Recreation and Welfare Association of National Institutes of Health

Voluntary Hospital Indemnity Coverage

Prudential

NOTICE FOR TEXAS RESIDENTS

Have a complaint or need help?

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

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

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

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

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

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

¿Tiene una queja o necesita ayuda?

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

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

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

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

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

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

Disclosure Notice

FOR ARKANSAS RESIDENTS

Prudential's Customer Service Office:

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

Telephone: 844-455-1002

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

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

FOR ARIZONA RESIDENTS

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

FOR CALIFORNIA RESIDENTS

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

FOR COLORADO RESIDENTS

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

FOR FLORIDA RESIDENTS

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

FOR IDAHO RESIDENTS

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

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

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

FOR INDIANA RESIDENTS

Questions regarding your policy or coverage should be directed to:

The Prudential Insurance Company of America
844-455-1002

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

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

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

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

FOR MARYLAND RESIDENTS

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

FOR NORTH CAROLINA RESIDENTS

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

FOR NEW MEXICO RESIDENTS

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

FOR OKLAHOMA RESIDENTS

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

FOR TEXAS RESIDENTS

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

NOTICE FOR VERMONT RESIDENTS

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

FOR WISCONSIN RESIDENTS

KEEP THIS NOTICE WITH YOUR INSURANCE PAPERS

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

Prudential's Customer Service Office:

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

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

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

THE PRUDENTIAL INSURANCE COMPANY OF AMERICA

Group Insurance Certificate

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

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

Coverage and Amounts: The available Coverage and the amounts of insurance are described in the Group Insurance Certificate.

If You are insured, this document is Your Group Insurance Certificate. It replaces Group Insurance Certificates issued to You for the Coverages in the Group Insurance Certificate's Schedule of Benefits. All Benefits are subject in every way to the entire Group Contract which includes the Group Insurance Certificate.

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

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

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 CERTIFICATE IS NOT MEDICAL COVERAGE. It does NOT provide any type of medical Coverage and is not a substitute for medical Coverage or disability insurance.

The Group Contract provides Hospital Indemnity Coverage ONLY.

HOSPITAL INDEMNITY COVERAGE

“Limited Benefit, Please Read Carefully”

Welcome Message

We are pleased to present You with this Group Insurance Certificate. 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 Group Insurance Certificate carefully. If You have any questions about the Program, We will be happy to answer them.

IMPORTANT NOTICE: *This is your Group Insurance Certificate. It is an important document and should be kept in a safe place.*

IMPORTANT INFORMATION FOR RESIDENTS OF CERTAIN STATES: *There are state-specific requirements that may change the provisions under the Coverage(s) described in this Group Insurance Certificate. If You live in a state that has such requirements, those requirements will apply to Your Coverage(s) and are made a part of Your Group Insurance Certificate. Prudential has a website that describes these state-specific requirements. You may access the website at www.prudential.com/etonline. When You access the website, You will be asked to enter Your state of residence and Your Access Code.* ***Your Access Code is VHIP1.***

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

TABLE OF CONTENTS

Schedule of Benefits

Covered Classes: All Full-time Active Members under age 80 scheduled to work at least 20 hours per week and are citizens or legal residents of the United States of America, its territories, and protectors; excluding temporary, leased, or seasonal employees.

Program Date: October 1, 2023. This Group Insurance Certificate describes the benefits under the Group Program as of the Program Date.

- This document is your Group Insurance Certificate. The Coverage in this Group Insurance Certificate 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.

The Contract Holder expects to continue the Group Program indefinitely. But the Contract Holder reserves the right to change or end it at any time. This would change or end the terms of the Group Program in effect at that time for active and retired Members.

This Group Insurance Certificate describes all of the options available under the Group Contract.

HOSPITAL INDEMNITY 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.

The amount of insurance is the amount for Your Benefit Class. You may enroll for the plan shown below. If You 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 Plan Administrator and reported to Prudential.

Benefit Class

All Members

For Your Spouse, Civil Union Partner or Domestic Partner

For Your Child

CORE BENEFITS	**Amount of Insurance**
Hospital Admission Benefit	$2,500 per admission No more than 5 Confinements per Covered Person, per Calendar Year.
Hospital Confinement Benefit	$150 per day No more than 5 Confinements per Covered Person, per Calendar Year.

Intensive Care Unit (ICU) Admission Benefit:	$5,000 per admission No more than 5 Confinements per Covered Person, per Calendar Year.
Intensive Care Unit (ICU) Confinement Benefit:	$300 per day No more than 5 Confinements per Covered Person, per Calendar Year.

Please note: If more than one of the following benefits listed below are payable for the same day as a result of a Covered Loss, We will only pay one benefit for that day, whichever is greatest:

- Hospital Admission Benefit;
- Hospital Confinement Benefit;
- Intensive Care Unit (ICU) Admission Benefit;
- Intensive Care Unit (ICU) Confinement Benefit;

OTHER INFORMATION

Contract Holder: RECREATION AND WELFARE ASSOCIATION OF NATIONAL INSTITUTES OF HEALTH

Group Contract No.: HG-71710-DC

Contract Anniversary: October 1 of each year, beginning in 2024.

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

Prudential's Address:
The Prudential Insurance Company of America
213 Washington Street
Newark, NJ 07102

WHEN YOU HAVE A CLAIM

Each time a claim is made, it should be made without delay. Use a claim form and follow the instructions on the form.

If you do not have a claim form, contact your Plan Administrator.

General Definitions

FOR YOU AND YOUR DEPENDENTS

Some of the terms used in the Coverage.

Active Work Requirement: A requirement that you be working in your customary manner at your regular occupation or profession or performing the substantial and material duties of your occupation or profession.

Calendar Year: A year starting January 1.

Child/Children: Please see the “Who is Eligible to Become Insured” section of this Group Insurance Certificate.

Complications of pregnancy: A condition, when pregnancy is not terminated, whose diagnosis is distinct from pregnancy but adversely affected or caused by pregnancy. Complication of pregnancy includes, but is not limited to, non-elective Cesarean section; termination of ectopic pregnancy; spontaneous termination of pregnancy occurring during a period of gestation in which a viable birth is not possible; acute nephritis or nephrosis; cardiac decompensation; missed abortion; and similar medical and surgical conditions of comparable severity. It does not include false labor; occasional spotting; morning sickness; Doctor prescribed rest; hyperemesis gravidarum; pre-eclampsia or any other condition associated with the management of a difficult pregnancy not consisting of a nosologically distinct complication of pregnancy.

Confined or Confinement: The assignment to a bed as a resident inpatient in a Hospital (including a Hospital Intensive Care Unit (ICU) on the advice of a Doctor.

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

Contributory Insurance: Contributory Insurance is insurance for which the Contract Holder has the right to require You to pay all or any portion of the Premium payment.

Coverage: A part of the Group Insurance Certificate 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 Loss: A loss, treatment, illness, injury, or other condition for which benefits are payable under this Group Insurance Certificate.

Covered Person: A Member who is insured under the Coverage; a Qualified Dependent for whom A Member 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 Civil Union Partner, Your Domestic Partner, or a Child, brother, sister, or parent of You or Your Spouse, Civil Union Partner or Domestic Partner as a Doctor for a claim that You send to us.

Emergency Room: A special, designated area in a Hospital that is supervised by Doctor's and equipped and staffed to render immediate medical attention on an outpatient basis, 24 hours a day, 7 days a week for the sudden onset of symptoms related to a Covered Loss. An Emergency Room is not a clinic, an Urgent Care Facility or Doctor's office.

Member: A person who is an active dues paying member in good standing of the Association. The term also applies to that person for any rights after insurance ends.

Member Insurance: Insurance on the person of a member.

General Anesthesia: The induction of a balanced state of unconsciousness, accompanied by the absence of pain sensation and the paralysis of skeletal muscle over the entire body.

Hospital: An institution that meets either of these tests:

(1) It is accredited as a Hospital under the Hospital Accreditation Program of the Joint Commission on Accreditation of Healthcare Organizations.

(2) It is legally operated, has 24 hour a day supervision by a staff of Doctors, has 24 hour a day nursing service by registered graduate Nurses, and complies with (a) or (b):

   (a) It mainly provides general inpatient medical care and treatment of sick and injured persons by the use of medical, diagnostic and major surgical facilities. All such facilities are in it or under its control.

   (b) It mainly provides specialized inpatient medical care and treatment of sick or injured persons by the use of medical and diagnostic facilities (including X-ray and laboratory). All such facilities are in it, under its control, or available to it under a written agreement with a Hospital (as defined above) or with a specialized provider of those facilities.

But Hospital does not include a nursing home. Neither does it include an institution, or part of one, which: (1) is used mainly as a place for convalescence, rest, hospice, skilled nursing care for the aged or drug addicts; treatment of alcoholics; or (2) furnishes mainly homelike or Custodial Care, or training in the routines of daily living; or (3) is mainly a school; or (4) for solely providing psychiatric services to mentally ill patients.

Hospital Confinement: A Hospital stay, for at least one full day, for which a room and board charge is made by the Hospital.

Intensive Care Unit (ICU): A special, designated area in a Hospital that:

(1) provides the highest level of care and is restricted to the treatment of patients who are in acute and critical condition;

(2) is permanently furnished with emergency life-saving equipment and supplies that are immediately at hand;

(3) staffed 24 hours a day by Nurses who are specially trained to work in such a special area;

(4) equipped and staffed to monitor each patient's vital signs around-the-clock; and

(5) Operates pursuant to any jurisdictional requirements for Intensive Care Units and is listed in the current edition of the American Hospital Association Guide or is eligible to be listed therein. This guide lists three types of units that meet this definition: 1) Intensive Care Units; 2) cardiac care units; and 3) infant (neonatal) Intensive Care Units.
Intensive Care Units do not include surgical recovery rooms, privately monitored rooms, observation units, labor or delivery rooms, step-down units, Sub-Acute Intensive Care Units or any other facilities, regardless of name, that do not meet the above requirements.

Nurse: A registered professional Nurse (R.N.), licensed practical Nurse (L.P.N.) or licensed vocational Nurse (L.V.N.) who is licensed under the laws where the services are performed.

The term Nurse does not include:

(1) You;

(2) Your Spouse, Civil Union Partner or Domestic Partner or anyone to whom You are related by blood or marriage;

(3) anyone with whom You are residing;

(4) Your adopted or stepchild;

(5) anyone with whom You share a business interest; or

(6) Your Employer.

Observation Unit: A specified area within a Hospital, separate from the Emergency Department, where a patient can be monitored following a surgical procedure performed on an Outpatient Basis or treatment in the Emergency Department. The Observation Unit must:

(1) be under the direct supervision of a Doctor or registered Nurse;

(2) be staffed by Nurses assigned specifically to that unit; and

(3) provide care 24 hours per day, seven days per week.

Outpatient Surgery: Surgery performed on an outpatient basis.

Premium: The amount required to pay for Your insurance.

Prudential: The Prudential Insurance Company of America.

Rehabilitation Facility: An appropriately licensed facility that provides rehabilitation care services on an inpatient basis. Rehabilitation care services consist of the combined use of medical, social, educational, and vocational services to enable patients disabled by accidental injury or sickness to achieve the highest possible functional ability. Services are provided by or under the supervision of an organized staff of Doctors. The Rehabilitation Facility may be part of a Hospital or a freestanding facility.

A Rehabilitation Facility is not:

(1) a nursing home; or

(2) an extended care facility; or

(3) a Skilled Nursing Facility; or

(4) a rest home or home for the aged; or

(5) a Hospice Care Facility; or

(6) a place for alcoholics or drug addicts; or

(7) an assisted living facility.

Routine Childbirth: The vaginal delivery of a child or children or the delivery of a child or children by elective cesarean section.

Routine Pregnancy: A normal pregnancy that does not have Complications of Pregnancy.

Schedule: The applicable Schedule of Benefits that appears in this Group Insurance Certificate.

Sickness: Any disorder of the body or mind of a Covered Person, but not an Injury; Routine Pregnancy of a Covered Person, including abortion, miscarriage or Routine Childbirth.

The term Sickness does not include:

(1) an illness, infirmity or disease caused or contributed to by a Covered Person's employment for wage or profit; or

(2) routine nursery care or well-baby care for a newborn child.

Skilled Nursing Facility: An institution or distinct part of an institution which:

(1) provides skilled nursing care for sick and injured persons;

(2) is supervised at all times by a Doctor or registered professional Nurse;

(3) has a Doctor available at all times;

(4) meets all licensing and legal requirements;

(5) is not mainly a place for rest, custodial care, or care of the aged, drug addicts, alcoholics, or those with mental or nervous disorders, or a hotel or similar establishment; and

(6) has a transfer agreement in effect with one or more participating Hospitals.

The term "Skilled Nursing Facility" does not include swing bed Hospitals authorized to provide and be paid for extended care services.

Surgical Procedure: The cutting into the skin or other organ to accomplish any of the following goals:

(1) further explore the condition for the purpose of diagnosis;

(2) take a biopsy of a suspicious lump;

(3) remove diseased tissues or organs;

(4) remove an obstruction;

(5) reposition structures to their normal position;

(6) redirect channels;

(7) transplant tissue or whole organs;

(8) implant mechanical or electronic devices;

(9) repair an area that has been injured or affected by trauma, overuse, or disease; or

(10) restore proper function.

Terminal Illness: A Doctor certifies that a Covered Person's Injury or Sickness is likely to result in his or her death within 24 months.

Urgent Care Facility: A health care facility:

(1) that maintains all appropriate licensing for a facility that provides urgent or immediate care;

(2) that is supervised by a Doctor;

(3) that is separate from a Hospital or is a separate unit within a Hospital; and

(4) the primary purpose of which is the offering and provision of immediate, short-term medical care.

We: The Prudential Insurance Company of America.

You and Your: A Member.

Benefit Definitions

CORE BENEFITS

FOR YOU AND YOUR DEPENDENTS

This Coverage pays the following benefits for Hospital Indemnity.

Hospital Admission Benefit:

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

(1) The admission must occur within 90 days after the Covered Loss occurs; and.

(2) The Hospital Admission Benefit is not payable for Emergency Room treatment, outpatient treatment, or a stay in an Observation Unit; and

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

(4) We will only pay one Hospital Admission Benefit per Covered Person, per Covered Loss. If the Covered Person moves from or to an Intensive Care Unit (ICU) after initial admission to a Hospital, We will not pay an additional Hospital Admission Benefit or Intensive Care Unit (ICU) Admission Benefit; and

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

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

   (b) 5 Confinements per Covered Person, per Calendar Year.

If a Covered Person is admitted to a Hospital and becomes admitted again within 180 days for the same or related condition, We will treat the admission as a continuation of the prior admission. If more than 180 days have passed between the periods of admission, We will treat this admission as a new admission.

Hospital Confinement Benefit:

Prudential will pay the Hospital Confinement Benefit shown in the Schedule of Benefits section for each 24-hour period, after the day of admission to the Hospital, if the Covered Person is Confined in the Hospital for treatment of a Covered Loss subject to all of the following:

(1) The initial Hospital Confinement must begin within 90 days after the Covered Loss occurs; and

(2) The Hospital Confinement Benefit is not payable for a day in which the Hospital Admission Benefit or Intensive Care Unit (ICU) Admission Benefit is payable or for a Confinement of less than 24 hours; and

(3) The Hospital Confinement Benefit is payable for up to 30 days per Confinement, per Covered Person, per Covered Loss; and

(4) We will pay the Hospital Confinement Benefit no more than 5 Confinements per Covered Person, per Calendar Year; and

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

If a Covered Person is Confined in a Hospital and becomes Confined again within 180 days for the same or related condition, we will treat the Confinement as a continuation of the prior Confinement. If more than 180 days have passed between the periods of Confinement, we will treat this Confinement as a new Confinement.

Intensive Care Unit (ICU) Admission Benefit:

Prudential will pay the Intensive Care Unit (ICU) Admission Benefit shown in the Schedule of Benefits section, if a Covered Person, upon initial admission as an inpatient to a Hospital for treatment of a Covered Loss, is admitted to an Intensive Care Unit (ICU), subject to the following:

(1) The admission must meet the requirements for payment of the Intensive Care Unit (ICU) Admission Benefit, and

(2) The admission must occur within 90 days after the Covered Loss occurs; and

(3) We will only pay the Intensive Care Unit (ICU) Admission Benefit for a Covered Person for one Hospital admission at a time, even if the admission is caused by more than one Covered Loss.

(4) If the Covered Person moves to an Intensive Care Unit (ICU) after initial admission to a Hospital, We will not pay the Intensive Care Unit (ICU) Admission Benefit; and

(5) We will only pay one Hospital Admission Benefit per Covered Person, per Covered Loss. If the Covered Person moves from or to an Intensive Care Unit (ICU) after initial admission to a Hospital, We will not pay an additional Hospital Admission Benefit or Intensive Care Unit (ICU) Admission Benefit; and

(6) We will pay the Intensive Care Unit (ICU) Admission Benefit no more than:

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

(b) 5 Confinements per Covered Person, per Calendar Year.

If a Covered Person is Confined in a Hospital and become Confined again within 180 days for the same or related condition, We will treat the Confinement as a continuation of the prior Confinement. If more than 180 days have passed between the periods of Confinement, We will treat this Confinement as a new Confinement.

Intensive Care Unit (ICU) Confinement Benefit:

Prudential will pay the Intensive Care Unit (ICU) Confinement Benefit shown in the Schedule of Benefits section, for each 24-hour period the Covered Person is Confined in an Intensive Care Unit (ICU) for treatment of a Covered Loss and meets the requirements for payment of the Hospital Confinement Benefit, subject to all of the following:

(1) The Confinement in the Intensive Care Unit (ICU) must begin within 90 days after the Covered Loss occurs; and

(2) The Intensive Care Unit (ICU) Confinement Benefit is not payable for a day in which the Hospital Admission Benefit or Intensive Care Unit (ICU) Admission Benefit is payable or for a Confinement of less than 24 hours; and

(3) The Intensive Care Unit (ICU) Confinement Benefit is payable for up to 30 days per Confinement, per Covered Person, per Covered Loss; and

(4) We will pay the Intensive Care Unit (ICU) Confinement Benefit no more than 5 Confinements per Covered Person, per Calendar Year; and

(5) We will only pay the Intensive Care Unit (ICU) Confinement Benefit for a Covered Person for one Hospital Confinement at a time, even if the Confinement is caused by more than one Covered Loss.

If a Covered Person is Confined in a Hospital and becomes Confined again within 180 days for the same or related condition, we will treat the Confinement as a continuation of the prior Confinement. If more than 180 days have passed between the periods of Confinement, we will treat this Confinement as a new Confinement.

Who is Eligible to Become Insured

FOR MEMBER INSURANCE

You are eligible for Member Insurance while:

- You are a Member working full-time of the Association; and
- You are in a Covered Class; and
- You are under age 80.

You are Full-time if You are regularly working at least the number of hours in the normal Full-time work week for Your class, but not less than 20 hours per week.

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 a Member of more than one Employer included under the Group Contract: For the insurance, You will be considered a Member of only one of those Employers. Your service with the others will be treated as service with that one.

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

FOR DEPENDENTS INSURANCE

You are eligible for Dependents Insurance while:

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

Qualified Dependents:

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

- A person under age 80 who is Your Spouse, Civil Union Partner or Domestic Partner prior to their enrollment for Dependents Insurance.

  Your Spouse means an unmarried same or opposite sex adult who resides with You and has registered in a state or local domestic partner registry with You. Whenever the term Spouse appears in the Policy this provision includes the definition of Domestic Partner and Civil Union Partner into the Group Contract.

  Civil Union Partner means a person who you are together with in a recognized Civil Union.

  Civil Union is defined as a same sex relationship similar to a marriage that is recognized as a Civil Union by the District of Columbia.

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

(1) An unmarried same or opposite sex adult who resides with the covered person and has registered in a state or local domestic partner registry with a Covered Person; or your company's requirements.; 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. Such certification shall be in a format satisfactory to Prudential.

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

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

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

- Your Children include Your:

  (1) Biological children;

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

  (3) Foster children;

  (4) Domestic Partner's children; and

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

(a) have been appointed the legal guardian; and

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

A Child who is Your, Your Spouse's Your Civil Union Partner'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.

Exceptions:

Your Spouse, Civil Union Partners or 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 A Member; or

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

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

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

(2) the Member who has the longest continuous service with the Association, 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 MEMBER INSURANCE

Your Member Insurance under the Coverage will begin the first day of the month on which:

- You have enrolled, if the Coverage is Contributory; and
- The billing period defined by Your Plan Administrator begins; and

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

For Contributory Insurance, You must enroll on a form approved by Prudential and agree to pay the required contributions. Your Plan Administrator 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.

FOR DEPENDENTS INSURANCE

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

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

For Contributory Insurance, You must enroll your Qualified Dependent on a form approved by Prudential and agree to pay the required contributions. Your Plan Administrator will tell You whether contributions are required and the amount of any contribution when You enroll your Qualified Dependent.

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

Newborn Child Exception: Your newborn Dependent Children will automatically be covered for 31 days from their date of birth if You are insured. If You wish to continue coverage for Your Dependent Child, You must notify us on or before the end of the 31 day period and pay any additional premium. If You already have coverage for Your Dependent Children, then all eligible Dependent Children will be covered, and You do not need to notify us or pay any additional premium for the newly eligible Dependent Child.

Delay of Effective Date

FOR MEMBER INSURANCE

Your Member 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. The Delay of Effective Date 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.

At live birth, a newborn Qualified Dependent Child is eligible for only the following benefits under the Coverage until they are released from the Hospital:

(1) Hospital Admission Benefit

(2) Intensive Care Unit (ICU) Admission Benefit

(3) Hospital Confinement Benefit

(4) Intensive Care Unit (ICU) Confinement Benefit

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) You enroll for Dependents Insurance for Your Child; or

(2) is Your first Qualified Dependent; or

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

When Your Insurance Ends

MEMBER AND DEPENDENTS INSURANCE

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

- Your membership in the Covered Classes for the insurance ends because Your employment or membership ends (see below) or for any other reason; or
- Your class is removed from the Covered Classes for the insurance; or
- The date the Group Contract providing the insurance ends; or
- You reach age 80; or
- You die; or
- For Contributory Insurance under the Coverage, You fail to pay, when due, any required contribution; or
- The insurance is Dependents Insurance, and Your Member Insurance under the Coverage ends.
- Your Dependents Insurance for a Qualified Dependent under the Coverage will end on the first of the month following the first of these to occur:
- That person ceases to be a Qualified Dependent for the Coverage. A Spouse, Ciil Union Partner or Domestic Partner will cease to be a Qualified Dependent at age 80. A Dependent Child will cease to be a Qualified Dependent at age 26. or
- You reach age 80.

End of Employment: For insurance purposes, Your employment will end when You are no longer a Full-time Employee actively working at least 20 hours per week at work for the Employer.

Your membership 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 Contract Holder.

Claims Incurred During Continuation Eligibility Period

A claim may be payable under this Section if:

(1) the claim is incurred within 31 days after You cease to be a Covered Person; and

(2) You are entitled (under the previous Section) to continue Your Coverage; and

(3) the claim qualifies for payment based on the provisions defined within this Group Insurance Certificate

The amount of any benefit payable is equal to the amount of the benefit that would have been payable as a member of the Covered Class. It is payable even if You did not elect to continue Your Coverage. It is payable when Prudential receives written proof of claim in addition to any required proof that demonstrates that the claim qualifies for payment based on the definitions, requirements, and exclusions outlined in this Group Insurance Certificate.

General Information

A. CLAIM RULES.

These rules apply to payment of benefits under the Coverage.

Notice of Claim: Notice of claim should be sent 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 Plan Administrator, or You can request a claim form from us. If You do not receive the form within 15 days of Your request, send Prudential written proof of claim without waiting for the form.

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

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

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

All benefits will be paid to You, if living, or to the Beneficiary. If no Beneficiary is living, benefits will be paid to Your estate. If benefits are payable to Your estate, We may pay up to $1,000 to any relative of Yours who We find is entitled to it. Any payment made in good faith will fully discharge Us to the extent of the payment.

To Whom Payable: Benefits are payable to You.

Physical Examinations and Autopsy: The insurer, at its own expense, shall have the right and opportunity to examine the person of the insured when and as often as it may reasonably require during the pendency of a claim hereunder and to make an autopsy in case of death where it is not forbidden by law.

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

B. INCONTESTABILITY OF INSURANCE TO WHICH THE CLAIM RULES APPLY.

This limits Prudential's use of a Covered Person's statements in contesting an amount of that insurance for which the Covered Person is insured. These are statements made to persuade Prudential to effect an amount of that insurance. They will be considered to be made to the best of The Covered Person's knowledge and belief. These rules apply to each statement:

(1) It will not be used in a contest to avoid or reduce that amount of insurance unless:

(a) it is in a written instrument signed by the Covered Person; and

(b) a copy of that instrument is or has been furnished to the Covered Person.

(2) It will not be used in the contest after that amount of insurance has been in force, before the contest, for at least two years during the Covered Person's lifetime.

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 A Member 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 Prudential via payroll deduction or direct bill. 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 monthly. 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 60 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.

(4) Policy will be reinstated lacking such approval, upon the 45th day following the date of conditional receipt unless the insurer has previously notified the insured in writing of its disapproval of the application.

If Prudential approves Your request, the reinstatement will be effective on the first day of the month following the approval date.

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

Exclusions

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

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

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

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

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

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

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

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

  (a) treat a Covered Loss;

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

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

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

  (b) an "over the counter" drug, medication or sedative taken as directed.
- Hospital Confinement caused by, contributed to by, or resulting from Mental Illness. However, dementia as a result of stroke, trauma, viral infection, Alzheimer’s disease or other conditions not listed which are not usually treated by a mental health provider or other qualified provider using psychotherapy, psychotropic drugs, or other similar methods of treatment are covered under this Group Contract.

Vermont Mandatory Civil Union Endorsement

PURPOSE

Vermont law requires that health insurers offer coverage to parties to a civil union that is equivalent to coverage provided to married persons. This endorsement is part of and amends this policy, contract or certificate to comply with Vermont law.

DEFINITIONS, TERMS, CONDITIONS AND PROVISIONS

The definitions, terms, conditions and any other provisions of the policy, contract, certificate and/or riders and endorsements to which this mandatory endorsement is attached are hereby amended and superseded as follows:

Terms that mean or refer to a marital relationship, or that may be construed to mean or refer to a marital relationship, such as "marriage," "spouse," "husband," "wife," "dependent," "next of kin," "relative," "beneficiary," "survivor," "immediate family" and any other such terms include the relationship created by a civil union established according to Vermont law.

Terms that mean or refer to the inception or dissolution of a marriage, such as "date of marriage," "divorce decree," "termination of marriage" and any other such terms include the inception or dissolution of a civil union established according to Vermont law.

Terms that mean or refer to family relationships arising from a marriage, such as "family," "immediate family," "dependent," "children," "next of kin," "relative," "beneficiary," "survivor" and any other such terms include family relationships created by a civil union established according to Vermont law.

"Dependent" means a spouse, a party to a civil union established according to Vermont law, and a child or children (natural, step-child, legally adopted or a minor or disabled child who is dependent on the insured for support and maintenance) who is born to or brought to a marriage or to a civil union established according to Vermont law.

"Child or covered child" means a child (natural, stepchild, legally adopted or a minor or disabled child who is dependent on the insured for support and maintenance) who is born to or brought to a marriage or to a civil union established according to Vermont law.

CAUTION: FEDERAL LAW RIGHTS MAY OR MAY NOT BE AVAILABLE

Vermont law grants parties to a civil union the same benefits, protections and responsibilities that flow from marriage under state law. However, some or all of the benefits, protections and responsibilities related to health insurance that are available to married persons under federal law may not be available to parties to a civil union. For example, federal law, the Member Income Retirement Security Act of 1974 known as "ERISA," controls the Contract Holder/Member relationship with regard to determining eligibility for enrollment in private employer health benefit plans. Because of ERISA, Act 91 does not state requirements pertaining to a private employer's enrollment of a party to a civil union in an ERISA Member welfare benefit plan. However, governmental employers (not federal government) are required to provide health benefits to the dependents of a party to a civil

union if the public employer provides health benefits to the dependents of married persons. Federal law also controls group health insurance continuation rights under "COBRA" for employers with 20 or more employees as well as the Internal Revenue Code treatment of health insurance premiums. As a result, parties to a civil union and their families may or may not have access to certain benefits under this policy, contract, certificate, rider or endorsement that derive from federal law. You are advised to seek expert advice to determine your rights under this contract.

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 Contract Holder/Policyholder acts on its own behalf or as an agent of its members. Under no circumstances will the Contract Holder/Policyholder be deemed the agent of The Prudential Insurance Company of America, absent a written authorization of such status executed between the Contract Holder/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.