Exelixis, Inc.

Critical Illness Coverage

Prudential

NOTICE FOR TEXAS RESIDENTS

Have a complaint or need help?

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

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

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

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

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

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

¿Tiene una queja o necesita ayuda?

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

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

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

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

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

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

Disclosure Notice

FOR ARKANSAS RESIDENTS

Prudential's Customer Service Office:

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

Telephone: 1-844-455-1002

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

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

FOR ARIZONA RESIDENTS

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

FOR CALIFORNIA RESIDENTS

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

FOR COLORADO RESIDENTS

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

FOR FLORIDA RESIDENTS

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

FOR IDAHO RESIDENTS

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

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

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

FOR INDIANA RESIDENTS

Questions regarding your policy or coverage should be directed to:

The Prudential Insurance Company of America
1-844-455-1002

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

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

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

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

FOR MARYLAND RESIDENTS

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

FOR NORTH CAROLINA RESIDENTS

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

FOR NEW MEXICO RESIDENTS

NOTICE TO CONSUMER: This is a limited benefits health plan. The benefits provided are supplemental to, and not a substitute for, major medical coverage, even in combination with other limited

benefits plans. To apply for an individual or small-group major medical plan, please visit the website of the New Mexico Health Insurance Exchange at www.bewellnm.com or call 1-833-862-3935 (TTY: 711).

FOR NEVADA RESIDENTS

THIS CRITICAL ILLNESS COVERAGE IS NOT COMPREHENSIVE HEALTH INSURANCE COVERAGE (OFTEN REFERRED TO AS "MAJOR MEDICAL COVERAGE").

IT DOES NOT SATISFY THE INDIVIDUAL MANDATE OF THE AFFORDABLE CARE ACT. IT DOES NOT MEET THE REQUIREMENTS OF MINIMUM ESSENTIAL COVERAGE AS DEFINED IN FEDERAL LAW.

FOR OKLAHOMA RESIDENTS

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

FOR TEXAS RESIDENTS

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

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

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

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

THE PRUDENTIAL INSURANCE COMPANY OF AMERICA

Certificate of Coverage

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

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 the 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.

Coverage and Amounts: The available Coverage 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 Coverage 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.

Changes: 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 from the date it would otherwise take effect, and Prudential will refund your contributions, if any within 31 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 substitute for essential health benefits or minimum 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 specified disease coverage ONLY.

CRITICAL ILLNESS COVERAGE

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.

CRITICAL ILLNESS COVERAGE FOR YOU AND YOUR DEPENDENTS

The items below are only highlights of your coverage. For a full description please read this entire Group Insurance Certificate.

BENEFIT AMOUNTS FOR YOU:

The amount of insurance is the amount for your Benefit Class. You may enroll for the plan shown below. If you may choose the amount of insurance or if there are options from which to select, the amount for which you enroll will be recorded by your Employer and reported to Prudential.

Amount of Insurance For Each Benefit Class:

Benefit Classes	Amount of Insurance
All Employees	
Option 1	$10,000.
Option 2	$20,000.
Option 3	$30,000.

Lifetime Maximum Benefit: No more than the Lifetime Maximum Benefit will be paid for all of your Critical Illnesses.

The Lifetime Maximum Benefit is 500% of your Amount of Insurance.

BENEFIT AMOUNTS FOR YOUR DEPENDENTS:

The amount of insurance is the amount for your Benefit Class. You may enroll your Qualified Dependents for the plan shown below. If you may choose the amount of insurance or if there are options from which to select, the amount for which you enroll will be recorded by your Employer and reported to Prudential. Your Benefit Class is determined by the classification of your Qualified Dependents and the amount for which you enroll as shown in this table.

Qualified Dependents Classification	Amount of Insurance*
Your Spouse or Domestic Partner	
Option 1	$10,000.
Option 2	$20,000.
Option 3	$30,000.
Your Children	
Option 1	$5,000.
Option 2	$10,000.
Option 3	$15,000.

- The amount of insurance on your Qualified Dependent Spouse or Domestic Partner will not exceed 100% of the amount for which you are insured under the Critical Illness Coverage. The amount of insurance on each of your Qualified Dependent Children will not exceed 50% of the amount for which you are insured under the Critical Illness Coverage.

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

The Lifetime Maximum Benefit is 500% of the Qualified Dependent's Amount of Insurance.

ADDITIONAL BENEFIT AMOUNTS FOR YOU AND YOUR DEPENDENTS UNDER THE CRITICAL ILLNESS COVERAGE

For the purposes of determining benefits under the Coverage, Amount of Insurance does not include any additional amount payable as shown below.

Wellness Benefit Amount Payable: $50.

Wellness Benefit Daily Limit: The Wellness Benefit is limited to payment of one benefit per Covered Person, per day.

Wellness Benefit Annual Limit: The Wellness Benefit is limited to one benefit payment per Calendar Year for each Covered Person.

National Cancer Institute (NCI) Evaluation Benefit Amount Payable: An amount equal to:

(1) $500; plus

(2) $250 for the transportation and lodging of the Covered Person requiring the evaluation if the NCI facility is more than 100 miles from the Covered Person's primary residence.

NCI Evaluation Benefit Lifetime Limit: The NCI Evaluation Benefit is payable once during the lifetime of each Covered Person.

Transportation Benefit Amount Payable: An amount equal to the lesser of:

(1) the actual charges incurred for travel by train, plane or bus, plus $0.50 per mile for travel by personal car; and

(2) $1,000.

Transportation Benefit Annual Limit: The Transportation Benefit is limited to one benefit payment per Calendar Year for each Covered Person receiving treatment during that visit.

Lodging Benefit Amount Payable: $100 per day.

Lodging Benefit Annual Limit: The Lodging Benefit is limited to 60 days per Calendar Year for each Covered Person receiving treatment during that visit.

OTHER INFORMATION

Contract Holder: EXELIXIS, INC.

Group Contract No.: GC-60356-CA

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.

Employment Waiting Period: 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.

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
Prudential Insurance Company

Telephone: 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

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General Definitions

FOR YOU AND YOUR DEPENDENTS

Some of the terms used in the Coverage:

Active Work Requirement: A requirement that you be actively at work on a full-time or part-time basis at the Employer's place of business, or at any other place that the Employer's business requires you to go. You are considered actively at work during weekends or Employer-approved vacations, holidays or business closures if you were actively at work on the last scheduled work day preceding such time off.

Calendar Year: A year starting January 1.

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

Contributory Insurance, Non-contributory Insurance: Contributory Insurance is insurance for which you must contribute toward the cost of the premium. Non-contributory Insurance is insurance for which the Employer pays the entire premium. 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 Person: An Employee who is insured under the Coverage; a Qualified Dependent for whom an Employee is insured, if any, under the Coverage.

Dependents Insurance: Insurance on the person of a dependent.

Doctor: A licensed practitioner of the healing arts acting within the scope of the license. Prudential will not recognize any relative including, but not limited to, you, your Spouse, your Domestic Partner, or a Child, brother, sister, or parent of you or your Spouse or Domestic Partner as a doctor for a claim that you send to us.

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

Employee Insurance: Insurance on the person of an Employee.

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

First Occurrence: The first time the person is diagnosed with the Critical Illness while a Covered Person.

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.

Prudential: The Prudential Insurance Company of America.

You: An Employee.

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 unmarried Children 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) Biologic 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) Child(ren) 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 the age limit for a Qualified Dependent Child.

  You must provide Prudential with 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; 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.

You must enroll on a form approved by Prudential and agree to pay the required contributions. You may enroll within 31 days of when you could first be covered, or within 31 days of a Life Event. 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 “Life Event” means.

FOR DEPENDENTS INSURANCE

Your Dependents Insurance under the Coverage for a person will begin the first day on which all of these conditions are met:

- You have enrolled for Dependents Insurance under the Coverage.
- The person is your Qualified Dependent.
- You are in a Covered Class for that insurance.
- You are insured for 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 that Coverage is part of the Group Contract.

You must enroll on a form approved by Prudential and agree to pay the required contributions. You may enroll within 31 days of when you could first be covered, or within 31 days of a Life Event. Your Employer will tell you whether contributions are required and the amount of any contribution when you enroll.

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

The General Definitions section explains what “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.

Critical Illness Coverage

FOR YOU AND YOUR DEPENDENTS

This Coverage pays benefits for certain Critical Illnesses.

Critical Illnesses means the person's:

- **Alzheimer's Disease:** Alzheimer's Disease means permanent and significant loss of cognitive ability. **It does not include any other type of dementia.** Medical evidence of a definite clinical diagnosis of Alzheimer's Disease by a qualified medical professional is required as proof of claim.

- **Benign Brain Tumor:** Benign Brain Tumor means a non-malignant tumor or cyst that is one centimeter or greater in size and located in the brain, cranial nerves or meninges within the skull. **It does not include tumors of the pituitary gland or tumors of blood vessels known as angiomas or aneurysms.** Medical evidence of a definite diagnosis of Benign Brain Tumor by a Doctor is required as proof of claim.

- **Cancer:** Cancer means any malignant tumor positively diagnosed with histological confirmation and characterized by the uncontrolled growth of malignant cells and invasion of tissue. The term malignant tumor includes leukemia, lymphoma, sarcoma and multiple myeloma.

  Cancer does not include the following:

  (a) pre-malignant lesions;

  (b) benign tumors or polyps.

  The benefit that applies to Cancer depends on whether the Cancer is ***Full Benefit Cancer; Partial Benefit Other Than Skin Cancer***; or ***Partial Benefit Cancer, Skin Cancer***.

  ***Full Benefit Cancer* means** any type of Cancer except Partial Benefit Other Than Skin Cancer or Partial Benefit Skin Cancer**.**

  Partial Benefit Other Than Skin Cancer means:

  (a) Cancer classified as TisN0M0, provided that surgery, radiotherapy or chemotherapy has been determined to be medically necessary by a qualified medical professional in the medical specialty that is appropriate for the type of Cancer involved;

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

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

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

PLEASE NOTE: This means, for example, that a partial (reduced) benefit amount may be payable for the diagnosis of certain types of prostate or breast Cancer.

Partial Benefit Cancer, Skin Cancer means any malignancy of the skin diagnosed with histological confirmation and characterized by uncontrolled growth of malignant cells and invasion of tissue. It includes:

(1) basal cell carcinoma; and

(2) squamous cell carcinoma.

It does not include malignant melanoma, or any condition which may be considered precancerous, such as leukoplakia; actinic keratosis; carcinoid; hyperplasia; non-malignant melanoma; moles; or similar diseases or lesions.

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

- **Cerebral Palsy:** Cerebral Palsy means a non-progressive neurological defect affecting muscle control which is characterized by spasticity and lack of co-ordination of movements. Medical evidence of a definite diagnosis of Cerebral Palsy by a qualified medical professional is required as proof of claim.

- **Cleft Lip or Cleft Palate:** Cleft Lip means a narrow opening or gap in the skin of the upper lip that extends all the way to the base of the nose, including unilateral clefting and bilateral clefting. Cleft Palate means an opening between the roof of the mouth and the nasal cavity. Medical evidence of a definite diagnosis of Cleft Lip or Cleft Palate by a Doctor before or after live birth is required as proof of claim.

- **Coma:** Coma means a state of unconsciousness with no reaction to external stimuli or internal needs which requires the use of life support systems and results in permanent neurological deficit with persistent clinical symptoms continuously for at least 96 hours. **It does not include:**

  (a) coma due to either alcohol or drug abuse;

  (b) persistent vegetative state; or

  (c) medically-induced coma.

  Medical evidence of a definite diagnosis of Coma by a Doctor is required as proof of claim.

- **Cystic Fibrosis:** Medical evidence of a definite diagnosis of Cystic Fibrosis by a qualified medical professional based on diagnostic tests either before or after birth is required as proof of claim.

- **Down Syndrome:** Down Syndrome means a congenital disorder arising from a chromosome defect involving chromosome 21, causing intellectual impairment, physical abnormalities and developmental delays. Down Syndrome includes but is not limited to:

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

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

(c) Mosaicism: The individual has an extra chromosome 21 in only some of the cells but not all of them. The other cells have the usual pair of chromosome 21's.

Medical evidence of a definite diagnosis of Down Syndrome through the study of chromosome 21 before or after live birth is required as proof of claim.

- **Heart Attack:** Heart Attack means death of heart muscle, as a result of a primary cardiac condition, due to inadequate blood supply, that has resulted in both of the following evidence of acute myocardial infarction, as certified by a Doctor:

  (a) new characteristic electrocardiographic changes; and

  (b) characteristic rise of cardiac enzymes or troponins recorded at the following levels of higher - troponin T>1.0ng/ml, AccuTnl>0.5ng/ml.

  It does not include heart attack that occurs during a non-cardiac surgical procedure.

  Medical evidence of a definite diagnosis of Heart Attack by a qualified medical professional is required as proof of claim.

- **Major Organ Failure:** Major Organ Failure means the irreversible failure of a Major Organ due to an End Stage Disease, the result of which is the need to be placed on an organ transplant waiting list. Major Organ means heart, liver, lung, pancreas or bone marrow. End Stage Disease means end stage heart disease, end stage liver disease, end stage lung disease, total pancreas failure or severe bone marrow failure. Failure of more than one Major Organ due to an End Stage Disease is considered a single Major Organ Failure for the purpose of determining benefits under this critical illness plan.

  Proof of claim for Major Organ Failure must show:

  (1) medical evidence of a definite diagnosis of Major Organ Failure by a Doctor; and

  (2) approval for participation on an organ transplant waiting list, or approval for a bone marrow or stem cell transplant.

- **Muscular Dystrophy:** Muscular Dystrophy means well-defined neurological abnormalities confirmed by electromyography and muscle biopsy. Medical evidence of a definite diagnosis of Muscular Dystrophy by a qualified medical professional is required as proof of claim.

- **Paralysis of Limbs:** Paralysis of Limbs means total and irreversible loss of muscle function to the whole of any two limbs. **It does not include paralysis of limbs due to Stroke.** Medical evidence of a definite diagnosis of Paralysis of Limbs by a Doctor is required as proof of claim.

- **Renal (kidney) Failure:** Renal Failure means chronic and end stage (irreversible) failure of both kidneys to function, the result of which is the need for regular dialysis for a period of at least three months. Medical evidence of a definite diagnosis of Renal Failure by a Doctor is required as proof of claim.

- **Severe Coronary Artery Disease:** Severe Coronary Artery Disease means:

  (1) more than 50% blockage in the left main coronary artery;

  (2) more than 70% blockage in the proximal left anterior coronary artery; or

(3) more than 50% blockages in all three of the following arteries: the left anterior descending artery, the left circumflex artery and the right coronary artery.

Medical evidence of a definite diagnosis of Severe Coronary Artery Disease by a qualified medical professional is required as proof of claim.

- **Sickle Cell Anemia:** Medical evidence of a definite diagnosis of Sickle Cell Anemia by a qualified medical professional, confirmed with hemoglobin electrophoresis, is required as proof of claim. **Having sickle cell trait alone does not qualify as a valid claim.**

- **Spina Bifida:** Spina Bifida means a congenital defect of the spine in which part of the spinal cord and its meninges are exposed through a gap in the backbone. Spina Bifida includes Meningocele or Myelomeningocele. Spina Bifida does not include a diagnosis of spina bifida occulta. Medical evidence of a definite diagnosis of Spina Bifida by a Doctor before or after live birth is required as proof of claim.

- **Stroke:** Stroke means death of brain tissue due to inadequate blood supply or hemorrhage within the skull resulting in a permanent and significant neurological deficit with persistent clinical symptoms. **It does not include transient ischemic attacks ("TIA").** Medical evidence of a definite diagnosis of Stroke by a qualified medical professional is required as proof of claim.

- **Third Degree Burns:** Third Degree Burns means burns covering either 20% of the body's surface area or 50% of the surface area of the face, requiring skin grafting. Medical evidence of a definite diagnosis of Third Degree Burns by a Doctor is required as proof of claim.

See the Benefit Definitions for a definition of each Critical Illness.

A. BENEFITS.

Benefits for a Critical Illness are payable only if:

(1) the person is diagnosed with the Critical Illness while a Covered Person; and

(2) that diagnosis occurs during the Covered Person's lifetime; and

(3) after the Covered Person completes the applicable Waiting Period.

Not all such Critical Illnesses are covered. See Critical Illnesses Not Covered below.

First Occurrence Benefit Amount Payable: The amount payable for the First Occurrence of a Critical Illness depends on the type of Critical Illness as shown below. Benefits are subject to the Lifetime Maximum Benefit as described below.

Critical Illness:	**Percent of the Person's Amount of Insurance or Benefit Amount Payable**
Alzheimer's Disease	100%
Benign Brain Tumor	100%
Cerebral Palsy (for children age 5 or younger)	100%
Cleft Lip or Cleft Palate	100%
Coma	100%
Cystic Fibrosis	100%
Down Syndrome	100%

Heart Attack.....100%
Cancer - ***Full Benefit***.....100%
Major Organ Failure 100%
Muscular Dystrophy.....100%
Paralysis of Limbs 100%
Renal (kidney) Failure 100%
Severe Coronary Artery Disease 100%
Sickle Cell Anemia 100%
Spina Bifida 100%
Stroke 100%
Third Degree Burns.....100%

Cancer - ***Partial Benefit Other Than Skin Cancer***.....25%

Cancer - ***Partial Benefit, Skin Cancer*** $250

The example below illustrates the effect of the application of the Percent of the Person's Amount of Insurance for Partial Benefit Cancer and an Amount Limit Due to Age on your Amount of Insurance.

Example:

Your Amount of Insurance = $10,000

Percent Payable for Partial Benefit Cancer = 25%

Limited Percent at age 65 = 65%

($10,000 x .25) x .65 = $1625.0

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

Reoccurrence of a Critical Illness other than Skin Cancer means:

(1) a person is positively diagnosed by a Doctor as having an additional occurrence or reoccurrence of a Critical Illness other than Skin Cancer for which a benefit was paid under this Coverage; and

(2) the date of the diagnosis of the additional occurrence or reoccurrence is more than 180 days after the date of the last medical treatment for the previous occurrence.

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

Reoccurrence of Skin Cancer means a person is positively diagnosed by a Doctor as having an additional occurrence or reoccurrence of Partial Benefit Cancer, Skin Cancer for which a benefit was paid under this Coverage.

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

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

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

B. CRITICAL ILLNESSES NOT COVERED.

A Critical Illness is not covered if it is caused by any of these:

(1) Attempted suicide, while sane or insane.

(2) Intentionally self-inflicted Injuries, or any attempt to inflict such Injuries.

(3) War, or any act of war. "War" means declared or undeclared war and includes resistance to armed aggression.

(4) Travel or flight in any vehicle used for aerial navigation. This (4) does not apply if the person is riding as a fare paying passenger in a licensed aircraft provided by a common carrier on a regularly scheduled route.

(5) Commission of a crime for which you have been convicted under state or federal law.

(6) Being intoxicated or under the influence of any controlled substance unless administered on the advice of a Doctor.

The Claim Rules apply to the payment of the benefits.

Additional Benefits under Critical Illness Coverage

FOR YOU AND YOUR DEPENDENTS

An additional benefit may be payable under this Coverage. Any such benefit is payable in addition to any other benefit payable under this Coverage. A Covered Person's Lifetime Maximum Benefit under this Coverage will not be reduced by the amount of any additional benefit payable under this part of the Coverage. Any additional conditions that apply to an additional benefit are shown below. An additional benefit is payable only if those conditions are met.

A. WELLNESS BENEFIT.

This additional benefit for wellness pays benefits for a Covered Person's health screening test, upon submission of proof, only if the Covered Person receives one of the following health screening tests, or any other generally medically accepted cancer screening tests, while not confined in a hospital:

- routine health check-up exam;
- biopsies for cancer;
- blood chemistry panel;
- blood test to determine total cholesterol;
- blood test to determine triglycerides;
- bone marrow testing;
- breast MRI;
- breast ultrasound;
- breast sonogram;
- cancer antigen 15-3 blood test for breast cancer (CA 15-3);
- cancer antigen 125 blood test for ovarian cancer (CA 125);
- carcinoembryonic antigen blood test for colon cancer (CEA);
- carotid doppler;
- chest x-rays;
- clinical testicular exam;
- colonoscopy;
- complete blood count (CBC);

- dental exam;
- digital rectal exam (DRE);
- Doppler screening for cancer;
- Doppler screening for peripheral vascular disease;
- echocardiogram;
- electrocardiogram (EKG);
- electroencephalogram (EEG);
- endoscopy;
- eye exam;
- fasting blood glucose test;
- fasting plasma glucose test;
- flexible sigmoidoscopy;
- hearing test;
- hemoccult stool specimen;
- hemoglobin A1C;
- human papillomavirus (HPV) vaccination;
- immunization;
- lipid panel;
- mammogram;
- oral cancer screening;
- pap smears or thin prep pap test;
- prostate-specific antigen (PSA) test;
- serum cholesterol test to determine LDL and HDL levels;
- serum protein electrophoresis;
- skin cancer biopsy;
- skin cancer screening;
- skin exam;
- stress test on bicycle or treadmill;
- successful completion of smoking cessation program;

- tests for sexually transmitted infections (STIs);
- thermography;
- two hour post-load plasma glucose test;
- ultrasounds for cancer detection;
- ultrasound screening of the abdominal aorta for abdominal aortic aneurysms;
- virtual colonoscopy.

Wellness Benefit Amount Payable: The additional amount payable is shown in the Schedule of Benefits.

Wellness Benefit Limits: The Wellness Benefit is not payable for a test if benefits are paid or are payable for that same test under another section of this Certificate.

Wellness Benefit Daily Limit: The Wellness Benefit is limited to payment of one benefit per Covered Person, per day.

Wellness Benefit Annual Limit: The Wellness Benefit is limited to one benefit payment per Calendar Year for each Covered Person.

B. BENEFIT FOR NATIONAL CANCER INSTITUTE (NCI) EVALUATION.

This additional benefit for NCI evaluation pays benefits for a Covered Person's evaluation or consultation at an NCI-designated cancer center only if both of these conditions are met:

(1) The Covered Person is seeking the evaluation or consultation as a result of receiving a diagnosis of Cancer.

(2) The purpose of the evaluation or consultation is to determine the appropriate course of treatment.

NCI Evaluation Benefit Amount Payable: The additional amount payable is shown in the Schedule of Benefits.

NCI Evaluation Benefit Lifetime Limit: The NCI Evaluation Benefit is payable once during the lifetime of each Covered Person.

C. TRANSPORTATION BENEFIT.

This additional benefit for transportation pays benefits for the travel expenses associated with a Covered Person's round trip travel between the Covered Person's primary residence and a hospital or medical facility only if both of these conditions are met:

(1) The Covered Person needs to travel to the hospital or medical facility to receive treatment for a Critical Illness.

(2) The hospital or medical facility is more than 50 miles from the Covered Person's primary residence.

Transportation Benefit Amount Payable: The additional amount payable is shown in the Schedule of Benefits.

Transportation Benefit Annual Limit: The Transportation Benefit is limited to one benefit payment per Calendar Year for each Covered Person receiving treatment during that visit.

D. LODGING BENEFIT.

This additional benefit for lodging pays benefits for a Covered Person's lodging expenses only if all of these conditions are met:

(1) The Covered Person needs to stay overnight in order to receive treatment for a Critical Illness at a hospital or medical facility.

(2) The hospital or medical facility is more than 75 miles from the Covered Person's primary residence.

(3) The lodging occurs not more than 24 hours prior to the treatment, and not more than 24 hours after the treatment.

Lodging Benefit Amount Payable: The additional amount payable is shown in the Schedule of Benefits.

Lodging Benefit Annual Limit: The Lodging Benefit is limited to 60 days per Calendar Year for each Covered Person receiving treatment during that visit.

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 reach your Lifetime Maximum Benefit.
- 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:

- The Qualified Dependent reaches the Lifetime Maximum Benefit for that Qualified Dependent.
- 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.

Continued Insurance during Absence from Work Because of a Labor Dispute: These provisions apply only if any part of the premium for the insurance under the Coverage is paid by the Employer under the terms of a collective bargaining agreement. They apply when your Employee or Employee and Dependents Insurance under the Coverage would otherwise end on any date because of your absence from work as a result of a labor dispute. Your insurance under the Coverage will not end on that date. It will be continued during such absence from work from the date it would have ended until the first of these occurs:

(1) The end of the six month period immediately following the first day of your absence from work.

(2) The date you become actively engaged in work on a full-time basis for another employer.

(3) The first day you fail to pay, when due, any contribution required for the continued insurance. Your contribution will not be more than the premium that applies to your Covered Class on the first day of your absence from work.

(4) The first day the entity responsible for collecting Employee contributions fails to pay, when due, the premium required for the continued insurance.

(5) The part of the Group Contract providing the insurance ends.

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 12 months 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 your Employer, along with the required first payment, by the later of:

(1) the thirty-first day after the Coverage would otherwise have ended; and

(2) the fifteenth day after you receive the notice informing you of your right to continue. But, in no event may election be made if you do not apply for continuation of Coverage and pay the first payment prior to the ninety-second day after you cease to be covered for the Coverage.

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

(1) You reach age 100.

(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 critical illness 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.)

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

(1) Your Amount of Insurance may not be more than 100% of your Amount of Insurance under the Group Contract when the Coverage would have ended, but not less than $1,000. The Amount of Insurance on each dependent may not be more than the Amount of Insurance on the dependent under the Group Contract when the Coverage would have ended.

(2) 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.

General Information

A. CLAIM RULES.

These rules apply to payment of benefits under the Coverage.

Notice of Claim: Written notice of claim must be given to Prudential within 20 days after the occurrence or commencement of any loss covered by the Group Contract, or as soon thereafter as is reasonably possible. Notice given by or on behalf of the Covered Person to Prudential at Voluntary Benefit Services, P.O. Box 696035, San Antonio, TX 78269-6035, or to any authorized agent of Prudential, with information sufficient to identify the Covered Person, 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: Written proof of loss must be sent to Prudential within 90 days of the date of such loss. Failure to furnish such proof within the time required shall not invalidate nor reduce any claim if it was not reasonably possible to give proof within such time, provided such proof is furnished as soon as reasonably possible and in no event, except in the absence of legal capacity, later than one year from the time proof is otherwise required.

Time of Payment of Claim: Prudential will pay benefits immediately after receiving written proof of loss.

Payment of Claims: Critical Illness benefits are payable to you with these exceptions:

(1) If you are not living, benefits that are unpaid at your death will be payable to the first of the following: Your (a) surviving spouse or Registered 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 have assigned the insurance, benefits will be paid to the assignee. (See the Limits on Assignments section.)

Physical Examinations: Prudential, at its own expense, shall have the right and opportunity to examine the Covered Person for whom the claim is made. Prudential may do this when and as often as it may reasonably require during the pendency of a claim hereunder.

Legal Actions: No action at law or in equity shall be brought to recover on this Group Insurance Certificate prior to the expiration of 60 days after written proof of loss has been furnished in accordance with the requirements of this Group Insurance Certificate. No such action shall be

brought after the expiration of three years after the time written proof of loss is required to be furnished.

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. REINSTATEMENT.

If your insurance ends because you did not pay any Premium by the end of its grace period, you may be eligible to reinstate the insurance subject to these rules:

(1) You must request reinstatement within 180 days of the date of the first unpaid Premium;

(2) You must pay all overdue Premiums; and

(3) If you request reinstatement more than 60 days after the end of the grace period, you must complete a Request for Reinstatement with attestation of good health.

If Prudential approves your request, the reinstatement will be effective on the first day of the month coinciding with or next following the approval date.

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

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. Critical Illness 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.