Holley Performance Products Incorporated

Your Critical Illness Plan

Policy No. 987176 011

Underwritten by Unum Insurance Company

10/2/2025

Unum Insurance Company
2211 Congress Street
Portland, ME 04122
(877) 225-2712
services.unum.com

Group Critical Illness Insurance Certificate of Coverage

Policyholder: Holley Performance Products Incorporated

Policy Number: 987176 011

Policy Effective Date: January 1, 2026

Policy Anniversary: January 1

Governing Jurisdiction: Kentucky

This Certificate of Coverage (the "certificate") is issued to you under the policy which is a contract between us and the Policyholder. If the provisions of this certificate conflict with the provisions of the policy, the provisions of the policy will govern. The policy is delivered in and is governed by the laws of the governing jurisdiction and to the extent applicable, the laws of other states and the Employee Retirement Income Security Act of 1974 (ERISA) and any amendments.

This certificate provides benefits under a non-participating policy. The limited benefits provided under this certificate are a supplement to major medical coverage and are not a substitute for major medical coverage or other minimal essential coverage as required by federal law.

This certificate contains proof of loss requirements, limitations, exclusions, and other provisions that may reduce benefits or prevent an Insured from receiving benefits under this certificate. Please read your certificate carefully and keep it in a safe place.

All references to defined terms, provision titles, and section headings have been capitalized.

If you have any questions about provisions of this certificate, please contact your Employer, or you may contact us at (877) 225-2712 Monday through Friday 8 a.m. to 8 p.m. Eastern Standard Time.

Consumer Complaint Notice

If you are a resident of New Mexico, your coverage will be administered in accordance with the minimum applicable standards of New Mexico law. If you have concerns regarding a claim, premium, or other matters relating to this coverage, you may file a complaint with the New Mexico Office of Superintendent of Insurance (OSI) using the complaint form available on the OSI website and found at: https://www.osi.state.nm.us/ConsumerAssistance/index.aspx.

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Critical Illness Insurance provides financial protection for an Insured by paying a lump-sum benefit if the Insured is diagnosed with a Covered Condition payable under this certificate.

This section includes highlights of an Insured's coverage. Please refer to the **Critical Illness Details** for further information on the benefits available.

Eligible Group(s)

Full-Time Employees Excluding Owners in Active Employment in the United States working a minimum of 30 hours per week.

Paying for Coverage

For you
Contributory Coverage
You must make premium contributions for your coverage.

For your Spouse
Contributory Coverage
You must make premium contributions for your Spouse's coverage.

For your Children
Coverage for your Children is automatically included in the cost of your coverage.

Coverage Amount

The following Coverage Amounts are available to you. If you choose to apply and become insured for coverage, your Children will automatically be enrolled for coverage. You will also have the opportunity to apply for coverage for your Spouse.

Option A

For You	For your Spouse	For your Children
$10,000	100% of your Coverage Amount	50% of your Coverage Amount

Option B

For You	For your Spouse	For your Children
$20,000	100% of your Coverage Amount	50% of your Coverage Amount

Option C

For You	For your Spouse	For your Children
$30,000	100% of your Coverage Amount	50% of your Coverage Amount

Benefit Amount

The Benefit Amount is the amount an Insured may receive for a Payable Claim. The Benefit Amount is calculated using the Insured's Coverage Amount multiplied by the Percentage of Coverage Amount for the Covered Condition, subject to all other terms and provisions of this certificate.

The Percentage of Coverage Amount payable for each Covered Condition is listed in the Critical Illness Details section.

Any dollar amount listed under the Percentage of Coverage Amount will be the Benefit Amount payable for that Covered Condition.

Certificate Riders

The following riders are attached to this certificate:

Be Well Benefit
Portability of Critical Illness Insurance

Covered Conditions for you, your Spouse, and Children:

Critical Illnesses	Coronary Artery Disease (Major)	Major Organ Failure Requiring Transplant
	Coronary Artery Disease (Minor)	Stroke
	End Stage Renal (Kidney) Failure	Sudden Cardiac Arrest
	Heart Attack (Myocardial Infarction)	
Cancer	Invasive Cancer (including all Breast Cancer)	Skin Cancer
	Non-Invasive Cancer	
Supplemental Critical Illnesses	Benign Brain Tumor	Loss of Speech
	Bone Marrow or Stem Cell Transplant	Occupational Human Immunodeficiency Virus (HIV) or Hepatitis
	Coma	Occupational Post-Traumatic Stress Disorder (PTSD)
	Infectious Disease	Permanent Paralysis
	Loss of Hearing	Pulmonary Embolism
	Loss of Sight	Transient Ischemic Attack (TIA)
Progressive Diseases	Addison's Disease	Multiple Sclerosis (MS)
	Amyotrophic Lateral Sclerosis (ALS)	Muscular Dystrophy
	Dementia (including Alzheimer's Disease)	Myasthenia Gravis
	Functional Loss	Parkinson's Disease
	Huntington's Disease	Systemic Sclerosis (Scleroderma)
	Lupus	

Covered Conditions for your Children:

Additional Critical Illnesses for your Children	Cerebral Palsy	Down Syndrome
	Cleft Lip or Palate	Sickle Cell Anemia
	Congenital Heart Disease	Spina Bifida
	Cystic Fibrosis	Type 1 Diabetes

The information in this section provides details about the benefits that may be payable, any applicable Exclusions and Other Features included in an Insured's coverage.

Benefits will only be payable for an Insured's Covered Conditions that have a Date of Diagnosis on or after the Insured's Coverage Effective Date.

Covered Condition Benefit

The Covered Condition Benefit is payable once per Covered Condition per Insured.

We will pay a Covered Condition Benefit for a different Covered Condition if:
- the new Covered Condition is medically unrelated to the first Covered Condition; or
- the Date of Diagnoses are separated by more than 180 days.

If an Insured's diagnosis satisfies the Condition Definition and Date of Diagnosis requirements for more than one Covered Condition, we will pay the Covered Condition with the highest Percentage of Coverage Amount.

Reoccurring Condition Benefit

We will pay the Reoccurring Condition Benefit for the diagnosis of the same Covered Condition if the Covered Condition Benefit was previously paid and the new Date of Diagnosis is more than 180 days after the prior Date of Diagnosis.

The Benefit Amount for any Reoccurring Condition Benefit is 100% of the Percentage of Coverage Amount for that Covered Condition.

The following Covered Conditions are eligible for a Reoccurring Condition Benefit:

Benign Brain Tumor	Invasive Cancer (including all Breast Cancer)
Bone Marrow or Stem Cell Transplant	Major Organ Failure Requiring Transplant
Coma	Non-Invasive Cancer
Coronary Artery Disease (Major)	Occupational Post-Traumatic Stress Disorder (PTSD)
Coronary Artery Disease (Minor)	Pulmonary Embolism
End Stage Renal (Kidney) Failure	Stroke
Heart Attack (Myocardial Infarction)	Sudden Cardiac Arrest
Infectious Disease	Transient Ischemic Attack (TIA)

Covered Conditions

Critical Illnesses		Percentage of Coverage Amount
Coronary Artery Disease (Major)	*Condition Definition* A narrowing or blockage of one or more coronary arteries resulting from plaque buildup. *Date of Diagnosis* The date a Physician recommends the Insured undergo a Surgical Procedure for an Abdominal Aortic Aneurysm, Coronary Artery Bypass Graft, or valve replacement.	**50%**
Coronary Artery Disease (Minor)	*Condition Definition* A narrowing or blockage of one or more coronary arteries resulting from plaque buildup. *Date of Diagnosis* The date a Physician recommends the Insured undergo one of the following procedures: - a catheterization procedure of balloon angioplasty;	**10%**

- stent placement;
- atherectomy;
- automatic implantable (or internal) cardioverter defibrillator (AICD);
- laser angioplasty;
- pacemaker placement;
- thrombectomy.

End Stage Renal (Kidney) Failure — **100%**

Condition Definition
A chronic irreversible failure of the function of both kidneys.

Date of Diagnosis
The earliest date:
- a Physician recommends regular hemodialysis or peritoneal dialysis to sustain life;
- the Insured has a kidney transplant performed; or
- the Insured is placed on the UNOS (United Network for Organ Sharing) list for a kidney transplant.

Heart Attack (Myocardial Infarction) — **100%**

Condition Definition
The death of a portion of heart muscle (myocardium) as a result of obstruction of one or more of the coronary arteries. A positive diagnosis of a heart attack must occur and must be supported by two or more of the following:
- chest pain;
- electrocardiographic (EKG) changes indicative of a heart attack;
- elevation of biochemical markers of myocardial necrosis; or
- confirmatory imaging studies.

For purposes of this benefit, the following do not meet the Condition Definition of Heart Attack:
- an established (old) heart attack;
- angina;
- atherosclerotic heart disease;
- cardiac arrest (including arrhythmias);
- congestive heart failure;
- Coronary Artery Disease; and
- any other disease, Injury, or dysfunction of the cardiovascular system.

If a heart attack results in death, an autopsy confirmation or death certificate verifying the heart attack as the cause of death will be accepted.

Date of Diagnosis
The date the death of a portion of the heart muscle occurred based on the criteria listed under the Heart Attack Condition Definition.

Major Organ Failure Requiring Transplant — **100%**

Condition Definition
Failure of the heart, liver, both lungs, or pancreas resulting in the Insured being placed on the UNOS (United Network for Organ Sharing) list for a transplant.

If an Insured is on the UNOS list for a combined transplant (example: heart and lung), a single benefit will be paid.

Date of Diagnosis
The date the Insured is placed on the UNOS list for organ transplant(s).

Stroke — **100%**

Condition Definition

The sudden death of brain cells due to lack of oxygen, caused by blockage of blood flow or rupture of an artery to the brain.

For purposes of this benefit, the following do not meet the Condition Definition of Stroke:
- Transient Ischemic Attack;
- brain injury associated with hypoxia, anoxia, or hypotension;
- brain injury related to trauma or infection;
- ischemic disorders of the vestibular system; and
- vascular disease affecting the eye or optic nerve.

If a stroke results in death, an autopsy confirmation or death certificate verifying the stroke as the cause of death will be accepted.

Date of Diagnosis
The date a Stroke occurs and the diagnosis must be supported by:
- neurological deficits persisting for at least 30 days after the Stroke including but not limited to impaired motor function, altered sensation, vision loss, difficulty swallowing, or Cognitive Impairment confirmed by a Physician; and
- confirmatory neuroimaging studies consistent with the diagnosis of a new Stroke.

Sudden Cardiac Arrest	*Condition Definition* The sudden, unexpected loss of heart function in which the heart, abruptly and without warning, stops working as a result of an internal electrical system heart malfunction due to Coronary Artery Disease, cardiomyopathy, or hypertension. For purposes of this benefit, a Heart Attack (Myocardial Infarction) does not meet the Condition Definition of Sudden Cardiac Arrest. *Date of Diagnosis* The date the pumping action of the heart fails based on the Sudden Cardiac Arrest Condition Definition.	**100%**

Cancer		**Percentage of Coverage Amount**

Invasive Cancer (Including all Breast Cancer)	*Condition Definition*
	A disease which is identified by the presence of malignant cells or a malignant tumor characterized by the uncontrolled and abnormal growth and spread of invasive malignant cells.
	
	Any cancer of the breast is considered Invasive Cancer including breast cancer which is classified as Stage 0 or In Situ.
	
	For purposes of this benefit, the following do not meet the Condition Definition of Invasive Cancer:
	- pre-malignant conditions or conditions with malignant potential;
	- cancer that has not yet become invasive, typically classified as Stage 0 or In Situ; and
	- cancer on the surface of the body (skin) that may be:
	  - melanomas that are in situ or Stage 1, which require only local treatment and affect only the melanoma and area close to it;
	  - basal cell carcinoma; or
	  - squamous cell carcinoma of the skin.
		100%

Date of Diagnosis
The date the tissue specimen, blood samples or titer(s) are taken on which the Pathological Diagnosis of Invasive Cancer is based. We will accept a Clinical Diagnosis if a Pathological Diagnosis cannot be made.

Any subsequent Date of Diagnosis for Invasive Cancer must follow a period of at least 180 days where the Insured has had no evidence of disease or treatment for cancer. Evidence of disease or treatment does not include preventive medications or routine scheduled follow-up visits to a Physician.

If the Insured is diagnosed with Non-Invasive Cancer after the Coverage Effective Date and receives a benefit, and that cancer spreads and meets the Condition Definition for Invasive Cancer, we will pay the difference in Percentage of Coverage Amount.

Non-Invasive Cancer — **100%**

Condition Definition
A malignant tumor which is typically classified as Stage 0 or In Situ, that has not yet become invasive but is confined to the site of origin without having invaded neighboring tissue.

For purposes of this benefit, the following do not meet the Condition Definition of Non-Invasive Cancer:
- pre-malignant conditions or conditions with malignant potential;
- any Stage 0 or In Situ cancer of the breast; and
- cancer on the surface of the body (skin) that may be:
  - melanomas that are in situ or Stage 1, which require only local treatment and affect only the melanoma and area close to it;
  - basal cell carcinoma; or
  - squamous cell carcinoma of the skin.

Date of Diagnosis
The date the tissue specimen, blood samples or titer(s) are taken on which the Pathological Diagnosis of Non-Invasive Cancer is based. We will accept a Clinical Diagnosis if a Pathological Diagnosis cannot be made.

Any subsequent Date of Diagnosis for Non-Invasive Cancer must follow a period of at least 180 days where the Insured has had no evidence of disease or treatment for cancer. Evidence of disease or treatment does not include preventive medications or routine scheduled follow-up visits to a Physician.

Skin Cancer — **$500**

Condition Definition
Cancer on the surface of the body (skin) that may be:
- melanomas that are in situ or Stage 1, which require only local treatment and affect only the melanoma and area close to it;
- basal cell carcinoma; or
- squamous cell carcinoma of the skin.

Date of Diagnosis
The date the tissue specimen is taken on which the Pathological Diagnosis of Skin Cancer is based. We will accept a Clinical Diagnosis if a Pathological Diagnosis cannot be made.

Supplemental Critical Illnesses		**Percentage of Coverage Amount**
Benign Brain Tumor	*Condition Definition* A non-cancerous brain tumor resulting in neurological deficits including but not limited to loss of sight, loss of hearing, or balance disruption. For purposes of this benefit, the following do not meet the Condition Definition of Benign Brain Tumor: - tumors of the skull; - pituitary adenomas; and - germinomas. We will not pay this benefit if an Insured is diagnosed with any of the following conditions prior to their Coverage Effective Date: - Neurofibromatosis I; - Neurofibromatosis II; - Von Hippel Lindau; - Tuberous Sclerosis; - Li-Fraumeni Syndrome; - Cowden Disease; and - Turcot Syndrome. *Date of Diagnosis* The date of the examination of tissue (biopsy or surgical excision) or specific neuroradiological examination.	**100%**
Bone Marrow or Stem Cell Transplant	*Condition Definition* A surgical transplant of bone marrow or peripheral stem cell for the treatment of invasive cancer. *Date of Diagnosis* The date the Insured undergoes the actual surgery for a bone marrow or stem cell transplant or the date the Insured is diagnosed by a Physician as requiring the recommended transplant. We will pay this benefit only if there is medical evidence to support the diagnosis, and the Insured is too ill to undergo the recommended transplant. This benefit is payable once per Insured.	**25%**
Coma	*Condition Definition* A continuous state of profound unconsciousness requiring intubation for respiratory assistance lasting for a period of 7 or more consecutive days, characterized by the absence of: - eye opening; - verbal response; and - motor response. For purposes of this benefit, the following do not meet the Condition Definition of Coma: - Coma due to Stroke; and - any medically induced Coma. *Date of Diagnosis* The date a Physician confirms a Coma.	**100%**
Infectious	*Condition Definition*	**25%**

Disease

A severe infectious or contagious disease diagnosed by a Physician that results in an Insured being Confined to a Hospital for 7 or more consecutive days. Infectious or contagious diseases may include, but are not limited to:

- Rabies;
- Meningitis;
- Lyme Disease;
- Antibiotic resistant bacteria (including MRSA);
- Sepsis;
- Tuberculosis;
- Diphtheria;
- Encephalitis;
- Legionnaire's disease;
- Malaria;
- Necrotizing fasciitis (flesh eating bacteria);
- Osteomyelitis;
- Tetanus;
- COVID-19.

Date of Diagnosis
The date a Physician confirms the diagnosis of an Infectious Disease.

Loss of Hearing — **100%**

Condition Definition
Total and irrecoverable Loss of Hearing in both ears that follows a period where an Insured had the ability to hear.

For purposes of this benefit, the following do not meet the Condition Definition of Loss of Hearing:

- congenital birth defects;
- developmental delays; and
- any Loss of Hearing that can be corrected by any procedure, aid, or device.

Date of Diagnosis
The date a Physician confirms Loss of Hearing in both ears.

Loss of Sight — **100%**

Condition Definition
Permanent reduction in sight certified by a Physician that follows a period where an Insured was not legally blind such that:

- sight in the better eye reduced to a best corrected visual acuity of 20/200 or less (Snellen or E-Chart Acuity); or
- visual field remaining is less than 20° in the better eye.

For purposes of this benefit, the following do not meet the Condition Definition of Loss of Sight:

- congenital birth defects;
- developmental delays; and
- any loss of sight that can be corrected by any procedure, aid, or device.

Date of Diagnosis
The date a Physician confirms Loss of Sight.

Loss of Speech — **100%**

Condition Definition
Total and irrecoverable Loss of Speech that follows a period where an Insured had the ability to speak.

For purposes of this benefit, the following do not meet the Condition Definition of Loss of Speech:

- congenital birth defects;

- developmental delays; and
- any loss of speech that can be corrected by any procedure, aid, or device.

Date of Diagnosis
The date a Physician confirms Loss of Speech.

Occupational Human Immunodeficiency Virus (HIV) or Hepatitis — **100%**

Condition Definition
An infection resulting from exposure to HIV or Hepatitis B, C, or D contaminated fluids as the result of a Covered Accident during the normal course of duties for an occupation in which an Insured is regularly engaged and for which compensation is earned.

For purposes of this benefit, the following do not meet the Condition Definition of Occupational HIV or Hepatitis:
- exposure or infection as the result of IV drug use;
- exposure or infection as the result of sexual transmission; and
- exposure or infection determined that is not the result of an occupational Covered Accident.

Date of Diagnosis
The date a state certified and licensed laboratory receives a positive confirmatory antibody test for HIV or Hepatitis B, C, or D provided the following actions have been taken:
- within five days of the Covered Accident, it is reported and recorded by the appropriate person according to the legislation, regulations, standards, or guidelines that apply to the Insured's occupation or profession;
- the Covered Accident is investigated by the employer and we receive a copy of the Written investigation report;
- an initial confirmatory antibody test is taken within five days of the Covered Accident and is negative for the presence of HIV or Hepatitis B, C, or D; and
- a follow-up confirmatory antibody test is taken between 90 and 180 days from the date of the initial confirmatory antibody test and is positive for HIV or Hepatitis B, C, or D.

Occupational Post-Traumatic Stress Disorder (PTSD) — **100%**

Condition Definition
A Mental or Nervous Disorder that is the direct result of a Traumatic Occupational Event characterized by persistent mental and emotional stress resulting in the following that persist for at least 30 days following the date of the Traumatic Occupational Event:
- recurrent, involuntary, and intrusive memories of the Traumatic Occupational Event;
- recurrent distressing dreams, dissociative reactions, or flashbacks related to the Traumatic Occupational Event;
- psychological distress or physiological reactions to cues that resemble or remind an Insured of the Traumatic Occupational Event;
- behaviors of avoidance of stimuli or external reminders associated with the Traumatic Occupational Event;
- negative alterations in cognition, mood, or behavior that begin or worsen after the Traumatic Occupational Event; and
- impairments in social, occupational, and other areas of daily functioning.

For purposes of this benefit, the following do not meet the Condition Definition of Occupational PTSD if the:
- condition is the result of reactivation of symptoms from a Traumatic Occupational Event that occurred prior to the Insured's Coverage Effective Date;

- PTSD is the result of any non-occupational event or the event took place outside of the normal course of an Insured's occupational duties for their Employer;
- condition is better explained as bereavement;
- condition meets the criteria of another Mental or Nervous Disorder; or
- symptoms are due to the direct physiological effects of Substance Abuse.

Date of Diagnosis
The date a Physician diagnoses the Occupational PTSD. The diagnosis must be supported by the following in accordance with the criteria described in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM):
- medical evidence;
- psychiatric assessment; or
- psychological screening.

Permanent Paralysis — **100%**

Condition Definition
The complete and permanent loss of the use of two or more limbs due to a new paralysis for a continuous period of at least 90 days.

For a severed spinal cord with supporting clinical and radiological evidence and no expectation of return of function, the continuous 90 day requirement will be waived.

For purposes of this benefit, losing the use of two or more limbs as the result of a Stroke does not meet the Condition Definition of Permanent Paralysis.

Date of Diagnosis
The date a Physician diagnoses the paralysis or severed spinal cord.

Pulmonary Embolism — **25%**

Condition Definition
A sudden blockage in a pulmonary artery or a branch of a pulmonary artery due to a blood clot as confirmed by a pulmonary angiogram, ventilation perfusion scan, computerized tomography scan, magnetic resonance imaging, or other reliable imaging techniques.

Date of Diagnosis
The date a Physician confirms the diagnosis based on the criteria listed under the Pulmonary Embolism Condition Definition.

Transient Ischemic Attack (TIA) — **25%**

Condition Definition
A temporary ischemic event (including prolonged reversible ischemic attacks) in which:
- there are measurable, functional neurological impairments that are focal and confined to an area of the brain perfused by a specific artery; and
- there is no evidence of cerebral tissue damage on diagnostic imaging.

Date of Diagnosis
The date a Physician confirms the diagnosis based on documented neurological deficits, neuroimaging studies, and reversible functional neurological impairments.

If an Insured is diagnosed with a Stroke within 90 days of a covered Transient Ischemic Attack (TIA), we will pay the difference in

Percentage of Coverage Amount between these two benefits.

Progressive Diseases		**Percentage of Coverage Amount**
Addison's Disease	*Condition Definition* A long-term endocrine or hormonal disorder that occurs when the adrenal glands do not produce sufficient amounts of certain hormones, including cortisol. For purposes of this benefit, adrenal insufficiency resulting from prolonged corticosteroid treatment does not meet the Condition Definition of Addison's Disease. *Date of Diagnosis* The date the Insured is unable to perform two of more Activities of Daily Living or becomes Totally Disabled for 90 days due to Addison's Disease as diagnosed by a Physician.	**100%**
Amyotrophic Lateral Sclerosis (ALS)	*Condition Definition* A nervous system disease that causes muscle weakness and impacts physical function. ALS, also known as Lou Gehrig's disease, causes nerve cells to gradually break down and die. *Date of Diagnosis* The date the Insured is unable to perform two or more Activities of Daily Living or becomes Totally Disabled for 90 days due to Amyotrophic Lateral Sclerosis (ALS) as diagnosed by a Physician.	**100%**
Dementia (Including Alzheimer's Disease)	*Condition Definition* A progressive, degenerative disorder that attacks the brain's nerve cells or neurons, and may result in loss of memory, thinking, language skills, or behavioral changes. *Date of Diagnosis* The date the Insured is unable to perform two or more Activities of Daily Living or is Cognitively Impaired or becomes Totally Disabled for 90 days due to Dementia (including Alzheimer's Disease) as diagnosed by a Physician.	**100%**
Functional Loss	*Condition Definition* An Injury, Sickness, or other infirmity of a progressive condition not otherwise listed that for a period of at least 90 days, an Insured: - is prevented from performing at least two Activities of Daily Living; or - is Totally Disabled. For purposes of this benefit, functional loss due to paralysis does not meet the Condition Definition of Functional Loss. *Date of Diagnosis* The date the Insured is unable to perform two or more Activities of Daily Living or becomes Totally Disabled for 90 days due to a Functional Loss as diagnosed by a Physician.	**100%**
Huntington's Disease	*Condition Definition* A hereditary disease characterized by gradual loss of brain function and voluntary movement due to degenerative changes in the cerebral cortex and basal ganglia.	**100%**

	Date of Diagnosis The date the Insured is unable to perform two or more Activities of Daily Living or becomes Totally Disabled for 90 days due to Huntington's Disease as diagnosed by a Physician.	
Lupus	*Condition Definition* An autoimmune disease where the body's immune system attacks healthy tissue, leading to long-term inflammation. This disease is primarily characterized by joint pain and swelling. *Date of Diagnosis* The date the Insured is unable to perform two or more Activities of Daily Living or becomes Totally Disabled for 90 days due to Lupus as diagnosed by a Physician.	**100%**
Multiple Sclerosis (MS)	*Condition Definition* A chronic disease involving damage to the protective sheaths of nerve cells in the brain and spinal cord. Symptoms may include numbness, impairment of speech and of muscular coordination, blurred vision, and severe fatigue. Eventually, the disease can cause the nerves themselves to deteriorate or become permanently damaged. *Date of Diagnosis* The date the Insured is unable to perform two or more Activities of Daily Living or becomes Totally Disabled for 90 days due to Multiple Sclerosis (MS) as diagnosed by a Physician.	**100%**
Muscular Dystrophy	*Condition Definition* A genetic disease that causes progressive weakness and degeneration in the musculoskeletal system and where such muscles are replaced by scar tissue and fat. Muscular Dystrophy is characterized by progressive skeletal muscle weakness, defects in muscle proteins, and the death of muscle cells and tissues. *Date of Diagnosis* The date the Insured is unable to perform two or more Activities of Daily Living or becomes Totally Disabled for 90 days due to Muscular Dystrophy as diagnosed by a Physician.	**100%**
Myasthenia Gravis	*Condition Definition* A disease characterized by progressive weakness and exhaustibility of voluntary muscles without atrophy or sensory disturbance and caused by an autoimmune attack on acetylcholine receptors at the neuromuscular junction. *Date of Diagnosis* The date the Insured is unable to perform two or more Activities of Daily Living or becomes Totally Disabled for 90 days due to Myasthenia Gravis as diagnosed by a Physician.	**100%**
Parkinson's Disease	*Condition Definition* A disease of the nervous system marked by tremor, muscular stiffness, and slow, imprecise movement. It is associated with degeneration of the basal ganglia of the brain and a deficiency of the neurotransmitter dopamine. *Date of Diagnosis* The date the Insured is unable to perform two or more Activities of Daily Living or becomes Totally Disabled for 90 days due to Parkinson's Disease as diagnosed by a Physician.	**100%**

Systemic Sclerosis (Scleroderma)	*Condition Definition* A progressive autoimmune disease characterized by the hardening and tightening of the skin and connective tissues. *Date of Diagnosis* The date the Insured is unable to perform two or more Activities of Daily Living or becomes Totally Disabled for 90 days due to Systemic Sclerosis (Scleroderma) as diagnosed by a Physician.	**100%**

Additional Critical Illnesses for your Children		**Percentage of Coverage Amount**
Cerebral Palsy	*Condition Definition* A group of non-progressive disorders of movement and posture attributed to abnormal development of, or damage to motor control centers of the brain while a child's brain is still developing before, during, and immediately after birth. The motor disorders of Cerebral Palsy are often accompanied by disturbances of sensation, cognition, communication, perception, and behavior, as well as seizures and secondary musculoskeletal problems. *Date of Diagnosis* The date a Physician makes or confirms an initial diagnosis of Cerebral Palsy after live birth.	**100%**
Cleft Lip or Cleft Palate	*Condition Definition* Cleft Lip: A narrow opening or gap in the skin of the upper lip that extends all the way to the base of the nose, including unilateral clefting and bilateral clefting. Cleft Palate: An opening between the roof of the mouth and the nasal cavity. *Date of Diagnosis* The date a Physician makes or confirms an initial diagnosis of a Cleft Lip or Cleft Palate after live birth.	**100%**
Congenital Heart Disease	*Condition Definition* A congenital disorder of the structure of the heart that includes a defect of the inside walls of the heart, the valves of the heart, or the large blood vessels that carry blood to and from the heart. *Date of Diagnosis* The date a Physician makes or confirms an initial diagnosis and recommends surgery of Congenital Heart Disease after live birth.	**100%**
Cystic Fibrosis	*Condition Definition* A hereditary disorder affecting the exocrine glands. It causes the production of abnormally thick mucus, leading to the blockage of the pancreatic ducts, intestines, and bronchi and often resulting in respiratory infection. *Date of Diagnosis* The date the condition is first diagnosed by a Physician and supported by a sweat test with sweat chloride concentrations greater than 60 mmol/L.	**100%**
Down Syndrome	*Condition Definition*	**100%**

A congenital disorder arising from a chromosome defect involving chromosome 21, causing intellectual impairment, physical abnormalities and developmental delays. Down Syndrome includes:

Trisomy 21	An individual has three instead of two chromosome 21's.
Translocation	An extra part of chromosome 21 is attached to another chromosome.
Mosaicism	The individual has an extra chromosome 21 in only some of the cells but not all of them. The other cells have the usual pair of chromosome 21's.

Date of Diagnosis
The date a Physician makes or confirms an initial diagnosis of Down Syndrome through the study of chromosome 21 after live birth.

Sickle Cell Anemia — **100%**

Condition Definition
A disorder of the blood caused by inherited abnormal hemoglobin, which produces distorted (sickled) red blood cells.

For purposes of this benefit, sickle cell trait (sicklemia) does not meet the Condition Definition of Sickle Cell Anemia.

Date of Diagnosis
The date a Physician makes or confirms an initial diagnosis of Sickle Cell Anemia after live birth.

Spina Bifida — **100%**

Condition Definition
A congenital defect of the spine in which part of the spinal cord and its meninges are exposed through a gap in the backbone. Spina Bifida includes Meningocele or Myelomeningocele.

For purposes of this benefit, a diagnosis of spina bifida occulta does not meet the Condition Definition for Spina Bifida.

Date of Diagnosis
The date a Physician makes or confirms an initial diagnosis of Spina Bifida, Meningocele, or Myelomeningocele after live birth.

Type 1 Diabetes — **100%**

Condition Definition
A chronic condition in which the pancreas produces little or no insulin, typically resulting from auto-immune destruction of the insulin-producing cells in the pancreas. Type 1 Diabetes is commonly referred to as juvenile diabetes or insulin-dependent diabetes.

Date of Diagnosis
The date a Physician makes or confirms the diagnosis of Type 1 Diabetes of a dependent that is supported by medical evidence, diagnostic testing, or confirmation of the cause of low insulin production.

This certificate is subject to all Exclusions and Limitations in this section, unless stated otherwise in a specific provision.

Exclusions

We will not pay benefits for any Covered Loss that is caused by, contributed to by, or occurs as a result of any of the following:
- committing or attempting to commit a felony;
- being engaged in an illegal occupation;
- being engaged in an illegal activity;
- injuring oneself intentionally or attempting or committing suicide, whether sane or not;
- active participation in a riot, insurrection, or terrorist activity. This does not include civil commotion or disorder, Injury as an innocent bystander, or Injury for self-defense;
- war or any act of war, whether declared or undeclared;
- combat or training for combat while serving in the National Guard or the armed forces of any nation, state, authority, or organization;
- voluntary use of or treatment for voluntary use of any prescription or non-prescription drug, poison, fume, or other chemical or controlled substance unless taken as directed by the manufacturer, or as prescribed or directed by the Insured's Physician;
- being Intoxicated;
- a Covered Loss that occurs while an Insured is incarcerated in a penal or correctional institution or under house arrest or confinement.

Additionally, no benefits will be paid for a Covered Loss that occurs prior to the Coverage Effective Date.

Pre-existing Condition

We will not pay benefits for a claim when the Covered Loss occurs in the first 6 months following an Insured's Coverage Effective Date if the Covered Loss is caused by, contributed to by, or occurs as a result of any of the following:
- a Pre-existing Condition; or
- complications arising from treatment or surgery for, or medications taken for, a Pre-existing Condition.

An Insured has a Pre-existing Condition if, within the 3 months just prior to their Coverage Effective Date, they have an Injury or Sickness, whether diagnosed or not, for which:
- medical treatment, consultation, care or services, or diagnostic measures were received or recommended to be received during that period;
- drugs or medications were taken, or prescribed to be taken during that period; or
- symptoms existed.

Pre-existing Condition requirements are not applicable to:
- Children who are newly acquired after your Coverage Effective Date; and
- any coverage applied for when an Insured is first eligible to enroll.

The Pre-existing Condition provision applies to any Insured's initial coverage and any increases in coverage. Coverage Effective Date refers to the date any initial coverage or increases in coverage become effective.

Waiting Period

The Waiting Period is the continuous period of time you must be in an Eligible Group before you are eligible for coverage. Your Waiting Period is as follows:

If you are in an Eligible Group on or before January 1, 2026: None
If you enter an Eligible Group after January 1, 2026: None

Rehire
If your employment ends and you are rehired within 12 months, any prior period of work in an Eligible Group with your Employer, will apply toward the Waiting Period.

Coverage Eligibility Date

The date on which you, your Spouse, and your Children become eligible for coverage.

For you
If you are in an Eligible Group, you are eligible for coverage on the later of:
- the Policy Effective Date; or
- the day after any applicable Waiting Period has been satisfied.

For your Spouse
If you elect coverage for yourself, your Spouse is eligible for coverage on the later of:
- the date you are eligible for coverage; or
- the date you first acquire a Spouse.

For your Children
If you elect coverage for yourself, your Children are eligible for coverage on the later of:
- the date you are eligible for coverage; or
- the date you first acquire a Child.

Applying for Coverage

Initial Enrollment
Contributory Coverage
You may apply for any coverage available for you, your Spouse, and your Children within 31 days of an Insured's Coverage Eligibility Date.

Late Enrollment
Contributory Coverage
If you do not apply for coverage during an Insured's Initial Enrollment or you voluntarily cancelled coverage for an Insured and are re-applying, you may apply for coverage during any scheduled Enrollment Period.

Applying for Changes in Coverage

Contributory Coverage
You may increase coverage for an Insured subject to the Coverage Amounts available during any scheduled Enrollment Period or within 31 days of a Qualifying Life Event.

Any increase in Coverage Amounts applied for as the result of a Qualifying Life Event, must be appropriate and consistent with the Qualifying Life Event.

You may also decrease coverage for an Insured subject to the Coverage Amounts available or cancel coverage for an Insured at any time during the Policy Year.

Coverage Effective Date

Initial Enrollment
Contributory Coverage
Coverage for an Insured will begin on the later of:
- the Insured's Coverage Eligibility Date if you apply on or before that date; or
- the date you apply for the Insured's coverage, if coverage is applied for within 31 days of the Insured's Coverage Eligibility Date.

Late Enrollment
Contributory Coverage
Coverage for an Insured will begin on the first day of the next Policy Year.

Coverage Effective Date for

Contributory Coverage
Increases in coverage made during a scheduled Enrollment Period will begin on the first

Changes in Coverage

day of the next Policy Year.

Increases in coverage made due to a Qualifying Life Event will begin on the later of:
- the date of a Qualifying Life Event, if you apply for the increase in coverage on or before that date; or
- the date you apply for the increase in coverage if you apply within 31 days of the Qualifying Life Event.

Any decrease or cancellation in coverage made at any time during the Policy Year will begin on the date you apply for the decrease or cancellation in coverage.

Any decrease or cancellation in coverage will not affect a Payable Claim that occurs prior to the decrease or cancellation.

Coverage Effective Date for Plan Changes Requested by the Employer

Changes in coverage due to a plan change requested by your Employer will begin on the date of the plan change.

Coverage Effective Date if you are not in Active Employment

You must be in Active Employment in order for coverage to become effective for any Insured in accordance with the Coverage Effective Date provision.

If you are not in Active Employment due to a covered extended absence as outlined under the Continuation of your Coverage During Extended Absences provision on the date coverage would become effective for any Insured, the Insured's Coverage Effective Date will be the date you return to Active Employment.

Coverage Effective Date for Initial Enrollment, Late Enrollment, and Changes in Coverage is subject to this provision.

A delay of Coverage Effective Date for an increase in coverage will not affect coverage that is currently in force.

Continuation of your Coverage During Extended Absences

Leave of Absence, other than a Family and Medical Leave of Absence
You will be covered through the end of the month that immediately follows the month in which your Leave of Absence begins, provided premium is paid.

Family and Medical Leave of Absence
We will continue coverage in accordance with your Employer's Human Resource policy on family and medical leaves of absence if premium payments continue and your Employer approved your leave in Writing. You will be covered up to the end of the latest of:
- the leave period required by the Federal Family and Medical Leave Act of 1993, and any amendments; or
- the leave period required by applicable state law; or
- the leave period provided to you for an Injury or Sickness, provided premium is paid and your Employer has approved your leave in Writing.

If your Employer's Human Resource policy doesn't provide for continuation of your coverage during a family and medical Leave of Absence, coverage will be reinstated when you return to Active Employment.

We will not:
- apply a new Waiting Period; or
- apply new Pre-existing Condition requirements.

Leave of Absence due to Injury or Sickness
You will be covered, provided premium is paid.

Temporary Layoff
You will be covered through the end of the month that immediately follows the month in which your temporary Layoff begins, provided premium is paid.

End of Coverage

For you
Your coverage under this certificate ends on the earliest of:
- the date the policy is cancelled by us or your Employer;
- the date you are no longer in an Eligible Group;
- the date your Eligible Group is no longer covered;
- the date of your death;
- the last day of the period any required premium contributions are made; or
- the last day you are in Active Employment.

However, as long as premium is paid as required, coverage will continue:
- while benefits are being paid;
- in accordance with the Continuation of your Coverage During Extended Absences provision; or
- if you elect to continue coverage for you, your Spouse, and your Children under Portability of Critical Illness Insurance.

We will provide coverage for a Payable Claim that occurs while you are covered under this certificate.

For your Spouse
Your Spouse's coverage will end on the earliest of:
- the date your coverage under this certificate ends;
- the date your Spouse is no longer eligible for coverage;
- the date your Spouse no longer meets the definition of a Spouse;
- the date of your Spouse's death; or
- the date of divorce or annulment.

If your Spouse's coverage ends as a result of your death, divorce or annulment, your Spouse may elect to continue Spouse and Children coverage, as long as premium is paid as required under Portability of Critical Illness Insurance.

We will provide coverage for a Payable Claim that occurs while your Spouse is covered under this certificate.

For your Children

Your Children's coverage will end on the earliest of:

- the date your coverage under this certificate ends;
- the date your Children are no longer eligible for coverage; or
- the date your Children no longer meet the definition of Children.

We will provide coverage for a Payable Claim that occurs while your Children are covered under this certificate.

Filing a Claim

Provide notice of a claim for benefits under this certificate as soon as possible. If there are any questions on how to file a claim, please contact us or your Employer.

Step 1 - Starting a Claim

Notice of a claim may be provided in Writing, online at: **services.unum.com,** or by contacting us directly at 1-800-635-5597. Notice of a claim should be provided within 30 days from the date of the Covered Loss. If notice of a claim is not provided within this time period, it will not affect a Payable Claim as long as notice is provided as soon as reasonably possible.

Step 2 - Claim Forms

After receiving notice of a claim, we will send a claim form to you or your authorized representative within 15 days from the date we receive the notice of a claim. Claim forms may also be available from your Employer or from us online at: **services.unum.com**.

When you or your authorized representative receive the claim form, you or your authorized representative and your Employer must fill out your own section of the claim form and provide the Insured's Physician with the applicable section of the claim form. The Insured's Physician should complete their section of the form and send it directly to us.

If you or your authorized representative do not receive a claim form from us within 15 days after we receive notice of a claim, a Written statement from you or your authorized representative establishing the nature and extent of the Covered Loss will be deemed Proof of Loss, if sent to us within the time limit stated in the Proof of Loss section below.

Completed claim forms may be submitted online or sent to us by mail or fax:

Mailing Address: The Benefits Center
P.O. Box 100158
Columbia, South Carolina 29202-3158
Fax: (800)447-2498

Step 3 - Proof of Loss

Proof of Loss must be sent to us no later than 90 days after the date of Covered Loss. If it is not reasonably possible to provide Proof of Loss within this time period, it will not affect a Payable Claim if it is provided within one year, unless the Insured lacks the legal capacity to do so.

In no event can Proof of Loss be submitted after the expiration of the time limit for commencing Legal Action as stated in this certificate, even if the failure to provide Proof of Loss is due to a lack of legal capacity or if state law provides an exception to the one year time period.

Proof of Loss, provided at your or your authorized representative's expense, must establish the nature and extent of the Covered Loss and should include but not be limited to the following:

- documentation of diagnosis or treatment provided by a Physician or medical facility and supported by clinical, radiological, histological, pathological, or laboratory evidence;
- it may also include one or more of the following:
  - a Physician's bill;
  - a Hospital bill; or
  - other proof of charges or services; and
- in the case of death, a certified copy of the death certificate, or other lawful evidence providing equivalent information.

If the Proof of Loss is not complete, we may require you to submit additional information.

After the Insured or the Insured's authorized representative have satisfied the

requirements of this provision, we will process and evaluate the information to determine if a claim is payable. We will notify the Insured or the Insured's authorized representative of a claim decision and issue payment for a Payable Claim in accordance with the Payment of Benefits provision.

Authorization for Release of Information

We may require Written authorization from an Insured or an authorized representative to allow us to obtain necessary medical and non-medical information needed for Proof of Loss. Failure to provide us with Written authorization may result in the denial of a claim if the Insured or the authorized representative does not send proof to us and we are not able to obtain the proof required to make a claim decision.

Right to Exam, Test, or Interview

We may require the Insured to be examined or tested by one or more Physicians, other medical practitioners, or vocational experts of our choice. We may also require the Insured to be interviewed by an authorized representative of ours.

We have the right to interview the Insured and to have the Insured examined or tested as often as is reasonably necessary. Any examination, test, or interview that we require will be at our expense. If the Insured fails to attend or fully participate, we will not pay benefits or we will stop sending benefits under this certificate.

Autopsy

We will have the right, at our expense, to request an Autopsy where it is allowed by law.

Payment of Benefits

All benefits will be paid to you, unless otherwise noted or unless we receive Written authorization to pay them elsewhere. This is an assignment of benefits, refer to the Assignment provision in the General Provisions section of this certificate.

In the event of your death, any unpaid benefits will be paid to your beneficiary in accordance with the Beneficiary Designation and Change provision.

In the event of your Spouse's death, should your Spouse have survived you and continued coverage, any unpaid benefits for your Spouse, will be paid to your surviving Spouse's beneficiary in accordance with the Beneficiary Designation and Change provision.

Payment of Interest

Any benefit payment issued after 30 days from the date we receive satisfactory proof will accrue simple interest on the net benefit amount to be paid in accordance with the state requirements of the state where the Insured resides, beginning on the 30th day and ending on the date we make the payment.

Beneficiary Designation and Change

When a person becomes insured under this certificate, you are responsible for designating a primary and, if applicable, a contingent beneficiary in Writing for any benefits due in the event of the Insured's death. It is important to list the full name of each beneficiary and that all beneficiary designations are kept current and provided to us or the Employer. A beneficiary designation form may be available from the Employer or from us online at: **services.unum.com**.

You are the beneficiary for any Insured under this certificate while you are still living unless there is a valid change in beneficiary designation by an Insured. If you wish to change your beneficiary designation, you may do so by sending us or the Employer a completed, dated, and signed beneficiary designation change form. However, if you designated an irrevocable beneficiary, such beneficiary designation cannot be changed without the consent of the irrevocable beneficiary. Changes in beneficiary designations will take effect on the date notice of the beneficiary designation is signed by you.

Payment of Benefits will be administered based upon the currently available beneficiary designation on file with us or the Employer. If we have taken any action or made any payment before receiving notice of a beneficiary designation, that beneficiary designation will not go into effect for those actions taken or payments made.

If more than one beneficiary is named and the order or share of payments is not designated, the beneficiaries will share equally. The share of a beneficiary who dies

before you, the share of a beneficiary who is legally unable to receive benefits, or the share of benefits that are unallocated will pass to any surviving beneficiaries in proportion to their current allocations. The aggregated shares of benefits in excess of 100% will be deducted from surviving beneficiaries in proportion to their current allocations. If you, or a party legally acting on your behalf, has made an administrative error in completing the beneficiary designation form, we may, in our discretion, and when possible to do so, interpret the designation in a reasonable way to enable us to pay the benefits promptly.

If a beneficiary is not named, or if all named beneficiaries do not survive you, or the named beneficiary is legally unable to receive benefits, any benefits due will be paid to the first surviving family member in the order that follows:
- you;
- your Spouse;
- your natural offspring and legally adopted Children in equal shares;
- your mother or father, or if paying both, in equal shares; or
- your sisters and brothers in equal shares.

Instead of making a payment to a surviving family member, we have the right to pay any benefits due to your estate. If there are no surviving family members, or if we are unable to determine the appropriate beneficiary(ies), any benefits due will be paid to your estate. If there is no estate, benefits will be paid as required by law.

Also, at our option, we may pay up to $1,000 to the person or persons who, in our opinion, have incurred expenses for an Insured's last Sickness and death. Any such payment will reduce the Benefit Amount payable by us.

In the event of your death, should your Spouse survive you and elect to continue coverage under Portability of Critical Illness Insurance, your surviving Spouse should name a beneficiary according to the requirements specified within this provision.

Payments to a Minor or Incompetent Insured or Insured's Beneficiary

If an Insured or an Insured's beneficiary is a minor or is incompetent, we can pay up to $2,000 to the person or institution that appears to have assumed the custody and main support of the Insured, the minor, or the Insured's beneficiary unless or until that Insured, the minor, or the Insured's beneficiary's appointed legal representative makes a formal claim. If we pay benefits to such person or institution, we will not have to pay those benefits again. Any such payment will reduce the Benefit Amount payable by us.

Overpayment of Claims

We have the right to recover any overpayments due to:
- Fraud; and
- any error made in processing of a claim.

We must be reimbursed in full. If it is not possible for you to reimburse us in a lump sum payment, we will develop a reasonable method of repayment. This may include reducing or withholding future payments. We must notify you within two years following the date of the claim payment of the amount of the overpayment and your obligation to reimburse us. If the overpayment was due to your failure to provide complete information, any Misstatement of Information, or Fraud, the two year time limit shall not apply.

Unpaid Premium

Any Unpaid Premium due for an Insured's coverage at the time of payment for a claim may be deducted from the Insured's claim payment.

Legal Actions

If you or your authorized representative disagree with our decision, you or your authorized representative can start Legal Action regarding your claim 60 days after Proof of Loss has been given to us and up to three years from the latest of when:
- original Proof of Loss was first required to have been given to us;
- your claim was denied; or
- your benefits were terminated,

unless applicable law requires us to afford a longer period within which to bring Legal Action.

When Days Begin and End

For the purpose of all dates under this certificate, all days begin at 12:01 a.m. and end at 12:00 midnight.

Certificate of Coverage

We will provide the Employer with a certificate for distribution to each insured Employee. The certificate describes:
- the coverage to which an Insured may be entitled;
- to whom we will make a payment; and
- the limitations, exclusions, and requirements that apply to an Insured's coverage.

If the provisions of this certificate conflict with the provisions of the policy, the provisions of the policy will govern.

Certificate of Coverage Contents

Coverage for an Insured is provided under the provisions of this certificate. The provisions of this certificate are made part of the policy issued to the Policyholder.

The policy consists of all provisions of the policy, the provisions of this certificate, the Policyholder's application, and all related schedules, riders, amendments, and endorsements.

Cancellation or Modification to the Policy and this Certificate of Coverage

The policy and this certificate may be cancelled or modified by the Employer at any time without the Insured's consent. Any cancellation or modification to the policy or certificate requested by the Employer will take effect on the date agreed upon by us and the Employer.

All policy and certificate modifications will take effect according to the provisions in the Start of Coverage section of this certificate.

Policy Change Authority

No other person, including a broker or agent, may change or waive any part of the policy. This Policyholder and Unum may mutually agree to change the policy at any time without the Insured's consent. No change to the policy will be effective unless signed by an officer of our company and endorsed on or attached to the policy.

Representation in Applications

Any statements made by you will be considered a representation and not a warranty. Such statements will not be used to avoid insurance, reduce benefits, or deny a claim unless they are included in an application in Writing from you.

Assignment

An Assignment transfers all or part of your legal title and rights under the policy and this certificate to someone else, known as an "assignee." We will recognize your assignee(s) as owners of the rights you transferred under the policy and this certificate if:
- the Written form has been signed by you and the assignee and the Assignment in its Written form is acceptable to us; and
- in our discretion, we may reject and have no obligation under an Assignment unless a signed or certified copy of the Written Assignment has been received and recorded by us prior to the loss.

An Assignment will take effect on the date you sign the Assignment. However, if we have taken any action or made any payment before we receive a notice of the Assignment, that Assignment will not go into effect for those actions taken or payments made prior to our receipt of the notice of Assignment. Unless stated otherwise in, or allowed by the Assignment, the assignment does not change a beneficiary designation.

You are responsible for assuring the validity of any assignment. Please verify with your own legal counsel that your Assignment meets the legal requirements in your state.

Contestability

We will take legal or other action, if appropriate to do so, to cancel, to deny, or limit coverage or benefits based on statements made in signed applications for coverage, including Evidence of Insurability forms, only when a Covered Loss occurs during the first two years after an Insured's Coverage Effective Date. However, in the event of fraud, we can take legal or other action at any time as permitted by applicable law.

To confirm the accuracy of your signed application, we may require additional information,

including but not limited to completion of a medical treatment form and medical records.

Misstatement of Information

If we receive information about an Insured that is incorrect, we will:
- review the information to decide whether the Insured has coverage and in what amounts; and
- if necessary, make the applicable premium adjustments.

Fraud

We want to make sure you and your Employer do not incur additional insurance costs as a result of the effects of insurance fraud. We promise to focus on all means necessary to support fraud detection, investigation, and prosecution.

It is a crime to defraud or attempt to defraud us into issuing coverage or paying benefits that we would otherwise not have issued or paid. This includes filing a claim or providing information that contains any false, incomplete, or misleading information.

Fraudulent and deceptive actions may result in denial of a claim, and may be subject to prosecution and punishment under state and federal law. We will pursue all appropriate legal remedies in the event of insurance fraud.

Agency

For purposes of the policy, your Employer acts on its own behalf or as your agent. Under no circumstances will your Employer be deemed our agent.

Workers' Compensation or State Disability Insurance

This certificate does not provide coverage under any workers' compensation or state disability insurance law.

Communicating With you or your Employer

We may communicate verbally or in Writing with you or your Employer.

To protect our customers, we will abide by all applicable privacy laws and regulations.

Privacy and Data Protection

We will abide by all applicable privacy and data protection laws and regulations.

Abdominal Aortic Aneurysm

An Aneurysm located in the abdominal (lower) part of the aorta as confirmed by ultrasound, computerized tomography scan, magnetic resonance imaging, angiogram, or other reliable imaging techniques and which is:
- 5 centimeters or larger in size;
- is less than 5 centimeters and is rapidly expanding, and surgery has been recommended by a Physician; or
- is a Dissecting Aneurysm or a Ruptured Aneurysm.

Active Employment

You are working for your Employer for earnings that are paid regularly and you are performing the Material and Substantial Duties of your Regular Occupation. You must be regularly scheduled to work at least the minimum number of hours defined by your Employer.

Your work site must be:
- your Employer's usual place of business in the United States;
- an alternative work site in the United States at the direction of your Employer; or
- a location in the United States to which your job requires you to travel.

Normal vacation, holidays, or temporary business closures are considered Active Employment provided you are in Active Employment on the last scheduled work day preceding such time off.

For purposes of this certificate, temporary business closures that meet the Glossary definition of Active Employment include, but are not limited to:
- inclement weather;
- power outages; and
- public health agency orders.

Temporary and seasonal workers are excluded from coverage.

Activities of Daily Living (ADLs)

A person is considered unable to perform an Activity of Daily Living if the activity cannot be performed safely without Substantial Assistance. Activities of Daily Living include the following:

Bathing	The ability to wash oneself either in the tub, shower, or by sponge bath, with or without equipment or adaptive devices.
Dressing	The ability to put on and take off all garments, and medically necessary braces or artificial limbs usually worn including fastening or unfastening them.
Toileting	The ability to get to and from and on and off the toilet and to maintain a reasonable level of personal hygiene.
Transferring	The ability to move in and out of a chair or bed with or without equipment such as canes, quad canes, walkers, crutches, grab bars, or other support devices including mechanical or motorized devices.
Continence	The ability to either voluntarily control bowel and bladder function; or if incontinent, be able to maintain a reasonable level of personal hygiene.
Eating	The ability to get nourishment into your body by any means once it has been prepared and made available to you.

Aneurysm

A balloon-like bulge or weakening in the walls of an artery. An Aneurysm means any of the following:
- an Abdominal Aortic Aneurysm or Thoracic Aortic Aneurysm; or
- a Carotid Aneurysm, Cerebral Aneurysm or Renal Aneurysm where such Aneurysm is a Dissecting Aneurysm or Ruptured Aneurysm.

Aneurysm does not include an Aneurysm caused by a trauma.

Carotid Aneurysm

An Aneurysm located in the portion of the carotid artery that is in the neck.

Cerebral

An (intracranial or brain) Aneurysm located in an artery in the brain.

Aneurysm

Children

Any Child from live birth to age 26 who is:
- your own natural offspring;
- your Spouse's Child;
- your lawfully adopted Child as of the earliest of the date:
  - the Child is placed in your home or in a medical facility;
  - a petition is filed for you to adopt the Child; or
  - an adoption agreement, signed by you that includes your binding obligation to assume financial responsibility for the Child;
- a foster Child placed with you by an authorized placement agency or by judgment, decree, or other order of any court of competent jurisdiction;
- grandchildren, nieces, and nephews living with you in a regular parent Child relationship that are dependent on you for primary financial support; or
- any other Child residing with you through legal mandate that is dependent on you for financial support.

Coverage for your Child may be continued past age 26 if your Child is incapable of self-sustaining employment due to permanent intellectual or physical incapacity prior to reaching age 26 and is dependent upon you for support and maintenance.

You must submit proof of the Child's incapacity and dependency to us within 120 days of the Child's 26th birthday or we will accept proof within 120 days of the Child's Coverage Eligibility Date that the Child was continuously covered under this or another similar group policy since age 26. Ongoing proof of incapacity and dependency must be provided when requested by us, but not more frequently than once a year.

Your Children may not be insured as both a Child and an Employee.

Your Children may not be insured by more than one Employee.

Clinical Diagnosis

A diagnosis based on the study of symptoms that meets the following criteria:
- a Pathological Diagnosis cannot be made because it is medically inappropriate or life-threatening;
- there is medical evidence to support the diagnosis; and
- a Physician is treating the Insured for Invasive Cancer, Non-Invasive Cancer, or Skin Cancer.

Cognitively Impaired or Cognitive Impairment

A deterioration or loss in intellectual capacity that requires another person's stand-by assistance or verbal cueing for an Insured's protection or for the protection of others. It is measured by clinical evidence and standardized tests which reliably measure impairment in:
- short or long term memory;
- orientation to people, places, or time; or
- deductive or abstract reasoning.

Complications of Pregnancy

Abnormal conditions or concurrent diseases that significantly affects the pregnancy's usual medical management. A complication may exist during the pregnancy, during the delivery, or after the delivery.

Confined or **Confinement**

Assignment to a bed as a resident inpatient in a medical or treatment facility, including an Observation Unit, for a minimum of 20 continuous hours on the advice of a Physician.

Contributory Coverage

Any amount of coverage for which you pay all or part of the premium. The maximum amount that you may be required to contribute to the cost of your coverage shall not exceed the premium charged for the amounts of your coverage.

Coronary Artery Bypass Graft

Undergoing open heart surgery to correct narrowing or blockage of one or more coronary arteries utilizing venous or arterial grafts, excluding procedures such as, but not limited to, balloon angioplasty, valve replacement surgery, laser relief, stents or other non-surgical procedures.

Covered Accident

An unintended or unforeseen bodily Injury sustained by an Insured, wholly independent of disease, bodily infirmity, illness, infection, or any other abnormal physical condition and which:
- occurs on or after the Coverage Effective Date;
- occurs while coverage is in force; and
- is not excluded by name or specific description in this certificate.

Covered Condition

Any Sickness, diagnosis, or loss listed in the Critical Illness Details section.

Covered Loss

A Covered Condition or Covered Accident for which benefits are payable under this certificate.

Date of Diagnosis

The date a Physician confirms or a test proves that a Covered Condition exists. Date of Diagnosis requirements vary by Covered Condition.

Dissecting Aneurysm

A condition where a tear or split develops in a layer of an artery wall causing bleeding into and along the layers of the artery wall as confirmed by ultrasound, computerized tomography scan, magnetic resonance imaging, angiogram, or other reliable imaging techniques.

Employee

A person, also referred to as "you," or "your" who is in Active Employment in the United States with the Employer.

Employer

The Policyholder, including all covered United States divisions, subsidiaries, and affiliated companies of the named Policyholder for whom premium is being paid.

Enrollment Period

A period of time determined by your Employer and us during which you are eligible to enroll for or change your coverage. This period of time may be limited.

Hospital

A licensed institution supervised by Physicians and operated pursuant to law on a full-time basis. The Hospital must:
- provide overnight care to people with Injuries or Sicknesses;
- have full-time Nurses on duty or on call who are supervised by a registered Nurse; and
- have X-ray equipment, a laboratory, and a surgical operating room at its locations or available to use on a pre-arranged basis.

For purposes of this certificate, the following hospital units meet the Glossary definition of Hospital:
- Hospital Subacute ICU;
- Progressive Care Unit;
- Intermediate Care Unit; and
- Step-Down Unit.

For purposes of this certificate, the following do not meet the Glossary definition of Hospital:
- a nursing home, a rest home, home for the aged, or an assisted living facility;
- a Hospice care facility;
- a Subacute Rehabilitation Unit or Rehabilitation Unit;
- a psychiatric unit or facility for the treatment of Mental or Nervous Disorders; and
- a facility for the treatment of Substance Abuse.

Injury

Any damage or harm to the body that is the direct result of an accident and not related to any other cause. Injuries that occur prior to an Insured's Coverage Effective Date will be treated as any other Sickness.

Insured

Any person who has coverage under the policy.

Layoff

Temporary absence from Active Employment for a period of time that has been agreed to in advance by your Employer.

Normal vacation time, holidays, or temporary business closures is not considered a temporary Layoff.

Leave of Absence

Temporary absence from Active Employment for a period of time under a leave granted in Writing by your Employer that is in accordance with your Employer's formal leave policies.

Normal vacation time, holidays, or temporary business closures is not considered a Leave of Absence.

Material and Substantial Duties

Duties that:
- are routinely required for the performance of your Regular Occupation; and
- cannot be reasonably omitted or modified.

Mental or Nervous Disorders

A psychiatric or psychological condition classified in the most recent *Diagnostic and Statistical Manual of Mental Health Disorders* (DSM) published by the American Psychiatric Association (APA), as of the date of Covered Loss. If the DSM is discontinued or replaced, these disorders will be those classified in the diagnostic manual then used by the APA as of the date of Covered Loss. If the APA no longer publishes a diagnostic manual or the APA ceases to exist, we will use a comparable diagnostic manual.

Nurse

A healthcare professional trained to care for people with Injuries or Sicknesses. A Nurse may include a graduate Registered Nurse (R.N.), Licensed Practical Nurse (L.P.N.), or Licensed Vocational Nurse (L.V.N.).

We will not recognize you, your Spouse, Children, parents, siblings, a business or professional partner, or any person who has a financial affiliation or business interest with you, as a Nurse for a claim that you send to us.

Pathological Diagnosis

A diagnosis made by a Pathologist based on a microscopic study of fixed tissue or preparations from the hemic (blood) system. This type of malignancy diagnosis must be in accordance with the standards set up by the American Board of Pathology.

Pathologist

A Physician licensed by the American Board of Pathology to practice pathological anatomy or a Physician certified by the Osteopathic Board of Pathology as an osteopathic pathologist.

We will not recognize you, your Spouse, Children, parents, siblings, a business or professional partner, or any person who has a financial affiliation or business interest with you, as a Pathologist for a claim that you send to us.

Payable Claim

A claim for which we are liable under the terms of the policy.

Physician

A person performing tasks that are within the limits of their medical license and is also:
- a legally qualified medical practitioner according to the laws and regulations of the governing jurisdiction;
- licensed to practice medicine, prescribe and administer drugs, or to perform surgery; or
- a person with a doctoral degree in Psychology (Ph.D. or Psy.D.) whose primary practice is treating patients.

We will not recognize you, your Spouse, children, parents, siblings, a past or present business or professional partner, or any person who has a financial affiliation or business interest with you, as a Physician for a claim that you send to us.

Plan

Your Employer's Critical Illness Welfare Benefit Plan under ERISA, which includes this certificate, your Employer's Group Critical Illness Insurance Policy, and other benefit plan documents consistent with this Plan.

Policyholder

The entity to which the policy is issued.

Qualifying Life Event

For coverage eligibility purposes, a Qualifying Life Event includes, but is not limited to:
- birth, adoption, or addition of a Child;
- a change in legal marital status;
- a change in employment status; or
- death of an Insured.

as permitted under Internal Revenue Code section 125.

Changes in coverage made as a result of a Qualifying Life Event must be consistent with the Qualifying Life Event.

For further information regarding Qualifying Life Events, please refer to your Employer's Human Resource policy and plan documents.

Regular Occupation

The occupation you are routinely performing when your Injury or Sickness begins. We will look at your occupation as it is normally performed in the national economy, instead of how the work tasks are performed for a specific employer at a specific location.

Renal Aneurysm

An Aneurysm located in the renal artery.

Ruptured Aneurysm

A condition in which the Aneurysm bursts and causes bleeding inside the body as confirmed by ultrasound, computerized tomography scan, magnetic resonance imaging, angiogram, or other reliable imaging techniques.

Sickness

An illness or disease.

Spouse

The sole person who is your partner through lawful marriage, civil union, domestic partnership (established by a declaration acceptable to us), or your legally separated Spouse.

Your Spouse may not be Insured as both a Spouse and an Employee.

Substance Abuse

Abuse of or addiction to drugs or alcohol.

Substantial Assistance

Physical, stand-by or verbal cueing assistance from another person, or adaptive devices which are required for the Insured to perform Activities of Daily Living.

Surgical Procedure

The cutting into the skin or other organ to accomplish any of the following goals:
- further explore the condition for the purpose of diagnosis;
- take a biopsy of a suspicious lump;
- remove diseased tissues or organs;
- remove an obstruction;
- reposition structures to their normal position;
- redirect channels;
- transplant tissue or whole organs;
- implant mechanical or electronic devices;
- repair an area that has been injured or affected by trauma, overuse, or Sickness; or
- restore proper function.

For purposes of this certificate, the following do not meet the Glossary definition of Surgical Procedure:
- venipuncture (drawing blood);
- lumbar puncture;
- epidural steroid injections;
- removal of skin tags; and
- foreign body removal from the eye.

Thoracic Aortic Aneurysm

An Aneurysm located in the thoracic (upper) part of the aorta as confirmed by ultrasound, computerized tomography scan, magnetic resonance imaging, angiogram, or other reliable imaging techniques and which is:
- 5 centimeters, or larger in size;

- is less than 5 centimeters and rapidly expanding, and surgery has been recommended by a Physician; or
- is a Dissecting Aneurysm or a Ruptured Aneurysm.

Total Disability or Totally Disabled

The Insured is Totally Disabled when, as a result of a Covered Loss, the Insured is unable to perform with reasonable continuity the Material and Substantial Duties necessary to pursue the Insured's Regular Occupation.

Traumatic Occupational Event

The Insured's direct experience with or exposure to actual or threatened death, serious destruction, serious bodily harm, or sexual violence while performing the duties of their Regular Occupation that is:

- reported by the Insured to their Employer in accordance with the Employer's procedures and policies for such events; and
- investigated and reported by the Insured's Employer to appropriate authorities or entities in accordance with any applicable legislation, regulations, standards, or guidelines that apply to the Insured's Regular Occupation.

Unum Insurance Company

Referred to as "Unum" and "we," "us," and "our."

Writing or Written

A record on or transmitted by paper, electronic, or telephonic means consistent with applicable law.

Unum Insurance Company
2211 Congress Street, Portland, ME 04122
(877) 225-2712
services.unum.com

Be Well Benefit

We encourage our Insureds to maintain a healthy lifestyle. For those who take precautionary measures by receiving routine health screenings, we offer a Be Well Benefit. This is an annual cash benefit that may be claimed after completing an eligible Be Well Screening, and may be used to help with monetary expenditures such as transportation, missed work, or other incidentals.

For the purpose of determining your coverage and eligibility for the Be Well Benefit, all terms and provisions of your Certificate of Coverage apply unless modified below.

Policyholder: Holley Performance Products Incorporated

Policy Number: 987176 011

Policy Effective Date: January 1, 2026

Be Well Benefit Effective Date: January 1, 2026

Eligible Group(s)

Full-Time Employees Excluding Owners in Active Employment in the United States working a minimum of 30 hours per week.

Paying for Coverage

The Be Well Benefit is automatically included in the cost of your Critical Illness Insurance coverage.

Be Well Benefit

For You	For your Spouse	For your Children
$50	$50	$50

Be Well Benefit Payment Conditions

Each Insured is eligible to receive a maximum of one Be Well Benefit per Calendar year.

The Be Well Benefit will become payable provided the following conditions are met:
- the date of the Be Well Screening is after the Be Well Benefit Effective Date; and
- an Insured's coverage is in force.

Be Well Screenings

Cholesterol and Diabetes	Eligible screenings include, but may not be limited to: blood test for triglycerides, fasting plasma glucose (FPG), fasting blood glucose test, hemoglobin A1C(HbA1c), Serum cholesterol test to determine total, HDL and LDL cholesterol levels, two hour post-load plasma glucose.
Cancer	Eligible screenings include, but may not be limited to: colonoscopy, virtual colonoscopy, CEA (blood test for colon cancer), low-dose computerized tomography (CT) (imaging study for lung cancer), double-contrast barium enema, fecal immunochemical testing, fecal DNA testing, PSA (blood test for prostate cancer), bone marrow testing, serum protein electrophoresis (blood test for myeloma), dermatological screenings for skin cancer, flexible sigmoidoscopy, hemoccult stool analysis, pap smear, thin prep pap test, cytology

	(PAP) smear, CA 15-3 (blood test for breast cancer), CA-125 (blood test for ovarian cancer), BRCA1 or BRCA2 testing.
Cardiovascular Function	Eligible screenings include, but may not be limited to: echocardiogram, electrocardiogram, stress test on a bicycle or treadmill, myocardial perfusion imaging.
Imaging Studies	Eligible screenings include, but may not be limited to: chest x-ray, carotid ultrasound (Doppler), mammography, breast ultrasound, breast MRI, breast thermography, transvaginal ultrasound, bone density scans, aortic ultrasound.
Annual Examinations by a Physician	Eligible examinations include sports physicals, annual exams for adults, and well-child visits.
Immunizations	Eligible immunizations include, but may not be limited to: HPV, Hepatitis B, chicken pox, MMR, meningitis, tetanus, pneumonia, influenza.

Unum Insurance Company
2211 Congress Street, Portland, ME 04122
(877) 225-2712
services.unum.com

Portability of Critical Illness Insurance

Portability allows you, your Spouse and Children to continue coverage when coverage under the Employer's group Policy would otherwise end due to an Eligible Portability Event. The certificate in force at the time of an Insured's Eligible Portability Event will reflect the terms and conditions of the coverage that can be continued.

Portability of Critical Illness Insurance is made a part of the Critical Illness Insurance Policy and is subject to all of the provisions, limitations and exclusions of the Policy and certificate, unless changed by this document. Additionally, defined terms found within Portability of Critical Illness Insurance have been capitalized and have the same meaning as the terms in the Glossary section of the Certificate of Coverage.

Any future changes made in the Employer's group Policy will not apply to coverage an Insured has ported, unless required by law.

If you have any questions about portable coverage, please contact your Employer or us.

Policyholder: Holley Performance Products Incorporated

Policy Number: 987176 011

Policy Effective Date: January 1, 2026

Portability Effective Date: January 1, 2026

Portability Provisions

Eligible Portability Events

You are eligible to port coverage on the date of the following Eligible Portability Events:
- your employment with your Employer ends; or
- you are no longer in an Eligible Group.

However, you will not be considered eligible to port coverage at the time of an Eligible Portability Event if the Employer's Policy is cancelled by us.

Portable Coverage Available

The amount of coverage in force for each Insured on the date of your Eligible Portability Event is available to port subject to the following:

For you
The maximum amount of coverage available to port is your in force Coverage Amount at the time of your Eligible Portability Event.

For your Spouse
The maximum amount of coverage available to port is your Spouse's in force Coverage Amount at the time of your Eligible Portability Event.

For your Children
The maximum amount of coverage available to port is your Children's in force Coverage Amount at the time of your Eligible Portability Event.

If you wish to make a change to an Insured's in force coverage at time of port, please refer to Changes to Ported Coverage for guidelines in changing coverage.

Coverage for any Insured cannot be increased above the amount currently in force at the time you apply for portable coverage.

Applying for Portable Coverage

If you choose to apply for portable coverage for yourself, you may also port coverage for your Spouse and Children.

You must apply for portable coverage and pay the first premium within 31 days from the date of an Eligible Portability Event.

Applications for Portability are available from your Employer.

Ported Coverage Effective Date

Once premiums and all forms have been received, ported coverage is effective on the day after coverage would have otherwise ended under your Employer's Policy.

Changes to Ported Coverage

You may decrease coverage for an Insured subject to the Coverage Amounts available at any time.

Ported coverage cannot be increased at any time for any Insured.

Decreases in coverage will take effect on the first of the month following the date we process the change.

Any decrease in coverage will not affect a Payable Claim that occurs prior to the decrease.

End of Ported Coverage

If you choose to cancel your ported coverage, coverage for all Insureds will end on the first of the month following the date you provide notification to us.

For you

Otherwise, your ported coverage will end on the earliest of:

- the date the Employer's group Policy is cancelled upon 45 days Written notice;
- the date you fail to pay the required premium within 31 days of a premium due date;
- the date you are rehired by your Employer or return to an Eligible Group and are covered under the Employer's group Policy;
- the date coverage provided under Portability is cancelled by us for any reason upon 45 days Written notice; or
- the date you die.

For your Spouse

Your Spouse's ported coverage will end on the earliest of:

- the date your ported coverage ends;
- the date your Spouse is no longer eligible for coverage;
- the date your Spouse no longer meets the definition of a Spouse;
- the date of your Spouse's death; or
- the date of divorce or annulment.

If your Spouse's coverage ends as a result of your death, divorce or annulment, your Spouse has the option to port coverage in accordance with Portability for your Spouse and Children in the Event of your Death, Divorce or Annulment.

For your Children

Your Children's ported coverage will end on the earliest of:

- the date your ported coverage ends;
- the date your Children are no longer eligible for coverage; or
- the date your Children no longer meet the definition of Children.

Once ported coverage ends, it cannot be reinstated.

Paying for Ported Coverage

You must make all premium contributions for ported coverage. We will bill you directly for any premium due.

Rates for Ported

Premium will be based on the rates for Portability in effect on the date you apply to port

Coverage coverage.

Portability rates may be changed by us at any time. We will provide Written notice at least 45 days before any change is to take effect.

Portability for your Spouse and Children in the Event of your Death, Divorce or Annulment

Eligible Portability Events for your Spouse

Your Spouse is eligible to port Spouse and Children coverage on the date of the following Eligible Portability Events for your Spouse:

- your death; or
- divorce or annulment.

Portable Coverage Available

The amount of coverage in force for each Insured, on the date of the Eligible Portability Event for your Spouse, is available to port subject to the following:

For your Spouse

The maximum amount of coverage available to port is your Spouse's in force Coverage Amount at the time of the Eligible Portability Event for your Spouse.

For your Children

The maximum amount of coverage available to port is your Children's in force Coverage Amount at the time of the Eligible Portability Event for your Spouse.

If your Spouse wishes to make a change to an Insured's in force coverage at time of port, please refer to Changes to Ported Coverage for guidelines in changing coverage.

Coverage for any Insured cannot be increased above the amount currently in force at the time your Spouse applies for portable coverage.

Applying for Portable Coverage

If your Spouse chooses to apply for portable Spouse coverage, your Spouse may also apply for portable Children coverage.

Your Spouse must apply for portable coverage and pay the first premium within 31 days from the date of the Eligible Portability Event for your Spouse.

Applications for Portability are available from us.

Ported Coverage Effective Date

Once premiums and all forms have been received, ported coverage is effective on the day after coverage would have otherwise ended under the Employer's Policy.

Changes to Ported Coverage

Your Spouse may decrease their Spouse and Children coverage subject to the Coverage Amounts available at any time.

Ported coverage cannot be increased at any time for any Insured.

Decreases in coverage will take effect on the first of the month following the date we process the change.

Any decrease in coverage will not affect a Payable Claim that occurs prior to the decrease.

End of Ported Coverage

If your Spouse chooses to cancel ported coverage, your Spouse and Children's coverage will end on the first of the month following the date your Spouse provides notification to us.

For your Spouse

Otherwise, your Spouse's ported coverage will end on the earliest of:

- the date the Employer's group Policy is cancelled upon 45 days Written notice;
- the date your Spouse fails to pay the required premium within 31 days of a premium due date;
- the date your Spouse is no longer eligible for coverage;
- the date coverage provided under Portability is cancelled by us for any reason upon

45 days Written notice; or
- the date of your Spouse's death.

For your Children

Your Children's ported coverage will end on the earliest of:
- the date your Spouse's ported coverage ends;
- the date your Children are no longer eligible for coverage; or
- the date your Children no longer meet the definition of Children.

Once ported coverage ends, it cannot be reinstated.

Paying for Ported Coverage

Your Spouse must make all premium contributions for Spouse and Children ported coverage. We will bill your Spouse directly for any premium due.

Rates for Ported Coverage

Premium will be based on the rates for Portability in effect on the date your Spouse applies to port Spouse and Children coverage.

Portability rates may be changed by us at any time. We will provide Written notice at least 45 days before any change is to take effect.

GROUP CRITICAL ILLNESS

THE FOLLOWING NOTICES AND CHANGES TO YOUR COVERAGE ARE REQUIRED BY CERTAIN STATES. PLEASE READ CAREFULLY.

State variations apply and are subject to change. Consult your Employer or plan administrator for the most current state provisions that may apply to you.

Full effect will be given to your state's civil union, domestic partner and same sex marriage laws to the extent they apply to you under a group insurance policy issued in another state.

If you have a complaint about your insurance you may contact us at 1-800-321-3889, or the department of insurance in your state of residence. Links to the websites of each state department of insurance can be found at www.naic.org.

Si usted tiene una queja acerca de su seguro puede comunicarse con nosotros a traves del numero 1-800-321-3889, o al departamento de seguros de su estado de residencia. Puede encontrar enlaces a los sitios web de los departamentos de seguros de cada estado en www.naic.org.

The states of **Florida and Maryland** require us to advise residents of these states that if your Certificate was issued in a jurisdiction other than the state in which you reside, it may not provide all of the benefits required by the laws of your residence state.

The state of **Montana** requires us to notify you that the provisions in the Policy, including those in the Certificate of Coverage, conform to the minimum requirements of Montana law and control over any conflicting statutes of any state in which the Insured resides on or after the Policy Effective Date.

If you are a resident of one of the states noted below, and the provisions referenced below appear in your certificate in a form less favorable to you as an Insured, they are amended as follows:

For residents of Alaska

The **Filing a Claim** provision for *Claim Forms* in the **Claim Provisions** section of the certificate is amended so that claim forms will be sent to you within 10 working days from the date we receive the notice of a claim.

The **Filing a Claim** provision in the **Claim Provisions** section of the certificate is amended so that notification of a claim decision and payment issued for a Payable Claim is within 30 days after receipt of satisfactory Written Proof of Loss.

A **Payment of Interest** provision is added to the **Claim Provisions** section of the certificate to read as follows:

> Any benefit payment issued after 30 days from the date we receive satisfactory Written Proof of Loss will accrue simple interest on the net benefit amount at the rate of 15% per year. Interest will accrue beginning on the day following the date that the benefit payment was due and ending on the date we make that benefit payment.
>
> For purposes of this provision, a benefit payment is considered paid on the date payment is mailed or transmitted electronically.

The **Overpayment of Claims** provision in the **Claim Provisions** section of the certificate is amended by limiting the right to recover overpayments to 365 days from the date the claim was paid. This provision is amended to read as follows:

> We have the right to recover any overpayments made on a prior claim up to 365 days from the date the claim was paid. However, in the event that we have clear and documented proof of Fraud or other intentional misconduct, we have the right to recover any overpayments at any time. In any event, we will provide Written notice at least 30 days before we seek recovery of an overpayment. Written notice will include adequate information to identify the specific claim and the specific reason for the recovery.

We must be reimbursed in full. If it is not possible to reimburse us in a lump sum payment, we will develop a reasonable method of repayment. This may include reducing or withholding future payments.

The **Confined** o**r Confinement** definition in the **Glossary** section of the certificate is amended to read as follows:

Assignment to a bed as a resident inpatient in a medical or treatment facility, including an Observation Unit, on the advice of a Physician.

For residents of Arkansas

The **Children** definition in the **Glossary** section of the certificate is amended for a Child who is incapable of self-sustaining employment due to permanent intellectual or physical incapacity to read as follows:

Coverage for your Child may be continued past age 26 if your Child is incapable of self-sustaining employment due to permanent intellectual or physical incapacity prior to reaching age 26 and is dependent upon you for support and maintenance.

You must submit proof of the Child's incapacity and dependency to us in order to continue coverage that would have otherwise ended due to age. Ongoing proof of incapacity and dependency must be provided, at our expense, when requested by us.

For residents of Idaho

The *Date of Diagnosis* for **End Stage Renal (Kidney) Failure**, a Covered Condition found under **Critical Illnesses** in the **Critical Illness Details** section of the certificate is amended to read as follows

The date the Physician diagnoses the Insured as having End Stage Renal (Kidney) Failure.

The *Condition Definition* and *Date of Diagnosis* for **Major Organ Failure**, a Covered Condition found under **Critical Illnesses** in the **Critical Illness Details** section of the certificate is amended to read as follows:

Irreversible and end-stage failure of the heart, liver, both lungs, or pancreas.

The date a Physician diagnoses the Insured as having Major Organ Failure.

The *Date of Diagnosis* for **Addison's Disease**, a Covered Condition found under **Progressive Diseases** in the **Critical Illness Details** section of the certificate is amended to read as follows:

The date a Physician diagnoses the Insured with Addison's Disease.

The *Date of Diagnosis* for **Amyotrophic Lateral Sclerosis (ALS)**, a Covered Condition found under **Progressive Diseases** in the **Critical Illness Details** section of the certificate is amended to read as follows:

The date a Physician diagnoses the Insured with Amyotrophic Lateral Sclerosis (ALS).

The *Date of Diagnosis* for **Dementia (including Alzheimer's Disease)**, a Covered Condition found under **Progressive Diseases** in the **Critical Illness Details** section of the certificate is amended to read as follows:

The date the Insured is Cognitively Impaired due to Dementia (including Alzheimer's Disease) as diagnosed by a Physician.

The *Date of Diagnosis* for **Huntington's Disease**, a Covered Condition found under **Progressive Diseases** in the **Critical Illness Details** section of the certificate is amended to read as follows:

The date a Physician diagnoses the Insured with Huntington's Disease.

The *Date of Diagnosis* for **Lupus**, a Covered Condition found under **Progressive Diseases** in the **Critical Illness Details** section of the certificate is amended to read as follows:

The date a Physician diagnoses the Insured with Lupus.

The *Date of Diagnosis* for **Multiple Sclerosis (MS)**, a Covered Condition found under **Progressive Diseases** in the **Critical Illness Details** section of the certificate is amended to read as follows:

The date a Physician diagnoses the Insured with Multiple Sclerosis (MS). The diagnosis must be supported by one or more of the following:
- two or more separate clinical attacks, confirmed by magnetic resonance imaging (MRI) of the nervous system, showing multiple lesions of demyelination;
- well-defined neurological abnormalities lasting more than six months, confirmed by MRI of the nervous system, showing multiple lesions of demyelination; or
- a single attack, confirmed by repeated MRI of the nervous system, which shows multiple lesions of demyelination which have developed at intervals at least one month apart.

The *Date of Diagnosis* for **Muscular Dystrophy**, a Covered Condition found under **Progressive Diseases** in the **Critical Illness Details** section of the certificate is amended to read as follows:

The date a Physician diagnoses the Insured with Muscular Dystrophy.

The *Date of Diagnosis* for **Myasthenia Gravis**, a Covered Condition found under **Progressive Diseases** in the **Critical Illness Details** section of the certificate is amended to read as follows:

The date a Physician diagnoses the Insured with Myasthenia Gravis.

The *Date of Diagnosis* for **Parkinson's Disease**, a Covered Condition found under **Progressive Diseases** in the **Critical Illness Details** section of the certificate is amended to read as follows:

The date a Physician diagnoses the Insured with Parkinson's Disease. The Insured must exhibit two or more of the following clinical manifestations for a period of at least 90 days:
- muscle rigidity;
- tremor; and
- bradykinesia (abnormal slowness of movement, sluggishness of physical and mental responses).

The *Date of Diagnosis* for **Systemic Sclerosis (Scleroderma)**, a Covered Condition found under **Progressive Diseases** in the **Critical Illness Details** section of the certificate is amended to read as follows:

The date a Physician diagnoses the Insured with Systemic Sclerosis (Scleroderma).

The **Exclusions** provision in the **Critical Illness Details | Exclusions and Limitations** section of the certificate is amended to read as follows:

We will not pay benefits for any Covered Loss that is caused by, contributed to by, or occurs as a result of any of the following:
- participation in a felony;
- being engaged in an illegal occupation;
- being engaged in an illegal activity;
- injuring oneself intentionally or attempting or committing suicide, whether sane or not;
- active participation in a riot or insurrection. This does not include civil commotion or disorder, Injury as an innocent bystander, or Injury for self-defense;
- war or any act of war, whether declared or undeclared;
- combat or training for combat while serving in the National Guard or the armed forces of any nation, state, authority, or organization;
- voluntary use of alcohol or drugs or treatment for alcoholism or drug addiction unless taken as directed by the manufacturer, or as prescribed or directed by the Insured's Physician.

Additionally, no benefits will be paid for a Covered Loss that occurs prior to the Coverage Effective Date.

The **Pre-existing Condition** provision in the **Critical Illness Details | Exclusions and Limitations** section of the certificate is amended so that the number of months just prior to the Insured's Coverage Effective Date referenced in that section is no more than 6 months and the rest of the text is amended to read as follows:

An Insured has a Pre-existing Condition if, within the 6 months just prior to their Coverage Effective Date, they have an Injury or Sickness for which medical advice, diagnosis, care, or treatment were received or recommended to be received during that period.

The **Children** definition in the **Glossary** section of the certificate is amended to read as follows:

Any Child from live birth to age 26 who is:
- your own natural offspring;
- your Spouse's or Domestic Partner's Child;
- your lawfully adopted Child as of the earlier of;
  - the date the Child is physically placed with you in your care; or
  - the date you sign an adoption agreement that includes your binding obligation to assume financial responsibility for the child, if physical placement is prevented due to the medical needs of the child;
- a foster Child placed with you by an authorized placement agency or by judgment, decree, or other order of any court of competent jurisdiction;
- grandchildren, nieces, and nephews living with you in a regular parent Child relationship that are dependent on you for primary financial support; or
- any other Child residing with you through legal mandate who is receiving more than one half of their primary financial support from you or your Spouse or Domestic Partner.

Coverage for your Child may be continued past age 26 if your Child is incapable of self-sustaining employment due to an intellectual disability or physical disability prior to reaching age 26 and is dependent upon you for support and maintenance. Coverage for your Child will be continued subject to the End of Coverage provision.

You must submit proof of the Child's disability and dependency to us within 31 days of the Child's 26th birthday or we will accept proof within 31 days of the Child's Coverage Eligibility Date that the Child was continuously covered under this or another similar group policy since age 26. During the first two years following the Child's 26th birthday or Coverage Eligibility Date, additional proof of a disability and dependency may be required at reasonable intervals. After this two year period, subsequent proof may be required but not more than once a year.

Your Children may not be insured as both a Child and an Employee.

Your Children may not be insured by more than one Employee.

For residents of Louisiana

The **Exclusions** provision in the **Critical Illness Details | Exclusions and Limitations** section of the certificate is amended to read as follows:

We will not pay benefits for any Covered Loss that is caused by, contributed to by, or occurs as a result of any of the following:
- committing or attempting to commit a felony;
- being engaged in an illegal occupation;
- being engaged in an illegal activity;
- injuring oneself intentionally or attempting or committing suicide, whether sane or not;
- active participation in a riot, insurrection, or terrorist activity. This does not include civil commotion or disorder, Injury as an innocent bystander, or Injury for self-defense;
- war or any act of war, whether declared or undeclared;
- combat or training for combat while serving in the National Guard or the armed forces of any nation, state, authority, or organization;
- voluntary use of or treatment for voluntary use of any intoxicants or narcotics, unless administered on the advice of prescription or non-prescription drug, poison, fume, or other chemical substance or controlled substance unless taken as directed by the manufacturer, or as prescribed or directed by the manufacturer, or as prescribed or directed by the Insured's Physician;
- being intoxicated;
- a Covered Loss that occurs while an Insured is incarcerated in a penal or correctional institution, except when the insured is legally detained in a correctional facility and has not been adjudicated or convicted of a criminal offense, or under house arrest or confinement.

Additionally, no benefits will be paid for a Covered Loss that occurs prior to the Coverage Effective Date.

The **Payment of Benefits** provision in the **Claim Provisions** section of the certificate is amended in that we may be subject to a penalty, payable to you, of double the amount of benefits due to the Insured under the terms of the certificate during the period of delay should we issue any benefit payment after 30 days from the date we receive satisfactory proof. This penalty may also include attorney's fees to be determined by the court.

The **Children** definition in the **Glossary** section of the certificate for "any other Child residing with you through legal mandate that is dependent on you for financial support" is amended to read as follows:

- any other Child residing with you through legal mandate;

The **Children** definition in the **Glossary** section of the certificate is amended to include any other Child if placed following an execution of an act of voluntary surrender on the date on which the act of voluntary surrender becomes irrevocable.

For residents of Minnesota

The **Exclusions** provision in the **Critical Illness Details** section of the certificate is amended so that any exclusion for claims caused by, contributed to by, or occurs as a result of injuring oneself intentionally or attempting or committing suicide, whether sane or not, is amended by removing the phrase, "or attempting or committing suicide."

The **Filing a Claim** provision for *Starting a Claim* in the **Claim Provisions** section of the certificate is amended so that notice of a claim can be provided to us by any of our authorized agents.

The **Representation in Applications** provision in the **General Provisions** section of the certificate is amended to read as follows:

In the absence of Fraud, any statements made by you will be considered a representation and not a warranty. Such statements will not be used to avoid insurance, reduce benefits, or deny a claim unless they are included in an application in Writing from you. Statements may not be used in contesting the validity of the insurance with respect to which the statements were made after the insurance has been in force before the contest for a period of two years during the Insured's lifetime.

An **Intoxicated** definition is added to the **Glossary** section of the certificate to read as follows.

The Insured's blood alcohol level or THC level exceeds the legal limit for operating a motor vehicle in the state where the Accident occurred.

For residents of Montana

For purposes of the *Date of Diagnosis* in "**Cerebral Palsy**", "**Cleft Lip or Cleft Palate**", "**Congenital Heart Disease**", "**Down Syndrome**", "**Sickle Cell Anemia**", or "**Spina Bifada**" under the **Additional Critical Illnesses for your Children** in the **Critical Illness Details** section of the certificate, Children are defined as any Children from birth to age 26.

The **Exclusions** provision in the **Critical Illness Details | Exclusions and Limitations** section of the certificate is amended to read as follows:

We will not pay benefits for any Covered Loss that is caused by, contributed to by, or occurs as a result of any of the following:
- convicted of committing or attempting to commit a felony;
- being engaged in an illegal occupation;
- being engaged in an illegal activity;
- injuring oneself intentionally or attempting or committing suicide, whether sane or not;
- active participation in a riot, insurrection, or terrorist activity. This does not include civil commotion or disorder, Injury as an innocent bystander, or Injury for self-defense;
- war or any act of war, whether declared or undeclared;

- combat or training for combat while serving in the National Guard or the armed forces of any nation, state, authority, or organization;
- voluntary use of or treatment for voluntary use of any prescription or non-prescription drug, poison, fume, or other chemical substance or controlled substance unless taken as directed by the manufacturer, or as prescribed or directed by the Insured's Physician;
- being intoxicated;
- a Covered Loss that occurs while an Insured is incarcerated in a penal or correctional institution,or under house arrest or confinement.

Additionally, no benefits will be paid for a Covered Loss that occurs prior to the Coverage Effective Date.

The **Pre-existing Condition** provision in the **Critical Illness Details | Exclusions and Limitations** section of the certificate is amended so that the number of months just prior to the Insured's Coverage Effective Date referenced in that section is no more than 6 months and the rest of the text is amended to read as follows:

An Insured has a Pre-existing Condition if, within the 6 months just prior to their Coverage Effective Date, they have an Injury or Sickness for which medical advice, diagnosis, care, or treatment were received or recommended to be received during that period.

The **Filing a Claim** provision for *Starting a Claim* in the **Claim Provisions** section of the certificate is amended so that notice of a claim should be provided within 180 days from the date of the Covered Loss.

The **Payment of Benefits** provision in the **Claim Provisions** section of the certificate is amended so that benefits for which we are liable will be paid within 30 days after receipt of Written Proof of Loss.

A **Payment of Interest** provision is added to the **Claim Provisions** section of the certificate to read as follows:

Any benefit payment issued after 30 days from the date we receive satisfactory proof will accrue simple interest on the net benefit amount at the rate of 10 percent per year. Interest will accrue beginning on the 31st day and ending on the date we make the payment.

The **Overpayment of Claims** provision in the **Claim Provision** section of the certificate is amended by limiting the right to recover overpayments to 12 months from the date of payment. This provision is amended to read as follows:

We have the right to recover any overpayments for up to 12 months due to:
- Fraud;
- Misstatement of Information; or
- any error we make in processing a claim.

The 12 months we have to recover overpayments will begin:
- for Fraud, on the date the Department of Insurance (DOI) determines insufficient evidence of Fraud exists. If we suspect a claim is overpaid as the result of Fraud, we will report the activity and evidence to the DOI;
- for reasons other than Fraud, including error, omissions, misstatement, misrepresentation, or concealment of information, on the date we have actual knowledge of the invalid claim, overpayment, or other incorrect payment. We will not request reimbursement of an unpaid claim not the result of fraud more than 24 months from the date of payment, regardless of the date we obtain actual knowledge of the invalid claim, overpayment, or other incorrect information.

We must be reimbursed in full. If it is not possible for you to reimburse us in a lump sum payment, we will develop a reasonable method of repayment. This may include reducing or withholding future payments.

The **Representation in Applications** provision in the **General Provisions** section of the certificate is amended to read as follows:

In the absence of Fraud, any statements made by you will be considered a representation and not a warranty. Such statements will not be used to avoid insurance, reduce benefits, or deny a claim unless they are included in an application in Writing from you.

The **Children** definition in the **Glossary** section of the certificate is amended to read as follows:

Any Child from birth age 26 who is:
- your own natural offspring;
- your Spouse's child;
- your lawfully adopted Child as of the date the Child is placed in your physical custody for the purpose of adoption and must continue unless the placement of the Child is disrupted prior to legal adoption and the Child is removed from placement. Coverage at the time of placement must include the necessary care and treatment of medical conditions existing prior to the date of placement and may not impose a Pre-existing Condition exclusion;
- a foster Child placed with you by an authorized placement agency or by judgment, decree, or other order of any court of competent jurisdiction;
- grandchildren, nieces, and nephews living with you in a regular parent Child relationship that are dependent on you for primary financial support; or
- any other Child residing with you through legal mandate that is dependent on you for financial support.

Coverage for your Child may be continued past age 26 if your Child is incapable of self-sustaining employment due to permanent intellectual or physical incapacity prior to reaching age 26 and is dependent upon you for support and maintenance.

You must submit proof of the Child's incapacity and dependency to us within 120 days of the Child's 26th birthday or we will accept proof within 120 days of the Child's Coverage Eligibility Date that the Child was continuously covered under this or another similar group policy since age 26. Ongoing proof of incapacity and dependency must be provided when requested by us, but not more frequently than once a year.

Your Children may not be Insured as both a Child and an Employee.

Your Children may not be Insured by more than one Employee.

For residents of New Hampshire

The **Contestability** provision in the **Policy Provisions** section of the Policy is amended to remove reference to Fraud. Language has been replaced to read as follows:

However, in the event of non-payment of premium by the Insured or the Policyholder, we can take action at any time under the provision titled Cancellation or Modification of this Policy by Us and as permitted by applicable law.

The *Condition Definition* for **Infectious Disease**, a Covered Condition found under **Supplemental Critical Illnesses** in the **Critical Illness Details** section of the certificate, is amended for the number of days an Insured must be confined to a Hospital to read 7 or more consecutive days.

The *Date of Diagnosis* for **Occupational Human Immunodeficiency Virus (HIV) or Hepatitis**, a Covered Condition found under **Supplemental Critical Illnesses** in the **Critical Illness Details** section of the certificate, is amended for time periods to read as follows:
- an initial confirmatory antibody test is taken within 23 days of the Covered Accident and is negative for the presence of HIV or Hepatitis B, C, or D; and
- a follow-up confirmatory antibody test is taken between 180 and 270 days from the date of the initial confirmatory antibody test and is positive for HIV or Hepatitis B, C, or D.

The **Exclusions** provision in the **Critical Illness Details | Exclusions and** Limitations section of the certificate is amended to read as follows:

We will not pay benefits for any Covered Loss that is caused by, contributed to by, or occurs as a result of any of the following:
- participation in a felony;
- being engaged in an illegal occupation;
- injuring oneself intentionally or attempting or committing suicide, whether sane or not;
- active participation in a riot or insurrection. This does not include civil commotion or disorder, Injury as an innocent bystander, or Injury for self-defense;
- war or any act of war, whether declared or undeclared;
- combat or training for combat while serving in the National Guard or the armed forces of any nation, state, authority, or organization;

- voluntary use of or treatment for voluntary use of any prescription or non-prescription drug, poison, fume, or other chemical substance or controlled substance unless taken as directed by the manufacturer, or as prescribed or directed by the Insured's Physician.

Additionally, no benefits will be paid for a Covered Loss that occurs prior to the Coverage Effective Date.

The **Pre-existing** Condition provision in the **Critical Illness Details** section of the certificate is amended so that the number of months prior to the Insured's Coverage Effective Date referenced in that section is no more than 6 months. The number of months after the Insured's Coverage Effective Date referenced in that section is no more than 6 months. Pre-existing Condition requirements are not applicable to congenital anomalies of a Child.

The **Payment of Benefits** provision in the **Claim Provisions** section of the certificate is amended to read as follows:

Payment of Benefits
Benefits for which we are liable will be paid within 30 days after we receive written Proof of Loss. All benefits will be paid to you, unless otherwise noted or unless we receive Written authorization to pay them elsewhere. This is an assignment of benefits, refer to the Assignment provision in the General Provisions section of this certificate.

In the event of your death, any unpaid benefits will be paid to your beneficiary in accordance with the Beneficiary Designation and Change provision.

In the event of your Spouse's death, should your Spouse have survived you and continued coverage, any unpaid benefits for your Spouse, will be paid to your surviving Spouse's beneficiary in accordance with the Beneficiary Designation and Change provision.

The **Assignment** provision in the **General Provisions** section of the certificate is amended to reflect that in no event may an Insured's assignee be a healthcare provider.

The **Contestability** provision in the **General Provisions** section f the certificate is amended to remove reference to Fraud. The last sentence has been replaced to read as follows:

However, in the event of non-payment of an Insured's premium, we can take action at any time under the provision titled Canncellation or Modification to the Policy and this Certificate of Coverage as permitted by applicable law.

If your certificate includes coverage for your Child to be continued past the age limit for Child coverage that would otherwise apply, the language specific to this coverage in the **Children or Child** definition in the **Glossary** section of the certificate is replaced as follows:

Coverage for your Child may be continued past age 26 if your Child is incapable of self-sustaining employment due to intellectual or physical incapacity prior to reaching age 26 and is dependent upon you for support and maintenance.

You must submit proof of the Child's incapacity and dependency to us within 120 days of the Child's 26th birthday or we will accept proof within 120 days of the Child's Coverage Eligibility Date that the Child was continuously covered under this or another similar group policy since age 26. Ongoing proof of incapacity and dependency must be provided when requested by us, but not more frequently than once a year.

The **Covered Accident** definition in the **Glossary** section of the certificate is amended to read as follows:

An unintended or unforeseen bodily Injury sustained by an Insured, wholly independent of disease, bodily infirmity, or illness and which:
- occurs on or after the Coverage Effective Date; and
- occurs while coverage is in force.

The **Injury** definition in the **Glossary** section of the certificate is amended to read "Any damage or harm to the body."

The **Nurse** definition in the **Glossary** section of the certificate is amended to read as follows:

A healthcare professional trained to care for people with Injuries or Sicknesses. A Nurse may include an Advanced Practice Registered Nurse, a graduate Registered Nurse (R.N.), Licensed Practical Nurse (L.P.N.), or Licensed Vocational Nurse (L.V.N.).

We will not recognize you, your Spouse, Children, parents, siblings, a business or professional partner, or any person who has a financial affiliation or business interest with you, as a Nurse for a claim that you send to us.

The **Be Well Benefit** is called the **Health Screening Benefit**.

For residents of Ohio

The **Payment of Benefits** provision in the **Claim Provisions** section of the certificate is amended to read as follows:

Payment of Benefits
Benefits for which we are liable will be paid immediately after we have received Written Proof of Loss. All benefits will be paid to you[, unless otherwise noted or unless we receive Written authorization to pay them elsewhere. This is an assignment of benefits, refer to the Assignment provision in the General Provisions section of this certificate.

In the event of your death, any unpaid benefits will be paid to your beneficiary in accordance with the Beneficiary Designation and Change provision.

In the event of your Spouse's death, should your Spouse have survived you and continued coverage, any unpaid benefits for your Spouse, will be paid to your surviving Spouse's beneficiary in accordance with the Beneficiary Designation and Change provision.

For residents of South Carolina

The **Autopsy** provision in the **Claim Provisions** section of the certificate is amended so that when we request an Autopsy it will be at our expense.

The **Legal Actions** provision in the **Claim Provisions** section of the certificate is amended to read as follows:

If you or your authorized representative disagree with our decision, you or your authorized representative can start Legal Action regarding your claim 60 days after Proof of Loss has been given to us and up to six years from the latest of when:
- original Proof of Loss was first required to have been given to us;
- your claim was denied; or
- your benefits were terminated,

Unless applicable law requires us to afford a longer period within which to bring Legal Action.

For residents of South Dakota

The **Exclusions** provision in the **Critical Illness Details | Exclusions and Limitations** section of the certificate is amended so that any exclusions for any Covered Loss that is caused by, contributed to by, or occurrs as a result of:

- voluntary use of or treatment for voluntary use of any prescription or non-prescription drug, poison, fume, or other chemical or controlled substance unless taken as directed by the manufacturer, or as prescribed or directed by the Insured's Physician;
- being intoxicated;

are removed.

The **Pre-existing Condition** provision in the **Critical Illness Details | Exclusions and Limitations** section of the certificate is amended so that the number of months just prior to the Insured's Coverage Effective Date referenced in that section is no more than 6 months.

The **Physician** definition in the **Glossary** section of the certificate is amended to read as follows:

A person performing tasks that are within the limits of his or her medical license and is also:
- a legally qualified medical practitioner according to the laws and regulations of the governing jurisdiction;
- licensed to practice medicine, prescribe and administer drugs, or to perform surgery; or
- a person with a doctoral degree in Psychology (Ph.D. or Psy.D.) whose primary practice is treating patients.

We will not recognize you, your Spouse, children, parents, siblings, a past or present business or professional partner, or any person who has a financial affiliation or business interest with you, as a Physician for a claim that you send to us. This exclusion does not apply in those areas in which the above mentioned person is the only Physician in the area and acting within the scope of their normal employment.

For residents of Texas

The **Pre-existing Condition** provision in the **Critical Illness Details | Exclusions and Limitations** section of the certificate is amended to read as follows:

We will not pay benefits for a claim when the Covered Loss occurs in the first 12 months following an Insured's Coverage Effective Date if the Covered Loss is caused by, contributed to by, or occurs as a result of any of the following:
- a Pre-existing Condition; or
- complications arising from treatment or surgery for a Pre-existing Condition.

An Insured has a Pre-existing Condition if, within the 12 months just prior to their Coverage Effective Date, they have an Injury or Sickness, whether diagnosed or not, for which medical treatment or care were received or recommended to be received during that period.

Pre-existing Condition requirements are not applicable to:
- Children who are newly acquired after your Coverage Effective Date; and
- any coverage applied for when an Insured is first eligible to enroll.

The Pre-existing Condition provision applies to any Insured's initial coverage and any increases in coverage. Coverage Effective Date refers to the date any initial coverage or increases in coverage become effective.

An **Extension of Benefits** provision in the **Start of Coverage** section of the certificate is added to read as follows:

If coverage under this certificate ends while an Insured is disabled, the Insured's Group Critical Illness coverage may be continued, subject to the payment of premium, for up to the earliest of:
- the date the Insured is no longer disabled; or
- the date the Insured is covered for Group Critical Illness through another Employer.

Coverage ending will have no effect on benefits that would have otherwise been payable if this certificate had remained in force.

The **Payment of Benefits** provision in the **Claim Provisions** section of the certificate is amended to read as follows:

Payment of Benefits
Benefits for which we are liable will be paid within 60 days after we receive Written Proof of Loss. All benefits will be paid to you or to your assignee, refer to the Assignment provision in the General Provisions section of this certificate. Benefits for Children who are receiving financial and medical benefits through the Texas Health and Human Services Commission will be paid to the Texas Health and Human Services Commission whenever:
- the Texas Health and Human Services Commission is paying benefits pursuant to Chapters 31 and 32 of the Human Resources Code, i.e., financial and medical assistance service programs administered pursuant to the Human Resources Code;

- the parent who is covered by this certificate has possession or access to the Child pursuant to a court order, or is not entitled to access or possession of the Child and is required by the court to pay child support; and
- we are notified at the time of claim that the Child is receiving financial and medical assistance.

In addition, benefits for Children may also be paid to a possessory or managing conservator of the Child if the appointment for that Child was issued by a court in this or another state.

In the event of your death, any unpaid benefits will be paid to your beneficiary in accordance with the Beneficiary Designation and Change provision or, if required, to the Texas Health and Human Services Commission.

In the event of your Spouse's death, should your Spouse have survived you and continued coverage, any unpaid benefits for your Spouse, will be paid to your surviving Spouse's beneficiary in accordance with the Beneficiary Designation and Change provision.

The **Representation in Applications** provision in the **General Provisions** section of the certificate is amended to read as follows:

In the absence of Fraud, any statements made by you will be considered a representation and not a warranty. The validity of this certificate may not be contested after it has been in force for two years after its date of issue. A statement made by you may not be used in contesting the validity of the insurance with respect to which the statement was made:
- after the insurance has been in force before the contest for two years during your lifetime; and
- unless the statement is contained in an application or is contained in a written instrument signed by you, and a copy of the signed application or written instrument containing the statement has been provided to you. If the statement was made by you and you have become incapacitated or died, a copy of the signed application or written instrument containing the statement will be provided to your beneficiary or your authorized representative.

The **Assignment** provision in the **General Provisions** section of the certificate is amended to read as follows.

An Assignment transfers all benefits payable under this certificate to someone else, known as an "assignee." We will recognize your assignee(s) under this certificate if:
- the Written form has been signed by you and the assignee and the Assignment in its Written form is acceptable to us; and
- in our discretion, we may reject and have no obligation under an Assignment unless a signed or certified copy of the Written Assignment has been received and recorded by us.

You may assign benefits payable under this certificate to a healthcare provider for which such benefits are payable.

An Assignment will take effect on the date you sign the Assignment. However, if we have taken any action or made any payment before we receive a notice of the Assignment, that Assignment will not go into effect for those actions taken or payments made prior to our receipt of the notice of Assignment. Unless stated otherwise in, or allowed by the Assignment, the assignment does not change a beneficiary designation.

You are responsible for assuring the validity of any assignment.

The **Children** definition in the **Glossary** section of the certificate is amended to read as follows:

Any Child from live birth to age 26 who is:
- your own natural offspring;
- your Spouse's Child;
- your lawfully adopted Child once a petition is filed for you to adopt the child;
- a foster child placed with you by an authorized placement agency or by judgment, decree, or other order of any court of competent jurisdiction;
- grandchildren;
- any other child residing with you through legal mandate; or
- any other child for whom you are required to insure under a medical support order issued under Chapter 154, Family Code, or enforceable by a court in this state.

Coverage for your Child may be continued past age 26 if your Child is incapable of self-sustaining employment due to permanent intellectual or physical incapacity prior to reaching age 26 and is dependent upon you for support and maintenance.

You must submit proof of the Child's incapacity and dependency to us within 120 days of the Child's 26th birthday or we will accept proof within 120 days of the Child's Coverage Eligibility Date that the Child was continuously covered under this or another similar group policy since age 26. Ongoing proof of incapacity and dependency must be provided when requested by us, but not more frequently than once a year.

Your Children may not be insured as both a Child and an Employee.

Your Children may not be insured by more than one Employee.

The **Total Disability or Totally Disabled** definition in the **Glossary** section of the certificate is amended to read as follows:

The Insured is Totally Disabled when, as a result of a Covered Loss, the Insured is unable to perform with reasonable continuity the Material and Substantial Duties necessary to pursue the Insured's Regular Occupation. The Insured is Totally Disabled when they are Confined in a Hospital for treatment of a Critical Illness.

For residents of Utah

The **Exclusions** provision in the **Critical Illness Details | Exclusions and Limitations** section of the certificate is amended by providing that any exclusion for any Covered Loss that is caused by, contributed to by, or occurs as a result of committing or attempting to commit a felony; being engaged in an illegal occupation or activity; or active participation in a riot, insurrection, or terrorist activity is applied only if you were a voluntary participant.

The **Exclusions** provision in the **Critical Illness Details | Exclusions and Limitations** section of the certificate for the "being Intoxicated" exclusion is amended to read as follows:

- being Intoxicated in violation of a law. For purposes of this exclusion, "intoxicated" means the insured's blood alcohol level met or exceeded the level that creates a legal presumption of intoxication under the laws of the jurisdiction in which the incident occurred.

The **Pre-existing Condition** provision in the **Critical Illness Details | Exclusions and Limitations** section of the certificate is amended so that the number of months just prior to the Insured's Coverage Effective Date and following the Insured's Coverage Effective Date referenced in that section is no more than 6 months.

The **End of Coverage** provision in the **End of Coverage** section *For your Children* of the certificate is amended to read as follows:

Your Children's coverage will end on the earliest of:
- the date your coverage under this certificate ends;
- the end of the month in which your Children are no longer eligible for coverage; or
- the end of the month in which your Children no longer meet the definition of Children.

The **Children** definition in the **Glossary** section of the certificate is amended to read as follows:

Any Child from the moment of birth to the end of the month in which they reach age 26 who is:
- your own natural offspring;
- your Spouse's child;
- your lawfully adopted Child as of the earliest of the date:
  - the child is placed in your care or in a medical facility. If placement for adoption occurs within 30 days of the child's birth, coverage begins from the moment of birth. If placement for adoption occurs 30 days or more after the child's birth, coverage begins from the date of placement;
  - a petition is filed for you to adopt the child; or
  - an adoption agreement, signed by you that includes your binding obligation to assume financial responsibility for the child;

- a foster child placed with you by an authorized placement agency or by judgment, decree, or other order of any court of competent jurisdiction;
- grandchildren, nieces, and nephews living with you in a regular parent child relationship that are dependent on you for primary financial support; or
- any other child for whom you are required by court or administrative order to provide coverage for.

Coverage for your Child may be continued past the end of the month in which they reach age 26 if your Child is incapable of self-sustaining employment due to permanent intellectual or physical incapacity prior to reaching age 26 and is dependent upon you for support and maintenance.

You must submit proof of the Child's incapacity and dependency to us within 120 days of the Child's 26th birthday or we will accept proof within 120 days of the Child's Coverage Eligibility Date that the Child was continuously covered under this or another similar group policy since age 26. Ongoing proof of incapacity and dependency must be provided when requested by us, but not more frequently than once a year.

Your Children may not be Insured as both a Child and an Employee.

Your Children may not be Insured by more than one Employee.

The **Hospital** definition in the **Glossary** section of the certificate is amended to read as follows:

An institution licensed as a hospital and operating within the scope of its license and provides medically necessary hospital confinement or treatment for sick or injured people.

For purposes of this certificate, the following hospital units meet the Glossary definition of Hospital:
- Hospital Subacute ICU;
- Progressive Care Unit;
- Intermediate Care Unit; and
- Step-Down Unit.

For purposes of this certificate, the following do not meet the Glossary definition of Hospital:
- a nursing home, a rest home, home for the aged, or an assisted living facility;
- a Hospice care facility;
- a Subacute Rehabilitation Unit or Rehabilitation Unit;
- a psychiatric unit or facility for the treatment of Mental or Nervous Disorders; and
- a facility for the treatment of Substance Abuse.

The **Nurse** definition in the **Glossary** section of the certificate is amended to be defined as a healthcare professional trained, duly licensed, and operating within the scope of their license to care for people with Injuries or Sicknesses.

The **Pathological Diagnosis** definition in the **Glossary** section of the certificate is amended to read as follows:

A diagnosis made by a Physician based on a microscopic study of fixed tissue or preparations from the hemic (blood) system. This type of malignancy diagnosis must be in accordance with the standards set up by the American Board of Pathology.

The **Physician** definition in the **Glossary** section of the certificate is amended to read as follows:

A person performing tasks that are within the limits of his or her medical license.

We will not recognize you, your Spouse, children, parents, siblings, a past or present business or professional partner, or any person who has a financial affiliation or business interest with you, as a Physician for a claim that you send to us.

For residents of Vermont

The minimum hours requirement of the **Eligible Groups** provision in the **Critical Illness Highlights** section of the certificate is amended to cover eligible employees working at least 17.5 hours per week.

The **Exclusions** provision in the **Critical Illness Details | Exclusions and Limitations** section of the certificate is amended by providing that any exclusion for any Covered Loss that is caused by, contributed to by, or occurs as a result of oneself intentionally or attempting or committing suicide, whether sane or not is applied only if you were sane when the event occurred.

The **Exclusions** provision in the **Critical Illness Details | Exclusions and Limitations** section of the certificate is amended so that any exclusions for any Covered Loss that is caused by, contributed to by, or occurs as a result of:

- voluntary use of or treatment for voluntary use of any prescription or non-prescription drug, poison, fume, or other chemical or controlled substance unless taken as directed by the manufacturer, or as prescribed or directed by the Insured's Physician; and
- being intoxicated;

are removed.

The **Autopsy** provision in the **Claim Provisions** section of the certificate is amended so that when we request an Autopsy where it is allowed by law, and not prohibited by the Insured's religion, it will be at our expense.

The **Fraud** provision in the **General Provisions** section of the certificate is amended to read as follows:

We want to make sure you and your Employer do not incur additional insurance costs as a result of the effects of insurance fraud. We promise to focus on all means necessary to support fraud detection, investigation, and prosecution.

Anyone who knowingly, and with intent to injure, defraud, or deceive us may be guilty of Fraud as determined by a court of law. This includes filing a claim or providing information that contains any false, incomplete, or misleading information.

We will pursue all appropriate legal remedies in the event of insurance fraud.

The **Covered Accident** definition in the **Glossary** section of the certificate is amended to read as follows:

A bodily Injury sustained by an Insured, which is the direct cause of the loss, independent of disease or bodily infirmity and which:
- occurs on or after the Coverage Effective Date;
- occurs while coverage is in force; and
- is not excluded by name or specific description in this certificate.

The **Hospital** definition in the **Glossary** section of the certificate is amended to remove the following criteria from what does not meet the Glossary definition of Hospital:

- a psychiatric unit or facility for the treatment of Mental or Nervous Disorders; and
- a facility for the treatment of Substance Abuse.

For residents of Wisconsin

A **Grievance Procedure** provision is added to the **Claim Provisions** section of the certificate to read as follows.

Once you have received a decision on your claim or notice of coverage termination you have the right to submit a Written Grievance. Within five business days of receiving your Grievance, we will deliver or deposit in the mail to you or your authorized representative a Written acknowledgement confirming receipt of your Grievance. We will promptly investigate your Grievance.

If a Grievance is filed by you or on your behalf, you or your authorized representative have the right to appear in person before a Grievance panel to present Written or oral information. Prior to appearing before the Grievance panel, you or your authorized representative may submit written questions to the person(s) responsible for making the decision on your claim or to terminate your coverage.

We will provide you or your authorized representative with Written notification of the time and place of any Grievance panel meeting at least seven calendar days before the meeting and will make reasonable accommodations to allow you or your authorized representative to participate in the meeting.

The Grievance panel will consist of at least one person authorized to take corrective action on your Grievance, and, to the extent reasonably possible, at least one insured other than you who is not an Employee of the plan. The panel will not include the person who made the initial decision. Provided the panel consists of at least three persons, it may then include no more than one subordinate of the person who made the initial decision on your claim. Additionally, the panel may consult with the decision-maker and, if appropriate, a licensed health care provider with expertise in the field relating to your Grievance.

We will provide you and your authorized representative with Written notification of the disposition of your Grievance and any corrective action taken on your Grievance within 30 days of our receipt of your Grievance. Such notification will be signed by one voting member of the panel and will include a Written description of position titles of panel members involved in making the decision. If we are unable to resolve your Grievance within 30 calendar days, we may extend the time period by an additional 30 calendar days. If such an extension is needed, we will provide you and your authorized representative with Written notification which will include the reason additional time is needed and when resolution of your Grievance may be expected.

After the Grievance procedure is concluded, you may have a right to an independent review of any determination by us that the treatment provided does not meet the policy's requirements for medical necessity, appropriateness, health care setting, level of care or effectiveness. You must request an independent review within four months after you receive notification of the disposition of your Grievance. You may request the review by providing Written notice to us of your request for the independent review and the independent review organization selected by you to conduct the review. Upon your request, we will provide you a copy of the listing of certified independent review organizations, or you may request the listing from the Commissioner of Insurance for the State of Wisconsin.

A **Grievance** definition is added to the **Glossary** section of the certificate to read as follows.

Any dissatisfaction with our provision of services or claim practices that is expressed to us in writing by you or on your behalf. It may include any of the following:

- provision of services;
- determination to reform or rescind a policy;
- determination of a diagnosis or level of service required for evidence-based treatment of autism spectrum disorders; or
- claim practices.

ERISA

Additional Summary Plan Description Information

If the Policy provides benefits under a Plan which is subject to the Employee Retirement Income Security Act of 1974 (ERISA), the following provisions apply. These provisions, together with your Certificate of Coverage, constitute the summary plan description. The summary plan description and the Policy constitute the Plan. Benefit determinations are controlled exclusively by the Policy, your Certificate of Coverage and the information contained in this document.

Name of Plan:
Holley Performance Products Employee Benefits Plan

Name and Address of Employer:
Holley Performance Products Incorporated
2445 Nashville Rd Ste B1
Bowling Green, Kentucky
42101

Plan Identification Number:
a. Employer IRS Identification #: 61-1291482
b. Plan #: 503

Type of Welfare Plan:
Critical Illness

Type of Administration:
The Plan is administered by the Plan Administrator. Benefits are administered by the insurer and provided in accordance with the insurance policy issued to the Plan.

ERISA Plan Year Ends:
December 31

Plan Administrator, Name, Address, and Telephone Number:
Holley Performance Products Incorporated
2445 Nashville Rd Ste B1
Bowling Green, Kentucky
42101
(270) 782-2900

Holley Performance Products Incorporated is the Plan Administrator and named fiduciary of the Plan, with authority to delegate its duties. The Plan Administrator may designate Trustees of the Plan, in which case the Administrator will advise you separately of the name, title and address of each Trustee.

Agent for Service of Legal Process on the Plan:
Holley Performance Products Incorporated
2445 Nashville Rd Ste B1
Bowling Green, Kentucky
42101

Service of legal process may also be made upon the Plan Administrator, or a Trustee of the Plan, if any.

Funding and Contributions:
The Plan is funded by insurance issued by Unum Insurance Company, 2211 Congress Street, Portland, Maine 04122, under 987176 011. Contributions to the Plan are made as stated under Paying for Coverage in the Certificate of Coverage.

Employer's Right to Amend the Plan
The Employer reserves the right, in its sole and absolute discretion, to amend, modify, or terminate, in whole or in part, any or all of the provisions of the Plan (including any related documents and underlying

policies), at any time and for any reason or no reason. Any amendment, modification, or termination must be in Writing and endorsed on or attached to the Plan.

Employer's Right to Request Policy Change

The Employer can request a Policy change. A change to the Policy will be made valid once approved by one of our officers. The change must be in Writing and endorsed on or attached to the Policy.

Cancellation of the Policy by the Employer

The Employer may cancel the Policy by providing us Written notice. In any event of cancellation, coverage will continue through the end of the day the cancellation takes effect.

A cancellation of the Policy will not affect a Payable Claim.

Cancellation or Modification of the Policy by Us

In addition, we may cancel or modify the Policy if the Policy terms are not met, the Employer fails to satisfy its obligations, premium is not paid, a change in the Employer or in the law impacts the benefits payable or the risks insured or, depending on the Policy, at our election after any rate guarantee period.

In any event, we will provide Written notice to the Employer prior to any cancellation or modification date. The Employer may cancel the Policy if it chooses not to accept the Policy modifications made by us.

A cancellation of the Policy will not affect a Payable Claim.

Your Rights Under ERISA

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

Receive Information About Your Plan and Benefits

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

Obtain, upon Written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The Plan Administrator may make a reasonable charge for the copies.

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

Prudent Actions by Plan Fiduciaries

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

Enforce Your Rights

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

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of Plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator.

If you have a claim for benefits that is denied or ignored, in whole or in part, you may file suit in a state or federal court. If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated

against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, if, for example, it finds your claim is frivolous.

Assistance with Your Questions

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

Privacy Notice

This Privacy Notice applies to Unum Group's United States insurance operations and is being provided on behalf of its affiliates listed below ("Unum" "we"), as required by the Gramm-Leach Bliley Act and state insurance laws. This Notice describes how we collect, share, and protect nonpublic personal information (NPI).

COLLECTING INFORMATION
We collect NPI about our customers to provide them with insurance products and services, perform underwriting, provide stop loss coverage, and administer claims. The types of NPI we collect for these purposes may include telephone number, address, Social Security number, date of birth, occupation, income, and medical history, including treatment. We may receive NPI from your applications and forms, medical providers, other insurers, employers, insurance support organizations and service providers.

SHARING INFORMATION
We share the types of NPI described above primarily with people who perform insurance, business and professional services for us, such as helping us perform underwriting, provide stop loss coverage, pay claims, detect fraud, and to provide reinsurance or auditing. We may share NPI with medical providers for insurance and treatment purposes and with insurance support organizations. The organizations may retain the NPI and disclose it to others for whom it performs services. In certain cases, we may share NPI with group policyholders for reporting and auditing purposes, with parties for a proposed or final sale of insurance business or for study purposes. We may also share NPI when otherwise required or permitted by law, such as sharing with governmental or other legal authorities. When legally necessary, we ask your permission before sharing NPI about you. Our practices apply to our former, current and future customers.

We do not share your health NPI to market any product or service. We also do not share any NPI to market non-financial products and services.

The law allows us to share NPI as described above (except health information) with affiliates to market financial products and services. The law does not allow you to restrict these disclosures. We may also share with companies that help us market our insurance products and services, such as vendors that provide mailing services to us. We may share with other financial institutions to jointly market financial products and services. When required by law, we ask your permission before we share NPI for marketing purposes.

When other companies help us conduct business, we expect them to follow applicable privacy laws. We do not authorize them to use or share NPI except when necessary to conduct the work they are performing for us or to meet regulatory or other governmental requirements.

Unum companies, including insurers and insurance service providers, may share NPI about you with each other. The NPI might not be directly related to our transaction or experience with you. It may include financial or other personal information such as employment history. Consistent with the Fair Credit Reporting Act, we ask your permission before sharing NPI that is not directly related to our transaction or experience with you.

SAFEGUARDING INFORMATION
We have physical, electronic and procedural safeguards that protect the confidentiality and security of NPI. We give access only to employees who need to know the NPI to provide insurance products or services to you.

ACCESS TO INFORMATION
You may request access to certain NPI we collect to provide you with insurance products and services. You must make your request in writing, providing your full name, address, telephone number and policy number, to the address below. We will reply within 30 business days of receipt. If you request, we will send copies of the NPI to you or make available to you at our office. If the NPI includes health information, we may provide the health information to you through a health care provider you designate. We will also send you information related to disclosures. We may charge a reasonable fee to cover our copying costs.

This section applies to NPI we collect to provide you with coverage. It does not apply to NPI we collect in anticipation of a claim or civil or criminal proceeding.

CORRECTION OF INFORMATION
If you believe the NPI we have about you is incorrect, please write to us and include your full name, address, telephone number and policy number if we have issued a policy, and the reason you believe the NPI is inaccurate. We will reply within 30 business days of receipt. If we agree with you, we will correct the NPI and

notify you and insurance support organizations that may have received NPI from us in the preceding 7 years. We will also, if you ask, notify any person who may have received the incorrect NPI from us in the past 2 years.

If we disagree with you, we will tell you we are not going to make the correction and the reason(s) for our refusal. We will also tell you that you may submit a statement to us. Your statement should include the NPI you believe is correct and the reason(s) why you disagree with our decision not to correct the NPI in our files. We will file your statement with the disputed NPI to be accessible. We will include your statement any time the disputed NPI is reviewed or disclosed. We will also give the statement to insurance support organizations that gave us NPI and to any person designated by you, if we disclosed the disputed NPI to that person in the past two years.

COVERAGE DECISIONS
If we decide not to issue coverage to you, we will provide you with the specific reason(s) for our decision. We will also tell you how to access and correct certain NPI. You may submit a written request for the reason(s) for our decision within 90 business days of our decision. We will reply within 21 business days of receipt with the specific reasons, if not initially furnished, and specific items of information that supported our decision.

CONTACTING US
For additional information about Unum's commitment to privacy and to view a copy of our HIPAA Privacy Notice, please visit: unum.com/privacy or coloniallife.com. You may also write to: Privacy Officer, Unum, 2211 Congress Street, B267, Portland, Maine 04122 or at Privacy@unum.com.

We reserve the right to modify this notice. We will provide you with a new notice if we make material changes to our privacy practices.

Unum is providing this notice to you on behalf of the following insuring companies: Unum Life Insurance Company of America, Unum Insurance Company, First Unum Life Insurance Company, Provident Life and Accident Insurance Company, Provident Life and Casualty Insurance Company, Colonial Life & Accident Insurance Company, The Paul Revere Life Insurance Company and Starmount Life Insurance Company.

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