County of Sacramento

Critical Illness Coverage

Disclosure Notice

FOR ARKANSAS RESIDENTS

Prudential's Customer Service Office:

The Prudential Insurance Company of America
Customer Services Department
Prudential Insurance Company
Group Insurance-Record Keeping
P.O. Box 13676
Philadelphia, PA 19176

Telephone: 877-920-4778

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 INDIANA RESIDENTS

Questions regarding your policy or coverage should be directed to:

The Prudential Insurance Company of America
877-920-4778

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 NEW MEXICO RESIDENTS

This type of plan is NOT considered "minimum essential coverage" under the Affordable Care Act and therefore does NOT satisfy the individual mandate that you have health insurance coverage. If you do not have other health insurance coverage, you may be subject to a tax penalty. Please consult your tax advisor.

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:

The Prudential Insurance Company of America
Customer Services Department
Prudential Insurance Company
Group Insurance-Record Keeping
P.O. Box 13676
Philadelphia, PA 19176
877-920-4778

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 contact the Office of the Commissioner of Insurance 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

THIS NOTICE IS FOR TEXAS RESIDENTS ONLY

IMPORTANT NOTICE

To obtain information or make a complaint:

You may call Prudential's toll-free telephone number for information or to make a complaint at:

877-920-4778

You may contact the Texas Department of Insurance to obtain information on companies, coverages, rights or complaints at:

1-800-252-3439

You may write the Texas Department of Insurance:

P.O. Box 149104
Austin, TX 78714-9104
Fax: (512) 475-1771

Web: http://www.tdi.texas.gov

Email: consumerprotection@tdi.texas.gov

PREMIUM OR CLAIM DISPUTES:

Should you have a dispute concerning your premium or about a claim you should contact Prudential first. If the dispute is not resolved, you may contact the Texas Department of Insurance.

ATTACH THIS NOTICE TO YOUR POLICY:

This notice is for information only and does not become a part or condition of the attached document.

AVISO IMPORTANTE

Para obtener información o para someter una queja:

Usted puede llamar al numero de telefono gratis de Prudential para informacion o para someter una queja al:

877-920-4778

Puede comunicarse con el Departamento de Seguros de Texas para obtener información acerca de compañías, coberturas, derechos o quejas al:

1-800-252-3439

Puede escribir al Departamento de Seguros de Texas:

P.O. Box 149104
Austin, TX 78714-9104
Fax: (512) 475-1771

Web: http://www.tdi.texas.gov

Email: consumerprotection@tdi.texas.gov

DISPUTAS SOBRE PRIMAS O RECLAMOS:

Si tiene una disputa concerniente a su prima o a un reclamo, debe comunicarse con Prudential primero. Si no se resuelve la disputa, puede entonces comunicarse con el departamento (TDI).

UNA ESTE AVISO A SU POLIZA:

Este aviso es sólo para propósito de información y no se convierte en parte o condición del documento adjunto.

____
Signature of Employee

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.

RIGHT TO EXAMINE THIS GROUP INSURANCE CERTIFICATE: YOU MAY RETURN THIS GROUP INSURANCE CERTIFICATE TO PRUDENTIAL, FOR ANY REASON, WITHIN 30 DAYS AFTER YOU RECEIVE IT VIA REGULAR MAIL. 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 30 DAYS AFTER WE RECEIVE THE RETURNED CERTIFICATE.

Prudential's Address:

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

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

This is a supplement to health insurance. It is not a substitute for hospital or medical expense insurance, a health maintenance organization (HMO) contract, or major medical expense insurance.

The Group Contract provides specified disease coverage ONLY.

CRITICAL ILLNESS COVERAGE

Welcome Message

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

We believe this Program provides worthwhile protection for you and your family.

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

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

IMPORTANT INFORMATION FOR RESIDENTS OF CERTAIN STATES: *There are state-specific requirements that may change the provisions under the Coverage described in this Group Insurance Certificate. If you live in a state that has such requirements, those requirements will apply to your Coverage and are made a part of your Group Insurance Certificate. This means the requirements of the state where you reside at the time of loss could change the benefits to which you may be entitled under the Group Insurance Certificate. Prudential has a website that describes these state-specific requirements. You may access the website at www.prudential.com/etonline. When you access the website, you will be asked to enter your state of residence and your Access Code.* ***Your Access Code is 46915.***

If you are unable to access this website, want to receive a printed copy of these requirements or have any questions, call Prudential at 1-866-439-9026.

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Schedule of Benefits

Covered Classes: The "Covered Classes" are these Employees of the Contract Holder (and its Associated Companies): All Employees.

Program Date: January 1, 2015. 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	Any multiple of $10,000.
	Minimum Amount: $10,000.
	Maximum Amount: $100,000.

Guaranteed Issue Limit on the Amount of Employee Insurance: There is a limit on the amount for which you may be insured without submitting evidence of insurability. This is called the Guaranteed Issue Limit.

Your Guaranteed Issue Limit is $30,000.

See the Guaranteed Issue Limit on the Amount of Employee Insurance provision of the When You Become Insured section.

Increases and Decreases: You may elect to have your amount of insurance under the Coverage changed. You must do this on a form approved by Prudential and agree to make any required contributions.

If you request an increase, you must give evidence of insurability. The amount of your insurance will be increased when you have provided evidence and you meet the Active Work Requirement.

If you request a decrease, the amount of your insurance will be decreased on the first of the month following the date of your written request.

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

The Lifetime Maximum Benefit is 200% of your Amount of Insurance.

Employee Amount Limit Due to Age: When you are age 65 or more, your amount of insurance is limited. It is the Limited Percent (for that Age) of the amount for which you would then be insured if the Amount Limit Due to Age was not applied. Each Age and the Limited Percent for that Age are shown below.

Age	Limited Percent
65	65
70	50
75 and more	25

Each Limited Percent for an Age takes effect on the first day of the month following your birthday for that Age.

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 Registered Domestic Partner	Any multiple of $5,000.
	Minimum Amount: $5,000.
	Maximum Amount: $50,000.
Your children	Any multiple of $2,500.
	Minimum Amount: $2,500.
	Maximum Amount: $15,000.

- The amount of insurance on your Qualified Dependent spouse or Registered Domestic Partner will not exceed 50% 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.

Guaranteed Issue Limit on Dependent Spouse or Registered Domestic Partner Amounts: There is a limit on the amount for which your Qualified Dependent spouse or Registered Domestic Partner may be insured without submitting evidence of insurability for the spouse or Registered Domestic Partner. This is called the Guaranteed Issue Limit.

The Guaranteed Issue Limit for Dependent Spouse or Registered Domestic Partner Amounts is $15,000.

See the Guaranteed Issue Limit on Dependent Spouse or Registered Domestic Partner Amounts provision of the When You Become Insured section.

Increases and Decreases: You may elect to have the amount of insurance on your Qualified Dependents changed. You must do this on a form approved by Prudential and agree to make any required contributions.

If you request an increase in the amount of insurance for a spouse or Registered Domestic Partner, you must give evidence of insurability for the spouse or Registered Domestic Partner. The amount of insurance for the spouse or Registered Domestic Partner will be increased when you have provided evidence and the spouse or Registered Domestic Partner is not home or hospital confined for medical care or treatment.

If you request an increase in the amount of insurance on a dependent child, the amount of insurance on that child will be increased on the date of your written request or, if later, when that child is not home or hospital confined for medical care or treatment. Evidence of insurability is not required for an increase in the amount of insurance on a child.

If you request a decrease in the amount of insurance for a Qualified Dependent, the amount of insurance for the Qualified Dependent will be decreased on the first of the month following the date of your written request.

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

The Lifetime Maximum Benefit is 200% of the Qualified Dependent's Amount of Insurance.

Dependent Amount Limit Due to Age: When you are age 65 or more, your Qualified Dependent spouse's or Registered Domestic Partner's amount of insurance is limited. It is the Limited Percent (for that Age) of the amount for which your Qualified Dependent spouse or Registered Domestic Partner would then be insured if the Amount Limit Due to Age was not applied. Each Age and the Limited Percent for that Age are shown below.

Age	**Limited Percent**
65	65
70	50
75 and more	25

Each Limited Percent for an Age takes effect on the first day of the month following your birthday for that Age.

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.

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) $1,500.

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: $60 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: COUNTY OF SACRAMENTO

Group Contract No.: GC-46915-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
80 Livingston Avenue
Roseland, New Jersey 07068

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

The Prudential Insurance Company of America
Prudential Insurance Company
Group Insurance-Record Keeping
P.O. Box 13676
Philadelphia, PA 19176

Telephone: 877-920-4778

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

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 Registered Domestic Partner, or a child, brother, sister, or parent of you or your spouse or Registered 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: With respect to a Critical Illness, it is the date the person is diagnosed with the Critical Illness for the first time. With respect to a Critical Procedure, it is the date the person has the Critical Procedure for the first time.

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 are age 64 or under; 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 40 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 20 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:

- Your spouse or Registered Domestic Partner under age 65.

  Your spouse means your lawful spouse.

  Your Registered Domestic Partner means a person whose domestic partnership with you has been validly registered by the California Secretary of State; or a person with whom you have established a union other than marriage, recognized under California law as the equivalent of a Registered Domestic Partner.

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

- Your children from 14 days to 26 years old.

Your children include your legally adopted children, children placed with you for adoption prior to legal adoption, and each of your stepchildren, Registered Domestic Partner's children and foster children. 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 a newborn child born to you.

Exceptions:

Your spouse, Registered 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, Registered Domestic Partner or child has protection under any Employee Coverage of the Group Contract after the spouse's, Registered 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
- you have met any evidence requirement for Employee Insurance (see the rules for when evidence is required below); 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. 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.

When evidence is required: In any of these situations, you must give evidence of insurability. This requirement will be met when you have provided evidence.

(1) You enroll for Employee Insurance under the Coverage more than 31 days after you could first be covered.

(2) You request an increase in your amount of insurance under the Coverage more than 31 days after you are first eligible for that amount.

(3) You re-enroll for Employee Insurance under the Coverage after you voluntarily cancelled it.

(4) You re-enroll after any of your insurance under the Group Contract ends because you did not pay a required contribution.

(5) You have not met a previous evidence requirement to become insured under any Prudential group contract covering Employees of the Employer.

(6) You enroll for an amount of insurance that is over the Guaranteed Issue Limit.

Guaranteed Issue Limit on the Amount of Employee Insurance: There is a limit on the amount for which you may be insured without submitting evidence of insurability. This is called the Guaranteed Issue Limit.

If the amount of insurance for your Class and age at any time is more than the Guaranteed Issue Limit, you must give evidence of insurability to Prudential before the part over the Limit can become effective.

This evidence requirement applies:

- when you first become insured;
- when your Class changes; or
- if you request an increase in your amount of insurance.

Even if you are currently insured for an amount over the Limit, if you want to increase your amount of insurance you must still give evidence of insurability to Prudential before that additional amount can become effective. The amount of your insurance will be increased to the amount for your Class and age when you have provided evidence and you meet the Active Work Requirement.

Your Guaranteed Issue Limit is $30,000. If the Amount Limit Due to Age shown in the Schedule of Benefits applies at any time to your amount of insurance, that Limit will also apply to the Guaranteed Issue Limit as if it were an amount of insurance.

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.
- You have met any evidence requirement for that Qualified Dependent (see the rules for when evidence is required below).
- 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 without evidence of insurability. Your Employer will tell you whether contributions are required and the amount of any contribution when you enroll.

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

When evidence is required: In any of these situations, you must give evidence of insurability for a Qualified Dependent. This requirement will be met when you have provided evidence.

(1) For Contributory Insurance, you enroll for Dependents Insurance under the Coverage more than 31 days after you are first eligible for Dependents Insurance.

(2) You request an increase in the amount of insurance for a Qualified Dependent more than 31 days after you are first eligible for that amount.

(3) You re-enroll a Qualified Dependent after you voluntarily cancelled insurance for that Qualified Dependent.

(4) You re-enroll for Dependents Insurance after any insurance under the Group Contract ends because you did not pay a required contribution.

(5) The Qualified Dependent is a person for whom a previous requirement for evidence of insurability has not been met. The evidence was required for that person to become covered for an insurance, as a dependent of an Employee. That insurances is or was under any Prudential group contract for Employees of the Employer.

(6) You enroll for an amount of insurance for a Qualified Dependent spouse or Registered Domestic Partner that is over the applicable Guaranteed Issue Limit on Dependents Amounts.

Guaranteed Issue Limit on Dependent Spouse or Registered Domestic Partner Amounts: There is a limit on the amount for which your Qualified Dependent spouse or Registered Domestic Partner may be insured without submitting evidence of insurability for that spouse or Registered Domestic Partner. This is called the Guaranteed Issue Limit.

If you elect an amount of insurance for your Qualified Dependent spouse or Registered Domestic Partner above the Guaranteed Issue Limit, you must give evidence of insurability for that spouse or Registered Domestic Partner to Prudential before the part over the Limit can become effective.

This requirement applies:

- when you first become insured with respect to the Qualified Dependent spouse or Registered Domestic Partner; or

- if you request an increase in the amount of insurance for the Qualified Dependent spouse or Registered Domestic Partner.

Even if you are insured with respect to a Qualified Dependent spouse or Registered Domestic Partner for an amount over the Limit, if you want to increase the amount of your Qualified Dependent spouse's or Registered Domestic Partner's insurance you must still give evidence of insurability to Prudential before that additional amount can become effective. The amount of your Qualified Dependent spouse's or Registered Domestic Partner's insurance will be increased when you have provided evidence and your spouse or Registered Domestic Partner is not home or hospital confined for medical care or treatment.

The Guaranteed Issue Limit for Dependent Spouse or Registered Domestic Partner Amounts is $15,000. If the Amount Limit Due to Age shown in the Schedule of Benefits applies at any time to the amount of insurance for a Qualified Dependent spouse or Registered Domestic Partner, that Limit will also apply to the Guaranteed Issue Limit on Dependent Spouse or Registered Domestic Partner Amounts as if it were an amount of insurance.

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 Registered Domestic Partner only.

- Qualified Dependent spouse or Registered 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 and Procedures.

Critical Illnesses and Procedures 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.

- **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) skin cancer, other than malignant melanoma;

  (b) pre-malignant lesions;

  (c) benign tumors or polyps.

  The benefit percentage that applies to Cancer depends on whether the Cancer is ***Full Benefit Cancer*** or ***Partial Benefit Cancer***.

  ***Full Benefit Cancer* means** any type of Cancer except Partial Benefit Cancer**.**

  Partial Benefit 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.

  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.

- **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.

- **Coronary Artery Bypass Surgery:** Coronary Artery Bypass Surgery means the undergoing of surgery requiring media sternotomy (surgery to divide the breastbone) on the advice of a qualified medical professional to correct narrowing or blockage of one or more coronary arteries with by-pass grafts.

- **Deafness:** Deafness means permanent and irreversible loss of hearing in both ears to the extent that the loss is greater than 70 decibels across all frequencies in both ears using a pure tone audiogram. Medical evidence of a definite diagnosis of Deafness by a Doctor is required as proof of claim.

- **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.

- **Heart Valve Replacement:** Heart Valve Replacement means the undergoing of surgery requiring median sternotomy (surgery to divide the breastbone) on the advice of a qualified medical professional to replace or repair one or more heart valves. **It does not include surgical procedures that do not involve open-heart surgery.**

- **Major Organ Transplant:** Major Organ Transplant means the undergoing as a recipient of a human-to-human transplant of bone marrow or of a complete heart, kidney, liver, lung or pancreas, or inclusion on the Organ Procurement and Transplantation Network waiting list for such a procedure. **It does not include the transplant of any other organs, parts of organs, stem cells, tissues or cells.** Simultaneous transplant of multiple organs is considered a single organ transplant for the purpose of determining benefits under this critical illness plan.

- **Parkinson's Disease:** Parkinson’s Disease means permanent clinical impairment of motor function with associated tremor, rigidity of movement and postural instability. Medical evidence of a definite diagnosis of Parkinson’s Disease by a qualified medical professional 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. **It does not include renal failure due to diabetes mellitus or hypertension.** Medical evidence of a definite diagnosis of Renal Failure by a Doctor 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.

- **Terminal Illness:** Terminal Illness means advanced or rapidly progressing incurable illness where the Covered Person's life expectancy is 12 months or less. **Terminal Illness does not include any other Critical Illness or Procedure covered under this critical illness plan.** Certification by a Doctor that the Covered Person's life expectancy is 12 months or less, and supporting medical evidence are required as proof of claim.

See the Benefit Definitions for a definition of each Illness and Procedure.

A. BENEFITS.

Benefits for a Critical Illness or Procedure are payable only if:

(1) the person is diagnosed with the Critical Illness for the first time while a Covered Person and that diagnosis occurs during the Covered Person's lifetime; or

(2) the person has the Critical Procedure for the first time while a Covered Person and that Critical Procedure occurs during the Covered Person's lifetime.

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

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

Critical Illness or Procedure:	**Percent of the Person's Amount of Insurance**
Heart Attack	100
Cancer - ***Full Benefit***	100
Major Organ Transplant	100
Renal (kidney) Failure	100
Stroke	100
Alzheimer's Disease	25
Cancer - ***Partial Benefit***	25
Coma	25
Coronary Artery Bypass Surgery	25
Deafness	25
Heart Valve Replacement	25
Parkinson's Disease	25
Terminal Illness	25

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 = $1,625

Reoccurrence Benefit Amount Payable: The amount payable for a Reoccurrence of a Critical Illness or Procedure is 50% of the amount paid to the person for the First Occurrence of the Critical Illness or Procedure. All benefits are subject to the Lifetime Maximum Benefit below.

Reoccurrence of a Critical Illness or Procedure means:

(1) a person is positively diagnosed by a Doctor as having an additional occurrence or reoccurrence of a Critical Illness or Procedure 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 such prior benefit payment.

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

The Lifetime Maximum Benefit for a Covered Person is 200% of the person's Amount of Insurance.

B. CRITICAL ILLNESSES OR PROCEDURES NOT COVERED.

A Critical Illness or Procedure 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 and the To Whom Payable part of the Schedule of Benefits 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. 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.

B. 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 or to have a Critical Procedure performed.

(2) The hospital or medical facility is more than 100 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.

C. 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 or to have a Critical Procedure at a hospital or medical facility.

(2) The hospital or medical facility is more than 100 miles from the Covered Person's primary residence.

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

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 because 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 80.
- You reach your Lifetime Maximum Benefit.
- The date 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.
- The person ceases to be a Qualified Dependent for the Coverage. A spouse or Registered Domestic Partner will cease to be a Qualified Dependent at age 65. (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

FOR YOU AND YOUR DEPENDENTS

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 you a written election notice of your right to continue the Coverage. The notice will state the amount of the payments required for the continued 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 Coverage will be continued from the date it would have ended until the first of these occurs:

  (a) If you fail to make any payment required by the Employer for the continued Coverage, the end of the period for which you have made required payments.

  (b) The date you attain age 80.

  (c) The date you become covered under any other group critical illness plan.

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

(1) The Delay of Effective Date Section will not apply.

(2) 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.

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

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

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 Group Insurance-Record Keeping, P.O. Box 13676, Philadelphia, PA 19176, 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 on forms satisfactory to Prudential. Insurance under the Coverage may be assigned only as a gift assignment. Any rights, benefits or privileges that you have as an Employee may be assigned. This includes any right you have to continue coverage under the Group Contract. Prudential will not decide if an assignment does what it is intended to do. Prudential will not be held to know that one has been made unless it or a copy is filed with Prudential through the Contract Holder.

The Claims and Appeals section

is not part of the

Group Insurance Certificate.

CLAIMS AND APPEALS

Plan Benefits Provided by

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

This Group Contract underwritten by The Prudential Insurance Company of America provides insured benefits. For all purposes of this Group Contract, the Employer/Policyholder acts on its own behalf or as an agent of its employees. Under no circumstances will the Employer/Policyholder be deemed the agent of The Prudential Insurance Company of America, absent a written authorization of such status executed between the Employer/Policyholder and The Prudential Insurance Company of America. Nothing in these documents shall, of themselves, be deemed to be such written execution.

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 date on which you respond to the request for additional information.

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 be written in a manner calculated to be understood by you and shall include:

(a) the specific reason(s) for the denial,

(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 description of Prudential's appeals procedures and applicable time limits, and

(e) 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 request.

2. Appeals of Adverse Determination

If your claim for benefits is denied or if you do not receive a response to your claim within the appropriate time frame (in which case the claim for benefits is deemed to have been 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. 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 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 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 date on which you respond to the request for additional information.

If the claim on appeal is denied in whole or in part, 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:

(a) the specific reason(s) for the adverse determination,

(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 you have the right to obtain upon request and free of charge, a copy of internal rules or guidelines relied upon in making this determination, and

(f) a statement describing any appeals procedures offered by the plan.

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 or if you do not receive a response to your appeal within the appropriate time frame (in which case the appeal is deemed to have been 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. 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 date on which you respond to the request for additional information.

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.