Exelixis, Inc.

Voluntary Accident Coverage

Prudential

NOTICE FOR TEXAS RESIDENTS

Have a complaint or need help?

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

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

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

Call: Prudential Life Claim Division
Toll-free: 1-800-524-0542
Mail: P.O. Box 8517, Philadelphia, PA 19176

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

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

¿Tiene una queja o necesita ayuda?

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

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

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

Llame a: Prudential Life Claim Division
Teléfono gratuito: 1-800-524-0542
Dirección postal: P.O. Box 8517, Philadelphia, PA 19176

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

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

Disclosure Notice

FOR ARKANSAS RESIDENTS

Prudential's Customer Service Office:

The Prudential Insurance Company of America
Customer Services Department

Voluntary Benefit Services
P.O. Box 696035
San Antonio, TX 78269-6035

Telephone: 844-455-1002

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

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

FOR ARIZONA RESIDENTS

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

FOR CALIFORNIA RESIDENTS

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

FOR COLORADO RESIDENTS

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

FOR FLORIDA RESIDENTS

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

FOR IDAHO RESIDENTS

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

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

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

FOR INDIANA RESIDENTS

Questions regarding your policy or coverage should be directed to:

The Prudential Insurance Company of America
844-455-1002

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

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

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

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

FOR MARYLAND RESIDENTS

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

FOR NORTH CAROLINA RESIDENTS

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

FOR NEW MEXICO RESIDENTS

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

FOR OKLAHOMA RESIDENTS

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

FOR TEXAS RESIDENTS

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

NOTICE FOR VERMONT RESIDENTS

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

FOR WISCONSIN RESIDENTS

KEEP THIS NOTICE WITH YOUR INSURANCE PAPERS

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

Prudential's Customer Service Office:

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

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

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

THE PRUDENTIAL INSURANCE COMPANY OF AMERICA

Certificate of Coverage

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

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

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

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

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

Right to Examine this Group Insurance Certificate: You may return this Group Insurance Certificate to Prudential, for any reason, within 31 days after you receive it. If you return it within this period, the insurance will be void the date it would otherwise take effect, and Prudential will refund Your contributions, if any, within 30 days after we receive the returned certificate.

Prudential's Address:

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

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

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

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

The Group Contract provides accident Coverage ONLY.

VOLUNTARY ACCIDENT COVERAGE

Welcome Message

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

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

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

IMPORTANT NOTICE: *This Booklet is an important document and should be kept in a safe place. This Booklet and the Certificate of Coverage made a part of this Booklet together form Your Group Insurance Certificate.*

IMPORTANT INFORMATION FOR RESIDENTS OF CERTAIN STATES: *There are state-specific requirements that may change the provisions under the Coverage(s) described in this Group Insurance Certificate. If You live in a state that has such requirements, those requirements will apply to Your Coverage(s) and are made a part of Your Group Insurance Certificate. Prudential has a website that describes these state-specific requirements. You may access the website at www.prudential.com/etonline. When You access the website, You will be asked to enter Your state of residence and Your Access Code.* ***Your Access Code is VACC1.***

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

Table of Contents

Schedule of Benefits

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

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

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

This Booklet describes all of the options available under the Group Contract.

VOLUNTARY ACCIDENT COVERAGE FOR YOU AND YOUR DEPENDENTS

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

CORE BENEFITS

Accidental Losses:

Accidental Dismemberment/Functional Loss/Paralysis Benefits

Broken Tooth Benefit

Crown $300

Extraction $150

Filling $75

Burn Benefit **Percentage of total surface skin area that is burnt**	**Benefit for 2nd Degree burn**	**Benefit for 3rd Degree burn**
Less than 10%	$100	$1,000
At least 10% but less than 25%	$200	$2,000
At least 25% but less than 35%	$500	$5,000
35% or more	$1,000	$10,000
Skin Graft Benefit	50%	50%

Coma Benefit $10,000

Concussion Benefit $4,000

Dislocation Benefit: **Full Dislocation Benefit**	**Benefit for Closed Reduction**	**Benefit for Open Reduction**
Dislocation, lower jaw	$600	$1,200
Dislocation, spine	$1,200	$2,400
Dislocation, collar bone	$500	$1,000
Dislocation, shoulder joint	$500	$1,000
Dislocation, rib	$500	$1,000
Dislocation, elbow	$500	$1,000
Dislocation, wrist	$500	$1,000
Dislocation, hand except fingers	$500	$1,000
Dislocation, finger	$100	$200
Dislocation, hip	$3,000	$6,000
Dislocation, knee	$2,000	$4,000
Dislocation, ankle	$1,000	$2,000
Dislocation, foot except toes	$1,000	$2,000
Dislocation, toe	$100	$200
Dislocation, partial	25%	25%

Eye Injury Benefit (removal of foreign object) $150

Eye Injury Benefit (surgery) $300

Fracture Benefit:	**Benefit for Closed Reduction**	**Benefit for Open Reduction**
Fracture, skull (simple non-depressed)	$2,000	$4,000
Fracture, skull (depressed)	$3,000	$6,000
Fracture, facial bone including nose except upper or lower jaw	$1,000	$2,000
Fracture, upper jaw	$1,000	$2,000
Fracture, lower jaw	$500	$1,000
Fracture, spine (vertebral processes)	$500	$1,000
Fracture, spine (vertebral body except vertebral processes)	$2,000	$4,000
Fracture, collar bone	$500	$1,000
Fracture, shoulder blade	$500	$1,000
Fracture, breast bone	$500	$1,000
Fracture, rib	$500	$1,000
Fracture, pelvis except tailbone	$2,000	$4,000
Fracture, tailbone	$500	$1,000
Fracture, upper arm	$1,000	$2,000
Fracture, forearm	$500	$1,000
Fracture, wrist	$500	$1,000
Fracture, hand except fingers	$500	$1,000
Fracture, finger	$100	$200

Fracture, hip or thigh or both	$3,000	$6,000
Fracture, kneecap	$500	$1,000
Fracture, leg except thigh	$1,000	$2,000
Fracture, ankle	$500	$1,000
Fracture, foot except toes	$500	$1,000
Fracture, toe	$100	$200
Fracture, chip	25%	25%

Laceration Benefit

Repaired without stitches $50

Repaired with stitches:
Lacerations, total is less than two inches $100

Lacerations, total is two to six inches $200

Lacerations, total over six inches $400

Puncture Wound Benefit $100

Paralysis Benefit

Paralysis, four limbs $20,000
Paralysis, three limbs $15,000
Paralysis, two limbs $10,000
Paralysis, one limb $5,000

ACCIDENT MEDICAL TREATMENT AND SERVICES BENEFITS

Air Ambulance Benefit $1,000

Ground Ambulance Benefit $300

Blood/Plasma/Platelets Benefit $500

Emergency Care Benefit

Emergency Room $150

Physician's Office $50

Urgent Care $50

Non-Emergency Initial Care Benefit $50

X-Ray Benefit $100

Advanced Diagnostic Testing Benefits

CAT.....$200

EEG.....$200

MMRI.....$200

MR.....$200

NCV.....$200

PET.....$200

Physician Follow-Up Visits.....$75

Medical Appliance Benefit

Brace.....$100

Cane.....$100

Crutches.....$100

Walker-expected use less than 1 year.....$200

Walker-expected use 1 year or longer.....$500

Walking boot.....$100

Wheel chair or motorized scooter-expected use less than 1 year.....$200

Wheel chair or motorized scooter-expected use 1 year or more.....$1,000

Other medical device used for mobility.....$100

Prosthetic Device Benefit

One device only.....$750

More than one device.....$1,500

Therapy Services Benefit

Cognitive Behavioral Therapy.....$25

Occupational Therapy.....$25

Physical Therapy.....$25

Respiratory Therapy.....$25

Speech Therapy.....$25

Vocational Therapy.....$25

Lodging Benefit $200

Transportation Benefit.....$400

Surgical Repair Benefit

Abdominal Pelvic Cavity $2,000

Cranial $2,000

Hernia Repair.....$200

Ruptured Disc $1,000

Tear, cartilage in knee $750

Torn, ruptured or Severed Tendon/Ligament/Rotator Cuff

One tendon/ligament/rotator cuff $750

Two or more tendons/ligaments/rotator cuffs $1,000

Thoracic cavity.....$2,000

Exploratory Surgery Benefit (without repair) for any of the procedures listed above or outpatient surgery $200

Other Outpatient Surgery Benefit $300

Pain Management Benefit

Epidural anesthesia $100

General anesthesia $100

ACCIDENT HOSPITAL BENEFITS

Hospital Admission Benefit.....$1,500

Intensive Care Unit (ICU) Admission Benefit $1,500

Hospital Confinement Benefit.....$300 per day

ICU Confinement Benefit .....$600 per day

Inpatient Rehabilitation Benefit.....$200 per day

ADDITIONAL BENEFITS

Modification Benefit $1,000

Wellness $50

OTHER INFORMATION

Contract Holder: EXELIXIS, INC.

Group Contract No.: GVA-60356-CA

Contract Anniversaries: January 1 of each year, beginning in 2025.

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

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

Prudential's Address:

The Prudential Insurance Company of America
213 Washington Street

Newark, New Jersey 07102

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

The Prudential Insurance Company of America
Customer Services Department

Voluntary Benefit Services
P.O. Box 696035
San Antonio, TX 78269-6035

1-844-455-1002

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

California Department of Insurance
Consumer Services Division
300 South Spring Street
Los Angeles, California 90013
1-800-927-HELP
https://interactive.web.insurance.ca.gov/contactCSD/ContactUs.jsp

General Definitions

FOR YOU AND YOUR DEPENDENTS

Some of the terms used in the Coverage.

Active Work Requirement: A requirement that you be actively at work Full-time or Part-time at the Employer's place of business or at any other place that your Employer's business requires you to go. You are considered actively at work during normal vacation if you were actively at work on your last regular scheduled workday.

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

Calendar Year: A year starting January 1.

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

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

Coverage: A part of the Booklet consisting of:

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

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

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

Covered Accident: A sudden, unforeseeable, external event that was the proximate cause of a Covered Loss and meets all of the following conditions:

(1) occurs while the Covered Person is insured under this Policy;

(2) is not otherwise excluded under the terms of this Policy.

Covered Injury: Injury to the body of a Covered Person.

Covered Person under the Coverage**:** An Employee who is insured for Employee Insurance under that Coverage; a Qualified Dependent for whom an Employee is insured for Dependents Insurance under that Coverage.

Covered Surgery means any of the following procedures:

- Cranial Surgery
- Skin graft to treat a burn for which the Burn Benefit was paid

- Surgery to treat a Hernia
- Thoracic Cavity and Abdominal Pelvic Cavity Surgery
- Surgery to treat a Ruptured Disc
- Surgery to treat torn cartilage in the knee (meniscus)
- Surgery to treat a torn, ruptured or severed tendon, ligament or rotator cuff

Dependents Insurance: Insurance on the person of a dependent.

Doctor: A licensed practitioner of the healing arts acting within the scope of the license.

Earnings: This is the gross amount of money paid to you by the Employer in cash for performing the duties required of your job. Bonuses, commissions, overtime pay, Earnings for more than 40 hours per week, and all other benefits are not included.

Employee: A person employed by the Employer; a proprietor or partner of the Employer. The term also applies to that person for any rights after insurance ends.

Employee Insurance: Insurance on the person of an Employee.

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

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

(1) your marriage or divorce;

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

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

(4) the birth or adoption of your child;

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

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

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

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

Outpatient Surgery: Surgery performed on an outpatient basis, other than a Surgery for which the Inpatient Surgery Benefit is payable.

Premium: The amount that you are required to pay for your insurance. The required Premiums are to be paid by you to the Contract Holder on each Premium Payment Date.

Prudential: The Prudential Insurance Company of America.

Rehabilitation Facility A facility that:

- provides rehabilitation care services on an inpatient basis; and

- maintains all required licenses and certifications.

Rehabilitation care services consist of the combined use of medical, social, educational, and vocational services to enable patients disabled by an Injury to achieve the highest possible functional ability. Services are provided by or under the supervision of an organized staff of Physicians.

The term Rehabilitation Facility does not include:

- a nursing home;
- an extended care facility, unless the Covered Person is receiving rehabilitation care services on an inpatient basis at the extended care facility;
- a Skilled Nursing Facility, unless the Covered Person is receiving rehabilitation care services on an inpatient basis at the facility;
- a rest home or home for the aged;
- a hospice care facility;
- a place for recovery from alcoholic or drug addiction; or
- an assisted living facility.

You: An Employee.

Benefit Definitions

FOR YOU AND YOUR DEPENDENTS

This Coverage pays the following benefits for Accident.

Ambulance Benefit (Air): Prudential will pay the benefit shown in the Schedule of Benefits section if a licensed professional Air Ambulance service is required to transport any Covered Person by air to or from a Hospital or between medical facilities where treatment is received due to an accidental injury.

The Air Ambulance transportation must be within 90 days after the Covered Accident occurs or Covered Injury.

Prudential will pay this benefit 1 time per Accident and a maximum of 2 times per Covered Person, per Calendar Year.

Ambulance Benefit (Ground/Water): Prudential will pay the benefit shown in the Schedule of Benefits section if a licensed professional Ambulance service is required to transport any Covered Person by ground to or from a Hospital or between medical facilities where treatment is received due to an accidental injury

The Ambulance transportation must be within 90 days of the Accident.

Prudential will pay this benefit 1 time per Accident, Covered Injury and a maximum of 2 times per Covered Person, per Calendar Year.

Blood / Plasma / Platelets: Prudential will pay this benefit if a Covered Person sustains an accidental injury and receives a transfusion of blood, plasma or platelets subject to the following:

The blood, plasma or platelets must be administered within 90 days of the Accident and must be prescribed by a Doctor on an emergency basis or provided while the Covered Person is undergoing Surgery.

Prudential will pay this benefit 1 time per Covered Person, per Accident and a maximum of 3 times per Covered Person, per Calendar Year.

Broken Tooth Benefit: If a Covered Person sustains an accidental Injury that results in a Broken Tooth and the tooth is repaired by a dental crown or filling, or is extracted, We will pay the Broken Tooth Benefit, shown in the Schedule of Benefits, that is applicable to the dental crown, filling and/or extraction, subject to all of the following:

(a) The dental services must begin within 90 days after the Covered Accident or Covered Injury occurs.

(b) If there are multiple Broken teeth, we will pay no more than 1 crown, no more than 1 filling and no more than 1 extraction per Covered Person, per Covered Accident or Covered Injury.

(c) We will pay the Broken tooth benefit no more than 3 times per Covered Person, per Calendar Year.

Prudential will not pay for an Injury to a tooth that is not a sound, natural tooth or for an Injury caused by biting or chewing.

Burn Benefit: Prudential will pay this benefit if a Covered Person sustains an accidental Injury that is a second or third degree burn, We will pay the Burn Benefit, shown in the Schedule of Benefits, that is applicable to the size and severity of the burn, subject to all of the following:

(1) The burn must be treated by a Doctor within 48 hours after the Covered Accident or Covered Injury occurs.

(2) If a burn meets more than one of the burn classifications shown in the Schedule of Benefits, the amount We pay will be based on the classification of the burn that pays the highest benefit.

(3) We will pay the Burn Benefit no more than:

  (a) one time per Covered Person, per Covered Accident or Covered Injury; and

  (b) 1 time per Covered Person, per Calendar Year.

(4) No benefit is payable for a first degree burn.

Coma Benefit: Prudential will pay this benefit if a Covered Person sustains an accidental injury that is a Coma, as diagnosed by a Physician. We will pay the Coma Benefit shown in the Schedule of Benefits, subject to the following:

(1) The Coma must begin within 90 days after the Covered Accident

(2) We will pay the Coma Benefit no more than 1 time per Covered Person, per Accident and a maximum of 1 time per Covered Person, per Calendar Year.

Coma means a persistent vegetative state, diagnosed by a Physician, in which there is no response to stimuli lasting for 7 consecutive days or more.

Prudential will not pay for a medically induced Coma.

Concussion Benefit: If a Covered Person sustains an accidental Injury that is a Concussion, Prudential will pay the Concussion Benefit shown in the Schedule of Benefits, subject to all of the following:

(1) The Injury must be diagnosed as a Concussion by a Physician within 48 hours after the Accident occurs.

(2) We will pay the Concussion Benefit no more than 1 time per Covered Person, per Calendar Year.

Advanced Diagnostic Testing Benefit: Means any of the following:

- magnetic resonance imaging (MRI) or magnetic resonance (MR)
- nerve conduction velocity test (NCV)
- computed tomography scan (CT) or computed axial tomography (CAT)
- electroencephalogram (EEG)
- positron emission tomography (PET)

Prudential will pay this benefit if a Covered Person sustains an accidental injury and receives any of the above medical tests to evaluate the injury, We will pay the Advanced Diagnostic Testing Benefit shown in the schedule of benefits subject to the following:

(1) The test must be ordered by a Physician and be performed within 90 days after the Covered Accident occurs.

(2) We will pay the Diagnostic Testing Benefit no more than 1 time per Covered Person, per Accident and up to a maximum of 3 times per Covered Person, per Calendar Year.

Dislocation Benefit: If a Covered Person sustains an accidental injury that is a Dislocation, Prudential will pay the Dislocation Benefit shown in the Schedule of Benefits that is applicable to the type of Dislocation the Covered Person sustained, subject to the following:

(1) The injury must be diagnosed and treated as a Dislocation by a Physician within 90 days after the accident occurs.

(2) The Dislocation must require, and be corrected by, open (surgical) or closed (non-surgical) reduction by a Physician.

(3) Prudential will pay this benefit once for the Dislocation of a joint after the coverage effective date. No benefit is payable for subsequent Dislocations of the same joint after the coverage effective date.

(4) If the person suffers more than one Dislocation as a result of the same Accident, the total benefit payable for all such Dislocations is limited to 2 times the benefit amount payable for the joint involved which has the highest benefit amount.

(5) The Partial Dislocation Benefit will be 25% of the Dislocation Benefit shown in the Schedule of Benefits for a Full Dislocation of the joint involved.

Dislocation means a separated joint of a body part that is listed on the Schedule of Benefits under the Dislocation Benefit. The term Dislocation does not include vertebral subluxation complex (misaligned vertebrae).

Full Dislocation means a Dislocation in which the joint is completely separated.
Partial Dislocation means a Dislocation in which the joint is not completely separated.

Physician Follow-Up Visit Benefit: Prudential will pay the benefit shown in the Schedule of Benefits if a Covered Person sustains an accidental injury and receives follow-up care for the injury, that is recommended by a Physician, subject to the following:

(1) Treatment must begin within 90 days after the Accident occurs and be provided within 365 days after the Accident occurs.

(2) Treatment must be specific to the injury.

(3) Treatment must occur on an outpatient basis.

(4) Treatment must not be for preventative testing, or any treatment for which a benefit is payable under the Therapy Services Benefit, Emergency Care Benefit or Non-Emergency Care Benefit.

(5) Prudential will pay this benefit no more than 2 times per Covered Person, per Covered Accident, and up to a maximum of 6 times per Covered Person per Calendar Year.

Emergency Care Benefit: If a Covered Person sustains an accidental injury and receives initial care from a Physician for the injury in an Emergency Room, a Physician's office, or an Urgent Care Facility, within 96 hours after the Accident occurs, Prudential will pay the Emergency Care Benefit, shown in the Schedule of Benefits that is applicable to the place where care is received.

If a Covered Person sustains an injury and receives initial care from a Physician for the injury in an Emergency Room, a Physician's office, or an Urgent Care Facility, more than 96 hours but less than 90 days after the Accident occurs, We will pay the Non-Emergency Initial Care Benefit shown in the Schedule of Benefits.

Payment of the Emergency Care Benefit and the Non-Emergency Initial Care Benefit is subject to both of the following:

(1) We will never pay both the Emergency Care Benefit and the Non-Emergency Initial Care Benefit for the same Covered Person, for the same Accident.

(2) If We pay either the Emergency Care Benefit or the Non-Emergency Initial Care Benefit, We will pay the benefit no more than one time per Covered Person, per Accident.

Eye Injury Benefit: If a Covered Person sustains an accidental injury to an eye, Prudential will pay the Eye Injury Benefit shown in the Schedule of Benefits, subject to all of the following:

(1) The Injury to the eye must require Surgery or the removal of a foreign object by a Physician within 90 days after the Accident occurs.

(2) We will pay the Eye Injury Benefit no more than:

  (a) 1 time per Covered Person, per Accident; and

  (b) 3 times per Covered Person, per Calendar Year.

Fracture Benefit: If a Covered Person sustains an accidental injury that is a Fracture, Prudential will pay the Fracture Benefit shown in the Schedule of Benefits that is applicable to the type of Fracture sustained by the Covered Person, subject to all of the following:

(1) The injury must be diagnosed and treated as a Fracture by a Physician within 90 days after the Accident occurs.

(2) The Fracture must require, and be corrected by, open (surgical) or closed (non-surgical) reduction by a Physician. Closed reduction includes immobilization.

(3) We will pay no more than one Fracture Benefit per bone, per Accident

(4) If the Covered Person suffers more than one Fracture as a result of the same Accident, the total benefit payable for all such Fractures combined is limited to 2 times the benefit amount payable for the Fracture involved which has the highest benefit amount.

(5) If an injury is a Chip Fracture, Prudential will pay the Chip Fracture Benefit instead of the Fracture Benefit. The Chip Fracture Benefit will be 25% of the Fracture Benefit shown in the Schedule of Benefits for the bone involved.

(6) If the same Fracture is treated with both open reduction and closed reduction, we will pay no more than the Fracture Benefit payable for the open reduction.

Fracture means a break in a bone that is listed on the Schedule of Benefits under Fracture Benefit, which can be detected by an x-ray or similar diagnostic exam.

Chip Fracture means a Fracture in which a small fragment of the bone is broken off.

General Anesthesia Benefit: If a Covered Person sustains an accidental injury and undergoes Surgery, for which a benefit is payable under this Certificate, for such injury in a Hospital or Outpatient Surgery Facility, Prudential will pay the General Anesthesia Benefit shown in the Schedule of Benefits, subject to all of the following:

(1) General Anesthesia must be:

  (a) administered within 90 days after the Accident occurs, during Surgery to treat the injury; and

  (b) administered by a Physician.

(2) We will pay the General Anesthesia Benefit no more than 1 time per Covered Person, per Accident, up to a maximum of 3 times per Covered Person, per Calendar Year.

(3) We will not pay a General Anesthesia Benefit for local anesthesia or regional anesthesia (including epidural anesthesia or spinal anesthesia).

General Anesthesia means an induced state of unconsciousness accompanied by a loss of protective reflexes, including the ability to maintain an airway independently and respond purposely to physical stimulation or verbal command.

Hospital Admission Benefit: Prudential will pay the Hospital Admission benefit shown in the Schedule of Benefits section, if a Covered Person is admitted to a Hospital for treatment of an accidental injury, subject to all of the following:

(1) the admission must occur within 90 days after the Accident occurs.

(2) The Admission Benefit is not payable for Emergency Room treatment, outpatient treatment, or a stay of less than 20 hours in an observation area.

(3) We will only pay the Admission Benefit for a Covered Person for one Hospital admission at a time, even if the admission is caused by more than one Accident and/or injury.

(4) We will pay the Admission Benefit no more than:

  (a) one time per Covered Person, per Accident; and

  (b) 3 times per Covered Person, per Calendar Year.

If a Covered Person is Admitted to a Hospital and becomes Admitted again within 90 days for the same or related condition, We will treat the Admission as a continuation of the prior Admission. If more than 90 days have passed between the periods of Admission, We will treat this Admission as a new Admission.

ICU Admission Benefit: Prudential will pay the ICU Admission Benefit shown in the Schedule of Benefits section, if a Covered Person, upon initial admission to a Hospital for treatment of an accidental injury, is admitted to an ICU, subject to the following:

(1) The admission must meet the requirements for payment of the Admission Benefit.

(2) The admission must occur within 90 days after the Accident occurs.

(3) The ICU Admission benefit is not payable for a stay of less than 20 hours.

(4) If the Covered Person moves to an ICU after initial admission to a Hospital, We will not pay the ICU Admission Benefit.

(5) We will pay the ICU Admission Benefit no more than:

(a) one time per Covered Person, per Accident.

(b) 3 times per Covered Person, per Calendar Year.

If a Covered Person is Confined in a Hospital and becomes Confined again within 90 days for the same or related condition, We will treat the Confinement as a continuation of the prior Confinement. If more than 90 days have passed between the periods of Confinement, We will treat this Confinement as a new Confinement.

Hospital Confinement Benefit: Prudential will pay the Hospital Confinement Benefit shown in the Schedule of Benefits for each day, after the day of admission to the Hospital, if the Covered Person is Confined in the Hospital for treatment of an accidental Injury subject to all of the following:

(1) The initial Hospital Confinement must begin within 90 days after the Accident occurs.

(2) The Hospital Confinement benefit is not payable for a day in which the Hospital Admission or ICU Admission benefit is payable or for a Confinement of less than 24 hours.

(3) The Hospital Confinement Benefit is payable for up to 365 days per Covered Person, per Accident.

(4) We will pay the Hospital Confinement Benefit no more than 3 times per Covered Person, per Calendar Year.

(5) We will only pay the Hospital Confinement Benefit for a Covered Person for one Hospital Confinement at a time, even if the Confinement is caused by more than one Accident and/or Injury.

(6) We will only pay one Hospital Confinement Benefit per day. If the Covered Person has a non-ICU Hospital Confinement and an Intensive Care Unit Confinement on the same day, We will only pay the Hospital Confinement Benefit that applies to Intensive Care Unit Confinement.

If a Covered Person is Confined in a Hospital and becomes Confined again within 90 days for the same or related condition, We will treat the Confinement as a continuation of the prior Confinement. If more than 90 days have passed between the periods of Confinement, We will treat this Confinement as a new Confinement.

Intensive Care Unit (ICU) Confinement Benefit: Prudential will pay the ICU Confinement Benefit shown in the Schedule of Benefits section, for each day the Covered Person is Confined in an Intensive Care Unit for treatment of an accidental injury and meets the requirements for payment of the Confinement Benefit, subject to all of the following:

(1) Confinement in the Intensive Care Unit must begin within 90 days after the Accident occurs.

(2) The ICU Confinement benefit is not payable for a day in which the Hospital Admission or ICU Admission benefit is payable or for a Confinement of less than 24 hours.

(3) The ICU Confinement Benefit is payable for up to 30 days per Covered Person, per Accident.

(4) We will pay the ICU Confinement Benefit no more than 3 times per Covered Person, per Calendar Year.

If a Covered Person is Confined in a Hospital and becomes Confined again within 90 days for the same or related condition, We will treat the Confinement as a continuation of the prior Confinement. If more than 90 days have passed between the periods of Confinement, We will treat this Confinement as a new Confinement.

Laceration Benefit: If a Covered Person sustains an accidental injury that is a Laceration and receives treatment from a Physician to repair it, Prudential will pay the Laceration Benefit, shown in the Schedule of Benefits, that is applicable to the length of the Laceration and the treatment received as follows:

(1) If the laceration is repaired with stitches, We will pay the Laceration Benefit repaired with stitches; or

(2) If the Laceration is repaired without stitches, We will pay the Laceration Benefit repaired without stitches.

Payment of the Laceration Benefit is subject to all of the following:

- The Laceration must be treated by a Physician within 96 hours after the Accident occurs.
- If the Laceration is repaired with sutures or staples it will be considered to be repaired with stitches for the purposes of the Laceration Benefit.
- If a Covered Person has more than one Laceration, the amount We pay will be based on the total length of all Lacerations received in the same Accident that are repaired with stitches. If some, but not all, of the Lacerations require repair with stitches, We will not pay any benefit for the Laceration(s) that are repaired without stitches.
- If an injury meets the definition of both a Laceration and a Puncture Wound, we will only pay the benefit which has the higher benefit amount.
- We will pay the Laceration Benefit no more than one time per Covered Person, per Accident; and up to a maximum of 3 times per Covered Person, per calendar year.

Laceration means a cut of the full thickness of the skin.

Lodging Benefit: If a Covered Person is Confined in a Hospital for treatment of an accidental injury, and a companion who accompanies the Covered Person while the Covered Person is so Confined stays in a Lodging for which a charge is made, Prudential will pay the Lodging Benefit shown in the Schedule of Benefits subject to all of the following:

(1) We will pay the Lodging Benefit for each day the companion stays in a Lodging while the Covered Person is Confined in a Hospital for treatment of an accidental injury.

(2) We will pay the Lodging Benefit for up to 30 days per Calendar Year.

(3) The Lodging Benefit is only payable for a day for which We are paying a Confinement Benefit for a Covered Person.

(4) You must submit Proof that the companion incurred an expense for staying at a Lodging for each day of the stay.

Lodging means an establishment licensed under the laws where it is located, such as a motel, hotel, or other facility that provides sleeping accommodations to the general public in exchange for a fee and is located at least 50 miles from the Covered Person's Primary Residence.

Medical Appliance: Prudential will pay the benefit as shown in the Schedule of Benefits for the type of Medical Appliance prescribed if a Covered Person sustains an accidental injury for which a Physician prescribes the use of a Medical Appliance as an aid in personal locomotion or mobility, subject to all of the following:

(1) The use of such Medical Appliance must begin within 90 days after the Accident occurs.

(2) The amount We will pay for all Medical Appliances combined will be no more than $1,000 per Covered Person, per Accident.

(3) Prudential will not pay the Medical Appliance Benefit for the replacement of a Medical Appliance.

Medical Appliance means any of the following:

- brace for the neck, back or leg
- cane
- crutches
- walker
- walking boot that extends above the ankle
- wheelchair or motorized scooter for medical purposes
- any other medical device used for mobility

Modification Benefit: If a Covered Person sustains an accidental injury for which We paid a Paralysis Benefit, We will pay the Modification Benefit shown in the Schedule of Benefits for Modifications made to the Covered Person's Primary Residence or vehicle, subject to all of the following:

(1) A Physician must certify that because of the accidental injury, the Modification is necessary to help enable the Covered Person to live in his or her Primary Residence or travel in his or her primary vehicle.

(2) The Modification must be made within 180 days after the Accident occurs.

(3) We will pay the Modification Benefit no more than:

  (a) 1 time per Covered Person, per Accident; and

  (b) 1time per Covered Person, per Calendar Year.

Other Outpatient Surgery Benefit: If a Covered Person sustains an accidental injury and undergoes Other Outpatient Surgery to treat the injury in an Outpatient Surgery Facility, Prudential will pay the Other Outpatient Surgery Benefit as shown on the Schedule of Benefits, subject to all of the following:

(1) The Covered Person must be treated by a Physician for the injury within 90 days after the Accident occurs.

(2) The surgery must be performed by a Physician in an Outpatient Surgery Facility within 180 days after the Accident occurs.

(3) If, as a result of the same Accident, a Covered Person has a Covered Surgery and another Outpatient Surgery performed at the same time, We will only pay one benefit which will be the benefit with higher benefit amount.

(4) We will pay the Other Outpatient Surgery Benefit no more than 1 time per Covered Person, per Accident and up to a maximum of 3 times per Covered Person, per Calendar Year.

Pain Management Benefit: (Epidural Anesthesia): If a Covered Person sustains an accidental injury and receives epidural anesthesia to manage pain from the injury, Prudential will pay the Pain Management Benefit shown in the Schedule of Benefits, subject to all of the following:

(1) The epidural anesthesia must be administered within 180 days after the Accident occurs.

(2) Epidural anesthesia to manage pain from an injury must be prescribed by a Physician.

(3) We will pay the Pain Management Benefit no more than 1 time per Covered Person, per Accident and up to a maximum of 3 times per Covered Person, per Calendar Year.

Paralysis Benefit: If a Covered Person sustains an accidental Injury that results in Paralysis, Prudential will pay the Paralysis Benefit shown in the Schedule of Benefits that applies to the type of Paralysis that the Covered Person sustained, subject to all of the following:

(1) Paralysis must be documented by a Doctor within 90 days after the Accident occurs.

(2) If a Covered Person sustains an accidental Injury that results in a Paralysis that falls under more than one classification on the Schedule of Benefits, We will only pay the benefit that applies to the classification that pays the highest benefit.

(3) We will pay the Paralysis Benefit no more than one time per Covered Person, per Covered Accident or Covered Injury.

Paralysis means the permanent total and irrecoverable loss of movement of 1 or more limbs:

(1) that has lasted for a continuous period of not less than 90 days as confirmed by a Doctor; or

(2) as a result of transected spinal cord with supporting clinical and radiological evidence and no expectation of return to function.

The term Paralysis does not include a Dismemberment or Coma.

Prosthetic Device Benefit: If a Covered Person sustains an accidental injury that is a loss of limb, hand, foot, or sight in an eye and receives a Prosthetic Device as a result of the loss, Prudential will pay the Prosthetic Device Benefit shown in the Schedule of Benefits, that is applicable to the number of Prosthetic Devices the Covered Person receives, subject to all of the following:

(1) The Prosthetic Device must be received within 365 days after the Accident occurs.

(2) No benefit will be payable for replacement of a Prosthetic Device.

(3) No benefit will be payable for more than one Prosthetic Device for the same body part.

(4) We will not pay the Prosthetic Device Benefit for a joint replacement such as an artificial hip or knee.

(5) For a Dependent Child who is under age 18, We will pay the Prosthetic Device Benefit no more than:

(a) 1 time, per Accident; and

(b) 1 time per Calendar Year.

(6) For all other Covered Persons, We will pay the Prosthetic Device Benefit no more than:

(a) 1 time per Covered Person, per Accident; and

(b) 1 time per Covered Person, per Calendar Year.

Prosthetic Device means an artificial device that replaces a missing body part. The term Prosthetic Device does not include hearing aids, dental aids (including false teeth), eyeglasses, or cosmetic prostheses such as wigs.

Puncture Wound: If a Covered Person sustains an accidental injury that is a Puncture Wound and such wound is treated by a Physician, Prudential will pay the Puncture Wound Benefit shown in the Schedule of Benefits, subject to all of the following:

(1) The Puncture Wound must be treated by a Physician within 96 hours after the Accident occurs.

(2) We will pay the Puncture Wound Benefit no more than 1 time per Covered Person, per Accident, up to a maximum of 3 times per Covered Person, per Calendar Year.

Puncture Wound means an injury caused by an object, including a needle, that pierces or penetrates the full thickness of the skin.

Inpatient Rehabilitation Benefit: If a Covered Person is transferred to a Rehabilitation Facility immediately after a period of Confinement for treatment of an accidental injury for which We paid a Confinement Benefit, We will pay the Inpatient Rehabilitation Benefit shown in the Schedule of Benefits, subject to all of the following:

(1) We will pay the Inpatient Rehabilitation Benefit for each day of the Covered Person's continuous stay as a resident inpatient in a Rehabilitation Facility, up to a maximum stay of 15 days per Covered Person, per Covered Accident or Covered Injury but not to exceed 30 days per Calendar Year.

(2) The Covered Person's inpatient stay in the Rehabilitation Facility must start within 365 days after the Accident.

(3) After the Covered Person is discharged from the Rehabilitation Facility, We will not pay the Inpatient Rehabilitation Benefit for a subsequent admission to a Rehabilitation Facility for treatment of the same accidental injury for which We already paid the Inpatient Rehabilitation Benefit.

We will not pay the Inpatient Rehabilitation Benefit for any day for which We paid a Confinement Benefit.

Surgery Benefit: If a Covered Person undergoes a Covered Surgery to treat an accidental injury, while Confined, Prudential will pay the applicable benefit shown in the Schedule of Benefits under

Surgery Benefit, for the type of Covered Surgery the Covered Person undergoes, subject to all of the following:

- The Covered Person must be treated by a Physician for the injury within 90 days after the Accident occurs.
- The Covered Surgery must be performed by a Physician within 180 days after the Accident occurs.
- If the Covered Surgery is performed with repair, We will pay the Surgical Repair Benefit shown in the Schedule of Benefits for the applicable procedure.
- If the Covered Surgery performed is Exploratory Surgery, We will pay the Exploratory Surgery Benefit shown in the Schedule of Benefits.
- If as a result of the same Accident, the Covered Person has a Covered Surgery and another Outpatient Surgery performed at the same time, We will only pay one benefit which will be the benefit that pays the higher amount.
- If as a result of the same Accident, the Covered Person has more than one Covered Surgery performed at the same time, We will only pay a benefit for one Covered Surgery, which will be the Covered Surgery with the highest benefit amount.
- We will pay the Surgery Benefit no more than 1 time per Covered Person, per Accident, up to a maximum of 3 times per Covered Person, per Calendar Year.

Exploratory Surgery means a Covered Surgery performed without surgical repair. For surgery to treat torn cartilage in the knee, if the cartilage is shaved or trimmed from the knee, the Surgery will be considered Exploratory Surgery and not a Surgery with Repair.

Therapy Services Benefit: If a Covered Person sustains an accidental injury and receives Therapy Services, Prudential will pay the Therapy Services Benefit shown in the Schedule of Benefits that applies to the type of Therapy Service received, subject to all of the following:

(1) Therapy Services must:

  (a) Begin within 90 days after the Accident occurs and be provided within 365 days after the Accident occurs;

  (b) Be provided on an outpatient basis;

  (c) Be prescribed by a Physician; and

  (d) Be provided by a practitioner licensed to provide the type of Therapy Services provided and operating within the scope of such license.

(2) We will pay the Therapy Services Benefit for Therapy Services no more than:

  (a) 10 times per Covered Person, per Accident; and

  (b) 10 times per Covered Person, per Calendar Year.

We will not pay a Therapy Services Benefit for Therapy Services received by the Covered Person on the same day for which the Inpatient Rehabilitation Benefit or the Skilled Nursing Facility Benefit is payable.

Therapy Services means any of the following:

- cognitive behavioral therapy
- occupational therapy
- physical therapy
- respiratory therapy
- speech therapy
- vocational therapy

Transportation Benefit: Prudential will pay the Transportation Benefit shown in the Schedule of Benefits when a Covered Person travels more than 50 miles one way for follow-up treatment of an accidental injury for which We pay a benefit under this Certificate, at a Hospital or other treatment facility, subject to all of the following:

(1) Mileage is measured from the Covered Person's Primary Residence to the facility where the follow-up treatment is provided.

(2) The follow-up treatment must be prescribed by a Doctor and not available within 50 miles of the Covered Person's Primary Residence.

(3) You must submit Proof that the follow-up treatment was provided.

(4) We will pay the Transportation Benefit no more than:

(a) 1 time per Covered Person, per Covered Accident; and

(b) 3 times per Covered Person, per Calendar Year**.**

(5) We will not pay the Transportation Benefit if the Ground Ambulance Benefit or Air Ambulance Benefit is payable for the trip.

Wellness Benefit: Prudential will pay the Wellness Benefit if a Covered Person takes one of the screening prevention measures listed below, upon submission of Proof, We will pay the Wellness Benefit shown in the Schedule of Benefits for the day that the measure is taken subject to all of the following:

(a) We will only pay one Wellness Benefit per Covered Person, per day;
(b) We will only pay the Wellness Benefit 1 time per Covered Person, per calendar year.
(c) We will not pay a Wellness Benefit for a screening/prevention measure if benefits are paid or are payable for that same screening/prevention measure under another section of this Certificate.

The screening/prevention measures for which a Wellness Benefit may be paid are:
1.Routine health check-up exam;
2. Biopsies for cancer;
3. Blood chemistry panel;
4. Blood test to determine total cholesterol;
5. Blood test to determine triglycerides;
6. Bone marrow testing;
7. Breast MRI;
8. Breast ultrasound;
9. Breast sonogram;
10. Cancer antigen 15-3 blood test for breast cancer (CA 15-3);

11. Cancer antigen 125 blood test for ovarian cancer (CA 125);
12. Carcinoembryonic antigen blood test for colon cancer (CEA);
13. Carotid doppler;
14. Chest x-rays;
15. Clinical testicular exam;
16. Colonoscopy;
17. Complete blood count (CBC);
18. Dental exam;
19. Digital rectal exam (DRE);
20. Doppler screening for cancer;
21. Doppler screening for peripheral vascular disease;
22. Echocardiogram;
23. Electrocardiogram (EKG);
24. Electroencephalogram (EEG);
25. Endoscopy;
26. Eye exam;
27. Fasting blood glucose test;
28. Fasting plasma glucose test;
29. Flexible sigmoidoscopy;
30. Hearing test;
31. Hemoccult stool specimen;
32. Hemoglobin A1C;
33. Human papillomavirus (HPV) vaccination;
34. Immunization;
35. Lipid panel;
36. Mammogram;
37. Oral cancer screening;
38. Pap smears or thin prep pap test;
39. Prostate-specific antigen (PSA) test;
40. Serum cholesterol test to determine LDL and HDL levels;
41. Serum protein electrophoresis;
42. Skin cancer biopsy;
43. Skin cancer screening;
44. Skin exam;
45. Stress test on bicycle or treadmill;
46. Successful completion of smoking cessation program;
47. Tests for sexually transmitted infections (STIs);
48. Thermography;
49. Two hour post-load plasma glucose test;
50. Ultrasounds for cancer detection;
51. Ultrasound screening of the abdominal aorta for abdominal aortic aneurysms;
52. Virtual colonoscopy.

X-ray Benefit: If a Covered Person sustains an accidental injury and receives an X-ray to evaluate the injury, Prudential will pay the X-ray Benefit shown in the Schedule of Benefits subject to all of the following:

(1) The x-ray must be prescribed by a Physician and be performed within 90 days after the Accident occurs.

(2) We will pay the X-Ray Benefit no more than 1 time per Covered Person, per Accident, up to a maximum of 3 times per Covered Person, per Calendar Year.

Who is Eligible to Become Insured

FOR EMPLOYEE INSURANCE

You are eligible for Employee Insurance while:

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

You are Full-time if You are regularly working for the Employer at least the number of hours in the Employer's normal Full-time work week for Your class, but not less than 30 hours per week.

You are Part-Time if You are regularly working for the Employer at least the number of hours in the Employer's normal Part-Time work week for Your class, but not less than 30 hours per week. If You are a partner or proprietor of the Employer, that work must be in the conduct of the Employer's business.
Your class is determined by the Contract Holder. This will be done under its rules, on dates it sets. The Contract Holder must not discriminate among persons in like situations. You cannot belong to more than one class for insurance on each basis, Contributory or Non-contributory Insurance, under the Coverage. “Class" means Covered Class, Benefit Class or anything related to work, such as position or Earnings, which affects the insurance available.

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

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

FOR DEPENDENTS INSURANCE

You are eligible for Dependents Insurance while:

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

Qualified Dependents:

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

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

  Your Spouse means Your lawful Spouse.

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

(1) Satisfies the requirements for being a Domestic Partner, registered Domestic Partner or party to a civil union under the law of Your jurisdiction of residence; or

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

(a) is age 18 or older; and

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

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

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

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

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

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

(h) is financially interdependent with You.

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

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

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

  *This age limit will not apply until the end of the month in which your Qualified Dependent Child attains age 26.

- Your Children include Your:

(1) Biological children;

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

(3) Foster children;

(4) Domestic Partner's children; and

(5) Children for whom You, Your Spouse or Your Domestic Partner:

(a) have been appointed the legal guardian; and

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

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

- Your Incapacitated Children.

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

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

  (2) Your Child is so incapacitated before the Child reaches age 26.

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

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

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

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

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

Exceptions:

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

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

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

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

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

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

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

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

When You Become Insured

FOR EMPLOYEE INSURANCE

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

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

For Contributory Insurance, You must enroll on a form approved by Prudential and agree to pay the required contributions. You may enroll for Contributory Insurance (1) within 31 days of when You could first be covered, (2) within 31 days of a Life Event, or (3) during the Annual Enrollment Period without evidence of insurability. Your Employer will tell You whether contributions are required and the amount of any contribution when You enroll.

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

The General Definitions section explains what “Annual Enrollment Period” and “Life Event” means.

FOR DEPENDENTS INSURANCE

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

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

For Contributory Insurance, You must enroll your Qualified Dependent on a form approved by Prudential and agree to pay the required contributions. You may enroll for Contributory Dependents Insurance (1) within 31 days of when You could first be covered, (2) within 31 days of a Life Event, or (3) during the Annual Enrollment Period without evidence of insurability. Your Employer will tell You whether contributions are required and the amount of any contribution when You enroll your Qualified Dependent.

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

The General Definitions section explains what “Annual Enrollment Period” and “Life Events” means.

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

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

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

Forms are available for reporting these changes.

Delay of Effective Date

FOR EMPLOYEE INSURANCE

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

FOR DEPENDENTS INSURANCE

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

Newborn Child Exception: This section does not apply to a Child of Yours at that Child’s birth if the Child is born to You and either:

(1) is Your first Qualified Dependent; or

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

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

When Your Insurance Ends

EMPLOYEE AND DEPENDENTS INSURANCE

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

- Your membership in the Covered Classes for the insurance ends on the last day of the month in which your employment ends (see below) or for any other reason.
- Your class is removed from the Covered Classes for the insurance.
- The date the Group Contract providing the insurance ends.
- You reach age 100.
- You die.
- For Contributory Insurance under the Coverage, You fail to pay, when due, any required contribution. But, if Employee Insurance is Contributory, failure to contribute for Dependents Insurance will not cause Your Employee Insurance to end.
- The insurance is Dependents Insurance, and Your Employee Insurance under the Coverage ends.
- Your Dependents Insurance for a Qualified Dependent under the Coverage will end on the first of these to occur:
- That person ceases to be a Qualified Dependent for the Coverage. A Spouse or Domestic Partner will cease to be a Qualified Dependent at age 100. (See Continued Coverage for an Incapacitated Child below.)

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

Your employment in the Covered Classes will not be considered to end while You are absent from work due to leave for which insurance is required to be continued under the Federal Family and Medical Leave Act of 1993 or a state law requiring similar continuation, as reported to Prudential by the Employer.
If You stop active Full-time or Part-time work for any reason, You should contact the Employer at once to determine what arrangements, if any, have been made to continue any of Your insurance

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

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

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

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

Continuation of Coverage at Your Option:

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

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

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

  (b) Your work hours were reduced.

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

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

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

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

(1) 31 days after the Coverage would otherwise have ended; and

(2) 15 days after You receive the notice informing You of Your right to continue. But, in no event may election be made if You do not apply for continuation of Coverage and pay the first payment prior to 92 days after You cease to be covered for the Coverage.

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

(1) You reach age 100.

(2) You reach Your Lifetime Maximum Benefit.

(3) You die.

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

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

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

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

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

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

(3) You reach age 100.

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

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

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

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

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

EXTENSION OF BENEFITS

If a Covered Person is Confined on the date Your insurance ends and You do not continue insurance under the Continuation of Coverage at Your Option section, We will pay certain benefits for such Covered Person if the Confinement continues after Your insurance ends, in accordance with, and subject to all of the following:

- No benefits will be available under this Extension of Benefits provision if Your insurance ends due to non-payment of premium.
- The Hospital Admissions Benefit, the Daily In-Hospital Stay Benefit, and the Hospital Intensive Care Unit Benefit (ICU) will be payable if requirements for payment of those benefits are met while the Covered Person is Confined. No other benefits will be payable.
- Benefits payable under this Extension of Benefits provision will be paid in accordance with and subject to the terms and conditions of this Certificate, except as set forth in this provision.
- Benefits under this Extension of Benefits provision will end on the earlier of:

  (1) the date the Covered Person is no longer Confined; or

  (2) the end of the number of days that Confinement Benefits are payable for the Confinement, not to exceed 30 days.

- If the Covered Person is again Confined at any time after discharge, no further benefits will be payable.

Amount of Extended Benefit: This amount is determined as if You had remained a Covered Person under the Accident plan. But it is reduced by any amount payable under the Schedule of Benefits or any Prudential group insurance that replaces this Coverage for a class of Employees.

Effect of Continuation: Continued insurance under the Continuation of Coverage at Your Option provision will be in place of all rights under this Section. But if You have met the requirements of this Section, You can obtain these rights in exchange for all benefits of the continued insurance. Premiums paid under the continued insurance will be refunded.

CHANGE IN CLASS

If there is more than one class eligible for insurance under the Group Policy, and each class has its own certificate, instead of receiving a new certificate when You move between classes, You will remain insured under this Certificate if:

- You move to a class that is eligible for Accident Insurance under the Group Policy; and
- the benefits available to Your new class are identical to the benefits available under this Certificate.

In all other cases when You move between classes, Your insurance under this Certificate will end on the date You are no longer an Employee of the class eligible for insurance under this Certificate.

General Information

A. CLAIM RULES.

These rules apply to payment of benefits under the Coverage.

Notice of Claim: Written notice of claim should be sent to Prudential within 20 days of the date of the occurrence or commencement of a loss, or as soon as reasonably possible. Notice given by or on behalf of the insured or the beneficiary to the insured to Prudential at , or to any authorized agent of Prudential, with information sufficient to identify the insured, shall be deemed notice to Prudential.

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

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

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

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

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

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

To Whom Payable: Benefits are payable to You with these exceptions:

(1) Benefits for any of Your Losses that are unpaid at Your death or become payable on account of Your death will be paid to the first of the following: Your (a) surviving Spouse or Domestic Partner; (b) surviving Child(ren) in equal shares; (c) surviving parents in equal shares; (d) surviving siblings in equal shares; (e) estate.

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

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

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

Physical Exam or Autopsy: Prudential, at its own expense, has the right to examine the person for whom the claim is made. Prudential may do this when and as often as is reasonable while the claim is pending and to make an autopsy in case of death where it is not forbidden by law.

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

B. TIME LIMIT ON CERTAIN DEFENSES.

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

C. LIMITS ON ASSIGNMENTS.

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

D. PAYMENT OF PREMIUMS - GRACE PERIOD.

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

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

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

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

E. CHANGE OF BENEFICIARY.

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

Exclusions

Prudential will not pay benefits for any loss caused by, contributed to by, or resulting from, directly or indirectly, any of the following:

- Suicide or attempted suicide, while sane.
- Intentionally self-inflicted Injuries, or any attempt to inflict such Injuries.
- Medical or surgical treatment, whether the claim results directly or indirectly from the treatment.
- Taking part in any riot or insurrection.
- War, or any act of war. War means declared or undeclared war, and includes resistance to armed aggression. Terrorism is not considered an act of war.

  Terrorism means the deliberate use of violence or the threat of violence against civilians to create an emotional response through the suffering of victims or to achieve military, political, religious or social objectives.
- An Accident that occurs while the person is serving on Full-Time active duty for more than 90 days in any armed forces. But this does not include Reserve or National Guard active duty for training.
- Travel or flight in any vehicle used for aerial navigation, if:

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

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

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

  This includes getting in, out, on or off any such vehicle.
- Commission of or attempt to commit a felony.
- Being under the influence of alcohol or alcohol intoxication, including but not limited to having a blood alcohol level above the limit for permissible operation of a motor vehicle in the jurisdiction where the Accident occurred, regardless of whether the person: (a) was operating a motor vehicle; and (b) was convicted of an alcohol related offense.
- Being under the influence of or taking any non-Prescription Drug, medication, narcotic, stimulant, hallucinogen, barbiturate, amphetamine, gas, fumes or inhalants, poison or any other controlled substance as defined in Title II of the Comprehensive Drug Abuse Prevention and Control Act of 1970, as now or hereafter amended, unless prescribed by and administered in accordance with the advice of the person's Doctor.
- Participation in these hazardous sports: scuba diving; bungee jumping; base jumping; skydiving; ziplining; parachuting; hang gliding; paragliding; paramotoring; parascending; or ballooning.

- Treatment for dental care or dental procedures, unless treatment is the result of a Covered Accident, Covered Injury or Covered Illness.
- Elective procedures and/or cosmetic surgery or reconstructive surgery, unless it is a result of trauma, infection or other diseases.
- Cosmetic Surgery, except when such Surgery is performed to:

  (a) treat an Injury or Sickness;

  (b) correct a disorder of normal bodily function or structure that was caused by an Injury or Sickness for which Coverage is not otherwise excluded under this Certificate; or

  (c) reconstruct a part of the body which was disfigured or removed as a result of an Injury or Sickness for which Coverage is not otherwise excluded under this Certificate.
- The Covered Person's mental illness, or the diagnosis or treatment of such an illness, except for the Covered Person's use of:

  (a) any drug, medication or sedative that is taken or used as prescribed by a Doctor; or

  (b) an "over the counter" drug, medication or sedative taken as directed; or

  (c) activities required by the Covered Person's service in the armed forces or any auxiliary unit of the armed forces of any country or international authority.
- Hospital Confinement caused by, contributed to by, or resulting from Mental Illness. However, dementia as a result of stroke, trauma, viral infection, Alzheimer’s disease or other conditions not listed which are not usually treated by a mental health provider or other qualified provider using psychotherapy, psychotropic drugs, or other similar methods of treatment are covered under this Policy.

THIS NOTICE IS FOR NEW HAMPSHIRE RESIDENTS ONLY

N.H. Rev. Stat. § 151:21
151:21 Patients' Bill of Rights.
Effective: July 1, 2022

Rights and responsibilities of each patient admitted to a facility, except those admitted by a home health care provider:

I. The patient shall be treated with consideration, respect, and full recognition of the patient's dignity and individuality, including privacy in treatment and personal care and including being informed of the name, licensure status, and staff position of all those with whom the patient has contact, pursuant to RSA 151:3-b.

II. The patient shall be fully informed of a patient's rights and responsibilities and of all procedures governing patient conduct and responsibilities. This information must be provided orally and in writing before or at admission, except for emergency admissions. Receipt of the information must be acknowledged by the patient in writing. When a patient lacks the capacity to make informed judgments the signing must be by the person legally responsible for the patient.

III. The patient shall be fully informed in writing in language that the patient can understand, before or at the time of admission and as necessary during the patient's stay, of the facility's basic per diem rate and of those services included and not included in the basic per diem rate. A statement of services that are not normally covered by medicare or medicaid shall also be included in this disclosure.

IV. The patient shall be fully informed by a health care provider of his or her medical condition, health care needs, and diagnostic test results, including the manner by which such results will be provided and the expected time interval between testing and receiving results, unless medically inadvisable and so documented in the medical record, and shall be given the opportunity to participate in the planning of his or her total care and medical treatment, to refuse treatment, and to be involved in experimental research upon the patient's written consent only. For the purposes of this paragraph “health care provider” means any person, corporation, facility, or institution either licensed by this state or otherwise lawfully providing health care services, including, but not limited to, a physician, hospital or other health care facility, dentist, nurse, optometrist, podiatrist, physical therapist, or psychologist, and any officer, employee, or agent of such provider acting in the course and scope of employment or agency related to or supportive of health care services.

V. The patient shall be transferred or discharged after appropriate discharge planning only for medical reasons, for the patient's welfare or that of other patients, if the facility ceases to operate, or for nonpayment for the patient's stay, except as prohibited by Title XVIII 1 or XIX 2 of the Social Security Act. No patient shall be involuntarily discharged from a facility because the patient becomes eligible for medicaid as a source of payment.

VI. The patient shall be encouraged and assisted throughout the patient's stay to exercise the patient's rights as a patient and citizen. The patient may voice grievances and recommend changes in policies and services to facility staff or outside representatives free from restraint, interference, coercion, discrimination, or reprisal.

VII. The patient shall be permitted to manage the patient's personal financial affairs. If the patient authorizes the facility in writing to assist in this management and the facility so consents, the assistance shall be carried out in accordance with the patient's rights under this subdivision and in conformance with state law and rules.

VIII. The patient shall be free from emotional, psychological, sexual and physical abuse and from exploitation, neglect, corporal punishment and involuntary seclusion.

IX. The patient shall be free from chemical and physical restraints except when they are authorized in writing by a physician for a specific and limited time necessary to protect the patient or others from injury. In an emergency, restraints may be authorized by the designated professional staff member in order to protect the patient or others from injury. The staff member must promptly report such action to the physician and document same in the medical records.

X. The patient shall be ensured confidential treatment of all information contained in the patient's personal and clinical record, including that stored in an automatic data bank, and the patient's written consent shall be required for the release of information to anyone not otherwise authorized by law to receive it. Medical information contained in the medical records at any facility licensed under this chapter shall be deemed to be the property of the patient. The patient shall be entitled to a copy of such records upon request. The charge for the copying of a patient's medical records shall not exceed $15 for the first 30 pages or $.50 per page, whichever is greater; provided, that copies of filmed records such as radiograms, x-rays, and sonograms shall be copied at a reasonable cost.

XI. The patient shall not be required to perform services for the facility. Where appropriate for therapeutic or diversional purposes and agreed to by the patient, such services may be included in a plan of care and treatment.

XII. The patient shall be free to communicate with, associate with, and meet privately with anyone, including family and resident groups, unless to do so would infringe upon the rights of other patients. The patient may send and receive unopened personal mail. The patient has the right to have regular access to the unmonitored use of a telephone.

XIII. The patient shall be free to participate in activities of any social, religious, and community groups, unless to do so would infringe upon the rights of other patients.

XIV. The patient shall be free to retain and use personal clothing and possessions as space permits, provided it does not infringe on the rights of other patients.

XV. The patient shall be entitled to privacy for visits and, if married, to share a room with his or her spouse if both are patients in the same facility and where both patients consent, unless it is medically contraindicated and so documented by a physician. The patient has the right to reside and receive services in the facility with reasonable accommodation of individual needs and preferences, including choice of room and roommate, except when the health and safety of the individual or other patients would be endangered.

XVI. The patient shall not be denied appropriate care on the basis of age, sex, gender identity, sexual orientation, race, color, marital status, familial status, disability, religion, national origin, source of income, source of payment, or profession.

XVII. The patient shall be entitled to be treated by the patient's physician of choice, subject to reasonable rules and regulations.

XVIII. The patient shall be entitled to have the patient's parents, if a minor, or spouse, or next of kin, unmarried partner, or a personal representative chosen by the patient, if an adult, visit the facility, without restriction, if the patient is considered terminally ill by the physician responsible for the patient's care.

XIX. The patient shall be entitled to receive representatives of approved organizations as provided in RSA 151:28.

XX. The patient shall not be denied admission to the facility based on medicaid as a source of payment when there is an available space in the facility.

XXI. Subject to the terms and conditions of the patient's insurance plan, the patient shall have access to any provider in his or her insurance plan network and referral to a provider or facility within such network shall not be unreasonably withheld pursuant to RSA 420-J:8, XIV.

XXII. The patient shall not be denied admission, care, or services based solely on the patient's vaccination status.

XXIII. (a) In addition to the rights specified in paragraph XVIII, the patient shall be entitled to designate a spouse, family member, or caregiver who may visit the facility while the patient is receiving care. A patient who is a minor may have a parent, guardian, or person standing in loco parentis visit the facility while the minor patient is receiving care.

(b)(1) Notwithstanding subparagraph (a), a health care facility may establish visitation policies that limit or restrict visitation when:

(A) The presence of visitors would be medically or therapeutically contraindicated in the best clinical judgment of health care professionals;

(B) The presence of visitors would interfere with the care of or rights of any patient;

(C) Visitors are engaging in disruptive, threatening, or violent behavior toward any staff member, patient, or another visitor; or

(D) Visitors are noncompliant with written hospital policy.

(2) Upon request, the patient or patient's representative, if the patient is incapacitated, shall be provided the reason for denial or revocation of visitation rights under this paragraph.

(c) A health care facility may require visitors to wear personal protective equipment provided by the facility, or provided by the visitor and approved by the facility. A health care facility may require visitors to comply with reasonable safety protocols and rules of conduct. The health care facility may revoke visitation rights for failure to comply with this subparagraph.

(d) Nothing in this paragraph shall be construed to require a health care facility to allow a visitor to enter an operating room, isolation room, isolation unit, behavioral health setting or other typically restricted area or to remain present during the administration of emergency care in critical situations. Nothing in this paragraph shall be construed to require a health care facility to allow a visitor access beyond the rooms, units, or wards in which the patient is receiving care or beyond general common areas in the health care facility.

(e) The rights specified in this paragraph shall not be terminated, suspended, or waived by the health care facility, the department of health and human services, or any governmental entity, notwithstanding declarations of emergency declared by the governor or the legislature. No health care facility licensed pursuant to RSA 151:2 shall require a patient to waive the rights specified in this paragraph.

(f) Each health care facility licensed pursuant to RSA 151:2 shall post on its website:

(1) Informational materials explaining the rights specified in this paragraph;

(2) The patients' bill of rights which applies to the facility on its website; and

(3) Hospital visitation policy detailing the rights and responsibilities specified in this paragraph, and the limitations placed upon those rights by written hospital policy on its website.

(g) Unless expressly required by federal law or regulation, the department or any other state agency shall not take any action arising out of this paragraph against a health care facility for:

(1) Giving a visitor individual access to a property or location controlled by the health care facility;

(2) Failing to protect or otherwise ensure the safety or comfort of a visitor given access to a property or location controlled by the health care facility;

(3) The acts or omissions of any visitor who is given access to a property or location controlled by the health care facility.

Additional Information About Your Plan

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

Plan Name

Exelixis, Inc. Accident Insurance Plan

Plan Number

502

Type of Plan

Employee Welfare Benefit Plan

Plan Sponsor

Exelixis, Inc.
1851 Harbor Bay Parkway
Alameda, California 94502

Employer Identification Number

04-3257395

Plan Administrator

Exelixis, Inc.
Attention: Human Resources Department
1851 Harbor Bay Parkway
Alameda, California 94502

650-837-8229

Agent for Service of Legal Process

Exelixis, Inc.
Attention: Human Resources Department
1851 Harbor Bay Parkway
Alameda, California 94502

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

Plan Year Ends

December 31

Plan Benefits Provided by

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

Plan Sponsor's Designation of Prudential As Claims Administrator

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

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

Plan Sponsor, Policyholder and Employer not Agents of Prudential

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

Allocation of Contributions

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

Loss of Benefits

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

Plan Sponsor May Amend or Terminate the Plan at any Time

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

describes your rights upon termination of the plan.

Claim Procedures

1. Determination of Benefits

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

If your claim for benefits is denied, in whole or in part, you or your authorized representative will receive a written notice from Prudential of your denial. The notice will include:

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

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

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

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

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

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

(g) copies of any internal rules, guidelines, protocols, standards or other similar criteria relied upon in making this determination or, alternatively, a statement that such rules,

guidelines, protocols, standards or other similar criteria do not exist.

2. Appeals of Adverse Determination

If your claim for benefits is denied, you or your representative may appeal your denied claim in writing to Prudential within 180 days of the receipt of the written notice of denial or 180 days from the date such claim is deemed denied. Similarly, if Prudential does not decide your claim within the time described in Section 1 above, you may appeal, although you are not required to do so. You may submit with your appeal any written comments, documents, records and any other information relating to your claim. Upon your request, you will also have access to, and the right to obtain copies of, all documents, records and information relevant to your claim free of charge.

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

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

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

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

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

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

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

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

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

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

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

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

If the appeal of your benefit claim is denied, you or your representative may make a second, voluntary appeal of your denial in writing to Prudential within 180 days of the receipt of the written notice of denial or 180 days from the date such claim is deemed denied. Similarly, if Prudential does not decide your appeal within the time described in Section 1 above, you may appeal again, although you are not required to do so. You may submit with your second appeal any written comments, documents, records and any other information relating to your claim. Upon your request, you will also have access to, and the right to obtain copies of, all documents, records and information relevant to your claim free of charge.

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

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

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

Time Limit To File Suit

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

Rights and Protections

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

Receive Information about Your Plan and Benefits

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

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

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

Prudent Actions by Plan Fiduciaries

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

Enforce Your Rights

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

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report from the plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the plan administrator to provide the materials and pay you a fine that accrues on a daily basis (based on amounts set by the Department of Labor) from the time the materials were due to you until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court. If it should happen that plan fiduciaries misuse the plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal

court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions

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