.

PREMIUM CHARGES FOR INDIVIDUAL EMPLOYEE CHANGES - When insurance for an Employee is added or changed on other than a premium due date, premium for the Employee is charged beginning from the effective date.

When insurance for an Employee is terminated on other than a premium due date, premium for the Employee is charged up to the next monthly premium due date.

SECTION 9 - CLAIM PROVISIONS

NOTICE OF CLAIM - Written notice of claim must be given to us within 30 days after the incurred date of the services provided for which benefits are payable or as soon as reasonably possible. Notice must be given to the Company or its Administrator, or to one of Our agents. Notice should include the Policyholder's name, Insured's name, Certificate number and Policy number. If it will not be reasonably possible to give written notice within the 30-day period stated above, We will not reduce or deny a claim for this reason if notice is filed as soon as is reasonably possible.

CLAIM FORMS - When We receive the notice of claim, We will send the claimant forms and instructions for filing proof of loss. If these forms are not furnished within 15 days after We have received the notice, the claimant will meet Our proof of loss requirements by giving us a written statement of the nature and extent of loss within the time limit for filing proofs of loss.

PROOF OF LOSS - Written proof of loss must be given to us within 90 days of such loss. If it was not reasonably possible to give written proof within the 90-day period, We will not reduce or deny a claim for this reason if the proof is filed as soon as it is reasonably possible. In any event, We must receive proof no later than one year from the time specified, except in the absence of legal capacity. We have the right to require proof of the continuance of Total Disability at any time during the first two years after receipt of initial proof of Total Disability. Thereafter, such proof must be provided once a year.

TIME OF PAYMENT - We will pay all benefits upon receipt of due written proof of loss.

PAYMENT OF CLAIMS - All benefits will be paid to the Insured, unless an assignment of benefits has been requested by the Insured or We have the obligation to pay the facility or Provider directly. Any payment made by Us in good faith pursuant to this provision will fully release Us from liability to the extent of such payment.

The Company will either pay the death benefit in one sum or in a method comparable to one sum. Other methods of payment may be made available.

SECTION 10 - GENERAL PROVISIONS

ENTIRE CONTRACT - The contract between the parties consists of:

1. the Policy;
2. the application of the Policyholder, which is made a part of the Policy when issued;
3. this Certificate;
4. any endorsements, amendments or riders; and
5. the enrollment forms, if any, of each Insured.

All statements made by the Policyholder and Insured shall be deemed representations and not warranties and no statement made by an Insured shall void the insurance or be used in defense to a claim hereunder unless a copy of the instrument containing such statement is or has been furnished to such Insured.

CHANGE IN THE POLICY OR THIS CERTIFICATE - The Company reserves the right to make changes in the Policy or this Certificate which are consistent with the Interstate Insurance Product Regulation Commission standards . The Company will give the Policyholder 31 days' advance written notice of any change. No agent has authority to change or waive any part of the Policy. To be valid, any change or waiver must be in writing on Company letterhead and/or email, approved by one of Our officers: (1) the President; (2) a Vice President; or (3) the Secretary. The approval must be endorsed on or attached to the Policy.

CLERICAL ERROR - Clerical errors or delays in keeping records for the Policy:

1. will not deny insurance which would otherwise have been granted;
2. will not continue insurance which otherwise would have ceased; and
3. may call for an adjustment of premium benefits to correct the error.

CERTIFICATES - The Company will supply individual Certificates for each Insured.
This Certificate will describe:

1. the insurance benefits;
2. to whom benefits will be paid;
3. any limitations of the Policy; and
4. all other essential features of the Policy.

If more than one Certificate is issued under the Policy to an Insured, only the last one issued will be in effect.
If requested, the Certificates will be provided electronically at no additional cost.

CONTINUITY OF INSURANCE COVERAGE - We will provide continuity of coverage under Our Policy if both of the following are true:

1. You are not in Active Employment due to sickness or injury other than Total Disability or due to an Employer approved non-medical leave of absence on the date the Employer changes insurance carriers to Our Policy; and
2. You were covered under the prior group life policy, including payment of premiums to the prior insurance carrier when due, on the day before the coverage for Your Eligible Class under Our Policy became effective.

You are not eligible under this provision if any of the following are true:

1. Your coverage is being continued under a waiver of premium (or any similar) provision of the prior policy;
2. Your coverage is being continued under a continuation or portability provision of the prior policy;
3. You converted or were eligible to convert Your coverage with the prior insurance carrier; or
4. You are not in Active Employment due to reasons other than sickness, injury or an Employer-approved non-medical leave of absence.

If You are eligible for continuity of coverage under this provision, We will provide coverage for 6 months under this Certificate.

Coverage under this provision will begin on the date Your Eligible Class is covered under Our Policy and will continue until the earliest of the following:

1. the date You return to Active Employment;
2. the date the Employer-approved leave of absence ends;
3. the date Your continuation would end under the terms of Our Policy;
4. the date Your continuation would have ended under the terms of the prior Policy;
5. the date coverage would otherwise end, according to the provisions of Our Policy; or
6. 12 months following the date You were last in Active Employment.

Your coverage under this provision is subject to payment of premiums.

Any benefits payable under this provision will be the lesser of the amount of coverage under the prior Policy had it remained in force, or the amount You are eligible for under Our Policy. We will reduce Our payment by any amount paid under the prior Policy.

If Your coverage under this provision ends while the Policy is in force, and You are not otherwise eligible for insurance under the Policy, then You will be eligible for conversion as described in the Right to Convert provision.

If You were not covered under the Employer's prior Policy on the date that the Policy begins, then the Eligibility and Effective Dates provision will apply.

ERISA - If the Policy is an integral part of an Employee welfare benefit plan subject to the provisions of the Employee Retirement Income Security Act (ERISA) of 1974, as amended, We are is a claim fiduciary. As such, We shall have the authority to determine eligibility for benefits and to construe the terms of that part of the ERISA plan represented by this contract. Any judicial review of a decision of Ours shall be conducted under the arbitrary and capricious standard of review with deference given to the claim fiduciary's decision.

EXAMINATION OF POLICYHOLDER'S RECORDS - We will be allowed to examine the records of the Policyholder relating to the Policy. This may be done at any reasonable time up to two years after the cancellation of the Policy, or until settlement of all claims, whichever is later.

POLICY INSPECTION - The Policy may be inspected by any Insured person any time during the regular business hours of the Policyholder.

LEGAL ACTIONS - Unless otherwise specified by the laws of the state where this Certificate was issued, no legal action may be brought against Us until at least 60 days after the Insured sends Us the required proof of loss. No such action may be brought against Us after three years after proof of loss is required.

CONFORMITY WITH STANDARDS - This Certificate and the Policy are approved under the authority of the Interstate Insurance Product Regulation Commission (Commission) and issued under Commission standards. Any provision of the Certificate or Policy that on the provision's effective date is in conflict with Commission standards for this product type is hereby amended to conform to the Commission standards for this product type as of the provision's effective date.

INCONTESTABILITY - We have the right to contest the validity of this Certificate, the Policy and any attached riders based on material misrepresentations made in the enrollment form or application. However, We cannot contest the validity of this Certificate, the Policy or any attached riders after it has been in force during a Policyholder's lifetime for two years from the Issue Date, except for fraudulent misstatements in the application when permitted by applicable law in the state where the Certificate is delivered or issued for delivery. Any Policyholder's statements within the application or enrollment form that We contest must be signed by the Policyholder. The statement upon which the contest is based shall be material to the risk accepted or the hazard assumed by the Company.

MISSTATEMENT OF AGE - If the date of birth or age of any Insured has been misstated, an adjustment of premium will be of an amount that the Premium paid would have purchased at the correct date of birth or age.

PHYSICAL EXAMINATIONS AND AUTOPSY - We, at Our expense, will have the right and opportunity to have the Insured examined as often as reasonably necessary while the claim is pending. We at Our own expense will have the right to make an autopsy in case of death, unless it is forbidden by law. If the Insured fails to submit proof of continuing Total Disability when required or fails to be examined medically when required, no further benefit will be provided for that Total Disability.

ASSIGNMENT – The Certificateholder can transfer, or assign, some or all of the Certificate's rights, while the Insured is alive, to someone else by making a contract with that person. We are not responsible for the validity of any assignment of the Certificate, nor are We bound by an assignment until We receive a copy of the assignment at Our office.

When We furnish written acknowledgement of the assignment, the assignment becomes effective on the date the Owner signed Our form unless a later date is specified. We are not liable for payments made or action taken prior to Our written acknowledgement of the assignment.

STATEMENT OF ERISA RIGHTS

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

1. Receive Information About Your Plan and Benefits

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

b) 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 (Form5500 Series) and updated summary Plan description. The administrator may make a reasonable charge for the copies.

c) 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.

2. 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.

3. 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 the Plan requires you to complete administrative appeals prior to filing in court, your right to file suit in state or Federal court may be affected if you do not complete the required appeals. 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.

4. Assistance with Your Questions

If you have any questions about your Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need

assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration (formerly known as the Pension and Welfare Benefits Administration), U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200
Constitution Avenue N.W., Washington, D.C. 20210.

You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

A. Claims Filing PROCEDURES

Written notice of claim must be furnished to Companion Life Insurance Company, 1301 Gervais Street, Suite 900, Columbia, SC 29201, within twenty (20) days after the event on which the claim is based, or as soon thereafter as is reasonably possible. Notice of claim should include the Employer's name, Insured's name, and Employer's Group Number. Failure to give notice within the time does not invalidate nor reduce any claim if the claimant can show that it was not reasonably possible to give the notice within the required time frame and if notice was given as soon as reasonably possible. Upon receipt of the notice, Companion Life will furnish or cause a claim form to be furnished to the claimant. If the claim form is not furnished within fifteen (15) days after Companion Life receives the notice, the claimant will be deemed to have complied with our proof of loss requirements. The claimant must submit written proof covering the nature and extent of the claim within the policy time limit for filing proof of loss.

PROOF OF CLAIM

1. Companion Life must receive the claim within ninety (90) days after the beginning of services. Failure to file the claim within the ninety (90) day period, however, will not prevent payment of Covered Expenses if the Insured Employee shows that it was not reasonably possible to file the claim timely, provided the claim is filed as soon as is reasonably possible. In any event, except in the absence of legal capacity, claims must be filed by the end of the calendar year after the calendar year in which the loss occurred or the claim will be denied.

2. Receipt of a claim by Companion Life will be deemed written proof of loss and will serve as written authorization from the Insured Employee to Companion Life to obtain any medical or financial records and documents useful to Companion Life. Companion Life, however, is not required to obtain any additional records or documents to support payment of a claim and is responsible to pay claims only on the basis of the information supplied at the time the claim was processed. Any party who submits medical or financial reports and documents to Companion Life in support of an Insured's claim will be deemed to be acting as the agent of the Insured Employee.

3. There are four (4) types of claims: Pre-Service Claims, Urgent Care Claims, Post-Service Claims, and Concurrent Care Claims. Companion Life will make a determination for each type of claim within the following time periods:

    a. Pre-Service Claim.

        i. A determination will be provided in writing or in electronic form within a reasonable period of time, appropriate to the medical circumstances, but no later than fifteen (15) days from receipt of the claim.

        ii. If a Pre-service Claim is improperly filed, or otherwise does not follow applicable procedures, the Insured Employee will be sent notification within five (5) days of receipt of the claim.

        iii. An extension of fifteen (15) days is permitted if Companion Life determines that, for reasons beyond the control of Companion Life, an extension is necessary. If an extension is necessary, Companion Life will notify the Insured Employee within the initial fifteen (15) day time period that an extension is necessary, the circumstances requiring the extension, and the

date Companion Life expects to render a determination. If the extension is necessary to request additional information, the extension notice will describe the required information. The Insured Employee will have at least forty-five (45) days to provide the required information. If Companion Life does not receive the required information within the forty-five (45) day time period, the claim will be denied. Companion Life will make its determination within fifteen (15) days of receipt of the requested information, or, if earlier, the deadline to submit the information.

b. Urgent Care Claim.

   i. A determination will be sent to the Insured Employee in writing or in electronic form as soon as possible taking into account the medical exigencies, but no later than seventy-two (72) hours from receipt of the claim.

   ii. If the Insured Employee's Urgent Care Claim is determined to be incomplete, the Insured Employee will be sent a notice to this effect within twenty-four (24) hours of receipt of the claim. The Insured Employee will then have forty-eight (48) hours to provide the additional information. Failure to provide the additional information within forty-eight (48) hours may result in the denial of the claim.

   iii. If the Insured Employee requests an extension of Urgent Care Benefits beyond an initially determined period and makes the request at least twenty-four (24) hours prior to the expiration of the original determination period, the Insured Employee will be notified within twenty-four (24) hours of receipt of the request for an extension.

c. Post-Service Claim.

   i. A determination will be sent within a reasonable time period, but no later than thirty (30) days from receipt of the claim.

   ii. An extension of fifteen (15) days may be necessary if Companion Life determines that, for reasons beyond the control of Companion Life, an extension is necessary. If an extension is necessary, Companion Life will notify the Insured Employee within the initial thirty (30) day time period that an extension is necessary, the circumstances requiring the extension, and the date Companion Life expects to render a determination. If the extension is necessary to request additional information, the extension notice will describe the required information. The Insured Employee will have at least forty-five (45) days to provide the required information. If Companion Life does not receive the required information within the forty-five (45) day time period, the claim will be denied. Companion Life will make its determination within fifteen (15) days of receipt of the requested information, or, if earlier, the deadline to submit the information.

d. Concurrent Care Claim.

   The Insured Employee will be notified if there is to be any reduction or termination in coverage for ongoing care sufficiently in advance of such reduction or termination to allow the Insured Employee time to appeal the decision before the Benefits are

reduced or terminated.

4 Notice of Determination.

a. If the Insured Employee's claim is filed properly, and the claim is in part or wholly denied, the Insured Employee will receive notice of an Adverse Benefit Determination that will:

i. State the specific reason(s) for the Adverse Benefit Determination;

ii. Reference the specific Plan of Benefits provisions on which the determination is based;

iii. Describe additional material or information, if any, needed to complete the claim and the reasons such material or information is necessary;

iv. Describe the claims review procedures and the Plan of Benefits and the time limits applicable to such procedures, including a statement of the Insured Employee's right to bring a civil action under section 502(a) of ERISA following an Adverse Benefit Determination on review;

v. Disclose any internal rule, guideline, or protocol relied on in making the Adverse Benefit Determination (or state that such information is available free of charge upon request); and,

vi. If the reason for denial is based on a lack of Medical Necessity or Investigational or Experimental Services exclusion or similar limitation, explain the scientific or clinical judgment for the determination (or state that such information will be provided free of charge upon request).

b. The Insured Employee will also receive a notice if the claim is approved.

B. Appeal procedures for an ADVERSE BENEFIT DETERMINATION

1. Insured Employee has one hundred eighty (180) days from receipt of an Adverse Benefit Determination to file an appeal. An appeal must meet the following requirements:

a. An appeal must be in writing; and,

b. An appeal must be sent (via U.S. mail) to Companion Life Insurance Company at the address on the Insured's Identification Card; and,

c. The appeal request must state that a formal appeal is being requested and include all pertinent information regarding the claim in question; and,

d. An appeal must include the Insured's name, address, social security number and any other information, documentation or materials that support the Insured's appeal.

2. The Insured Employee will have the opportunity to submit written comments, documents, or other information in support of the appeal, and will have access to all documents relevant to the claim. A person other than the person who made the initial

decision will conduct the appeal. No deference will be afforded to the initial determination.

3. If the appealed claim involves an exercise of medical judgment, Companion Life will consult with an appropriately qualified health care practitioner with training and experience in the relevant field of medicine. If a health care professional was consulted for the initial determination, a different health care professional will be consulted on the appeal.

4. Companion Life will make a final decision on the appeal within the time periods specified below:

   a. Pre-Service Claim.

   Companion Life will decide the appeal within a reasonable period of time, taking into account the medical circumstances, but no later than fifteen (15) days after receipt of the appeal. If the Insured Employee disagrees with Companion Life's decision, the Insured Employee can submit a second appeal within ninety (90) days after receipt of the final decision of the first appeal. Companion Life will decide the second appeal within a reasonable period of time, taking into account the medical circumstances, but no later than fifteen (15) days after receipt of the second appeal.

   b. Urgent Care Claim.

   The Insured Employee may request an expedited appeal of an Urgent Care Claim. This expedited appeal request may be made orally, and Companion Life will communicate with the Insured Employee by telephone or facsimile. Companion Life will decide the appeal within a reasonable period of time, taking into account the medical circumstances, but no later than seventy-two (72) hours after receipt of the Request for an expedited appeal.

   c. Post-Service Claim.

   Companion Life will decide the appeal within a reasonable period of time, but no later than thirty (30) days after receipt of the appeal. If the Insured Employee disagrees with Companion Life's decision, the Insured Employee can submit a second appeal within ninety (90) days after receipt of the final decision of the first appeal. Companion Life will decide the second appeal within a reasonable period of time, but no later than thirty (30) days after receipt of the second appeal.

   d. Concurrent Care Claim.

   Companion Life will decide the appeal of Concurrent Care Claims within the time frames set forth in (B)(4)(a-c) depending on whether such claim is also a Pre-Service Claim, an Urgent Care Claim or a Post-Service Claim.

5. Notice of Appeals Determination.

   a. If an Insured Employee's appeal is denied in whole or in part, the Insured Employee will receive notice of an Adverse Benefit Determination that will:

      i. State specific reason(s) for the Adverse Benefit Determination;

ii.. Reference specific provision(s) of the Plan of Benefits on which the benefit determination is based;

iii. State that the Insured Employee 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;

iv. Describe any voluntary appeal procedures offered by Companion Life and the Insured Employee's right to obtain such information;

v. Disclose any internal rule, guideline, or protocol relied on in making the Adverse Benefit Determination (or state that such information will be provided free of charge upon request);

vi. If the reason for an Adverse Benefit Determination on appeal is based on a lack of Medical Necessity, Investigational or Experimental Services or other limitation or exclusion, explain the scientific or clinical judgment for the determination (or state that such information will be provided free of charge upon request); and

vii. Include a statement regarding the Insured Employee's right to bring an action under section 502(a) of ERISA.

b. The Insured Employee will also receive a notice if the claim on appeal is approved.

COMPANION LIFE INSURANCE COMPANY
1301 Gervais Street, Suite 900, Columbia, SC 29201
P.O. Box 100102, Columbia, South Carolina 29202-3102
(803) 735-1251

NOTICE CONCERNING COVERAGE
LIMITATIONS AND EXCLUSIONS UNDER THE NORTH CAROLINA
LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION ACT

Residents of this state who purchase life insurance, annuities or health insurance should know that the insurance companies and Health Maintenance Organizations (HMOs) licensed in this state to write these types of insurance are members of the North Carolina Life and Health Insurance Guaranty Association. The purpose of this association is to assure that policyholders will be protected, within limits, in the unlikely event that a member insurer or HMO becomes financially unable to meet its obligations. If this should happen, the guaranty association will assess its other member insurance companies for the money to pay the claims of the insured persons who live in this state and, in some cases, to keep coverage in force. The valuable extra protection provided by these insurers through the guaranty association is not unlimited, however. And, as noted in *the box* below, this protection is not a substitute for consumers' care in selecting companies that are well-managed and financially stable.

The North Carolina Life and Health Insurance Guaranty Association may not provide coverage for this policy. If coverage is provided, it may be subject to substantial limitations or exclusions, and require continued residency in North Carolina. You should not rely on coverage by the North Carolina Life and Health Insurance Guaranty Association in selecting an insurance company or in selecting an insurance policy.

Coverage is NOT provided for your policy or any portion of it that is not guaranteed by the insurer or for which you have assumed the risk, such as a variable contract sold by prospectus.

Insurance companies or their agents are required by law to give or send you this notice. However, insurance companies and their agents are prohibited by law from using the existence of the guaranty association to induce you to purchase any kind of insurance policy.

The North Carolina Life and Health Insurance Guaranty Association
4441 SIX FORKS RD STE 106-153
Raleigh, NC 27609-5729
https://www.nclifega.org/

North Carolina Department of Insurance, Consumer Services Division
1201 Mail Service Center
Raleigh, North Carolina 27699-1201

The state law that provides for this safety-net coverage is called the North Carolina Life and Health Insurance Guaranty Association Act. *On the next page* is a brief summary of this law's coverages,

exclusions and limits. This summary does not cover all provisions of the law; nor does it in any way change anyone's rights or obligations under the act or the rights or obligations of the guaranty association.

COVERAGE

Generally, individuals will be protected by the life and health insurance guaranty association if they live in this state and hold a life or health insurance contract, or an annuity, or if they are insured under a group insurance contract, issued by a member insurer or HMO. The beneficiaries, payees or assignees of insured persons are protected as well, even if they live in another state.

EXCLUSIONS FROM COVERAGE

However, persons holding such policies are not protected by this association if:

- They are eligible for protection under the laws of another state (this may occur when the insolvent insurer was incorporated in another state whose guaranty association protects insureds who live outside that state);
- The insurer was not authorized to do business in this state;
- Their policy was issued by a fraternal benefit society, a mandatory state pooling plan, a mutual assessment company or similar plan in which the policyholder is subject to future assessments, or by an insurance exchange.
- They acquired rights to receive payments through a structured settlement factoring transaction.

The association also does not provide coverage for:

- Any policy or portion of a policy which is not guaranteed by the insurer or for which the individual has assumed the risk, such as a variable contract sold by prospectus;
- Any policy of reinsurance (unless an assumption certificate was issued);
- Interest rate yields that exceed the average rate specified in the law;
- Dividends;
- Experience or other credits given in connection with the administration of a policy by a group contract holder;
- Employers' plans to the extent they are self-funded (that is, not insured by an insurance company, even if an insurance company administers them);
- Unallocated annuity contracts (which give rights to group contractholders, not individuals), unless they fund a government lottery or a benefit plan of an employer, association or union, except that unallocated annuities issued to employee benefit plans protected by the Federal Pension Benefit Guaranty Corporation are not covered.
- A policy or contract commonly known as Medicare Part C, Medicare Part D, Medicaid or any regulations issued pursuant thereto.

LIMITS ON AMOUNT OF COVERAGE

The act also limits the amount the association is obligated to pay out as follows:

(1) The guaranty association cannot pay out more than the insurance company would owe under the policy or contract.
(2) Except as provided in (3), (4), and (5) below, the guaranty association will pay a maximum of $300,000 per individual, per insolvency, no matter how many policies or types of policies issued by the insolvent company.
(3) The guaranty association will pay a maximum of $500,000 with respect to a health benefit plan.

(4) The guaranty association will pay a maximum of $1,000,000 with respect to the payee of a structured settlement annuity.

(5) The guaranty association will pay a maximm of $5,000,000 to any one unallocated annuity contract holder.

NOTICE

THIS NOTICE IS TO BE ISSUED WITH ANY POLICY, CONTRACT, CERTIFICATE, OR EVIDENCE OF COVERAGE OF GROUP HEALTH OR LIFE INSURANCE ISSUED IN THE STATE OF NORTH CAROLINA.

STATE OF NORTH CAROLINA GENERAL STATUTE SECTION 58-50-40

"UNDER NORTH CAROLINA GENERAL STATUTE SECTION 58-50-40, NO PERSON, EMPLOYER, PRINCIPAL, AGENT, TRUSTEE, OR THIRD PARTY ADMINISTRATOR, WHO IS RESPONSIBLE FOR THE PAYMENT OF GROUP HEALTH OR LIFE INSURANCE OR GROUP HEALTH PLAN PREMIUMS, SHALL:

(1) CAUSE THE CANCELLATION OR NONRENEWAL OF GROUP HEALTH OR LIFE INSURANCE, HOSPITAL, MEDICAL, OR DENTAL SERVICE CORPORATION PLAN, MULTIPLE EMPLOYER WELFARE ARRANGEMENT, OR GROUP HEALTH PLAN COVERAGES AND THE CONSEQUENTIAL LOSS OF THE COVERAGES OF THE PERSONS INSURED, BY WILLFULLY FAILING TO PAY THOSE PREMIUMS IN ACCORDANCE WITH THE TERMS OF THE INSURANCE OR PLAN CONTRACT, AND

(2) WILLFULLY FAIL TO DELIVER, AT LEAST 45 DAYS BEFORE THE TERMINATION OF THOSE COVERAGES, TO ALL PERSONS COVERED BY THE GROUP POLICY A WRITTEN NOTICE OF THE PERSON'S INTENTION TO STOP PAYMENT OF PREMIUMS. THIS WRITTEN NOTICE MUST ALSO CONTAIN A NOTICE TO ALL PERSONS COVERED BY THE GROUP POLICY OF THEIR RIGHTS TO HEALTH INSURANCE CONVERSION POLICIES UNDER ARTICLE 53 OF CHAPTER 58 OF THE GENERAL STATUTES AND THEIR RIGHTS TO PURCHASE INDIVIDUAL POLICIES UNDER THE FEDERAL HEALTH INSURANCE PORTABLILITY AND ACCOUNTABILITY ACT AND UNDER ARTICLE 68 OF CHAPTER 58 OF THE GENERAL STATUTES.

VIOLATION OF THIS LAW IS A FELONY. ANY PERSON VIOLATING THIS LAW IS ALSO SUBJECT TO A COURT ORDER REQUIRING THE PERSON TO COMPENSATE PERSONS INSURED FOR EXPENSES OR LOSSES INCURRED AS A RESULT OF THE TERMINATION OF THE INSURANCE."

END OF NOTICE

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Our Privacy Promise

We understand the importance of handling your medical information with care. We are committed to protecting the privacy of your medical information. State and federal laws require us to make sure that your medical information is kept private. Federal law requires that we provide you with this Notice of Privacy Practices, which describes our legal duties and privacy practices with respect to your medical information and your legal rights with respect to our use and disclosure of your medical information. We are required by law to follow the terms of the Notice currently in effect. This Notice is effective September 23, 2013, and will remain in effect until it is changed or replaced.

We reserve the right to change our privacy practices and the terms of this notice at any time, as long as the law allows. These changes will be effective for all medical information that we keep, including medical information we created or received before we made the changes. When we make a material change to our privacy practices, we will provide a copy of a new notice (or information about the changes to our privacy practices and how to obtain a new notice) in a mailing to members who are covered under our health plans at that time.

Uses and Disclosures of Medical Information

Treatment, Payment, Health Care Operations

We may use and disclose your medical information for purposes of treatment, payment and health care operations.

Treatment: We may disclose your medical information to a physician or other health care professional to help him or her provide your treatment.

Payment: We may use or disclose your medical information for these and other activities related to payment:

- Paying claims from physicians, hospitals and other health care providers.
- Obtaining premiums.
- Issuing explanations of benefits to the named insured.
- Providing information to health care professionals or other entities that are bound by the federal Privacy Rules for their payment activities.

Health Care Operations: We may use or disclose your medical information in the normal course of conducting health care operations, including such activities as:

- Quality assessment and improvement activities.
- Reviewing the qualifications of health care professionals.
- Compliance and detection of fraud and abuse.
- Underwriting, enrollment and other activities related to creating, renewing or replacing a plan of benefits. We may not, however, use or disclose genetic information for underwriting purposes.
- Providing information to another entity bound by the federal Privacy Rules for its health care operations, in limited circumstances.

You and Your Family and Friends
We may use and disclose your medical information to communicate with you for purposes of customer service or to provide you with information you request. We may disclose your medical information to a family member, friend or other person to the extent necessary for him or her to assist with your health care or payment for your health care. Before we disclose your medical information to that person, we will give you a chance to object to us doing so. If you are not available, or if you are incapacitated or in an emergency situation, we may, in the exercise of our professional judgment, determine whether the disclosure would be in your best interest. We may also use or disclose your medical information to notify (or help notify, including identifying and locating) a family member, a personal representative or other person responsible for your care of your location, general condition or death.

Your Employer or Organization Sponsoring Your Group Health Plan
We may disclose summary information and enrollment information to your employer (or other plan sponsor). Summary information is a summary of the claims history, claims expenses or types of claims that members of your group health plan have filed. The summary information will not include demographic information about you or others in the group health plan, but your employer or plan sponsor may be able to identify individuals from the summary information provided.

Disaster Relief
We may use or disclose your medical information to a public or private entity authorized by law or by its charter to assist in disaster relief efforts.

Public Benefit
We may use or disclose our members' medical information as authorized by law for the following purposes that are in the public interest or benefit:

- As required by law.
- For public health activities, including disease and vital statistics reporting, child abuse reporting, FDA oversight, and to employers regarding work-related illness or injury.
- To report adult abuse, neglect or domestic violence.
- To health oversight agencies.
- In response to court and administrative orders and other lawful processes.
- To law enforcement officials in response to subpoenas and other lawful processes concerning crime victims, suspicious deaths, crimes on our premises, reporting crimes in emergencies and to identify or locate a suspect or other person.
- To coroners, medical examiners and funeral directors.
- To organ procurement organizations.
- To avert a serious threat to health or safety.
- In connection with certain research activities.
- To the military and to federal officials for lawful intelligence, counterintelligence and national security activities.
- To correctional institutions regarding inmates.
- As authorized by state workers' compensation laws.

Your Authorization
We may not use or disclose your medical information without your written authorization, except as described in this notice. You may give us written authorization to use your medical information or to disclose it to anyone for any purpose. If you give us authorization, you may revoke it at any time by notifying us of your revocation in writing. Your revocation will not affect any use or disclosure permitted by the authorization while it was in effect. We need your written authorization to use or disclose psychotherapy notes, except in limited circumstances such as when a disclosure is required by law. We also must obtain your written authorization to sell your medical information to a third party or, in most circumstances, to send you communications about products and services. We do not need your written authorization, however, to send you communications about health-related products or services, as long as the products or services are associated with your coverage or are offered by us.

Individual Rights

You have certain rights with respect to the medical information we maintain about you. To exercise any of these rights or to obtain more information about these rights (including any applicable fees), contact us using the information listed at the end of this notice.

Access
You have the right to inspect or receive a paper or electronic copy of your medical information, with some exceptions. To inspect or receive your medical information, you must submit the request in writing. If you request to receive a copy of your records, we are allowed to charge a reasonable, cost-based fee.

Disclosure Accounting

You have the right to request, in writing, a record of instances in which we (or our business associates) disclosed your medical information for purposes other than treatment, payment, health care operations, and as allowed by law. We will provide you with a record of such disclosures for up to the previous six years. If you request a record of disclosures more than once in a 12-month period, we may charge you a reasonable, cost-based fee for each additional request.

Restriction

You have the right to request, in writing, that we place additional restrictions on our use or disclosure of your medical information. By law, we are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency). Any agreement to additional restrictions will be made in writing and signed by a person authorized to make such an agreement for us.

Confidential Communications

You have the right to request, in writing, that we communicate with you about your medical information by other means, or to another location. We are not required to agree to your request unless you state that you could be in danger if we do not communicate to you in confidence. In that case, we must accommodate your request if it is reasonable, if it specifies the other means or location, and if it permits us to continue to collect premiums and pay claims under your health plan. We will not be bound to your request unless our agreement is in writing.

Even if we agree to communicate with you in confidence, an explanation of benefits we issue to the named insured for health care services the named insured (or others covered by the health plan) received might contain sufficient information (such as deductible and out-of-pocket amounts) to reveal that you obtained health care services for which we paid.

Amendment

You have the right to request, in writing, that we amend your medical information. Your request must explain why we should amend the information. We may deny your request if we did not create the information you want amended and the person or entity that did create it is available, or we may deny your request for certain other reasons. If we deny your request, we will send you a written explanation.

Notice of Breach
We are required to notify affected individuals following a breach of unsecured medical information.

Electronic Notice
You may request a written copy of this notice at any time or download it from our website.

Privacy Questions and Complaints

If you want more information about our privacy practices, or if you have questions or concerns, please contact us using the information below.

If you believe we may have violated your privacy rights, you may submit a complaint to us using the contact information listed below. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with that address upon request.

We support your right to the privacy of your medical information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Contact Information

Attn: Privacy Officer
I 20 East@Alpine Road (AX-E0l)
Columbia, SC 29219

(803) 264-7258 (telephone) (803)
264- 7257 (fax)

Non-Discrimination Statement and Foreign Language Access

We do not discriminate on the basis of race, color, national origin, disability, age, sex, gender identity, sexual orientation or health status in our health plans, when we enroll members or provide benefits.

If you or someone you're assisting is disabled and needs interpretation assistance, help is available at the contact number posted on our website or listed in the materials included with this notice (TDD: 711).

Free language interpretation support is available for those who cannot read or speak English by calling one of the appropriate numbers listed below.

If you think we have not provided these services or have discriminated in any way, you can file a grievance by emailing contact@hcrcompliance.com or by calling our Compliance area at 1-800-832-9686 or the U.S. Department of Health and Human Services, Office for Civil Rights at 1-800-368-1019 or 1-800-537-7697 (TDD).

Si usted, o alguien a quien usted está ayudando, tiene preguntas acerca de este plan de salud, tiene derecho a obtener ayuda e información en su idioma sin costo alguno. Para hablar con un intérprete, llame al 1-844-396-0183. (Spanish)

如果您，或是您正在協助的對象，有關於本健康計畫方面的問題，您有權利免費以您的母語得到幫助和訊息。洽詢一位翻譯員，請撥 1-844-396-0188。(Chinese)

Nếu quý vị, hoặc là người mà quý vị đang giúp đỡ, có những câu hỏi quan tâm về chương trình sức khỏe này, quý vị sẽ được giúp đỡ với các thông tin bằng ngôn ngữ của quý vị miễn phí. Để nói chuyện với một thông dịch viên, xin gọi 1-844-389-4838 (Vietnamese)

이 건강보험에 관하여 궁금한 사항 혹은 질문이 있으시면 1-844-396-0187로 연락해 주십시오. 귀하의 비용 부담없이 한국어로 도와드립니다. (Korean)

Kung ikaw, o ang iyong tinutulungan, ay may mga katanungan tungkol sa planong pangkalusugang ito, may karapatan ka na makakuha ng tulong at impormasyon sa iyong wika nang walang gastos. Upang makausap ang isang tagasalin, tumawag sa 1-844-389-4839. (Tagalog)

Если у Вас или лица, которому вы помогаете, имеются вопросы по поводу Вашего плана медицинского обслуживания, то Вы имеете право на бесплатное получение помощи и информации на русском языке. Для разговора с переводчиком позвоните по телефону 1-844-389-4840. (Russian)

إن كان لديك أو لدى شخص تساعده أسئلة بخصوص خطة الصحة هذه، فلديك الحق في الحصول على المساعدة والمعلومات الضرورية بلغتك من دون اية تكلفة.للتحدث مع مترجم اتصل ب 1-844-396-0189 (Arabic)

Si ou menm oswa yon moun w ap ede gen kesyon konsènan plan sante sa a, se dwa w pou resevwa asistans ak enfòmasyon nan lang ou pale a, san ou pa gen pou peye pou sa. Pou pale avèk yon entèprèt, rele nan 1-844-398-6232. (French/Haitian Creole)

Si vous, ou quelqu'un que vous êtes en train d'aider, avez des questions à propos de ce plan médical, vous avez le droit d'obtenir gratuitement de l'aide et des informations dans votre langue. Pour parler à un interprète, appelez le 1-844-396-0190. (French)

Jeśli Ty lub osoba, której pomagasz, macie pytania odnośnie planu ubezpieczenia zdrowotnego, masz prawo do uzyskania bezpłatnej informacji i pomocy we własnym języku. Aby porozmawiać z tłumaczem, zadzwoń pod numer 1-844-396-0186. (Polish)

Se você, ou alguém a quem você está ajudando, tem perguntas sobre este plano de saúde, você tem o direito de obter ajuda e informação em seu idioma e sem custos. Para falar com um intérprete, ligue para 1-844-396-0182. (Portuguese)

Se tu o qualcuno che stai aiutando avete domande su questo piano sanitario, hai il diritto di ottenere aiuto e informazioni nella tua lingua gratuitamente. Per parlare con un interprete, puoi chiamare 1-844-396-0184. (Italian)

あなた、またはあなたがお世話をされている方が、この健康保険についてご質問がございましたら、ご希望の言語でサポートを受けたり、情報を入手したりすることができます。料金はかかりません。通訳とお話される場合、1-844-396-0185 までお電話ください。 (Japanese)

Falls Sie oder jemand, dem Sie helfen, Fragen zu diesem Krankenversicherungsplan haben bzw. hat, haben Sie das Recht, kostenlose Hilfe und Informationen in Ihrer Sprache zu erhalten. Um mit einem Dolmetscher zu sprechen, rufen Sie bitte die Nummer 1-844-396-0191 an. (German)

اگر شما یا فردی که به او کمک می کنید سؤالاتی در باره‌ی این برنامه‌ی بهداشتی داشته باشید، حق این را دارید که کمک و اطلاعات به زبان خود را به طور رایگان دریافت کنید. برای صحبت کردن با مترجم، لطفاً با شماره‌ی 1-844-398-6233 تماس حاصل نمایید. (Persian-Farsi)

Ni da doodago t'áá háída bíká'aná nílwo'ígíí díí Béeso Ách'ą́ąh naa'nilígi háá'ída yí na' ídíł kidgo, nihá'áhóót'i' nihí ká'a'doo wołgo kwii ha'át'íshį́į bí na'ídołkidígi doo bik'é'azláagóó. Ata' halne'é ła' bich'į' ha desdzih nínízingo, kojį' béésh bee hólne' 1-844-516-6328. (Navajo)

Vann du adda ebbah es du am helfa bisht, ennichi questions hend veyyich *deah health plan*, hend diah's recht fa hilf un information greeya in eiyah aykni shprohch unni kosht. Fa shvetza mitt en interpreter, roof deah nummah oh 1-833-584-1829. (Pennsylvania Dutch)

Revised 08/27/2019

Companion Life

Companion Life Insurance Company
P.O. Box 100102
Columbia, SC 29202

NOTICE OF OUR PRIVACY POLICIES AND PRACTICES

This Privacy Notice has been prepared to inform you of our practices related to information we collect about you. When necessary to provide our products and services to you, we may disclose the information we collect, as described below, (a) to companies that provide services on our behalf and (b) to affiliated and nonaffiliated third parties, such as to health care providers and those who process insurance applications, pay claims, coordinate benefits and administer premiums. Otherwise, we do not disclose any nonpublic personal information about our customers or former customers to anyone, except as permitted by law. If you are a plan sponsor or group policyholder, this Privacy Notice describes our practices for safeguarding nonpublic personal financial information that we collect about participants and beneficiaries of your employee benefit plan(s).

Information we collect and maintain: We collect information about you from the following sources:

- Information we receive from you on applications or on other forms
- Information we obtain from your transactions with us, our affiliates or others
- Information we receive from consumer-reporting agencies

How we protect information: We restrict access to nonpublic personal information about you to those who need to know the information to provide our products and services to you and as permitted by law. We maintain physical, electronic and procedural safeguards that comply with applicable legal requirements to guard your nonpublic personal financial information. We have installed usernames, passwords and other safety features on web applications to help ensure that the information about you that we collect and maintain remains safe and secure.

Changes to this notice: We may amend our privacy policies and practices at any time, and we will inform you of any material changes, as required by law.

YOU DO NOT NEED TO DO ANYTHING IN RESPONSE TO THIS NOTICE.

THIS NOTICE IS MERELY TO INFORM YOU ABOUT OUR PRIVACY POLICIES AND PRACTICES.